“Am I doing it right?”: a discursive analysis of cancer narratives

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“Am I doing it right?”:
A Discursive Analysis of Cancer Narratives

by
Rosemary Chapman

A Doctoral Thesis
Submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy of Loughborough University

December, 2001

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Dedication

This thesis began because Charles Cohen, one of my dearest and finest friends, received a terminal cancer diagnosis. In the time he had left to live we shared a lot about what we both felt about cancer. One of the most poignant things he said to me was “Am I doing it right?”

We talked openly and endlessly about his illness and coping with life. We became acutely aware of the expectations of the medical profession and of the difficulties all of us, including Charles, his friends and family had in talking to him; knowing what to say, how to give him the support he needed, when he needed it, and knowing when to step back when he did not. We all wanted to help in whatever way we could to support him in living life to the full, for each and every moment.

When he asked John, our mutual friend and me to ‘take care of his death and be there for him at the end’, we both said yes, but I had no way of knowing what I was about to embark upon. This experience was both extremely painful and full of wonderful moments that have enriched my life and it was certainly a momentous life-changing event for me. Before he died on 12 March 1994, Charles made me promise to try to increase awareness of the problems we had all experienced. Fulfilling this promise is the motivation and driving force for my thesis. I hope it helps anyone who finds themselves in a similar situation, and provides an understanding of the difficulties that are usually not talked about.

Soon after I moved to Loughborough from London to begin my studying, my only brother Mike King was also diagnosed with terminal cancer. Mike was a quiet and private man who found it difficult to talk about his illness but he told me that he could trust and talk to me because he felt, because of Charles, I was able to understand some of what he was going through. The loss and sadness of Charles’ death enabled Mike and I to share a special closeness and trust which I am eternally thankful for. This was both a gift from Charles and a gift from Mike. We talked for hours sharing memories of our past lives, our present and the future. I was with Mike when he died on 7 November 1997.

This thesis is dedicated to you Charles, my most treasured friend in life and in death and to you Mike, my dearest and beloved brother. You have both taught me so much and I miss you so. Bless you.
Acknowledgements

Firstly, my very special thanks go to all the people who participated in the interviews. I am indebted to you all. Thank you for your trust in me and for telling me your wonderful stories without which this thesis would not have been possible.

I am grateful to the Economic and Social Research Council for providing the funding to enable me to carry out my research. Throughout the years of writing this thesis, I have received support and guidance from countless academics and friends and I thank you all. Thank you Charles Antaki and Celia Kitzinger for your encouragement and supervision in the early stages of my research.

I am extremely grateful to Derek Edwards whose passion for language and inspirational supervision throughout has taught me so much. Thank you too Derek for ‘being patient’ and ‘being positive’!

One of the benefits of being at Loughborough is the privilege of being able to be a member of the Discourse and Rhetoric Group (DARG). I would like to thank past and present members for providing a stimulating and challenging environment to discuss and explore ideas. The Social Sciences Department at Loughborough University is a unique combination of people who I have had the privilege to get to know over the years. I would like to say thank you to all of you who have shown an interest in my work, particularly Mick Billig, Jonathan Potter and Alan Radley. I have also been lucky to have found some very special friendships along the way too, so thank you Jackie Abell, Abi Locke, Sharon Lockyer, Deirdre Lombard, Ann Smith, Mary Horton-Salway and Sally Wiggins for your friendship, encouragement and support, and making what at times seemed a daunting task such a valuable and enjoyable experience.

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Abstract

This thesis explores the difficulties of talking about cancer. Conversational interviews with 17 people diagnosed with cancer are analysed from the perspective of discursive psychology which treats accounts and the description of events as discourse practices and categories. Cancer is considered a mysterious and frightening disease associated with myths and taboos. It is a sensitive topic and talking about it can be a delicate and difficult thing to do for all concerned. If a person with cancer (PWC) is not seen or heard to be 'being positive' or 'adopting a fighting spirit', they could be left with a sense of blame, guilt or failure. It is proposed that not only do they have to contend with managing to live with a life threatening illness but the metaphorical descriptions attributed to cancer, the 'heroic model' and its accompanying discourses and expectations construct the ill person as being morally accountable. Narrative themes of discovery, diagnosis, doctors and delay, social relationships, the indignities of treatment and talk of death and dying are analysed. The analysis reveals some of the problems and interactional difficulties that participants have to manage, and it considers some of the dilemmas and problems produced in cancer narratives and how discursive practices, such as laughter, are displayed. It considers the way participants discursively construct notions such as 'doing being responsible, 'complaining and blaming' and 'doing being positive' and it reveals how participants' concerns of identity and moral accountability are rhetorically accomplished and managed. The findings of this thesis emphasise how PWC work to maintain the identity of someone who is bearing their illness 'patiently', without complaining and are seen to be a 'good patient'. The analysis reveals that participants construct their identity as someone who is being positive and that they not only have to manage the interactional problems that their illness poses for others and their inadequacies to cope with people with cancer, but additionally they have to manage the moral restrictions on not being able to admit that they are not coping. It is suggested that an increased awareness of the psychological burdens and interactional difficulties people with cancer report in their accounts can contribute to a better understanding of what and how people with cancer manage these additional burdens in their social lives.
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Chapter 1
Introduction: ‘Being patient’

This first chapter introduces the motivation and evolution of the final analysis and presents an overview of the contents of the thesis.

My topic of research emerged from personal experience that began some years ago when my closest friend Charles was diagnosed with cancer and I discovered how difficult it became for us to talk about his illness. Sometime after he was given a terminal diagnosis, in one of the many conversations we had talking about doctors, life, death and dying and how to cope, he asked me “Am I doing it right?” implying that there was a ‘right’ or a ‘wrong’ way to have cancer. At the time, I found the moral expectations and burden of this question staggering. This question, then and since, has had a profound effect on me and it was the catalyst for my research. From my personal experience of being close to family and friends with a life threatening illness and through my subsequent interviews, I discovered our experiences were not unique. I have heard countless stories revealing a diversity of problems and moral dilemmas. Accompanying this experience was the discovery that talking about cancer, whether it was with the medical profession, family or friends, was full of difficulties for all concerned. The recognition of these difficulties with such a highly charged and sensitive topic is the starting point of this thesis.

Once a person is diagnosed with an illness, the medical profession refers to them as a ‘patient’. Under the influence of the reductionist medical model, a ‘patient’ is diminished to being an object and an individual’s agency is limited to compliance. The medical professional becomes the active agent in the illness process and the patients’ experience of the illness itself is cast off (Frank, 1997).

A discussion with Derek Edwards, my supervisor, about my reticence to refer to my participants as ‘patients’ prompted us to look in the Oxford English Dictionary
to review the meaning of the word. The essence of the definitions given construct not only what labelling someone as a patient is, a sufferer, but how they are expected to be, someone who suffers patiently. Throughout my analysis participants display both their resistance and acceptance of being labelled as a patient which denotes that they should bear or endure pain, affliction, trouble or evil of any kind with composure, without discontent or complaint, and exercise or possess patience. I have found these definitions somewhat contradictory in that in reviewing the literature and listening to my participants' accounts, the loss of agency, passivity and compliance of 'being a patient' is only deemed appropriate in the medical encounter. In contrast, outside the confines of the medical institution, the patient is expected to play an active role in their recovery and is held morally accountable for doing so. The notion of this passive/active stance is full of contradictions and dilemmas and as my analysis reveals, it becomes a participants' concern.

Consequently, I have chosen to resist using the category of 'patient' throughout my own analysis. Instead I refer to my participants as people (or persons) with cancer (PWC) thus giving them the agency and recognition of being actively involved in their illness, in stark contrast to the passivity of being a patient, which is how they are normatively expected to manage their illness. I also refer to participants' 'narrative accounts' or 'stories' of living with a cancer diagnosis rather than talk about the 'experience of cancer' or 'the illness experience'. These two choices were made because the definition of patient itself dis-empowers and objectifies the person who is ill and the word 'experience' is too

\[\text{Patient - A. Adj. 1. a. Bearing or enduring (pain, affliction, trouble, or evil of any kind) with composure, without discontent or complaint; having the quality or capacity of so bearing; exercising or possessing patience.}\\ b. Longsuffering, forbearing; with to, towards, lenient towards, bearing with (others, their infirmities, etc.)\\ c. Calmly expectant; not hasty or impetuous; quietly awaiting the course or issue of events etc.\\ d. Continuing or able to continue a course of action without being daunted by difficulties or hindrances; persistent, constant, diligent, unwearied\\ B. n. 1.a. A sufferer; one who suffers patiently. Now rare.\\ 2. One who is under medical treatment for the cure of some disease or wound; one of the sick persons whom a medical man attends; an image of an infirmary or hospital\\ 3. A person subjected to the supervision, care, treatment or correction of some one.\\ 4. A person or thing that undergoes some action, or to whom or which something is done; 'that which receives impressions from external agents' (OED, 1994). (Underlining added for emphasis)\]
broad a term that carries with it multiple conceptual meanings and cultural baggage of what 'experience' is.

When I began my literature review, I found that the volume of research and publishing in the field of health and illness, particularly cancer, was extensive and the choice was infinite. My starting point was to follow the trajectory from the initial medical encounter through diagnosis, treatment, coping strategies and the experience of the illness. Much of this literature, 'the voice of medicine' (Mishler, 1984) was rooted in the positivist paradigm, which views illness from outside the experience of illness itself and minimises or ignores the subjective reality of the suffering. In other words, this 'outsider perspective' (Conrad, 1990) views the 'patient', and the disease or illness as an object or as something to be affected.

I also reviewed the extensive literature on illness narratives and the 'experience of illness', the 'insider' perspective (Conrad) or 'the patient's view', (Armstrong, 1984) which claims to focus directly and explicitly on the subjective experience of living with illness. The chosen methodology consists principally of qualitative analysis of biographical interview material and aims to explore the patients' view of how they adapt to their changing social world.

Social scientists, including anthropologists, medical sociologists, health psychologists and psychosocial oncologists, have proposed and developed a diversity of prescriptive ways of defining how to 'cope with cancer' and what the 'meaning' and 'experience of illness' is for the patient. However, few have considered the problems PWC might encounter or how and what they have to actively manage in social interaction.

I discovered a vast collection of personal published accounts of illness, or illness narratives (e.g. Broyard, 1992; Caine, 1990; Diamond, 1998; DiGiacomo, 1995; Frank, 1991, 1995; Lorde, 1980; Paget, 1993; Picardie, 1999; Rollason, 2000; Tilberis, 1998 and Stacey, 1967) which also have a particular influence, in that they effect how others tell their stories, creating a social rhetoric of illness (Frank, 1995). In addition, television companies regularly produce documentary accounts of people's cancer stories (e.g. Diamond, Rollason, 'Living with Leslie') and
several journalists published accounts in newspapers (Diamond, Harris, Picardie).

I originally thought that these accounts would form part of the data for my thesis, but the authors were writing rather than talking about their illnesses (and narratives do not talk back) while my growing concern was with face-to-face interaction. In the final analysis my own data was so rich that there was insufficient room to include these sources, but I did carry out a preliminary analysis on some of the accounts and found that the concerns they raised and the moral dilemmas they faced, had many similarities with my interview data.

My extensive reading produced many interesting topics that I would like to have explored, both in the literature and my own data. However, in the final analysis, much of this earlier reading was not very relevant to my theoretical approach and analytic topic and consequently much as been left out.

Accounts of cancer always include stories. Many people will not have personally encountered these stories in their lives, but what they serve to highlight is the importance of how everyday conversations, and what we might say to someone with cancer, could be adding to PWC's problems. My analytical interest is in what and how people talk about this culturally taboo topic, and I examine some of the problems and dilemmas a person with cancer might face.

I have chosen the most appropriate method to examine this phenomenon, namely discursive psychology (Edwards and Potter, 1992) and discourse analysis (Potter and Wetherell, 1987). Discourse analysis is the ideal approach to look at the difficulties of talking about a delicate and sensitive topic. It looks at the discourse as a performative domain of action in itself, and keeping in mind the title of this thesis, "Am I doing it right?" this approach does not impose positivist paradigms such as cognitivist and behavioural interpretations and expectations onto the participant. By focusing on what issues are of expressed concern to the person with cancer, discourse analysis provides a way of revealing and understanding how the difficulties of talking about cancer are managed.
My analysis focuses on how people talk about their illness and treatment experiences, and more particularly on the topics that are the participants' own expressed concerns. There are various ways in which the order of presentation through successive chapters could have been organised, but I have chosen to follow the illness trajectory itself, from initial discovery, diagnosis, and reports of subsequent social relationships, to talk about death and dying.

**Thesis Overview**

The participants are people who had been given a cancer diagnosis and volunteered to talk to me about their illness. The integrating theme is encapsulated in the title of this thesis "Am I doing it right?" and the title of this introduction, 'Being patient'.

Cancer occurs within a particular culture that fundamentally shapes and influences the way the illness is experienced. Chapter 2 reviews the main literature relevant to my thesis and looks at how what I term the *culture of cancer* has been constructed in medical and social science research. I discuss one of the key constructs in the psychosocial oncology literature, namely 'coping with cancer', and focus on two key elements, attitude of mind and social support, both of which are considered to be highly influential factors in successful coping with illness. Additionally I provide an account of how the *language of cancer* dominates the culture of cancer by describing how someone is expected to cope with their illness. Historically cancer has been constructed as a dreaded illness that equates with a 'death sentence'. Consequently, it is difficult for people to talk about, even when they are directly affected. So, this chapter also reviews how researchers have studied 'troubles talk' and talk about sensitive issues.

Chapter 3 introduces my chosen theoretical and analytical approach, discursive psychology (DP) and discourse analysis (DA), and highlights some of the key analytical features that inform the analysis. This chapter also describes the complex process of finding participants and how I selected and prepared the data for analysis.
The data analysis begins in Chapter 4. This chapter identifies a number of key concepts and devices that participants employ in talking about cancer, considered as a species of 'troubles talk', which are then referred to throughout the subsequent analyses of data extracts. The analysis in Chapter 4 is divided into two parts: firstly participants’ discovery accounts, and secondly accounts of going to the doctor's. The route to diagnosis can be complex and long and, as a background to the specific analysis of this chapter, I provide a brief account of the literature concerned with the issue of who is responsible for diagnostic delay, patient or provider. People delaying reporting suspicious symptoms to their doctor is a concern for the medical profession, and the research focus for psychosocial oncologists is why ‘patients’ might delay reporting their symptoms. My analysis reveals that the notion of diagnostic delay is also a PWC's concern, and presents a different story. I show how PWC attend to issues of doing being responsible and account for any notion of diagnostic delay in their own terms.

Chapter 5 builds on the diagnostic delay theme, and focuses on how participants received the news of their cancer diagnosis. ‘Patients' are expected to quietly await the course of events, without complaint. An interesting feature of the analysis is how participants talk about the medical profession, and I examine how accounts of diagnostic delay, and of receiving the news of their diagnosis, are rhetorically constructed as complainable matters.

In Chapter 6, the topic is the problems that PWC describe in their stories of everyday conversations with family, friends and colleagues. The analysis examines what kinds of things they report people say to them, and how they respond. In particular I look at how the language of cancer, and the cultural expectations and difficulties of knowing what to say, can produce a number of dilemmas and problems for the PWC to manage.

Chapter 7 is in two parts and addresses how the prescription of being positive places PWC in a position of being morally accountable for how they manage their illness. Part 1 of the chapter looks at how doing being positive is managed as a participants' concern, and how this is rhetorically constructed in stories, where a key factor is the importance of ‘doing being ordinary’ (Sacks 1984a) and being
able to do normal everyday activities. Part 2 examines how participants use laughter and humour as a device for doing being positive and for managing stories about treatment and interactions with the medical profession that, without it, could be heard as serious complaints, or indeed as evidence that the speaker is not adopting a positive attitude.

In Chapter 8, the final analytical chapter, the topic is talk about death and dying. Again, the notions of doing being positive, and the uses of laughter and humour, are examined as accounting devices. This time they are used to resist 'doom and gloom', and we find that in various ways the talk is about living (and its limitations), rather than dying per se.

Chapter 9 summarises the findings of the analytical chapters. I discuss how these can contribute to our understanding of some of the problems PWC face, and draw together what is involved in managing to be a good cancer patient, along with the expectations of how they are expected to 'cope'. I suggest that such expectations produce moral dilemmas and additional burdens for the PWC. Finally, I will discuss how a discourse analytical approach to talk about illness can reveal different ways of understanding that are beneficial, not only to people with cancer, but for those who are involved in their care.
Chapter 2
The Social Construction of the
Culture of Cancer: Knowledge and Talk

As a main focus of attention talk is unique... for talk creates for the participant a
world and a reality that has other participants in it.


Introduction

This thesis examines what and how someone who has been given a cancer
diagnosis talks about their life. Cancer is not an easy topic of conversation and
participants' accounts display the difficulties and dilemmas of talking with others
about their illness. Their accounts are informed by the language of cancer which
has been derived from medical, social and cultural knowledge.

The aims of Chapter 2 are firstly to review how our social and cultural knowledge
of cancer has been socially constructed. I will present a brief account of the
development of research on disease and illness, as constructed by the scientific
world (the medical model) and the social scientific world (including the
biopsychosocial model, health psychology, the 'illness experience' perspective
and psychosocial oncology). In particular, I will address how what I term the
culture of cancer constructs a series of concerns and moral dilemmas for a
person with cancer (PWC) and will indicate how these concerns form the basis of
my analytical focus.

I will present a commentary on the significance of the change in doctor-patient
communication and its impact on research into clinical and institutional practices.
Finally, I will present an account of the construction of the language of cancer
that informs our cultural knowledge and I will show how researchers have studied
talking about 'troubles talk' and delicate and sensitive issues.

1 The term oncology is derived from oncogenes, the prefix onco refers to cancer and oncology
refers to the study of cancer. Oncogenes are a viral gene held to be responsible for transforming a
host cell into a tumour cell.
2:1 Cultural psychology, social construction and the culture of cancer

I firstly want to provide a context for my review of the literature and its relevance to my analysis. It is appropriate to clarify and distinguish what is meant by the categories of traditional cultural psychology, social constructionism (SC), and my definition of the culture of cancer as viewed by discursive psychology which informs the analytical approach of this thesis.  

A part of this chapter’s concern is to present the author’s description of how the discourse of cultural knowledge, in this instance the culture of cancer, is relevant and how participants orient to pragmatic intersubjectivity, and shared knowledge. Pragmatic intersubjectivity involves the dialogical interactions of daily life and shared knowledge is defined as something that is practically managed in talk, rather than a series of actual mental states that precede it and result from it (Edwards, 1997:20). It is also a participant’s practical concern, as to how and when their talk is treated as shared, and as Edwards proposes the study of pragmatic intersubjectivity overrides and subsumes the other two senses of shared knowledge, i.e. cultural and mutual knowledge.

Discursive and cultural psychologies are related enterprises (Edwards, 1997). Discourse is primarily what we produce, as academics, researchers, and writers of cultural and other psychologies. This discourse is made up of descriptions, theories and versions. The point made by anthropological writers such as Clifford Geertz (1983), sociologists of science (Mulkay, 1985, Ashmore, 1989) and philosophers (Rorty, 1980) is that it is not easy to make a distinction between our own texts and the objects of our investigations. Edwards proposes that “it is our texts, our discourses, and our descriptive practises that bring their ‘objects’ into being. At least they bring them into being as the objects of our understanding: the objects of a ‘cultural psychology’ for example. These versions are descriptions that rhetorically convince us of the world ‘as it is’, as if it

2 Discursive psychology and discourse analysis will be discussed more fully in Chapter 3.
possessed the *described* nature independently of those descriptions* (Edwards, 1997:45).

This chapter raises the concern of how this cultural knowledge of cancer, which it is suggested raises a number of dilemmas for the PWC, is managed in everyday life. In traditional health psychology or psychosocial oncology terms, this culture is brought into being by the description of 'coping with cancer'. 'Coping', like any other object of academic study, is brought into being as soon as we start to define its nature and scope (Edwards, 1996). The construction of the constituents of 'coping' and its social and moral implications for someone with cancer will be discussed later in this chapter.

Another classic term employed in health and illness research is 'making sense of illness'. Making sense of illness events is fundamentally a linguistic phenomenon that integrates two levels of socially constructed contents. *Cultural knowledge* (the collective level) is defined as things that people generally know about the world, and is associated with the circulation of ideas and socially instituted practices. In much of cultural psychology, mind is 'socially constructed' ontologically, in the same sense as, for Piaget, it is constructed through the internalisation of actions. The analytic task is to explain how mind is built with a real world of cultural settings and practices; that mind is real for theorists and analysts. However, the major sense of 'social constructionism' in discursive psychology is epistemic in that it is about the constructive nature of *descriptions*, rather than of the entities that (according to descriptions) exist beyond them. "Mind and reality are treated analytically as discourse's topics and business and the analytic task is to examine how participants descriptively construct them" (ibid: 48). As Edwards notes, there is an important related distinction between those for whom social constructionism is primarily an ontological position and those who take it as primarily an epistemological claim.

In recent years, it has become common practice to make a distinction between these positions and the different styles of discourse analysis (See Antaki, 1994; Burman and Parker, 1993; Parker, 1992; Widdicombe and Wooffitt, 1995). Edley and Wetherell (1997) define these distinctive styles as 'top-down' and 'bottom-up'
approaches. The 'top down' discursive approach is defined as being concerned with issues of power, ideological practice and social process (e.g. Hollway, 1984; Parker, 1992; Wetherell and Potter 1992) and take this lead from the work of Foucault who defines discourses as being "practices that systematically form the objects of which they speak" (Foucault, 1972:49). Investigations typically draw upon "analytical concepts of discursive regimes, interpretative repertoires, cultural narratives and subject positions in order to highlight the ways in which people are spoken through or by discourses" (Edley and Wetherell, 1997:205). They study the way people are positioned by and effected through discourse and emphasise the social constitution of mind, taking mind and the social as (more or less) real and conventionally describable entities.

In the contrasting 'bottom-up' approach (influenced by Sacks) researchers locate their concerns within the traditions of ethnomethodology and conversation analysis (CA) and their primary interest is in social interaction (e.g. Antaki, 1988; Edwards, 1997; Edwards and Potter, 1992; Widdicombe and Wooffitt; 1995). The emphasis here is on the action orientation (Heritage, 1984a) of people's discourse, in other words the kinds of things that are accomplished through talk, such as accusation, criticism and blame. The analytical focus is on "the constructed and relative nature of talk and studies how versions of events, including analysts' versions, are built and worked up to become factual, persuasive and presented as 'just the way the world is'" (Edley and Wetherell, 1997:206).

2:2 Social constructionism: Disease, health and illness

The social constructionist argument underlies many of the theoretical approaches to understanding the 'illness experience' and as Radley (1994) suggests the examination of these constructions provides a way of "freeing ourselves from the everyday assumptions (reifications) of medicine" (ibid: 33) and can lead to a different understanding of the influences of health and illness. Shotter (1992) proposed that rather than attempting to supplant traditional approaches and set up a fresh hegemony of perspective, social constructionism can open up a dialogue with alternative views. In this way, "without the need to privilege itself
over competing perspectives, it can function as a new analytic device to reveal aspects of human conduct 'obscured' by other forms of talk" (Shotter, 1992:9). But, whatever knowledge claims social constructionists produce, like this thesis, they are a social construction themselves.

Berger and Luckmann (1966) state that all scientific work involves the social construction of facts and interpretative schemes.

"Scientific paradigms are frameworks of formal knowledge that members of a given scientific community share, mainly due to having undergone similar educations and professional initiations: to sharing common professional language, rules of evidence and conceptual schemas and to relying on the same professional literature and communication of the same scientific community."

(Kuhn, 1970:1976).

The social constructionist approach is informed by the work of Berger and Luckmann (1966) who argued that 'reality' is constructed by a range of social processes and consequently knowledge cannot be seen as the product of discovering objective, natural phenomena that exist independently of our constructive practices. Additionally, it is not the isolated individual's imagination that is looked to for this mechanism of construction but it is believed that that construction arises out of the social, cultural and historical interaction between people (cf. Gergen 1985; Shweder and Miller, 1985). So, the idea that there is any distinction between things that are 'real' and 'out there in the world' and things that are the product of cultures and societies, is itself reduced to the level of a social artefact. That is, from this perspective, our only access to the world in which we live and breathe occurs via the medium of culture, and as a result anything we might take to be 'real' and 'out there' has already been shaped or 'constructed' by social forces (Gergen and Davis, 1985). The problem here is that when social scientists analyse the constructive processes of others, they are themselves engaging in the business of constructing their own version of reality (Ashmore, 1989; Clifford, 1988; Geertz, 1983; Horton-Salway, 1998; Mulkay, 1979; Woolgar, 1988).

Social constructionism is particularly amenable to methodological diversity and having abandoned the limitations of a search for 'objective truth' analysis using
qualitative methods has become as acceptable as the vast sweeps of quantitative research. It embraces fields as diverse as psychology, rhetoric, literary theory, philosophy and medical sociology.

Medical knowledge is treated as problematic and as a central issue in analysis. Medical and social scientists' ideas about disease and illness, regardless of their scientific claims, are still the product of social processes and are continually changing. Freidson (1970) challenged medicine's claim to have access to the natural world and language of disease and stated that "While illness as a biophysical state exists independently of human knowledge and evaluation, illness as a social state is created and shaped by human knowledge and evaluation" (Freidson, 1970:212).

Social constructionists in medical sociology claim that "medical knowledge, no less than medical practice is socially constructed" (Bury, 1986:137) and deals mainly with the origins of professional beliefs and with diagnosis. Its ways of 'knowing' are grounded in the medical framework, contemporary moral and ethical views, the socialisation of medical providers (especially physicians), the professional and institutional practices of the health care system and the larger social structures of the society (Bury, 1986). It is also argued that medical knowledge contributes to the shaping of social relations.

Bury also states, "the objects of medical science are not what they appear to be; the stable realities of the human body and disease are in fact 'fabrications' or 'inventions' rather than discoveries" (ibid: 137).

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3 Latour (1987) argues that the production of scientific facts is the result of mutually conceived actions by scientists in everyday life in the laboratory, combined with scientist's efforts to promote their work in public and official venues.
However, in the sociology of scientific knowledge (SSK)\(^4\) and discursive psychology, there is no equation between 'constructed', 'false' or 'fabricated' and it is proposed that reality, like 'appearance' is also a construction.

The power of modern medicine is that it has defined the 'reality' of disease and the physical body (Bury, 1986). As Radley suggests, "bodily growth, decay and death can be considered organismic process, but they are also something else...society penetrates the organism by defining, regulating and valuing its functions" (Radley, 1994:33). Whilst I am not refuting that disease and illness do exist as 'realities', how they are constructed, labelled, treated and responded to in medical and psychological knowledge also permeates our social knowledge and understanding about them.

For the purposes of this thesis, I am looking at how cancer is socially constructed in the medical and social sciences literature and how models of illness behaviour and psychological responses have been constructed to produce what I term the *culture of cancer*. I propose that this culture provides a context for a 'specialised' descriptive *language of cancer*, which is full of attributions and issues of moral accountability.

One of my aims is to examine how the cultural knowledge of cancer influences, permeates and shapes not only the language and understanding of the person with the diagnosis but also those people they interact with, including the medical profession, family, friends and colleagues.

\(^4\) The sociology of scientific knowledge (SSK) which emerged in Britain in the 1970s (Mulkay, 1979; Ashmore, 1989; Collins, 1983) rejected the "standard view" dominating science until then. The "standard view" entails an evaluation of science as humanity's uniquely successful mode of knowing. Its success consists of an ever more complete description and explanation of the way the world is, as attested to ("proved") by its predictive and technological utility. Its success is predicated on its mastery of The Scientific Method. SSK sought to radically extend the role of "the social" in knowledge production (and the role of sociology in its description and explanation). SSK was influenced by the work of Garfinkel (1967), Kuhn, (1970) and Wittgenstein, (1953) and seeks to demonstrate that the very content of science, the knowledge product, is thoroughly socially constructed (Ashmore, 1989).
2:3 Labels and definitions:
2:3.1 Disease and illness

Psycholinguistic perspectives of word meaning assume that language is merely an abstract idealised system of categories and rules (Chomsky, 1965, 1966, 1968). Words merely represent things that already exist in the world independently of the way people describe them. So, the phenomena of disease and illness, such as AIDS/HIV, heart disease and cancer are seen as pre-existing the label. This realist assumption implies that disease and illness are a natural set of things that are already ‘out there’ waiting to be discovered by scientists and to be given appropriately descriptive names.

The radical relativist position argues that the relationship between language and reality is that in naming things we constitute their essence (Edwards, 1997, Edwards, Ashmore and Potter, 1995; Edwards and Potter, 1992; Woolgar, 1985).

Another view of naming and labelling is that a diagnostic label can also be viewed as a matter of social definition. As noted in Chapter 1, being labelled as a ‘patient’ carries its own definitions and expectations. The labels and definitions of disease and illness are accompanied by social definitions that have become part of the culture and language of cancer. The discursive label of illness, especially if the disease has specific moral connotations surrounding it, can have considerable consequences for the patient and their social identity. George and Davis propose that the “clinical label becomes a master status, one that swamps all other identities and compresses the identity of the person into a narrow and constricting mould” (George and Davis, 1998:266).

Cancer is labelled as both a physical disease and an illness. A clear distinction has been made between these two terms which also characterises the course of the different theoretical approaches adopted by medical and social scientists. According to the traditional ‘realist’ perspective, the phenomenon of ‘disease’ is an undesirable physiological process or state potentially discoverable by the scientific techniques of medicine and the medical model.
"Disease is something that physicians diagnose and treat. Examples include influenza, cancer and tuberculosis. [...] it can be said that disease refers to pathological changes in the body so that a main symptom of each of the diseases mentioned might include fever, a growth, and extreme coughing"

(Eisenberg, 1977 in Radley, 1994: 3)

Helman defines diseases as being "the named pathological entities that make up the medical model of ill health" (Helman, 1981:548). The transformation of physiological symptoms becomes a diagnosis or illness description, and this is accompanied by socially constructed appropriate illness behaviour and heroic and stigmatised social statuses (Lorber, 1997).

The definition of illness fits more readily into the domain of the social sciences where it is primarily treated as a discoverable phenomenon available to the social scientist through the accounts of the sufferers.

"patients suffer 'illnesses'... illness is defined to mean the experience of disease, including the feelings relating to changes in bodily states and the consequence of having to bear that ailment; illness, therefore, relates to the way of being for the individual concerned"

(Eisenberg, 1977 in Radley, 1994:3)

Illness refers to the subjective response of the patient to being unwell (Helman, 1981:548) and "how the sick person and members of the family or wider social network perceive, live with and respond to symptoms and disability" (Kleinman, 1988: 3). The experiential aspects of illness are also "shaped by cultural factors governing perception, labelling, explanations of the discomforting experience" (ibid: 3) and individuals interpret their experience using cultural categories and the influences of social relations (Kleinman, 1995; Young, 1982). Disease and illness are seen as products of cultural contexts and the social processes of constructing knowledge and the 'experience' of illness is to some extent dependent on such cultural and social definitions (Horton-Salway, 1998:5).

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5 Mechanic (1977) gave the name illness behaviour to the ways in which symptoms may be differentially perceived, evaluated and acted upon. He saw it as having a place in what might be termed the states of sickness falling 'logically and chronologically' between the appearance of signs of disease and subsequent medical treatment.
2:3.2 Chronic Illness

"Having a chronic illness is in some ways similar to being held prisoner with no definite release date"


Cancer has another dimension, it is not only a disease and an illness but it is also categorised as a chronic illness. By definition, chronic illnesses are ongoing, recurrent and often degenerative. They are slow developing diseases that people may have to live with for a long time and in many cases, they are incurable. For people with a chronic condition, illness becomes a part of life, and will "affect our lives, our selves, our ability to function, our family, our work, our recreation, and our use of formal health care systems and folk remedies" (Cotler, 1996:647).

Chronic illness has a socio-cultural course as well as a biological one and has far reaching social, emotional, psychological, moral and spiritual implications (Kleinman, 1978, 1988, 1995). A chronic illness such as cancer and the disabilities that may accompany it require the management of many elements over long periods of time. It is not only the disease condition that has to be contained by medication and therapies, it is also likely that the PWC's lifestyle must also be modified and in certain cases, the management of the disease and illness becomes a daily regime (Brooks and Matson, 1982, 1987; Strauss, 1979). In addition, many symptoms such as fatigue and pain come and go and are invisible to others.

The diseases' potential impact and effects are extraordinarily variable. Radley (1993) suggests that the chronically ill are subject to cultural expectations and that an expression of public morality is expressed in the evaluation of the personal and social status of the afflicted. For the PWC, illness not only becomes a part of life but it also carries additional burdens of prescriptive, expected responses and behaviour that can threaten a person's sense of self and identity.

6 Today, chronic illnesses, especially heart disease, cancer and diabetes, are the main contributors to disability and death.

7 Different types of chronic illnesses have their own social implications, "lived-with" illness, such as asthma and diabetes; "at risk" illnesses which include inherited "environmental" or "personal" behaviour risks; and "mortal" illness such as some cancers and HIV/AIDS (Conrad, 1987).
Someone with a chronic illness such as cancer has to confront a number of day to day problems, the organisation of their social and working environments, managing the attitudes of others and maintaining their sense of self and identity (Freund and McGuire, 1999). How a PWC manages these social and moral dilemmas against the cultural and normative backdrop of the demands of illness is of analytical interest throughout this thesis.

2:4 Theories of disease, health and illness

Radley (1994) claims that the distinction between disease and illness has been used to justify the different interests of social science as compared with medicine. Medicine is concerned with classification in order to produce knowledge which will be effective in the course of healing (Kleinman, 1973) whilst "social science is concerned with the meanings and behaviours that organise the experience of illness for the individuals involved" (Idler, 1979 in Radley, 1994:5). Radley makes the point that disease, illness and sickness do not stand in some kind of practical or theoretical vacuum, but that they have independent meanings and are spoken about within different theoretical perspectives. The distinction between the three has been constructed to "justify the different interests of social science as compared with medicine" (ibid: 5). I will now present an overview of the main theories including the medical model, the biopsychosocial model, health psychology and psychosocial oncology.

2:4.1 Medicine, disease and the biochemical machine:

The medical model

"Biomedicine was founded on a Cartesian division of man into a soulless mortal machine capable of mechanistic explanation and manipulation and a bodyless soul, immortal, immaterial, and properly subject to religious authority, but largely unnecessary to account for physical disease and healing"

(Kirmayer, 1988:57)
This perspective, often referred to as 'the biomedical model'\(^8\), has dominated the thinking of most health practitioners for the last 300 years. In Western, individualistic societies, the culture and language of health, illness and medicine originates from science, medical science. It has greatly influenced the patients' role as being passive, and provides the framework for the way we talk about what we expect doctors to do and what we expect them to know. In turn, this model's dominating ideological influence has permeated the health care system and the health professionals whose training is primarily located in the disciplines and doctrines of medical science and consequently, the style of doctor-patient communication. According to Mishler (1984) the 'voice of medicine' dominates the comings and goings of diagnosis and treatment and creates a distance between the medical practitioner and the 'patient', which enables them to deal with the disease and the disease alone.

The model asserts that all diseases and physical disorders can be explained by disturbances in physiological processes and that the body is separate from psychological and social processes of the mind. Disease and illness are understood exclusively as bodily processes and the body is typically constructed as a 'biochemical machine' (Kirmayer, 1988:57).\(^9\)

The medical model poses a number of problems, especially for the person who is ill. It is a reductionistic single factor model that explains illness in terms of a biological malfunction rather than recognising that a variety of factors, only some of which are biological, may be responsible for the development of illness. It assumes a mind-body dualism, that is, there is a clear dichotomy between the mind and the body; physical diseases are presumed to be located solely within the body. The social, psychological and behavioural dimensions of illness are excluded and thus prevent any conception of how aspects of an individual's

\(^8\) Mishler (1984) presents this model as maintaining that disease is a deviation from normal biological functioning, that diseases have specific causes that can be located in the ill person's body, that they have the same symptoms and outcome in any social situation and that medicine is a socially neutral science. It is assumed that all illness can be explained on the basis of aberrant somatic processes such as biochemical imbalances or neuro-physiological abnormalities and assumes that psychological and social processes are largely independent of the disease process.
social or emotional life might affect their physical health. Social conditions that may contribute to the illness or to promoting healing are mostly ignored (Freund and McGuire, 1999). In other words, the body is understood and treated in isolation.

One of the oldest Western images for understanding the body is the metaphor of comparing the body with the functioning of a machine. This *machine metaphor* is reinforced by viewing disease as the malfunction of some constituent mechanism (such as the breakdown of the heart)\(^{10}\) and encourages the notion that physicians can "repair" one part of the body in isolation from the rest (Berliner, 1975).

Partly as a product of the *machine metaphor* and the quest for mastery, the medical model also conceptualises the body as the proper object of regimen and control (Foucault, 1979). This accentuates the moral responsibility placed upon the *individual* to exercise control in order to maintain or restore their health.\(^{11}\) Such expectations present moral dilemmas for anyone who becomes ill.

The problem with this model for someone with a chronic illness such as cancer or HIV/AIDS is that they are not just diseases of the body, whereby the symptoms and pathological processes can be managed and treated by medical processes alone. Such diseases can result in social and psychological problems, which the paradigm of the medical model does not and can not address. This thesis explores how participants attend to these prescriptions of responsibility and how they manage issues of moral accountability.

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9 Linn, Linn and Stein, (1982) suggested that the person without cancer can afford to be more dogmatic about cancer and likely to think in stereotypes. The closer they come to dealing with the disease, the less clear-cut and more complex the explanations may become.

10 Modern medicine has not only retained the metaphor of the machine but also extended it by developing specialisations along the lines of machine parts, emphasising individuals' systems or organs to the exclusion of an image of the totality of the body.

11 This moral assumption meshes with other values, represented by the medical and social emphasis on standardised body disciplines such as diets, exercise programmes, non-smoking, routines of hygiene and even sexual activity (Turner, 1984: 157-203) which are also the concerns of health psychologists.
2:5 Social Science and its approach to disease and illness

2:5.1 The Biopsychosocial model

Engel, (1977) a psychiatrist, questioned the inadequacies and the restrictive boundaries of the dominating medical model. He challenged both the reductionist and the exclusionist positions, that disease does not exist as such unless some biochemical evidence can be identified to explain the phenomenon in terms of cause and effect. Engel proposed the 'biopsychosocial model', which was based on a systems theory.\(^{12}\) As the model's name implies, its fundamental assumption is that health and illness are consequences of the interplay of biological, psychological and social factors (Engel, 1977; 1980). The model maintains that multiple factors produce multiple effects and that mind and body cannot be distinguished in matters of health and illness because they both influence an individual's well being. The model also emphasises health and illness rather than regarding illness as a deviation from some steady state (Taylor, 1999).

Although Engel's model went someway to addressing the inadequacies of the medical model, it is still rooted in the essentially medical perspective of the positivist paradigm (and therefore restricted by its limitations). However, it did make explicit the significance of the relationship between patient and practitioner by clearly implying that the medical practitioner must understand the social and psychological factors that contribute to an illness in order to treat it appropriately.

2:5.2 Health psychology and the biopsychosocial model

In a social climate that was beginning to challenge many deep-rooted notions of approaches to health and illness, psychologists became more concerned with other issues surrounding health and illness. Cognitive-emotional processes

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\(^{12}\) Systems theory maintains that all levels of organisation in any entity are linked to each other hierarchically and that change in any one level will effect change in all the other levels. This means that the micro-level process (such as cellular changes) are nested within the macro-level processes (such as societal values) and that change on the micro-level can have macro-level effects (and vice versa). Consequently, health, illness and medical care are all interrelated processes involving interacting changes within the individual and on these various levels. (Schwartz, 1982).
involved in 'coping' with illness attracted comparatively little attention until the development of the new discipline of health psychology in the late 1970s, coincidental with an intense debate about the nature of psychology as a science.

Drawing on Engel's biopsychosocial model, health psychologists readily endorsed the idea that in matters concerning health and illness it was logical to study the mind and the body together. This has resulted in a growing interest in how people cope with the psychological problems of living with chronic illness and the accompanying disabilities, both in terms of the best strategies to ameliorate the stress of illness, and the mechanisms whereby 'coping behaviour' might influence the development of illness.

Health psychology's mission is a broad one involving most branches of psychology in almost all aspects of the health enterprise (Taylor, 1999) and today it is a clearly recognised designated field of study.

Conrad (1990) has suggested social scientists researching health and illness have adopted two overriding research orientations which he has termed the 'outsider' and 'insider' approaches.14

From the 'outsider' orientation, health psychology's primary focus is based on 'outcomes' as measures of successful treatments, mortality and morbidity, and psychological adjustment to illness. The measured outcomes are deemed as 'expert' representations derived from a system of psychological knowledge reproduction which ensures their objectivity, and where discourse is taken as the

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13 Stress has been labelled the 20th century disease, as there is a widespread concern of stress being a factor in ill health.
14 This description is drawn from a distinction made by Pike (1954), and is derived from the linguistic categories 'phonetic' and 'phonemic'. An 'etic' approach attempts to describe cultural objects and activities in generalised, objective terms that are applicable to any culture. 'Etic' categories are in principle universal; they can be formulated prior to any particular analysis and be applied afterwards to cases at hand (the outside approach). Pike suggests etic descriptions or analyses are an 'alien view' with criteria that are external to the system. An 'emic' approach describes cultural practices in terms that are internal to that culture and in relation to other parts of the culture rather than to generalised, cross-cultural criteria. Hence 'emic' categories focus on one particular and they are 'discovered' during the investigation into that particular culture (a distinction often made by anthropologists). Edwards (1997) suggests that although they are useful distinctions, they are somewhat idealised.

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means through which various aspects of the reality of health and illness are represented. The ownership of expertise is taken away from the lay person, the person who is ill, and the idea that they are ‘experts’ on their own illness is disregarded and devalued (Williams and Popay, 1994).

Quantitative methods of ‘objective’ measurement and the identification of statistical associations between (so-called) psychological variables have dominated research in an attempt to provide a respectability and status within the wider scientific community. Complex psychological, social and behavioural phenomena are conceptualised as separate and often isolated variables. These variables are then “measured, manipulated, and analysed to reveal some generalisable ‘truth’” (Zyzanski, McWhinney, Blake, Crabtree and Miller 1992:244). However, the theories and research methods have tended to focus on the individual as a rational decision-maker who is often stripped of social context.\footnote{This is most apparent in a range of cognitive models which have been developed, for example locus of control (Rotter, 1966), models of health behaviour, such as the health belief model (Rosenstock, 1974) and the theory of reasoned action (Fishbein and Ajzen, 1975).} As in the biopsychosocial model, the standard view of psychology prevails where people are treated as objects of study.

In contrast, the ‘insider’ approach breaks away from the dominating biomedical model. Instead of measuring outcomes and identifying problems such as adjustment, acceptance, temporary disruption and ‘coping’ behaviours, the ‘insider’ approach has shown that the way in which symptoms are regarded and reported, and the actions taken to manage them, are profoundly social phenomena (Conrad, 1990; Yardley, 1996). Researchers focus on the cultural and communicative aspects of illness (often treating it as a phenomenon seemingly isolated from the biological processes labelled disease) and in what is referred to as the ‘experience of illness framework’ (Conrad, 1990) and patients are recognised as “experienced subjects who can contribute knowledge and take an active part in decisions” (Hardey, 1998:84).

This approach examines the ‘illness experience’ in what it claims to be a more enlightened manner where ‘meaning’ and ‘making sense of the illness...
experience' are central in providing a greater role for approaches encompassing 'subjectivity' and 'reflexivity' (Crossley, 2000). By integrating the mind-body dichotomy into the social context and acknowledging that people are more than physiological entities it also ensures that patients are treated as people, not objects, and that they are seen holistically (See Charmaz, 1983, 1990; Kleinman, 1988; Morse and Johnson, 1991).

Social constructionist ideas have made a major contribution to the study of the 'illness experience' and have provided the basis for some new methods recently adopted within health psychology including grounded theory (Charmaz, 1983), phenomenology (Smith, Flowers and Osborn, 1997), and the discursive approach (for example Brown, 1999; Horton-Salway, 1998; Paris Spink; 1999; Stainton Rogers, 1996; Yardley, 1997).

Methods of analysis are extensive and vary from straightforward sampling and reporting of illustrative segments from interview transcripts to more sophisticated and formalised techniques (e.g. 'grounded theory', Strauss and Corbin, 1990; Charmaz, 1987; 1990; 1991). A recent method of analysis for understanding the self, identity and the 'experience of illness' is narrative analysis (Crossley, 2000; Garro, 1994; Gordon and Paci, 1994; Hunt, 1994; Kleinman, 1988; Murray, 1997; Riessman, 1990; 1993). Central to a narrative psychological approach is the development of a phenomenological understanding of the unique 'order of meaning' constitutive of human consciousness (see Crossley, 2000; Polkinghorne, 1988).

However, "the analysis of narratives in the human and social sciences has mostly ignored the interactional business that people might be doing in telling them...and studies of narrative have tended to pursue generalized types and categories of narrative structure, rather than dealing with how the specific story content, produced on and for occasions of talk, may perform social actions in-the-telling" (Edwards 1997:265-266). A discursive analysis of narrative sees the events and the 'reality of the illness', 'making sense' and 'identity' as something participants must manage and deal with. When telling a story, people do not just turn their understandings and perceptions, their sense making and meaning making into 'best sense stories'. Storytelling is a discursive action; it is
constructive rather than merely descriptive, and in providing narrative accounts of their illness, participants employ discursive devices to accomplish for example a particular identity (see Chapters 5 and 7).

Although health psychologists have endeavoured to include the individual and the social in the health equation, and to advocate the biopsychosocial model of health and illness, in practice, they have given very little attention to the integration of the social, psychological and biological factors (Chamberlain, Stephens and Lyons, 1996). The search for 'meaning' in cancer is the attempt to place it in its physical, psychological, social and spiritual context (Cunningham, 1993). Researchers claim that the construction of meaning takes place in social interaction and is influenced by language, family and culture (Bruner, 1990; Freeman, 1993), yet few studies have analysed this interaction. Meaning is still studied in isolation and viewed as something that participants reveal in an appropriately labelled package in their interviews. Additionally, relatively little research has considered the way in which the social environment can influence how people cope. More significantly, they have not reflected on the social origins and implications of the concept of 'coping' and its impact on the individual (Yardley, 1997) or how social relationships and how cultural knowledge informs and shapes our lives, which are analytical concerns throughout this thesis.

The basic difference between the traditional approaches to health and illness referred to above and discursive psychology is that traditionalists treat language as an expression of something psychological (meaning, sense of self, loss, etc). In discursive psychology and discourse analysis, (discourse) is analysed itself, so the notions such as 'experience' and 'meaning' are examined to see how they are deployed in ways that are, for instance, rhetorical, variable, and/or manage accountability. In a discursive analysis, 'experience' and 'meanings' are considered as a feature of social interaction, rather than speakers' intentions. They are interactionally accomplished and "intentions, goals, mental contents and their intersubjective 'sharing' are analysed as kinds of business that talk attends to, rather than being the analyst's stock assumption concerning what is actually going on" (Edwards, 1997:107).
"Distinctions between what is intentional or not, and meant or not, are deployed and at stake in talk, and are thereby analytically available. That is not the same thing as eschewing meaning and intention altogether as the behaviourists do, nor of trying to discover for ourselves as 'explanations' what real intentions lurk behind, explain or precede the things people say (as cognitivists do)” (Edwards, 1997:108).

So, although this turn towards the individual's experience and narratives of their illness provides another insight into meaning, that meaning is produced for the most part in interaction, and the analytical details of how this is accomplished are not examined.

2:5.3 Psychosocial oncology and 'coping with cancer'

Since the late 1970s there has been an increased awareness of the role of psychosocial factors in the onset, development, treatment and management of cancer (Beckman, 1989; Somerfield and Curbow, 1992; Watson and Morris, 1985). Along with the advances in medical science and technology that have dramatically altered the prognosis for PWC, there has been a shift from the concern with issues of death and dying to an emphasis on the psychological processes of successful recovery and survival.16 Understanding how people cope with cancer has led to the emergence of another new discipline, psychosocial oncology (a sub-discipline in oncology) which has evolved alongside health psychology, and, as its name implies, focuses on the psychosocial issues encountered by someone diagnosed with cancer.

2:5.3.1 'Coping with cancer'

'Coping with cancer' has become a much used term, both within institutional health organisations, academic research and the public domain. The topic of 'coping' is considered as being one of the most widely studied psychosocial

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16 Oncology was one of the first areas in medicine to include quality of life on the treatment agenda. Quality of life emerged as a central oncologic topic in the late 1970s and 1980s in part because of an explosion of growth in medical technology aimed at treating cancer, and the increasingly complex treatment decisions that have ensued (Maguire and Selby, 1989).
factors, (Somerfield and Curbow, 1992) especially as it is perceived as being a possible mediator of the psychological impact of cancer (Parle, Jones and Maguire, 1996).

‘Coping’, classically defined in Lazarus and Folkman’s seminal work, is the ongoing and changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus and Folkman, 1984:141). They claim ‘coping’ is determined by the relationship between the person and the environment, and that it is a transactional process with problem-focussed and emotion-focussed functions. Accordingly, they propose that the appraisal of a chronic disease as threatening or challenging leads to the initiation of ‘coping’ efforts’. The medical and psychological literature implies that people with cancer are expected to cope with their illness, and according to psychological theory, there are certain normative rules of ‘coping behaviour’.

The impetus for research is based on the clinical and empirical evidence that PWC (given similar levels of disease and toxicity of treatment) have different levels of physical, psychological and social responses to their diagnosis and illness. Researchers have identified a number of psychological problems that a PWC might face after receiving a diagnosis of cancer including: significant anxiety, depression or suicidal thoughts; dysfunctions in the central nervous system produced by the illness and treatment, such as the inability to concentrate; specific problems that have arisen as a consequence of the illness and its management and/or social dynamics; and previously existing psychological problems that have been exacerbated by cancer (Holland, 1973). It is argued that if a patients’ psychological problems can be identified at an early stage, then more effective psychosocial interventions can be devised and implemented for the benefit of the patient. Consequently, psychosocial oncologists are concerned with developing models that will detect people who

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17 Intervention is a key action in psychosocial oncology and psychotherapeutic interventions based on cognitive-behavioural techniques have been developed to help manage a number of cancer related problems - including individual psychotherapy, group therapy, family therapy and cancer support groups, in an attempt to meet the psychosocial and informational needs of cancer patients.
may be at risk for what is termed 'adverse outcomes', beyond what would *normally* be expected.

'Coping with cancer' research focuses on how individuals cope with their illness and the relationship between defined 'coping' strategies and what is known as psychological adjustment (Burgess, Morris and Pettingale, 1988; Cooper and Watson, 1991; Dunkel-Schetter, Feinstein, Feifel, Strack and Nagy, 1987; Taylor and Falke, 1992; Welsman and Worden, 1976-77). Studies are mostly based on the medical model and on cognitive theories which are predetermined by the expectations of the psychological knowledge of what 'coping' means. In order to measure coping responses and psychological outcomes, cancer patients are invited to provide answers to numerous questionnaires constructed to establish this 'reality' or 'truth' about their beliefs, feelings and attitudes to their illness and treatment. The subsequent analysis of this data then categorises and labels the PWC as being either a 'coper' or 'non-coper'. This information is then used as a guide for health professionals in providing the appropriate support interventions.

The psychosocial oncology literature continues to provide 'normative' and statistical data on the 'problems of cancer patients'. However, even traditional researchers have challenged the accuracy of the information collected and the appropriateness of methods for measuring the complex and varying states that accompany cancer (Temoshok and Heller, 1984). One of the problems associated with these methods of data collection is that the information is invariably derived from self-report questionnaires that have been constructed as being objective representations of a number of expected norms of behaviour and reactions. These 'objective' results can only demonstrate 'coping strategies' measured against a wide range of sometimes conflicting variables already predefined and categorised by the social scientist. Underlying these methods of measuring coping attitudes is the assumption that there is something enduring within people which the scale is measuring, i.e. the attitude (also see 2:5.3.2, this chapter).

Discursive psychology highlights the difficulties with this approach to attitudes and raises a number of questions. When people are completing an attitude
scale, are they “performing a neutral act of describing or expressing an internal mental state, their attitude, or are they engaged in producing a specific linguistic formulation appropriated for the situation at hand?” (Potter and Wetherell, 1987:45). From the DP perspective, if a PWC expresses a particular attitude on one occasion this does not imply that they will express this same attitude when asked on another occasion. People say things differently at different times so there is likely to be some variability in what is said on a particular occasion which casts doubt on the enduring homogenous nature of the supposed internal mental attitude (ibid).

For discourse analysts the phenomenon of variability is recognised as a feature of discourse whereas the theoretical approach in standard social science is to search for consistency and general laws. Consequently, any sign of variability is viewed as problematic; it is a nuisance factor and is considered an error. But for the discourse analyst, variability is something to be understood, including the way in which participants use variability to construct their talk for different occasions, for different audiences and for different purposes, and the aim is to understand this variability and to employ it for analytical purposes (ibid).

Secondly, whilst the negative connotation of not ‘coping’ (maladaptive coping) prompts the introduction of intervention measures, there is a potential for further problems for the PWC. They may not wish to talk about or disclose any information about themselves in ways that would result in them being categorised as depressed, anxious or needing help as they are likely to be categorised as not ‘coping’ with their illness. At the same time any such categorisation could produce further negative feelings or guilt for the PWC, creating additional burdens of having to ‘adjust’ and manage coming to terms with their inability to cope (See Chapter 7, 7:1).

Although the ‘discovery’ that someone is failing to cope can provide beneficial information for intervention measures, Pollock (1993) suggests that patients may also be condemned as either weak, defective or culpably lacking in motivation or effort. Encouragement to cope, therefore, may be experienced as a pressure to conform to society’s ideal of normality, either by concealing and overcoming
physical disabilities (Ville, Ravaud, Diard and Paicheter 1994) or by stoically enduring pain (Jackson, 1992).

Evidence suggests that PWC who adjust and cope successfully are likely to have increased survival rates, (Greer, Morris and Pettingale, 1979; Morris, Pettingale and Haybittle, 1992; Pettingale, Mars, Green and Haybittle, 1985; Spiegel, Bloom Kraemer and Gottheil, 1994) therefore, there is an implication that ‘bad coping’ or ‘maladaptive coping’ will have the opposite affect on their survival. However, this expected norm can create problems for PWC. If they are expected to cope, they may find it more difficult to proffer information that they are experiencing problems. An anecdotal account given to the author by a PWC who sought informational support from a health professional later discovered that her case file indicated that she had been categorised as a ‘non-coper’. She claimed this knowledge made her angry and had a detrimental effect on her because she felt she could no longer seek help or support if this resulted in being categorised in this way.

Conversely, for the psycho-oncologist failing to discover someone is not ‘coping’ is also problematic. Ibbotson, Maguire, Selby, Priestman, and Wallace, (1994) reported a major concern in that only 20-50% of patients experiencing problems are actually identified and treated appropriately. They also found that a contributing problem is that patients are reluctant to disclose their mood disorder, while doctors and nurses are hesitant to enquire about it.

This highlights the issue of how PWC talk about the sensitive nature of their illness. It also emphasises that traditional methods of identifying such dilemmas cannot provide any beneficial understanding of how a PWC attends to and manages these dilemmas in their everyday accounting practices. In discursive psychology, subjective dimensions and theoretical artefacts of an individual’s approach to illness e.g. asking questions such as “how well do you cope?” are viewed as discursive accomplishments which become participants’ concerns and issues of accountability. Chapters 6 and 7 identify some of the discursive practices that participants display in attending to such dilemmas.
Like cancer, the literature is complex and sometimes variable in its trajectory, but for the purposes of this thesis, I have selected two key 'coping' constructs relevant to my analysis. Firstly, the PWC's psychological response to their illness in relation to how they adjust or adapt, with particular reference to the 'coping' strategies of a 'fighting spirit' and a 'positive attitude' and secondly, how 'social support' is an integral part of successful 'coping'.

2:5.3.2 Attitude of mind: To cope or not to cope

One of the most prolific and promoted strategies of 'coping' with a cancer diagnosis in Western culture, and frequently quoted in the literature, is adopting a certain 'attitude of mind'. This is clearly articulated in the commonly referenced metaphor of 'fighting' illness (Blaxter and Paterson, 1982; Crawford, 1984; Doan, and Gray 1992; Doan, Gray and Davis, 1993; 1992; Herzlich, 1973, 1985; Pill and Stott, 1982, 1985; Williams, 1983). People are advised to 'beat it', to adopt a 'positive attitude' and to 'think positively' (Greer, et al, 1979, Greer and Watson, 1987; Morris, Greer and White, 1977; Pettingale, et al, 1985; Watson, Greer, Young, Inayat, Burgess, and Robertson, 1988). Adopting such attitudes as psychological responses to cancer, or adopting an attitude of helplessness and hopelessness towards the disease have been suggested as prognostic factors which can have an influence on survival (Watson, Haviland, Greer, Davidson and Bliss, 1999).

This recommendation to adopt a 'positive attitude' or a 'fighting spirit' has been determined by researchers employing a highly used and influential measure developed to assess 'adjustment' or responses to the diagnosis of cancer, known as the Mental Adjustment to Cancer Scale\(^\text{18}\) (MAC), a self-report questionnaire with a 40-item scale, incorporating five sub-scales including fighting spirit; helpless/hopeless; anxious preoccupation; fatalism; and avoidance (Watson et al, 1988). A number of studies using this scale have reported that the coping styles of 'fighting spirit' and 'denial' tend to be associated with better outcomes in terms of psychological morbidity and, slightly more tentatively, overall survival.

\(^{18}\)The MAC Scale is now one of a handful of questionnaire measures of cancer coping styles that are currently available and extensively used.
and recurrence-free survival (Greer et al., 1979; Maguire, 1985a, 1985b; Morris et al., 1992; Pettingale et al., 1985). The statements about positive thinking are taken as evidence of a 'fighting spirit'. Likert attitude scale response alternatives such as 'applies to me' or 'does not apply to me' to a statement such as 'I try to fight my illness' are typically treated as if they were a literal description of an internal mental entity or response disposition. Evidence that someone is 'thinking positive' is derived, unproblematically, from self-report, which is generally treated as offering (more or less accurate) depictions of the participants' psychological states. Responses are treated as if in a vacuum, as providing a transparent window on underlying cognitive processes of 'the attitude' rather than being seen as variable, complex linguistic acts in themselves (Potter and Wetherell, 1988).

Consequently, patients are expected to 'beat it', 'fight it', 'deny it', 'to be anxious' and to need support to help them cope. Interventions are directed towards helping PWC to cope better with their illness because it can both improve their quality of life and may even influence the progress of the disease process (Steptoe and Wardle, 1994). However, as Antaki and Rapley suggest in a study looking at the Quality of Life, "although psychologists are committed to assessing the well-being of their clients, their theorisation of quality of life and their diagnostic interview procedures cordon off its official definition from ordinary usages" (1996:294).

Another problem and a contradictory one is that despite the importance placed on the use of surveys and questionnaires in measuring attitudes, researchers are aware that minor alterations in wording often lead to variability of responses, which in turn affects the response patterns. As highlighted earlier, in standard traditional approaches, variability is considered as problematic and indicates some form of error, whereas for discourse analysts, variability is more than this and provides an opportunity to discover the phenomena of how versions of accounts may be produced on and for the occasion.

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19 Despite Folkman, Lazarus, Dunkel-Schetter, DeLongis and Green (1986) and Greer, Moorey and Watson’s (1989) cautions and provisos regarding the reliability and validity of self report data, this evidence is essentially read off as unproblematic from either what someone might say in a semi-structured interview or what item they might tick to the effect that they are ‘thinking positively’, regardless of the constructs or categories.
The continued emphasis on the use of idioms such as ‘coping with cancer’, adopting a ‘fighting spirit’ and a ‘positive attitude’ have become part of the repertoire and canonical script in the language of cancer. The construction of the language of cancer is discussed later in this chapter. How ‘coping’ gets done and how participants manage these prescriptive coping styles in their accounts will be discussed in Chapters 6 and 7. I will show how rather than accurate reports of internal cognitive states, these idioms are moral prescriptions that PWC attend to in their accounts.

2:5.3.3 Social support

The second coping construct is ‘social support’, a general term for the many different resources that aid people in times of crisis and help them ‘cope with life’ (Freund and McGuire, 1999). Social support is another multi-dimensional construct and has been formulated as a highly valued and recommended coping resource strategy.

In Helgeson and Cohen’s (1996) review of the literature they identified three main types of supportive social interactions linked to the psychological adjustment to cancer, namely emotional support, which involves providing empathy, caring, love and/or trust to another; informational support which provides a person with information that can be used to help cope with personal and environmental problems and instrumental support which is when someone assists with practical problems, such as paying bills (House, 1981; House and Kahn, 1985; Kahn and Antonucci, 1980; Thoits, 1985).

The impact of being given a cancer diagnosis inevitably results in life and identity changes. ‘Coping’ with treatment, pain, family stresses, occupational disruption and the threat of death is liable to challenge a person’s social identity and because of the negative connotations surrounding cancer, is likely to put them at risk of social exclusion. These changes not only impact on the quality of the life of the PWC, but family, friends and colleagues who may be engaged in providing support are also affected. Emotional and social support from the family is said to promote good psychological adjustment (Helgeson and Cohen, 1996; Mesters, van den Borne, McCormick, Pruyn, de Boer and Imbos, 1997). Social support is
also associated with less adverse reactions to stressful events, such as serious illness (Cohen and Syme, 1985; House, Landis and Umberson, 1988; Pistrang, Barker and Rutter, 1997). A positive relationship between social and emotional support is often attributed as being a critical factor to adaptation, adjustment and ‘coping’ with cancer (Hegelson and Cohen, 1996; Wortman, 1984).

Freund and McGuire (1999) suggest that social relationships function as mirrors that help reflect messages of self-affirmation back to us. The corollary is that if the support is perceived as 'negative' this could have detrimental psychological effects (see Chapters 6 and 7). Emphasising the beneficial aspects of social support can create a number of dilemmas, especially as a lack of social support is associated with ‘coping’ strategies that are, in the long run, less adaptive.

If a PWC does not have a readily available resource network to provide the much credited attributes of social support, or finds that supportive relationships are not available at the time when they are most needed, coping is likely to be more stressful. So, by implication, the lack of such support could contribute to a PWC feeling more vulnerable and less able to cope in an ‘adaptive’ manner. If social support is said to provide the promotion of stability, predictability and self worth, in contrast, social isolation is likely to have detrimental effects on health, self-esteem and recovery (Bell, LeRoy and Stevenson, 1982). A further problem is that if coping is seen to be successful, by implication, non-coping is failure.

An added complication is that PWC frequently report that some of their friends disappeared after their cancer was diagnosed. Early explanations of this indicated that people felt uncomfortable in the presence of someone with cancer due to its stigma (Cobb, 1976; Cobb and Erbe, 1978). Stigma holds that illness is a socially or culturally devalued condition that sets people apart and discredits or disqualifies them from full social participation (Goffman, 1963). Rather than see stigma in Goffman’s terms, as a description of an existing state with a predictable reaction, what is of interest in my analysis is how the topic of stigma becomes a device for PWC in accounting for identity and managing certain dilemmas when giving descriptions of their social relationships (See Chapter 6).
In order to receive 'appropriate' support, PWC need to find a balance between being able to ask for help and not being seen as helpless. How participants account for the roles of their family and friends and in particular the rhetorical nature of these accounts in relation to their identity as someone who is coping, forms part of the analysis in Chapter 6.

The literature has consistently indicated that social support is beneficial to cancer patients in adjusting to the stress of their disease (e.g. Bloom, 1982; Dunkel-Schetter, 1984; Funch and Mettlin, 1982). But, as Atkinson, Liem and Liem (1986) note, social support should not be treated as stable; levels and appropriateness of social support do not remain constant over time, and stressful events and social support are not independent factors, they interact with each other. However, there is a noticeable absence of research examining how social support functions interactionally.

In discursive analytical terms, social support is in itself a discursive phenomenon which is produced by participants in their accounting practices. My analysis highlights that participants often provide accounts of a role reversal in their claims that it is they who are having to provide reassurance and support to their significant others and that not everyone in a support network provides what they consider as 'positive' and appropriate support. In Chapter 6, I look at how talking about social relationships does identity work and is often a resource for PWC to display and account for doing being normal. The concept of what is characterised as a positive attitude and the ascriptions of being positive or doing being positive will also be proffered and discussed (See also Chapter 7).

The methodology and theories presented in this chapter are disciplines that have, to an extent, produced particular images of what the 'normal' and 'adaptive' psychological response to cancer should be (Frank, 1991, 1992, 1997). Rather than viewing the 'patient' holistically, the PWC is fragmented into manageable psychological states that can be measured and quantified during the course of clinical trials. The research focus is primarily driven by the needs of the medical professionals, to ascertain how someone responds or copes with their illness. This results in an emphasis on producing individualistic theoretical models of
illness behaviour for the purposes of managing the patients’ illness. There is also an implication that illness is a stable entity, when palpably it is not (Radley, 1999).

Additionally, the language used by medical sociologists and psychologists to label and categorise people objectifies the ill. Williams (1993) states that we have to recognise:

"...that the expressive terms people use cannot be reduced to instrumental terms of 'adjustment' and 'adaptation'. These concepts, staple components of the rehabilitation literature, tend to be ethically judgmental because they are unrelated to the context of the moral life of the person concerned. In order to avoid the pitfalls of judgement, we need to see coping strategies as moral practices..."

(Williams, 1993:105).

The approaches described above, although intentionally for the benefit of the patient, are a series of prescriptive designs constructed to meet the needs of medical practitioners and health professionals. They do not examine how these prescriptions and constructions are worked up as a potential burden that participants have to manage and are held accountable for, both inside and outside the confines of the medical institution and the analyst's concerns.

In discursive psychology, formulations such as 'coping', social factors and influences are treated as being discursive accomplishments. My analysis will examine how participants invoke 'cultural knowledge', 'coping' and 'social relationships' as topics of business to be managed in their narratives and I will examine the rhetorical constructions and variability in these accounts.

How people account for and talk about their social relationships is a domain which has remained unexplored in the 'coping with cancer' research. Those involved in the medical profession and social support network will have been exposed to the culture and language of cancer; it is an available resource for them to draw upon and is likely to influence the nature of the interaction. Throughout this thesis, I will show how the categorisations of coping strategies
are social and moral concerns that PWC orient to in their accounts and descriptions of their changing social worlds.

2:6 Cancer Talk: The culture and language of cancer:

Earlier in this chapter, I gave an account of the language that informs medical knowledge, that the PWC is categorised as a 'patient', that cancer is a disease and the body is regarded as a machine. I also discussed how social scientists produce prescriptive constructions of coping with the illness problems of cancer that are constituted in analysts' categories such as 'adjustment', 'coping', a 'positive attitude' and 'meaning'.

The discourses of medicine and social science permeate the public arena and are parodied and reinforced in the media. Together they have produced a range of categories, concepts and descriptions which form what I describe as the culture and language of cancer, but, more importantly, they have influenced the discursive practices of how cancer is talked about today.

Burr (1995) suggests that "by placing everyday interactions between people centre stage, and seeing these interactions as actively producing the forms of knowledge we take for granted and their associated social phenomena" then "it follows that language has to be more than simply a way of expressing ourselves. When people talk to each other, the world gets constructed" (Burr, 1995:7).

This section focuses on the construction of the culture and language of cancer which is an available resource for people to draw on to jointly create and inform their worlds. I will firstly present a brief account of cancer's history and reveal why it is difficult to talk about. Secondly I will present an account of how talking about cancer was avoided in the doctor-patient relationship, and how a change in policy, telling people of their cancer diagnosis, has led to a new topic of research into doctor-patient communication and delivering bad news. Finally, I will refer to some studies of 'troubles talk', an area of research that is closely linked to the concerns of this thesis.
2:6.1 What is cancer?

Nobody knows what the cause is,
Though some pretend that they do;
It's like some hidden assassin
Waiting to strike at you.

W. H. Auden

Cancer and its aetiology have a long and descriptive history within competing scientific theories of disease (Rather, 1978). Although today there may be alarmingly high rates of increase in the occurrence of cancer, it is not an exclusively modern disease, "tumours have been found in Egyptian mummies dating from 2000 to 3000 B.C. and physicians...knew of and treated patients for cancer of several sites" (Benedek and Kiple, 1994:102).

In ancient Greece Hippocrates is credited with having named the disease cancer from karcinos, the Greek word for crab, perhaps because some cancers of the breast have a crab-like appearance or perhaps because the pain that cancer can produce resembles the pinching of a crab. Similarly, neoplasm, meaning 'new formation' and oncology, literally, 'the study of masses' are derived from the Greek, as is the word tumour\(^{20}\) (ibid:102). The word 'cancer' in Latin or its old spelling 'canker', is used “to describe anything which erodes, sloughs, rots, corrupts and so on...the word thus implies destruction, eating away, a spreading of evil or corruption" (Deeley, 1979:3).

For centuries, from Ancient Greece and Rome to the latter part of the twentieth century there was little treatment to offer victims of the disease and cancer was seen as carrying the "knell of doom to the victim" (Kelly and Frieson, 1950:822).

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\(^{20}\) In Hippocratic medicine, tumours were seen to be caused by abnormal accretion of 'humours' and were, overall, thought best left untreated. In general however, cancers were not distinguished from other kinds of benign or inflammatory tumours, all of which were accounted for a humoral theory of disease (Rather, 1978). Galen, a Roman physician, made a scientific connection which today would be both highly controversial and politically incorrect that there was a possible link between psychological factors and cancer, and he is reputed to have noted that 'melancholic' women were at a greater risk than women with a more 'sanguine' temperament. This model of disease became canonical within medicine up until the seventeenth century. Even today, clinicians have described certain personality attributes seemingly characteristic of cancer patients as well as the occurrence of life crises immediately preceding the appearance of cancer (Mettler and Mettler 1947). Some researchers claim that there is a cancer-prone personality (categorised as Type C), but there is little evidence to support this (Greer and Watson, 1985).
Some people perceived it to be a rather unclean disease which evokes responses of disgust, revulsion and fear.

There are over two hundred medically differentiated types of cancer. What they have in common is the way they develop. According to contemporary oncology textbooks, cancer is a disease of the cells of the body, characterised by:

"uncontrolled growth, and the ability to infiltrate surrounding tissues and spread to distant sites...most cancers arise from a mutation in a single cell and therefore represent a monoclonal population, but some growths are polyclonal, indicating that they have developed following more than one mutation"

(Rees, Goodman and Bullimore, 1993:3)

In lay terms, cancer is a loss of control and occurs when one group of cells grows and multiplies in a disorderly and uncontrolled way. By various means, one type of cell becomes able to disobey or escape from the control mechanisms that keep cells growing in their normal orderly way. However, despite its antiquity, the disease itself is viewed as largely a twentieth-century phenomenon (Benedek and Kiple, 1994).

Today's estimates are that one in three people will develop cancer at sometime in their lives and as the risk of cancer increases with age, the longer we live, there is a higher risk of developing and possibly dying from cancer. In the United Kingdom, cancer is a major cause of morbidity and there are more than 300,000 new cases of cancer every year. 165,000 people die of the disease per year, accounting for about a quarter of all deaths in the UK (Pitts and Phillips, 1998). In 1985, the American Cancer Society reported that although cancer was still a

\[21\text{Normally cells divide to produce more cells only when the body requires them and at a relatively slow rate; cells that are cancerous multiply very rapidly. If they divide without regulation, a mass of excess tissue is formed which is called a tumour. Tumours can be benign or malignant (cancerous). Cells in malignant tumours invade and destroy nearby tissue, or they can break away from the tumour and travel via the bloodstream or the lymphatic system through the body and form new tumours in different sites. The spread of cancer in this way is known as metastasis. Cancer can be classified into two broad types: haematological (malignancies of the blood) and solid tumours. The name of a cancer describes the type of tissue or location of the site wherever it develops. A sarcoma describes a cancer developing in bone, muscle or connective tissue; carcinoma describes cancers arising in the cells of glands, organs and other similar locations (Buckmann, 1996).}\\]

\[22\text{The Cancer Research Campaign (2001) featured an advertisement depicting this statistic.}\\]
leading cause of death, with the availability of improved treatments and diagnosis, approximately one of every two cancer patients would survive beyond five years from the time of diagnosis.

2:6.2 Why is cancer difficult to talk about?

In the 1920s George Groddeck, a psychoanalyst, wrote:

"Of all the theories put forward in connection with cancer, only one has in my opinion survived the passage of time, namely, that cancer leads through definite stages to death. I mean by that that what is not fatal is not cancer. From that you may conclude that I hold out no hope of a new method of curing cancer...[only] the many cases of so-called cancer..."

(George Groddeck, The Book of the It, 1923).

Despite the progress in treating cancer and increased survival rates, many people still subscribe to Groddeck’s equation, a cancer diagnosis equals death. In the 19th century, a TB diagnosis was tantamount to hearing a sentence of death. It was common practice to conceal the identity of the disease from *tuberculars* and even when patients were informed about their disease, doctors and family were reluctant to talk freely (Sontag, 1978, 1989). "Verbally I don’t learn anything definite," Kafka wrote to a friend in April 1924 from the sanatorium where he died two months later, "since in discussing tuberculosis...everybody drops into a shy, evasive, glassy-eyed manner of speech" (Kafka, 1924 in Sontag, 1978:7). Today, in the popular imagination, cancer and HIV/AIDS are equated with death and are considered to provoke the deepest dread. The word *cancer* with all its cultural baggage has become difficult to talk about.

In the UK everyday another 850 people are diagnosed as having cancer (Cancerbacup, 2001)

Psychoanalysts like Groddeck and Reich sought to investigate the cultural meaning of cancer, rather than accepting its ‘organic’ presentation as a purely biological phenomenon. Reich sought to explain Freud’s own cancer of the jaw, in terms of ‘his unhappy personal life and his repression of emotion’ (Turner, 1984:238). Reich believed that Freud smoked heavily because “he wanted to say something that never came out of his lips” (Reich, in Turner, 1984:238). Reich argued that Freud’s bitten-back emotions found an outlet in the cancer through which he ‘chose’ to express them. Groddeck also saw cancer as a symbol of repressed emotions and desires. In this context, the body is read as the cultural map of the psyche. Bodily memories are seen to threaten the health of the person by holding trauma or tension within the body. Thus, disease is the bodily expression of the distress that could not be fully forgotten (Stacey, 1997:117). Psychodynamic theories have been influential in the construction of meaning and self help approaches to cancer (see Hay, 1988; Siegel, 1988; Simonton et al, 1978).
Heart attacks can be equally life threatening and when someone has one attack they are vulnerable and likely to have another. However, this 'truth telling' is not concealed from a cardiac patient; there is nothing shameful about a heart attack. The medical model can provide an adequate explanation for this difference. Cardiac disease implies a weakness, a mechanical failure, so there is no disgrace attached to a heart attack. The metaphors associated with heart disease are 'heart-break', or 'heart-ache', 'the blues' or 'the jitters', rather than the military and heroic metaphors of cancer. They are not adorned with the cultural baggage of stigma, shame and dread, nor do they carry the taboos that once surrounded people with TB and now surround those with cancer and HIV/AIDS.

Cancer is also universally known to have emotive connotations which can evoke psychologically disabling trauma and social dilemmas. In her classic and influential book, *Illness as a Metaphor*, Susan Sontag describes some of the problems the disease can evoke:

"...cancer arouses thoroughly old fashioned kinds of dread. Any disease that is treated as a mystery and acutely enough feared will be felt to be morally if not literally, contagious. Thus a surprisingly large number of people with cancer find themselves being shunned by relatives and friends and are the object of practices of decontamination by members of their household, as if cancer, like TB, were an infectious disease."

(Sontag, 1978:6 emphases added).

Sontag raises a powerful notion in that cancer "will be felt to be morally if not literally, contagious" which could result in isolation and PWC may be 'shunned', posing a threat of exclusion from social life. One commonly held view of avoiding moral contagion and isolation is not to say the word itself.

"Whatever you do, don't say 'cancer'. The unspoken word, written on everyone's lips, must not be voiced"

(Stacey, 1997: 66).

Karl Menninger wrote, "The very word 'cancer' is said to kill some patients who would not have succumbed (so quickly) to the malignancy from which they suffer"

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25 Sontag (novelist and essayist) and Stacey (sociologist) are writing from the knowledge of their own experiences of living with a cancer diagnosis.
The word arouses thoroughly old-fashioned kinds of dread synonymous with an inevitable, slow, painful and undignified death and it is said that hope and cancer are mutually exclusive (Fallowfield, 1990). There can be no doubt that it is a dramatic disease. The utterance of the name of 'cancer' (as was the case with tuberculosis in the 19th century) amounts to condemning the sufferer to a whole mythology that has been constructed around it (Herzlich and Pierret, 1987).

So, to compensate, all kinds of euphemisms are used to avoid actually saying the word. Metaphors employed to describe the experience, treatment and management of the illness have become integral to the culture and language of cancer.

Doctors often avoid using the word too. When discussing a diagnosis with a patient, they also draw on euphemisms such as growth, lump, wart or polyp, which may not pose such a great threat or stigma or evoke the emotional charge in either the patient or the doctor. In diagnostic accounts, (see Chapter 5) PWC often report that it was left for them to name the disease for themselves. In writing about her own experiences of cancer, Stacey (1997) reported that when she was in hospital the medical staff were unable to say the word cancer in front of her. She concluded that their not speaking the word conveyed to her a sense of embarrassment which added a feeling of shame to the already intense emotional charge of having the disease.

It could be argued that some of the medical profession might consider that these euphemisms protect the patient from all the accompanying dilemmas of the disease (see 2:6.4). In some cases this may be so but there is rarely any attempt to explore how the PWC might manage the burden of not knowing about their illness or respond to their communication with doctors (see Chapter 5).

In the public domain, the group of diseases known as cancer are often reduced to a single disease, 'the Big C'. The word remains so unspeakable that another word, phrase or reference is often employed to make the speaker and the listener feel more comfortable: 'something nasty', 'a lump', 'the big C', 'the cruel
C'. On occasions, these euphemisms are whispered softly, with head hung low or with sideways glances.

According to Zipf's law, euphemisms and abbreviations are employed because this requires less effort to explain the apparent equilibrium between diversity and uniformity. But the euphemisms and abbreviations invoked in cancer talk do more than this: they are a way to manage talking about a sensitive and taboo topic and a way of avoiding the 'unmentionable' and the accompanying cultural associations.

2:6.3 The discourse of heroes

Because of all its negative connotations, a new style of language has been formulated to counter the fear and dread of cancer to provide PWC with optimism and hope for survival. From being condemned as 'victims', or 'sufferers', PWC are now identified as 'heroes', 'survivors', 'victors', and 'exceptional patients' (Siegel, 1988).

The slogan 'Cancer can be beaten' was originally introduced in the United States as a rallying cry designed to encourage the public to contribute funds to support research. Today it has become a call for the individual with cancer to become a hero in the tradition of the archetypal hero myth (Doan and Gray, 1992). According to Becker, (1973) the heroic urge is our most common defence against death. So, language becomes a representation of a moral and mental attitude to the disease. The underlying morality implies that only those who fight hard against their cancer survive it or deserve to survive it. More and more the illness

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26Zipf's law, in simplest terms, states that there exists equilibrium between uniformity and diversity, which shows that there is an inverse relationship between the length of a word and its frequency. In English, for example, the majority of the commonly used words are monosyllables. This effect seems to account for our tendency to abbreviate words when their frequency of use rises, e.g. the routine reduction of microphone to mic by radio broadcasters. It would also seem to be an efficient communicative principle to have the popular words short and the rare words long. Factors such as efficiency and ease of communications appealed strongly to Zipf, who argued for a principle of 'least effort' to explain the apparent equilibrium between diversity and uniformity in our use of sounds and words. The simpler the sound and the shorter the word, the more often human beings will want to use it. (Crystal, 1987).
is being confronted as a personal challenge and PWC are now expected to treat their illness as an enemy to 'fight' and 'beat'.

In an attempt to 'combat' the negativity associated with cancer, the concept of adopting a 'fighting spirit' has been incorporated into what has become known as the 'heroic model' (Doan and Gray, 1992). This model is defined as a disposition towards cancer (and other chronic illnesses including HIV/AIDS) that is characterised by the belief that positive thoughts and feelings, a 'fighting spirit' and an optimistic outlook will promote cancer recovery and/or remission.27

How people talk about life with cancer is informed by the machine metaphor of the medical model and the psychosocial military metaphors (first revealed in Sontag's classic work on metaphor). People with cancer are told to 'fight it' and when describing themselves as a fighter they are drawing on the cultural discourse of the heroic response to threat. The resulting language is one of warfare. Whereas other diseases are described as being infecting, cancer cells are said to invade; they colonise the body by setting up 'outposts' far distant from the primary site. No matter how determined the patient is to 'fight' the cancer, invariably the body 'defences' are breached and the patient is overwhelmed.

Having set up the context of a battleground, media headlines report of people 'fighting the big C' or of 'beating breast cancer'. The usage of terms like 'battle', 'brave', 'crusade', 'victims', 'victory' and the 'war against cancer' are currently prevalent in the language of cancer (Clarke, 1986; 1992; Seale 2001). When reporting a cancer death, the headlines describe this as 'having lost the battle against cancer' or that 'they put up a brave fight'. In contrast, newspapers do not report 'after a lengthy battle with schizophrenia' (read killed self) or 'a lengthy battle with life' (read died of old age). Throughout the course of writing this thesis I have regularly read The Saturday Times obituary columns and noticed an

27In the public domain, the influence of the heroic model is perhaps best exemplified in the writings of the psycho-spiritual approach to illness, including Simonton's Getting Well Again (1978), Louise Hay, You can Heal Your Life (1988) and Dr. Bernie Siegel's Love, Medicine and Miracle (1988) and its sequel Peace, Love and Healing (1989). Doan and Gray report that in their clinical practice, they have seen very few patients who have not read one or other of these one-sided arguments in support of psychological and spiritual influence on illness (Doan and Gray 1992:33).
interesting characteristic. If someone 'died of cancer' this would be stated, however, if someone died of some other cause, this was rarely mentioned. This practice reinforces the equation that for many, cancer equals death and a diagnosis of cancer is equal to "death notified" (Ellis and Abrams, 1994:8).

Today, cancer continues to be a high profile topic in the media where the heroic model and the language of cancer are headlined and reinforced. Television companies produce documentary accounts of the experiences of 'cancer celebrities' and members of the public where the messages of 'think positive', 'fight it' and 'beat it' are reinforced to encourage audiences to develop a particular mental attitude to the disease. Media 'celebrities' write about it in the broadsheets and tabloid press (Diamond, The Times; Picardie, The Observer; Harris, The Spectator) or publish books on their experiences of living with cancer (Diamond, 1998; 1991, 1995; Lorde 1980; Picardie, 1999; Rollason 2000; Stacey, 1997): the list is endless. Radio regularly broadcasts news of the latest and often controversial issues surrounding the disease and cancer stories are a regular feature in television 'soaps'.

The psychosocial oncology literature endorses the 'heroic model' with the added dimension that 'thinking positive' is connected and by extension, causally implicated, in the mental health, morbidity and mortality rate of the individual with cancer (see Watson et al, 1988, cited earlier in this chapter). Again, the research literature constructs and reinforces a prescriptive and moral order in that in the Western world, individualisation is favoured. Displays of 'coping' represented in 'rising above adversity' and a 'stiff upper lip' are seen and received favourably. But, if someone does not subscribe to the 'heroic model', they do not 'fight' or are not 'brave', they are likely to be thought of as cowardly, defeatist, or to be surrendering to their illness.

One of many issues at stake for the PWC is that "negative ideas are drawn from other areas of life and are imported into the illness experience and create an unnecessary burden for the ill" (Radley, 1994:113). Equally, I would suggest that 'positive' ideas could also become an imposition and an additional burden. Whichever approach a PWC adapts, it is likely to produce a moral dilemma.
The warfare of the 'heroic model' coupled with the discourses on a 'positive attitude' have become integral components of the everyday language of 'coping with cancer'. The cultural metaphors of cancer and the shifting identities that illnesses bring in their trajectory are not simply 'there'; they are learned and deployed in social interaction (Antaki, 1996). They are defining features of cancer's interpretative repertoires, and their usage in how participants accomplish accountability and manage issues of stake and interest will be discussed in Chapters 3, 6, 7 and 8. My particular analytical interest in the coping strategies of the 'heroic' and 'positive attitude' repertoires is how 'being a hero' or being positive actually gets done in talk and how cancer patients do coping and attend to these prescriptive coping styles (see Chapter 7).

2:6.4 Doctor-Patient Interaction: Is Ignorance really bliss?

Up until about fifty years ago, doctors did not disclose a cancer diagnosis. It was considered to be in the best interest of the patient to leave them unaware of the nature of their illness and therefore unable to make a link with the associated problems and difficulties of their illness.

The complex problem of whether 'to tell or not to tell' a patient that they have cancer underwent significant changes in the 20th century. A number of surveys conducted from 1950 to 1970, when treatment prospects were bleak, revealed that most doctors did not disclose the 'bad news' of a cancer diagnosis. It was considered inhumane and damaging to the patient (Friedman, 1970; Glaser and Strauss, 1965; Oken, 1961). It was also assumed that people with cancer would prefer not to be told their diagnosis and that silence or reassurance was the best solution to avoid both the patient's and doctor's anxiety.

The non-disclosure policy was first challenged in the late 1950s when Aitken-Swan and Easson (1959) asked cancer patients whether they would prefer to be told about their illness diagnosis. (This in itself was quite unusual at a time when 28 The term 'bad news' is generally applied in “situations where there is either a feeling of no hope, a threat to a person's mental or physical well-being, a risk of upsetting an established life style, or where a message is given which conveys to an individual fewer choices in his or her life” (Bor, Miller, Goldman and Scher, 1993:96).

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patients were seen but not heard). Having studied the reactions of 231 cancer patients they concluded and recommended that someone with cancer should be told about their diagnosis. This recommendation is further supported by more recent research suggesting that withholding information from patients denies them autonomy and contributes to the depersonalisation of patient care resulting in negative consequences for the patient's psychological state (Field, 1989).  

Twenty years later it was reported that there had been a major shift in the medical profession's attitudes to delivering a cancer diagnosis. 97% of American physicians said they routinely disclosed the diagnosis of cancer (Novack, Plumer, Smith, Ochitill, Morrow and Bennett, 1979). Today, most patients are informed of their diagnosis and the consensus is that patients should not only be told their diagnosis but also given information about their illness.

Not surprisingly, it has been reported that medical practitioners do vary in their notions of when and what should be disclosed to a patient, in part because they perceive their mission to be one of instilling hope for the future (Good, Good, Schaffer and Lind, 1990). Many oncologists embrace this mission, not because they believe, as some do, that the mind can really influence disease, but rather because they believe that hope helps patients adopt a 'positive attitude' which helps with forging a 'partnership' with them in the essential healing process (Matthews, Lanin and Mitchell, 1994).

Telling patients their diagnosis is now common practice and is recommended as a beneficial factor in aiding the provision of emotional and informational support (Helgeson and Cohen, 1996). Studies also indicate that well-informed patients tend to experience less anxiety and cope with their treatment better than those who have been inadequately briefed or left uninformed (Fallowfield, 1990). Throughout history, views held about cancer and survival have been pessimistic so it is not so surprising that the medical profession withheld disclosing the bad news of a cancer diagnosis and hedged around such absolutes in their

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29 This interesting contrast resonates with the differences in the medical and psychosocial approaches. As highlighted earlier, the introduction of psychological approaches to studying health and illness found that provision or lack of provision of informational support influences how people are likely to adjust to their illness (Mitchell and Glicksman, 1977).
conversations with patients. Until recently, the only treatment available for cancer was surgery. The success rate was very low because there were usually tiny bits of the tumour or secondary tumours left behind. Current treatment advances have changed the course of cancer; cure rates have improved, remissions have led to a five-year survival rate and today, not all cancers are fatal\textsuperscript{30} so now it is possible to offer patients hope when disclosing the diagnosis. Medical and health care professionals are now faced with a new challenge: helping people live with cancer or live with having had cancer (Scott and Eisdendrath, 1986).

Up to this time of change, delivering the bad news of a cancer diagnosis was not part of a doctor's training or practice; patients were talked about but not talked to. Doctors themselves were neither skilled in delivering such potentially bad news, nor were they insulated from the cultural knowledge and experience on which the fear of cancer is based.

New developments have created a need for medical professionals to acquire communication skills in delivering bad news, including news about the recurrence or spread of the disease, or the presence of irreversible side effects, or raising the issue of hospice care. Consequently, a new research topic has emerged, doctor-patient communication. The literature is full of papers examining this complex relationship but they are mostly written from the institutional perspective of the medical profession, with little or no direct inclusion of the patient's perspective (Falvo and Smith, 1983; Peteet, Abrams, Ros and Stem 1991; Ptacek and Eberhardt, 1996). Usually the traditional research paradigms of cognitive and behavioural psychology frames the studies. A key focus has been on the mechanics of communication and how to facilitate what was termed as 'open awareness' in the institutional and medical setting. (See Faulkner, 1993; Salway, 1992; Timmermans, 1994).

The majority of studies looking at the delivery of bad news comprise of institutional data obtained from doctor-patient communications and counselling sessions. For the most part, the studies focus on how the delivery of bad news

\textsuperscript{30} Despite this improvement in treatment and survival, few cancers are considered completely curable.
or death announcements are organised and produced by medical and counselling professionals. Much of this research was rooted in the improvement of the doctor's skills in delivering bad news to the patient, rather than looking at how patients responded and managed the news, and how they then talked about it to others. Analysts have also introduced a certain bias to their assessment of patient's talk, which has mainly been viewed in terms of responses to doctor's questions, rather than to the patient's perspective. Drew (2001) makes an interesting observation about this research by pointing out the paradox that in censuring medical practice for silencing the voice of the patient, this research has itself largely ignored the role of patients in their interactions with the doctor.

Although much research shows that disclosing bad news of a cancer diagnosis is now a recommended policy, it will be shown that participants' accounts report that even trained medical and health professionals still struggle to manage this action and avoid talking about cancer. Participants' accounts of the delivery of their diagnosis, what is termed 'bad news', will be presented and analysed in Chapter 5.

2:6.5 'Troubles Talk'

Fifty years ago, cancer was not only a disease that was rarely talked about, but the word cancer was rarely mentioned. It is a different story today, but regardless of cancer being more in the public eye and talked about more openly, the cultural knowledge appears to be embedded. Whenever the word cancer is invoked, it comes laden with negative connotations. Consequently a commonly held view is that regardless of who is talking about cancer, (whether it is a health or medical professional, a family member, a friend, the person with a cancer diagnosis, or a social science researcher) it is a difficult, sensitive and delicate topic. Not only are metaphors a feature of cancer talk but also the word cancer has acquired an excess of meaning and has become a pervasive metaphor for describing any insidious assault on organisational integrity. Cancer is synonymous with uncontrollable destruction, unseen and unheard; it represents the ultimate alien invasion and complete loss of autonomy and control. It is a
disease that has long been associated with certain death, and usually a protracted, painful death (Faithful, 1994; Robinson, 1992).

A cancer diagnosis is informed by culturally constructed and socially reproduced structures of metaphor and meaning. Stacey states that "it is impossible to have cancer and not be seduced by the power of such compelling cultural narratives" (Stacey, 1997:13). Consequently, any form of interaction is burdened with a wide range of problems and sensitivities to be managed.

Against the background of 'open awareness', social scientists have pursued another field of study, how people talk about difficult and sensitive topics such as death and dying in the medical arena (see Clark and LaBeff, 1982; Ellis; 1993; Glaser and Strauss, 1965, 1968; Langley-Evans and Payne, 1997; Maguire and Faulkner, 1988a, 1988b, 1988c, 1993; Sudnow, 1967).


Additional CA studies have looked more generally at how ‘troubles talk’ and talk about sensitive issues gets done, but not necessarily in the context of illness. ‘Troubles talk’ consists of portraying (and interaction about) aspects of peoples’ lives as undesired and perhaps warranting a change in behaviour and perspective. It can range from portrayals of peoples’ life experiences as serious problems that necessitate professional intervention, to portrayals of undesired circumstances as mildly irksome, to denials of the existence of any trouble (Silverman, 1997).
Jefferson (1988) reports that 'troubles talk' in ordinary conversation is complex, varied, and even 'disordered'. CA studies have primarily focused on the sequential properties of 'troubles talk' across a variety of speakers and social environments, in order to identify generic practices such as telling and receiving troubles stories, initiating repair, marking a 'change of state', closure of prior and movement toward next topics (see Anderson, Beach and Dixson, 2001; Beach, 1996; Beach and Dixson, 2001; Heritage, 1984b; Holt, 1993; Jefferson, 1981, 1984a, 1984b, 1988, Jefferson and Lee, 1981, 1992; Miller and Silverman, 1995; Sacks, 1992; Schegloff, 1986, 1987, 1992a).

Harvey Sacks (1976, in Jefferson, 1984a) proposes that some topics, such as "embarrassing" and "controversial" topics pose a particular sort of problem for conversation and Jefferson noted that a troubles telling is tantamount to getting out of the conversation itself. "To get off them and to go anywhere else from them, one has specifically to do "getting off of them". (Jefferson, 1984a:191). How participants manage to talk about cancer, a species of 'troubles talk', is an analytical feature throughout this thesis.

Conversations between AIDS counsellors and their clients bring delicate and potentially threatening issues into play. A number of CA studies have explored HIV counselling and questioning techniques as social interaction and 'troubles talk' is treated as a major socially organised aspect of their work (Gubrium, 1989, 1992; Miller, 1986; 1990). The institutional interaction and clinical practice of AIDS counselling has received a considerable amount of attention from conversation analysts (e.g. Peräkylä and Silverman). But interactional studies of 'troubles talk' for a PWC either in the institutional environment or the home environment is relatively unexplored.

However, there has been a noticeable breakthrough in the recognition that we need to understand talking about cancer outside of the institutional setting and to look at how families and carers manage social relationships with someone with a cancer diagnosis. Beach (2001a) is currently conducting some groundbreaking research, (the first of this kind), a longitudinal project, which he refers to as the 'malignancy calls'. This comprises of a corpus of fifty-four recorded and
transcribed phone conversations occurring between family members whose wife (mother, sister, daughter-in-law) have been diagnosed with lung cancer, (eventuating in complications and death nearly 12 months later). Beach’s study represents the first natural history (i.e. from initial diagnosis to death) of a family’s ongoing interactional attempts, (conducted via local and long-distance telephone calls) and aims to understand and deal with cancer and its developmental consequences in a family interactional context.

Surprisingly little is known about how PWC talk about cancer to others, and Beach (2001a) notes that examples of communication per se in the psychosocial oncology literature are anecdotal, self descriptive and expressive, reported about, and or/hypothetical. Investigations of 'uncertainty' 'decision making', and/or 'hope optimism', for example, have been rooted in individuals' perceptual orientations (ibid: 242). In a review of the communication literature Beach and Anderson, (2001) did not find any studies addressing the interactional achievements through what Beach terms the "cancer journey". This discovery also highlights another omission from the literature, namely how cancer gets talked about in the social research interview.

Talking about cancer is a species of 'troubles talk' and my concerns in this thesis are to analyse how PWC account for their various 'troubles'. Whilst not addressing the omission stated by Beach directly, my analysis looks at how these accounts are provided in the context of the social research interview, an important and fundamental element of how the knowledge and culture of cancer are reported and constructed academically.

Summary

Cancer is no ordinary disease and it appears that to be categorised as a person with cancer or a cancer 'patient' is to be made exceptional. Despite the popularity of the counselling and therapy culture of the late twentieth-century Western world, in which the cure-all for everything is apparently to talk about it openly, talk about cancer prevails as a ubiquitous presence in everyday culture (Stacey, 1997). For many, the topic of cancer remains something that is difficult,
if not impossible to discuss and to respond to. Once a person is diagnosed with cancer, they enter what Stacey refers to as 'stigmatised territory'.

Negative associations with myths31 and misconceptions are, sadly, still widespread (Eardley, 1986). Some people fear contagion and contamination; others feel embarrassment in not knowing what to say. Corner (1988) reported that the general public viewed cancer very negatively and unfortunately there is little or no evidence to date that suggests that the feelings of the general public have substantially altered (Whyte and Smith, 1997). Today there is a very real possibility of a PWC being refused a mortgage, health and life insurance or even a job. A PWC is invariably constructed as being different and they have become categorised as deviant in that they are no longer 'ordinary' or 'normal'.

It is therefore not surprising that people find talking about cancer difficult. How do the medical profession tell someone that they have a potential death sentence? How does someone tell their family and friends this devastating news? Life after a cancer diagnosis for the person diagnosed and those around them inevitably changes and is problematic.

In contrast to the silences and avoidance of talking about it, today cancer receives a great deal of attention, not only in the medical world and academic circles, but also in the public arena through the media including television, radio, newspapers, the Internet and in the book publishing world. It has become a familiar, much talked about disease, but for the most part the negative myths, and difficulties prevail.

Whenever people meet and talk, whether in institutional encounters or in their private everyday life, communication is not simply a matter of the efficient and rational transfer of information. People often tell their troubles to others and invariably follow a rationality informed by moral choices. “All verbal behaviour is governed by social norms specifying participant roles, rights and duties vis à vis

31 Myth is used here in an anthropological sense in that it is not something false or erroneous, but as a set of beliefs adopted by individuals and societies that give meaning and direction, and the beliefs influence and shape how people manage ‘reality’ and form the cultural knowledge drawn upon in social interaction.
each other, permissible topics, appropriate ways of speaking and ways of introducing information" (Gumperz, 1982:165). Collectively the discourses of medicine, social scientists and the media have created a set of rules and norms and appropriate illness behaviour responses which equate to the culture of cancer.

This thesis suggests that the metaphorical descriptions attributed to cancer, the 'heroic model' and its accompanying discourse construct the ill person as being morally accountable, adding additional burdens for them to cope with apart from their illness. This discourse translates into everyday talk and although many problems have been identified and researched in relation to the psychosocial aspects of living with cancer, few have looked at how, when talking about their illness, this available discourse is brought into being in social interaction.

As much as is known about cancer, in all its abominable and as yet uncured manifestations, there exists only a myopic grasp of how people talk about the aftershocks of a cancer diagnosis and treatment, and how people manage the diverse demands and problems in social interaction. Comparatively little is understood about interactional involvement addressing medical concerns in the family and home environment (Beach 1996). Although the data for this thesis comprises of interview data, it is hoped to contribute to the understanding of interactional involvement in addressing concerns about cancer outside of the institution of medicine.

This thesis examines how, in the construction of this cultural backdrop of social influence and normative and abnormal responses to illness, participants orient to and take up the moral ground. Talking about cancer is an interactionally sensitive and delicate topic and it is proposed that participants manage to bring off, describe and account for their actions with regard to certain rules and norms\(^{32}\), rather than simply following or breaking them.

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\(^{32}\) Norms as an explanation of actions are not favoured by experimental social psychologists because it sharpens the contrast between norms as explanations of actions, and norms as resources that participants use in explaining actions (Edwards, 1997).
The concerns of this thesis are how people manage what they determine as the problematics of a cancer diagnosis in social interaction and how they talk about a difficult, taboo topic. The following chapter provides the background and methods of my chosen theoretical approach, discursive psychology, and the method of analysis, discourse analysis, together with a brief outline of the topics that will be the focus of analysis throughout.
Chapter 3
Discourse Analysis: Theory and Method

"Consider language as a series of tools which acquire their purpose and function
from the social and cultural milieus in which they are used."


Introduction

In Chapter 2, I gave an account of how the topic of cancer and the identity of
someone with a cancer diagnosis has been constructed by medical and social
scientists, clinical practitioners and the media and I highlighted some of the
psychological and psychosocial problems associated with the illness. I also
emphasised that despite cancer being talked about more openly, it remains a
topic surrounded by myths of fear and avoidance. Consequently, talk about
cancer endures as an acutely sensitive and delicate topic, not only for the person
with cancer (PWC) but also for the listener.

The traditional literature outlined in Chapter 2 treated peoples' talk in their
responses to questionnaires and interviews as reflecting some kind of cognitive
reality rather than analysing what else might be going on and what participants
were doing and accomplishing in their talk. I noted that social support (which is
conducted through social interaction with others) is considered an important
aspect of how people cope with their illness. However, researchers have
generally omitted to examine what resources participants draw on to construct
and/or contest versions of reality or how they manage and overcome the
difficulties of talking about cancer. The result is a lack of focus on the problems
of social interaction.

The aim of this chapter is to introduce the chosen theoretical and analytical
approach of this thesis, discursive psychology (DP) and discourse analysis (DA)
and to highlight some of the key analytical features that inform my data analysis.
The final section of this chapter describes how the data was collected and
prepared for analysis.
Before presenting the discursive analytical themes which frame my analysis I will present a brief account of three relevant theoretical influences that inform discursive psychology which will be applied throughout this thesis, namely, ethnomethodology, conversation analysis and the study of scientists' discursive practices in the sociology of scientific knowledge (SSK).

Secondly I will introduce the key features of discursive psychology and discourse analysis based on the three categories contained in the Discursive Action Model, (DAM) action, fact and interest and accountability (Edwards and Potter, 1992). I will present the elements of this model that will be drawn on throughout the analysis including talk as social action, fact construction, stake and interest, rhetoric, accountability and ideological dilemmas.

Finally, I will provide details of how the data was collected, including finding the participants, ethical considerations, the style of interview, tape-recording and transcription, the process of selecting the data for analysis and finally, the coding themes for the analysis.

3:1 Ethnomethodology

The first influence of DP is rooted in ethnomethodology and as its name suggests, ethnomethodology is concerned with the study of (ology) ordinary people's (ethno) methods. The methods studied are the mundane practices, or the common sense methods we use to make sense of our everyday experiences that constitute social realities (Garfinkel, 1967). Garfinkel termed his approach as 'the documentary method of interpretation' where the goals and aims of ordinary people are treated as similar to the goals and aims of the social researcher. In other words, people, like scientists, are continually endeavouring to understand what is going on in any situation and these understandings are then utilised to produce appropriate behaviour of their own.

Two key notions of the ethnomethod are to treat the appearance of an individual as the 'document of an underlying pattern' and secondly, that an individual's appearance is interpreted by members on the basis of what is known about the
'underlying pattern'. The fundamental idea of ethnomethodology is that the sense of social action is accomplished through the participants' use of tacit, practical reasoning skills and competencies. Much of social life is mediated through spoken and written communication, so this placed the study of language at the very heart of ethnomethodology's sociological enterprise (Holstein and Gubrium, 1995).

This notion is of particular interest in this thesis because it provides a good example of how language is used in everyday situations and how members socially construct, interact and display issues of accountability with the 'underlying patterns' of the discourse of cancer.

Whilst Garfinkel subscribes to the notion that members' demonstrations of context-bound activities are 'normative' or obvious phenomena, this thesis considers how the cultural discourses of cancer, that have been socially constructed, prescribed and reinforced by the 'other', are replayed and displayed by people talking about cancer. How participants account for and sometimes reject the normative notions and prescriptive actions and 'attitudes' of the language of cancer in their talk is a feature of the analysis. It will be shown how participants' own accounts are 'indexical' and 'reflexive' and attend to what I suggest has become cancer's canonical script.

A feature of interest here is the ethnomethodological stance taken by Dorothy Smith (1978) in her analysis of how people are assigned to mental illness categories by way of 'contrast structures'. Contrast structures are a discursive organisation which both describe the activity and provide cues to understand something as abnormal or bizarre. The following brief extract, where Angela is

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1 Indexicality is a feature of discourse in which the meaning of an utterance depends on its context of use. "Descriptions...are not to be regarded as disembodied commentaries on states of affairs. Rather, in the ways in which they (1) make reference to states of affairs and (2) occur in particular interactional and situational contexts, they will unavoidably be understood as actions which are chosen and consequential. Like other actions, descriptions are "indexical" and are to be understood by reference to where and when etc. they occur" (Heritage, 1984a: 140).

2 The term 'contrast structures' was coined by Dorothy Smith (1978) (cf. Atkinson, 1984a), in her celebrated article 'K is mentally Ill' and are featured in Chapter 7.

3 Smith noted how, in descriptions constructing K's behaviour as anomalous, 'a description of K's behaviour is preceded by a statement which supplies the instructions for how to see that behaviour
making a statement about K, highlights four aspects of ethnomethodological analysis and illustrates how people attend to the category of mental illness.

Angela We would go to the beach or pool on a hot day, I would sort of dip in and just lie in the sun While K insisted that she had to swim 30 laps

("K is mentally ill", Smith, 1978:43).

Firstly, Angela’s claims are expressed as straightforward, declarative statements that could be treated as descriptive of her own and K’s behaviour and as dealing with matters of fact rather than evaluation. However, for ethnomethodologists such descriptive practices are reality-creating activities through which behaviours, circumstances and people are cast as representations of cultural categories where moral and political significance can be assigned. Secondly, whilst Angela does not make it specific, her description and contrast involve several assumptions (or background expectancies) about mental illness. Two significant assumptions are that mental illness is a departure from what might be called a normal state of mind, and that signs of mental health and illness may be ascertained from someone’s behaviour. A third aspect of Angela’s account is that it involves reflexivity and localness. As previously mentioned, Angela’s description creates the social reality of mental illness by treating K’s behaviour as an instance of this cultural category. But the reflexivity of the account involves more than this. It also constructs a social world in which Angela and K are assigned distinct contrastive and hierarchical positions and identities. In this world, Angela is positively positioned as normal and K as mentally ill. The

as anomalous’ (ibid:39). Further examples include: (1) when asked casually to help in a friend’s garden, she went at it for hours, never stopping, barely looking up (2) she would take baths religiously every night and pin up her hair, but she would leave the bath dirty (3) when something had gone radically wrong, obviously her doing, she would blandly deny all knowledge. Examples 2 and 3 are what Edwards (1997) terms ‘script formulations’. The first example is constructed as a one-off, but it is also provided as an instance of what K would generally do. In these examples, the pathologising work is done by presenting them contrastively against an implied norm. Smith’s examples show that the discursive practice of formulating things into contrasts and oppositions is not just a matter of deploying ready-made conceptual resources that are built into semantic categories, but something people can do flexibly and inventively, for just about any set of objects or events. It is not difficult to imagine K’s gardening activities being described non-anomalously, or even contrastively as a sign of diligence and selflessness. Edwards “suggests that the presence in languages of more conventional or even semantically ready-made contrast sets may be a function of the rhetorical uses of discourse and that conceptual categories are designed in this way for talk, for performing talk’s business” (Edwards, 1997:23).
account is *local* because its meaning is inextricably linked to the practical circumstances in which it was voiced and interpreted by others. These circumstances might be analysed as the contingencies that Angela orients to in offering the account and which others orient to in their interpretation of it.

In ethnomethodology, all constructions of social reality are potentially open to contest and change. So, Angela's description might not always be treated as evidence of K's mental illness. If for instance we assume that K is an Olympic swimmer in training then the contrast between Angela's and K's orientations to swimming might be taken as evidence of K's dedication and commitment to athletic excellence. So, ethnomethodologists ask two principal questions, firstly what are the circumstances and secondly how socially constructed realities change. Both questions point to the potential instability of meaning in everyday life, and the practical moral and/or political implications those different social realities might have for individuals and groups.

Garfinkel's position is that 'situational context' is best approached as what participants treat as such, and make relevant to their activities as part of their activities. These questions are of specific interest because the participants in this study are already categorised as people with a cancer diagnosis and such a descriptive category carries certain socially constructed 'realities' and moral implications. Contrast structures are a pervasive feature in the rhetorical construction of participants' accounts and will be discussed throughout the analytical chapters.

Ethnomethodology's contribution to discursive psychology is that it has elucidated how the ordinary and pervasive ways in which everyday descriptions and psychological attributions perform normative, reality-defining intersubjectivity-oriented work when they are viewed in the contexts of their occurrence as discourse (Edwards, 1997).
3:2 Conversation Analysis

Conversation analysis (CA) developed simultaneously with ethnomethodology and focuses on the ways in which social realities and relationships are constituted through people's talk-in-interaction (Sacks, Scheglof f and Jefferson 1974). The term "conversation analysis" is now used almost exclusively to refer to the pioneering researches of Harvey Sacks into the social organisation of talk-in-interaction, the interactional and interpretative competencies of the interactants, and how they collaborate to construct social realities.

In the 1960s, Harvey Sacks and Emanuel Schegloff were graduate students in the Sociology Department of the University of California at Berkeley, where Erving Goffman was teaching. Goffman had developed a rather distinctive personal style of sociological analyses, based on observations of people in interaction, but ultimately oriented to the construction of a system of conceptual distinctions. Goffman's example opened up an interesting area of research for his students, the area of direct, face-to-face interaction, what he later called 'the interaction order' (1983). Goffman was interested in documenting the ritual procedures which inform the orderly conduct of everyday life. When he studied talk he maintained a strict distinction between its 'system' properties (the features ensuring basic intelligibility, such as orderly turn taking) and its 'ritual' properties (which had to do with such things as the protection of 'face', the ways in which we tend to avoid giving offence to others, politeness and the many other 'ceremonial' aspects of interaction). For Goffman, these were two theoretically distinct modes of the interaction order. He established that social interaction embodies a distinct moral and institutional order that can be treated like other social institutions such as education, religion and the family (Goffman, 1955, 1983).

Although Sacks undoubtedly drew from Goffman's interest in the orderly properties of face-to-face interaction, for Sacks, there is no meaningful difference between 'system' and 'ritual' aspects of talk-in-interaction. In his paper 'Everyone has to lie' (Sacks, 1975) he shows that the 'polite' answer to a "How are you?" enquiry, that is, "Fine" has as much to do with what Goffman called system
requirement as it does with ritual requirements. This is because the question itself sets up a particular sequential trajectory. Normally, we do not expect someone to respond to "How are you?" (HAY) with a literal account of their state of health. But if for instance someone wanted to 'tell the truth' about how he or she actually was, they might need to indicate that special circumstances were being brought into play. Similarly to respond with anything other than a neutral 'fine' or 'okay', such as 'awful' or 'fantastic' would set up its own sequential trajectory and the onus would then be on the original inquirer to invite the speaker to provide a further explanation of this. So, Sacks' interest in the ritual or ceremonial order differed fundamentally from Goffman's, in that it began from the sequential order of talk-interaction itself (Hutchby and Wooffitt, 1998:28-29). The relevance of category membership (e.g. a person with cancer) in being asked a simple everyday question such as "How are you?" will be analysed in Chapter 6.

The fundamental questions for the conversation analyst are: 'What do we actually do when we talk?' 'How is talk organised and co-ordinated in interaction?' and 'What role does talk play in the wider scheme of social processes?' CA shares ethnomethodologists' interest in interpretative methods, but they treat these methods as emerging from the distinctive structure and processes of talk-in interaction. In other words, at its most basic CA is the systematic analysis of talk in interaction, that is, talk produced in everyday situations of human interaction. Communication and interaction are seen as inherently social processes, deeply embedded in the production and maintenance of all kinds of institutional settings, from everyday intersubjectivity, to the family, to the nation state (Hutchby and Wooffitt, 1998).

Hutchby and Wooffitt provide a very clear account of the focus of CA:

"Conversation analysis is characterized by the view that how talk is produced and how the meanings of that talk are determined are the practical, social and interactional accomplishments of members of a culture. Talk is not seen simply as the product of two 'speakers-hearers' who attempt to exchange information or convey messages to each other. Rather, participants in conversation are seen as mutually orienting to, and collaborating in order to achieve, orderly and meaningful communication. The aim of CA is thus to reveal the tacit, organized reasoning procedures which inform the production of naturally occurring talk. The way in which utterances are designed is informed by the organized
procedures, methods and resources which are tied to the contexts in why they are produced, and which are available to participants by virtue of their membership in a natural language community”.

(Hutchby and Wooffitt, 1998:1)

Historically, the tendency of conversation analytic investigations has been to focus on social actions which comprise of the organisation of ‘episodic’ moments of ordinary and institutional interactions (e.g. see Atkinson and Heritage, 1984; Drew and Heritage, 1992).

Both conversation analysts and discourse analysts treat talk as action, and these actions are performed using a diversity of devices. Using a tool kit metaphor, the idea is that different tools, for example, active voicing (Wooffitt, 1992) extreme case formulations (Pomerantz, 1986, Edwards, 2000) and footing (Clayman, 1992) can be drawn upon to accomplish and do particular business. Whilst I am not applying CA as a systematic form of analysis, the use of some of these devices, how they are deployed and what they accomplish in talk will be commented on throughout my analysis.

3:2.1 Category entitlement and category membership

CA is of particular relevance in this thesis to the extent that it provides many useful tools for analysis. Of specific interest is one of Sacks’ key notions, of category entitlement and entitlement to experience, together with the relationship of category membership and social identity⁴ (See also Potter, 1996).

Categories are often deployed in talk. What is of value in Sacks’ approach is that the categories of interest are those that are made relevant in and constructed by participants in interaction, rather than either the analyst’s categories, or the category produced by, for example, the medical practitioner or health professional.

Certain categories of people, in certain contexts, are treated as knowledgeable. In practice, category entitlement eliminates the need to ask someone how they know something; simply ‘being a member’ of some category, for example, a
doctor, a social researcher, or a person with cancer, is treated as providing sufficient information to account for and warrant their knowledge of a specific domain. But, ‘being a member’ is not quite that simple. Membership can be achieved or worked up and people can fail to be treated as having certain memberships. The nature, boundaries and implication of both categories and their entitlements can be reworked in a whole range of ways (Gilbert and Mulkay, 1984: Ch. 6; Potter, 1988). Jayyusi (1984) notes that whilst some categories are visible, or given official credentials, others are highly localised and negotiable. Throughout this thesis, attention will be given to the membership category of a person with cancer and how this is either worked up or down-played (see Chapters 6 and 7).

Category membership is another endemic feature of discourse and indicates that there is generally something at issue. How social categories are handled in use are a particular feature of Harvey Sacks’s (1979, 1992) ‘hotrodder’ study which focused on a group of 1960s ‘teenagers’ and how they talked around issues of who they were and what they did in group therapy sessions. The term ‘hotrodder’ was used by the participants and is a word derived from ownership and activities with customised cars (hotrods). Sacks showed how the “deployment of the term ‘hotrodder’ as a description of people, was an effective way of drawing boundaries around who did and did not count (for a current speaker, in the current talk) as a legitimate member of that category.” (Edwards, 1998:115). Sacks highlighted a number of features of how the use of this word functioned, for example “how it was aligned with various other terms (e.g., descriptions of cars and activities) and how it contrasted with alternatives (e.g. ‘teenager’, which was an adult’s, outsider’s description)” (ibid: 15).

The analysis throughout this thesis emphasises how outsiders, including the medical profession, friends, family and colleagues (i.e. those without a cancer diagnosis) make use of category descriptions. Sacks’s general concern was with how conversational participants use descriptive categories of this kind, and apply membership criteria, as a way of performing various kinds of discursive actions. His approach contrasts with how such categories figure in other kinds of social

4 DP’s approach to the study of social identity will be discussed later in this chapter.
science, as analysts’ categories of people, according to which the analyst offers explanations of what they do, what they say, and how they think. This shift, towards treating categorisations of that kind as topics under investigation (participants’ resources for doing descriptions and explanations) rather than as analysts’ explanatory resources, is not only a key feature of ethnomethodological work (Wieder, 1988) but is also a feature in discourse analytic studies of group identity (Wetherell and Potter, 1992).

According to Sacks, categories are not neutral descriptions, they are ‘inference rich’ which means they are linked to particular activities (category-bound activities) and consequently, there are strong expectations and conventions associated with them. In interaction participants display their orientations to the kinds of inferences which may warrantably be drawn about them by virtue of their membership of a category. (See also Hester and Eglin, 1997a; Jayyusi, 1984; Widdicombe and Wooffitt, 1995). Sacks provided a classic illustration of category bound activities in his lectures. He noticed the following story opening in a book of stories by children: “The baby cried. The mommy picked it up” (Sacks, 1992). Most people reading or hearing this will have made the assumption that ‘the mommy who picks up the baby is the mommy of the baby; similarly, the reason for mommy to pick it up will be associated with the baby’s crying. This precise detail is not contained in the extract itself, but each reader/hearer is likely to arrive at the same interpretation because of the common-sense expectations associated with categories like mommy (e.g. that they care for babies and children when they are in distress) and the way in which categories are grouped in relation to other categories (Sacks, 1972).

Watson and Weinberg, (1982:60) suggest that “Membership categories may conventionally be seen as having category-bound predicates...they are loci for the imputation of conventional expectations, rights and obligations concerning activities (for instance) which is expectable or proper for an incumbent of a given category to perform.” In other words, when we assign a person to a category this ensures that the conventional knowledge about the behaviour of people
categorised in this way can then be cited, or invoked to explain or interpret the actions of that person.\(^5\)

Discursive analysis is concerned with how, when and why categories are constructed and mobilised in talk, and it is suggested that categories are constructed and made relevant to talk in the routine business of negotiating one's own accountability. So, a category may be constructed in order to ascribe a particular identity to the self, or alternatively may be deployed to construct the identity of 'others' with whom the self can then be rhetorically compared, contrasted and evaluated against.

Category-bound predicates are of particular relevance for anyone who is categorised as a person with cancer. In their accounts to me as a social researcher and in their accounts of their everyday social interaction, it is common to find sequences in which they report 'others' sensitivity to the inferential implications of the category ascription (See Chapters 5 - 8).

3:2.2 Identity

Categories provide us with convenient labels so the category of 'a person with cancer', or a 'patient', provides an identity with a set of inferential resources (culturally available) which can be used by others to understand and interpret the behaviour of the categorised person. The analytic task is to find out if, when and for what, these categories have such relevance (Schegloff, 1992b).

The notions of social identity and category membership are crucially linked. When we refer to a person's social identity, we are also indexing their membership of a specific category. Social identity is a description which is available for people to invoke and deploy in mundane interactions. Antaki, Condor and Levine (1996) explored social identity as a resource deployed in conversational texts. They claimed that speakers' identities are much subtler than simple pre-given category labels suggest, and that they change rapidly as a

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\(^5\) Baker (1997) notes that membership categorisation devices are a key to treating interview data differently. The significance of this will be noted in the Data section of this chapter.
function of the ephemeral (but socially consequential) demands of the situation (Antaki et al 1996:473).

In DA, when someone claims an identity for themselves or an 'other', categories are deployed as a cultural resource for warranting, explaining and justifying behaviour (Widdicombe, 1998). In turn, this provides the basis for the "legitimate (that is, conventional and warranted) imputation of motives, expectations and rights associated with that category and its incumbents" (ibid: 52-53).

Edwards suggests that identity is also a locally managed concern for participants in that "they are potentially available for doing discursive 'business'. Categories such as gender, age, parental and marital status, nationality etc., are not merely factual, or even value-laden observations that have an automatic relevance to people's conversational activities; they are culturally available resources in our language that identify and describe people, which allow us to make reference to other people or to ourselves" (Edwards, 1998:20). The relevance and concerns of identity and how this is managed by a PWC will be discussed further in Chapters 5, 6 and 7.

3:3 Scientists' discursive practices in the sociology of scientific knowledge (SSK)

Although I will not be doing an explicit repertoire analysis, Gilbert and Mulkay's work is a key feature informing discourse analysis and is presented here as part of the construction of DP and DA. Gilbert and Mulkay's Opening Pandora's Box (1984) is regarded by many as 'the classic discourse analysis study' and provides an insight to how scientists construct their versions of accounts in such a way as to be believable, factual and 'true'. They examined the ways in which scientists' discourse reproduces the independent and objective status of the objects or processes they study. Gilbert and Mulkay's work contrasts markedly with most studies of scientific knowledge. Unlike empirical relativists and social interest researchers, their aim was not to provide an account of what science is really like, but to see how scientists constructed accounts of theory and choice and in particular, in the variations between such accounts. They noted that
scientists typically offered one version of theory choice when describing their own theory selections, but a rather different one when criticising as misguided the theory choices of competing scientists (Mulkay, 1991: ch.10, Potter, 1984).

They defined how scientists employ two functionally distinctive and contrasting vocabularies or 'interpretative repertoires' when accounting for their actions and beliefs in different social situations, namely the empiricist repertoire (formal) and the contingent repertoire (informal) (Gilbert and Mulkay's terms) and found that scientists used these repertoires to construct asymmetrical accounts of truth and error. The empiricist repertoire, applied to scientific papers, has a coherent and distinctive set of linguistic and rhetorical features, which are clustered around three broad themes. Firstly, scientists use an impersonal style of language using constructions such as 'the hypothesis proposed', 'results suggest' which helps minimise subjectivity. Secondly, the data are treated as primary and generally the theory is developed from the empirical data, rather than preceding it. Constructions such as 'these data suggest...' and 'the findings point to...' are prevalent in scientific reports.

Finally, laboratory work is characterised in a strongly conventional manner as being constrained by rules that have a clear-cut and universal application (Gilbert and Mulkay, 1984). The empiricist repertoire provides for descriptions of scientists' actions and beliefs, which minimise the involvement of the scientist in constructing and interpreting what is studied. The scientist becomes passive, the data takes on a life of its own, and Potter (1996) suggests that the empiricist repertoire is a standard device for constructing the out-there-ness of scientific phenomena. Gilbert and Mulkay claim that it "portrays scientists' actions and beliefs as following unproblematically and inescapably from the empirical characteristics of an impersonal natural world" (Gilbert and Mulkay, 1984:56).

But there has to be some way of accounting and managing for error even though in science methodology, errors should not occur. Gilbert and Mulkay identified

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6 Another approach to producing out-there-ness involves constructing consensus and corroboration by presenting a description as shared across different producers, rather than being unique to one (Potter, 1996).
that in more informal settings, in interview talk and where appeals to the personal context-motive bias, speculation and intuition, and the social context of research (that are normally excluded from scientific reports) the 'contingent repertoire' was deployed to account for mistakes and discredited findings.

The empiricist repertoire alone is inadequate for science in practice and some contingent form of accounting is required. Error accounts are essential to the credibility of factual accounts, so despite their absence from formal reports "in much informal talk among scientists such things are discussed, are taken to be an essential part of science and are depicted as influencing the course of scientific development" (ibid: 110). In order to achieve this, scientists made use of a 'Truth will out device' (TWOD), which is a discursive way of rescuing the empiricist repertoire when a scientist's own position is under threat from a contingency account. The TWOD reinforces the idea that the disagreements, glitches and setbacks that are attributable to human error will be overcome and the scientific empiricism will eventually prevail as 'truth'.

The empiricist repertoire is not confined to the scientific community, particularly where the factual grounds of reports and the objectivity of claims are important participants' concerns. Potter (1996) proposed that constructions of impersonality in news reports, (e.g. 'it is believed that') and fact agency (e.g. 'the facts show that') are commonly used. Potter notes that in situations of conflict in both scientific and everyday settings people will increasingly provide technical support for positions and be increasingly concerned with giving a basis to their claims (Latour, 1987; Pomerantz, 1984b). Potter suggests that this form of empiricist discourse can be understood as an extension of this process. "The support is built up by constructing the facts, the record, and the evidence, as having its own agency. Such constructions obscure the work of interpretation and construction done by the description's producer: 'the facts' are, first not being constructed as facts, and second, their significance is not being generated by their producer, it is provided by the facts themselves" (Potter, 1996:158).

This phenomenon is relevant here because despite the contradictory findings of scientific reports on the benefits of social support, adopting the 'heroic model'
and how having a ‘positive attitude’ can contribute to a more successful prognosis; the empiricist repertoire maintains its influence. The findings of these scientific studies are taken up and portrayed in the media, in all its various forms, and have become part of the repertoire of medical and health professionals, family, friends, carers and colleagues.

But interestingly, many headlines also subscribe to the uncertainty about cancer. The contingent repertoire is often headlined in cancer support literature relating to treatments and cures, where the facts are contingently constructed (for example, ‘Aspirin and ibuprofen may protect against some cancers’; ‘new drug for prostate cancer may have few side effects’; ‘complementary therapies can help combat cancer pain’).

The contingent repertoire can be drawn on to make relevant the subjective and constructed nature of people’s claims and accounts in a way that undermines their factual basis (Horton-Salway, 1998). Edwards (1997) states that interpretative repertoires are fundamental in discourse analysis because they are categories that participants themselves treat as meaningful concerns.

3:4 Discursive Psychology and Discourse Analysis
3:4.1 Discursive psychology and Its origins

Discursive psychology (Edwards and Potter, 1992) is an approach that draws on ethnomethodology, conversation analysis, rhetorical analysis and discourse analysis.

Discursive psychology (DP) focuses on the action orientation of talk and writing and studies the relationship between psychological states and the external world as common sense discourse practices and categories.

Edwards and Potter define DP as follows:

“For both participants and analysts, the primary issue is the social actions, or interactional work, being done in the discourse. But rather than focusing on the usual concerns of social interactional analyses, such as the way social and
intergroup relationships are conducted (through forms of address, speech accommodation and so on), or how 'speech acts' might be identified, the major concern is epistemological. We are concerned with the nature of knowledge, cognition and reality: with how events are described and explained, how factual reports are constructed, how cognitive states are attributed. These are defined as discursive topics, things people topicalize or orientate themselves to or imply in their discourse. And rather than seeing such discursive constructions as expressions of speakers' underlying cognitive states, they are examined in the context of their occurrence as situated and occasioned constructions whose precise nature makes sense, to participants and analysts alike, in terms of the social actions those descriptions accomplish."

(Edwards and Potter, 1992:2).

A key feature of discursive psychology is as Edwards states "the lack of a clear distinction between theory, phenomena and method. The same features of discourse that are the topic or focus of analysis also seem to feature as theoretical positions and as analyst's tools" (Edwards, 1994:17), in other words, theory, topic and method are closely linked.

It is therefore not a simple task to separate the theoretical position of DP and the analytical tools of discourse analysis. An appropriate beginning is to outline some of the elements of the Discursive Action Model (DAM), a conceptual framework devised by Edwards and Potter which captures some of the features of participants' discursive practices and illustrates some of the relationships between them (Edwards and Potter, 1992:155). This model forms the basis of discourse analysis and is divided into 3 sections: action, fact and interest and accountability (see figure 1). It was devised with the purpose of preventing discourse analysis being treated as a psychological 'method'; "there is more than a methodological shift at work; there is some fairly radical theoretical rethinking" (ibid: 11). In other words, discourse analysis reflects a theoretical position as well as a mode of analysis. Edwards and Potter also note that their model should not be understood in the traditional cognitive psychological sense of a 'model'. Rather than "specify mental processes", it is "a set of policies and recommendations for discursive enquiry..."(ibid: 155). The relevance of these sections and their relationship to the analysis that follows will be discussed briefly.
The Discursive Action Model

Action

1. The research focus is on action rather than cognition or behaviour.

2. As action is predominantly, and most clearly, performed through discourse, traditional psychological concepts (memory, attribution, categorisation) etc. are reconceptualised in discursive terms.

3. Actions done in discourse are overwhelmingly situated in broader activity sequences of various kinds.

Fact and Interest

4. In the case of many actions, there is a dilemma of stake or interest, which is often managed by doing attribution via factual reports and descriptions.

5. Reports and descriptions are therefore constituted/displayed as factual by a variety of discursive devices.

6. Factual versions are rhetorically organised to undermine alternatives.

Accountability

7. Factual versions attend to agency and accountability in the reported events.

8. Factual versions attend to agency and accountability in the current speaker’s actions, including those done in the reporting.

9. Concerns 7 and 8 are often related, such that 7 is deployed for 8, and 8 is deployed for 7.


3:4.2 Talk as social action

The term ‘discourse’ refers to all forms of talk and texts, whether it be interview data, naturally occurring conversations, or written texts of any kind. DA treats talk and texts as being active. The emphasis is on action rather than cognition. Accounts of memories and attributions are redefined as “reportings (and accounts, descriptions, formulations, versions and so on) and the inferences that
they make available" (ibid: 154). DA also concerns itself with the variability of accounts which points to the situated and functional character of versions (Potter and Wetherell, 1987).

Discourse is viewed not just as an object but as a way of treating language. Jonathan Potter defines discourse analysis as:

"...an analytic commitment to studying discourse as texts and talk in social practices. That is, the focus is not on language as an abstract entity such as a lexicon and set of grammatical rules (in linguistics), a system of differences (in structuralism), a set of rules for transforming statements (in Foucauldian genealogies). Instead, it is the medium for interaction; analysis of discourse becomes the analysis of what people do"

(Potter, 1997: 146)

In other words, language is not just a tool for description and a medium of communication (the conventional view), but it is a social practice and a way of doing things. DA "is concerned with what people do with their talk (and writing) and with the kinds of resources they draw on in the course of their discourse practices (e.g. the devices, category systems, narrative characters and interpretative repertoires) which provide a perspective on social life that is both methodological and conceptual" (Potter and Wetherell 1995:81). It is not simply an alternative to conventional methodologies; it is an alternative to the perspectives in which those methodologies are embedded. Its aim is to contribute "to our understanding of issues of identity, the nature of mind, constructions of self, other and the world and the conceptualization of social action and interaction" (Potter and Wetherell, 1995:81).

A major assumption is that the phenomena of interest in social and psychological research are constituted in and through discourse. Talk does not simply reflect or mirror what is assumed to be already there, it creates the social world in an ongoing and continuous way (Edwards, 1997, Potter, 1996). "The metaphor of a mirror image or a photograph makes descriptions passive" (Potter, 1996:97) but the DA approach, contrary to traditional approaches in social psychology, stresses that the language of descriptions and accounts construct the world, in other words, language is constructive.
3:4.3 Fact construction

The term construction is linked to the principles of social constructionism (Gergen, 1985a), but in DA, construction has a strong analytic focus. Social construction is treated as epistemic, meaning that "it is about the constructive nature of descriptions, rather than of the entities that (according to descriptions) exist beyond them" (Edwards, 1997: 47-8). This kind of detailed study of participants' talk is concerned with "how events are described and explained, how factual reports are constructed, how cognitive states are attributed" (Edwards and Potter, 1992:2). These phenomena are analysed as discursive practices and constructions rather than as cognitive-perceptual processes.

Edwards and Potter state that construction and description are at the heart of DA and that the analytic concern is with how discourse is constructed to perform social actions. In interaction, the assembly of an account (or a version) of the world involves choosing or selecting from a number of different possible versions. Even the simplest of phenomena can be described in a variety of different ways and the resources that DA studies employ can be seen as the building blocks of convincing or at least rhetorically sustainable versions (ibid). Any particular description will depend upon the orientation of the speaker or writer (Potter and Wetherell, 1987, Potter and Edwards 1990). 7

In discursive terms, descriptions are not viewed as disembodied commentaries on states of affairs. Instead they are seen as ways in which they make reference to states of affairs and occur in particular interactional and situational contexts, that will unavoidably be understood as actions which are chosen and consequential. Descriptions, like other actions, are 'indexical' and should be understood in relation to when and where they occur. They are also 'reflexive' in maintaining or altering the sense of the activities and unfolding circumstances in which they occur (Heritage, 1984a).

7 The orientation of the writer of this thesis is as a social science researcher, someone who has personal experience of the difficulties of talking about cancer and a participant.
So, descriptions 'do things' for the speaker; they can blame, or make excuses, or they can present the speaker or the 'actor' in a positive light. We are all social 'actors' and continually orient to the interpretative context in which we find ourselves, and construct our discourse to fit that context. How we orient to an encounter with a medical professional presenting a diagnosis, a family member asking "how are you today?" or a social science researcher asking someone to talk about life with cancer, will vary in accordance with the context and situation of the nature of the interaction. They may attend to what they think the researcher wants to hear and the account they give to me as a social researcher in an interview setting is likely to be different to an account given to a family member or to a medical professional. For example, someone who has been burnt by their radiotherapy treatment might give a hearably complaining account to a friend, (or in an interview, see Chapter 7, extract 7:2.3) but might present a different account to the radiographer when receiving treatment. The issue in DA is that any account will vary, even within a research interview, according to the particular action that the talk is performing at that point.

3: 4.4 Stake and Interest

The analytic concern for DA is with the methods of description and how versions can become established as real and independent of the speaker. An important issue in the construction of versions is the management of stake or interest. Issues of stake and interest can become important resources for working-up and undermining the credibility of particular 'versions' of reality. In providing descriptions of events, people routinely attend to issues of agency and personal accountability. Speakers have something to gain or lose; they are not disinterested. "They have a stake in some course of actions, which the description relates to, or there are personal, financial or power considerations that come into play" (Potter, 1996:124). One of the concerns that participants attend to in the construction of their version of events is that their description might be contested on the grounds that they may have an 'axe to grind'. Whenever there is some difficulty or widespread issue to be managed, there are likely to be some well-developed procedures for dealing with it, such as stake inoculation (Potter, 1996). Interestingly, Potter aligns this with a medical
analogy. In order to avoid catching a disease such as tuberculosis people can be inoculated against it. Similarly, conversationalists and writers can limit the ease with which their talk and texts can be undermined by doing a *stake inoculation*. An injection can prevent a disease, so perhaps as Potter suggests, it is possible to inject a piece of discourse to prevent being undermined. What is at stake for many PWC is how they present themselves as someone who is managing or 'coping' with their illness in accordance with the prescriptive cultural norm of *being positive*. This topic is a pervasive feature of analytical interest throughout this thesis.

3:4.5 Rhetoric

Another central theme in DA is the rhetorical or argumentative organisation of talk and texts, and how claims and versions are constructed to undermine alternatives (Billig, 1987, 1991, 1996). A concern with rhetoric turns the research focus to a world of social conflict and undermines the common social psychological assumption that people exist as naturally disinterested information processors. Unlike conversational analysis, discourse analysis views social life as being characterised by various kinds of conflicts and much of discourse is involved in establishing one version of the world in the face of competing versions. Billig (1991) suggests that in order to understand the nature and function of any versions of events, we need to consider whatever real or potential alternative versions it may be designed to counter. Rhetoric should not be confined to obviously argumentative or explicitly persuasive communication, but should be seen as a pervasive feature of the way people interact and arrive at understanding (Billig, 1987, 1996). For example, what traditional social psychologists or psychosocial oncologists might treat as an individual's 'attitude' might through a rhetorical analysis reveal a view that is designed to counter a dominant but established alternative (Billig, 1991).

In traditional psychology, attitudes have been treated as individuals' isolated cognitive evaluations of parts of the world. Billig argues that they should be seen as public positions that are inseparable from current controversy; indeed there is no role for attitudes except in issues where there is conflict and dispute. The
implication of this is that "every attitude in favour of a position is also, implicitly but more often explicitly, also a stance against the counter position. Because attitudes are stances on matters of controversy, we can expect attitude holders to justify their position and to criticise the counter position" (Billig, 1991:143). (See Chapters 6 and 7). The reason for emphasising rhetoric here is that when descriptions are analysed, part of the interest will be in what alternative claims or arguments are being undermined. Through the use of rhetoric, one can change topics of conversation, or even remove certain matters from the dialogic agenda (Billig, 1991). A feature of any description is that it counters, actually or potentially, a range of competing alternative descriptions. (Potter, 1996).

The rhetorical nature or argumentative organisation of talk and text directs attention to the way in which accounts are designed and organised to be persuasive, which leads into a concern with ideological dilemmas (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988). Narrative accounts can be rhetorically constructed to rework, manage or reframe possible alternative descriptions (cf. offensive rhetoric, Potter, 1996). For example, PWC who organise their accounts to persuade someone that they are not blaming anyone for their delayed diagnosis, or they are not complaining, (see Chapter 5) or they are being positive (see Chapters 6 and 7) will employ a number of devices to accomplish their aims.

My analysis looks at how a range of techniques, including contrast structures (Smith, 1978), three-part lists (Heritage and Greatbatch, 1986) and extreme case formulations (ECFs, Pomerantz, 1986) are drawn on when claims are being bolstered against doubt or disagreement (Edwards, 1997). Of particular interest is how participants rhetorically construct their narratives to manage the normative cultural expectations and moral dilemmas accompanying cancer by displaying themselves as being accountable and being positive.
3:4.6 Ideological dilemmas

The importance of rhetoric in DA also has implications for ideological dilemmas. The term ideological dilemmas has been devised to explain speakers' orientations to attending to and solving contradictory issues.

Billig (1995) suggests that rather than conceive of ideologies as existing independently of individuals they should be viewed as "lived ideologies" which are negotiated in everyday mundane talk and that 'ideologies' also provide speakers with contradictory ways of talking.

Discursive theorists suggest that ideology provides the dilemmatic elements of common sense which speakers puzzle and argue over in their everyday talk. Rather than regard it as something that inhibits thought, it is treated as a social action, available in talk and therefore analysis. Billig et al state that:

"Many words are not mere labels which neutrally package up the world. They also express moral evaluations and such terms frequently come in antithetical opposites which enable opposing moral judgements to be made".

(Billig et al, 1988:16)

Common sense notions of health and illness reflect ideological values and representations and do so in ways that appear both dilemmatic and natural (Radley and Billig, 1996). When people have a chronic or life threatening illness they are likely to 'suffer' and Charmaz (1999) states this suffering is not just a physical experience, it has a profoundly moral status. The dilemma for the person who is ill is how to accede to this moral order of illness and suffering and not been seen as someone who is self-pitying, pitiful or not coping, but as someone who is active, 'fighting' it and being positive. The moral implications of illness have already been noted in Chapter 2. How participants manage their accountability and orient to the moral and dilemmatic elements of illness is a feature examined throughout the analytical chapters.
3:4.7 Accountability

The final theme in discursive psychology is accountability. Our accounting practices are deeply embedded in our everyday activities and Garfinkel states that:

"people's everyday activities are such that they reflexively contain within themselves methods for making those same activities visible-rational-and-reportable-for-all-practical purposes, in other words, 'accountable,' as organizations of commonplace everyday activities."

(Garfinkel, 1967:vii).

Simply, in everyday social life, people do not just passively happen to act in an accountable manner and to perceive events in accountable terms; their procedures of talking, listening, looking and acting are methodical. They act so as to make their behaviour (and talk-in-interaction) accountable; it is, says Garfinkel (ibid: 10) "an endless, ongoing contingent accomplishment"; and it is achieved by the use of certain methods and procedures that, he says, are experienced as "unproblematic...and are known only in the doing which is done skilfully, reliably, uniformly, with enormous standardization and as an unaccountable matter" (ibid: 10).

As previously mentioned, discursive psychology emphasises description as a resource for constructing particular versions of events, people, objects and places. In offering their accounts, people treat each other as having either something at stake or a particular interest in their accounts and actions; they routinely deal with matters of agency and responsibility (Edwards and Potter, 1992), and treat themselves as accountable for producing a particular version or description of reality. For example, an account that performs part of a complaint will have the potential requirements of accountability of that act. "The act of complaining could be inspected for its partial or motivated nature, for instance, or for its adequacy vis-à-vis some version of 'the facts" (ibid: 166).

It is argued that a speaker's talk is structured to attend to these issues of accountability and Edwards claims:
"...when people describe events, they attend to accountability. That is to say, they attend to events in terms of what is normal, expectable, and proper; they attend to their own responsibility in events and in the reporting of events"


Issues of accountability are also situated rhetorical concerns. However, in accounting for oneself, speakers must do more than talk about themselves (Radley and Billig, 1996). Accountability only arises in the first place because there are general concerns of value and morality.8

For the discourse analyst, the task is to consider how this accountability is constructed, challenged and defended in interaction and to examine the social actions that are accomplished through its management.

Shotter (1991, 1993) argues that psychology is a moral9 science and claimed that:

"One of the most significant features of human actions in everyday life is not only their situated, contexted, occasioned nature, but also their normative accountability. That is, in some sense they are not only made but judged in their making, by both those who perform them and those around them, as to both their social and moral appropriateness to the circumstances of their performance"

(Shotter, 1991:62)

Frank (1992) also argues that social science is a moral discourse which presents claims not only about the nature of suffering but also about the proper response to suffering and that research needs to recognise this moral dimension when evaluating others' lives. One of the concerns of this thesis is how the moral issues and categories that are attributed to and surround the disease of cancer and the accompanying illness are handled in social interaction. It is suggested that when participants attend to issues of moral accountability in their accounts

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8 Talking about one's own illness (or health) is to locate oneself within an ideological debate that requires what Hall (1981) once called a 'double signification'. This means that the statements ill (or healthy) people make to interviewers not only provide information but speakers also claim to depict, or represent a wider shared reality (Radley and Billig, 1996).

9 The meaning of moral in this context is reflected in the following definition taken from The New Shorter Oxford English Dictionary (Brown, 1993). “moral -adj. 1 concern with goodness or badness of human character or behaviour, or with the distinction between right and wrong. b concerned with accepted rules and standards of human behaviour. 2 a virtuous in general conduct. Be capable of moral action. 3 (of rights or duties etc.) founded on moral not actual law. 4 associated with the psychological rather than the physical
this poses ideological dilemmas for the person who is ill. Therefore, managing one's own accountability involves references to 'dilemmas' and the positioning of both speaker and 'other' in relation to such dilemmas. Speakers also manage their own accountability for particular events through the construction and positioning of their own identity and that of others within a moral order. Moral accountability will be discussed in more detail in Chapter 7.

This section has provided an overview of the main themes of the theoretical and analytical approach applied in this thesis. These include treating talk as action, fact construction, stake and interest, descriptions, category entitlement, identity, rhetoric, ideological dilemmas and finally, accountability.

It is proposed that analysing interviews with PWC using a discursive psychological approach and discourse analysis provides a different insight into our understanding of the social world of people living with a life threatening illness. DA offers an opportunity to discover patterns of talk and moral and social concerns that are more difficult to discover if traditional theoretical models and analytical methods (with their accompanying predefined categories and expectations) are used to analyse the data.

The cultural knowledge of cancer influences, permeates and shapes not only the language and understanding of the person with a cancer diagnosis but also those people they interact with, including the medical profession, family, friends and colleagues. The language of cancer and the cultural expectations and difficulties of knowing what to say can produce a number of dilemmas and problems for the PWC to manage. This thesis aims to show how participant's accounts discursively attend to:

- the social interactional difficulties of talking about cancer and how talking about cancer is avoided
- how PWC attend to prescriptions of responsibility and how they manage issues of moral accountability

(moral courage; moral support). -n. 1 moral lesson of a fable, story, event, etc. 2 (in pl.) moral behaviour, e.g. in sexual conduct."
• how PWC attend to issues of *doing being responsible* and account for any notion of diagnostic delay
• how accounts of diagnostic delay, receiving the news of their diagnosis and receiving treatment are rhetorically constructed as complainable matters
• how *doing being positive* is managed as a participant's concern
• how laughter and humour are employed as a device for *doing being positive*

3:5 The Method of Data Collection

The following section details how participants became involved in my research, the nature and style of the interview, tape-recording, the process of transcription, the criteria of how I selected my data for analysis and finally how the coding themes for analysis were developed.

3:5.1 Data sources: Finding the participants

16 females and 1 male who had been diagnosed with various forms of cancer including breast, ovarian, throat and lung cancer, volunteered to participate in this research and their ages ranged from 35 to 70 years old.

Firstly, I will outline the process of finding people to talk to me. The sensitive nature of talking about cancer is reflected in this process. One of the most difficult practical problems in conducting research is obtaining access to people, particularly if the topic is a sensitive one. Although there has been a considerable amount of CA research in clinical and counselling settings, (e.g. see Maynard, 1991, 1997, 1998; Peräkylä 1989, 1995, 1998 and Silverman, 1990; 1997), and more recently Beach's longitudinal 'malignancy calls' study (2000; 2001) very little CA or discourse research has looked at face to face interaction with individuals with a cancer diagnosis outside of the clinical setting and the doctor-patient or counsellor-patient relationship.

My 17 participants were found through 3 different sources, two cancer support groups (Group 1 and Group 2) in Leicestershire (overall membership of approximately 350) and through personal contact. Because my primary concern
was to research what anyone who had been given a cancer diagnosis would talk about, my criteria for selecting participants was unrestricted by categories and demographics.

Categories, such as the type of cancer they had been diagnosed with, (e.g. breast cancer, prostate cancer) the stage of their illness, (or stage of remission) age, gender or status were not factors of selection and are not the basis of theoretical generalisations of any kind. I will however provide brief demographic information about each participant when an extract is analysed for the first time. The traditional assumption behind providing this information is that it is in someway relevant to our understanding of what is going on; that certain demographic information (e.g. age, class, gender and occupation) is the kind of information we need to know. However, in DA, it is argued that demographic categories are used, made relevant and are constructed as significant concerns by the participants' themselves and contribute to how their identities are managed and constructed in talk (and text).

Edwards (1993, 1997) suggests that this rather neutral and routine looking 'information' is potentially available for doing discursive 'business'. Categories such as gender, age, parental and marital status, nationality etc., are not merely factual or even value-laden observations, they are automatically relevant to people's conversational activities. By providing this information it is possible to analyse how these category descriptions are actually drawn upon and actively used as resources in producing accounts and descriptions relevant to the participants' identity. They are not merely inactive labels and categories and such demographics will only be considered in the analysis if the participants make these relevant themselves.

Also not at issue was how they found out that they had cancer. The interview data includes people who went to the doctor's because they had some physical sign, such as stomach ache, bleeding or they had found a lump and may or may not have suspected that they may have cancer; those who went, unsuspectingly, for a routine mammogram; and others, who were suffering some pain but had no idea what was causing it. The data is rich in variability.
Group 1

Firstly I telephoned the manager of support Group 1 and explained that I was researching and writing a Ph.D. based on people's experience of living with cancer and that I would like to make contact with PWC who would be willing to talk to me about their experiences. In support of my request, I also explained something about my personal experience of being closely involved with friends and family who had cancer, elucidating that this was the principal motivating force behind my research. Because of the sensitive nature of the talk, it became clear that it was necessary firstly to gain the trust and acceptance from the manager in order for me to be introduced to members of the group. This initial conversation resulted in my being invited to the Group's offices for a face-to-face interview with the manager to explore the possibility of being introduced to the Group's members. When we met I outlined my concerns and interests in more detail and we talked more about my personal experience.

I was then invited to attend one of the group's regular informal coffee mornings so that I could be introduced to some of the support group members. This mostly involved them 'interviewing' me to establish if they felt comfortable in talking to me.

The coffee mornings are primarily a social and supportive occasion for people to get together and talk about all kinds of things, not necessarily about their illness. In order to build up a relationship and rapport with the members I attended several coffee mornings over several months. After a few weeks I was asked if I would like to become a member of the group as a volunteer 'befriender', which I willingly accepted. This enabled me to become a more active member in the group and whilst the meetings and interactions with other group members were not tape-recorded, occasionally I will draw on some of this ethnographic material as a secondary source of knowledge.

In addition to my active participation and the coffee morning meetings, I also placed a notice in the support group's quarterly magazine and received a number of telephone responses. Although I was approached by and talked to
approximately thirty people, eight people agreed to participate in my research and I was invited to visit them in their homes to talk about their experiences. Some of the people I talked to although initially agreeing to talk, found that they were either not feeling well, or were about to commence treatment and therefore decided not to proceed, or had decided that they wanted to put the experience into the past and no longer wanted to talk about it.

Group 2

I was given a personal introduction to a member of Group 2 (a breast cancer support group) and after an initial telephone conversation, she visited me at my home. Again, I was ‘interviewed’ to assess whether or not I could be given permission to contact members of the group. At the end of the meeting she not only agreed to participate in my research but also agreed to talk about my research and me at the next meeting of the group. This introduction resulted in a further seven people contacting me and sometimes lengthy and detailed telephone calls ensued. I again explained my motivation and research interests. Interviews were held either at the participants' homes or they came to my home.

Again, as with Group 1, I talked to a number of people who initially agreed to talk to me but then withdrew at a later stage. Some people were happy to talk to me but did not wish to be recorded or formally participate.

The remaining two participants were people I knew personally who were interviewed in their homes.

Twelve of the seventeen participants were interviewed on their own, but two groups of friends wanted to be interviewed together and one of my personal contacts wanted to be interviewed with his family present. There was only one male participant. Although membership of Group 1 was open to both men and women, men rarely attended the coffee mornings and did not show any interest in talking to me other than in the context of the social setting. Although I personally knew men with cancer, again, although they would talk to me about their illness, they did not wish to participate in a recorded interview.
As already discussed in Chapter 2, talking about cancer is a delicate and sensitive topic and finding the participants for this study reflected the complexities and sensitivities of this process. It became clear that people did not want to talk freely to just anyone, they needed time to establish a sense of trust and rapport.

The primary data sources for analysis are constituted from a corpus of conversational 'active' interviews conducted with seventeen people with cancer over a two year period and consist of approximately 39 hours of tape-recorded talk.

3:5.2 Ethics

As previously mentioned, I had either met face to face or spoken to participants on the telephone prior to the interview. Each participant was advised of the nature of the research, and asked for their agreement for the interview to be tape-recorded. Participants were advised that they could withdraw from the interview or the research at anytime. Because of the sensitive nature of the topic, if participants became upset or distraught during the course of the interview, the interviewer's (RC) previous training in counselling skills and techniques was available as a resource to manage any such situation. Additionally the counsellors resident at the two support groups could be contacted if needed. In accordance with the British Psychological Society ethical procedures, participants were asked to sign a consent form (see Appendix A) and because of the sensitive nature of the interview, a list of contact Helpline numbers (see Appendix B) was provided. At the end of the interview I ensured that participants were feeling comfortable before leaving. On many occasions, participants thanked me for the opportunity of being able to talk to someone about having cancer and that it had been very helpful for them.

3:5.3 Interviewing

As I have already argued (Chapter 2) constructing categories and structured questionnaires places predetermined categories and concerns upon the
participant. My interest was in what people would tell me if I asked them to talk to about their experiences since receiving their cancer diagnosis. As explained in my introduction, personal experience provided the impetus for this research, and my interest was to explore the issues and concerns that were relevant to the PWC rather than those imposed by existing theoretical models.

Interviewing provides a way of producing empirical data about a particular social world by asking people to talk about their lives. I therefore chose to conduct what is termed 'active' interviews (Holstein and Gubrium, 1997). In discourse analysis, interviews are viewed and carried out as conversational encounters. Interviewing in discourse analysis is similar to interviewing in other forms of qualitative research in that both types are relatively unstructured; in other words, questions are generally open-ended and are not specified in advance. They also use a variety of probes or follow-up questions. There are some differences, however, in that participants are encouraged to speak as much as they would like, without interruption, which has an affect of encouraging them to display the sort of variability that is a major feature of discourse and an analytical tool. Interviewing in this way also encourages story telling or narratives, "it allows participants to develop long turns and tell things 'in their own way'" (Edwards, 1997:280).

The interviews were divided into two sections. The first part of the interview was unstructured and having either had an initial meeting or spoken to participants on the phone, participants were aware of my background and interest in hearing them talk about their experiences of cancer. Throughout the process I interacted with participants and sometimes asked for more detailed explanations of what they were talking about. A key factor in their agreement to talk to me was based on my personal involvement with cancer. Consequently, because participants were aware of my personal circumstances on many occasions, I was asked to talk about my own experiences of being a carer, thus my involvement is as both interviewer and active participant. The interviews were therefore interactive, collaborative, and more characteristic of an exploratory conversation.

My primary interest in the interviews was how people with cancer would talk about it, what they would talk about and what their concerns were. However, in
the second part of the interview I did explore a number of topics that I was interested in hearing more about and I drew up a schedule of questions (see Appendix C) to ensure that each topic was taken up by each participant, if it was appropriate. If they did not respond, I allowed the conversation to be directed by the participants and followed up interesting topics as they occurred.

3:5.4 Tape-recording

Tape-recordings are an important feature of CA and DA. Heritage (1984a) states:

"the use of recorded data is an essential corrective to the limitations of intuition and recollection. In enabling repeated and detailed examination of the events of interaction, the use of recordings extends the range and precision of the observations which can be made. It permits other researchers to have direct access to the data about which claims are being made, thus making analysis subject to detailed public scrutiny and helping to minimise the influence of personal preconceptions or analytical biases. Finally, it may be noted that because the data are available in 'raw' form, they can be re-used in a variety of investigations and can be re-examined in the context of new findings"

(Heritage, 1984a:238).

All interviews were tape-recorded. Because of the sometimes extremely sensitive nature of the talk, voice levels were extremely variable and at times, it was not possible to decipher everything that was said. It is important to point out that this was not through a technical problem and, when relevant, the phenomenon of voice levels will be addressed as a performative feature of sensitive talk in the analysis. Sometimes there were tears, but mostly there was laughter.

3:5.5 Transcription

Producing a high-quality transcript is an important prerequisite for discourse research and one of the benefits of a detailed transcript is that it provides a permanent and accessible record of the interview data. Transcription itself is a constructive, interpretative process. In the process of transcribing it is possible that attention will be paid to different aspects of talking, depending on the interests of the transcriber. Often, words and sentences are only fully understood...
by the researcher, who generally has some background and cultural knowledge of the data. This means that the transcript itself is already an interpretation of the event it is recording. However, a transcript can only provide a partial record because it cannot faithfully reproduce every aspect of talk and of course, non-verbal responses are not documented. However, wherever possible, some non-verbal responses were noted.

The tape-recorded interviews were transcribed verbatim. For the 'first pass' of transcription basic transcription notations were used. Once an extract was found appropriate for a particular theme of analysis it was then transcribed in detail adapting Jefferson's (1985b) transcription procedures and notational symbols which convey features of vocal delivery that have been shown to be interactively important to participants (see Appendix D). This involved continually listening to the tapes in conjunction with the first pass transcripts in order to capture all the subtleties discernible in the tone of voice, the pauses and any additional comments on intonation were added into the transcript for analysis. Interviewees have been given pseudonyms. Each interview was numbered and line numbers were added to the typed transcripts and subsequently categorised into theme headings.

3:5.6 Criteria for selecting extracts for analysis

"What one 'sees' in a text, what one regards as worth describing, and what one chooses to emphasise in a description are all dependent on how one interprets a text. There is a positivist tendency to regard language texts as objects; whose formal properties can be mechanically described without interpretation. But try as they may, analysts cannot prevent themselves [from] engaging with human products in a human, and therefore interpretative way"

(Fairclough, 1989:27).

The combination of the style of active conversational interviews and the knowledge that I would be using discourse analysis, provided me with an 'open book' when it came to discovering the emerging analytical categories. Although my initial interests outlined in my interview schedule had been on the topics of communication, change and quality of life, what has emerged is quite different.
George Psathas, amongst others, stated that the task is not to look for expected kinds of phenomena, but to engage in what is termed 'unmotivated looking':

"Data may be obtained from any available source, the only requirement being that these should be naturally occurring, rather than produced for the purpose of study, as in the case of laboratory experiments or controlled observations. In practice, this has meant interactional phenomena that would have occurred regardless of whether the researcher had come upon the scene; therefore conversations, news interviews, therapy sessions, telephone calls, dinner table talk, police calls, as well as all manner of interactional phenomena that a researcher may be able to come upon and record are potential data sources"

(Psathas, 1995:45).

Although Psathas' comment would seem to eliminate interview data, Edwards proposes that "any interactional phenomenon can be naturalized by treating it as natural" (Edwards, 1997:89). Interview data can therefore be treated as a "species of talk-in-interaction, as 'interview', rather than treating the questioner as researcher, the question schedule as 'method' and only the responses as 'data'" (ibid: 89) (cf. Wetherell and Potter, 1992; Widdicombe and Wooffitt, 1995; Wooffitt, 1992).

The notion of 'unmotivated looking' encapsulates an important analytical principle, that is to avoid 'reading into' the data a set of ready-made analytical categories. So, rather than start with a ready-made issue, such as 'how do people with cancer cope with stigma?' it is preferable to follow Sacks' advice that "the first rule is to learn to be interested in what you've got. I take it that what you want to do is pose those problems that the data bears" (Sacks, 1992: 471).

The results can be quite surprising and as Sacks's own analysis has demonstrated, "it is precisely what opens up, rather than prevents, the possibility of empirical work on participants' categories of the ostensibly non-discursive, including everything from group membership to personal identity, institutional settings, matters of belief, cognition, and constructions of what is routine and exceptional in life" (Edwards, 1997:89).

Although transcribing interview data using Jefferson's guidelines is a time consuming and demanding process, it does provide the opportunity to become very familiar with the content. So, whilst transcribing, thoughts about patterns,
themes and topics emerged and so I made notes as I went along, noting possible topics or extracts that held particular interest. This produced a very long list of interesting topics, which initially seemed disparate but in the course of analysis, eventually merged together.

Potter and Wetherell (1992) proposed a ten-stage process of discourse analysis. They suggest that these should not be taken as sequential steps but as phases which have a tendency to merge together. I will give a brief summary of each stage.

Stage 1: The research question(s). Participants' discourses are approached in their own right and not as a secondary route to things 'beyond' the text, such as attitudes or cognitive processes. Research questions are broadly concerned with the construction and function of discourse, of how it is put together and what is gained by this construction. My primary research questions are: "What would people tell me when asked to talk about their illness", "How do people talk about the sensitive topic of cancer?" "How do people ‘do coping’ in their talk?" and “What functions are being managed, constructed and accomplished?"

Stage 2: Sample selection. Because DA concerns itself with the use of language, the success of a study is not dependent on the size of the sample, so small samples or a few interviews are quite adequate for investigating interesting phenomena. What is important is to provide a clear and detailed description of the nature of the material.

Stage 3: The collection of records and documents. The primary records for my analysis are transcripts of tape-recorded interviews. Secondary sources from the social science literature, the media and published literary accounts provide additional documents.

Stage 4: The interview. Potter and Wetherell suggest that naturalistic records of conversations do have a number of advantages and that, "interviews have the virtue of allowing the researcher room for active intervention" (Potter and Wetherell, 1992:163). The interview schedule provided the continuity throughout
the interviews whereby, if appropriate, I was able to explore the same issues with each participant. DA Interviews differ from conventional interviews in three ways. "First, variation in response is as important as consistency. Techniques which allow diversity rather than those which eliminate it are emphasised, resulting in more informal conversational exchanges and finally, interviewers are seen as active participants rather than speaking questionnaires" (ibid: 165).

Stage 5: Transcription. A good transcript is essential for DA. The transcription process itself helps the researcher become familiar with the data, and the process is in itself a constructive and conventional activity.

Stage 6: Codings. Once the transcripts have been completed, it is time to consider coding. The purpose of coding is to break the discourse into manageable chunks, quite distinct from the analysis itself. My initial coding categories fell comfortably into the trajectory of the illness, from discovering something wrong, to the diagnosis phase, social relationships, treatment and talk about recovery, death and dying. During the coding process, pages of transcripts containing relevant extracts were reproduced, cross referenced where appropriate and put into their own document file, ready for the analysis stage.

Stage 7: The analysis. "There is no mechanical procedure for producing findings from an archive of transcripts" (ibid: 168). There are two closely related phases in analysis. Firstly, the search for patterns in the data. "Patterns will be in the form of both variability: differences in either the content or form of accounts, and consistency: the identification of features shared by accounts" (ibid: 168). People's talk fulfils a number of functions and has varying effects so the second concern is with function and consequence. This second phase involves forming hypotheses about the functions and effects and searching for the linguistic evidence.

Stage 8: Validation. There are four main analytical techniques that can be used to validate the findings of DA: (1) coherence (2) participants' orientation (3) new problems and (4) fruitfulness.
Coherence: Analysis should show how the discourse fits together and how discursive structure produces effects and functions. When a regular pattern of accounting is discovered, then it is also necessary to search for 'deviant' cases. "Cases that lie outside the explanatory framework of a theory are almost always more informative than those that lie within" (ibid: 170).

Participants' orientation. It is not sufficient for the analyst to say that there is variability and consistency. For discourse analysts "the important thing is the orientation of the participants, what they see as consistent and different" (ibid: 170) and what they make distinctive in their interactions.

New problems. One of DA's primary aims is to explain how linguistic resources are used to make certain things happen. Not only will these resources solve problems but they will also create new ones. "The existence of new problems and solutions, provides further confirmation that linguistic resources are being used as hypothesised" (ibid: 171).

Fruitfulness. "This refers to the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations. This is of course a general criterion of validity for scientific explanations and theories; if they can be used to generate fresh solutions to the problems in a field of research then we accord them more respect" (ibid: 171).

Stage 9: The thesis itself. The final thesis constitutes part of the confirmation and validation procedures. The goal is to present the analysis and its conclusions in a way that enables the reader to assess the researcher's interpretations. A representative set of examples needs to be included along with a detailed interpretation which links analytic claims to specific parts or aspects of the extracts. The analytical section is considerably longer and more detailed than in the traditional style of reports. In summary, the stages leading up to the final presentation "involves fluid movement between the different stages, with coding, analysis, validation and writing, each leading back to earlier phases and ultimately to the talk and writing which were the original point of departure" (ibid: 174).
Stage 10: Application. Potter and Wetherell recommend that researchers should pay more attention to how their work can be used in practice. There are many critics of the lack of a practical application for DA work. The raison d'être of my thesis is that the knowledge and understanding revealed about the dilemmas faced by a person with cancer will have some practical use not only for them, but my findings will also specifically provide a different understanding of some of these problems for the medical professionals, friends, family and carers who come into contact with someone with cancer.

3:5.7 Coding themes and Analysis

I will now provide an account of how the coding themes emerged. In my repeated listening, transcribing and reading through the transcripts, some noticeable features became apparent. One of the initial discoveries in my own data was the number of long narrative accounts of events and secondly, the amount of irony and laughter present in the talk. Some very clear themes of talk were soon apparent and interestingly the structures of the narratives often followed the trajectory of the disease, from diagnosis, treatment, and managing social relationships to finally, talk about death and dying.

The first general theme is framed in the interactions with the medical profession. Participants invariably talked of how they discovered something wrong, prompting a visit to the doctor, or went for a routine mammogram, which led into stories of how the bad news of a cancer diagnosis was received.
Another major theme was how they then passed on the news to family and friends. This involved accounts of other people's reactions and their difficulties in responding to the news.

A dominant theme was how participants described their lives now, with particular attention to being normal and carrying on doing ordinary things. Others talked of major, life changing decisions.
Inevitably with a cancer diagnosis that many equate with a death sentence, some participants talked about death and dying and contrasted this with talk about living.

Because of the structure of the interview schedule, issues relating to what they thought caused their illness rarely arose. There was very little talk of pain and discomfort, and when this did arise, this was reflected in narrative accounts of the treatment and procedures, which were often told with irony, humour and imbued with laughter. Although I raised the topic of the quality of life, participants did not particularly engage with this as a topic.

Other features included stories of the endless waiting in hospitals, taking responsibility for their actions, not denying something was wrong, telling their family and friends, the lack of or amount of support from family and friends or the medical profession; the notion of the treatment process as being like a ‘production line’, other people with cancer, death and dying, spiritual beliefs, change and continuity, before and after stories, what sort of person they were, or were not, what other people said or thought, not being a burden and being normal.

So, there were many interesting topics to analyse, and as stated earlier, some seemed disparate at first. After looking for similarities, variability and deviant cases the process of analysis produced the following analytical chapters: Chapter 4, Discovery, Diagnosis and Delay: Who is accountable? Chapter 5, Further Accounts of Diagnosis and Delay: Receiving the bad news; Chapter 6, Dilemmas of Talking about Troubles: The things people say; Chapter 7, Moral Accountability: Doing being positive; Chapter 8, Death and Dying: Whose Dilemma?

My analysis treats participants’ accounts as discourse practices, in which accounts themselves, their construction and function, are the analysable activities, the phenomena under investigation. The analysis focuses on how participants’ accounts are constructed, how they construct the nature of the events described and what kinds of discourse activities these accounts perform.
in the context of their production. The analysis does not seek to find the world behind or beyond these accounts, whether the world of external events or the mental states of the people speaking. When people invoke their thoughts and feelings, or describe things that have happened to them, their discourse is not treated analytically as a window upon, nor as an expression of those feelings and events. Rather, thoughts, feelings, and events are approached as the talk's topics and concerns and analysed as such.

The extracts selected provide a representative sample of the discursive phenomena discovered in the overall corpus of data. In addition to the transcribed data, the analysis was also guided by a reflexive ethnography (Atkinson, 1990) of my involvement with Group 1 and my personal relationships with people with cancer.
Chapter 4
Discovery, Diagnosis and Delay:
Accounting for diagnostic delay

Introduction

The principal analytical focus in this thesis is how and what people talk about when asked to relate their experiences since receiving a cancer diagnosis, where a key orientation in their talk is how they 'cope' with their diagnosis. The stories participants tell are of course (re)constructed for the occasion of the interview, some time after the events of their initial cancer diagnosis. The purpose of the analysis is to show what participants make relevant in their accounts of what happened, and what functions these descriptions perform.

This first analytical chapter identifies a number of key concepts and devices participants employ in talking about cancer (considered as a species of 'troubles talk') including accountability, rhetorical construction, script formulation, active voicing, active thinking, the XY phenomenon and laughter. These will be referred to throughout this and the next four analytical chapters.

In Chapter 2, I presented some of the issues that have been constructed in the psychosocial oncology literature, with specific reference to the emphasis placed on 'coping' and the recommended 'coping' strategies including the 'heroic model', a 'positive attitude', and the benefits of social support. Although they are not the key themes of analytical interest in this chapter, which focuses on participants' own talk, these concepts will inevitably overlap and be relevant in various ways throughout the thesis. In Chapter 2, I also drew attention to the culture and language that surrounds cancer. Participants are producing their accounts\(^1\) of

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\(^1\) The term account will be referred to throughout and most broadly refers to a person's version of events in the world, of the self and of others. It may also refer to a particular version directed toward making events both interpretable and warrantable, that is, understandable and justifiable (cf. Antaki, 1994) and toward promoting the presentation of self as a rational and worthy being (cf. Harré, 1978).
what happened at the time of discovery and at the time of diagnosis, after those events took place. Therefore, they are likely to be drawing on the *culture and language of cancer* that they have become aware of, and somewhat drawn into, through the day to day management of their illness. In other words, throughout the interview, they are invariably attending to their identity as someone who is normatively categorised as a person with cancer, and accounting for their actions within a somewhat ready-made framework of accountability.

Chapter 2 also briefly introduced some of the literature on the change in doctor-patient relationships and studies concerning the delivery of 'bad news'. Finally, I introduced some studies that have looked at a range of 'troubles talk' and established that talking about cancer equates with talking about troubles; it is a sensitive and often dreaded topic of talk. Those literatures also have a normative relevance to how participants recount their experiences.

One of the first noticeable (and dominating) topics produced throughout the interviews were long, elaborate and descriptive narratives about interactions with a range of medical professionals. These often involve accounts of the difficulties of diagnosis, and of delays in receiving a confirmed and accurate diagnosis and these accounts are the analytical focus of this chapter.

Before presenting the analysis, I will provide a brief account of the issues surrounding 'diagnostic delay' that have been reported in the psychosocial oncology literature.

**Who is accountable: patient or provider?**

There is no denying that cancer is a complex and enigmatic disease and one of its many associated problems is that it is not always possible to detect it from early presentation of symptoms. Symptoms are variable and sometimes people report that they have a specific pain, that they are bleeding, that they have noticed an abnormality in their nipple, or a lump in their breast or groin that prompts them to go to the doctor's. But not everyone has an obvious sign that something is wrong. They may have discovered their cancer through going for a
routine screening or mammogram, which in itself also becomes an issue of accountability.

According to the literature, *patient delay* is quite prevalent. Common sense (informed by cultural knowledge) tells us that any form of delay in reporting symptoms is likely to have implications for cure, recurrence and survival of cancer. The longer cancer remains undetected, the more problematic and life threatening it becomes. Not only may the individual be placed under the additional stress of managing the uncertainty of what is wrong, but a delayed diagnosis can often result in increased morbidity and mortality (Andersen, Cacioppo and Roberts, 1995).

The theory informing and linking the delay/diagnosis literature is that the earlier a (correct) cancer diagnosis can be given, the sooner the most appropriate action and treatment can be given. If cancer can be diagnosed in the early stages it is more likely that the disease will be less advanced and the likelihood of cure may be increased, or at least the interval between initial treatment and recurrence (disease-free interval) may be lengthened (Robinson, Mohilever, Zidan and Sapir, 1984). So, minimising 'diagnostic delay' in the reporting of symptoms (by the patient) and minimising the delay in reaching a diagnosis at an earlier stage of the disease (by the medical provider) can often provide a better prognosis.

Research undertaken by psychosocial oncologists focuses on trying to understand what causal factors might influence someone delaying in reporting their symptoms to the doctor. Their emphasis is located on the individual who is attributed as being morally responsible and accountable for reporting their symptoms, and accordingly, any delays that occur in receiving a diagnosis.

When people initially consult their doctor with some physical problem they do not necessarily experience 'symptoms' of cancer per se, or view their illness as particularly serious or life threatening. Nevertheless, a considerable amount of research has looked at how health and illness behaviours can be influenced, and how attitudes can be changed. As a result health promotional campaigns have been introduced with the purpose of encouraging and supporting people not only
in taking an active part in their health and well being, but also to encourage them to be proactive and take the appropriate action when suspecting some possible illness symptom.

The biomedical and psychosocial oncology literature is replete with research pointing to the patient as being responsible for a delayed diagnosis. The focus is on discovering and attributing causes to delay, and on the medical profession's concern with people delaying in presenting and reporting symptoms. People who discover symptoms of cancer are not supposed to delay their diagnosis and treatment; they are expected to take an active role in their health, immediately take the appropriate action and report their symptoms to the doctor. People classified as delaying reporting symptoms to their doctor are considered to be taking risks with their lives and those risks remain as an increased chance of recurrence or lack of cure (Frank, 1995). However, what length of time constitutes 'delay' is variable, whether it is three days, three weeks or three months, and the marking point of when delay is measured is often contested (Facione, 1993).

The literature reveals from the very outset that any thoughts that the symptoms could result in cancer can have a traumatic impact on the individual concerned. When the word cancer, with all it's accompanying baggage of cultural knowledge, is either thought or spoken aloud, it has a tendency to conjure up fear and dread (Fallowfield, 1991). Consequently, the likelihood of someone, patient or medic, putting off confirmation of this dreaded news is, they claim, likely to invoke a number of reactions such as avoidance, denial or delay (Cameron and Hinton, 1968, Eardley and Wakefield, 1976; Watson, Greer, Young, Inayat, Burgess and Robertson, 1988).

By looking at how delay has been constructed and attended to in research it is clear that it is a complex term to define because it can be interpreted in a number of ways, and research findings appear to be variable and contradictory.

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2 In the UK, the Government has now announced plans to ensure that any patient with suspected cancer will be able to see a specialist within two weeks of their GP deciding they need to be seen urgently. The Advocate Spring, (2000). UK Breast Cancer Coalition.
However, I will not engage in the arguments about identifying and attributing causal factors and behaviour or how much time constitutes delay by social scientists. Although concerns about people delaying visiting the doctor and seeking a diagnosis for their symptoms is acknowledged as an important problem, it is the impact of ‘diagnostic delay’, from the patient or sufferer's perspective, that is of interest here, a perspective invariably missing from most accounts in the relevant literature. My analysis will show how participants attend to the notion of any form of delay in their diagnostic stories.

Fallowfield (1991) stated that retrospective accounts of reporting delay could be managing feelings of guilt, the need to rationalise, embarrassment at having behaved ‘stupidly’ or the fear that delay in reporting their symptoms may have caused a poorer prognosis. In other words, such accounts may be biased and factually unreliable. This worry about the accuracy of accounts is reflected in Facione's (1993) suggestion that many studies examining delay deal with retrospective accounts, and therefore represent the individual's schema for the symptom episode, where the emotional crisis which surrounds diagnosis may also impact on the accuracy of recall. It is also likely that the trauma of the events at the time might prevent people from talking about the dilemmas they face for a number of reasons, such as a fear of worrying or burdening others. (See Chapter 6, extracts 6:3.1 and 6:3.3).

As outlined in Chapter 2, participants themselves are likely to draw on cultural knowledge and expectations about events, including these kinds of concerns with accuracy and culpability, to inform their accounts. However, in discourse analysis, such accounts are viewed as providing a valuable insight and source of knowledge about how people with cancer manage and talk about such difficulties which can provide a valuable addition to our understanding of how people ‘cope’ with and manage the traumatic events of cancer. Rather than making an analytical issue of such notions as accuracy or bias in reporting, which would lead towards a rejection of retrospective accounts as interesting, the stance taken by DA is to examine how those very concerns are oriented to and managed by participants as an integral part of how they rhetorically construct their accounts.
What is termed *provider delay* has not received a great deal of research attention and information on this is limited. Back in 1938 Pack and Gallo declared that one month was an "adequate time for physicians to take appropriate action", implying that at the time, this was the standard typically met by physicians. They did not however completely dismiss any provider component to delay and did find in some cases (approximately 15% of their sample) that patients had received what they described as "poor advice", which took the form of mis-diagnosis or false reassurance that the lesion was benign. This "poor advice" resulted in treatment delay, often to the point where the cancers were termed "not survivable" (Pack and Gallo, 1938).

Over 60 years later it is a different story. Current studies (media reports and participants' accounts) show that delays in diagnosis attributable to the provider are considerably longer than estimated by Pack and Gallo. In a recent survey (1998), the UK Breast Cancer Coalition found that a total of 31% women had waited from between one and four months before being diagnosed. However, these statistics do not take into account the crucial difference between patient delay and GP delay, that is, how long it took for the patient to be referred to a cancer specialist. Research generally considers the consultant/physician diagnosis rather than the delay between GP visit and referral.

Facione's (1993) review of the literature reports that no studies gave primary focus to the time period beginning with a woman's seeking an evaluation of a self-discovered breast symptom to the ending, the initiation of treatment, the period she classes as 'provider delay'. Although several studies did offer observations on provider delay (see Facione, 1993) little attention has been paid to the relative contributions of the patient and medical profession (the provider). It is a feature of these studies that they construct delay in standard statistical terms, and do not actually analyse the patients' perspective.

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3 47% of NHS patients were diagnosed within a fortnight and 12% within 3 weeks. Only 13% of women aged 50-64 were diagnosed via the National Screening Programme. Test results within the NHS were given to 65% of women within a week compared with 87% of private patients. 17% of the respondents were treated privately and indicated that they had joined the UKBCC to campaign for all women to have the standard of care they had received (UKBCC, 1988).
In contrast to the limited view of provider delay presented in the literature, my concern in this chapter is to highlight the problems that the PWC has to manage, regardless of how delay is defined in previous research. Whilst is it not denied that people may delay reporting their symptoms, a feature of my analysis highlights that when accounting for their diagnosis (and sometimes misdiagnosis), whilst not attributing direct blame, PWC construct themselves as being responsible and accountable, and it is the medical profession who are hearably responsible for the delay.

A feature of personal event narratives is that participants routinely attend to issues of responsibility, causality, agency and accountability for those events, as well as managing accountability for the current action being done in the reporting (Edwards and Potter, 1993). The following analysis examines how ‘diagnostic delay’ features as an issue of concern for participants, and looks at the way they describe the events that construct the ‘diagnostic delay’ story.

The Analysis

The analysis throughout identifies the cultural scripts that PWC draw upon and the devices they employ to manage the difficulties of talking about the taboos and troubles associated with having cancer. Of particular concern in this chapter (see also Chapter 5) is the management of moral responsibility and identity when talking about the discovery of symptoms and their encounters with the medical profession. Several analytical themes, including moral accountability, issues of identity and accounting for being positive have been identified that will emerge throughout the thesis.

In this first analytical chapter the narrative follows the trajectory of what I term the ‘diagnostic account’ and is composed of two related parts. The first part relates to the issues participants have to cope with and manage in producing accounts of their own discovery of an abnormal symptom or a sign indicating some kind of
health problem. Secondly, having made the discovery, how they account for their decision as to what they should do about it.\(^4\)

A further feature of the analysis concerns how participants manage their stories in such a way as to present them as what I term, 'diagnostic delay accounts' (they could also be categorised as misdiagnosis, or even seen as medical malpractice). What is of interest here is how participants present these stories, and what issues are at stake in the telling. A particular feature of the analysis focuses on how participants rhetorically construct their 'diagnostic accounts' in terms of accountability and identity. Delay becomes a participants' concern of 'doing being responsible' and as such, is a matter of accountability. Accountability of actions and social settings is a persistent feature of social life, where to be 'accountable' means to be "available to members as situated practices of looking and telling" (Garfinkel, 1967:1).\(^5\) In Chapter 5, I will show how such 'diagnostic delay accounts' could also be constructed as a hearably serious complaint (see also Chapters 5 and 7).

The analysis is divided into how participants attend to the issues at stake in relation to the following events in the 'diagnostic account':

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\(^4\) Some participants were only aware of their illness because they had attended a routine mammogram or screening and these accounts will appear in Chapter 5. The analytical focus is on participants' descriptions of encounters with medical professionals and includes their accounts of receiving the 'bad news' of their cancer diagnosis.

\(^5\) As Heritage (1984a:182) points out, "accountability has a "double edged character." On one hand, "incarnate" accountability involves routine observability and intelligibility; social activities and settings are routinely produced and recognised as observable and as making sense without the producers or observers focusing their attention on that production. The other aspect of accountability involves "accounting" as a distinct activity. When routine production or recognition of activities or settings is breached, the actors are held explicitly answerable for their actions. That is, they are expected to be able to give reasons for whatever they are doing" (See also Buttny, 1993; Scott and Lyman 1968). Garfinkel's (1967:116-85) famous case study of "Agnes" who changed his sex from male to female encapsulates both aspects of accountability. "In the process of adopting the female identity, Agnes adopted innumerable practical actions that make up the incarnate accountability of being a woman: Dressing, talking and walking like a woman are only the most obvious. In her interactions with those who knew her "secret" however, Agnes also needed to give explicit reasons for her claim of being female. For example, she described her biography in ways indicating that she had always "really" been female" (Heritage 1984a:180-98).
4:1 Initial Discovery and Reactions: from the mundane to the extraordinary
4:2 Doing being responsible: doing the right thing
4:3 'Knowing' or 'not knowing'
4:4 Diagnostic Delay: "I went to the doctor's...but"

The extracts chosen are representative of the findings in my corpus of data, but should be recognised as only small fragments of what are mostly long, detailed narrative accounts of events.

4.1 Initial Discovery and Reactions

One response when discovering some ailment or symptom of potential illness might be to push it aside, play down its significance or ignore it. However, if the symptoms persist or present themselves in such a way that a simple explanation does not suffice, then a doctor's expertise may be sought. However, in the case of finding a lump in the breast, given the current climate of understanding and concern, most women realise the possible implications of their symptoms straight away. In the first three extracts (4:1.1, 4:2.1, 4:3.1) I analyse how Sara and Jo account for the discovery of a lump in their breast.

Extract 4:1.1 is taken from the beginning of Sara's virtually uninterrupted 'diagnostic delay account', from discovery, to action, to receiving her diagnosis. I will make plenty of use of this full and very rich account (lasting for over ten minutes) in this chapter (see extracts 4:1.1, 4:2.1, and Chapter 5, extracts 5:1.1-5:1.8). I interviewed Sara at her home with her friend Chloe. Sara was born in the West Indies fifty years ago and has been living in England for more than half of her life. At the time of being interviewed, she was living with her teenage son Jason, who suffers with asthma, and was working as a nurse at a local hospital. At the time of the interview Sara had been given a breast cancer diagnosis and had already received a series of radiotherapy treatments (see Chapter 7, extract 7:2.1-7:2.3).
Extract 4:1.1 Sara 15/1/1.36 “I was er having a bath this morning”

1 RC I just want to listen to what your experiences were
2 → Sara I mean er (.) I was er (1.0) having a bath this morning (.)
3 and it's something that always brings back memories (.)
4 to me (.) because that's where I found it (.) .hh
5 → as I was soaping my bo(hh)dy (.), hh ha ha ha y'know (.)
6 my fingers just went over this little th(hh)ing (.)
7 → just sli(hh)pped off of it and I thought (.) oh (1.0)
8 → there's something the::re (.) y'know (.)
9 So I rubbed again and as I did- which- this is- er this is-
10 → I think you can find out (.) if you've got things on you
11 when you've got a so:apy bo:dy (.)
12 RC Uh huh
13 Sara because your hand goes over it so smo:oth (.)
14 → you can just feel every little (.) y'know (.) and then I did
15 → and thought oh >yes there is and it was just about the size
16 of a pe:a (1.0)< at at er the- at the root of the breast (.)
17 and er umh and I got out the bath (.) dried myself (.) and
18 what have you (.) and I went to the bath- bedroom (.)
19 and >I was fee:(hh)ling .hh everywh(hh)ere no(hh)w
20 → you see< .hh ha ha ha I am looking and I thought
21 .hh (.) yes *there is a little thing the(hh)re*

The first point of interest in extract 4:1.1 is that Sara begins the interview with a 'discovery account'. Sara's response to RC's request (line 1), to listen to Sara's experiences is to begin by describing an event that happened to her on the morning of the interview. She says that she was "having a bath this morning" (line 2). Normally, there is nothing extraordinary about having a bath. For most people bathing is a routine daily activity, but Sara diverts this mundane activity into something else, a descriptive and accountable story of discovery. She does this by saying that it is an activity "that always brings back memories to me" (lines 3-4).

Her inclusion of *always*, an extreme case formulation (ECF), (Pomerantz, 1986) is a device used in legitimising claims that deploys extreme expressions, (e.g.
always, absolutely, everyone, every time, never). Pomerantz claims that ECFs are ways of referring to an object or an event which invoke its maximal or minimal properties. They are frequently used in the rhetoric of factual descriptions and normative accountability (Edwards and Potter, 1992; Hutchby and Wooffitt, 1998; Potter, 1996) and they can also be used to defend positions against refutation, to make complaints and to justify factual claims (Edwards, 2000).

So for Sara, the use of always here helps to emphasise the importance of the event being described and that having a bath now "always brings back memories to me". Additionally it is quite a dramatic way to indicate that it is something she is not likely to forget but at the same time, she constructs the event as being normal. Her reference to bringing back 'memories' is a way of grounding and setting up her story. She does this by working up her 'memories' in descriptive detail, which provides a basis for displaying accuracy and reliability of the event. Sara's introduction of her account as rooted in repeated, reliable, experientially rich memory, performs one of the discourse functions that I mentioned earlier in the review of traditional literature (Facione, 1993; Fallowfield, 1991); it attends to, and counters, any notion of her retrospective recall of being weak or unreliable.

The mundane activity of bathing acts (in Sara's account) as a trigger to the experiential memory of the time of her discovery, and sets up her story as a discovery of something out of the ordinary "because that's where I found it" (line 4). Note how the 'it' is not defined until lines 15-16; there is a narrative sense here of a significant discovery in the offing. Before that, she builds her description of events by justifying her actions of "soaping her body y'know" (lines 5-16).

"Y'know"7 is a common marker in talk (Schiffrin, 1987) and in script formulation

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6 Pomerantz (1986) proposes that ECFs tend to be used to do one of three kinds of work: (1) to defend against or to counter challenges to the legitimacy of complaints, accusations, justifications and defences a speaker is making (2) to produce a phenomenon whereby a speaker attributes a cause to an object or person and (3) they may be used to propose the 'rightness' or 'wrongness' of an action or a state of affairs by virtue of its status as frequently occurring or common.

7 Schiffrin (1987:268) suggests two discourse functions of y'know: (1) "as a marker of meta-knowledge about what speaker and hearer share and (2) as a marker of meta-knowledge about what is generally known".
"Script formulations are descriptions of actions and events that characterise them as having a recurring, predictable, sequential pattern" (Edwards, 1995: 319). In other words, they formulate the event being described as a member of a recognisable class of things that usually happen. Sara constructs the description of what she was doing as normal routine, and the use of 'y'know' helps to locate her actions in a normative frame; it normalises what Sara is doing; it is something people, in this case, women do. 'Y'know also orients to Sara seeking a consensus that she is doing something normal, that anyone else would do the same, or recognise it as normal.

However, it is notable that Sara does not claim to have been performing the kind of systematic self-examination for lumps in the breast, that have been widely recommended for women to do in order to avoid diagnostic delays. Rather, her discovery is constructed as accidental and un-looked for, merely the result of having a routine bath (lines 5-6). Note particularly the word "just" in "my fingers just went over this little th(hh)ing", which is a way of showing that the discovery was casual and serendipitous. One thing that this account accomplishes is a sense that Sara was not looking for what she found, not motivated to find it, and therefore unlikely to jump to prejudiced or premature conclusions about it. Indeed, this is a robust feature of claims for unmotivated 'discoveries' even in science (Woolgar, 1988), and of accounts designed to fend off any accusation of prejudice or bias (Edwards, in press). Again, we see how careful analysis can show how participants themselves attend to issues of accuracy and bias, in the course of producing their accounts.

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8 "One way that scripted versions of events work is that formulating events as regular makes them both factually robust, and also somewhat knowable in advance without having to wait and see for any specific instance. Script formulations are presented as if based on lots of instances, and perhaps lots of people's repeated (consensual) experiences of instances. There are two features here, with regard to mind-world relations. First, events are offered as falling into a regular pattern, and therefore an empirically robust one. Second, being a regular pattern, it is therefore indicative of dispositional tendencies that can be attributed to the actors (cf. Smith, 1978). These are very general and pervasive features of script and disposition talk, and we find them in lots of discourse settings. Person-characterising formulations, such as racial characteristics, or the speaker's own balanced point of view, can be descriptively built as script and disposition formulations" (Edwards, in press).
Talking about such an intimate activity as soaping her body can be a rather delicate and potentially embarrassing topic of talk. Sara manages this by introducing (line 5) laughter particles and open laughter. The laughter could be viewed from the traditional notion that laughter is a discharge mechanism for the release of 'nervous energy' or emotions, (Freud, 1905, 1966) possibly signalling some form of embarrassment. Koestler's (1964) influential theory claims that laughter is a reflex action and occurs as an involuntary, automatic response to external stimuli of an amusing kind. But because the nature of the talk here is on a 'troubles' topic, which is difficult to talk about, I suggest that laughter performs other functions. It is an interactional device rather than merely a psychological expression, and specifically it can signal a 'bright side' (Holt, 1993) to a sensitive or sad story. 

Jefferson (1979) pioneered the study of the organisation of laughter in interaction and she demonstrated the value of close attention to exactly how and where laughter occurs. Jefferson has also looked at the organisation of laughter in 'troubles talk' and found a recurrent phenomenon, that when the person talking about the trouble laughs, the listener does not laugh (i.e., withholds the kind of affiliative co-laughter that occurs in other contexts), but often produces a serious response. Note however that the recipients' response of appropriate or inappropriate laughter will also depend on their category membership and 'entitlement' to laugh. Here the laughter is contained in a narrative account and by laughing at her own troubles, Sara is displaying that she is taking her trouble lightly, exhibiting what Jefferson (1984b) defines as a stance of 'troubles resistance'. This also displays something about how Sara is managing her identity in this interaction with regard to the sensitive topic and how she is coping with her troubles. She looks on the 'bright side'. In Chapter 7, I will discuss how laughter is also an interactional device used to present a positive attitude, to disguise complaints or blame or can be used to avoid any overly sympathetic responses.

9 Laughter is a common feature in talking about sensitive and delicate issues and is recognised as an interactional device (see Chapman, 1996; Glenn, 1989, 1995; Jefferson 1985b; Jefferson, Sacks and Schegloff, 1987). Laughter will be a feature of the analysis in Chapter 7.
Sara is building up to an announcement of what she found, and produces 'active thinking' by saying "I thought (.) oh (1.0)" (line 7). 'I thought' followed by 'oh' is a recurrent phrase in this corpus of data (this extract plus see 4:3.1 and 4:3.3) and this will be referred to as 'active thinking', a device for disclosing as participants' internal dialogues, what they were actively thinking at the time. As with 'active voicing' (Wooffitt, 1992), this kind of quotative talk generally functions alongside graphic, moment-to-moment narrative descriptions in building a sense of fresh, direct witnessing, of 'being there'. So, Sara accomplishes two things here, she is talking about what she 'thought' at the time, and this is punctuated with "oh", a change of state token (Heritage, 1984b). This signifies a sudden change of awareness, the act of discovery itself, in that what follows in line 8 is, "there's something there y'know". So, the mundane activity of taking a bath has now become something out of the ordinary.

Sara does various kinds of accountability to establish the credibility of her discovery. She shows that she was not just imagining things, nor looking for things, but just found what was actually there (lines 9-16). She also counters any likelihood of Chloe or RC misconstruing her actions, by appealing to cultural knowledge about finding lumps in the breast (lines 10-14). By using the generalised 'you' in "you can find out (.) if you've got things on you". She aligns her soapy body with being able to feel "every little (.) y'know". The ECF 'every' helps warrant her claim that there was something significant there, even though it was "just about the size of a pea".

Having moved herself from the bathroom to the bedroom (lines 18-19) she systematically verifies her discovery, rather like any good scientist would; she "was fee(hh)ling .hh everywh(hh)ere no(hh)w." Again, laughter particles are

10 Active voicing can be used in a variety of ways in order to warrant the factual status of claims and to undermine the possibility of any sceptical responses (Hutchby and Wooffitt, 1998). Speakers may formulate information so that it can be heard as reported talk, when in fact it is unlikely, or in some cases impossible, that the words as reported were actually said in that way (Wooffitt, 1992).

11 The use of the particle 'oh' is often used to acknowledge new information and in contexts where 'oh' is produced as a response to information of some kind it functions as a 'change of state token' (Heritage, 1984b; Schiffrin, 1987). It also functions as a way of registering a change in the speaker's state of knowledge and can register a change in orientation or awareness (Heritage 1984b; James, 1972; Jefferson, 1978; Schiffrin 1987).
introduced inside the word 'everywh(hh)ere', orienting to the possible extremity of her described actions, and she begins to laugh again (line 20). Having carried out a further investigation of her body, Sara again does 'active thinking' in "and I thought oh". But this time, she follows this with a softly spoken confirmation "there is a little thing the(hh)ere" (line 21); justifying that she did not only feel it when her body was 'soapy' but even when she was looking, there was something there. The softened, quieter enunciation marks out the dramatic significance of her discovery; in the context of the interview and its known topic, this was now something serious. The descriptive detail and rhetorical construction of how Sara is able to "find out (.) if you've got things on you when you've a so:ap:y bo:dy" (lines 10-11) becomes particularly relevant later in this narrative when she describes her meeting with the doctor. (see Chapter 5, extract 5:1.1).

One interesting characteristic of this extract is how Sara begins her discovery story. It is typical of those found not only in my own data but is reflected elsewhere in the literature. Wooffitt (1992) who examined entirely different types of data revealed that speakers regularly report mundane circumstances prior to talking about traumatic or unusual events. In analysing people talking about paranormal phenomena, he found that speakers employed a two-part format when accounting for the first experience of their respective phenomena and identified this as "I was just doing X...when Y". The 'X' component is the speaker's description of the mundane activities at the time, and the 'Y' component reports the speaker's first awareness of the extraordinary phenomenon. These observations are not just restricted to paranormal events, but are often located in other accounts of unusual experiences. Interestingly, to support his formula, Wooffitt cites an extract from an interview with a woman who is describing the moment that she realised that she had breast cancer, which has many similarities to Sara's account.

\[(x) \text{I was turning over in bed}
\]
\[(y) \text{and I thought oh no - I knew exactly what it was.}
\]
\[\text{I woke up my husband and I said to him 'I've got cancer'.}
\]

(Fallowfield, 1991:34)

In Sara's account, the activities introduced in the first part of the format (X), "I was er (1.0) having a bath this morning" and "as I was soaping my bo(hh)dy" are
the mundane circumstances prior to the onset of the ‘discovery’ experience (Y), “my fingers just went over this little th(hh)ing (. )”. Having a bath is a type of routine, everyday activity, which is not normally memorable or notable but this ordinary everyday event, is used to set up something extraordinary and now has an added meaning for Sara. Again, the interactional function of such accounts is to build them as factually reliable, against any possibility that they may be taken as inaccurate, biased, or the product of prejudicial assumptions.

The emphasis on ‘unmotivated discovery’ here is that something out of the ordinary has been found, that it was not there before (and therefore should accountably have been discovered earlier), and that its discovery was unexpected.

4:2 Doing being responsible: Doing the right thing

The discovery of a lump in the breast, or anywhere else in the body, represents something alien or foreign. It was not there before and by implication, should not be there now. It is possible that someone discovering a lump will draw on culturally available knowledge and might think that it is cancerous, but, thankfully, not all lumps are malignant, though they do need to be investigated. So, finding a lump, or any other illness symptom, may trigger two (accounts of) reactions; it may prompt someone to take the appropriate action, to ‘do the right thing’, to ‘be responsible’, and go to see their doctor. Or, alternatively, they may ignore it or delay taking any immediate action (See extracts 4:3.1-4:3.3).

In extract 4:2.1, Sara continues her story and the analysis looks at how Sara manages the discovery of a lump in her breast and how she attends to her identity as being someone who is responsible and morally accountable. This is typical, in its main features, of other accounts of discovery and consequent action throughout my data corpus.

Extract 4:2.1 Sara/15/02 “I made my appointment for the same week”

22 → Sara and so I thought straight away (. ) I couldn't care less
whether it was benign or malignant (.)
I am going straight to the doctor because (. ) I know from experience .huh that you don't put these things off (. ) y'know- and er I'm not going to be sort of bashful or shy say well (. ) I'm .huh not going to the doctor with this y'know I'll- I'll wait and see what happens (. ) I didn't (. ) In the same week I made an appointment as a matter of fact my husband came into the bedroom (. ) and he says what are you doing? (. ) he says have you got something there y'know and I said yes it feels like a little lump so he says (. ) well you'd better get to see the doctor then so and I says oh well I had thought y'know that's what I'd do anyway. RC umh Sara and I made my appointment for the same week (. ) to go and see: my doctor

Sara displays her awareness of finding a lump and asserts her control and counters any hearing of her being fearful of finding a lump "I couldn't care less whether it's benign or malignant" (lines 22-23) whilst at the same time she attends to the possibility of it being cancer. Sara presents a forceful personalised account of what she ‘actively’ thought, and does this by presenting and discounting a possible alternative course of action. She displays taking control by making contrasts. Her immediacy of action, directly countering any notion of delay, is expressed by the ECFs “straight away” and “going straight to the doctor” (lines 22 and 24). Speculating that one might have some form of cancer and receiving such confirmation could instil fear and anxiety. However, Sara says that she was not going to put off finding out whether it was benign or malignant, that “you don’t put these things off” (line 25). She qualifies and emphasises this, “I know from experience” (lines 24-28) what you should do. She mixes her personalised knowledge with the generalised you, formulated as a rule for anybody: “you don’t put these things off”. She constructs a sense of herself acting as she should, with regard to how anybody should act, and as being in control and decisive. This is strengthened by its contrast with the alternative line
of action available, which she presents in the form of a three-part list (lines 26-28) (Jefferson, 1990)\textsuperscript{12}, which is an effective way of making specific points that can strengthen or affirm a broader, overarching position or argument. In Sara's case, it characterises what she was not going to do on the basis of what kind of person she is; she was "not going to be sort of bashful or shy" and "say well (. ) I'm not going to the doctor with this y'know", "I'll- I'll wait and see what happens (. )" (lines 26-28).

Instead, Sara claims that "in the same we:ek I made an appointment" (line 29). In accounting for her reactions to her discovery in this way, she is also able to announce that she is doing being responsible and is accountable for her actions. Not only did she act responsibly and not delay seeking medical diagnosis, but the credibility of that reported action is rooted in how she is not the sort of person who would do that (cf. Edwards, 1995, on scripts and dispositions).

What Sara says next is interesting because she draws her husband into the story. The use of 'active voicing' (lines 31-34) acts as a confirmation that she was 'doing the right thing'. She reports that he says "well you'd better get to see the doctor then" (line 34), which formulates it as good advice ("you'd better"), and as a consequence of what she had told him ("then"). Sara cites her husband's advice, but formulates her actions as not merely compliance with it, but as merely confirming what she herself had already decided to do (lines 35-36). So Sara's thoughts and actions are reported in graphic narrative detail and articulated against a rejected alternative, such that they emerge as decisive and immediate (undelayed), and warranted by independent corroboration from her husband. The fact that Sara's account is retrospective, and that there is no way of knowing what might have actually occurred at the time, may be a cause of concern for

\textsuperscript{12} Gail Jefferson (1990) noted that it was very common for lists to be delivered with three parts or items. There are various features of the delivery of lists that indicate that three-partedness may often have a conventional or normative status. For example, people are rarely interrupted after the second part of such a list, even where there is plenty of opportunity presented by their groping for a suitable term for the third part and often draw on 'generalised list completers' such as 'et cetera' or 'that kind of thing' (Potter 1996). Jefferson's point is not that lists of all kinds are not properly formed unless they have three parts, after all, shopping lists, lists of items to take on holiday, and so on appropriately have widely varying numbers. Her point is that specifically, three part lists are frequently used to summarise some general class of things.
traditional research users of interview materials. But I think that what is important here is how, in presenting this story, Sara produces an account of someone who is not a 'delayer', that despite the knowledge that it could be cancer, she does the right thing, she acts sensibly. Sara produces the details of finding her lump and going to the doctor's as rationally accountable in common sense terms (see also Wynne, 1988). It is also the first step to formally identifying and resolving the problem. Consulting the doctor can be considered a problem solving measure with the objective of obtaining a diagnosis, treatment, reassurance or information, and to legitimate illness (Locker, 1981). In this context, consulting the doctor serves both as a possible mode of coping and as an affirmation of illness.

Throughout extracts 4:1.1 and 4:2.1, Sara has employed a number of rhetorical devices that add credibility to her account, managing the unmotivated discovery of something out of the ordinary, while attending to alternative, rejected ways of thinking and acting. Through the details of her accounts, including specific word selections, quotative talk, contrasts and laughter particles, she displays herself with regard to a range of normative considerations as rational, competent, 'coping', and doing the right thing.

4:3 Accounting for delay: 'Knowing' and 'not knowing'

Another reaction to discovering some kind of lump or alien thing in the body is in fact to delay doing anything about it. Extract 4:3.1 is taken from an interview with Jo, who was the only participant who reported that she had actually delayed going to the doctor. Jo is a single mother in her early forties and was initially diagnosed with breast cancer. In this extract, Jo gives an account (and of course, thus treats it as accountable) of why she delayed reporting the discovery of a lump in her breast for five months. She does not talk about fear or anxiety of what she has found, but instead she presents a series of practical reasons and circumstances for the delay, resulting in her account being full of warrants and justifications.
Jo has indicated that she went for a mammogram, which prompts RC's question (lines 1-2). What follows is interesting in that Jo provides an account of why she delayed going to her doctor's, despite finding a lump. She states that "I knew I'd had the lump and I'd had it for about 5 months" (lines 3-4). In contrast to Sara in extract 4:1.1, Jo's reaction to finding a lump was not one of going "straight to the doctor". Instead, she works up an account of her delay as something normatively understandable, attributing it (lines 5-6) to various external factors and considerations. Despite not having three distinct items, Jo constructs this in the form of a personalised three part list consisting of "other things going on", she had "just started a job" and how it was "not the ri(hh)ght time to be de(hh)aling with" it.

13 Jo was later given a terminal diagnosis and sadly died on 20th July 1998.
The production of a three-part list effectively strengthens her reasons. She is busy with living, and then alludes to instinct and intuition as her way of ‘knowing’. She frames her actions using the generalising ‘you’, as being what anyone else might normatively do under the circumstances, and compares her knowing to other important, potentially life-changing events: “when you know you are pregnant” or “your partner’s having an affair (. )” (line 10). The first could be either good or bad news but in any case disruptive (particularly for someone who has just started a new job and for whom it was not planned); the second, presumably is bad news, but it is also a dramatic event that is likely to be life changing.

What is interesting is the issue of how Jo is able to make this claim that she “knew it was a malignant lump” (line 11), despite this not being medically known at the time of her discovery. How did she ‘know’ that the lump was malignant? Again, rather than this being a researcher’s worry about the accuracy or rationality of a retrospective account, it can be approached as something produced and attended to by Jo herself, within the interactional setting of the interview. Although such confirmation might require technical medical tests, accounts of ‘knowing’ can be worked up by participants in ways that they attend to their grounds or plausibility. Although Jo does not give what would be a medically satisfactory or other evidentially grounded explanation of her ‘knowing’ that the lump was malignant, what she does is attend to that absence by invoking another kind of ‘knowing’ that is culturally recognisable. She provides for it as a category of ‘knowing’ alongside two other instances of the category, when a person knows something important in subtle personal ways, when they may not be able, or inclined, to point to objective evidence, such as being pregnant, or becoming aware of relationship problems.

Of course, the participants now know that they have cancer, so saying, “I knew” is additionally warranted and made plausible by this retrospective fact. These accounts are not factual reports but it is interesting to see how they are constructed as such (see extract 4:4.5). This is particularly relevant in extracts 4:4.1-4:4.4) analysing ‘diagnostic delay accounts’ where knowing it all along becomes part of a story that confers blame onto the medical profession for a
delayed diagnosis. If the participants knew all along, and of course it turns out on medical grounds that they were correct, then the category ‘knew’ (not just suspected or feared) becomes an accountable issue for the medics, because they have no excuse for getting it wrong or delaying.

RC effectively challenges Jo’s account, orienting to it as insufficient to account for her delay in going to the doctor’s, “But you delayed going” (line 12). RC’s use of “but” marks an upcoming contrast (Schiffrin, 1987). Jo is then prompted to provide a further explanation, attending to her status as someone who was being responsible about it because she nevertheless “checked it every day” (line 14), another ECF strengthening an account under scrutiny. Jo reports that, by the end of the five month period of delay, the lump was noticeably bigger (lines 15-17), and this is the point at which she sought medical help. Even then, the fact that she was not “in any pain” and “there was no discomfort” provides a basis for non-urgency, but action was now, at this point required because, the “lump was there and it was hard”. Note how Jo, in her narrative, actively thinks that she has reached a change in awareness, “I thought, well oh ok I’ve got to deal with this now” (line 18) and now acknowledges her delay as accountable that she has “put it off for long enough” (line 19) and announces that she went to see her GP. Note how the expression “long enough” formulates her delay as delay, but also as having reached a reasonable length of time, and as now ending at an understandable, accountable point. Again, what is interesting in this extract is how Jo handles or manages the issue of delay herself, in reporting her lump to her doctor.

Despite Jo’s account being somewhat exceptional, as a confession of delay in spite of ‘knowing’ she had a malignant lump, my analysis shows how the details of her account nevertheless attend to her normative, rational accountability. Extracts 4:3.2 and 4:3.3 are also accounts of delay in reporting symptoms and in both cases, the accounts are clearly produced as understandable and rational. However, both these accounts differ from Jo’s, who ‘knew’ she had a lump in her breast. Both tell how, at the time of discovery, they had not thought about cancer.
At the time of the interview at Andy's home, he was retired and in his early seventies. He is married to Pam who participated in the interview and their niece Mary was also present. Like most of the accounts in this thesis they are extracted from long, descriptive event narratives. I will only highlight the key points of interest to show how Andy and Pam manage the notion of delay and doing being responsible. Immediately before extract 4:3.2 begins, Andy has explained that he had had an ulcer in his mouth, so initially he went to his dentist, prefacing that story with "well it all happened in er early 91, just after I'd retired actually".¹⁴

Extract 4:3.2 Andy 17/01 “It didn't really hurt”

25 Andy after about two month was it, three months (0.5)
26 I found I was still having, not so much problems but
27 there, there seemed to be something there
28 RC umh
29 Andy In my mouth all the time and er (.) when we looked closely,
30 I'd got er an ulcer under me tongue (.) and umh
31 → Pam at the first start didn't think much to it did you y'know
32 Pam no because it was only small=
33 Andy =only very small (.) and umh (1.0) it didn't really worry me then
34 → although with hindsight y'know, it didn't hurt, it wasn't painful or
35 anything
36 RC umh umh
37 → Andy I mean mouth ulcers are usually fairly painful so, so at that stage
38 it didn't really hurt, but anyway (.) a few weeks later, when would
39 it be umh umh ((makes boom boom boom sounds))
40 → [February, March, April, May
41 Pam [oh it was, it was when we were on
42 Andy May
43 Pam yes when we were on holiday in Wales
44 Andy yeah
45 → Pam and er you kept saying there's something there and it's getting
46 bigger I'm sure it is umh and when I looked again,
47 it was definitely, it had grown from .hhh [shall we say er from a

¹⁴ Andy died in 1998.
The first point of interest in this 'discovery account' is how in line 25 Andy makes time a relevant issue by announcing that having been to the dentist "two month was it, three months", he was "still having, not so much problems but there, there seemed to be something there in my mouth all the time" (lines 27-28). Andy's previous account of it being perceived as a dental problem has already done some of the accounting work for his delay in seeking medical diagnosis, but three months later, he discovers that he had "got er an ulcer" (line 30). However, he does not categorise this as particularly problematic, and Pam Is attributed with not thinking there was "much to it" (line 31). As we saw in extract 4:2.1, the rationality of actors and narrators can be grounded in corroboration of judgements by spouses. Pam provides a rational account for this "because it was only small", which Andy immediately upgrades to "very small" (see Pomerantz, 1984a, on how upgrades perform confirmatory second assessments).

Note Andy's appeal to hindsight (line 34) as a way of acknowledging mistakes in his thinking back then, while at the same time providing an account for them. Hindsight is a conventional basis for knowing now what one might have, but understandably did not, know then. A symptom that back then may have led to underestimating the problem (the lack of pain) is retrospectively available, but only in hindsight, as a significant danger signal.

A further delay ensues "a few weeks later" (line 38), when they are on holiday. Pam reports Andy as saying that "there's something there and it's getting bigger I'm sure it is" (line 45). Along with the active voicing (direct quotation) of Andy's words, the expression "I'm sure it is" helps to convey something other than mere certainty, but more a sense of someone coming to conclusions, a sense of
thought processes at work, inferences going on and conclusions being reached. During this time, they report noticing that "it had grown...from a little pimple to very nearly a two penny piece" (line 47-49). And it is Pam who accounts for what is to be done saying "I think you'd better go (.) we'd better go and get, go and see the doctor" (lines 52-53). The repair of 'you'd' to 'we'd' (line 52) denotes that this is a decision reached jointly, but it has been preceded by rational accounts of justifiable reasons for not previously doing anything about it.

Throughout this extract Andy and Pam are constructing the story and collaborating with each other on the changing significance of the ulcer and its growth, over almost five months. They do this by providing rational explanations and justifications until the growth has become so significant that they decide to go to the doctor. The issue here is not one of them not being responsible for not going to the doctor, but is accounted for by describing a series of events and developments as warranting their not taking action earlier. Whatever grounds there might have been for acting earlier, are acknowledged now as being available only with hindsight, which is surely a nice general device for retaining accountability for not doing what one maybe had grounds for doing (or vice versa).

In the final extract concerning delay in reporting symptoms, Jan also provides an account of delay whereby, although acknowledging there is something wrong, she works it up as rational and understandable. As with Andy and Pam, it is produced as a collaborative account, but here, as with both Jo and Sara, Jan's collaborative accounting is produced via the device of 'active voicing'.

Extract 4:3.3 follows an exchange between Jan and Bee. Jan and Bee are friends and were interviewed together in Jan's home. Jan is in her mid sixties and was diagnosed with breast cancer. She lives alone but has an extensive family and friends, one of whom is Bee. They met at support Group 1 and became close friends. Bee has just announced that she has another appointment at the hospital.
Extract 4:3.3 Jan 14/01 “I had never seen the nurse”

1 Jan Do you want anyone to go with you?
2 Bee No, no it's all right,
3 Jan Are you ok?
4 Bee I always go on me own, yes
5 Jan I'm a bit like that I must admit .hh [ha ha
6 Bee [hh ha ha ha ha,]
7 RC So you go on your own too?
8 Jan Yes, yes
9 Bee yes yes
10 RC Even the first time you went (.) when you were
11 Jan Yes (.) well (.) no actually I'd didn't go on my own the first
12 time I went, I was working and umh it was through
13 this particular person, the technician, like Paul, who was the
14 technician in our school at the Poly and I er
15 I just said to her (.) umh my nipples Inverting
16 → and she said why don't you go and see the nurse
17 and I had had er a fall (.) on er this particular spot
18 about six weeks previously and It was extremely painful
19 for about a month and umh I put it down to that
20 → but I thought oh it's not getting better (.)
21 → my nipples Inverting now (.) so I'd better go and see (.)
22 → I didn't think of cancer I must confess (.)
23 not until they gave me the leaf(hh)let ha ha ha er
24 and she said why don't you go and see the nurse so
25 → and I had never seen the nurse in all the years I'd been
26 at the Poly so I tripped over to see the nurse and umh
27 she couldn't feel anything but she suggested that I went to
28 see my dr::ctor (.)

What I find interesting about this extract is how Jan attends to RC's question (line 10). Asking Jan whether she went on her own the first time produces an agreement from Jan, but then she shifts her orientation away from this particular issue and produces an unsolicited account. She marks this (line 11) with "well" and produces an account of the circumstances that preceded her first visit to the
doctor’s. She establishes that at the time she was working and describes an encounter with ‘the technician’ (line 12). It is unlikely that Jan (line 15) actually started the conversation with the direct announcement “my nipples Inverting” but delivering this statement in such a matter of fact way helps discount any kind of implication that she is making any undue fuss, something she alludes to later (line 25) and again later in her story. Again, as we have seen in other extracts, the word “just” (line 15, “I just said to her”) is used to play down any special significance that Jan was giving to this announcement. She is merely providing a simple, matter of fact description of her problem.

Jan’s use of active voicing of what the technician said and change in footing15 “she said why don’t you go and see the nurse” (line 16), helps to display a sense of objective distance, giving credibility to Jan’s later claim, that she is not someone who normally rushes off to the nurse or the doctor’s. It is the suggestion of the ‘technician’ to go and see the nurse that she acts upon.

Jan then provides further warranting for why she has delayed doing anything about her discovery by attributing it to something more benign than cancer: “a fall (.) on er this particular spot about six weeks previously”, (lines 17-18) so that the notion of delay in her doing anything about it is made accountable. It is about a month later when she narrates a change of awareness, saying “I thought oh (.) it’s not getting better” because her nipple is inverting and she says “so I’d better go and see” (lines 20-21). The active voicing of her thoughts, together with the

Goffman (1981) introduced the term footing in his explorations of the nature of involvement and participation in social interaction. “Footing highlights the basis upon which an account is offered: does it come from direct experience and involvement, or is it a report based upon the testimony of a reliable witness, or is it a disinterested passing on of possibly contentious information” (Edwards and Potter, 1992:168). For example, people may make their own claims, or they may report claims of others; and when they report claims, they can display various degrees of distance from what they are reporting. In discursive psychology footing plays a central part in accountability (ibid: 168) by providing a set of distinctions that guide the assignment, of for example, blame or a compliment, or scepticism (Potter, 1996). Footing is usually studied in relation to speakers’ concerns with dilemmas of stake or interest and features in the analysis of complaining and blaming accounts in chapter 5.

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sudden change of state token "oh", mark this as the precise point at which she was starting to think there might be something else wrong. She then offers a "confession", that "she didn't think of cancer" (line 22), which provides a sense of herself as not someone who recognised her discovery as being something to worry about or threatening at the time. Jan has managed to construct an account whereby she has accounted for her delay for understandable reasons, and on the discovery of a further symptom is doing being responsible. Indeed, she has been responsible all along, having had good reasons for the delay, along with a self-characterisation as not a person disposed towards rushing for medical help on the slightest pretext. Additional expression of this is in lines 25-26: "I had never seen the nurse in all the years I'd been at the Poly".

This account could potentially be classified as Jan delaying doing the right thing, that is going to see the doctor as soon as she notices some form of symptom. But instead, what Jan does is manage her identity and any notion of her delay as rational, and normatively understandable. At the same time she displays herself as not the kind of person who rushes to the doctor all the time (again, a script-and-disposition kind of reasoning: Edwards, 1995).

In extracts 4:1.1-4:3.3, the participants are managing issues of being responsible and accountable for their actions by providing justifiable reasons for any delay that ensued from their initial discovery of something wrong. In the following extracts, the element of delay takes on another form. The participants all report going to their doctor when they had a symptom, but what is revealed is that there are further issues to be managed and that further delays may ensue, such that arriving at a correct diagnosis can take some considerable time.

4:4 Diagnostic Delay: "I went to the doctor's...but!"

Once a symptom is discovered, the next normative stage is 'action', and usually the first stage of action is contacting the doctor. Delay becomes an issue of accountability again. But again the notion of delay resides in issues of concern made relevant by participants, such as being believed, being told not to worry despite their suffering; of being dismissed, of not being taken seriously, or of
being treated only as a body that needs repair, or as being treated as an object without any regard to their identity or for the consequences of living with a potentially life threatening illness.

One of the significant themes emerging out of extracts 4:4.1-4:4.5 is that there is often a considerable 'delay' from the time of the initial visit to the doctor to the time that a cancer diagnosis is given. The route to diagnosis is far from straightforward. A number of concerns emerge through these retrospective accounts which are presented through the narration of elaborate and detailed stories of a series of meetings and consultations with doctors. Note that these stories provide a notion of agency different from that generally found in the medical and psychological literature concerning who is responsible and accountable for delay. In the following extracts the notion of delay, rather than being an issue of personal accountability for participants, is now constructed as emanating from the medical professionals.

Extracts 4:4.1-4:4.5 are from very early in the interviews. RC asks a different question in each case and the participants produce 'diagnostic delay accounts'. What these extracts have in common, along with extract 4:4.1, is that participants deal with the issue of personal accountability in reporting that they 'did the right thing'. They went to the doctor as soon as they discovered something wrong, but from then on, in their encounters with the medical profession, it is a different kind of story. The continuation of Sara and Angie's 'diagnostic delay accounts' will be referred to again later in the analysis of accounts of receiving bad news (see Chapter 5).

The interview with Amy (extract 4:4.1) was carried out at the offices of Coping with Cancer where she was working part time. Amy is 35, married and lives with her husband and two small children. She was diagnosed with ovarian cancer in 1995 and at that time, was informed that her cancer was terminal. She is alive today (October 2001).
Extract 4:4.1 Amy 4/01: “It started two years ago at Easter”

In lines 1-3, RC asks Amy about when she first received her diagnosis. As the analysis throughout this thesis reveals, there is rarely a simple or straightforward answer to any of RC’s questions. Indeed, RC is perhaps projecting the potential difficulty of the question in how she approaches asking it “Well umh actually I need to ask you about...” (line 1). Rather than providing a simple answer, such as a specific date of her diagnosis, which is an expectable response to such a standard-looking Information-eliciting question at the beginning of an Interview, Amy begins a descriptive and detailed story indicating that her diagnosis was something that happened over a period of time: “Well, it started two years ago at Easter” (line 4).

“Well” is a response marker (Schiffrin, 1987) and often, in the form here called ‘well-prefacing’, begins turns (Sacks, Schegloff and Jefferson, 1974) and can
project a contrast with what might be normatively expected. In this instance, it is marking the beginning of a story. Amy does not just start at the point when she was diagnosed with cancer; it is going to be a more complex story than that. She builds a series of events that culminate in her eventually being given a cancer diagnosis. She then produces a time perspective "two years ago at Easter" and reveals how it all started (line 5) she was "getting stomach ache".

What is of interest is that at the time of interviewing the participants, I was not expecting that my participants' responses would often produce stories of delay and mis-diagnosis, and I had not planned an interview schedule to ask about it. Amy's initial response, (lines 4-5) introduces the process of 'diagnostic delay' as a participant's rather than an analyst's concern. She goes on to describe the complexity and difficulties she experienced that construct the delay (lines 6-14), which will be referred to later in this chapter, (see extract 4:4.3) but are included here to show how participants initially attend to the notion of delay. (See also Chapter 5, extracts 5:1.1-5:1.7).

Extract 4:4.2 is from an Interview with Angie, which took place at her home. She is in her mid fifties and has two teenage sons. Before her illness, she had held a senior management job. Prior to the Interview RC was unaware that it had taken eighteen months for Angie's illness to be correctly diagnosed; all that was known was that Angie had received a cancer diagnosis.

At the beginning of the Interview, RC asks Angie (line 1) what made her go to CWC. Angie's response again raises the issue of time and 'diagnostic delay'.

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16 Sacks, Schegloff and Jefferson, (1974) observed that 'well' often also figures in particular conversational moves. Schiffrin (1987) notes that the use of well displays a speaker's aliveness to the conversational demands for an answer and provides speakers with increased flexibility and a certain measure of looseness in complying with conversational demands. In other words, because beginning an answer with well anchors a speaker in the conversational exchange by displaying an aliveness to conversational demands, it actually allows a temporal suspension of other conversational expectations, especially the expectation for propositional completion of the answer through an immediately forthcoming answer.

17 Certain times throughout the cancer trajectory are more difficult to cope with than others and organisations such as Coping with Cancer (CWC) a self-help support group, provide a support network where people can meet and talk to others who are in a similar situation or can provide practical and pragmatic assistance and or counselling.
Extract 4:4.2 Angie 12/1: “it was ages before they diagnosed what was wrong”

1 RC What made you go to CWC?
2 Angie oh well it was when (1.0) I was trying to remember actually
3 but it was when I was umh (2.0) having treatment, chemo umh,
4 I think it was one of the Macmillan nurses suggested it
5 RC [oh right
6 → Angie [umh (2.0) because it was umh (3.0) very sort of,
7 → it was ages before they diagnosed what was wrong and
8 and then I had, well it was when I had the operation
9 → they found it was lymphoma
10 and then I had to have six months chemo
11 to make sure everything was clear

An interesting feature of this extract is that, when RC asks Angie (line 1) what made her go to CWC, Angie reveals that it was when she was having treatment and it was (line 4) at “one of the Macmillan nurses” suggestion. She does not continue with talking about CWC, the question’s topic, but instead introduces the lateness of her diagnosis, and is a little hesitant about it: “it was umh (3.0) it was ages before they diagnosed what was wrong” (lines 6-7). The use of ‘they’ diverts the agency from Angie and sets up the ‘other’, the medical profession, as being the agents responsible for the delay. As we saw with other participants, this provides (implicitly, at least) for Angie’s identity as not the kind of person to delay going to the doctor’s (see extract 4:3.3 and 4:4.3 below). The implication is that she has taken the appropriate action and gone to see her doctor on the discovery of something wrong, such that any subsequent delay was due to them. Angie provides an account for the medic’s late diagnosis, by revealing that the sequence of events (lines 8-9) was that “it was when I had the operation they found it was lymphoma.” She further alludes to the lengthy process of

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18 Throughout Angie’s account there are a number of long pauses, which are not taken up as an indication of a next turn by RC. A feature of Angie’s style of talking was slow, deliberate and ‘thoughtful’; the silences are representative of what she says (line 2) “I was trying to remember actually”.

19 The lymphomas are a group of more than two dozen types of cancer of the lymphocytes, the most important cells of the immune system. If they are localised to one or two lymph nodes only, they may be curable with radiotherapy. If they are more widespread, however, which they usually are — they are usually controllable for many years with mild chemotherapy, but are almost always incurable. (Buckman, 1996).
discovery, diagnosis and treatment (line 10) by saying she still had to have "six months chemo" (chemotherapy20).

In Angie's story, the trajectory is one of misdiagnosis, delay and disruption to her life. In extract 4:4.3 (following on from 4:4.2), she tells RC about when she first went to the doctor's.

Extract 4:4.3 Angle 12/2: 'It was er January, February, 1992'

1   RC          so er how, when did you first think that there was something
2               wrong, what made you go to the doctor's in the first place? (3.0)
3   → Angie     well umh (3.0) it was er January, February (1.0) 1992
4               I started having dreadful pains sort of here
5   RC          your stomach?
6   → Angie     yes (1.0) and I went to my doctor who said it was irritable bowel
7               syndrome and gave me tablets
8               and I kept going and I kept getting tablets (.)
9   → Angie     and I'd been made redundant so he said it was the stress
10              being out of work and umh (1.0) then the August of that year,
11              I got another job (. ) but the pains were still very bad
12              so then it was the stress of the new job (1.0)
13   RC          uh huh
14   Angie       and (. )
15   RC          how often were you going (. ) to the doctor's?
16   Angie       oh I can't remember now, but fairly frequently
17   RC          yeah (1)

In response to RC trying to establish when it all began, (lines 1-2) Angie takes some time before responding. Angie's initial problems (lines 3-4) are being dated here to a point in time which adds emphasis to her revelation that there was a considerable delay before she was diagnosed with what was causing her "dreadful pains" which prompted her (lines 6-7) to go to the doctor's. She does not give any detail of this encounter or how she presented her symptoms, but

20 Chemotherapy is the use of anti-cancer (cytotoxic) drugs to destroy cancer cells. It can be just one drug or taken from a choice of about 40 different drugs available. It can be used alone or used with surgery or radiotherapy, or both (Buckman, 1996).
she says that the doctor provided her with a diagnosis "it was irritable bowel syndrome and gave me tablets". Angie's dreadful pain has been identified and given a label. But this is narrated as a straightforward, cut and dried definitive diagnosis. There is no sense of the doctor acknowledging any kind of difficulty or ambiguity; and as it is now known, they got it wrong, but the delivery is reported as being given in a confident and rather abrupt manner. In extract 4:4.2, Angie reported two diagnoses, from her GP and a "younger chap" which were hearably delivered with abruptness (and were the wrong diagnosis). So not only is this account a 'diagnostic delay' story but it is also a delicately voiced and hearable complaint. (For a more detailed analysis of how complaints are produced, see Chapters 5 and 7).

In extract 4:4.3 the doctor persists in delivering these simple, confident misdiagnoses, one after another. They are reported by Angie in the same way, as confident, simple, abrupt and what are beginning to sound like 'knee-jerk reactions'. Angie presents a three-part list which strengthens her account "I kept going and I kept getting tablets (...) and I'd been made redundant" (lines 8-9). "Kept" is reiterated implying that Angie's continued pain is not being taken as a serious illness problem. She reinforces this difficulty in being taken seriously by reporting (line 9-10) that on one occasion, the doctor relates Angie's condition to being made redundant and "he said it was the stress being out of work". There is a sense of irony here in that the doctor's diagnosis is presented rather unsympathetically, as automatic, routine, rather than being thoughtful or carefully considered.

By describing the series of misdiagnoses in this way, as automatic, over-certain, abrupt and lacking any detail (in her account) without addressing any kind of difficulty, concern, or ambiguity, Angie's account rhetorically constructs a hearable non-explicit complaint against the doctors.
In addition to the "dreadful" pain\(^{21}\) (which, in contrast to the doctor's under-estimations of her problems, maximises it from Angie's own perspective, and of course, "dreadful" turns out to be right all along), IBS and stress, she has introduced yet another problem she has to manage. When she says that "the August of that year I got another job (.), but the pains were still very bad" (lines 10-11) the implication is that the doctor now (six months later) attributes the pain to the stress of the new job.

Now knowing that it was "ages" (extract 4:4.2) before Angie received a diagnosis, RC asks how often she was visiting the doctor (extract 4:4.3, line 15). Angie's reply indicates that the visits were too numerous to remember, but they were "fairly frequently" (line 16). The length of time involved from her initial visit to the doctor's and the delay that ensued before receiving a diagnosis has had an effect on her recall of events. This working up of frequent visits to the doctor contributes to the construction of this being a 'diagnostic delay account', and also to the complaint-relevant nature of the story, given the implication that the doctor had plenty of opportunities to get it right. Receiving and accepting a doctor's diagnosis normally ends the search for explanation, but Angie's story continues to reveal numerous visits to the doctor.

**Extract 4:4.4 Angie 12/03 “and she was so dismissive”**

16 → Angie umh (1) and then in the September, the pain was so bad that  
17 when I went to, actually I didn't see my regular doctor  
18 → I saw er another one (.) and she was so dismissive that I (.)  
19 became somewhat hysterical (hh) and demanded that I should  
20 see a specialist and have a second opinion (0.2) and er that was  
21 arranged and I saw the specialist (.) and he said "oh yes well  
22 you've definitely got irritable bo(hh)wel syndro(hh)me hhh" (2.0)  
23 and umh  
24 RC what sort of tests did they give you?  
25 → Angie I can't remember him doing anything (1.0) oh I think (1.0)

\(^{21}\) Chronic pain exists in the absence of identifiable organic pathology and is considered to be one of the more perplexing and even frustrating conditions doctors confront in their practice (Grace, 1995).
he did, I did- he did arrange for me to have an xray umh
RC umh
and then I went back to him and there was nothing on the xray,
yes it's irritable bowel syndrome, I'll see you again in (. ) x months
time (1.0) and by this time I was having difficulty eating and I was
losing weight and I was feeling dreadful (1.0) and it went on
did you have any suspicions about it?
no, I just couldn't understand why I was in such pain when
everyone was telling me it was nothing to worry about (3.0) umh
and I lost that job, I was made redundant again (2.0) [and
RC [oh my
goodness

By September, "the pain was so bad" (line 16) that she goes back to the doctor again but this time she presents a different account and takes an active rather than a passive stance to the way she is being treated. This coincides in the narrative with a move towards more explicit blaming. She claims (line 18) that the doctor was "so dismissive" (line 18). This time, in response to her worries being dismissed, and along with her more explicit blaming of the doctor, Angie produces a strong emotional statement (line 19) that she became "somewhat hysterical". She is no longer prepared to accept the doctor's explanation and treatment and "demanded that" (line 19) she should see a specialist. Yet, the (mis)diagnosis remains stubbornly the same, irritable bowel syndrome (line 22). The use of 'so' (lines 18) both exaggerates Angie's problem and the doctor's dismissiveness which help to set up the laughed-through irony of the specialist saying "oh yes well you've definitely got irritable bo(hh)wel syndro(hh)me" (lines 21-22). Note again how the sense of stubbornness and abruptness is brought off by Angie's simple description of what the doctor says, where the use of "yes" nicely signals an orientation to agreeing with the prior diagnosis of IBS. The message that the doctor indirectly transmits to Angie is that her view does not really matter much, with the "dismissive" delivery implying that the doctor knows best.

RC asks (line 24) about the sort of tests given. At first, Angie "can't remember him doing anything" (line 25). This reference to the medics not doing anything
adds substance to the 'diagnostic delay account'. She then recalls (lines 25-26) that they did arrange for an X-ray after which another visit was made to the specialist but "there was nothing on the xray" (line 28).

Line 29 further encapsulates the 'diagnostic delay account' in that she is dismissed by the doctor saying: "I'll see you again in (.) x months time". The 'dismissive' character is again accomplished by the brevity and abruptness of the quote and by its contrast with her physical condition (lines 30-31). The sense of an elongated narrative of a succession of delays and dismissals is contrasted against her condition. The contrast between the doctor's view, and what was really happening to Angie is provided in what she says next (lines 30-31) "and by this time" Angie is having additional symptoms and again she formulates this using a three part list "I was having difficulty eating and I was losing weight and I was feeling dreadful" and that "it went on". The implication is that again, her claims of being ill are not acted upon. Nothing further is done.

In response to RC's question (line 32) about any suspicions, Angie's reply is one of confusion. She sets up a contrast of her condition. She does not understand why she is in such pain and enhances this contrast by saying that "everyone" (an ECF) was telling her it was nothing to worry about. At the same time, the absence of any clear solution to her illness is producing further problems in that she was made redundant again.

She works up an account of frequent visits to the doctor's, of being persistent and trying to convince the doctors to do something about it. This is a story not only of 'diagnostic delay', but also of culpable delay. Angie's version of events works up a final outcome that she is 'right' and that the doctor's original diagnosis of irritable bowel syndrome was not only 'wrong', but in various ways stubbornly wrong. Reflexively, Angie's version of events implies of herself, that she did everything she could, in a responsible and accountable manner.

In extract 4:4.5, Dee provides a different kind of 'diagnostic delay account', at a different stage of the diagnostic trajectory. What is interesting is how she displays her insistence and demands from the medical profession that they do
something about her lump, which is based on her providing the knowledge that she 'knew' she had breast cancer. This is a contrast to Angie's account (extract 4:4.4) where Angie was not aware that she had cancer.

Dee is in her mid forties, and lives at home with her husband. She has an extended family and circle of friends. At the time of the interview she had a high-powered management post and was actively involved in voluntary work for people with cancer. She was initially diagnosed with breast cancer and later with secondary cancer. 

Extract 4:4.5 Dee 8/01: “but I knew”

1 → Dee ((...))but if you have a lump anywhere it's much better to have
2 it on er(.) a slab to have a look what it is than leave it (.)
3 umh and I had this pronounced lump which grew,
4 it doubled in size in twelve days (.) and er he said
5 well I'm going to South Africa for a month in a month Dee
6 so I said well I want this lump out before you go (.)
7 he said yes I agree and umh I was in surgery the following
8 Tuesday so I was about twelve days between seeing my GP and
9 having my surgery which is very good because my GP said
10 I'd have to wait six weeks to see an NHS consultant (..) and I
11 said, Jane, I can't wait six weeks, I will be mental by six weeks
12 RC yeah
13 → Dee I'd already waited over the Easter period because- it was our
14 twenty fifth wedding anniversary and my son's birthday that
15 weekend so we had a lot of family here and
16 we were going out to dinner when I found my lump (..) .hhhh
17 so that weekend was Easter, Easter Monday and Easter
18 Tuesday (.) no doctors, so I saw my doctor on the Wednesday
19 → (1.0) I got to the stage where if they'd said >there wasn't a spare
20 appointment on the Wednesday I was going to camp outside
21 because I was beside myself,> because everybody said,
22 oh it'll be nothing Dee, just a harmless little cyst,
23 → but I knew, RC, don't ask me how, I knew
24 RC umh
Dee that I had breast cancer (1) and it was my (. ) I think it was my worse fear fulfilled because I'd had a hysterectomy three years- nearly three years before

Prior to extract 4:4.5, Dee has been talking about already having attended for a routine mammogram22 and that she is a private patient. She is reporting on a meeting with her consultant. Dee prefaces her story with a generalised principle or lesson, to which the story is then hearably relevant: "if you have a lump anywhere it's much better to have it on er (. ) a slab". This provides a principled basis for what follows, which is her insistence on immediate treatment. She emphasises the urgency of this: "I had this pronounced lump which grew, it doubled in size in twelve days" (lines 3-4). This displays Dee as responsibly checking the lump regularly, and noticing the rapidity of its growth. She then introduces the notion of delay. Delay is a relevant term given how Dee quotes her consultant saying "well I'm gong to South Africa for a month in a month", (line 5) followed by Dee's orientation to that as problematic: "I want this lump out before you go" (line 6). Her status as a private patient is made delay-relevant in lines 7-9, where she mentions the briefness of the time between visiting her GP and the surgery. She describes it as "very good" in contrast to how, as an NHS patient, her GP said she would have "to wait six weeks to see an NHS consultant" (line 10).

Dee provides us with how even a six week wait would be problematic for her: "I will be mental by six weeks" (line 11). The next detail is interesting, in that it attends straight away to any notion that Dee might be being over-insistent or over-anxious: the delay would effectively be longer, given that she had "already waited over the Easter period" (line 13), which itself is accounted for in terms of pressing family engagements. Throughout the extract, Dee displays her own understanding about the right thing to do, which includes avoiding delay as much as possible, together with her own agency in minimising delay in the face of both normal NHS medical practice, and the imminent disappearance to South Africa of her private consultant.

22 Attending a routine mammogram also displays Dee as doing being responsible.
Dee makes relevant her identity as a wife, married for 25 years, and a mother, with a son and a "lot of family". This is part of the account for the Easter period delay, but also for the lump's initial discovery: "we were going out to dinner when I found my lump" (line 16). Dee is constructing herself as leading a normal family life, doing normal family things, when she discovers something out of the ordinary (cf. extract 4:1.1).

Once the lump was found, Dee acted with all possible speed (lines 18-20), including a determination to brook no delays by the hospital. In the face of any such difficulty, she would "camp outside". And in the face of what other people were saying, she somehow "knew" it was cancer. The use of extreme terms "everybody said" and "oh it'll be nothing" (lines 21-22), emphasises the contrast between what she knew, and what others were telling her.

Dee's claim (line 23) "I knew" (cf. extract 4:1.1) is assertive, while "don't ask me how" attends to her difficult epistemic ground for making such a claim. She also appeals to RC personally (line 23), which asks RC to take Dee's story as credible on just such a personal basis, on trust between persons, rather than, say, as something founded in objective evidence and subject to potential cross-examination. But Dee also provides some plausibility about her claim to know it was breast cancer and some understandable grounds for her concerns about delay, by supplying information about a previous medical problem, implying some relevant experience (lines 26).

In Dee's account, any delay in getting a definitive diagnosis was due to no blame on her part. Indeed, she creates a contrasting identity as someone strong and certain about her claims, and insistent upon proper and immediate attention.

Summary

This chapter has looked firstly at how PWC cope with the early signs of their illness. The analysis began with the diagnostic trajectory, the time when their identity as a healthy individual is transformed to a PWC. The analysis showed firstly how, in accounts of discovering their symptoms, the concern for
participants is to display their personal accountability for *doing being responsible* and doing the right thing by going to the doctor's. Secondly, the analysis showed how the delays or inadequacies on the part of the medical profession become salient features of how participants account for their experiences of what occurred and what they did at the time.

What is interesting across all these accounts is who is constructed as being accountable for 'diagnostic delay'. Participants for the most part avoid directly undermining or criticising the medical profession, or expressing any failure of confidence in it (see extracts 4:4.1-4:4.2; 4:4.5). There is, however, a pattern of rhetorically powerful moves in these accounts that effectively recruit the hearer's agreement, as stories of culpable 'diagnostic delay'. A notable feature of the accounts is how the descriptions are constructed in ways that provide resources for the hearer to draw these inferences and conclusions for themselves, rather than the participants actually voicing them directly. A rhetorical advantage of that 'evidential' way of talking is that it recruits the reader into those same inferences, while avoiding displaying the narrator as having some kind of axe to grind.

The extracts in Chapter 5 relate to participants' accounts of receiving the news that they have cancer. Many of these accounts overlap with stories of delay and complications but the analysis focuses on the main feature of interest, how participants construct their accounts of receiving the 'bad news' and how they manage potentially complainable matters.
Chapter 5
Further accounts of diagnosis and delay:
Receiving the bad news

"I wouldn't demand a lot of my doctors time: I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way"


Introduction

It was noted in Chapter 2 that a number of studies have looked at how people talk about various kinds of troubles (Brenneis, 1988; Jefferson 1981; 1984a, 1984b; Miller and Silverman, 1995). But again, the perspective of the person with cancer talking about how they received their diagnosis, their concerns and how they manage such problematic talk is mostly overlooked. The element of 'troubles talk' in this chapter looks at how a PWC talks about the events leading up to the 'bad news' delivery of a cancer diagnosis. Bad news can vary in how serious it is; a cancer diagnosis is at the severe end of the scale, and it can be a particularly sensitive and delicate topic for both teller and recipient.

Chapter 2 also noted that a considerable amount of research has looked at doctor-patient communication and, in particular, the delivery of 'bad news'. However, the primary concern of that work was to understand institutional interaction and asymmetry (Maynard, 1991a, Pilnick, 1998), of how the news is delivered in terms of sequences and organisation (Maynard 1991b, 1992, 1996, 1997, 1998), and sometimes to improve the communication skills of medical professionals (Fallowfield, 1993; Maguire and Faulkner, 1988a). These studies have resulted in a better understanding of this relationship, and have made recommendations on how the news should be delivered, for example in a comfortable location offering privacy and relative peace and dignity, or having someone present during the bad news transaction (Ptacek and Eberhardt, 1996). However, they have not looked at the patients' perspective and how they talk
about how this news was delivered or the problems that are managed in the process of telling. Also, breaking bad news in the cancer diagnostic trajectory is complex and far from straightforward. A diagnosis of cancer is typically not something that a person does not know about and then suddenly does. The person experiencing the symptoms has to have a series of tests resulting in meetings with various members of the medical profession, and possibly surgery, until, eventually, a diagnosis is reached.

In extracts 4:4.1-4:4.5 it was noted that on occasions participants introduce the idea that arriving at their diagnosis took place over an extended period of time; in other words, that there was some delay. The following analysis is formulated from two closely linked and analysable events of interest in the trajectory of diagnostic accounts: the notion of delay, and the account of how PWC received the news of their cancer diagnosis.

**Complaining and Blaming**

The analysis makes a link between participants' accounts of 'diagnostic delay', analysed in Chapter 4, and the construction of potentially complainable matters. There is a close relationship between 'troubles talk' and complaints, whether they are described as 'indirect' or 'direct' complaints.1 Drew and Holt (1988) identified a number of issues about complaints, which they proposed required empirical analysis,2 particularly how they are managed and organised in social activities. Emerson and Messinger (1977) suggest that complaints play a crucial part in the negotiated construction of versions of what exactly the trouble may be. Making a complaint is the point at which some vague perception of something being wrong

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1 According to Boxer, ‘indirect complaints’ are expressions of dissatisfaction “about oneself or someone/something that is not present” (Boxer, 1993:280) and that indirect complaints can be distinguished from ‘direct complaints’ because “the addressee is neither held responsible nor capable of remedying the perceived offence” (ibid: 280).

2 They proposed that that analysis of how complaints are managed should attend to: “how the troubles they report are formulated, how the recipient’s response might shape the formulation of trouble which emerges from the interaction; how complainants seek to persuade recipients of the validity of their accounts and hence of the justice of their complaints and how the extent of a recipients affiliation may have consequences for the organisation of the activity of complaining” (Drew and Holt, 1988: 400).
is cast into the public domain, in an effort to mobilise help in remedying the trouble.

Günthner noted that complaint stories occur when "speakers complain about the behaviour of one or several absent third persons" (Günthner, 1997:180). Making explicit complaints, or blaming doctors and the medical profession for any delay, can be a delicate or awkward topic to address. It is unlikely a PWC would want to upset or anger the medical professional at the time of diagnosis and treatment; after all their life is in their hands, and they might not want to put themselves at any risk (although there are exceptions as Dee extract 5:2.3 reports). Furthermore, PWC may understand, and orient to, the position of medical practitioners as experts in a technical field, so that complaints may appear unfair or naïve.

The Analysis

My analysis is based on participants' retrospective accounts of events, rather than on their conversations with medical practitioners. What actually happened and what was said at the time in question is not known, but interestingly my analysis reveals that in the rhetorical construction of their (sometimes long) 'diagnostic delay accounts', although not explicit, there is hearable complaining and blaming being done.

The troubles reported here are those PWC produce in relation to the complex route to diagnosis and how the news was delivered and received. Günthner notes that in telling complaint stories "participants actively constitute social closeness and bonding, common rejection of the portrayed behaviour and the constitution of common identity" (Günthner, 1997:213) and that complaint stories act to increase "solidarity among the complaining parties" and are "produced in contexts of social intimacy" (ibid: 213). What is also interesting in these accounts is how participants attend to the presence of others.

The analysis is divided into two parts:

5:1 "The Comedy of Errors": “it’s only cancer”
5:2. Companionable matters: Whose fault is it anyway?
5:1 “The Comedy of Errors”: “it’s only cancer”

The first group of extracts, 5:1.1-5:1.8 are taken from what I have termed “The Comedy of Errors” narrative. The ‘troubles talk’ and the implications of complaint and blame are subtly managed in Sara’s description of the course of events before she was eventually told she had breast cancer (see also extract 5:2.6).

Extract 5:1.1 Sara 15/03 “he just couldn’t find where it was”

40 Sara and as I got there umh (1.0) he had a  
41 look at me (.) and he couldn’t find it (.)  
42 → I mean it was that little (.)  
43 RC umh  
44 → Sara that he just couldn’t find where it was and I had to take  
45 his finger and more or less guide it on to the spot y’know  
46 .hh wh(hh)ere this li(hh)tle th(hh)ing was and er  
47 → he says oh yes there is there is a little thing there (.)  
48 → he says er but er (.) I don’t think it’s anything to worry  
49 → about but I’ll still send you to see the er specialist  
50 RC umh  
51 Sara I’ll make an appointment for you (.) so I says (.) ri::ght.  
52 RC umh .hh  
53 Sara so er, (.) eventually an appointment was made and er a  
54 letter came through the door (.) a few months after

When she first discovered the lump in her breast (extract 4:2.1) Sara reported that she made an appointment to go to see her GP. What now becomes relevant in extract 5:1.1, is Sara’s earlier detailed description of how she found her lump in the first place (see extract 4:1.1), because she is now accounting for the doctor’s difficulty in finding it. It is not that Sara is wrong about the lump being there, or that the doctor was being incompetent; it’s because “it was that little” (line 42). In order for any further action to be taken, the doctor has to independently make his own discovery and confirm Sara’s claim. But initially

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3 Sara’s “The Comedy of Errors” is reproduced in full in Appendix E.
there is a problem (line 44), "he just couldn't find it" and Sara has "to take his finger and more or less guide it on to the spot y'know" (lines 44-45). If the doctor cannot find it, then there is a problem for Sara’s credibility and being taken seriously, but (line 48) the actively voiced change of state token, "oh yes" displays the doctor finding it for himself.

Sara then reports the doctor giving her reassurance by saying "I don't think it's anything to worry about" (line 48). This reassurance works as the rhetorical opposite to there being anything to worry about. What is interesting here is that the rhetoric invokes what is not being said, that the lump could be a sign of breast cancer. Not saying what it could be is also reflected in the expression, that he will send her to "er a specialist" (line 49); no explicit mention is made of what kind of specialist that might be, such as oncology or gynaecology. The notion here is that the doctor avoids, but hearably avoids, making any reference to cancer. Yet note the detail in line 51 "so I says (. ) ri::ght." Sara voices her response as this minimal receipt, with a falling, drawn out intonation on "ri::ght" that leaves the 'rightness' in some doubt. RC orients to that feature in immediate next turn ("umh .hh", line 53). This sets up what follows, which is Sara's description of an appointment being made "eventually" and "a few months after" (lines 53-54). Without elaborating or making an explicit issue of it, Sara has started to introduce grounds for complaint. It is a long extract, and only parts will be analysed here, but I am reproducing most of it to show how the narrative is constructed as a continuing series of potentially complainable 'errors'.

Extract 5:1.2 Sara 15/04 “the wrong department”

55 er, (. ) knowing me, I'm usually so busy I I er just looked
56 at the date of when I was supposed to be there
57 RC umh
58 Sara and I thought, oh right, I'll be there for that date
59 → but I didn't look to see what department.
60 → I didn't read every single thing on the paper
61 RC right
62 Sara all I did was just look, for, y'know, I saw the date, that
63 I have to be there and, and er y'know well I thought right
that's good enough for me er because er I mean
what more is there to er (.) know, y' know, until I get there
so of course the day came (.) I went down, (.)
I was in the wrong department.
So he didn't send me to the right place (.)

Firstly, Sara establishes her role in events by accounting (line 55) for her own part in ending up in the wrong department, because she is busy and (line 60) stresses she “didn't read every single thing”. She sets up the event in such a way that she is able to say “of course...I was in the wrong department” (lines 66-67); she reports (reconstructs) her reasoning processes at the time (lines 63-65), accounting for her own actions as rationally grounded. One way for speakers to avoid imputation about their agency is to place the blame for any bad news elsewhere (Maynard, 1998) and in this instance, Sara directly attributes the blame to her GP, (line 68) “he didn’t send me to the right place”. Despite the doctor sending her to “er a specialist”, Sara knows that when she arrives in gynaecology, she had been sent (albeit to a women’s department) to the wrong department. However, she says that the doctor there does agree to see her (lines 88-89 below).

Extract 5:1.3 Sara 15/05 “it may be nothing”

she says but do you want me to have a look at you (.)
So I says, I don't mind. So she examined me down there as well
and er she says er, you're fine, nothing to worry about
and then she says I'll have a look at your lump and she did and
she says I should go back to your doctor immediately and tell
him to get you to the right department as soon as possible
it may not be anything, it may be something, she says,
but lumps are not supposed to be (.) there you take them out (.)

Sara’s recruitment of what the doctor in gynaecology says (lines 92-95) works to corroborate and objectify Sara’s worries and complaint, confirming that it is her GP who is responsible for sending her to the wrong department, that it is indeed
the wrong department, and that her lump is something potentially serious; she should go back to her doctor "immediately" and get sent to the right department "as soon as possible" (lines 92-93). These extreme formulations point up the urgency, and therefore also the potential seriousness of her condition, and along with that, the potential seriousness of the delay that has already occurred. Voicing all of this via the gynaecologist, Sara is able to objectify her complaint while distancing herself from the making of it.

Sara is again given reassurance and whilst "it may be anything, it may be something" (line 94) and again, nothing specific is said about breast cancer. Instead, the doctor says, "lumps are not supposed to be there you take them out" (line 95). The implication here is that whether they are benign or malignant, they need taking out, but we know, in retrospect, that Sara's lump is malignant.

But still Sara reports (lines 100-102) a lack of urgency in taking her lump seriously by indicating the passage of time again (see also extract 5:1.6 lines 146-148). Further, the 'right' department remains unnamed, but of course turns out to be oncology, as was well known at the time of the interview, when Sara's story was told. The retrospective nature of the interviews is not just a feature reflecting their accuracy, but permits the nature of events to be told against a ready-made shared understanding of significant features of how things turned out; most obviously, that the person indeed had cancer.

Extract 5:1.4 Sara 15/06 "three months had gone already"

97 Sara so I had to go back to him, and ask him (.) to send me to the
98 right department
99 → RC how long had you waited?
100 Sara this was, well about three months had gone already from
101 my first appointment, (.) then er I went to him and er (1.0)
102 a week had passed and I happened to be there again for
103 er, I think it was for Jason, something to do with his asthma and
104 umh I asked the Nurse, did Dr D send off my letter to the right
105 department and she looked up and says
106 → oh no it's still here (.) it's not gone yet
107 → Chloe [((gasps))]
108 RC   [((gasps))]
109 Sara She says I'll get it off as soon as possible
110 RC   So there was no sense of urgency at this stage?
111 Sara So there was no urgency there at all (. ) for it
112 RC   the only time the urgency (. ) happened was when I went again

In the above extract, Sara constructs a further sense of delay and RC's question (line 99) asking how long Sara had waited clearly displays receipt of Sara's account of undue delay. It is interesting to note that up until this point in the story, neither Chloe nor RC have said anything explicit, but have merely used 'continuers' such as 'right' or 'umh' for her to go on with her story. The next event Sara reports is a routine visit to her GP for her son Jason, and we hear (line 103) that her letter for a new appointment has still not been sent. Again, Sara does not explicitly make anything of this, and expresses no sense of urgency on her own part either.

Yet, for the recipients the delay complaint is becoming more and more clearly hearable. In lines 107-108 RC and Chloe both react with gasps (of astonishment) and it is RC (line 110) who questions whether there was any sense of urgency, and Sara simply agrees, in deadpan fashion: "there was no sense of urgency there at all" (line 111). Given the contrast with the gynaecologist's expressed urgency, and with the known eventual diagnosis of cancer, the accusatory finger clearly points now at Sara's GP. Yet on eventually reaching the right department, Sara's problems continue.

Extract 5:1.5 Sara 15/07 "it's probably nothing to worry about"

114   ((...)) and they tried to do a biopsy and
115 → they couldn't because it was too hard, and he couldn't get in
116 → and then it was bleeding and so an- and so I thought (.)
117 → right well I know what that is anyway
118   I- I didn't need, anybody else to tell me what was wrong .hhh

4 Continuers such as 'uh huh' 'umh' 'right' are a feature of interview talk which signify a request to the person speaking to continue with an elaboration of their prior turn. Additionally they acknowledge the receipt of what has already been said but demonstrate that they should continue (See Jefferson (1984b) and Schegloff (1982) on the use of continuers).
It is now some three months since Sara discovered her lump, and she now describes the difficulties that ensued when “they tried to do a biopsy” (lines 114-116). Sara reports how she drew her own conclusions, in the form of what she purportedly realised at the time, using active thinking (lines 116–121) “so I thought (. ) right well I know what that is anyway”, and how she did not need anyone to tell her. In spite of being in the hands of medical experts, their role is to delay a discovery that Sara herself reaches before them. Note, however, that Sara does not simply declare herself a better doctor than they are; her knowledge is of a different kind. Even though she ‘knows’, she counters any possibility of hubris or naivety by alluding (line 120) to the possibility that she could be wrong, and leaves the technical vocabulary to the consultant: “I don’t think it’s any er (. ) malignant umh tissue that’s here .hhh he says” (lines 133-134).

Again, of course, we are told this against the background of knowing that judgement to be false, along with the doctor’s normative reassurance, “it’s probably nothing to worry about” (lines 132-133). In the light of it being wrong,
this reassurance now sounds empty and conventional. He talks like friends do (or husbands, see Dee extract 5:2.2) providing reassurance, saying what they think is the best thing to say in the circumstances, rather than what may be best medical judgement. A source of problems for doctors therefore, as well as being a resource, is that they also talk like everyone else: they are people as well as medical experts. But on this occasion for the first time, a cancer term is explicitly used, if only to deny it: "I don't think it's any er (. ) malignant umh tissue" (line 134), which also invokes the specialist as a cancer specialist. Even now, a sense of further delay arises because rather than promising immediate action, the next move is "I'll make an appointment" (line 135).

The following three extracts (5:1.6-5:1.8) show the continuation of this narrative, but I will only highlight the features relevant to the theme of complaint. In extract 5:1.6, Sara again alludes to the amount of time that has passed, but now there is a sense of urgency.

Extract 5:1.6 Sara 15/08 —"A sense of urgency"

139 ((... then umh (. ) I went  
140 again (. ) the next week to (. ) for Jason to have another  
141 → check up with his asthma but I mean they don't do check ups  
142 on asthma every five minutes(.)  
143 RC Umh  
144 Sara So y'know there's a space in between and while he was the::re  
145 the nurse (. ) said to me who does- who was doing the asthma  
146 → and the check up (. ) how's your lump coming on Sara?  
147 So I says oh it's gro:::wing nicely (.1) so she sa:(hh)y::s  
148 .hhh ha ha ha can I (hh) ha:(hh)ve a lo:ok  
149 .hh ha ha ha (. ) hhh ha so she says can I have a look  
150 so I says yes of course so she took one look at it  
151 → so she says oh I better let Kevin come in and have a  
152 look at this (1.0) so in comes the doctor and he  
153 has a look at it and the next thing I know they've forgotten Jason  
154 was there for his asthma, and he was on the phone trying to get  
155 → to the doctor, (. ) then he was on the phone trying to get to  
156 pathology to see if they had the results of this er stuff that they'd
tried to get out of me (. ) pathology wouldn't give him any news at all of what's going on, the, the doctor, the consultant was in theatre so he couldn't get through to him and .hh he's flinging around like a whatsit, y'know, .hh so (. ) he <called me in the office at the end of the day because he just couldn't get through> to the hospital or to- to the pathology department (. ) so he says pathology wouldn't tell me er anything about er the er results and he says what I can make of it (. ) then y'know it has- it has got to be cancer (. ) because if it was hhh clear and it was nothing they'd probably say to me well oh everything's fine but they wouldn't let me know anything so (. ) all I can presume it is (. ).hh

RC umh

Sara is visiting her GP with her son Jason for his asthma check up and the nurse (note, not the GP) asks (line 146) "how's your lump coming on Sara?" Sara treats this with a sense of irony and laughingly says, "oh it's growing nicely" which indicates that it is no longer a 'little thing'. What is interesting is how Sara constructs what is now hearably a sense of urgency (lines152-160). As with the gynaecologist in extract 5:1.3, the urgency is produced as the nurse's rather than Sara's herself: note in particular "she took one look at it" (line150) and the actively voiced "Oh" etc., (line 151). Sara lists one quick action after another, until describing her GP as (line 159) "flinging around like a whatsit, y'know" and then the crescendo of activity calms down again as Sara is called into her GP's office.

Stories of how someone receives their cancer diagnosis seem far from simple. Sara has endured a considerable and avoidable delay, there were difficulties in doing the biopsy and then, further delay is implied in trying to get hold of the results, which eventually produce the news. Sara's GP, who initially sent her to the wrong department, provided erroneous reassurance and delayed making her revised appointment, now begins to act more decisively. In quoting his version of events, he appears to be at the mercy of an unco-operative pathology department, yet doing his best to find the facts and tell Sara the blunt truth.
Deliverers of bad news seek to avoid blame (Maynard 1998), and Sara’s account of her GP reflects that practice on his part.

One elaborate way of presenting bad news is to cast it as a “logical sequence of progressive events that leads to an inevitable conclusion” (Clark and LaBeff, 1982:376) which is how Sara has constructed this account. But the results here are not presented as conclusive, because her GP says “what I can make of it....it has got to be cancer” (lines 164-5). Although it is known that Sara was ultimately diagnosed and treated for breast cancer, it is interesting that throughout her story she provides for an alternative possibility, alive up until the definitive diagnosis, that they still could be wrong. There is a sense of collusion between her, the GP and the hospital, to put off ‘D Day’, the day of diagnosis.

Sara’s account of receiving the news, that she has cancer, is the culmination of what has gone before in her narrative; it is a long narrative, constructed in a way that distances her involvement in the frenzy of the “to-ing and fro-ing” that she describes happened in trying to get the results.

It is only in extract 5:1.7 that Sara produces an acceptance of what this protracted route to her diagnosis means, and attends to this by talking about her son (lines 173-83).

Extract 5:1.7 Sara 15/09 “it was so:: la::ld back”

171 → Sara  y‘know and he::(hh)S got this box of tissu(hhh)es
172 the(hhh)re y’ kno(hhh)w .hh ha ha ha hah hah hah .hhhh
173 and I tho(hh)ught o(hhh)h m(hh)y Go(hhh)d
174 Ja::(hh)so(hh)n [hah hah hah hah hah
175 Chloe                  [ha ha ha
176 Sara  I said .hhh wh(hh)o se go::(hh)ing to lo(hhhh)ok a(hh)fter
177 Jaso(hh)n .hh hah hah hah ha hh o:::h .hh de(hh)ar .hhh
178 and just the::n that was the only ti::me I ha::d a little
179 we::ep and a cry and what have you y‘know
180 RC   Umh
181 Sara  .hhh because I thought to myself (,) what er y‘know I-
the thought of not being able to look after Jason (.).
to see him grow up (.). hh he says (.)
oh don't worry about it you'll live long enough to see
Jason grow up to be a fine you::ng man he says
we'll get rid of that y'know (. it was so:: la::id back it [was
RC (umh
Sara so:: (. o::ka::y (. y'know so ca::sual (.)
oh it's o::nly ca::ncer y'know .hh ha ha ha .hhh

The confirmation that this is bad news is that (line 171) her GP has “got this box of tissu(hhh)es” in anticipation of her tears. Sara’s concerns for herself are expressed as concerns about what her illness and possible death will mean for her son Jason, and then the tears follow that. The possibility that she might die is indirectly invoked by “not being able to look after Jason (. to see him grow up” (line 182). Yet even now, the GP again provides reassurance and it was “so:: laid back...y'know so ca::sual (. oh it’s o::nly ca::ncer y'know” (lines 184-9). This “casual” delivery works to downplay any major concerns or worry and at the same time discounts any potential problems that the protracted route to delay could have implied.

The extract contains a lot of laughter, which helps to manage talking about the awful news for hearers, but also displays that Sara is not dwelling on this in an indulgent or self-pitying fashion, but that she is looking on the bright side, and ‘coping’ with these awful events. The laughter also contributes to her identity (built across much of her complaint-relevant stories) as someone who is not by nature a complainer or a moaner. (See Chapter 7 for more detailed analysis on the use of laughter in ‘troubles talk’).

In extract 5:1.8, Sara does some specific stake management along these lines, not only for herself, but also on behalf of the medical profession.

5 A common feature in participants accounts is their concern for others, particularly family (see Chapter 6, extract 6:3.1 and Chapter 8, extract 8:4.1).
Throughout her narrative Sara has pointed the finger at her GP for sending her to the wrong place, treating her problem lightly, and delaying getting it dealt with. But in the end we are left with an image of a conscientious, kind doctor doing his best for her. In fact she blames no one, and declares her doctor “a very nice doctor”, and she “wouldn’t change him for the world”. He is fallible only in so far as anybody is: “anybody (1.0) can overlook something or make a mistake...and this is how I look at it” (line 202). The last few words, “this is how I look at it” are particularly interesting however, in that they allow for the doctor’s failings to remain perhaps objective and culpable, while his blamelessness is framed as a matter of Sara’s own attitude, perspective, or generosity of spirit, of how she prefers to think.

Sara does not make direct and explicit complaints, but the complainable nature of the events told are hearable in how she describes them. One of the things she achieves is that she is managing and negotiating her identity as someone who is not bitter nor angry, not the sort of person disposed to complain, and gives all
sorts of reasons why, that she is normal, and "looking on the bright side". At the beginning of her interview, Sara also managed some identity business by constructing herself as a rational, understandable, responsible person, doing the right thing and not to blame for the events that followed. It is interesting how her stories and descriptions of the medical personnel enables her not to talk or dwell too much on the awfulness of having cancer. Rather, she talks about lumps as "growing nicely", and uses laughter to fend off or manage any problem of story recipients engaging in expressions of sympathy, while managing to construct her story in such a way that the hearers rarely take a verbally explicit turn.

5:2 Complainable behaviour: Whose fault is it anyway?

In contrast to Sara (extracts 5:1.1-5:1.8), Dee presents a rather different account of delay and of hearing her diagnosis. It is not worked up in the same episodic way as Sara's, but what is interesting is how the amount of time that constitutes delay becomes defined for Dee, and how she manages the bad news. Dee also sets up a contrast between her GP and the oncologist. The dominating theme throughout extracts 5:2.1-5:2.4 is the complainable behaviour of the oncologist, which is set against receiving her diagnosis.

Extract 5:2.1 Dee 08/02/2 “it's bloody awful news”

1 → Dee I had a very good GP (1.0). hh umh and I had an appointment to see the oncologist in eight days after surgery (1.0)
2 and we had the most horrendous meeting (2.0) umh (1.0)
3 → I think his words were something like,
4 ↑well we’ve got the histology back DEE,
5 it’s really bloody awful news↓ (. ) and I said fine,
6 he said er >you need chemotherapy, plus radiotherapy and the chances of you being here in two years are fifty per cent
7 and I think that’s generous< (2.0) and would we- would we like a wig (1.0) and this is all sort of thrown at you within about (. ) eight minutes (2.0)
Dee sets up a contrast here (lines 1-3), which is a useful device in talking about troubles, which accomplishes two things for her. She contrasts her GP, who is "very good", with a "horrendous meeting" with her oncologist, which provides a preliminary gloss (what narrative analyst William Labov, (1972) calls an "abstract"), on the complaint story that follows. What it also provides (as for Sara) is an alternative narrative frame, in that talking about encounters with the medical profession avoids talking about and managing the receipt of the bad news itself, and the difficulties that accompany talking about cancer. The contrast with her GP also serves to particularise Dee's complaint as specific to the oncologist and his behaviour, rather than any kind of general reaction on her part to the diagnosis itself. When people are on the receiving end of bad news, there is sometimes a tendency to blame the messenger (Maynard, 1998). Dee further manages any impression that she may be doing that by providing details of the oncologist's behaviour.

Her reporting of the news delivery (lines 5-6) is captured in a tentative voicing of his words to her: "Well we've got the histology back" (line 4). The technical medical term gives way to a common sense interpretation of what it equates with, "really bloody awful news". Dee's narrated receipt of this bad news pre-announcement is minimal: "fine". She continues her account (lines 7-9) focusing on the delivery of what is hearably an abrupt, matter of fact list of what the oncologist threw at her "within about eight minutes", (line 10) concerning her treatment programme and the prognosis ending with, "the chances of you being here in two years are fifty percent" (line 8). What Dee reports here, of course, takes much less than that eight minutes, but the inference is that he was bombarding her with rather brutal, factual information, with scant concern for her feelings.

Again, it is interesting what Dee does not say. She does not report anything that relates to herself on a personal level, nor does she elaborate on her reaction. That is part of how we hear the oncologist's news delivery as so abrupt; it is provided in the form of a condensed list of awful things as if simply said to her, with no mention of Dee's reactions along the way. It is RC's reaction (extract 5:2.2 below, line 12) that pursues Dee's feelings, picking up the complaint via the
possible absence of anyone else (given the oncologist's inadequacy) to be there for Dee. RC asks whether Dee was hearing all this on her own.

Extract 5:2.2 Dee 08/03 "you'll be alright"

12  RC  were you- did you have someone with you?
13   Dee  I had my husband with me
14   RC   umh
15 →  Dee  who continuously said >you'll be alright which er angered me
16  because how did he bloody know I was going to be alright,
17  they didn't know [that was my, my, that made me very cross]<
18   RC   [umh, umh, umh
19 →  Dee  because he didn't validate my illness (0.5) y'know he said
20 →   oh well it will all be alright, well it's not what I wanted to hear,
21 >even though he probably meant it in the best possible way<

RC's question serves to distract Dee, momentarily, from her focus on the oncologist. Dee says "I had my husband with me" (line 13). But this sets up another complaint. Dee answers that, presumably during the eight minute barrage of information, her husband was producing the normative response of reassurance to someone who has been given some awful news, that "you'll be alright" (line 15). But in contrast to a medical professional telling Dee this news (cf. Sara in extract 5:1.6) Dee is "angered" and her husband is held accountable for this: "how did he bloody know" because referring to the medics, that "they" didn't know (line 17).

Dee's account accentuates the difficulties for anyone, partners or medics, of knowing what to say to someone when they have been given such devastating news. Co-participants, or news recipients, normatively offer reassurance, that everything will be all right. But Dee (lines 17-19) makes it very clear why she is cross, in that "he didn't validate my illness" and that "it's not what I wanted to hear" (line 20). She is invoking familiar therapy talk here with the use of 'validate', which prescribes that, in order to manage a trouble more successfully, there is a need for other people to recognise and acknowledge the reality and legitimacy of a person's trouble, before starting to deny or counter it. Dee claims that her
husband was not dealing with her problem, even though for possibly laudable motives, those of trying to provide hope and to say the 'right' thing.

It is a difficult problem for her husband (or anyone else) to know what to say, which Dee does acknowledge by displaying her understanding that he "meant it in the best possible way" (line 21). Doctors, family, and friends invariably say "it will be alright", "you'll be fine" but this is not always what the PWC wants to hear. Dee's expressed anger (lines 15-17) and complaint (line 19) leave open the possibility that such reassuring reactions are designed more to manage the other person's interactional difficulties (whether a friend, husband, or medical professional delivering the diagnosis) rather than the PWC's. This is a theme I will return to in Chapter 6, category entitlement and the complainable nature of other people's ostensibly helpful reassurances.

Under the circumstances, Dee's husband's response is deemed inadequate, considering that she has been given such a prognosis, but what do you say? Dee exclaims it was not what she wanted to hear and she needed validation at this time. But on other occasions, participants do want to be told that everything is all right, they want to be treated normally (See Chapters 6, 7 and 8). It is not just friends and family who do not know what to say; medical professionals, other people with cancer (and interviewers) are subject to the same kinds of normative difficulties.

Dee resumes her story about the horrendous meeting (extract 5:2.3) and describes the behaviour of the oncologist, implying that he has his own difficulties in managing the delivery of such news.

Extract 5:2.3 Dee 08/04 “I'm shell-shocked”

22 so I looked at the consultant and I said, well I lost all my hair in a
23 RTA in 1978 (.) when I had my plate fitted (.) and I didn't wear a
24 wig (.) a wig is not an issue for me I'm quite prepared to have my
25 head chopped off and have it under my arm if I'm going to live
26 → (.) so he so(hh)rt of hh looked and said (.) I'll go and get you the
27 brochures on chemotherapy and radiotherapy (.) so he did, and
28 went out (.) and came back and he (.) tossed them across the
29 room and left- and he left the door open (2.0) and er he started
30 to sort of say er >well any questions< and I said, look I think you
31 know (.) we're not- you've either had a bad morning and
32 → I'm shell-shocked
33 RC umh
34 Dee and I probably need to see (.) a different oncologist because you
35 and I are probably not going to get on

In lines 26–31, Dee produces further details elaborating on her gloss that it was a
horrendous meeting. She constructs the oncologist's actions as being
unreasonable and uncaring; he “tossed” the brochures, and “left the door open”
producing a notion that he did not want to stay around; the open door tells of his
intentions, serving as a non-verbal invitation for Dee to depart, or at least a
rejection of the kind of privacy in which he might talk to her in a more personal or
caring fashion. What Dee's discourse does is to place the emphasis on the
inability of the oncologist managing this bad news, rather than on Dee herself.
His direct, unsympathetic manner is produced as a criticism, of what he is not
providing. However, Dee manages to display her own reasonableness under
these extreme circumstances, by providing an excuse for his behaviour, that he
may have "had a bad morning", but she then directly describes herself (line 32)
as, understandably, "shell-shocked". This is offered as a challenge to him *at the
time* (not just now, in retrospect). What follows (lines 36-49, see Appendix E) is
an account of how she negotiated the basis for any future meeting and in extract
5:2.4, Dee goes on to describe what happened at her next meeting.

Extract 5:2.4 Dee 08/05 “he had his entourage with him, as they do”

50 Dee .hhhh so we agreed that we’d meet at the CRI
51 [at radiotherapy (2.0)
52 RC [umh
53 → Dee and er we did (.) and he had his entourage with him, as they do
54 (.) and er I can remember it vividly >I sat down and he sat down<
55 he said (1.0) ↑right, how are we today↓ as if it was all my fault,
56 you see, so I said, I'm better (.) but I said
57 I've had a dreadful week I said (.) having my diagnosis was

156
nothing compared to the trauma of having your behaviour (.).

I said I find it very unacceptable I don’t consider I’m asking for anything out of the ordinary but I wanted to be treated like a piece of human flesh, not just er a you know another number

(2.0) oh he said, I’m very sorry DEE (. ) he said “I didn’t realise I upset you so much” and his staff were visibly shocked

I didn’t know why at the time but they all sort of went

((non verbal action – Dee gives astonished look))

it does sound unusual

Although Dee has provided grounds for finding her oncologist unreasonable, what is interesting in extract 5:2.4 is how she presents herself in such a way that she was not the one being unreasonable and warrants the grounds for her complaint. Their meeting takes place in a public place, the radiotherapy department where “he had his entourage with him, as they do” (line 53). The script formulation of ‘as they do’ attends to this as being a normal occurrence; consultants are invariably surrounded by others (see also extract 5:2.5).

Who is to blame for the horrendous meeting is being specifically attended to now in how Dee reports his manner of speaking “how are we today” which for Dee also construes that he is inferring “it was all my fault” (line 55). Then, in no uncertain terms, (lines 57 - 62) Dee sets up a contrast to how she has been feeling in relation to how he had behaved previously, that it’s “very unacceptable” (line 59) and how she does and does not want to be treated “not just er a you know another number” (line 61)\(^6\). This not only builds the effects of the presence of the entourage, but of being treated as an object rather than “human” and consequently, has a deindividuating effect. What RC points to, as sounding “unusual” line 66 is the response that Dee says she received from the oncologist. She not only gets an apology “I’m very sorry DEE” (lines 62-63), but it is also a public apology. Dee says that “his staff were visibly shocked” (lines 63). His apology makes her complaint not only believable but also credible; he is making a public apology, in front of his entourage, which validates Dee’s cause for

\(^6\) Being treated as a number, an object on a production line is a common feature of participants’ discourse, though not specifically addressed in my thesis but see Chapter 8, extract 8:4.1.
complaint. The entourage in Dee’s narrative functions like a Greek chorus, providing reactions that tell the listener what it all means. Dee says she does not know why at the time, nor does she go on to explain it in verbal detail, but the inference here is that oncologists (or members of the medical profession) are not known for making public apologies. Again, the breach of a norm provides for Dee’s complaint as well grounded and, if I may use the term, validated.

Dee’s complaint, unlike Sara’s (extracts 5:1.1-5:1.8) and Angie’s (extracts 4:4.2-4:4.3) is explicit and direct, as well as being carefully grounded in her narrative. Making direct complaints to the consultant responsible for your treatment, and therefore your life, can be controversial and threatening. Managing this is a delicate and complex matter but Dee presents herself as someone who is reasonable and is prepared to negotiate this relationship. At the same time, her story demonstrates that she is in control of how she wants to be treated. Despite how she was feeling ("shell-shocked" and "having a dreadful week") she manages to assert control and deflect the impact of the awful news onto the “trauma” of the oncologist’s behaviour in delivering it.

This is a common feature in my data, whereby participants tell long detailed stories in which complaints about medical professionals are either explicit or implicit and invite recipients to respond to this event, rather than to the diagnosis itself and all its connotations. This is presumably an interactional design feature of such stories, that they provide recipients with something else to respond and affiliate to, rather than the diagnosis itself. Again, I will comment on that kind of recipient-orientation at various points when examining features such as laughter.

Angie’s story is a stark contrast to those of Sara and Dee. She does not express or display any ‘knowing’ awareness of her illness, even in retrospect. As noted earlier, it was eighteen months before she was eventually given her cancer diagnosis, but her story of the receipt of the news is still hearably a complainable matter. Again, it is an account imbued with the difficulties that people have in talking about, relaying, and receiving the news of a cancer diagnosis.
RC er, so how do you remember how he told you,
139 I mean how, I mean, you, how you actually heard
the news from him?
140 Angie oh yes well, no I didn’t hear from the er umh [surgeon
what did he say?
142 Angie I heard from the houseman who came up to my bed and said
143 oh we’ve had the results of the test (1.0) so I said oh yes (.)
144 → umh yeah you’ve got lymphoma
145 ((very softly spoken, almost like muttering))
146 er I said er pardon ha ha, and he said umh,
147 RC they actually told you that it was lymphoma?
148 → Angie yes, he just said it in a very laid back way
149 and I said oh right
150 RC [right did you know what it was?
151 Angie and then I thought (.) well I don’t know what lympho(hhhh)ma is
152 → so I said well what’s lymphoma?
153 → and he looked acutely embarrassed (.)
154 and I can’t remember what he said (.)
155 → but I got the message it was a form of cancer and he walked off
156 (.) that was it (2.0) so I lay there thinking (.) heavens (.)
157 and then I think I got a bit weepy about it
158 → so a nurse came and talked to me and explained it (.)
159 → and really she (1.0) I mean the doctor was no help (.)
160 → neither use nor ornament (1.0) umh (1.0)
161 → but then the surgeon came and saw me (.)
162 sometime later and explained what would happen
163 → and that I’d have to go to the lymphoma clinic
164 → and all that sort of thing (1.0)

RC (lines 137-139) specifically addresses how Angie heard the news. And like Sara and Dee, Angie uses a contrast between one medical practitioner and another, in this instance the surgeon (who she later presents as a reasonable person) and the houseman. Again, this deflects from any notion that Angie’s
reactions might be simply due to the bad news itself, or else an indiscriminate or irrational shooting of the messenger. She establishes that the news is delivered in a public place (line 142). Again as in Dee's story, Angie's response to the houseman's pre-announcement "we've had the results" is to produce a simple acknowledgement of "oh yes", which orients to the yet-to-be-delivered nature of that news. It is of interest in its own right, though I will not pursue it here, that stories that reproduce dialogues may reproduce some functional features of actual recorded dialogues, reinforcing the notion that those features are indeed significant to participants, even though they would be unable to articulate what they are.

Angie goes on (using active voicing) to say that he tells her "you've got lymphoma" (line 144) which she says very softly. This also appears to be a representation of how he said it, because it seems she did not hear him; she says (line 146) "pardon" and the houseman repeats that "you've got lymphoma". Angie's "or something" nicely displays what she goes on to say, her lack of understanding of what that was. Angie provides no recognition or awareness of the houseman's announcement, such that RC questions whether they actually told her it was lymphoma, which Angie confirms. It is interesting because, like Sara, Angie reports that it was said in a "very laid back way" (line 148), which again Angie simply acknowledges. It appears that she is colluding with the doctor's discomfort, and could let the doctor get way with not telling her any more.

What is at stake here is that by asking him questions, she might get an answer that she did not want to hear. But at this point, RC asks, "did you know what it was?" (line 150) because not only has the houseman delivered a diagnosis (according to her story) in a laid back way, but he has also used a medical description, which it appears that Angie did not understand at the time because she had to ask, "what's lympho(hhh)ma?" (line 152). Angie then describes the houseman's apparent inability in providing an answer, because she describes his reaction: "he looked acutely embarrassed", implying difficulty on his part in talking explicitly about cancer. It is also hearable that his delivery of the news was done
quickly, and that "he walked off" leaving her to "lay there thinking (.) heavens" and "I got a bit weepy" (lines 156-157).

By describing the houseman's difficulties Angie also manages to avoid any response from her story recipient (RC) as to why Angie was perhaps not more insistent on getting the information she wanted. The houseman has delivered his bad news, in an uncomfortable manner, and has walked off and left her to deal with the emotional consequences. It is the nurse who is credited (line 159) with explaining it to her. Again this contrast points up how inept the houseman was, and she makes a direct complaint here (lines 159-160), about his inability to provide what she needed at the time; he was "no help, neither use nor ornament". Drew and Holt (1988) showed that proverbial, idiomatic and other figurative expressions are frequently used in making complaints, and do so in a way that does not invite their being unpicked or questioned in next turns. (Note the absence of response or pursuit in line 160).

After the initial bad news is broken, Angie's brief descriptions of her encounter with the nurse and later the surgeon (lines 161-164) are produced in a more positive fashion. It is again interesting to see how other people are recruited into the account to deal with (or not deal with) the accompanying problems of the diagnosis. A common feature of these accounts is that participants do not dwell on how they felt, nor account explicitly for why they did not pursue the medical people to provide them with the information they need. The discourse is focused more on what others, in particular the medical people, said and did at the time, and attends mainly to their incompetence or their inability to talk about the implications of the diagnosis of cancer.

Finally, I want to include two extracts, both taken from an interview with Bee, which also display 'blaming the messenger' for the news, though in contrast to Angie, Bee says she "knew" it was cancer. At the time of the interview (conducted along with her friend Jan) Bee had received two cancer diagnoses, the first having resulted in a hysterectomy, and later she was diagnosed with breast cancer.
In extract 5:2.6, Bee focuses on how she received the news of her breast cancer diagnosis and in extract 5:2.7, she recalls what happened when she had a hysterectomy operation. Again, as with Dee's accounts, these events are presented as hearably complainable matters, not so much concerning delay, but they demonstrate how the medical profession are reported as having difficulties in breaking bad news. Again, these narratives of events with the medical profession provide an opportunity for story recipients to attend to the issues they hear as complainable, and help deflect from any pursuit of personal interaction or accountability on the part of the PWC.

Extract 5:2.6 Bee 13/01 “I am afraid I've got to tell you”

5 Bee I forget how long I had to wait (.) I saw the consultant
6 and er within about three weeks I think
7 → before I got in there .hh and I .hh saw a .hh horrible .hh registrar (.).
8 hh ha a brutal registrar .hh
9 Jan O::h god
10 Bee and er (.) there was actually a cancer nurse in the room
11 (.) with me (.) and I don't think he said much,
12 I think he said oh I'll just get some fluid off here
13 → and then we'll see what it is (.) tch so .hhh I knew that it
14 was- I knew again that it was cancer (.)
15 so I had to go back again the next week and I saw the
16 → lady consultant, who was a decent old soul .hh and er
17 → she said, she said er well I am afraid I've got to tell you
18 that you've got cancer so I said yes I know.
19 So she said who told you, how do you know hh hh ha
20 I said because .hh ha because it’s me: ha (.)
21 Jan Umh

Although not the issue for this piece of analysis, the notion of delay is constructed (lines 5-7) and this is followed by Bee laughingly announcing that before that, she “saw a .hh horrible .hh registrar:.r (.)” whom she describes not only as horrible, but "brutal." Jan's receipt of this, "O::h god" (line 9) clearly affiliates with Bee's description (Jan also has breast cancer). Bee's mention of the cancer nurse being present is done relevantly straight after Jan's reaction, in
a way that retains the notion of how horrible Bee's experience was: the (male) nurse present ("with me", line 11) was clearly no comfort, saying little and doing formal nursing duties. This is somewhat reminiscent of extract 5:2.2 where, on hearing another horror story of diagnostic bad news delivery, RC asks "were you-did you have someone with you?" It is clearly a normatively expected feature of 'coping' with such news, that one might benefit from having a friend or other person with them to help (and one recommended in the research literature).

Again, it emerges as a robust feature across these accounts that there is generally a contrasting other member of the medical profession, whose deportment serves to point up the complained-of person as especially, and particularly, culpable. Bee's contrast against the brutal registrar is the "decent old soul" lady consultant (line 16) who, it turns out, is the ultimate bearer of the bad news. It is this lady consultant who, in Bee's narrative, prefaces the news with: "I am afraid I've got to tell you" (line 17), which is a polite way of saying that the bad news is something she cannot help telling, and a way of orienting to its nature for Bee, the PWC.

Bee's depiction of this latter interaction is a friendly and co-operative one. She effectively helps the consultant to relay the news, by declaring it as not really news at all, but something already known (line 17). I have already shown an aspect of how participants use the concept of 'knowing' they have cancer in Chapter 4. When the consultant is reported to have said "who told you, how do you know", Bee just claims laughingly "because it's me:". Again, as we have seen, the PWC's grounds for 'knowing' are not those of some kind of rival medical expertise, but rather, a different kind of personal knowing that people are 'entitled to' (see Potter, 1996) on a common sense basis of personal experience.

Extract 5:2.7 is part of Bee's account of what happened when she was in hospital previously, at the time of her hysterectomy.

Extract 5:2.7 Bee 13/02 "I was a demonstration model"
48 the University (. ) lecturer (. ) that lectures that er
49 Jan A professor was he?
50 → Bee No (. ) he wasn't .hh but umh hh I was a demonstration
51 model as I fo(hh)und out later (. ) .hh [huh hhhh
52 Jan [ha ha
53 RC So he had some other students there did he?
54 → Bee Oh thou(.hh)sands .hh be- because .hh ha ha I we(hh)nt
55 ba(hh)ck .hhhh and er ha (. ) and they said- they said to me
56 o:h now I have seen you before .hh you wouldn't
57 .hh ha reme:(hh)mbe(hh)r m(hh)e .hh [ha ha ha
58 Jan [ha
59 → Bee beca(hh)use .hh ha ha so:: .hh I knew th(hh)en (. )
60 [.hhh ha ha
61 Jan [yes .hh ha ye::s(.)
62 Bee I wasn't conscious you see (. ) and er others (. ) and when
63 → they came you see (. ) he came and .hh he brought them
64 all round my bed .hh and I think he brought them (. ) .hh
65 → to show (. ) er how (. ) to tell you that you've got cancer
66 (. ) to be quite [honest
67 RC [Oh that's' interesting
68 Bee Yes

69→ Bee But they wouldn't say so until they'd operated on me
70 → and then he came in the next day with all these folks
71 so he said (. ) oh (. ) he got one of the students
72 → to stand up and say, this lady has had a hysterectomy
73 I don't know whether he was talking to me or whether he
74 said you had a hysterectomy yesterday (. ) umh and then
75 Mr. K- that was the consultant (. ) he said (. ) we want you to er
76 go on (. ) Provera (. ) that's some pills and then we would
77 → like you to have a month of radiotherapy and I said
78 → oh it was cancer then (. ) and the whole of the students
What is interesting about Bee's account here is that she is describing what happened after she had had her operation; it is a story of an attempt by the surgeon to communicate with her. The role of the lecturer provides the occasion for telling something she found out later, during another event altogether. Again, the medical practitioner is produced in various ways as treating Bee as an object, rather than an individual with feelings: she was "a demonstration model" (line 50-51), first shown to the students when unconscious and apparently uninformed (lines 56-62), and later at some point, she does not know whether he was talking to her or to them (line 96). This also resonates with the metaphors of the medical model reviewed in Chapter 2, of the body as a machine that can be objectively repaired. Bee's account reflects the objectivity with which patients are often treated.

Bee's account also has similarities to Dee's description of the oncologist and his entourage (extract 5:2.4). When RC asks whether there were other students with him, Bee's response is ironically exaggerated: "oh thou(hh)sands", and she laughs through it (lines 54-58). Often narratives do not follow the strict temporal sequence of events (Young, 1987), and this happens here in that what she says is at first a little confusing. Bee has already given one account of how she received her diagnosis, and in this account, she is drawing on a previous occasion. She attends to the surgeon's difficulties, whilst on his rounds, of openly discussing her condition. Having established that she had previously been a "demonstration model", Bee makes a pre-announcement concerning why the consultant was currently there with his entourage (line 63-65), which sets the scene for her ironic account of what then happened (lines 93-95). The ironic nature of Bee's narration is interesting here, because it provides a way to tell her story of complainable experiences at the hands of the doctors, while at the same time displaying her own attitude as non-complaining, indeed as cheerfully making the best of things.
The irony continues with regard to the consultant's supposed purpose in being there, which was to demonstrate how properly to inform a patient they have cancer (line 65). In the event, in the story that follows, Bee is moved to say "oh it was cancer then (...)" (line 101), to which "the whole of the students gasped you see" (again, "the whole of the students" formulates this in extreme terms, further pointing up the irony: see Edwards, 2000). Patients are on certain occasions, generally expected to be passive in the presence of someone from the medical profession. The gasped reaction from the students could signal either that Bee is actively engaging with the consultant rather than lying there passively, or else mentioning the hitherto skirted-round word "cancer", or else pointing up the consultant's having culpably left her in a state of ignorance about her condition. In any case, what we are able to hear is a story of ironic complaint, of medical inadequacy at which Bee is now able to laugh at, embodying in that irony and laughter her positive, non-recriminatory way of 'coping' with it all. (See Chapter 7, extract 7:2.4 for more detailed analysis of the use of laughter in this extract).

Summary

This chapter has looked firstly at how the notion of delay is produced as an accountable issue, and is worked up as a participant's concern ostensibly in two ways: either as them being personally accountable, or as an issue of accountability for the medical profession. On close examination of the accounts, however, it emerges that the interviewees consistently attend to their own rational accountability in what they found and did. The route to diagnosis is clearly not straightforward, and reaching an eventual cancer diagnosis can be full of complexities. This gives rise to, and scope for, a range of issues to be managed in narrating this sometimes protracted span of time from discovery to being given the bad news.

The analysis also showed how accounts of delivering the bad news are closely tied to stories of delay. These accounts are invariably long, and are rhetorically constructed in a range of subtle ways as hearably complainable matters, while attending to the status of the teller as not personally disposed towards criticism or complaint.
In making what is hearably, and interactionally oriented to, as a complaint, participants routinely attend not only to the object they are complaining about, but also to their possible status as a complainer. They reflexively attend to the implication of their dispositional character, that they might be heard as just a 'moaner', or as talking out of shock and despair at the diagnosis itself, by managing that kind of stake or interest. They present themselves as someone who is being reasonable and not overly complaining and looking for trouble. In most instances, the extracts chosen are taken from even longer accounts, which provide further opportunities for participants to attend to a perception of themselves as to what kind of person they are, and what they expect from others.

One of the features of all these accounts is that participants present themselves as, basically, doing the right thing. The accounts are known in advance to be bad news stories; both RC and the participants know that the diagnosis is cancer. What is interesting is how the notion of a positive attitude, in other words doing being positive, permeates these accounts, and how telling stories about the medical profession provides participants with a way of managing the awfulness of (talking about) cancer itself (see Chapter 7). In this and other ways, the stories consistently orient to possible responses by the hearer. By producing their accounts in this way PWC make it easier for recipients to respond, because they can affiliate with the awfulness of the consultant or the registrar and they can affiliate with the story as a complaint, which diverts interactional attention, if any, onto the medical profession, rather than directly on the individual telling the story. The implied incompetence and culpability, along with the sometimes ironic nature of its narration also works to insulate the participants from reliving the badness of the bad news being told. It gives them something else to receive, and another story to tell.

Having received their cancer diagnosis, the next stage in the trajectory of these narratives-in-interview was for participants to manage their identity as a PWC, and how this new identity was attended to in their social relationships. Chapter 6 looks at accounts of the difficulties of talking to others, and in particular focuses on reports of what other people said to them, and the difficulties of knowing what to say.
Chapter 6

Dilemmas of talking about troubles:

The things people say

Please do not trivialise
My suffering

You who are healthy
You whose mortality is as yet
Only dimly perceived –
Please do not say
"You will be just fine".

I may well be – someday
But I do not know...
You do not know...

Lois Tschetter Hjelmstad (1998)

Introduction

In Chapters 4 and 5, the analysis looked at the first issues participants attend to and have to cope with in the diagnostic trajectory. Before and during the time of diagnosis medical professionals and others are reported as saying, “you'll be alright”, “there's nothing to worry about”, and “it will be nothing”. The next stage in the normative trajectory, despite being categorised as someone with cancer, is to carry on life as much as possible as normal, and participants work to prevent others from treating them differently. One of the recurring topics of analysis throughout this thesis is how participants manage and display their understanding of the interactional difficulties they face in social situations. In Chapter 2, I discussed how a cancer diagnosis carries ‘cultural baggage’ accompanied by prescriptive expectations from which other illnesses are exempt. So, when it is known that someone has cancer, social interaction can become problematic.

As previously noted, talk around and about the topic of cancer is categorised as ‘troubles talk’ and is a delicate and sensitive topic. The analytical concern of this chapter is with the problems that PWC encounter in their accounts of everyday conversations, the potential source of social support. What kinds of things do
people say to them, and how do PWC talk about and manage this? People, friends, family and the medical profession do want to say the 'right thing' but what is the right thing? And what do you say to someone who has an illness that most people dread?

In Chapter 2, I also identified how cultural knowledge and the language of cancer is constructed as a normative backdrop for participants to draw on. I proposed that the language surrounding cancer is replete with attributions, which become issues of moral responsibility and accountability for the PWC. Descriptions such as 'brave', 'a hero' or 'courageous' are often invoked in talk about how people are expected to cope with illness. Attributes such as a 'fighting spirit' and a 'positive attitude', part of cancer's culture, are assigned and prescribed as the appropriate way to cope, and are even suggested as offering better prognoses (Watson et al, 1999).

Consequently a PWC, along with their potentially life threatening diagnosis, has to contend not only with the physical management of their illness and its symptoms, but they also have to deal with the problems of social interaction, the pervading culture of cancer, and the additional moral accountability this can place upon them. The PWC cancer must “bear their illness in ways that do not imply either that this burden is too heavy for them, or that bearing it makes them markedly different from the healthy” (Goffman 1963:147). Radley (1993) suggests that it is a matter of maintaining an impression of oneself as being ordinary and being normal (just like other people) against the background of evidence that one is clearly not. The categories 'normal' and 'abnormal' are characteristic features of language associated with people with chronic illness and are culturally constructed and intimately associated with the social, political and moral order (Lock, 2000).

Illness calls upon people to account for both their condition and their handling of it in daily life, and to 'legitimise' their actions to avoid societal reproach (Radley, 1993). The identity of someone who is ill can become overshadowed by the moral and value judgements that accompany the illness, which in turn pose a
challenge to their sense of what is important about themselves, and I suggest this introduces a number of new dilemmas for the PWC to manage.

This chapter explores how people with a cancer diagnosis talk about the nature and difficulties of their everyday social interactions. The analysis focuses firstly on how participants account for how social interaction gets done in everyday conversation and, secondly, on how PWC deal with some of the dilemmas and complexities that arise.

A regularly reported statistic, and one that was used recently in an advertising campaign for cancer research, informs us that one in three of the population will be diagnosed with cancer. It is therefore highly likely that most people will at some point come into close contact with someone who has cancer. If someone has cancer, or they have been close to someone with cancer, they might have some idea of how difficult conversations can sometimes be. But, regardless of any previous experience, knowing what to say to someone who has cancer often remains problematic.

**The Analysis**

The analysis offered here shows how this difficulty is addressed in participants’ own accounts of it and how they use and respond to the everyday language of cancer. It appears that who says what, when and where contributes to whether what is said is deemed as appropriate support. Especially revealing is how participants report what they want and do not want people to say and how they produce their own expectations of how they want people to interact. This chapter aims to create an awareness that on certain occasions, some of the most straightforward kinds of everyday conversations can be problematic for those involved.

The extracts chosen for analysis are examples of the main topics that were identified as concerns by the participants themselves. I have organised them into the following themes:
6:1 Saying the right thing: "think positive", "you're gonna be fine", "be brave" "fight it": Acceptance and rejection

6:2 Saying the wrong thing: sympathy and compliments

6:3 Putting on a brave face

6:4 Asking "How are you?"

6:1 Saying the right thing: "think positive", "you're gonna be fine", "be brave" "fight it": Acceptance and rejection

In the following analysis, I look at how phrases such as 'think positive' or 'be positive' are produced in talk. There is a recurring pattern in 'troubles talk', that participants often present contrast stories. They first present a negative scenario, and then follow it with an upgraded positive scenario (see extract 6:1.1 and 6:2.1 below and Chapter 7, extracts 7:1.2-7:2.6).

Extract 6:1.1 Andy 17/02 "think positive"

11 Andy I can't remember us breaking down (1.0) er a lot (2.0)
12 and I think you probably did at some time
14 Pam yeah I think that we both did but
15 Andy but (2.0) umh (.) I think (4.0) the thing that encouraged me
16 most I mean y'know we- we asked Mr Brown y'know
17 RC umh
19 Andy and he said, well he said, I, if I have to operate I'll do my
20 best he says and er, if you think positive he said,
21 that'll help the job along he says but
22 if you don't think positive there's no hope for either of us
23 y'know and he more or less sort of (1.0) instilled into me
24 that I'd got to think positive and I think (2.0) umh (2.0)
25 we both took that attitude then
26 Pam umh
27 Andy didn't we, this is something we're gonna beat y' know and er
28 Pam no good feeling sorry for yourself
Extract 6:1.1 introduces 'think positive'; one of the canonical scripts in the language of cancer. 'Think positive' is not a singular item; on its own it is merely an empty idiom. What is interesting is how Andy and Pam effectively construct their notion of its meaning indexically, and place it in context.

Andy and Pam are talking about what happened shortly after they had been told Andy had cancer and they were feeling a bit drained. There is an interesting use of metaphor here resonating with the medical model and the machine metaphor, "I can't remember us breaking down" (line 11). But on this occasion it is indexed to emotions rather than anything physical in that Andy says, "I think I had a little weep over it" (line 12). The expression "a little weep" tells of their reaction to the seriousness of the diagnosis, while at the same time playing it down as not in any way overwhelming, and as something manageable. Indeed, as such it is apparently not even clearly remembered, "I can't remember" and "I think" (lines 11-12).

Jefferson (1980, 1984a, 1984b, 1988) noted that a central feature of 'troubles talk' was the tension between attending to the trouble while also attending to 'business as usual'. She found that there is a "trajectory which starts out attending to business as usual, moves gradually towards an attention to the trouble and then moves back to an attending to business as usual" (Jefferson, 1988: 419). In interviews with PWC the nature of the talk is inevitably indexed to 'troubles talk' throughout, and so there are other dimensions to Jefferson's notion, in that there is a tendency for PWC to contrast negative and positive situations in order to move from troubles (as with complaining and blaming and
praising and blaming discussed in Chapter 5). Rather than simply first saying what was bad and then moving to something more positive, Andy’s initial description (lines 11-13) of the bad time is already constructed in ways that define it as not so bad as it might have been, anticipating the more ‘positive’ approach that they went on to adopt.

In one of his unpublished lectures (April 9, 1976, p.9, in Jefferson, 1984a) Sacks proposed that ‘embarrassing’ and ‘controversial’ topics pose a particular sort of problem for conversation. He suggests that to get off them and to go anywhere else from them, the speaker has to specifically do ‘getting off of them’. He proposes that a prototypical way of doing this is to produce something that specifically marks a new topic. In this instance, Pam’s use of “but” (line 14) signals a shift in topic towards a contrast to the trouble. Andy moves on not only from the trouble talk but also contrasts this with something more positive, “the thing that encouraged me most” (line 15) which introduces his report of Mr Brown’s response to being asked “what the prog-“ (prognosis) was “likely to be” (line 17).

Mr Brown is voiced as indicating that it should be a collaborative effort, that “if I have to operate I’ll do my best”, (lines 19-20) which Andy does not elaborate on, but voices Mr Brown’s solution to the problem by saying, “if you think positive...that'll help the job along” (lines 20-21). This effectively places personal responsibility onto Andy, for the trajectory and outcome of his illness. Mr Brown is telling Andy to ‘think positive’, which attends to the abnormality of Andy’s trouble, that he has cancer. It is a normative and instructive notion related to the constructive process of helping the prognosis along, where “a positive patient is far easier to care for than a depressed or angry one” (de Raeve, 1997:250). But the exhortation to ‘think positive’ represents illness as a moral problem. Being told to ‘think positive’ makes it an accountable matter for Andy and his prognosis, given that Mr Brown is voiced as saying, in extreme terms, “if you don’t think positive there’s no hope for either of us” (line 22). This makes ‘thinking positive’ a far more consequential matter than it being merely a good way of psychologically ‘coping’ with illness.
Andy presents a sequential narrative here to unpack the gloss (Jefferson, 1985a) of ‘think positive’, (or in Wittgenstein’s terms, the rule that needs to be applied). Andy then says “we both took that attitude then” (line 25) and defines the illness as something that “we’re gonna beat” (line 27). The invocation of “we” here, for an illness that is physically his alone, nicely defines the ‘coping’ and beating of it as something social, a matter of how he and his wife, and whoever else, will together deal with it, based on adopting a positive attitude. The contrast to an active stance of ‘think positive’ would be a passive stance, to think negative. Pam unpacks this gloss a little more by saying that it is “no good feeling sorry for yourself” (line 28), and Andy provides his own version of that: “you can’t just go back home and sit there...not worry about it (.)” (lines 29 and 31). The word “just” figures again, as so often in moral accounts, to define an action contrastively against what might better have been done. The use of “sit there” is also interesting. It is a canonical posture for doing nothing, used metaphorically as well as literally, and doing nothing in this instance is clearly the wrong (negative) thing to do. It is connected with worrying about it and being negative and goes against the instructions of Mr Brown, that Andy has to ‘think positive’.

Pam then produces another dimension to the gloss, by introducing something they actively believe and take part in: “we’re connected with our church....we both believe in prayer” (lines 32-33). This is also produced as a contrast to sitting down doing nothing. Pam’s linking being positive with prayer not only offers prayer itself as an active instance of positive thinking, but recruits the agency of God on their side, revoking the non-agency of sitting doing nothing and merely worrying about it.

So in extract 6:1.1, Andy and Pam both work to construct what being told to ‘think positive’ means to them, and it is something that they embrace and accept. The credibility of this instruction is also made category¹ relevant, in that it is the "Knowledge is culturally and normatively linked to categories of actors in a variety of different ways. Certain categories of actors are treated as entitled to know particular sorts of things, and their reports and descriptions may thus be given special credence. At its simplest, a person visits the doctor because s/he is expected know something about illness. S/he is in a category of people who are treated as entitled to have such knowledge; s/he knows about illness by virtue of the fact that s/he is a doctor. That is, we assume that his/her category membership is a product of training, knowledge and so on" (Potter, 1996:114).

¹
consultant, Mr Brown, who has defined this action or attitude as a contributing factor to the success of the operation, and to Andy’s eventual prognosis.²

Telling a person to ‘think positive’, or ‘be positive’ is the more credible if it is done on some basis of knowledge and experience. Ann’s account (extract 6:1.2 below) of ‘be positive’ contrasts people’s different entitlements to say such things. It may be acceptable for the medical profession to say them, but on occasions, when it is ‘everybody’ saying it, with the sense of anyone, whoever, and routinely, then this can be heard as a platitude. Sometimes those who say it are not credited with having the knowledge to say it because they may not know what they are talking about (see also extract 6:1.3). The basis of accepting or rejecting advice is dependent on the advice giver. They have to be recognised by the recipient as being credible and entitled to offer it in the first place. To offer advice you have to be in a position to give it, such that certain felicity conditions³ have to prevail.

Using the terms ‘think positive’ or ‘be positive’ are appropriate to say when things are bad. When it is related to cancer, it is done in the social context of the culture of cancer whereby it is an appropriate and morally desirable reaction to illness. Its normative status is shown in Kitzinger’s (2000) finding that ‘think positive’ (or ‘be positive’) was never subject to overt question or explicit challenge. Rather, any resistance was signalled through silence and token agreements (such that accountability is evaded), or through the production of competing idioms. However, as in extracts 6:1.1 and 6:1.2, ‘think/be positive’ is treated as something to be unpacked, or elaborated, and participants themselves provide the contextual meaning.

² Being told to ‘think positive’ and ‘be positive’ are passive and active stances and participants unpack their relevance in both direct and indirect ways. How doing being positive gets done is an analytical feature in Chapter 7.
³ “There must exist an accepted conventional procedure having a certain conventional affect and further, the particular persons and circumstances in a given case must be appropriate for the invocation of the particular procedure. The procedure must be executed by all participants both (i) correctly and (ii) completely. Often (i) the persons must have certain thoughts, intentions etc., which are specified in the procedure, (ii) the procedure specifies certain conduct which must be adhered to” (Potter and Wetherell, 1987:16-17), following John Austin’s philosophy of speech acts.)
Ann is in her early forties, married, and at the time of the interview was working for a local company. She was diagnosed with breast cancer.

**Extract 6:1.2 Ann 09/01 “what do they mean, be positive?”**

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Ann questions "how on earth can you be positive with something that-" (lines 69-70). She does not complete the expression "something that-", but we know that "it" is cancer, and this is a cut-off description of what having cancer can mean. For Ann, the sense and value of being positive are something you realise on the basis of experience — "when you come through it" (line 70). Sheunpacks being positive as "you're gonna go forward in life" (line 71), and contrasts it with what she is not going to do (cf. Andy and Pam), “sit back and have it hit me again” (line 72). ‘Be positive’ is elaborated as something you do when you are in trouble, that it is an active stance, contrasted against sitting around doing nothing, being passive. Again, there is the sense of not giving up on life, and of carrying on doing normal things. Ann says that she has “done a lot with my life ever since I've been diagnosed”, which exemplifies her being positive. Note how it also provides the relevance for her opening lines, “anyone that can control it, inwardly and outwardly (.) they'll they'll come through better (lines 63-64). Ann is orienting to both the notions of ‘thinking’ and of doing being positive here; and
again there is the link between positive attitudes and positive medical outcomes (cf. Chapter 7, extracts 7:1.1-7:1.5).

As noted earlier, who says what and when produces varied accounts. The identity of the agents who produce descriptions can be worked on to build or undermine their credibility. Issues of stake or interest can be invoked in an attempt to undermine claims and accounts, and they can also be resisted. “Descriptions can also be given authority by emphasising or building up category memberships which imply particular knowledge entitlements, and the way these too may be undermined. The twin themes of stake and category entitlement are pervasive features of everyday reasoning about facts and descriptions. The facticity of an account can be enhanced through working up category entitlements; it can be weakened by emphasising the personal or institutional stake of the author’s account” (Potter, 1996:122).

The expectations of being positive offered by people in categories other than a PWC can present an additional burden and further difficulties, and the PWC can resist or reject these notions (see also extract 6:1.5). In extracts 6:1.3 and 6:1.4, RC asks what happens “when you don’t feel positive” and the responses are taken up in different ways.

RC asks whether Ann remembers anything when people were telling her to be positive (lines 80-86). Again, who is entitled to provide reassurance or advice is a source of concern for Ann.

Extract 6:1.3 Ann 09/02 “well shut up”

80 RC but what about when you don’t feel positive, I mean
81 do you have [or when- or when you perhaps did feel er- not feel
82 → Ann [very rarely happens
83 RC positive when you were going through it I mean
84 Ann umh
85 RC do you remember anything about that (.) about- and people were
86 telling you to be positive or
87 Ann well (1.0) I think when people oh it’s early days
Ann's initial response (in overlap) is that not feeling positive was something that "very rarely happens" (line 82), which of course is not only a report of, but also an instance of, that positive attitude. It endorses her earlier stance of being positive and active in extract 6:1.2. She does not directly address her response to RC's initial question, but instead takes up the topic of "people" saying the wrong thing to her. She also makes the stage of her illness relevant, in that people used to say, "oh it's early days". She takes issue with this and rejects it as a platitude, saying "well shut up because you've not had it" (line 88). Again, this is an invocation of knowledge entitlements, an absence of appropriate felicity conditions. It suggests that those people were not entitled to say such a thing because they did not have the required experience. The very general category "people" is rhetorically useful here, in that it does not specify anyone in particular, and so is not easily challenged.

Although whoever was saying these things was probably trying to be helpful and reassuring, Ann clearly rejects that as inappropriate. Indeed it "used to get up my nose" (line 88), which is another idiomatic expression, countering the common sense appeal of 'be positive' (cf. Kitzinger, 2000, on 'resisting an idiom'). Earlier Ann said that not feeling positive was something she rarely experienced. This at least minimally acknowledges RC's implication that it is not always possible to 'be positive', that it is not plausibly a constant state to be in. This can produce other dilemmas, as Dee deals with in extract 6:1.4, where any notion of not being positive becomes a matter of accountability.

Extract 6:1.4 08/06 “I should be positive”

1 RC  it's like one of the things that umh Zoe's talked about in our conversations is that y'know if you don't feel like being 
2 positive one day 
3 
4 Dee  umh 
5 RC  y'know=

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Other peoples' expectations for PWC to be positive can sometimes be problematic (see also extract 6:1.5). It makes PWC morally and interactionally accountable, and this is visible in how in their interview stories they attend to this possibility that they are deviating from normative expectations. Although people rarely reject the notion of thinking positive there are occasions “when participants talk about positive thinking in ways that can be read as resistant...and attempt to limit its applicability or to challenge its assumptions” (Wilkinson and Kitzinger, 2000: 808).

However, what I have discovered in my data is that participants report that the moral expectations associated with such idioms can produce feelings of guilt or make matters worse. In extract 6:1.5, RC refers to a conversation she has had with Zoe, a friend of Dee’s, about what happens “if you don’t feel like being positive one day” (1-3). Dee attends to this as something that she ‘should’ do. Although she does not make her response specific to RC’s question, she attends to this as a moral expectation hearable as Dee voicing what she says to herself, “I should be positive” (line 6). The use of “should” sets up a dilemma, that it is something that has a moral requirement and the implication is that if Dee is not positive, there are other consequences, “then you start feeling guilty, you start feeling worse” (line 7). Dee connects not being able to be positive with feelings of guilt and feeling worse and RC suggests that this moral expectation is an “imposition” (line 9). Interestingly Dee completes this sentence for RC saying, “posed on you (1.0) it’s pressure” (line 10). Pressure is associated with tension, with stress and strain, of being pushed into something and Dee then strengthens this in that “it’s real pressure” (line 12). Consequently, the expectation of being positive can be considered as an additional moral burden to carry.
It appears that the call for being positive raises a number of difficulties. How it is used, and what it means to different people, varies contextually. When it is voiced, by whom, and on what basis of entitlement, are major considerations in whether it is viewed as being helpful and supportive, or else rejected as inappropriate and even harmful. In Chapter 7 I will explore how the notion of being positive is produced and referred to in talk and in particular the analysis examines how PWC produce accounts that attend to what I term, doing being positive.

PWC not only have to be accountable for formulations of the notion of ‘thinking positive’, but they are also accountable to ‘fight it’, the canonical script encompassed in the ‘heroic’ model. War and military metaphors pervade the language of cancer, where descriptions of PWC as being ‘brave’, ‘courageous’ and a ‘fighter’ draw on a deeply embedded cultural discourse of defeating threats to one’s life. Contrasting descriptions such as ‘coward’, or just ‘not brave’ are also ways of moralising illness, opening up the possibility of having to account for being ill and how one deals with it. The analysis shows that “fighting it’ is also an idiomatic expression that participants elaborate (unpack) and formulate, in ways that give it specific meaning and contextual relevance. In extract 6:1.5 Zoe, like Dee in extract 6:1.4, attends to the moral pressure that such expectations can present. It is taken from a long extract where the issues of control, ‘coping’ and ‘fighting’ the disease are talked about (See Appendix E for a full transcript).

Zoe is in her early forties, married, with a teenage daughter. She was diagnosed with breast cancer and had a mastectomy. At the time of the interview, Zoe was writing an undergraduate dissertation on positive attitudes to cancer.

Extract 6:1.5 Zoe 07/01 “I don’t believe that you fight the disease”

11  Zoe  I- I think most people when they go, when- as- as they go
12  through their lives experience sort of some form of (1.0) er
13  depression be it mild or be it (. ) chronic or whatever
14    RC  umh
15  Zoe  .hh thinking o:::h god (2.0)
16    RC  uh huh (1.0)
In lines 11-13, Zoe constructs an interesting contrast here by comparing responses to a cancer diagnosis with the kinds of everyday depression that people normally go through in life. The point of interest here is that Zoe is unpacking what 'fighting' means to her. She does this by drawing an ironic contrast. People are ordinarily likely to respond with bouts of depression when faced with life's usual vicissitudes. This, though ranging from "mild" to "chronic" (line 13), is scripted as more or less routine and normal (via descriptions such as "most people", "as they go through their lives", and the generalising expressions "or whatever" and "and all the rest of it", lines 13 and 17). Yet when faced with something extraordinary and serious, something really threatening such as cancer (line 18), people can (and do) react positively. Again, this is scripted up as a general reaction, as what "you" do (lines 19, 22, 26-28). The contrast is heightened by the irony of it, and its unexpectedness, Zoe was "amazed" (line 18). Zoe's style of talk is very forceful, using extreme and dramatic idioms and metaphors, as in "you fight bloody tooth and nail" (line 22), again invoking the notion of physical combat. But what is interesting is that Zoe's formulation of 'fighting' is about control. She rejects the idea expressed by Andy and others, that "you fight the disease" (line 26). The object of the fight is not the disease itself, but you "fight for the control" (28). Her rejection of its direct medical relevance is vehement and extreme ("absolute crap", line 27). She further defines what the 'fighting' is about for her in extract 6:1.6 where she produces
another formulation of what she refers to as “this fighting stuff”, which is to say, this talk about ‘fighting’ that PWC are encouraged to adopt.

Extract 6:1.6 Zoe 07/02 “ it’s what people expect”

83 Zoe this is what it is, this is what it comes down to (1.0)
84 RC the coping stuff
85 Zoe if you’re in control of things then=
86 Zoe =its not about coping with the disease, its about coping with you
87 RC yeah
88 Zoe full stop, this is- this is partly why this- this fighting stuff and this-
89 Zoe this heroic image and er this er (0.5) you know (1.0) brave bit
90 Zoe makes me so cross because it is just absolute total bollocks
91 RC umh
92 Zoe I think it’s rubbish (0.5)
93 RC umh
94 Zoe and it’s rammed down your throat (0.5) and I don’t care what
95 RC anybody says, there is an expectation that that is the way you
96 Zoe should be, it’s what people expect (.)
97 RC yeah, and I think that’s er=
98 Zoe =and I think that’s where the strain comes in on the er individual
99 Zoe coping, because, you’re trying to do that for (.) other people and
100 for you

This extract is full of the language of cancer. Zoe talks about the ‘fighting stuff’, the ‘heroic image’, and the ‘brave bit’, which are ways of formulating these things as morally social expectations and ways of talking (explicitly so, in lines 94-95). The interesting thing is how and why she resists these ascriptions. She also invokes the notion of ‘coping’, unpacking this in a similar way to her formulation of ‘fighting’ the disease. She provides her version of what ‘coping’ is, that it is not “about coping with the disease”, again the object is disease, she makes the distinction emphasising that ‘coping’ is “about coping with you” (line 86). Her use of “full stop” (line 88) nicely indicates that this is not debatable, and that it is the end of any list of things that have to be coped with. Zoe links this with what she has talked about earlier, “this fighting stuff and this- this heroic image” and this “brave bit” (lines 88-90). Her rejection of these as ideas is expressed in terms of
her emotional reactions to them (they make her "so cross"), and through the use
of idiomatic and extreme expressions, it is "absolute total bollocks" and "rubbish".
One interesting thing here is that the forceful rhetoric of Zoe's account could itself
be heard as 'fighting talk', because she is resisting and rejecting these
prescriptive notions so strongly, indeed making the strength of her rejection a
very hearable, performative feature of her talk. But she then provides a warrant
for why she is rejecting this cultural script, because "it's rammed down your
throat" (line 94). Again Zoe chooses an extreme, graphic, idiomatic metaphor,
where ramming something down a person's throat is an image of involuntarily
being forced to swallow something you do not want. The vehemence of her
reaction only matches the forcefulness of how all this 'fighting' and 'coping' talk is
thrust upon her. She is also challenging the status quo, orienting to what she
opposes as being perhaps a majority view; she does not "care what anybody
says" (lines 94-95). The 'anybody' is a generalised other, regardless of who they
may be, who might be expected to disagree with her, yet whose opinions she
continues to oppose.

The key to Zoe's pointed remarks is that "there is an expectation that that is the
way you should be (. ) it's what people expect (. )" (lines 95-96). She is claiming
that it is other people who force the moral responsibility of this 'fighting stuff' on to
her, that it has become a normative expectation, such that Zoe is accountable for
rejecting it. These normative expectations are formulated as something that has
to be done for other people's sake, but at the same time, living up to them places
an additional burden of 'coping' on "you", the PWC generally, and of course on
Zoe herself. Accountability is distributed on a personal and a generalised level,
but what is hearable is that these expectations are unreasonable and
problematic. They contribute additional problems that have to be managed,
apart from the illness. Indeed, Zoe's strong separation of these psychological
and social matters, from those of the disease itself, helps to isolate them as
avoidable and unnecessary.

Extract 6:1.7 is taken from Jan's detailed narrative account of going to get the
results of her biopsy.
In Chapter 5 I suggested that one of the normatively expected features of receiving bad news, is that there might be some benefit in having a friend or other person present to support them. Jan herself links that notion to one of the topics of this chapter, in that going alone or going with someone to get her results relates to being brave. Again, it is a generalised, normative requirement: "you like to think you're brave" (lines 5-6). In contrast to that normative idea, Jan herself is "a terrible coward really". The "really" provides for a nice contrast, not only between Jan and other brave people, but between Jan as a real person and some possibly ideal expectation of how people should be.

We have no basis here, of course, for taking Jan's self-avowal as "a terrible coward" at face value, as an accurate description of her. Disclaiming heroism and bravery is a common and recognisable display; it can be part of what being brave is about (see also extracts 6:1.7, 6:3.1-6:3.2). If someone were to go around talking about how brave they were, this could be interpreted as boasting or bragging (cf. Mulkay (1985) on ceremonial discourses of Nobel prize winners and Pomerantz (1978; 1984c, on compliments). What Jan is providing for us is not so much herself as a cowardly exception to the usual pattern of brave people, but rather, an expression of the troublesome nature of expectations that are hard to live up to.

Extracts 6:1.1-6:1.7 looked at how the prescriptive language of having to think and be positive, 'fighting' and brave, were oriented to in accounts of interactions with the medical profession, and a category such as 'people' or 'everyone'. I now want to look at other things people are reported as saying, which participants formulate as being the wrong thing to say. Again PWC are placed in a position of
accountability in reporting these difficult interactions, and attend to presenting their identity as a reporter, as someone who is not being unreasonable or overly critical.

6:2 Saying the wrong thing: compliments and sympathy

When someone’s cancer diagnosis becomes public knowledge, everyday social interactions with others can become difficult because people may struggle to know what to say. The following analysis shows how PWC talked about their conversations with healthy people.

The first three extracts (6:2.1-6:2.3) are taken from a long account which focuses on the difficulties of saying the right or the wrong thing. Although there are lots of things going on in these extracts, my interest is how Ann talks about the kinds of talk she does and does not want to hear.

Prior to the beginning of extract 6:2.1, Ann has been praising how supportive her friends have been throughout her illness. But in extract 6:2.1, she sets up a stark contrast concerning what is, for her, an inappropriate response to her illness. Contrasts and oppositions are discursive practices, and such formulations are not “just a matter of deploying ready-made conceptual resources that are built into semantic categories, but something people can do flexibly and inventively, for just about any set of objects or events” (Edwards, 1997: 237; Smith, 1978). One of the interesting contrasts in the following extract is the interplay of positive and negative accounts (See also extract 6:6.1. and 7:1.2-7:2.6).

Extract 6:2.1 Ann 09/03 “there’s always the one”

1 Ann yeah, everyone was absolutely wonderful
2 RC yeah (.) I mean (1.0)
3 Ann I mean I haven't got brothers and sisters (1.0) but (1.0)
4 → I couldn't speak highly enough of the friends that I've got
5 you know they- they (.) the-there's always the one that you get

4 See Appendix E for a full extract.
that rings you up and says

and that is the last thing that you want

yes, yeah

and (0.2) I er (.) in the end I had to tell this lady er don't-
please don't phone me again because (.)

I didn't want to hear it (.) she was so ne::gative

[I couldn't believe it you know

[umh

oh well (.) what are you going to do y'know (.)

you've got this (0.5) er terrible disease and er (.) y'know (.)

[oh I'm so sorry I'm sorry for you and

umh

[but you want people to- that are positive at the side of you (.)

you don't want negative people

Ann begins by saying, "everyone was absolutely wonderful" (line 1), and these are presumably friends rather than relatives, given that she does not have "brothers and sisters" (line 3). Note the extreme case formulations (ECFs) here, "everyone" and "absolutely". It is a feature of ECFs that they are produced in contexts where rhetorical contrasts are being made (Pomerantz, 1986), and in ways that can signal a speaker's strong investment in what they are saying (Edwards, 2000). The contrast case is soon apparent. Some of the rhetorical work done by Ann's powerful prior endorsement of her friends is to demonstrate that her attitude to the contrasting individual, whose expressions of sympathy she rather strongly rejected (line 11), was not due to any lack of appreciation on her part of the kinds of help and succour that people may offer. It isolates the rejected caller as the sole problem. Indeed, the 'sole' nature of that person is explicit, "there's always the o:ne" (line 5). Here the ECF "always" defines such a person, however isolated, as nevertheless emblematic and recognisable via some kind of folk wisdom, invoked by this idiomatic formula.

There is some interesting detail in Ann's depiction of the troublesome caller (named Joan). It could conceivably be a healthy acquaintance, expressing concern as to what Ann is going to do, an enquiry into what kind of treatment she
may be having, or whether she was going to carry on working. But Ann provides a different impression through how she performs the quotations. The actively voiced "oh dear what are you going to do" (line 7) is defined as "the last thing you want" (line 8). The extended "oh" helps emphasise that the 'oh' is marking something other than merely a change of state token (Heritage, 1984b), but some kind of exaggerated, moaning, expression of sympathy. The combination of 'oh dear' invokes doom and gloom. Further, Ann's response was just that, a response, something she "had to" do, and even then not immediately, but "in the end" (lines 11-12), implying her having put up with it for some time.

The caller's crime was to be "so negative", which of course is the precise opposite of positive. Ann also treats Joan's words as being unbelievable, in that her friend, under the circumstances, was not providing her with a positive response. Ann is posing the notion that it is not only the PWC who should 'be positive' but others should be too. Ann could have presented the nature of the caller as someone who is trying to validate her illness (see Dee extract 5:2.2) but Joan's words are taken negatively. Ann's 's voicing of Joan's words: "what are you going to do y'know", and "you've got this (0.5) er terrible disease" (lines 16-17), display Joan as stating the obvious and implying that there is nothing imaginable to be done about it. Note the two uses of "y'know" here (lines 16 and 17), in which Ann presents Joan's talk as talk of a recognisable kind for the listening RC, it was that kind of stuff, negative, unhelpful and discouraging.

There is an interesting footing change (lines 19-20) marking what she says next as a normative requirement: "you want people to- that are positive" versus "you don't want negative people". Ann is attending to the normative response that anyone else would want. She adamantly rejects people saying, "oh I'm sorry for you" on the grounds that it is negative and is clearly not the 'right thing' to say, particularly at this time. Ann categorises such talk as being negative and unhelpful, where a direct, unmodified expression of pity, or stating the 'terribleness' of the disease, is deemed inappropriate talk from a friend.

Although (extract 6:2.1) Ann began by saying "everyone was absolutely wonderful" and then reveals that there is "always the one", the exception to the
rule in what follows (prior to extract 6:2.2). She also talks about people who "crossed the road" to avoid speaking to her, or "couldn't face" her, so it appears that not everyone was wonderful. One of the noticeable features in these accounts is that they are variable and often contradictory, but they do attend to different matters of accountability. The "everyone", given the range of exceptions to that "everyone", has to be heard functionally, as an ECF doing ECF business of the kind analysed here, rather than being, say, Ann's mentally computed and inconsistent assessment of how many people were helpful.

In extract 6:2.2 Ann makes it clear what she does and does not want people to say to her.

**Extract 6:2.2 Ann 09/03 “they haven't got a clue”**

60 RC but it's like, I know from my own experience when I say things
61 you know, talking about my brother or my friend .hh er y' know
62 some people know y'know how to say, or to respond or say you
63 know or can er speak to you but other people are er er y' know,
64 there's just, [they haven't got a clue what to say
65 Ann [well they annoy me a bit really because I think well
66 I- l-
67 → RC well they can't help it though can they?
68 Ann no, this is what I say but that it- it gets, it does get at you
69 RC yeah
70 Ann that people are like that I mean when I'd got this Joan on the
71 phone saying ↑to::h dear, oh dear what are you going to do↓
72 .hh hhhh you know, ↑well I'm gonna live↓
73 RC umh
74 Ann you know that's the first thing I'm gonna do, I'm going to live=
75 RC =yeah=
76 → Ann =↑an- and I'll be alright you know, but why should I be the one
77 telling her that I'm gonna be alright (.)
78 → she should be the one telling me↓
79 RC yeah
80 → Ann where's the support?
81 RC yeah
RC is empathising and aligning with Ann by talking about her own experiences of talking to people (lines 60-64). She does this, first by grounding her views on the matter in personal experience (RC therefore knows what she is talking about, and can independently contribute to the discussion), and secondly by generalising, or 'scripting', from that experience. These are not just personal observations, but patterns and rules: "it's like", "when I say things", "you know", and so on. RC suggests that people find it difficult to know what to say because, "they haven't got a clue what to say" (line 64) which is a no blaming formulation, they can not help it. Ann's "well" response (line 65) marks the start of at least a partial disagreement; she is less understanding and forgiving, because "they annoy me a bit really " (line 65), which displays that there is something wrong and she is critical of 'people's' inability to say the right thing. The suffix "a bit really" is a nice orientation to, or acknowledgement of, the validity of what RC has said. Although Ann produces a minimal 'no' an agreement she reiterates that it is a problem for her in that "it does get at you" (line 68). Again, note how this formulation of her experience casts it in general terms, as RC did, as a recognisable pattern or rule; "it does get at you" rather than, say, "it did get to me". Ann's reformulation of Joan's hopeless "oh dear what you are going to do" (line 71) provides Ann with the opportunity of asserting a contrary positive stance: "I'm gonna live" (line 72).

A point of interest here is that Ann is working up a definition of what appropriate support is (lines 70-80). Despite Joan's negativity, she repeats "I'm gonna live", (line 74). She is giving this priority over everything because it is "the first thing" she's going to do, (line 74) a first reaction, that could and should have been Joan's reaction, but (complainably) was not. It provides an interesting direct contrast with extract 6:2.1, where Ann says "it's the last thing you want" (e.g. pity, doom and gloom), along with the footing change in the defiant assertiveness of "I'm going to live"..."I'll be alright". Ann's complaint about Joan also works reflexively to display the kind of person Ann herself is, that she is 'coping', 'positive', and in control. Ann's positive personal identity is handled not merely
by direct narrative or descriptive talk about herself, which might risk boastfulness, but somewhat incidentally, by way of complaining about Joan.

Ann now attends to the notion of support and how this is performed in talk. Note the interesting reversal of expectations here, in contrast to extracts 6:1.4 and 6:1.7. Rather than the expectation being placed on Ann, she is placing the accountability on to others. For Ann it is not about her having to reassure others that she’s “gonna be alright”, but rather, she places this moral responsibility on to Joan by saying she “should be the one telling me”. The implication is that support is equated with the things people say, and if they do not say you are “gonna be alright”, Ann exclaims, “where’s the support?” (line 80). Ann has made a distinction between what she defines as being supportive, casting this in terms of what other people ‘should’ say to you in times of trouble, and what people such as Joan might take to be support, but is not. Support includes being positive, and not leaving the PWC to have to assert it for themselves.

Who says what, and when it is said, is an interesting feature of whether what is said by others is deemed appropriate or inappropriate. In extract 6:2.3, Ann presents the time of Joan’s call as relevant, that it was at the time before her operation.

Extract 6:2.3 Ann 09/05 “you’re gonna be fine (.) don’t worry about it”

6 RC well I mean you’ve mentioned the lady who- who was negative to
7 you (2.0) basically you didn’t communicate with her
8 Ann well I couldn’t, I- I wasn’t in er, in er sit- I wasn’t in the position
9 that I felt that I (1.0) I was quite tearful at that particular time
10 → because I’d just recently been diagnosed with a serious illness
11 RC yeah
12 Ann and I couldn’t (.) I couldn’t be bothered with her
13 I just didn’t want to know, I didn’t want this woman telling me
14 → oh I’m so sorry (.) I’m so sorry (.) I wanted someone to say (.)
15 Ann (.) you’re gonna be fine (.) don’t worry about it (.) you’re
16 going in you’re gonna have your operation (.) you will get over it
17 RC umh
In extract 6:2.3, Ann reveals that the timing of Joan’s doom and gloom reaction was just before her operation (to remove the breast lump). Again, Ann positions her response of what she did and did not want people to do and say. RC is fishing (Pomerantz, 1980) for Ann to tell her more, and sets up an accountable issue for Ann, “basically you didn’t communicate with her” (line 7). This is potentially hearable as an overreaction on Ann’s part; the fact that RC is putting it to her in this way for comment, implies that there is some further accounting to be done on Ann’s part. Ann responds with an inability account, (cf. Drew, 1984) that at the time she “wasn’t in the position”. She was also “quite tearful” (lines 8 and 9), “she couldn’t be bothered with her” and “just didn’t want to know” (line 12). So Ann’s reaction to Joan is eventually presented as a function both of Joan’s insensitivity, and also of its bad timing, including the state that Ann herself was in at that time, when what she needed was ‘support’ of the form typified in lines 14-16. Again, note how Ann works this up not only as a personal requirement on her own part, but as something recognisable and general, something that “any woman” would require (lines 18-20). This is a recurrent pattern in these data, the orientation towards personal experience, complaints, viewpoints and preferences, as being both grounded in experience, while also recognisably general.

What Ann achieves in this account is to claim that she it not going to be a victim of her suffering, and attends to the social moral order as being accountable, being ill, but being stoical about it. She might have what some consider a “terrible disease” but by contrasting the negative and positive nature of support, she also displays that she is ‘coping’ and being positive. In suggesting that “any woman that’s going in for an operation an- and er got that kind of illness I’m sure they
would agree with me" (lines 18-19), Ann warrants her wanting people to say the right thing as nothing out of the ordinary, while at the same time she asserts her own identity as being someone who is independent, who tries to “carry myself” (line 22).

Again, contradiction of that kind is not uncommon in participants’ accounts, but is best analysed as doing different kinds of rhetorical and interactional business (Potter and Wetherell, 1987). Although Ann expects people to be supportive, and to tell her she's "gonna be fine", at the same time she tries to carry herself. "Carry" implies that there is a load to carry, a burden additional to the disease itself, and that carrying anything for anyone else is not what she wants (or expects) to have to do. This also reflects that having to deal with the negative responses of people such as Joan is a burden because she says she does not want to carry others.

Often PWC do not look ill, especially if they are not receiving chemotherapy. This can give rise to disjunctions between what people normatively imagine cancer patients to look like, and how they actually look. Such disjunctions are complicated by the further normative considerations that come into play when people pass comment on each other’s appearance. Prior to extract 6:2.4, Dee has been talking about putting on a brave face, because it is what people want to see (see extract 6:3.2), and has also said that when people ask how you are, that they do not really want to know, “they want you to say I’m fine” (see extract 6:3.3). So, what Dee is producing here is an ironic take on what can happen in such circumstances.

Extract 6:2.4 Dee 08/09 “good god Dee you wouldn’t think you’d had cancer"

24 Dee if you happen to say, I mean- people- the one thing that (.)
25 → primarily irritated me above all else, not the be positive by people
26 but er, I didn't look( .) particularly unwell during the time I was
27 having my treatment
28 RC umh

5 The cultural expectation is that people do not look well if they have cancer.
Dee and I'd pop into work (.) or I'd pop into various places
to keep in touch with people (.) hh and the thing they would say,
was (.) they used to stand ba(hh)ck and sa(hh)y
good god Dee you wouldn't think you'd had cancer (.)
you look so::: we:::ill
RC umh
Dee and I said but it isn't my face that I have the problem with (.)
RC umh (.)
Dee go(hh)d I was so:: i:: rritated at people and then (.)
*and you haven't lost all your hair yet* (0.5) because I didn't
RC umh
Dee and I just thought, oh for goo::dness sake
I'm so irritated by this response

She refers to the notion of 'be positive' (line 25) but this is not what “irritated me above all else” (line 25). She says that she “didn't look (.) particularly unwell” during her treatment and this posed problems for her; the emphasis on “look” is contrastive, against the underlying reality of her illness (looks can be deceptive). Again, as we saw with Ann, people were not saying what Dee wanted to hear. "They would say...good God Dee you wouldn't think you'd had cancer you look so::: we:::ill" (line 32). Here, the emphasis on "so::: we:::ill" denotes deliberated talk. Dee's reported response to this is to say that "it isn't my face that I have the problem with" (line 35). I find this interesting because it flushes out what putting on a brave face can do. Although she does not draw on the description of a brave face, she does make 'face' the issue of contention, in that that is not her problem. What her friends are doing are complimenting her on how well she looks, but Dee finds this difficult to accept. Of course, it is not known how Dee responded to them at the time, only what she reports here. However, Pomerantz (1984c) has noted that people do seem to have difficulty in accepting compliments and in this instance complimenting Dee on how well she looks,

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6 Pomerantz (1984c) proposes that compliment responses are subject to two separate and conflicting sets of constraints. Firstly that there is the general constraint or expectation that evaluations expressed by an initial speaker should be accepted and agreed by the recipient. Positive evaluation of recipients by first speakers is regularly followed by appreciation tokens, such as, 'well, thank you', which tend to imply agreement with the initial speaker's evaluation and which often lead directly to the production of agreement components and has defined this as the 'preferred' action turn shape. The disagreement format is defined as a 'dispreferred' action.
under the circumstances, is not the response she wants. She does not go on to elaborate what she would like them to say, but as we saw in extract 5:2.1, Dee has previously expressed that she wanted people (e.g. her husband) to ‘validate’ her illness, rather than produce platitudes. What she reports here is that again this lack of validation or directness about her problem is clearly not what she wants to hear.

So, participants produce accounts of people saying the wrong thing, and of what they want people to say, and clearly, people do struggle to say the right thing. What is right for one person is not necessarily right for someone else. Some want recognition of their illness, whereas others have ways of avoiding talking about it. Some resist and others embrace the notion of being positive and adopting a ‘fighting spirit’. How PWC report their social relationships and how they evaluate them can be variable and contradictory. Yet on analysis, in the context of its production, whatever they say makes sense, as a functional way of telling and reporting, managing interactions, and handling complaints and identity.

6:3 Putting on a brave face

I have briefly noted occasions when the category ‘brave’ is invoked as an expectation for how a PWC should respond to their illness, and how this is often discounted (extracts 6:2.6-6:2.7). The penultimate analytical section of this chapter looks at two extracts showing how ‘putting on a brave face’ is oriented to and what this can accomplish. The analysis also shows that the use of ‘brave’ can be constructed with different meanings. Both extracts also include the routine question of asking someone “How are you?" which will be analysed in more detail in section 6:4.

Extract 6:3.1 Sue 03/01 “you try to be a bit brave”

1. RC so you didn't really talk about it very much to anybody (.)
2. do you think that would have helped
3. being able to talk about it (.)

7 The specific notion of ‘putting on a brave face’ is formulated in extract 6:3.2.
Sue: Yeah, I think it probably would have done, I mean.

RC: you wouldn't have approached anybody to talk to?

Sue: no, 'cause when you're that young, you-you-

RC: you try to be a bit brave and independent and you're,

Sue: you're just making relationships with people, you're making new

RC: friendships you don't (2.0) I wasn't- I say I'm not the sort who

Sue: would go and burden anybody with my problems

RC: umh

Sue: I mean if I felt that they were interested well fine, I might tell them

about how I was feeling, but nobody actually comes up to you

and says (.) how are you feeling ab(hhh)out it

Sometimes it is understandable that a PWC will resist talking to others for fear of receiving inappropriate responses. In extract 6:3.1 RC is pursing the topic of talking about 'it' (meaning cancer) and whether doing so is helpful to Sue, and of course this is set against the background that talking about cancer is difficult for all concerned because of all its 'cultural baggage' and expectations. Sue is a mother in her mid forties and was diagnosed with Hodgkinsons disease in her teenage years and skin cancer in her early twenties.

Clearly, those whom PWC find they are able to talk to is not straightforward. Some people want to communicate, whereas others do not. In Sue's case however she says that "I wouldn't have approached anybody to talk to" (line 5). RC reiterates this back to her and is 'fishing' (Pomerantz, 1980) for Sue to tell her more and Sue produces an account of why she did not approach people to talk to. What this extract brings together is the difficulties of talking and a way of countering any potential difficulties and Sue says, "you try to be a bit brave and independent" (line 8). If others see a 'brave face' this can fend off any inappropriate sympathy responses, but it can also work to deflect anyone asking how a PWC feels.

Sue is attending to the problems, especially whilst young, of "making relationships with people" and produces some identity work here in saying "I'm not the sort who would go and burden anybody with my problems" (line 11).
Again, note the orientation towards locating personal experiences and dispositions as part of (or as exceptional to) a normative, generalisable pattern. Sue’s actions are not just one-offs, but grounded in her nature, as “not the sort who”. Similarly, her response to RC’s questioning of her actions (line 6) is cast in terms of the generalised “you” (lines 7-9). This is a standard way of managing accountability, locating one’s own actions as those that anybody might do in the circumstances (cf. Edwards, 1995). Sue acknowledges the difficulties of talking about problems, and associates this with not wanting to be a burden to “anybody”. However, she might tell them about how she was feeling, but this is conditional: “if I felt that they were interested”, the implication being that people might make normatively polite inquiries without really wanting to hear truthful or detailed stories. Indeed, people tend to avoid eliciting those stories: “nobody actually comes up to you and asks how are you feeling ab(hhh)out it” (lines 14-15). The implication is that if people know you have got serious problems (such as knowing you have cancer) they do not ‘actually’ ask you about it. Indeed the word ‘cancer’ is not used throughout this extract, and is notably absent in most of these discussions of what people talk about. Having cancer, on Sue’s account, can place a person somewhat beyond the usual routine or polite inquiries into how they are, and a ‘brave face’ can be part of managing that. Indeed, the very notion of a brave face, rather than just bravery, signals the importance for participants of how they are seen, understood, and interacted with. The notion of interactional management, rather than simply being brave, is very much a participants’ category.

In extract 6:3.2, RC and Dee collaboratively produce the formulation of a “brave face”.

Extract 6:3.2 Dee 08/08 “he put on such a brave face”

1 Dee and ten years ago RC (.) I didn’t know anybody really who’d
2 RC been touched by cancer, apart from my neighbour
3 Dee umh
4 RC that was all
5 Dee and umh I mean, similarly, I mean I- I er only remembered
6 RC yesterday by seeing- it was an actor friend actually-
I saw his picture in a paper somewhere about him
and it clicked in my mind that yes his wife died of
spinal cancer about (1.0)

((telephone rings and answer machine picks up))
it would be (.) about ten years, well maybe not quite as long ago
as that, and I thought, I knew what it was but I had no more
concept of what it was, I had (0.5) no idea what he was going
through and one of the things was (.) that because he put on
such a [brave face

Dee [brave face he put on the world the face that people want
to see did he?

RC that's right

Dee is revealing that "ten years ago" she "didn't know anybody really who'd been touched by cancer" (lines 1-2). The mentioning of the word cancer is a rare occurrence in my data. This triggers a memory for RC who goes on to tell Dee about a friend, from years ago, whose wife had terminal cancer at the time and he was caring for her. Interestingly, it is an event, which also occurred ten years before, and at the time, RC "had no idea what he was going through". RC's not knowing what her friend was going through at the time is in essence partly disguised by the absence of not showing any sign of trouble, "because he put on such a brave face" (lines 13-14). Dee not only overlaps with this description but goes on to complete the sentence and again produces the normative expectation that a brave face is "the face that people want to see".

Bravery here is a matter of 'face', formulated as something stoic and protective, that can be "put on", as a form of disguise for other people so they do not have to engage in 'troubles talk'. There is an unspoken collusion between PWC and the people they interact with, where bravery is a normatively required performance. RC's reporting that she was ignorant of her friend's suffering is attributed to that performance. The implication here is that a brave face is put on, both for the sufferer as a sign of 'coping' and not burdening people, and for the people they interact with, who prefer to see them as being 'fine', because it makes interaction easier. This is something that Dee elaborates in extract 6:3.3 below, (which reiterates Sue's claim in extract 6:3.1).
Extract 6:3.3 08/09 “they don't really want to know how you are”

12 RC I had (0.5) no idea what he was going through
13 and one of the things was (.) that because he put on
14 → such a [brave face
15 Dee [brave face he put on the world did he?
16 RC that's right
17 → Dee because y'know when people say to you how are you?
18 → they don't really want to know how you are
19 RC most people don't, that's right
20 Dee if you ((answering machine plays))
21 oh sorry I just thought it was my husband umh (.)
22 → they want you to say I'm fine, thank you, I'm great
23 RC yes

Dee continues by providing an explanation connecting how ‘putting on a brave face’ works when it is combined with people routinely asking “how are you?” This was a theme noted earlier in this chapter, of how cancer can disrupt what would normally be polite inquiries into how people are. Dee makes a generalised statement, that “they don’t really want to know how you are” (line 18). Dee’s implication, that it is all ‘people’, is then softened by RC’s moderated agreement “most people don’t” (line 19); this fits Edwards’s (2000) analysis of how the softening of extreme descriptions serves to protect their truth value. Dee produces her motivation for saying this, (interrupted by the answering machine playing) that other people want you to provide a preferred, trouble free response, to say “I'm fine thank you, I'm great” (line 22) in order to prevent or avoid difficulties in talking about serious problems. So the idea of putting on a brave face can work to deflect from inviting or responding to talk about troubles, and this is not only an analyst’s observation about it, but also an idea that participants themselves construct and use.

The final analytical section of this chapter follows up the specific theme of the problems involved in being asked the everyday question, “How are you?” (HAY?).
6:4 Everyday conversation: Asking “How are you?”:
Everyone has to lie!

In extracts 6:3.1 and 6:3.3, I introduced the issue of asking “How are you?” which was also linked to putting on a brave face. The final part of this chapter addresses how this everyday convention becomes problematic.

Harvey Sacks’s (1975) fascinating paper, in which he characterises the actions that greetings such as asking “How are you?” (HAY?) perform, was given the rather extraordinary title, “Everyone has to lie”. According to Sacks, an initial HAY? is merely a greeting; it is not heard as a factual enquiry about the recipient, but rather a normative everyday social requirement. It is a casual enquiry that does not actually involve people in making an assessment about one another’s condition. In other words, they are not expected to report, factually, how they are, but are expected to produce what is termed a preferred, minimal response, such as ‘fine’, even if the facts may be to the contrary. Sacks suggests that such factual announcements are clearly done, but they are generally “held off” until the greeting sequence is completed, and at least a first topic is underway.¹

Sacks argues that this sense of conversational appropriateness, asking HAY? at the beginning of a conversation, results in his claim that initially “everyone has to lie.”¹ But asking HAY? in what Sacks calls the ‘initial position’, can also produce what is termed a dispreferred response (we are dealing with norms here, not statistical preponderances), such as ‘absolutely awful’, which in turn could make the conversation that follows prolonged and difficult. But the normative appraisal

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8 Sacks (1975) argues that the position of an utterance in the overall structure of an encounter can and does systematically influence the hearing or force that it will be given by a listener. Such is the case for the question “How are you?” and the response it engenders.

9 Schegloff (1968) suggested that greetings in casual conversation perform two basic functions: firstly they establish the identity of the speakers, and secondly, they re-align their states of knowledge relative to the encounter at hand.

10 Sacks suggests that it is only by reference to the sequential properties of talk in context that such an appreciation can be derived. In casual conversation, utterance positioning within greetings/alignment sequences is unambiguous. The HAY? that follows an exchange of hellos between friends or acquaintances is clearly an affiliate of the greetings, and is typically not a topic-initiating utterance. On the other hand, the same question when it is used to begin the assessment phase of a clinical interview solicits or obliges a topically relevant response, a chief complaint, or reason for the visit (Diaz, 2000).
of such a question is that the person asking does not really want a truthful answer. Consequently, asking someone 'how are you?' already somewhat ambiguous in what it seeks, becomes even more so when asking a PWC, and takes on different dimensions. Being the recipient of a simple HAY? can raise more complicated and problematic concerns for the PWC. If asked this by someone known to know about the cancer, it may be heard as not merely a casual greeting.

As previously noted, how a PWC responds to what other people say will depend on who is doing the asking, when and where. So, I want to add another dimension to a HAY? question’s everyday ambiguous agenda. When HAY? arises in conversation where one or both of the people involved are ill, or, more particularly, they have cancer, being asked, or asking this question can pose a number of dilemmas. Do they tell the truth? Or do they lie? As throughout this thesis, I am dealing here not with actual recorded greetings, but with how these are reported, and oriented to as problematical in various ways, in participants’ narrative accounts.

Extract 6:4.1 Dee 08/10 “It's a natural reaction”

32 Dee and I was sitting in clinic and thinking the only person I haven't
33 seen recently is Sandra and a person grabbed my arm and said
34 Dee (.) I said d'y'know I was just thinking about you
35 it's strange, it's eerie (.) and I went to say and I did say
36 → how are you? and I looked at her and as the words came out
37 I thought oh what a silly thing to say you can see what she's like
38 (.) ((voice lowers to a whisper))
39 → but y'know (.) it's a natural reaction
40 RC umh, umh

Extract 6:4.1 is taken from a long narrative where Dee is talking about how she met up with her friend Sandra in the oncology clinic (see also extract 7:1.2) having not seen her for some time. There are lots of interesting things going on in this extract but I only want to draw attention to a couple of points.
Firstly, the positioning of Dee's asking HAY? (line 36). She has set up the story in such a way that her initial speech act to Sandra is to produce a normal conventional greeting, "How are you?" Dee is not asking this question as if it was a natural question to ask someone who has cancer, but as something that is the normal thing to do, and says "it's a natural reaction" (line 39). But what follows is interesting because having automatically asked the routine question, without thinking, Dee immediately conveys the difficulties of asking such a question by saying, "oh what a silly thing to say" (line 37) and the change of awareness is signalled by 'oh'. She recognises how inappropriate it was for her to ask Sandra such a question (in the clinic) because "as the words came out" (line 36), it was a silly thing to say, because "you can see what she's like" (line 37).

Dee's appeal to how "you can see what she's like" implies that the function of a HAY? is to elicit factual information, such that seeing what someone is like makes such an enquiry redundant. In fact, there is a detail in Dee's story which may not be incidental in that regard. Prior to the reported HAY?, Dee tells that her initial utterance was something else: "I said d'y'know I was just thinking about you it's strange, it's eerie" (lines 34-35), and the subsequent HAY? is marked as indeed subsequent to that via "and I went to say and I did say..." (line 35).

So Dee's account leaves it open that her HAY? to Sandra was not her initial words, but something with sufficient delay to be heard as possibly a serious, factual enquiry. The difficulty that Dee is narrating is therefore nicely tied to the details of her account, and made hearable in those details. On this particular occasion, asking Sandra (someone with cancer) HAY? is not just treated as an initial normative greeting; it is quickly transformed into a literal meaningful enquiry where Dee really does want to know how Sandra is.11 Although Dee's HAY? was glossed as a routine form of greeting, a "natural reaction" (line 39), her HAY? was also available as a literal and genuine enquiry as to how Sandra was. On

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11 At the time of writing up this chapter, I happened to watch "Parkinson" on BBC1. He was interviewing George Best and he produced the normal "how are you?" greeting as Best arrived on the set, and then immediately said, "asking you how are you really means something doesn't it". The relevance here is that George Best had recently been through a well reported series of serious problems and illnesses and almost died. Parkinson attended to the notion that asking HAY? of such a person, in such known circumstances, is liable to be taken in more than one way.
this particular occasion, Dee could see that for herself (line 37). Greeting persons with mutually known serious problems can, on occasions, mean that not everyone has to lie. Indeed it can also produce a dispreferred, or ‘bad news response’, which is exactly what follows:

Extract 6:4.2: Dee 08/11 “you look very unwell”

41 Dee and she said “I’m very ill*, umh yeah you look very unwell
42 (.) and I said, what’s the problem?
43 she said I’ve got metastatic lung cancer (1.0)
44 and we sat (.) for about half an hour

Sandra’s reported response to Dee’s HAY? is “I’m very ill*” and when Dee responds with “you look very unwell”, and asks her what the problem is, the response given is news of the worst kind. Sandra announces that she has got metastatic lung cancer.\textsuperscript{12} The nature of this response requires more than politeness, and indeed it treats the prior enquiry as serious and factual. Dee then goes on to say how she then spent “about half an hour” (line 44) talking to Sandra who, she reveals later, was very upset. So on occasions, partly as a function of the precise positioning of a HAY? in a conversation, but also the function of known actual problems people may have, where asking someone how they are produces a serious factual report, and perhaps ‘a bad news response’.

Consequently, the continuing conversation becomes an elaboration of those problems, a spate of ‘troubles talk’, which may then be difficult to manage, whichever side of the teller-recipient relationship you are on.

In extract 6:4.1, Dee’s asking turned out to be both a casual greeting and a literal enquiry. What I find additionally interesting here is that Dee is not only analysing her own use and implications of asking “how are you?” but she is also managing

\textsuperscript{12} Metastasis is a secondary tumour, a further cancer that has grown when a fragment of the primary tumour detached itself and made its way to some distant part of the body (the process is called metastasising). A metastasis almost always has all or most of the characteristics of the primary tumour. Hence, if a person has breast cancer and it metastasises to the lung, the secondary metastases will behave like cancer of the breast (and have a high chance of responding to chemotherapy for example) rather than like primary cancer of the lung (Buckman, 1996:448).
this interaction from her viewpoint as a member of the same category, because both Sandra and Dee have cancer.

Responses to being asked a HAY? type question can vary according to who is asking the question and where it is asked. It can provoke a number of reactions from bad news and tears to anger and frustration. It will also depend on whether the recipient chooses to tell the truth or to 'lie'.

In extract 6:4.3, the category memberships are different. Jo, who has cancer, is recounting what happened at one of her check-ups with her oncologist. Jo is telling how she responded to being asked "how are you feeling?" and in doing so, she directly addresses the issue of its functional ambiguity.

Extract 6:4.3 Jo/02/02 "do you want the honest truth?"

1 Jo and then on one of my check ups with the oncologist (2.0)
2 → she said to me well how are you doing and asked me all
3 these banal questions
4 RC like what?
5 → Jo Well, how do you feel? well I said, do you want the honest truth
6 → or do you just want the bog standard answer that everyone
7 here gives you she said well y'know she said well
8 I'd hope you'd tell me the truth (.) I said well, I feel dreadful
9 RC uh huh
10 → Jo I feel absolutely dreadful I said (.) but I don't feel as bad as I did
11 when I was taking the tamoxifen and then I had to recount the
12 → whole story to her about how I'd stopped and y'know
13 RC umh umh

The event described above took place in a clinical setting and research shows that in such settings, HAY? is used both casually and clinically (Coupland, Coupland and Robinson, 1992; Diaz, 2000).¹³ We do not know the exact

¹³ In a clinical setting the asking of HAY can also be ambiguous and Diaz (2000) has noted that in the clinical environment whilst the casual use of 'how are you' (HAY?) is preserved. Its clinical use of assessing the patient's condition is also relevant. A straightforward HAY? at the beginning of the encounter opens up the possibility to take it up in either way. Frankel (1995) offers a range
sequence of the HAY? question here, only how Jo recounts it, but note how Jo expresses her concerns of what she says happened. She reports the oncologist asking "well how are you doing" (line 2) as if it was a casual type of enquiry. But she says that the oncologist followed this enquiry by asking a series of what she terms "banal questions" (line 3). RC asks Jo to elaborate, 'like what?' (line 4). Jo's response produces another HAY? style question, but this time it is the rather more specific, "how do you feel?" (line 5). Asking how someone feels does not sound particularly banal, and earlier in the interview, Jo has said that she was suffering considerable pain at the time of this visit. In this context, the question would appear to be a credible one for the oncologist to ask. How Jo attends to this conventional kind of question and everyday cultural politeness is interesting because she alludes to this enquiry as a casual one that does not invite a truthful answer, rather than one of a clinical nature.

Jo then challenges the question by saying, "do you want the bog standard answer that everyone here gives you?" (lines 6-7) which directly addresses, the oncologist's 'true' purpose of asking the question; the categories "bog standard" and "everyone" invoke the routine, 'everyone has to lie' greetings analysed by Sacks. The use of 'everyone' is used 'summatively', and sets up a possible difference by highlighting whether Jo should be like everyone else and conform to traditional responses and lie, or whether she should be 'truthful' and say what is going on. In doing this, she is implying that when people ask such questions, regardless of their category membership, whether they are friend, family, or as in this instance, a member of the medical professional, they may not really want to know the answer. Jo invokes the concept of truth telling and lies and implies that the "bog standard answer that everyone here gives you" is a lie; in other words does the oncologist want Jo to conform and do what 'everyone' else does?

Note that regardless of whether it is a casual or clinical enquiry, for Jo, the issue is whether or not to say how she really feels and at the same time she

of possible responses to a HAY? in clinical interviews, such that the clinical use can be delayed until the casual take-up is completed. The HAY? token is commonly introduced at the beginning of the consultation, often managing to establish the evaluation of the patient's condition as the first relevant activity. This sequential position opens HAY? to ambiguity, as general interest for a newcomer to an encounter is also appropriate in greetings.
demonstrates her awareness that the oncologist may not actually want a truthful response to her question.

Asking HAY? in the context of 'troubles talk' can produce different and difficult responses. Jo could have just said, 'okay fine' and moved on. On the other hand, she could tell the ‘truth’ and respond to the question as a meaningful literal enquiry, receiving the oncologist’s question as seeking a ‘truthful’ response. Jo’s report of the oncologist’s reaction clarifies the kind of answer, “well I’d hope you’d tell me the truth” (line 8).

One of the justifications or explanations for not telling the truth could be that it is likely that when asking someone who has a chronic illness how they are, they might tell you (see extract 6:4.1). As was shown in extracts 6:3.1 and 6:3.3, when people ask ‘how are you?’ participants claim those asking do not really want to know the answer, but are just being polite.

The consequences of Jo giving a truthful answer suggest that it is unlikely that there is going to be a short response enabling the conversation to move on to other things. Jo says “I feel absolutely dreadful” (line 10) which is accompanied by her saying that she then had to go on and recount “the whole story” (line 12) of how she had stopped taking tamoxifen.14

So, the response to a HAY? question is invariably complex for those involved and there are always exceptions to the standard rules of asking HAY? questions. Recipients themselves might want to treat it as a casual, rather than a literal enquiry and move on to less troubled talk. Jo’s account of this conversation, in terms of routine and factual HAY? questions provides the occasion for her telling how she was in some detail. Having made it a serious enquiry, she then “had to” go into all the details. Given how bad she was feeling, it may well be that what Jo is reporting here are the interactional moves she made so as to be in a position to tell those details, even to her oncologist, in the face of what ought normatively to be a mere greetings exchange. Even in conversations with an

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14 Tamoxifen is a hormonal medication used in the treatment of breast cancer.
oncologist, the telling of awful details in response to a ‘HAY?’ question can become an interactionally difficult and accountable matter.

In extract 6:4.4, Zoe, who at the time had recently finished chemotherapy, has been talking about relationships with friends and family. In this extract she is recounting a conversation she had with her mother.

Extract 6:4.4 Zoe 07/03 “I don’t like it”

1 Zoe but I- I er .hhh when she used to come and ask me stuff y’know,
2 I mean (. ) when I’d had chemotherapy she’d phone up an’ say
3 → how are you? I’d go fine .hh y’know and then she’d say
4 Have you been sick? how many times? get off
5 RC umh
6 → Zoe I don’t like it
7 RC umh, well talking about those kind of details is not (. ) particularly
8 helpful then?
9 Zoe no

Prior to the beginning of this extract, Zoe has been talking about her relationship with her mother and RC has asked whether her mother asks her how she is to which Zoe responded “she asks me all the while”. She goes on to account for her reaction to this. Zoe says that her mother “used to come and ask me stuff” (lines 1 and 2) and goes on to account for a time when she had “had chemotherapy”. Zoe’s reported response to her mother’s classic HAY? enquiry, “fine” (line 3) is a minimal, conventional response; it is a preferred, ‘no problem’ response which usually enables normal conversation to continue. However ‘serious’ her mother’s HAY? may have been, Zoe’s reaction was to treat it as the casual kind; “I’d go fine” (line 3), where the expression “I’d go” formulates it as a routine action, and the response “fine” is precisely the canonical one.

However, on this occasion the interaction does not remain routine, because Zoe reports that ‘she’ (her mother) continues to question her about her troubles:
"Have you been sick?" How many times?" (line 4) which Zoe responds to rather dismissively with "get off" (line 4), in other words, stop. She follows this with "I don't like it" (line 6).

In contrast to other participants' concerns, or to other occasions, Zoe's complaint is not about having to deal with routine enquiries from people who do not want to know how you are, but with serious, factual enquiries from someone who resists Zoe's own efforts ("I'd go fine") to treat it as a routine greeting. Although she does agree with RC's enquiry that asking these kinds of questions are not helpful (lines 7-8), just prior to this extract, Zoe has produced a form of justification for her reaction. She has displayed concerns for her mother, and explained that she does not want to talk about it because she wants to avoid worrying her. So, discouraging her mother from asking her such questions is motivated by attending to her mother's problems. As shown in other extracts, it also reflexively presents Zoe as independent and not wanting to be accountable to her mother for her troubles (Jefferson, 1980, 1984a, 1985b, 1988; Sacks, 1976, in Jefferson 1984a).

Participants often provide explanations and justifications for 'lying' and not saying how they really are, such as, that they do not want to trouble people, or be a burden (see extract 6:3.1). They also say they do not want people to really know how they are, because if they tell someone how they really are, this might make it difficult for them to know what to say, or they might worry. Again, this highlights PWC's concerns for others. So, in certain situations, it is much easier to say 'fine' or 'okay' and follow the conventions of a casual HAY? question, rather than take them as genuine inquiries. It also enables the PWC to deviate from any 'troubles talk' about how they are and to 'get off' the difficult topic (Jefferson 1988).

In extract 6:4.5, Jo reveals yet another view of HAY? during a second interview conducted after she had been given a terminal diagnosis. This time she is chastising the health professionals for not asking how are you?

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15 One of the generally known side effects of chemotherapy is sickness.
Extract 6:4.5 Jo/02/03 “Fragile – handle with care”

28  →  Jo  I'm not walking around with doom and gloom on my face
29                so I don't want to see it (1.0)
30            they may be feeling sorry for me or whatever,
31                it's not necessary (2.0) y'know,
32            I er prefer to see a happy smiling face and they can say
33  →            oh how are you ((up tone in voice)) that's fine
34       RC    uh huh
35  Jo    y'know just because I'm dying doesn't mean to say
36            they can't ask me that question (3.0)

Although Jo does not invoke the notion of putting on a brave face, she does say that she is “not walking around with doom and gloom” (line 28) on her face. But she makes it clear that it is not necessary for people to feel sorry for her (line 30) (cf. Ann extracts 6: 2.1-6:2.3). Jo prefers “a happy smiling face” (line 32) and regardless of the ambiguities and contradictions she voiced in extract 6:4.3, she voices that “they can say oh how are you”. In fact, rather than this being ‘regardless’ of such considerations, it is an acknowledgement of them. It is precisely in the face of such ambiguities and interpersonal difficulties that Jo asserts that she is above them, able to deal with them and not threatened by them. She says: “just because I’m dying doesn’t mean to say they can’t ask me that question” (lines 35-36). In saying that she wants people to be cheerful around her, and that she wants to be asked how she is, she orients to the expectable difficulties of doing that. On this occasion, the support she is asking for is to be treated as ‘normal’, not that she is someone who is dying, though of course the understood basis is that she is indeed dying, and everyone knows it. Her proclamation of this is working towards easing the social interaction around her at this difficult time and again, attends to her identity as someone who is being positive about her illness, and wanting others to be so too. However, how she would respond is not something she provides for in this account.

One of the purposes of analysing asking HAY? has been to get a better understanding of what the concerns are for PWC when they are asked such everyday but potentially difficult questions. Clearly, the differences between a
casual enquiry, a genuine, concerned enquiry, and a clinical enquiry require different management for those concerned. Whether it is a PWC to a PWC, oncologist to a PWC, mother to daughter, spouse to partner, whatever the relationship, what appears to be a simple everyday conversational question is full of complexities and pitfalls. Yet, as Jo implies (extract 6:4.5) people should not go round with doom and gloom on their faces, or be routinely overprotective and only 'handle with care', the question can still be asked.

This extract summarises the complexities of knowing what to say and when and how the PWC produces variable and sometimes contradictory accounts. But what the analysis reveals is that people with or without cancer are full of normative expectations, and that there are sets of normative rules which both they and others attend to.

The rules for asking everyday HAY? greetings are the same whether it is someone with or without cancer. But the analysis points out that others need to be aware of the sensitivities and ambiguities such a question can raise with someone who has cancer (or any other serious illness). PWC and their family and friends are likely to have variable needs and concerns. Sometimes, they do want to be asked HAY? and sometimes not. The same variability applies to acknowledging (and validating) their illness and as shown with Jo, there are times when it is important for people to exhibit cheerfulness. Introducing negative states such as doom and gloom might involve the PWC having to take on this additional burden of managing other peoples' interactional problems. This idea will be discussed, together with other themes, in the conclusion.

Summary

Chapter 6 has focused on the how PWC recall and produce some of the difficulties encountered in social interactions with friends, family and the medical profession. It has looked at how the cultural language of cancer is invoked and worked up to formulate its meaning for them. On occasions the expectations placed upon them are stressed as being "rammed down their throats", or that others are not entitled to say such things. Its contribution to this thesis is that the
PWC, in addition to having to manage their illness, is constantly placed into
difficult social situations where invariably, THEY are the ones who have to
display understanding and manage other peoples’ reactions to their illness. They
also display that they do not want to be treated with pity, nor do they want people
to feel sorry for them. Accounts construct this as being un-supportive, and when
they express concerns for worrying others or being a burden they account for
how putting on a brave face can fend off difficulties of talking about their troubles.
They also attend to issues of identity in presenting themselves as being positive,
and rather than talk about the expectations continually being placed on them,
they convey their expectations of others and how they want them to respond.

In Chapter 7, the analytical focus is on how PWC narrate stories which are
hearable as what I term doing being positive accounts. The focus is on how
doing being normal and laughter and humour are employed to fend off recipients
offering unwanted sympathy or engaging in talking about their troubles and how
laughter and humour also manages the potentiality of being heard as a self
pitying or a complainer.
Chapter 7
Moral accountability: Doing being positive

Introduction

In Chapter 2, I outlined how PWC are expected to cope and live with their illness. According to psychological theory and the influential self-health approach to cancer (considered by many as controversial), recovery depends upon the patients' attitude towards their illness. Many of these approaches, such as that of Louise Hay, rely heavily on a subjectivist philosophy. She expresses a view of health and illness as the unqualified truth of existence and suggests that "no person, no place, and no thing has any power over us...we create our experiences, our reality and everyone in it" (Hay, 1988:7). Similarly Simonton, Matthews-Simonton and Creighton suggest that "we all participate in our own health through our beliefs, our feelings and attitudes towards life and that we each have a responsibility to change negative thought patterns because they can directly affect our bodily health" (Simonton et al, 1978:32). This places the power of recovery in the hands of the individual and "if you follow the imperative to take responsibility for your disease and recognise that you are the one in charge ...[then] you will feel empowered" (Charles, 1990:7).

I have also discussed that certain rules of 'coping' are promoted such as adopting a 'positive attitude' and a 'fighting spirit'. Additionally these 'coping' attitudes are endorsed as being morally desirable reactions to negative events. Cultural and common sense notions of managing illness in the Western world also suggest that we should not talk about or dwell on our illness, that we adopt a stiff upper lip, put on a brave face, and 'think positive'. A practical problem for the PWC, within the moral order of illness, is to avoid denying the reality of their illness, while at the same time avoid being seen as self-pitying, pitiful or not coping.

In Chapter 6, I focused on how these moral ascriptions are taken up, and the analysis looked at PWC's accounts of the things people said to them. The
analysis revealed how when PWC are told to 'think positive' and to 'be positive' or asked “How are you?” that who was saying these words, and when they were said, was relevant to whether such 'advice' or concern was accepted or rejected. It generally depended on whether or not the source was treated as credible and entitled to give such advice or express such concerns.

In their analysis of breast cancer patients who directly reported that they were 'thinking positive', Wilkinson and Kitzinger (2000) argued that the participants voiced the claims in part to protect themselves against accusations of complicity in the onset and the progression of their cancer. They proposed that self-descriptions, such as 'I think positive' are partly designed to counter any such notions that the PWC may be responsible, if not for the onset of their own disease, at least for its progression (cf. de Raeve, 1997; Rittenberg, 1995; Gray and Doan, 1990). However, rather than look at participants' self descriptions of 'I think positive', this chapter aims to show how doing being positive is a participants' concern in much of their talk, and how this is discursively accomplished. Participants do not always make explicit claims that they are thinking positively or adopting a 'fighting spirit' (as defined in questionnaires such as the MAC: Watson et al., 1988) and, unlike in Chapter 6, in this chapter participants (with the exception of Gen extracts 7:1.6-7:1.8) do not directly voice the words "be positive" or "fight it". What they do is tell stories that display them doing being positive.

The idea of PWC being positive and how accountable they are for this prescriptive approach to their illness is a pervasive feature throughout this thesis. This chapter aims to emphasise some of the dilemmas this produces for a person with cancer and I will show how they attend to these dilemmas as potentially accountable issues. I show how PWC produce individual meanings of the notions of doing being positive and adopting a ‘fighting spirit’.

Edwards (1997) suggests that speakers' concerns with accountability are often managed at two levels of narration. The first is in the current interaction and the second is within the past event being recounted. Speakers also regularly attend to issues of moral accountability in their talk and this often occurs when multiple
and opposing versions are possible. Speakers have a rhetorical stake in the version of the story they tell and they present their versions in order to counter alternative accounts or other versions (Antaki, 1994; Billig, 1997). I will also show how their stories are rhetorically designed to construct a plausible, credible self or identity (cf. Antaki and Widdicombe, 1998) which counters any potential view of themselves as passive, pitiful, self-pitying or not 'coping'.

The Analysis

The analysis is divided into two parts:

7:1  Doing being normal
7:2  Seriously funny: Looking on the bright side

In the first part, (extracts 7:1.1-7:1.8) the analysis focuses on the construction of doing being normal. The second part (extracts 7:2.1-7:2.6) looks at how doing being positive is accomplished by invoking laughter, irony and humour.

7:1 Doing being normal

So far, the stories analysed have been about discovery accounts, diagnostic delay and what other people said during the early stages of illness. In this chapter, we continue the narrative trajectory of illness, to stories about how PWC continue with their everyday lives and visits to the hospital.

In order to convey the relationships across a sequence of stories and accounts, I am going to present 5 extracts taken from a long narrative given by Dee which is centred on her friend Sandra. It is an account of how Dee unpacks the gloss of doing being positive and is a detailed and representative example (that is, in terms of the kinds of accountability it manages) found in my data.

In extract 7:1.1, Dee, is giving an account about a friend of hers, Sandra. They are both members of a local cancer self-help support group.
Dee's rhetorical question, that “it's strange isn't it?” (line 2) defines Sandra's "tackling it the second time round much better" (line 1) as something out of the ordinary, especially as getting cancer for the second time is even worse news.¹ Dee puts forward the idea that Sandra's reaction is unusual, but at this point, she does not elaborate why this should be strange.

¹ A second cancer diagnosis is an indication that the initial treatment has failed. If the cancer had only invaded adjacent tissues, it would be curable (by surgery) in the vast majority of cases and there would not be a second time round. The significance of second time round, and what makes cancer so threatening and dangerous is that it (the cancer) has spread to other parts of the body and formed secondary cancers there. Dee also has secondary cancer.
The first time someone is given a cancer diagnosis, they are not likely to know what this entails; they are entering previously unknown territory and a whole new range of experiences. However they may draw on lay and culturally available knowledge about cancer and it is also likely they will have encountered the cultural metaphors and all the dreaded accounts of the disease.

Getting cancer for the second time is generally (and medically) understood as being far more serious and life threatening. It has its own individual meaning and it is a very different phenomenon to be managed. Dee says that "she's tackling it...much better" (line 1), which attends to the notion that the second time round brings with it the lived experience of the first diagnosis, and its strangeness is that she is tackling it better the second time round.

Dee then determines the significance of it being strange in the form of a contrast account. She begins by separating Sandra out as having been different from the rest of the group all along, saying "she was the one out of all of us" (line 4). Firstly, "all of us", is an ECF that maximises the number of people that Sandra is contrasted with. It implies that "all" are members of the same group of women with a cancer diagnosis and they have something in common. Proportional ECFs (Pomerantz, 1986) are normally used to indicate that any individual members of that category are not responsible for the state of affairs, that responsibility is to be attributed elsewhere. But the use of 'all' (line 4) separates Sandra as different, while also providing Dee, as she now tells the story, with a warrant to pick Sandra out. Setting Sandra up as different, as not fitting in with "the rest of us", is also a way of emphasising the strangeness (line 2) that makes Sandra's story worth telling.

One analytically interesting feature is how Dee describes Sandra as different (lines 5-9). She does this in the form of a five-part list of some of the ordinary mundane activities that Sandra failed to engage in. The sheer ordinariness of those activities constructs Sandra as an extreme case at the end of the

2ECFs have been linked to normative accountability and 'consensus formulations' in discursive psychology (Edwards and Potter, 1992) and are also applied to the behaviour of single or singled-out groups or individuals where they can pathologise or ironise, as well as normalise the way people behave (Edwards, 1994; 1995; 2000; Hutchby, 1992; cf. Smith 1978)
continuum, a person different from “all of us”. She gave up “walking her dogs,” “didn’t go down the garden,” “stopped shopping,” “didn’t go out in her car,” and “didn’t go out to dinner,” (lines 5-9). The essence of this is formulated in line 10, “she stopped living really”. The point being made here is that the notion of Sandra’s tackling it better the second time round also defines the negative way she acted the first time round, as being wrong, inappropriate, and unusual. Sandra’s inadequacy in dealing with her illness, is therefore constructed as a series of negatives or absences, that is, what she failed to do. What is also inferentially available is that Dee knew Sandra before she had cancer, enabling Dee to report that “she stopped living really in the terms she had before” (line 10). This provides a further contrast in terms of the sort of life Sandra lived before, implying that prior to her cancer she was actively engaged in a normal social life.

Having set up Sandra as not carrying out ‘normal activities’ Dee provides a generalised account of what “the re(hhh)st of us” did. They “sta(hh)ggered ro(hh)und the water works’ (lines 13-14). The laughter occurring within this description indicates that this is a possibly amusing description, conjuring up comical images of them not being able to walk normally. ‘Staggered’ is a word often applied to people who have had too much to drink; in this instance it indicates the lack of mobility and energy often attributed to the severe side effects of the treatment regime. Its presentation as comical is a reflexive display of making light of it, of not wallowing in the misery of it. The inference “you’d think” (line 15) is that anyone else would not “go on any more” (line 15) but that the “re(hh)st of us” did, which again emphasises the contrasting actions.

Rather than elaborate what else the ‘rest’ did, Dee now personalises her account, describing her own actions (lines 16-20), which are offered as getting on with ordinary, normal, routine activities. Note the series of details that provide a precise counterpoint to Sandra, going shopping, walking dogs, going out in the car. Sacks (1984) suggested that when people report events, they attend to the ordinariness or extraordinariness of what happened. In lines 16-25 what is interesting is that the very ordinariness of Dee’s reported actions are constructing normality, a sense of what doing being normal is. Again, by way of the contrast
with Sandra, Dee can also be heard as *doing being positive*. She is ‘coping’ with, rather than succumbing to her illness. Participants do not often directly voice that they are 'coping', but rather, their descriptions, narratives and contrasts orient to that notion. Dee contrastively celebrates being able to do the ordinary things; that she "carried on doing my shopping" (line 16) and that it was "very important" (line 18) that she "could do the wee:kly Sainsburys" (line 19). The emphasis on being able to "do" the "wee:kly Sainsburys" specifies this as a definite, recognisable and routine action. The phrase "the wee:kly Sainsburys" (in which both "weekly" and the definite article "the" are important) is emblematic of normality, of a routine and normal life.

Pomerantz (1984a) suggests that a routine way of agreeing with people is to provide an upgraded second assessment which is what RC provides (in overlap), with "yes" (line 20), upgraded to "yeah absolutely" (line 22). What Dee is making important and relevant here is the routine nature of the activity, rather than, say, that she needed to go and get food, which provided her with "the only se-sense of normality" (line 23). The explicit use of "normality" has a heightened sense in this context which stands in contrast to Sandra, who "stopped shopping" (line 7).

Everyday mundane activities are a pertinent feature of Dee’s (and others’) constructions of *doing being positive*. Participants regularly invoke descriptions of normal routine activities and say that this is their way of maintaining some degree of control and being 'normal'.

This importance of the *mundane* is highlighted when the ordinary thing is something that would usually (normally) be taken to be onerous or bad. For

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3 Sainsburys is a British supermarket chain.

4 Pomerantz suggests that different types of agreements are produced with second assessments. One type of agreement is the *upgrade*. "An upgraded agreement is an assessment of the referent assessed in the prior that incorporates upgraded evaluation terms relative to the prior. Two common techniques for upgrading evaluations are: (1) a stronger evaluative term than the prior, given graded sets of descriptors, is selected and (2) an intensifier modifying the prior evaluative descriptor is included" (Pomerantz, 1984a:65).
example, one participant claimed that having a common cold made her feel normal again.\footnote{Sacks (1984) discusses the notion of ordinariness as a concerted, interactional accomplishment. He notes how being ordinary is a recurrent pattern of social life: “it is almost everybody’s business to be occupationally ordinary, that people take on the job of keeping everything utterly mundane; that no matter what happens, pretty much everybody is engaged in finding only how it is that what is going on is usual, with every effort possible” (Sacks, 1984:419).}

The telling of routine activities is also a way of displaying and making light of an affliction by adopting, as far as possible, the behaviour appropriate to a healthy person. So, by recounting the ordinary normal positive things, Dee and “all of us” are ‘coping’ positively with extraordinariness, with being severely ill. Jefferson (1984c) and Wooffitt (1992) have also shown how the pursuit of ordinariness is a routine feature of the reporting of a wide range of unusual or dubious experiences. In the case of a PWC, it is also a way of bringing off being positive.

Descriptions can be given authority by emphasising or building up category memberships, which imply particular knowledge entitlements (Potter, 1996). Another feature of descriptive accounts is that they can also construct actions or events as normal or abnormal. In extract 7:1.1, Dee is engaged in constructing herself and “all of us” as doing normal activities and Sandra is constructed as being anomalous. In “K is mentally ill”, Dorothy Smith (1978) addressed the issue of how descriptions can present some actions as abnormal and notes that what counts as normal is indexical. In other words, it is not sufficient to simply describe an action, which will be consensually recognised as abnormal or weird but any notion of abnormality has to be constructed in discourse (Potter, 1996). As with K’s abnormality, Sandra’s abnormality is worked up principally using a contrast structure. Smith’s study focuses on how accounts work both to describe the activity, and provide cues to understand it as abnormal or bizarre.\footnote{In addition to Smith’s study, recent CA studies have yielded considerable information about the character and use of contrast structures in a variety of discursive circumstances: in political discourse (Atkinson, 1984a and b; Heritage and Greatbatch, 1986) and in selling techniques (Pinch and Clark, 1986). In these forms of language use, inferences about the preferability of one item are exposed and easily available from the contrast.}

One notable feature of everyday event descriptions is how they make inferentially available particular dispositional states of the actors; their moral character,
personality, or state of mind (Smith, 1978, Edwards, 1994; Edwards, 1995). Dee's account is potentially hearable as judgmental in that it could be inferred that if Sandra had behaved differently the first time round, she might not be experiencing secondary cancer now. In extract 7:1.2, Dee works on this possibility.

Extract 7:1.2 Dee 08/13 “Sandra did nothing”

25  Dee  I wash my own car still (1.0)
26                                and I drove all the while (1.0)
27  →  Sandra did nothing, she sort of (2.0) let the disease (2.0)
28                                dictate to her really I suppose in a way . hhh umh
29                                and I met her (.) after about six months
30  I hadn’t seen her for about six months -
31                                I met her in the clinic at County a year and a bit ago (.)
32  Dee                                and I was sitting in clinic and thinking the only person I haven’t
33                                seen recently is Sandra and a person grabbed my arm and said
34  →  Dee (.) I said d'y'know I was just thinking about you
35                                it's strange, it’s eerie (.) and I went to say and I did say
36                                how are you? and I looked at her and as the words came out
37                                I thought oh what a silly thing to say you can see what she’s like
38                                (.) ((voice lowers to a whisper))
39                                but y'know (.) it's a natural reaction
40  RC                                umh, umh

Extract 7:1.2 is a continuation of Dee's story about her friend Sandra (Note that part of this extract was analysed in Chapter 6, extract 6:4.1). One of the features of the everyday use of the category 'friend' is its implications of positive feelings and loyalty; friends are people you stick by and support. They are not people you are likely to be critical of or attack; so how does Dee manage the issue of stake and her friendship? 

7 “Stake inoculation works to build up the credibility or factuality of the description by heading off the discounting work of stake attribution. In situations where descriptions might be undermined as interested, stake inoculation presents a counter-interest” (Potter, 1996:128).
Participants also have a problem of avoiding making available a prejudiced or biased identity and in Dee’s case, being seen as judgmental. Potter (1996) suggests that people need to make their evaluations appear to be natural and obvious features of the world rather than reflections of their own psychology; they need to accomplish an *out-there-ness*.

Accounts which merely appear to be describing the world as it is are generally taken to be more persuasive than accounts motivated by the special interests or psychological disposition of the speaker (Smith, 1978, Potter and Wetherell, 1988). The psychological concept of motivation can be re-conceptualised as a participant’s rather than an analyst’s concern (Horton-Salway, 1998; cf. Mills, 1940). The construction of a particular identity, in this case Dee, as Sandra’s friend, and also someone with cancer provides grounds for being able to talk about Sandra’s response to her illness. Dee depicts herself as being someone who is concerned about her friend.

Dee continues to build and sustain the contrast with further examples of the ability to do ordinary things (despite having cancer). However, she does present this with a cautious and pensive delivery. “I wash my own car still (1.0)” and “I drove all the while (1.0)” (lines 25-26) and again contrasts her actions with Sandra who (again in extreme terms) “did nothing” (line 27). It is unlikely that Sandra literally did nothing, but again the use of this ECF maximises the rhetorical contrast and supports the action Dee is engaged in, of putting Sandra in a different category to “all of us”.

What is at stake for Dee is to be seen as sympathetic and sensitive towards her friend’s state, while nevertheless criticising her. Dee manages this by deliberating before delivering her assessment of Sandra, indicating her sensitivity. This helps to avoid being heard as simply making disparaging comments about her friend. Similarly, by proposing that Sandra failed to resist her illness but rather “she sort of (2.0) let the disease (2.0) dictate to her” (lines 27-28), Dee is also hedging her

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8 Dee describes herself as being active and Sandra as passive. In the MAC questionnaire (Watson et al, 1988), Dee’s actions in lines 4, 18, and 32 would be classified as adopting a ‘fighting spirit’ whereas Sandra would be classified as being helpless/hopeless.
comments by saying 'sort of', and 'I suppose'. Long pauses occurring in talk about difficult and sensitive issues have been noted to signal acknowledgement that it can be difficult to know what to say (Peräkylä, 1995); here, Dee’s two second pauses (line 27) act as reaction tokens signalling her sensitivity to what she is saying (See also extracts 7:1.6-7:1.8).

By attributing the disease with control and power Sandra is constructed negatively, as being someone who is not adopting a ‘fighting spirit’; that she is giving in to the disease. As previously noted being positive and adopting a ‘fighting spirit’ are idiomatic expressions of an attitude recommended by medical professionals and psychologists closely linked to mortality and morbidity. The problem with such assertions is that they load a lot of responsibility for illness and prognosis on to the sick individual. So saying that Sandra “did nothing” and “let the disease dictate to her” are statements with a potentially moralistic ring, but Dee works to manage this possible interpretation. As with Smith’s (1978) “K is mentally ill” study, what Dee is saying about Sandra includes much that could be treated as being critical and therefore as reflective upon Dee herself as a somewhat unsympathetic narrator, rather than telling us about Sandra. Dee’s approval of Sandra’s new attitude following her relapse is also a way of dispelling any such inferences about Dee.

Dee goes on to provide a first person narrative (lines 29-40) and a sequentially different account of Sandra, orienting to “tackling it the second time round a bit better” (extract 7:1:1, line 1). Dee sets the context of this meeting: “she hadn’t seen her (Sandra) for about six months” (line 30) which provides an opportunity for Dee to produce a contrasting account of how Sandra had been before the second diagnosis. They met in the clinic, “a year and a bit ago” (line 31). Dee describes when, where and how their meeting occurred and again invokes the strangeness of the situation. She says she was “sitting in clinic and thinking the only person I haven’t seen recently is Sandra” (line 32) and just as she was thinking, “a person grabbed my arm” (line 33). Dee reiterates that she had just been thinking of Sandra and again notes that “it’s strange, it’s eerie” (line 35). The references to “strange” and “eerie” are an indication of something being out
of the ordinary. They emphasise the strangeness of Dee sitting and thinking about Sandra, who then appears. Their use in this context helps work up the narrative of Sandra's different approach to her illness and also to something as being unusual, possibly inexplicable because in Sandra's case Dee is providing an account that something unexpected and unexplainable is occurring. Dee is not normalising her account as in Wooffitt's (1992) accounts of paranormal tales that attract 'normalising' devices such as 'I was just doing X when Y' or Sara's account of discussing her pea sized lump, (see Chapter 4 extract 4:1.1) Dee is giving this account as being something unexplainable, where it contributes to her contrastive narrative of "it's strange isn't it?" (extract 7:1.1 line 2).11

Dee says how she greeted Sandra, by asking "how are you?" (see detailed analysis chapter 6, extract 6:4.1). As was noted in chapter 6, the use of routine everyday enquiries of this kind usually assumes that you are well and that you are leading an ordinary, normal life, and will have nothing serious or detailed to report. However, for people who are ill, such everyday questions can be problematic. Nevertheless Dee, because she also has cancer, has the knowledge and experience that entitle her to talk to someone else with cancer. It is also likely easier for her to ask this, but it might pose more interactional problems for someone without cancer.

Entitlement to experience is a topic that Sacks (1992) discussed in his lectures. He presented a story told about coming across a horrific auto-accident where people were laid out and covered over on the pavement. He emphasised that the teller and the recipient of the story have differential 'rights' to feelings about

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9 On the MAC scale, Sandra would be classified as being helpless and hopeless.
10 This phenomenon is one many of us may be familiar with; when we are thinking of someone and the telephone rings; a familiar response is 'oh, I was just thinking about you'. Whatever its status as an event that actually happens, it is also a nice way of re-establishing the reciprocity of a relationship that the person being called, or approached, might otherwise be remiss in allowing to have lapsed.
11 Note that throughout extracts 7:1.1 and 7:1.2, Dee (and others, see extract 6:1.1) produces an 'active-passive' contrast. It is the passivity of having cancer, getting treatment, the possibility of dying, versus the agentive, active nature of 'coping', doing being positive and doing normal things. But, it is not easy, note how the agency of the latter is also built by the amount of effort it takes, like the "staggering" around the water works (extract 7:1.1, line 13), it is an effort, a strain and a struggle against adversity to make the best of it.
the accident. He states that the storyteller has a specific entitlement to feel awful, to cry, to have their day ruined in a way that the recipient does not:

"If you call up a friend of yours who is unaffiliated with the event you're reporting, i.e. someone who doesn't turn out to be the cousin of, the aunt of, the person who was killed in the accident, but just a somebody you call up and tell about an awful experience, then if they become as disturbed as you, or more, something peculiar is going on, and you might even feel wronged - though that might seem to be an odd thing to feel".  

(Sacks, 1992: 1, 242-8)

Sacks points out that it is the witness who has the entitlement to these feelings. Potter (1996) developed the 'entitlement to experience' theme by linking it to the idea of category entitlement; that is, the idea that certain categories of people, in certain contexts, are treated as knowledgeable (Whalen and Zimmerman, 1990). He suggests that in practice, category entitlements can obviate the need to ask how the person knows. Simply being a member of some category, such as a doctor, a tennis player or health professional, or as in this analysis, a person with cancer, is treated as sufficient to account for, and warrant, their knowledge of a specific domain.¹²

In extract 7:1.3, Dee recounts Sandra's response and Dee's category of entitlement to knowledge about cancer is made evident.

Extract 7:1.3 Dee 08/14 "she's just been wonderful this time"

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41    →    Dee and she said "I'm very ill" umh yeah you look very unwell
42    (. ) and I said (. ) what's the problem?
43    she said I've got metastatic lung cancer (1.0)
44    and we sat (. ) for about half an hour
45    because the consultant was so far behind and you
46    →    could see the people in the clinic becoming very unhappy
47    about two patients sitting discussing (. ) one patient's
48    terminal disease (. ) they were so uncomfortable
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¹² The nature, boundaries and implication of both categories and their entitlements can be reworked in a whole range of ways (Gilbert and Mulkay, 1984: Ch. 6; Potter, 1988; Shuman, 1992; Yearley, 1984). Additionally, while some categories are especially visible, or given official credentials, others are highly localised and negotiable (Jayyusi, 1984).
49  RC  umh
50  Dee  and I said look Sandra I said this is causing a few problems
51  Dee  in clinic I said why don't we go to the coffee shop and
52  RC  say to them we're in the coffee shop how long do you think we
53  Dee  will be before we're needed
54  RC  umh umh
55  Dee  and we did that in the end (1.0) umh (2.0)
56  →  and she was so feisty and she's been (.) I mean Zoe will tell you
57  →  she doesn't know her very well (.) she's met her once but (.)
58  →  she's just been wonderful this time and
59  →  I wonder sometimes if she could have input so much
60  RC  effort the first time what would have happened? (2.0)
61  RC  umh

The rhetorical construction setting the context for this story in extract 7:1.1 is unpacked in extract 7:1.3. Dee voices Sandra's response to being asked "how are you" which is delivered in a quiet, soft voice, "I'm very ill" (line 41) followed by Dee's agreement "umh yeah you look very unwell". Such a direct response of agreement under the circumstances of Sandra's illness may, in another context, seem highly inappropriate, especially coming from a friend. Pomerantz (1984a) found that the major exception to agreement being normatively 'preferred' is when the initial assessment is self-deprecating. However, this further highlights the significance in these special circumstances of asking "how are you?", of who asks it and when, and the likelihood of getting a bad news announcement in response. Dee has been displaying her friendship with Sandra and that she is someone with certain experience and knowledge entitlements. Having already asked Sandra how she is, she asks her "what's the problem?" (line 42) and voices Sandra's response: "I've got metastatic lung cancer (1.0)" (line 43). The one-second pause is an opportunity for RC to enquire what this might mean or entail, but she does not take this up. Neither does Dee exclaim, react or comment on this bad news announcement. This displays that particular knowledge has been assumed by Dee and RC, that they both understand the meaning of 'metastatic' and that it equates with very bad news.
We of course do not know exactly how this reported conversation occurred; we only have Dee's account of it. But active voicing can be used to warrant the factual status of claims and ward off the possibility of sceptical responses (Hutchby and Wooffitt, 1998). In this instance Dee's voicing of Sandra's response (softly spoken) is an indicator of their intimacy and demonstrates an alignment of sensitivity and understanding of the gravity of Sandra's situation. The outcome of this bad news revelation is that they "sat for about half an hour" (line 44), an opportunity created by the consultant being so far behind. But they are not sitting in silence. Dee highlights an interesting quandary (lines 46-51) attending to timing and place and the potential difficulties of asking someone who looks so ill, how they are. People in the clinic, i.e. other PWC, are likely to be at different stages of their disease and are probably there to receive some form of treatment or to be given results of tests. Dee "could see the people in the clinic becoming very unhappy" (line 46) indicating the difficulties of talking about "one patient's terminal disease" (line 48) even amongst PWC, is clearly not something which is comfortable. It is evident that people with cancer can also find conversations about terminal illness difficult to manage and Dee's orientation to this sensitivity is displayed by her suggesting "we go to the coffee shop" (line 51).

The revelation that Sandra's cancer is now almost definitely terminal adds to the strangeness of Sandra tackling it "much better" the second time round (extract 7:1.1, lines 1-2). Having not seen Sandra for six months, Dee says, "she was so feisty" (line 56) and "she's just been wonderful this time" (line 58). Dee also corroborates this by suggesting that it is not only she who noticed this, but there are corroborating witnesses: "I mean Zoe will tell you", (line 56). This is a sharp contrast to the previous construction of Sandra as someone who was passive and who had "stopped living". Dee now establishes Sandra as being active. This contrast has implications for what Dee says next (lines 59-60) and attends to the notion of the meaning and implications of doing being positive.

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13 See Chapter 8 for how PWC talk about death and dying.
Although Dee says that Sandra has "just been wonderful this time", she "wonders" (a mental state expression\(^{14}\)) whether "she could have input so much effort the first time what would have happened?" (lines 59-60). Mental state expressions perform an evaluation of actions, and also deal with an actor-narrator's accountability. Such expressions help create a sense of conveying genuine personal experiences and, as is apparent in Dee's account, they also attend to interactional concerns, in the telling, especially when this is something that needs to be managed with delicacy (Edwards, 1997). This state of "wondering" enables Dee to raise thoughts and possibilities without implying endorsement of them. The unspoken implication is that Sandra could be somewhat accountable for her relapse, by not having responded so wonderfully in the first place.\(^{15}\)

Dee is drawing on the idea that adopting a particular attitude may have an effect on your illness, in either a positive or negative direction (see Hay, 1988, 1989; Simonton et al, 1978; Watson et al, 1988). Throughout her account she has contrasted the notions of herself as doing being positive and Sandra's inactive stance, and she is invoking their existence now by producing a notion that this can have potentially crucial consequences. This is a notion that Dee refers to again later in this conversation (see extracts 7:1.4 and 7:1.5 below) where she makes this "wondering" more explicit.

\(^{14}\) "Mental states, including knowledge and belief and claims to remember or forget, feature in stories as an intrinsic part of the actions recounted, as well as performing evaluations of those actions, and dealing with an actor-narrator's accountability. Mental state descriptions feature in how narrators attend to factual authenticity, and create a sense of conveying genuine personal experiences. In doing all of that (rather than as some separate business) they also attend to interactional concerns in the telling, and this can be something very delicately managed" (Edwards, 1997:282-283).

\(^{15}\) The normative reaction is to make light of one's affliction, to carry on as usual, and as far as possible to adopt the behaviour appropriate to a healthy person, in other words, to do "being positive". While this type of reaction may have some adaptive value for the individual sufferer, it is likely that its greatest significance lies in facilitating the way in which the healthy accommodate the disabled. As Freidson (1970) notes, in contrast to acute illness, chronic disabilities are awarded permanent legitimisation. At the same time, this is conditional on sufferers making an effort to 'improve' themselves, and make themselves socially acceptable by minimising the demands s/he makes on other people. In other words, social stereotypes concerning the appropriate reactions to long-term and incurable illness limit the amount of 'deviant' behaviour that is tolerated among the chronically ill (Pollock, 1993).
Dee’s account does not end at this point. There is more to be told and more work to be done to account for this rather delicately introduced moral ascription, that Sandra may have been somewhat responsible for her relapse. Dee describes a distinct change in Sandra’s approach to her illness.

Extract 7:1.4 Dee: 88/15 541-800 “would it have made any difference”

62 Dee she’s so, I mean I take my hat off to her this time
63 I don’t know how she keeps going (.) and she does (1.0)
64 th- this is the third time that she’s lost her hair (.) hhh
((......))
65 → Dee umh but I often wonder to myself if she’d kicked in like feisty like
66 now before, would it have made any difference (.)
67 isn’t it strange? (1.0)
68 RC umh
69 Dee because she did actually give up (1.0) not give up but
70 → she just stopped living
71 RC but was she very poorly umh?
72 Dee no I don’t think she was as poorly as the rest of us really (.)
73 → she just thought that that’s how she should behave (2.0)
74 and er (1.0) it used to annoy me because I used to want to
75 shake her and say ◆come on◆
76 I’d say where have you been this week?
77 you know you meet in chemotherapy (.)
78 where oh where have you been this week?
79 ◆oh I’ve not been able to go anywhere◆
80 → I said have you not been shopping? (1.0)
81 ◆No, I can’t drive, she said I just can’t- I can’t drive◆
82 I said you could go to Fosse Park16 you could park outside
83 (1.0) ha ha because if I was fed up I’d get in the car
84 → go to Fosse Park for half an hour it sounds silly but that’s my (.)
85 form of therapy
86 RC umh
87 Dee just have a won- a wonder round and I still walked my dogs

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16 Fosse Park is a local shopping centre.
In extract 7:1.4, Dee now wonders “if she’d kicked in like feisty like now before, would it have made any difference” (lines 65-66) which she completes with a rhetorical question ‘isn’t it strange?’ (67). The expression “I often wonder to myself” conveys these thoughts as sensitive, as private and tentative, not the kind of thing that Dee would be publicly asserting. Dee reiterates in extreme terms, that Sandra “just stopped living” (line 70). RC attends to the possibility that Sandra’s past passivity could be due to her being especially ill, “very poorly”, which Dee denies (line 72). Instead, she suggests that Sandra assumed “that that’s how she should behave” (line 73). This contrasts with what Dee has established as the normally recognised and expected way to behave, which is to be positive.

Indeed Dee expresses annoyance at Sandra’s passivity (line 74), that she wanted to “shake her and say ‘come on’” (line 75). But Dee avoids any implication of lacking empathy, by encouraging Sandra to be active: “where have you been this week” (line 76). Note how the mundane activity of shopping features again, something that Dee has already said gives her a “sense of normality (line 23). She asks, “have you not been shopping?” (line 80). Dee reiterates the importance of the mundane and announces that “that’s my (. ) form of therapy”, followed by “I still walked my dogs” (line 87). Dee continues to construct being active and doing ordinary things as a constructive way of ‘coping’ with her illness. Again, this way of talking about Sandra could be heard as a criticism of someone who, after all, is probably (at this point) dying of cancer. Yet, it is not cast as an explicit criticism of Sandra, nor as a certainty, but as Dee’s “wondering”.

In extract, 7:1.5, RC explores the possibility of some explanation for Sandra’s response to her illness and Dee provides further grounds for why Sandra did not tackle her illness so well the first time by introducing the role Sandra’s husband played.
Extract 7:1.5 Dee 08/16 “she just became (1.0) totally unempowered by the disease”

88 RC so, what, what was it about her then that you think
89 stopped her from doing anything
90 [any ideas about that
91 → Dee I think she just became (1.0) totally unempowered by the disease (1.0) it overtook her whole reason for living (1.0)
92 and she had a- the strange thing is she had a husband like (1.0)
93 perhaps who would have suited me in a way but I suppose it
95 → it wouldn't have done because I'm not that sort of person (.)
96 → she had a husband who made it very easy
97 for her to negate her responsibilities
98 RC right
99 Dee he took over the shopping, he took over the chores (.)
100 he took over everything, he would drive her to every
101 → appointment (. so she- so the NEED for her to do these things
102 RC right
103 Dee was taken care of, so that made her, it made it very easy for
104 her- he would walk her dogs- their dogs

RC asks Dee what “stopped her from doing anything” (line 89). Dee’s response is to say that she “became (1.0) totally unempowered by the disease (1.0) it overtook her whole reason for living (1.0)” which also invokes the notion of the loss of control. Rather than personalise her account to Sandra, Dee introduces Sandra’s husband and implicates his actions as a contributory factor to her inactivity. However, Dee would not want to be heard as accusing Sandra’s husband of having contributed to her illness and counters this with some sensitivity by saying that he “would have suited me in a way” (line 94) but then discounts this by claiming that she is “not that sort of person”. Dee is doing some identity management here in that she is implying that she is an independent and responsible person, because “not being that sort of person” is indexed to Sandra’s husband “who made it very easy for her to negate her responsibilities.” This is a rather strong accusation implying that Sandra is not to blame for “negating her responsibilities”. However, Dee has already provided reasons for
this in that Sandra was "totally unempowered". This makes available the contrasting options for PWC, that they can allow the disease to take over and remove any sense of responsibility, or they can be empowered, be in control and 'get feisty'.

Dee is providing two versions of how to manage cancer. Potentially alternative versions of a social reality might be relevant in two ways. The first is where the analyst might be able to imagine how an account could have been different. The second (and more empirically tractable) is where the participants themselves attend to those alternatives (Horton-Salway, 1998).

Dee describes what Sandra’s’ husband did to “negate her responsibilities”. Not only was Sandra “unempowered” by the disease, but she was also “unempowered” by her husband’s actions, in that “he took over everything” (line 100), all the mundane activities, “the shopping”, “the chores” (line 99) that Dee has earlier claimed provided her with a sense of normality (extract 7:1.1). In doing this, she presents Sandra as not having any choice, that it was not her fault because “the NEED for her to do these things was taken care of” (lines 101 and 103) by her husband. Dee is careful not to overtly blame Sandra for her condition and she manages this by introducing Sandra’s husband who is described as taking the responsibility away from Sandra. This also provides an additional explanation of Dee’s state of “wondering” about Sandra’s first response in contrast to the second time around.

Dee’s initial description of Sandra could be compared with one of the most contentious areas of cancer research, that there is a relationship between personality type and a predisposition to cancer. Hans Eysenck and others have suggested there is a cancer-prone personality (Type C). This personality type has certain characteristics: reacting to stress with either helplessness or hopelessness; being passive, appeasing and repressing their emotional reactions (Eysenck, 1990; 1994).\textsuperscript{17} It is not that we might suppose Dee to be

\textsuperscript{17} Eysenck (1990) quotes a turn of the century doctor, Sir William Osler, who wrote in 1906: “It is many times more important to know what patient has the disease than what kind of disease the patient has.”
familiar with Eysenck's theories, rather that both Dee and Eysenck (and others) are drawing on ideas about relationships between psychological states and medical conditions, that are part of both medical and common sense discourse. In this case, common sense discourse has the advantage, given that Sandra's response was not fixed and consistent as personality theory would predict, but (in Dee's account) varied sharply between first diagnosis and relapse. Second time around, despite being given an even more serious diagnosis, Sandra is apparently positive, 'feisty', and 'coping' much better.

Clearly these are issues not just for analysts, but are displayed as participants' concerns. We do not actually know whether or not Sandra has gone through a change of personality or attitude: we only have Dee's account. But the interesting thing is Dee's account of all this and how she provides a 'before and after story' as a way of constructing the importance and possibility for anyone, no matter whom, of adopting a positive attitude: "if she had done things differently, what would have happened?"

As previously noted, the stage of someone's illness will produce variable accounts. Being positive can be very difficult, as Gen reports in extract 7:1.6-7:1.8. Unlike Dee's account, Gen directly invokes the words 'positive attitude' and 'fighting spirit' and, throughout the extracts, she is constantly being accountable to these moral prescriptions.

At the time of the interview, Gen was in her mid forties, married and had an eleven-year-old daughter. She was also extremely poorly and at times found it difficult to talk. Gen was originally diagnosed with breast cancer and had a full mastectomy but later she received a terminal diagnosis because the cancer metastasised to her bones, her lungs, and eventually her kidneys. She died in 1997.

Throughout this interview, Gen talked about the importance of having a positive attitude on numerous occasions. I have chosen these three extracts out of many possible choices to show how much a participants' concern this is, (even for someone in such an extreme state of ill health), and to highlight the dilemmas for
someone who is in severe pain and struggling to perform just the minimum of
everyday activities.

Extract 7:1.6 Gen 11/01 “I don't have a positive attitude”

| 6 | Gen | *I don't have a positive attitude* |
| 7 | RC  | you don't have a positive attitude, no (1.0) |
| 8 |     | but you have had one |
| 9 → Gen | *If I had a positive attitude I could (.) I'd probably recover |
| 10 |     | (1.0) I can't do it (5.0) just (.) the odd glimmer (.) I get the odd |
| 11 |     | glimmer (3.0) hhhhh and then somebody stamps on the ol' |
| 12 | RC  | fingers and back we go down the hole* (3.0) |
| 13 |     | right |
| 14 | Gen | always (.) I thought last week last week I thought I'm not |
| 15 |     | going to let it happen this time but it did (6.0) it's very |
| 16 |     | frustrating (2.0) |

Not being able to be positive is a concern Gen often addresses and holds herself
accountable for. In extract 7:1.6, she is denying that she has a positive attitude
(line 6). RC reiterates Gen's claim but displays some previous knowledge of Gen
that she has had a positive attitude. Gen's response to this attends to the idea
proposed by some researchers and therapists that a positive attitude aids
recovery (Hay, 1988; Simonton et al 1978).

Gen is expressing her belief in this doctrine, in that she equates a positive
attitude with recovery (line 9). Her account for not being positive is not that she
rejects the advisability of it, but that she is unable to comply: she "can't do it". She
does get the "odd glimmer", that sometimes she can be positive, but then
dramatically, "somebody stamps on the old fingers and back we go down the
hole" (lines 11-12).

The implication here is that every time she manages to do something positive,
something else happens. The "back down the hole" denotes that this occurs
frequently, and the image of a hole conjures up a notion of despair and hopelessness, that she is in the dark, and possibly falling.\footnote{Jefferson (1989) claimed that the 'standard maximum silence' after which a speaker will resume talking is about one second. Note that silences or long pauses normally denote difficulties and sensitivities in knowing what to say or they are used by interviewers in a more strategic fashion. As Houtkoop-Steenstra (2000:39) notes "just like continuers, silences may be used as an alternative to an explicit request for more talk or a different answer". However, throughout this interview Gen is not feeling at all well and many of the pauses are in part because she is finding it physically difficult to talk at times.}

In extract 7:1.7, Gen addresses the issue of variability, of not being able to be positive and the difficulties for her of trying to do normal things.

Extract 7:1.7 Gen 11/02 “I've been very negative this week”

1   RC   I mean how do you feel about things now?
2   →   Gen   I've been very negative this week (1.0) terrible (.)
3                      but last week was a lot better
4   RC   umh
5   →   Gen   I ca- find it very hard to answer these, once I got started on
6                      my tapestry I was feeling qui(hh)te ple(hh)ased with
7                      myse(hh)lf (4.0)
8   RC   so that cheered you up? (4.0)
9   Gen   I think it was the idea that I had a positive thought that had
10                      cheered me up really
11   RC   umh hhh
12   Gen   rather than, like you're, like other people you know (.)
13                      staring at the television or whatever
14   RC   yeah
15   →   Gen   I wanted to do something more creative
16   RC   yeah
17   Gen   which I thought was positive and that cheered me up (.)
18                      rather than the actual activity (3.0)
19                       (…)  
19   Gen   what is difficult is to get a positive life for you rather than cheer
20                      yourself up
21   RC   umh (1.0)
22   →   Gen   not to have impossible goals (1.0) like me, to jump in the car
and park outside CWC\textsuperscript{19} and climb up all the stairs and all that

I mean it's impossible (5.0)

RC umh (4.0)

Gen but I did manage to go round two fêtes last weekend

RC well exactly

Gen but then I've been poorly ever since so what do you do?

RC and- and you went to the seaside?

Gen oh yes, the second time was a lot better than the first

RC yes, so

Gen didn't feel half as bad that day (2.0) could have done(hh)ne without

the kids

RC ha ha ha (2.0) well it er, I mean I er

Gen but it is possible to- to lighten the mood, it is possible

RC yeah (2.0)

Gen but it doesn't happen often

Gen is accounting for not being positive, which of course is an orientation to 'positive' as the normatively expected and desirable way to be. It is not her condition that is described as "terrible" (line 2), but her attitude: she has "been very negative this week", but "was a lot better" the week before. Doing small things is the key, getting "started on my tapestry", but again there is the normative orientation: it was not that activity per se, but positivity itself that cheered her up: "it was the idea that I had a positive thought" (line 9). The nature of what counts as positive is produced by way of a contrast with the passivity of "other people you know" that stare at the television. In contrast, Gen "wanted to do something more creative" (line 15) and again it was the thought of being able to do it rather than the actual activity that cheered her up. At this point (line 18) positivity is interrupted by Gen not feeling well and needing to rest.

I have already noted that 'inability accounts' are routine ways of orienting to normative requirements, when those requirements are not met, such as when declining an invitation (Drew, 1984). In this and other ways, being positive is treated by Gen as something morally required of her. She constructs what being positive is for her, and it is about getting "a positive life for you" (line 19) and "not

\textsuperscript{19} Gen is referring to the offices of Coping with Cancer, (CWC) a self help support Group.
to have impossible goals" (line 20). She goes on to describe the recognisably mundane activities of getting in the car, and climbing some stairs, but for her at this point these things are "impossible" (line 21). Having managed (as an instance of being positive) to "go round two fetes", any further exertions along those lines have been prevented by being "poorly ever since".

RC co-operates in Gen's self-depiction, as inclined to be positive if only she could, by inviting a further instance of it: "and you went to the seaside?" (line 29) which reminds Gen that "the second time was a lot better than the first" (line 30). The reference to the "kids" (line 33) also implies that it would have been even better if the "kids" had not been there, which also displays Gen's difficulties in achieving her goals. So, from moving from an avowal of being very negative, at the beginning of the extract, Gen goes on to account for the extent of her efforts and constraints. Positivity is strongly endorsed, in that the only reason Gen is not positive is that she cannot be.

In extract 7:1.8, Gen deals with being accountable in terms of what kind of person she is.

Extract 7:1.8 Gen 11/03 “there must be a fighting spirit in there somewhere”

1    RC but I mean in the time I've known you I think your positive
2    → attitude has been absolutely incredible
3    Gen this is a joke (2.0)
4    RC well
5    Gen I'm the most negative person everyone's ever met they're
6    → always telling me (2.0)
7    → RC I've never found you like that
8    Gen in fa(hhh)ct er Claudia, Claudia says to me that
9    RC [I've found you negative at times but I mean to say, aren't we all
10   → Gen [she thinks it's absolutely amazing
11   RC who says to you?
12   Gen my homeopath, Claudia
13   RC oh
14   Gen somebody as negative as I am (1.0) has lasted this long (1.0)
RC is again providing support and encouragement by upgrading Gen's positive attitude in extreme terms, as "absolutely incredible" (line 2). However Gen counters this with extremity in the opposite direction: declaring it as "a joke", and describing herself as "most negative person everyone's ever met" and (using a further ECF), that "they're always telling me". The disagreement between RC and Gen is basically supportive of Gen, in that what RC is doing is the normatively 'preferred' thing to do with self-deprecations, to deny them. Again, this hinges on positivity being normatively preferred. The argument continues as an exchange of ECFs, with RC asserting that she has "never" found Gen like that. Gen recruits a corroborating witness, Claudia (lines 8 and 10), whose own version is produced as extreme ("absolutely amazing", line 10), and RC again uses extreme expressions on her side: "aren't we all" (line 9).

Although Gen is constructing herself here as non-positive in the extreme, the important feature for our purposes is that this is done in a way that strongly orients to positivity being what is normatively and properly required. Indeed, RC's efforts to resist Gen's negative versions of herself are orientations of the same kind. In recruiting Claudia to her side, Gen subscribes to the notion that a positive attitude is important to recovery: Claudia's view being that it is amazing Gen has "lasted this long", where the sheer fact that she has done so must indicate "a fighting spirit in there somewhere" (line 15). So in the very course of defining herself as negative in the extreme, and even as having put up a "front" (line 18), Gen manages to powerfully endorse the importance and value of being positive and at the same time introduces a sense of irony here, "but you only see the front (...) or did, when I had one" which points to the reality that she has had a full mastectomy.

In fact, Gen was the only one of my participants who continually produced accountability for her inability to have a positive attitude and I have included
these extracts here to emphasise how some participants might struggle with this, especially at times of feeling very ill.

The above analysis has emphasised how the cultural expectations of PWC being in control, of 'coping', 'fighting' and doing being positive are accomplished as participants' concerns. My analysis shows how Dee actively attends to the expectation of being positive, while at the same time, she also attends to the danger of being heard as judgmental, an object of pity, or as someone who cannot cope. In extracts 7:1.6-7:1.8, Gen displays that being positive is something variable for her, and she struggles to maintain a positive attitude and directly makes the link between a positive attitude and recovery. This analysis has shown that doing being positive is not always possible, and that the moral judgements overtly and covertly displayed by others, add an additional burden for the PWC to manage.

Doing being positive is handled in talk as an accountable matter, and is constructed using the contrasts of the active-passive stance, of taking an active role and continuing to do mundane activities, or of succumbing to it and doing nothing. The analysis produces an interesting contrast to the notion that being positive, is simply good psychological advice; it can be counter productive. In doing being positive, participants have to explain, make excuses, justify and deal with the issues of blame and moral accountability that accompany it. They have to manage the dilemmas it produces, of not being seen or heard as someone who is being negative, to be pitied or not 'coping'.

In part two of this chapter, the analysis looks at how laughter and humour are used as another resource that participants draw on to display doing being positive in difficult situations.

7:2 Seriously funny: Looking on the bright side

Laughter and humour are integral parts of everyday life but are not usually topics associated with potentially life-threatening illnesses such as cancer. However in
this section, the analysis shows how participants display *doing being positive*, by invoking laughter and humour.

Traditional psychological research and folk theories of laughter and humour claim that laughter is a discharge mechanism for the release of emotions (Koestler, 1964; Morreall, 1983); that it is an emotional release that helps to reduce tension (Freud, 1905, 1966); that it can act as a defence mechanism that provides an outlet for escaping from negative feelings such as anger (Fay, 1983), and that it offers a diversion and a distraction (Erdman, 1993). Some traditional studies have noted the overall benefits of laughter and humour when talking about troubles and illness (e.g., Coser, 1959, 1960; Ruxton, 1988; Smith-Dupré, 1992).

However, until Jefferson (1979) pioneered the study of the organisation of laughter in conversational interaction, laughter had merely been noted as having occurred, and traditional theories were applied to explaining it. Jefferson proposed that close attention to precisely how and where laughter occurs reveals it as a systematic activity that can be studied in its own right, and as an interactional resource. Subsequently a number of studies have identified laughter and humour as useful interactional tools in problematic situations (e.g. Chapman, 1996; du Pré, 1996; Glenn, 1989, 1995; Haakana, 2001; Holt, 1993, Jefferson, 1979, 1983, 1984b, 1985b; 1988, Jefferson, Sacks and Schegloff, 1987).

Laughter can signal many things; it is not always connected to humour and quite often, nothing particularly funny or humorous is going on. Laughter and humour are not necessarily only ways of managing emotions, but they are resources for managing a number of issues. A lot of laughter emerges from on-going interaction much of which is in the form of social play, expressed in vernacular terms such as kidding, punning and joking, and typically are not thought of as being associated with narratives about potentially life threatening illnesses.

However, it is also possible for people to use laughter and humour toward more serious goals. Costain, Schou and Hewison (1998, 1999) noted that the humour in a community cancer clinic often focused upon serious issues, and that
humorous remarks and banter provided an opportunity for serious issues to be aired, without the speakers being heard as making a direct complaint. Mulkay (1988) suggests that one way participants can incorporate potentially disruptive elements within their discourse, without actually causing disruption, is to present them in a humorous or ironic way. Similarly, forbidden topics and meanings can be introduced in a safe, indirect way (Crawford, 1995).

Jefferson (1988) found that people recounting 'trouble' stories make light of the trouble and often joke and laugh in the telling. Holt's (1993) conversational study suggests that talk about death announcements involves collaboration by both speakers, and that when speakers are giving bad news they often take a positive stance towards that news and end up evaluating bad news positively, or 'look on the bright side'. In a study on conversational laughter (Chapman, 1996, the author of this thesis) showed that laughter in talk about cancer is organised in some interactional detail, and oriented to managing potential interactional dilemmas.

In a CA study of recorded conversations between PWC and the medical profession in a breast care centre, du Pré (1998) analysed what she terms 'laughter-coated complaints'. She found that laughter-coated complaints are frequent, identifiable episodes in which a 'complaint' is mutually managed as something to laugh about. She suggests that cues emerge about why some complaints are managed as serious and some as 'laughables'. Note however that Du Pré's data was obtained in a medical setting. She notes that such institutional settings involve what she terms 'benevolent hurting' or 'for your own good' discomforts, and demonstrated that 'complaints' were managed in a playful rather than serious way, which gave rise to many "complaining-with-out-really-complaining behaviours" (du Pré, 1998:167, italics in original).

Although some of the CA studies have looked at how laughter manages interactional difficulties, and can be used to 'coat' complaints in the medical setting, I suggest that the use of laughter and humour are even more complex than this and perform a number of additional functions. The following analysis brings together the notions of doing being positive and the use of laughter and
humour. I show that their use is designed not only to manage problematic issues surrounding talk about sensitive issues for both the PWC and the recipient, but can also head off a number of potentially problematic issues such as: not to be seen as self pitying; being seen as someone who is in control, that they are 'coping', and despite their pain, discomfort and problems they are not overtly making a complaint. I also look at how the rhetorical construction of the narrative attests to presenting a plausible, credible self or identity; of 'being normal', and how potentially alternative interpretations are countered. The analysis shows how laughter and humour not only manage the identity of the PWC as looking on the bright side (doing being positive), but also help manage the delivery of potentially hearable complaints (see also Chapter 5 on complaining and blaming).

What is laughable or funny in illness narratives often occurs when a topic that may encroach on forbidden or taboo territory is talked about. So, the issue for participants becomes how they manage to talk about awful situations without recipients constantly being placed in an embarrassing or awkward situation where they are unable to adequately respond, beyond saying 'oh my god', 'how dreadful', or 'poor you' which, as shown in Chapter 6, could be received as unwelcome responses.

My data also shows there are three kinds of interactional laughter. The first kind is when participants report events and invoke laughter (see extracts 7:2.1-7:2.3). The second is when participants are reporting events where laughter occurred, and is again going on in the telling (extract 7:2.4). The third kind of interactional laughter is when participants talk about and construct their own meanings of what laughter is doing for them (extract 7:2.5).

The Analysis

Extracts 7:2.1-7:2.3 are from Sara's narrative about a day in radiotherapy. I want to focus on how Sara manages two moral difficulties in making what sound like complaints. Firstly, she works against being seen as the sort of person who is self-pitying; and secondly, in extracts 7:2.2 and 7:2.3, despite being burnt as part of the treatment, she shows how she is not a person disposed to
complaining. Throughout this narrative, Sara actively voices her thoughts, feelings and emotions several times. They could be hearable as self-pitying, or as the adoption of a complaining attitude, but on each occasion, she works against these possible reflexive interpretations about herself.

Extract 7:2.1 Sara 15/19 “one day (. ) when I went to radiotherapy”

<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sara So er uh (. ) yeah (. ) I- I er- work helped me a lot (. )</td>
</tr>
<tr>
<td>2</td>
<td>being able to go back out to work y'know</td>
</tr>
<tr>
<td>3</td>
<td>but at- at times I did feel a bit low and felt a bit down</td>
</tr>
<tr>
<td>4</td>
<td>and I thought to myself (0.2) .hhh</td>
</tr>
<tr>
<td>5</td>
<td>oh why should I feel like this when you know er</td>
</tr>
<tr>
<td>6</td>
<td>these- these nurses and they are fighting so hard</td>
</tr>
<tr>
<td>7</td>
<td>y'know especially (. ) one day (. ) when I went to radiotherapy and</td>
</tr>
<tr>
<td>8</td>
<td>I was lying there to have my treatment and y'know</td>
</tr>
<tr>
<td>9</td>
<td>how they put you in these positions and although the treatment</td>
</tr>
<tr>
<td>10</td>
<td>only takes about twenty seconds</td>
</tr>
<tr>
<td>11</td>
<td>you've got to take about ![inaudible)]</td>
</tr>
<tr>
<td>12</td>
<td>RC umh it takes it about fifteen minutes</td>
</tr>
<tr>
<td>13</td>
<td>for them to get you in the right spot (. ) yeah</td>
</tr>
</tbody>
</table>
| 14   | Sara hhh hah ha ha ha ![inaudible through low murmuring laughter by Chloe, Sara and RC)]

I have previously shown how participants may talk about doing normal activities as a way of managing their illness (see Chapter 6) and Sara begins by saying that what helped her a lot was “being able to go back out to work” (line 2). But she then contrasts this: “at times I did feel a bit low and felt a bit down” (line 3). Although as someone with cancer it might be acceptable and legitimate for her to say how ‘down’ or how ‘low’ she was feeling, there is a social expectation that sufferers are not supposed to wallow or dwell on their suffering and participants attend to this when talking about it. If Sara describes herself as someone who is in a terrible, pitiful position, she risks being heard as self-pitying. Instead, she orients to this possibility and manages her account to avoid being categorised in that way.
She does this by providing an alternative explanation to distract from dwelling on her feelings. She tells how she thought, questioning herself: "why should I feel like this?" (line 4). This is a dialogical formulation of Sara's thinking, as if there are two people there, one asking the other what to do. Whatever else such talk about what she 'thought' might do, it serves to display her as challenging her own feelings and behaviour. In doing so, she manages to shift the focus of attention from herself to the nurses, by way of introducing a contrast account. She plays down her own problems by empathising with (and 'fighting') the nurses' cause, implying that they are the ones with problems to contend with, because they "are fighting so hard" (line 6).\(^{20}\) This works against any interpretation or judgement recipients that might make of Sara as self-pitying. Although she might feel that as someone with cancer, she is entitled to feel self-pitying, this is not how she presents herself.

To warrant this shift in attention, Sara recounts a story about one day when she went to radiotherapy (lines 7-8). She describes a series of events about the treatment setting-up process where it is the nurses who have the problems in putting them (the PWC) in the right position: "y'know they put you in these positions" (line 9), and appeals to common knowledge of this being difficult. Note also how Sara changes footing from "I" to "they" (lines 8-9), which helps display a sense of distance from the account of her being low or down, and further deflects any artifice or subjectivity on her part (Goffman 1979, 1981). It is also interesting that the footing indicates Sara as being passive: "I was lying there to have my treatment" (line 8) and that it is the nurses who are active, because "they have to put you in these positions" (line 9) which also helps build the rhetorical contrast of the nurses who were "fighting so hard".

Radiotherapy treatment is not a comfortable experience and as will be shown in extract 7:2.2, it can result in the skin being burnt. What is at stake in the telling of this account is that Sara could again be heard as self-pitying. But, in telling how

\(^{20}\) Sara is a nurse by profession so she could also be showing empathy for other members of her profession who are trying to do their jobs well.
"the treatment only takes about a couple of seconds," the introduction of laughter particles within the talk suggests that the force of what she is saying is not to be taken too seriously. The use of the word 'about' to describe the amount of time it takes for the treatment is imprecise, and its vagueness helps make the unpleasant fact about radiotherapy treatment less obvious (Wodak, 1989). RC displays some knowledge of how this process is performed and orients to the nurses' task saying "it takes it about fifteen minutes for them to get you in the right spot" (lines 12-13) which causes Sara to laugh (line 14). What is said next is not clear because Sara's laughter has acted as a trigger for Chloe and RC who align with this scenario as being laughable and join in with laughter.

Sara's laughter has provided a cue to indicate to Chloe and RC how they should appropriately respond. At the same time, Sara adopts a position that blocks any requirement for expressions of empathy, or awkward receipts of horror stories. It is presented as nothing much to make a fuss about, nothing to feel particularly pitiful or self-pitiful about, because the treatment itself only takes a couple of seconds. The laughter serves to deflect from this being anything to be concerned about. Again, the emphasis is on how it is problematic for the nurses, rather than for Sara herself.

So although Sara began by describing herself as "feeling a bit low and a bit down", rather than dwell on this potentially self-pitying state, she manages the receipts and reactions of Chloe and RC in two ways. First, she diverts attention toward the nurses' difficulties, and second, she starts to establish the treatment process as laughable. Sara manages to construct her own identity, as someone who is not self-pitying or complaining, by constructing and comparing herself with 'others', in this case the nurses, while she herself remains looking on the bright side.

21 It is interesting to note that participants often state the seemingly very brief moments of some treatment or medical test, but this is always indexical to the story. See also extract 7:2.5.
22 When laughter is signalled within speech it described as laughter particles and these are noted in the transcription by h's in round brackets. Voiced laughter itself is noted as ha ha hah hah or he heh heh (Jefferson, 1988).
In extract 7:2.2, Sara continues her story by describing the effects of the radiotherapy treatment.

Extract 7:2.2 Sara 15/20 “wh(hh)at am I getting all worked up for?”

29 → Sara and again I was being burnt I was er er my skin
30 → was all pee:ling and burnt up as well and I er umh
31 → I looked at myself and I thought (. ) o:::hh (0.2)
32 → I never once think (0.2) or say (. ) well
33 → oh why did it have to happen to me: (. )
34 → that never went through my mind (. )
35 → RC right
36 → Sara all- my aim wa::s (.2) where do I go from here (.)
37 → [to get it better .hhh
38 → RC [yeah yeah
39 → Sara and I looked and I thought to myself
40 → o:hhh my go:sh* er oh:: I was feeling so down .hhh
41 → and er I was rea(hh)dy to .hh break down .hhh
42 → and I looked at the poor nurses going back and forth (. )
43 → trying to get it in- the right- e:xa:ctly ri::ght (. )
44 → y' know before they can do anything and then
45 → they've got this thing- this on the er- this thing so they
46 → they can see exactly what's [happening on like a
47 → RC [umh
48 → Sara television thing y' know .hhh and I thought to myself (. )
49 → wh(hh)at am I getting all worked up for?

Sara now introduces another contender for complaint and self-pity. She tells us how as a result of the treatment, her skin was being burnt and “was all pee:ling and burnt up as well” (lines 29-30). Although Sara does hesitate “I er umh” (line 30), giving Chloe or RC an opportunity to enter the conversation and indicate some empathy for her situation, or to express how awful this must be for Sara, neither respond to this awful news.

Rather than continuing with any direct complaint about being burnt, Sara reformulates her interest in this account by attending to any reading of her being
heard as a complainer, by producing what Potter (1996) refers to as a stake inoculation. Although her skin is being burnt and peeling she manages to imply that Chloe and RC should not hear her as feeling sorry for herself, nor that they should feel sorry for her. They should think about those poor nurses. Sara is reproducing the same rhetorical narrative of active thinking here as in extract 7:2.1, lines 3-4, of how you cope with your own accountability and is presenting herself as a moral individual, but in a slightly different way.

She does this by directly countering such notions by saying, "I looked at myself and I thought (.) o:::hh (0.2)" (line 31). One possible continuation here is that Sara is going to say how awful she looked, and to display how sorry she felt for herself, but instead, she changes direction, implying that the future starts now. She displays one of the features of doing being positive, which is not to dwell on problems and difficulties. What she does say is "I never once think or say well oh why did it have to happen to me" and "that never went through my mind" (lines 32-34) dispelling any notion of being prone to self pity.23

At the same time Sara manages to dismiss a fundamental question often raised by people with cancer, "why me?", claiming that it is something that she has (in extreme, absolute terms) "never" thought. Sara confirms this by providing an upbeat positive stance that "all- my aim wa::s (.2) where do I go from here (.) to get it better .hhh" (lines 36-37). Again, the use of the ECF "all" maximises her position, and in contrast to "never", the distance between how she actually was and how she might have been. So despite her having cancer and being burnt, she does not invite pity, but instead she is the one who is doing being responsible, and doing being positive, directing herself unambiguously and totally to getting better, and to not feeling sorry for herself.

Even though Sara "looked and thought to myself *o:hhh my go:sh* er oh:: I was feeling so down .hhh" and that she was "re(hh)ady to break down .hhh" (lines 39-41), she again does not dwell on these feelings or invite pity; there are even

23 Sara attends to what Kleinman (1988) suggests is the problem of illness as suffering that raises two fundamental questions for the person who is sick and the social group: Why me? (the question of bafflement) and What can be done? (the question of order and control). See also Bury; 1982; Gotay, 1985)
laughter particles in line 41 to head this off. Instead, she produces another contrastive account of "the poor nurses going back and forth" (line 42). This offers the "poor" nurses as the ones deserving of sympathy; they are the ones who are, in the particulars of Sara's account, going through difficulties, and again this shifts attention away from Sara herself and plays down her own sufferings.

She builds up their problem, that they have to be precise in "trying to get it in- the right- exactly right" (line 43) "before they can do anything" (line 44). The imprecision of 'anything' allows Sara to imply lots of things without being explicit (Gastil, 1992) which also helps build on the difficulty of the task. Again, "anything" is not only vague but also an ECF, maximising the range of problems the nurses face, in having to get it emphatically "exactly" right, in which the "exactly" is being produced as a repair to her initial utterance "right" (line 43). These details show Sara's production of maximal contrasts as a worked-up or worked-at rhetorical feature of her talk.

Sara is able to further emphasise the difficulties of the task for the nurses by being almost dismissive of herself, as she "thought to myself, wh(hh)at am I getting all worked up for?" (line 49). The use of dialogical formulations, or active thinking, "I thought o:::hh" (line 31) or "I thought to myself..." (line 48) display how she was thinking at the time, how it actually was for her, rather than, say, interpretations she might be making now, post hoc, in the telling. Again, of course, what is being analysed is the current telling; there is no simple window here to what Sara actually thought at the time. These are interactional and rhetorical features of how narrative accounts are produced.

The rhetorical constructions produced in extracts 7:2.1 and 7:2.2 build a strong case for the nurses, and the significance of their getting it "exactly right", which becomes apparent in extract 7:2.4. Despite reporting that she felt a bit low, Sara contrasts this with the nurses' problems, produced in some detail and with various contrastive and maximising devices, and producing a positive take on anything that could possibly be hearable as self-pitying. She has also managed to avoid overtly complaining about her skin being burnt.

24 The use of "break down" resonates with the medical model, of something mechanical that needs repair and can be easily fixed.
However, it may yet be that not overtly complaining is the most effective way to make a complaint. By focusing on the nurses, conjuring up empathy for them and saying positive things about them, Sara effectively disarms any notion that she is disposed toward complaining. Yet at the same time, she is providing some hearable grounds for complaint, where a complaint is presumably all the more credible when it comes from someone not disposed to complaining (stake management again: cf. Edwards and Potter, 1992; Potter, 1996). The last thing you want if you are making a complaint is for the hearer to focus on you and think that you are a complainer; that you have got an interest or something at stake, a disposition or an axe to grind. What Sara manages to do here is to talk about something that is hearably complainable without indexing herself as a complainer.

The effect of her discourse is that Sara is not overtly complaining, although her narrative is full of complainable things. I suggest that the way she manages this is far more effective than if she did overtly complain. Making direct complaints would set her up as somebody who is emotionally involved, who is possibly not being objective and is looking for complainable matters. This would have the effect of indexing her dispositionally as a complainer, rendering any actual complaint the less credible. Sara is managing two sets of identities and motives at the same time; the identity of the actors in the narrated events (including herself), and the identity at issue, here and now, for herself as an 'interested' teller of events.

In extract 7:2.3, which is a direct continuation of 7:2.2, Sara provides another hearably complainable account of the effects of burning. However, this time, instead of deflecting attention to the nurses, the issue of skin colour comes to the fore, and again the humour and laughter permeating the account display Sara as not someone disposed to complain.

Extract 7:2.3 Sara 15/21 “with us it’s different”

50 → Sara and with us it’s different because with you when they mark
51 your skin (0.5) .hh you’re white (.).hh the- the black marks are
52 going to stay very well for a long time but my skin was beginning
53 to get darker and darker from the treatment
54 so it was getting near enough the same colour as the pencil
55 that they marked me with
56 Chloe [ha ha ha ha ha ha ha
57 Sara of course they had to work double hard to make sure
58 that those marks were still there
59 RC Couldn't they have used something like a
60 ye(h)low pencil or something?
61 Chloe [ha ha ha ha ha ha
62 Sara [ha ha ha ha ye:s that's
63 Chloe why didn't they use Tippex? I said to them ye:(hh)hs
64 Sara couldn't you use some Tippex.hhh ha ha ha ha y'know
65 Chloe hah [hah hah hah
66 RC [gosh(.) how extraordinary(.) I never thought about that
67 Sara [yeah, yeah
68 Chloe ((inaudible))
69 Sara and you know and that pulled me out again(.)
70 thinking oh these poor nurses

Sara continues to avoid making any direct criticism, blame or complaint about the nurses or the treatment, and there are a number of important features in this extract, which show how she does this. She refers to 'us' (line 50) indicating Sara and Chloe's racial category membership: "with us it's different". Sara constructs her own (and Chloe's) black identity by contrast to RC: "when they mark your skin (.5) .hh you're white (.).hh the- the black marks are going to stay very well for a long time" (lines 51-52). Sara has raised a potentially controversial and sensitive issue, relevant to treatment and its effects: skin colour and the difference between RC being white and 'us' being black. Despite RC not herself being a PWC nor having her skin marked in this way, she serves here as a co-opted representative of the group of white cancer patients, via "with you" (line 50).
Neither Sara nor Chloe explicitly talk about being black, but it is reflected in the contrast between skin colour and emphasises how being black is relevantly different:

52 Sara ((...) but my skin was beginning
53 to get darker and darker from the treatment
54 → so it was getting near enough the same colour as the pencil
55 tha(h)t th(h)ey mar(h)ked me with

This again could be hearable as an incipient complaint, or where someone could say that because she is black, she is expressing a feeling of being victimised. But again, she manages any such possible judgement by introducing laughter particles (line 55) signalling that however awful this might sound, it is nothing to be serious about.

Clearly, it would be inappropriate to laugh at or in the face of another’s tragedy, but Chloe has some entitlement to join in here. She has already been identified as a member of the same group as Sara, as someone with cancer and black. Chloe aligns with Sara’s description by beginning to laugh, joining in with and overlapping Sara’s description (line 56). Note that RC, who is relevantly white and does not have cancer, does not join in with the laughter at this point. As Sara continues, her talk is imbued with laughter particles, and again she talks about her difficult experiences in terms of the problems that the nurses have. Because of her skin getting darker, “they had to work dou(h)ble ha:rd to make sure that those marks were still there” (lines 57-58). At this point RC asks: “couldn’t they have used some:th(h)ing like a ye(hh)llow pencil or something?” (lines 59-60). RC identifies the nurses as ‘they’ suggesting a different category membership but now orients to the irony by introducing laughter particles into her talk, affiliating with the laughter that first Sara and then Chloe have produced. RC’s practical suggestion about what to do with black skin receives laughter responses from both Chloe and Sara (lines 61ff) such that any potentially delicate race issue, or complaint on those grounds, is headed off by laughter and irony. Sara follows RC’s suggestion with agreement and builds on the irony of the situation, and the words are again imbued with laughter: "ye::s that’s wha(hht) I
sa(hh)id to the(hh)m .hh why didn't they use Tippex?" (a white correcting fluid used by typists) (lines 62-63). Again, this invokes even more laughter from both Chloe and Sara. Sara is reconstructing a painful past event here in the present, as something laughable now.

Once the laughter has subsided RC remarks “gosh (.) how extraordinary (.) I never thought about that” (line 68). Her suggestion that the nurses might use a yellow pencil also categorises the nurses as possibly being white, like RC, and implies that ‘they’ had not thought of this either. So, despite her own troubles, Sara identifies with those of the nurses, of them having to use a dark pencil on her burnt, dark skin, and how much harder it made it for them. Any notion of Sara being self pitying or complaining is again contrasted with the nurse’s struggle. The sympathy is focused on them rather than Sara herself, who if anything was cheered up by their comical plight: “that pu(hh)lled me out again, thinking o::h these poor nurses” (lines 71-72).

In extracts 7:2.1-7:2.3, Sara could be categorised as a victim on two accounts. First, she has cancer and is being burnt (possibly to an unnecessary extent) by the radiotherapy treatment; and second, that being West Indian disadvantaged her, the black pencil used to mark the point of radiation treatment being appropriate for a person with white skin, and failing to show up properly on hers. However, through the way she tells the story, including the precise location of her laughter, Sara emerges as someone being positive in the face of adversity.

Sara manages the sensitive issue of race without invoking any form of prejudice or victimisation, while her use of laughter and irony indicate to the other participants how they should hear the story and appropriately respond to it. Although she does not indicate that she was laughing at the time (beyond suggesting the use of Tippex, lines 65-66), clearly in the telling the irony produces the scene as laughable. (See extracts 7:2.5 and 7:2.6 and Chapter 8 for other uses of laughter as a resource participants draw on in difficult situations).
The potential problems of accountability, of blaming or complaining are complex. Sara manages rhetorically and persuasively to talk about and account for potentially troubling events, without being categorised as someone who is a pitiful victim of her circumstances, who is self-pitying or a complainer. One way Sara accomplishes disarming the notion or perception that she may be complaining is to disguise any hearably complainable account by introducing laughter and humour. This effectively indicates that these are not matters to be concerned about or to be taken seriously, while nevertheless she provides details that suggest avoidable discomfort and adversity. She also deflects attention away from her own circumstances by constructing comparative accounts of others (the nurses) who she implies have more to struggle with and complain about.

The laughter and irony throughout enables Sara to 'have her cake and eat it'. It manages interactional difficulty for the speaker in the current telling, providing the hearer with a way of responding to a tale of troubles. Secondly, it manages the indexicality of the speaker, as a long-suffering but cheerful 'coper' with events. Rather than being disposed to complaining, on the contrary, she can laugh it off, praise and sympathise with the nurses, see the humour and play down her own suffering. Irony and humour make her story tellable while managing its otherwise available repercussions on both teller and recipients. Additionally this helps with the story's factual credibility because it is not just a moaner's gripe, but a story from someone not disposed to complain. So the irony can, ironically, reinforce rather than undermine the story's facticity.

There is also an underlying moral theme throughout these extracts, which Sara attends to throughout: that is, she is heard as someone who is managing and 'coping' with her illness by doing being positive and looking on the bright side.

In extract 7:2.4, laughter is a prominent feature of Bee's encounter with the medical profession at the time of receiving the news of their diagnosis.
Extract 7:2.4 Bee 13/02 “I was a demonstration model”

Extract 7:2.4 precedes Bee’s account of receiving the bad news of her cancer diagnosis (see Chapter 5:2.7). What is interesting here is how the use of laughter and humour deflect from this being simply a bad news story, and how Bee places herself in a position of control. She says that she found out that she was “a demonstration model”, a term that Bee, and then Jan, laugh over (lines 50-52). The impression produced is that Bee is not bitter or angry about being treated as such an object. In fact, she uses this notion to create the ironical scene she goes on to describe. She builds the image of the accompanying entourage as being a cast of “oh thou(.hh)sands” and as she makes it clear later on, the purpose of the visit of the lecturer was to tell her the outcome of her operation. Bee’s voicing of the lecturer’s words are full of laughter, “you wouldn’t .hh ha reme:(hh)mbe(hh)r m(hh)e .hh [ha ha ha]” (lines 56-57). Bee is displaying the irony of the situation. The implication is that Bee was not supposed to know who he was or what he was there for. Her laughter throughout is also in
anticipation of what follows, and Bee says "I knew th(hh)en" (line 59) implying that she had inferred what he had come to say. She then goes on to warrant her knowing, and the irony of it, by saying "he brought them all round my bed .hh and I think he brought them (. hh) to show (. ) er how (. ) to tell you that you've got cancer" (lines 64-65).

Bee is indicating that she knows about the difficulties the medical profession have in breaking bad news. It would be easy to depict the scene as devastatingly clumsy, depersonalising and insensitive, and of course, that possibility has to be available in the details of what Bee provides. Yet the combination of being a demonstration model, with "thou(. hh)sands" of students surrounding the person responsible for telling the news is cast as a laughable situation, especially as later on Bee maintains her control over the situation by pre-empting his news, by saying to him "oh it was cancer then" (see Chapter 5, extract 5:2.7).

Here the laughter and the presentation of a situation as comical are used to show that, despite being treated as an object, and in spite of the lecturer's inability to break the news in anything like a sensitive or efficient manner, Bee is able to show a sense of control over the situation. Again the laughter displays Bee as managing the receipt of bad news by doing being positive, while again off-setting any difficult interactions from either Jan or RC.

Sometimes participants laugh when they are telling their accounts, and sometimes they orient to it and make laughter a feature of their talk. Extract 7:2.5 displays an interplay of laughter between two situations, the one being reported and the situation of the reporting itself. The laughter is being performed as part of the current telling, but it is also being voiced as having occurred at the time of the reported events. In extract 7:2.5 Jo is telling a story about when she was in hospital for her biopsy, and again, like radiotherapy treatment, an obviously unpleasant experience.
Jo: I went into see the consultant he said right well obviously I'll make an examination now and he said I need to take a biopsy. 

RC: Did you tell him that?

Jo: Yes, and he said I promise it won't hurt and I said I've heard that before.

RC: [laughs] Jo: well no just laughing but I mean it was done in jovial mood.

Jo: anyway so I'm up on the couch, stripped off again. 

RC: Was there anyone else in the room?

Jo: No, no just me. 

RC: =which is an eternity but it's an eternity.

Jo: But at the time it's an eternity.
Jo has already seen the radiologist who has confirmed that she has a lump and the consultant has said that he needs to take a biopsy (line 2). Jo produces the notion that the length of the needle is excessively long. The laughter featured in this extract appears in the words as Jo speaks them (lines 4-6). But, clearly, this is not self evidently a laughing matter because Jo tells us that she has a "dread of needles" (line 9). The alternative way to deal with this would be for her to get upset and recount other stories of her "dread of needles", but by using laughter Jo manages to lighten this revelation and heads off any requirement for sympathetic noises from RC (who is, after all, conducting a research interview).

Jo reports asking "does it have to be that long" (line 8) and then reveals that she has "this dread of needles"; so we are given both a serious and a jocular way of hearing Jo's plight. Both these elements, serious and jocular, are available in the description of the needle as excessive: "very long" and "exceptionally long", both descriptions being laughed through in their production.

Jo reports the consultant's response as making her a promise, "he said I promise it won't hurt". Jo's response is ironic, both in its jocular delivery and also in its orientation to the doctor's reassurance being unrealistic: "I've heard that before I says you'll forgive me if I doubt your word" (line 14). A contrast between quoted versions, and the reality they purport to describe, is a standard feature of irony (Wilson and Sperber, 1992). The ironic delivery manages a potentially problematic feature here, given that Jo is doubting the expert's reassurances, such that the laughter helps to avoid blaming the consultant for knowingly hurting her and providing false expectations. Not only is Jo describing this event and seeing the funny side of it now, she is also saying that although she was doubting the consultant's words, any potential criticism is again deflected because she reports that at the time "we were laughing but I mean it was done in jovial mood" (lines 15 and 17). The mutually shared "jovial mood" and laughter works to ease not only the interaction with the consultant at the time, but also the retelling of this story to RC. Jo then describes how the consultant prepared her: "he put some stuff which presumably numbs the area" (line 20). But Jo's dread of needles is described in visual
terms, a matter of seeing the size of it, so she describes herself as "looking at the ceiling going oh" (line 22) but then again produces laughter. It is not known whether she was laughing just so at the time, but again, in the telling, the laughter accentuates the scene as one that was laughable, because she was "doing anything...to try and distract myself" in the anticipation of being "stuck with this needle .hh" (lines 24-25).

Jo then describes what it was like when the needle went in:

27 Jo ((...)) er I said er well talk to me well say anything
28 while you're doing it because I'm going to leap off the bed and go
29(.) and he said oh come on it's not going to be that bad
30 ha ha anyway o(hhh) it was (.) ha ha that ba(hhh)d ha ha
31 it hurt umh and it went on for a good three or four seconds

Despite her reporting that the consultant said, "I promise it won't hurt" (line 12) which she had doubted at the time, Jo then invites the consultant to contribute to her distraction and "talk to me". She produces an extreme description of her possible reactions, in that she is "going to leap off the bed and go" (line 28) which underlines her "dread of needles" and serious concerns about being hurt. Although the consultant provides reassurance that "it's not going to be that bad", this is soon displayed as mere reassurance rather than accurate description; but again Jo laughs off any potential that provides for criticism: "ha ha anyway o(hhh) it was (.) ha ha that ba(hhh)d ha ha" (line 30). Clearly Jo was right all along, and the consultant wrong. Jo's laughter fends off what might otherwise be heard as a complaint about what was clearly a painful event for her, one that "went on for a good three or four seconds" (line 31). Although this does not sound on the face of it like a particularly long time, Jo starts to say that it was longer than it might sound (line 32). But, before she can finish, RC picks up her drift and provides it in the form of a heavily upgraded ECF: "it's an eternity", which Jo echoes. This final exchange nicely shows RC and Jo in harmony on both the seriousness of her painful experience, and also its ironic description.
The function of the "jovial mood", at the time of Jo's concern over the size of the needle, and the use of laughter in the telling of how bad it was, heads off any sympathetic or pitying responses from RC. It provides for RC's hearing of Jo's story as both serious and uncomplaining. It also enables Jo to make light of something that was traumatic at the time, rather than display herself as someone who is dwelling on her suffering.

Another feature of laughter is that it is referred to explicitly as something participants do. In extract 7:2.6, Amy is talking about the importance of laughter in the hospital environment.

Extract 7:2.6 Amy 04/02 "you laugh about it"

1 → Amy I used to make the others laugh in hospital
2   RC yeah
3   Amy about the awful conditions (.)
4   RC so then and now
5   Amy umh
6   RC yeah
7   Amy but people don't know how to take it, y'know
8 → some people think you ought to be sitting there looking miserable
9   (. ) so when you sit there saying >I burnt my bum on the
10   radiator (.)< that's stupid (.) y'know you've got a tiny little
11   toilet there hh and you're having to wee in a jug and all the
12   awful degrading things that you go through y' know but er
13   RC umh
14 → Amy people think it's awful but when you're in there with others
15   (.) you laugh about it
16   RC umh
17 → Amy because you do don't you, you're all in the same boat really
18   RC yeah
19   Amy and if you didn't you'd probably be sitting there crying all
20   the time so
21   RC yeah, yeah
22   Amy it depends who you've got in there with you really (1.0)
Amy's description of laughter includes various features of what I have been analysing here, based around its functional nature for PWC themselves, as a way of 'coping' with "awful conditions". There is also the thing it works against, the contrasted negativity of "sitting there looking miserable" (line 8) implying that "sitting looking miserable" is an inappropriate and inactive response, and aligning laughter with being positive. Her example of the indignities of the treatment environment has a comical, almost slapstick quality of its own: "you sit there saying I burnt my bum on the radiator" (lines 9-10), where "you have to wee in a jug and all the awful degrading things that you go through" (lines 11-12).

Amy generalises what 'people' think (line 14) implying that these 'people' are not in the same category as Amy and invokes category membership here by saying that "when you're in there with others (...) you laugh about it" (lines 14-15). Thus laughter is held to build relationships and support among sufferers, where laughing together and at each other's difficulties becomes a supportive act, "because...you're all in the same boat really" (line 17). Again Amy attends to how laughter functions for her, as a contrast to misery, as positive rather than negative: "if you didn't you'd probably be sitting there crying all the time" (lines 19-20). However, laughter is not universally applicable, always or for everyone: "it depends who you've got in there with you really" (line 22).

So for Amy, laughter is a multifunctional resource which can be drawn on, for making others laugh, to cope with the physical indignities, and it is also a way of building relationships which can manage interactional difficulties with others "in the same boat". It is those kinds of normative notions of the functions of laughter that Jo, Bee, Sara and Chloe were orienting to in their production of laughter as a feature of situations and reports of them. Whereas Amy can offer a kind of folk theory of what laughter does, my analysis has added some richness to those ideas by examining some actual deployments of laughter and irony as a feature of talk itself and as a way of doing being positive.
Summary

The analysis in this chapter has shown that participants attend to doing being positive, in two different ways. Firstly by doing being normal and secondly by looking on the bright side and invoking laughter, humour and irony into accounts of what could be potentially disruptive and interactionally difficult to manage.

The cultural expectations placed on the PWC of being in control, of ‘coping’, ‘fighting’ and doing being positive are accomplished as participants’ concerns. Despite the variability in being able to be positive all the time, participants display their accountability to such expectations and attend to the moral judgements that are overtly and covertly displayed by others. The analysis also reveals an interesting contrast to the notion that being positive, is simply good psychological advice; it can be counter productive. In doing being positive, participants have to explain, make excuses, justify and deal with the issues of blame and moral accountability that accompany it. They also have to manage the dilemmas it produces, of not being seen or heard as someone to be pitied or not ‘coping’. One way this is achieved is by using contrast structures of the active-passive stance, of taking an active role and continuing to do mundane, normal activities, rather than succumbing and doing nothing.

Laughter and humour can be invoked to divert attention away from descriptions of awful situations, which might place recipients in the embarrassing or awkward situation of not knowing what to say or how to respond. It also helps to manage the delivery of potentially hearable complaints (see also Chapter 5 on complaining and blaming). Additionally laughter and humour are an interactional device for fending off difficult interactions. The analysis showed how three kinds of interactional laughter were displayed, whereby participants reported events and invoked; reported events where laughter occurred, and was also pervasive in current the telling and that participants talked about and construct their own meanings of what laughter is doing for them.

Doing being normal and the functions of laughter and humour are participants' concerns, and accounts are constructed to display their meanings and function,
rather than those of the analyst. At the same time, the rhetorical construction of these accounts manages issues of identity and participants display that they are doing being positive and looking on the bright side rather than being seen as someone who is self-pitying, a complainer, or succumbing to their illness.

In Chapter 8, the final analytical chapter, the topic of analysis is how participants talk about death and dying, and again, the notions of being positive and laughter and humour are recurrent features.
Chapter 8
Death and Dying: Whose Dilemma?

Introduction

Alongside managing complaints and identifying themselves as doing being positive, another obvious domain of participants’ concerns was the realisation that their life may be shortened, and that they might die. Part of cancer’s horror is its association with being given a ‘death sentence’ and, although current rates of survival are much higher, for many, cancer still equates with death. As noted in Chapter 2, talking about troubles such as death and dying is generally recognised as a sensitive and taboo topic. This final analytic chapter looks at how participants talked about death and dying.

Most CA studies analysing talk about death and dying are comprised of institutional data obtained from doctor-patient communications and counselling sessions, and for the most part focus on how the delivery of bad news or death announcements are organised and produced by medical and counselling professionals.

Lutfey and Maynard’s (1998) study of breaking bad news in oncology examined how physicians and patients talk about death and dying without using those words, and examined how a terminal prognosis was ‘unpacked’. They analysed how the role of talk and interaction is embedded in the processes of death and dying, a strategy attuned to Longhofer’s (1980) neglected argument that dying is a social process better understood in the context of interaction and communication than as the internal and inherently progressive stages described by Kubler-Ross (1970). They noted that whilst counsellors often seek to encourage their clients or patients to talk about dreaded issues, they found that physicians not only solicit specific kinds of talk from their patients, but also seek to inform them about their illness trajectories as a way of revealing the bad news.
Bor and Miller (1988), Bor, Miller, Goldman and Scher, (1993) and Peräkylä (1995) have examined how professionals counselling AIDS clients address "dreaded issues" such as death and dying, deterioration, pain, separation, and loss, with a view to providing a better understanding of the interactional difficulties counselling professionals face in asking future-oriented hypothetical questions. Silverman and Peräkylä's (1990, 1995) work on AIDS counselling suggests that 'dreaded issues' talk trades off the hypothetical future possibilities, the serious things that may happen to the patient in the future.

These studies have mostly focussed on the medical or health professional's instigation of the topic or how the news was delivered and responded to. Despite focusing on the interactional features of such talk in institutional settings, studies of how the PWC reports these events and talks about death and dying are hitherto absent from CA and DA research.

**The Analysis**

Throughout this thesis my analytical concerns have been with what and how PWC talk about their illness. Some of the issues being managed when they talk about how they received the bad news of a cancer diagnosis have already been discussed in Chapter 5. However, I now want to focus on a somewhat different set of concerns. The words 'death' or 'dying' appear at different stages throughout the interviews and mostly (with one exception) are in descriptions of events other than diagnostic accounts. This chapter focuses on when these topics arise, how participants manage the morbidity of a potential death sentence, and how they talk about their mortality.

The topic of death and dying was always one that participants introduced themselves, rather than it being a question scheduled or raised by RC. It is interesting to note that participants attend predominantly to issues of life and living rather than death and dying per se; there is a noticeable lack of morbidity and confrontation with the process of dying, but rather their talk attends to the old cliché of 'carpe diem', and (as we have seen) thinking positively and optimistically about living. When talking about the possibility of death and dying,
participants' concerns are managed not just in a positive way, but they also orient to a 'hypothetical future' (Peräkylä, 1995). The talk is not done in any direct or 'head on' way but rather it is conducted in generalised terms, idiomatically, or as something laughable. On occasions, it is introduced as a device to formulate or rhetorically construct an aspect connected with some other concern. Thus talk about death and dying is framed as being a motivation for life.

The analysis explores the following themes:

8:1. Other peoples' dilemmas and the canonical script
8:2. Resisting doom and gloom
8:3. Life goes on: Negotiating living
8:4. Anticipating death
8:5. A deviant case: "Am I going to die?"

8:1 Other people's dilemmas and the canonical script

In extracts 8:1-8:4, the analysis reveals another set of participants' concerns to be managed when the topic of death and dying occur in the talk. In the four extracts analysed, two are reflexive accounts of interactions with and about the medical profession, and two relate to 'people' who represent the generalised 'other'.

Extract 8:1.1 is taken from the beginning of the interview with Jan and Bee. RC has just been talking about her brother who had been given a terminal cancer diagnosis.

Extract 8:1.1 Jan 14 03/31.5 "a pot- po- potential .hhhh de(hh)ath sent(hhh)ence"
16  RC  It's difficult for them, as well as the person that they are having to
17  tell
18  Jan  Yes, that's right
19  Bee  Oh it is
20 → Jan  .huh well I mean .huh how can you tell someone that er
21  you've got er- got er a pot- pot- potential .huhh
22  de(huh)ath sent(huh)ence .hh ha ha ha which .hh is
23  what people equa(hh)te with ca(hh)ncer hh isn't hh it? (.)
24  Bee  Ye::s
25  Jan  rightly or wrongly
26  RC  Yes
27  Bee  I think they hold back ever such a lot (.)
28  Jan  u::mh (0.1)
29  RC  So you think they hold back?
30  Bee  Ye::s (.) they wait for you to prompt them (0.2)

Jan's response to RC's story about her brother is to pick up on the doctors' difficulties: "how do you break the news to somebody" (line 12). The category "somebody" is already generalised and impersonal, Jan extends this theme with "realising that to them it's just one in thousands" (lines 12-13). This casts it as a general problem for doctors, even though the frequency and generality of having to deliver bad news make it part of their everyday experience. Bee, RC and Jan concur (lines 14-19).

It is in this context of agreeing about doctors' generalised difficulties that Jan introduces the topic of death (lines 20-23). She introduces it, therefore, not as a matter of any particular person's actual death, but as a cultural idiom (for a generalised "you", line 20) that need not be grounded in reality. The term 'death sentence' is itself idiomatic, a metaphor derived from courtrooms and criminal punishment. Jan produces it with further irony via some precisely located interpolated laughter (line 22), coupled with the disclaimer that it is "what people equa(hh)te with ca(hh)ncer hh isn't hh it?" (line 23), followed by "rightly or wrongly" (line 25). So, "death" is introduced in an occasioned, generalised, and ironic manner, and with regard to problems for the doctor rather than patient. Note how the metaphor "death sentence" exaggerates (again, as part of the
irony) the doctor's responsibility. Judges, who pass real death sentences, are not just telling but deciding that someone will die. In fact, the idea that doctors are giving a death sentence is somewhat of a contradiction, in that they are supposedly there to save lives, not to pronounce death. So, the idiom of a "death sentence" enhances the talk's topic, the problematic nature of telling people they have got cancer.

The way Jan talks of death also handles reflexive implications for herself. By in part disclaiming this cultural script, of telling someone they have cancer and it being a death sentence, she can, whilst orienting to this, position herself as being outside of the category of either someone who thinks like that, or as someone who may die of cancer. By thus orienting to the expected cultural script that accompanies the receipt of a cancer diagnosis, and to the difficulties for the medical profession in telling someone they have cancer, Jan manages to resist talking about her own personal and specific experiences or associations of cancer and death. At the same time, her ironic delivery and laughter works against any potential uptake of talking about death as a serious topic for this interaction. (See Chapter 7 for other uses of laughter when talking about sensitive issues).

Indeed, rather than continue the talk about death and dying, Bee's uptake on this is to say how the doctors manage their difficulty of presenting bad news. She says, "they hold back" and "they wait for you to prompt them" (lines 27 and 30). Note that both Jan and Bee treat death as relevant and on the minds of the doctors; not just absent or unconsidered. The implication is that it is actively repressed. By holding back, this places the agency and responsibility onto the patient to ask any further questions. Bee is commenting on the reluctance of the doctors to talk freely when giving a diagnosis, and that they wait to be prompted rather than offer information.

This is a reversal of the expectation of the patient being a passive agent in the medical encounter and leaves agency and control actively with the PWC (see extract 5:2.7). If they do not take active agency and 'prompt' the doctors with questions when they are given the diagnosis, the implication is that they are not
likely to be informed about their diagnosis and likely prognosis, or specifically, its death relevance. Interestingly, Bee's observation is supported by the work of Lutfey and Maynard (1998), who suggest that resistance or acceptance of delicate topics is an interactional achievement. So, if it is the PWC who is left to prompt the doctor to talk, then this is one way in which both the doctor and the PWC can display reluctance or resist talking about death.

A considerable amount of research has looked at the difficulties that arise in doctor-patient communication when delivering bad news from the viewpoint of the medical profession (see Chapter 2). Doka (1993) suggests that the increasing recognition, that not talking about dying has negative effects and that dying people need and want to talk about their condition, has produced a significant change in medical practice. He suggests that most physicians are now much more open in their communication with dying individuals and their families. He suggests that even though physicians do not generally volunteer or initiate discussions of prognosis, they will respond honestly to patients' questions.

It has been reported that telling someone they have cancer is problematic for doctors because of the anticipated suffering this is likely to cause the person who is receiving the news (Gordon and Paci, 1997). This is also a common sense expectation that Jo alludes to in extract 8:1.2. Lutfey and Maynard similarly found that the delicate topic of a PWC's terminal illness was approached with caution not just by physicians, but by patients and their families.

What is of particular interest in this analysis is how participants show their awareness of these problems, and orient to the difficulties experienced by the

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1 A doctor explaining why he never explicitly communicated the diagnosis of cancer to a patient said: "Without a doubt, there is difficulty on my part, and I think for everyone, in giving a sentence. I have difficulty in making someone suffer, in causing someone sorrow, a dispiacere, that I can cause when I tell him...[The patient] can understand everything, but I didn't say it, I didn't give it precisely the official stamp...The patient wants to have the confirmation [of the diagnosis]...But this confirmation is difficult to give, because it closes everything, closes all possibility, hopes, hope to participate in life, in everything. If he knows there is no more hope...it removes all possibility of living a period more serene, more tranquil, from a person in the very moment when he needs that instead of knowing the truth" (Gordon and Paci, 1997:1439).
doctors. Sometimes they produce explanations as to what is occurring or is being managed when the doctor does not engage in interaction and 'holds back'.

As has been shown throughout, one way participants manage to head off delicate and sensitive issues relating to themselves, is to invoke the difficulties of the medical profession or of others who are engaged in social interaction (see also Chapter 7).

Jan's ironic, idiomatic invocation of cancer's association with death prefaced her going on to tell the story of her own struggle and identity as someone who was not necessarily going to accept that cliché as true, but rather, she could then display a positive stance. One interesting feature is that Jan does not talk in any direct way about herself dying, (unlike in extract 8:5.1) nor of what it would be like. She shows her concern for others and talks about death and dying in general, emblematic and idiomatic terms. In this way, she is able to voice general concerns about death and dying rather than attending to her own problem of having cancer and the possibility of her own eventual death; it could be understood therefore as another way of doing being positive.

Talking about other people's problems, and invoking cultural scripts, are devices that participants use to generalise what is or may be happening to them. In extract 8:1.2, Jo, who has been given a terminal diagnosis, also talks about the difficulties for the doctor and formulates why it is difficult for them.

Extract 8:1.2 Jo 02/04 “it’s a very difficult job for a doctor”

1  RC  umh, what about umh, do you think the medical profession
2                                  as a whole understands your needs er since you've had your
3  Jo  I think they're getting better (2.0)
4  RC  umh
5  Jo  it’s a very difficult job for a doctor still [to have to tell a patient
6  RC  [umh
7  Jo  that she's dying (2.0) y'know that they can't do anything
9  Jo  because it goes against their whole (.) cre: dos isn't it
RC asks Jo whether "the medical profession as a whole" understands Jo’s needs. This is a generalised way of asking the question, one that avoids a requirement to cite specific individuals. Jo takes a few seconds before replying that "they’re getting better" (line 4), which takes up the generalised mode of talking, and nicely alludes to complainable matters that at this point have been previously discussed between RC and Jo, while managing to say something positive. By displaying an understanding of the difficult “position” doctors are in, that they "can’t do anything" (line 8), Jo can point to what is wrong without overtly blaming or complaining; situational accounts (“position”), and inability accounts (“can’t do anything”) are standard discursive ways of avoiding attributing agency and blame to people (Edwards and Potter, 1992). Jo goes on to provide an explanation of what makes it especially difficult for them: “because it goes against their whole cre: dos” (line 9). This appeals to common knowledge and the standard definition of what doctors do, where, over and above any difficulties that the general public might have in delivering such announcements, "being a doctor is to save lives" (line 11). For a doctor, announcing someone’s impending death can be regarded as a failure (Stacey 1997). Any doctor making such an announcement may have to work at being merely one of Goffman’s (1979) ‘animators’ of the message, rather than being responsible for it.

By voicing the doctor’s problem of telling a patient that she is dying, Jo, like Jan and Bee, is also invoking the cultural script of cancer equating with death, but again, she does not directly address her own potential death. Instead, she refers to the difficulties that others, and people in general, face: “to tell a patient that she’s dying”, where the relevant category is “a patient” rather than any particular person, or even Jo herself. It is a problem for doctors per se, dealing with patients per se, which is what makes it understandable. Again, in displaying a recognition of doctors’ difficulties, Jo also shows reflexively that she is an understanding person who can relate to other people’s problems and not necessarily dwell on her own, despite her own problem, as the PWC in question, being obviously far worse than that of the person who only has to tell her about it.
Extract 8:1.3 shows that, rather than the person with cancer having negative associations with their illness, it is again ‘people’, the generalised other, who adopt the negative cliché that cancer equates with death.

Extract 8:1.3 Kim 05/01 “they think we'll lie down and die”

1 Kim well the thing is er I mean er some people as soon as you
2 mention the word cancer, they think we'll lie down and die,
3 not me, you know hahh hahh ha
4 no they'll have to catch me walking (. ) standing
5 hahh hahh hahh hahh hahh

Kim again uses the contrast of what ‘some people’, a proportion of the population at large, think, irrespective of whether or not it is true. The expression “some people think” serves as a preface to denial; it sounds strange to imagine someone saying “some people think X... and they’re right!” Indeed Hutchby (1996) has examined cases where what other people “think” is formulated in contrast to a preferred version of what is actually the case. Kim also uses it as a device to resist such thinking, and by using laughter also displays that this thinking does not apply to her. Again, by talking about other people’s ascriptions of cancer, it enables participants to introduce the topic at a ‘safe’ distance. Another device is to invoke the cultural cancer script. The reference to “some people” is a non-specific category, but one that does not necessarily include what everyone thinks and is therefore a softened rather than extreme generalisation, robust against exceptions to it (Edwards, 2000). It also implies that those people are not cancer sufferers, and enables Kim to construct a rhetorical position to contrast what might be expected of her. Her response to what some people might think reflects a denial of the association of cancer with death; it may be cultural knowledge, a common assumption, but it does not fit the facts as they apply to Kim. Kim thus contrasts herself against common expectations. She is not going to passively lie down and die, like a canonical cancer patient. She is going to be active and heroic, in the face of any such expectations: “they'll have to catch me walking, standing” (line 4).
Note also the use of idioms here that signal the humour and resist dwelling on the morbidity of death: "they'll have to catch" her. The use of laughter (lines 3 and 5) also helps in the construction of the irony of lying down to die. "Lay down and die" is itself a cultural cliché, and contrasts with the comic scenario of Kim being pursued down the corridors of the hospital (lines 3 and 4) "they'll have to catch me". Kim is laying down the gauntlet, being defiant, heroic. The implication is that if Kim is active, this averts the passivity of what might happen if she lies down. Agency reverts to Kim (line 3). What she actually talks about is living, not dying, and by constructing this rhetorical opposition of agency, that she is different from what "they think" and expect, she displays herself as someone who is doing being positive.

In extract 8:1.4, Ann also produces an account of what some people think and expect, and resists it as not relevant or acceptable to her. Like Jo in extract 8:1.2, Ann provides an explanation for the difficulties that 'people' have to manage when they encounter someone with cancer.

Extract 8:1.4 Ann 09/05 “there is light at the end of the tunnel”

47 RC So (.) why do you think er (.) she found it er difficult then
48 or she couldn't look at you or
49 [why do you think she crossed the road?
50 Ann [well I think because she er- its that is sheer ignorance of (.)
51 people with breast cancer, she- she doesn't realise,
52 she probably thinks that when you've got breast cancer
53 no matter how bad it is (.) you're gonna die with it anyway
54 → so she couldn't fa::ce me (.) she trea::ed it as if it was a-
55 it was a bereavement (1.0) you know an- and umh er
56 I think it was just because of her ignorance (.)
57 she didn't realise that yes there is light at the end of the tunnel
58 RC so er she didn't know what to say to you?
59 Ann no, no she was embarrassed by it (3.0)
Another difficulty someone with cancer might face is how to manage the associated stigma\(^2\) that often accompanies the disease. In this extract, Ann is recounting the behaviour of a neighbour. Prior to the beginning of the extract, Ann has just been talking about a particular friend who found it difficult to talk to her (see Chapter 6 extracts 6:2.8 and 6:2.9).

RC asks Ann whether she has any explanation for her neighbour's avoidant behaviour "that she couldn't look at you" and asks why "she crossed the road?" (lines 47-49). Ann prefaces her response with "well I think" (line 50) indicating that she is about to say something that is speculative and possibly negative. Indeed the problem "is sheer ignorance of (. .) pe:ople with breast cancer" (lines 50-51). The term "sheer" defines the ignorance as profound or extreme. People without breast cancer are not privileged to know about the disease, such that their only resort is the cultural cliché that having cancer means death, that "no matter how bad it is (. .) you're gonna die with it anyway" (line 53), which produces an inability to "fa::ce me". In invoking ignorance rather than, say, lack of sympathy, Ann constructs the neighbour's reaction as normative, understandable, and not particularly blameworthy. The comparison to a "bereavement", another social scenario that provides for interactional difficulties, again directly invokes death.

The use of the expression "light at the end of the tunnel" (line 57) is an uplifting metaphorical contrast to other idiomatic expressions we have seen (see Chapter 6) that do not feature here, such as "doom and gloom" and going "back down the hole". The "light at the end of the tunnel" produces images of moving forward towards life and a future, a very positive image, by which Ann can resist the darker cliché of cancer and death. RC acknowledges the gloss on other people's difficulties, by re-formulating Ann's inability account ("she couldn't face me", line 54) with one of her own: "she didn't know what to say to you?" (line 58).

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\(^2\) Matheison and Stam (1997) found that people spontaneously mentioned what they categorised as 'stigma-related issues' during their interviews, despite the fact that a question about stigmas was never asked. As one patient commented, she felt as if she had 'leprosy' and was no longer "part of the human race". One woman recently diagnosed with breast cancer acknowledged that the issue of stigma (Matheison and Stam's term) finalised her decision not to tell her friends she had cancer because she "couldn't have run out to my four best friends and said, I got it girls, I got the Big C".
Ann then provides a further psychological gloss (in addition to ignorance) on the neighbour's problems: "she was embarrassed by it" (line 59).

Ann, like Jo in extract 8:1.2, is thus able to say what is wrong with her neighbour's reaction whilst at the same time not complaining or blaming her, at least overtly (there remains scope of course, though Ann does not develop it, for blaming people for being ignorant). As with the doctors, the neighbours get it wrong as well, but they do so normatively and understandably, and neither Jo nor Ann is disposed to blame them for it.

The above analyses have shown how participants define the difficulties faced by the medical profession of giving a cancer diagnosis, and their use of a common sense cultural script of how 'some people' equate cancer with death. It shows how participants manage this cultural expectation, that cancer equals death, by using common sense and normative ideas rhetorically, as points of contrast for displaying themselves as different from normative expectations, and as disposed toward positive (optimistic, coping, resisting) thought and action.

8:2 Resisting doom and gloom

In extract 8:2.1, we see how participants can resist any inappropriate notion of doom and gloom by formulating and attending to how they would prefer 'people' to respond to them. There are a number of interesting features in the extract, which again build on the uses of a rhetorical contrast against how 'they', the medical professionals, might have behaved. Whereas in extract 8:1.2 Jo was talking about the difficulties for the doctors in telling a patient she was dying, in extract 8:2.1, whilst recognising this difficulty, she now formulates how she wants the medical profession to behave.

Extract 8:2.1 Jo 02/05 "they could have been a bit more up-beat"

12 Jo and it's very what I've noticed is
13 that the people that have had to deal with me I.e.
14 in oncology (1.0) and palliative care (2.0)
15 → umh I think they could have been a bit more up-beat (2.0)
At this stage, Jo has been given a terminal diagnosis, and announces that she has “noticed” something when she comes into contact with the “people” in oncology and palliative care that have to deal with her (lines 12-14). The term “noticed” conveys this as a casual observation of some kind, rather than, say, something that Jo was looking for, or wanting now to make a big fuss over. Despite the fact that she is dying, she suggests that “they could have been a bit more up-beat” (line 15). Jo’s rather gently delivered complaint (the thing she has “noticed”) employing the idiom “up-beat” (lines 15 and 23), contrasts with the more expected idiom for people dealing with death and dying, “doom and gloom” (line 25). Idioms may can be introduced into a conversation possibly ironically or as a piece of ventriloquism by the very person who later goes on to resist it (Kitzinger, 2000). Again, overt blaming is avoided, not only by Jo’s merely “noticing” these things, but also by her overt recognition that “obviously it’s not a pleasant job for them” (line 18). She now formulates a positive suggestion, that
the medical profession who, having taken on their role and thus inherited more responsibility for their conduct than might be expected from, say, friends and neighbours, should "handle that job (1.0) in a more positive up-beat manner" and that they should "deal with it" (lines 22 and 23).

What is interesting and ironical here is that Jo is countering the notion of positive thinking being the onus of the cancer patient herself, which was explored in Chapters 6 and 7. Here Jo is demanding that when she goes to "these places" (line 24), meaning the hospital, that the medical profession set the tone by being positive too. She explicitly does not want to see them with "doom and gloom on their face" (line 25). As Kitzinger (2000) suggests, the use of idiomatic terms in the formulation of a complaint can represent their egregious character more powerfully than circumstantial detail can. Idioms are often designed to close a complaint sequence (Drew and Holt, 1988). However, it appears that they can not only open and close a complaint sequence but they can also be resisted and countered, and may even be produced as idioms, precisely in order to be discounted as clichés, or as "what people think" (cf. Kim in extract 8:1.3).

If we include negative descriptions of peoples' actions as 'complaints', even when the speaker is working to display themselves as not wanting to be critical (see also Chapters 5 and 7), then complaints also appear throughout PWC's accounts when the topic of death and dying is invoked. Complaints made to RC about the medical profession are best understood as what Sacks (1992) called 'safe' complaints, being made in a conversation where some affiliation could be assumed.³

³ Sacks has made numerous references to complaints and has defined the notion of complaints as 'safe' and 'unsafe.' A 'safe' complaint "is formulated as such a thing as any member of that category could say about that other. The 'safe' phenomena, according to Sacks "would have different characteristics depending on how the given population were to be formulated... 'Unsafe' complaints occur when co-members formulate a complaint, which other co-members do not make. Since speakers occupy multiple category positions, an unsafe complaint can easily occur in instances when the listener is 'too knowledgeable' concerning the topic of complaint. To guard against possible objections and challenges from co-members, who hear complaints as unsafe, complainants may actively engage in stake management" (Sacks, 1992: 597-600).
As noted in Chapter 5, many complaints do not merely reflect peoples' true attitudes towards the object or person in question, but rather, work to elicit particular interpersonal reactions from others, such as sympathy or approval. Parsons (1951) suggested that when someone is ill they may complain about their state of ill health, not because they actually feel sick but because the 'sick role' allows them to achieve secondary gains, such as the avoidance of aversive events or sympathy from others (see also Leary and Miller, 1986; Smith, Snyder and Perkins, 1983).

Kowalski suggests that a more appropriate conceptualisation of a complaint is that it is “an expression of dissatisfaction, whether subjectively experienced or not, which has a purpose, to vent emotions or achieve intrapsychic goals, interpersonal goals or both” (Kowalski, 1996:180). Such psychological-motivational explanations are beyond the remit of discourse analysis (Edwards, 1997), but they help point to the functional and interpersonal nature of complaints as something other then merely the expression of a speaker's single best judgement.

Jo's complaint is connected with the perceived inadequacies of the medical profession, and she is saying that she does not want them to feel sorry for her. Throughout this extract Jo is building a critical account of their interaction, whilst at the same time she provides a contrast account whereby she acknowledges that "it's not a pleasant job for them" (line 18). Sacks notes that the construct "a piece of praise plus 'but', plus something else may be routinely employed to do complaining" (Sacks, 1992: 360). However, in this instance, this construct is reversed and Jo proffers a complaint before expressing an understanding of their difficulties, which may signal praise. However, her display of understanding helps rather than undermines the force of the complaint. It works by reflexively displaying that Jo is objective, considerate, and reluctant to complain.

4 The best known outside sociological approach to illness is Parsons' "sick role" originally formulated in 1951, expanded in 1952 (Parsons and Fox) and reiterated in 1975. The 'sick role' is defined as a person's inability to satisfactorily carry out his or her normal roles so that a period of relief from everyday duties is allowed.
In doing this she manages not only to make a complaint about the interaction that occurs between the medical profession and herself, but by continually building a rhetorical contrast against what we might call the 'biological reality' of the situation, Jo is also able to position herself as doing being positive. She is "not walking around with doom and gloom on my face" (line 27) and she does not want to see "doom and gloom" even though "they may be feeling sorry" (line 29) for her. She dismisses this and makes a claim for normality. (This is particularly noticeable in a further complaint in lines 31-35. See also Chapter 6 extract 6:4.5).

Jo continues by saying she prefers "to see a happy smiling face" and that "they can say oh how are you" (lines 31 and 32). She implores that, "just" because she is dying, this is not sufficient grounds for them to treat her differently, not to greet her or to ask her the normative greeting of "how are you?" She does not talk about her dying; what she is making topical is how people should say "hello" to her, and that they should ask her how she is, as they normally would with anyone else. In defining the type of support she requires, Jo defines appropriate behaviour, that people should maintain a cheerful and optimistic demeanour. The object of her complaint is the medical profession's inability to address her in a normal way. Through making 'safe' complaints, talking about the failings of the medical profession to RC, and in a hedged and merely "noticing" manner, Jo is able to construct herself as someone who is different from normative expectations. The focus of attention is more on the medical profession than on herself, such that she manages to keep the topic of dying at arm's length. By talking about her troubles as being the interactional ones of dealing with other people's reactions, rather than dying itself, she manages to divert attention from talk about dying, and dying becomes incidental to the account. The rhetorical construction of her account reflexively produces an identity for Jo, that despite the knowledge that she is dying, she is someone who is doing being positive, via requiring positivity from others.

8:3 Life goes on: Negotiating living

Extracts 8:3.1 and 8:3.2 look at two different concerns when the prospect of death is invoked. Jo describes herself in terms of a general, normative
disposition in people to react in various ways, while Dee focuses on uncertainty. Both Jo and Dee talk about options they could take, but it is clear that the choices are difficult ones to make, where giving up or saying no to a harrowing regime of treatment are presented as conflicting with the values placed on life and living. Although both use idiomatic expressions of cancer equating with death, by talking about the "fight to live" and "I'm not going to let this beat me", they also negotiate alternatives and rhetorically construct their position as making informed choices, that they are in control of their lives, not the cancer. (cf. Chapter 7, extracts 7:1.2-7:1.5 when Sandra is reported as being unempowered and overtaken by the disease). Death is not talked about directly, but only alluded to via talk about living and living longer, and in terms of how, despite the possibility of life being shortened, the potential accompanying morbidity can be resisted.

In extract 8:3.1 Dee, who has secondary cancer, displays that there is a lot to consider.

**Extract 8:3.1 “the fight to live is huge isn’t it?”**

47 Dee I think the first time you’re (2.0) you’re in such a state
48 → that you- you go through blindly in a way
49 RC umh
50 Dee the momentum takes you, do y’know what I mean?
51 RC umh and then you don’t know
52 Dee [what’s coming and you don’t know what to expect
53 RC [and you have no knowledge of what’s coming
54 Dee and you- you don’t know the er- you don’t know what’s ahead
55 RC umh
56 Dee it’s a good job we don’t, but the second time (1.0)
57 you think, because I always said I wouldn’t have chemotherapy
58 again that was my (1.0) because I was asked at the last
59 chemotherapy by Sam, would you have chemotherapy again if
60 there was a five per cent chance that you would live longer (.)
61 and I said no there’d have to be a twenty per cent chance and
62 then I may consider it (2.0) but now, I wouldn’t say no,
63 I don’t know, I don’t think I would
Throughout this extract, Dee makes the point that there are difficult options to be considered, but expresses these in terms of choosing treatment. Dee has already experienced chemotherapy and is therefore in a position to make an informed choice; however, she is not morbid about it, she does not explain the physical discomforts of suffering, but talks about her concerns the second time round. She is able to contrast her previous knowledge, which she describes as not being able to see what is going to happen “you go through blindly in a way” (line 48). This implies that you can not see what is going to happen and that you do not have any control over the unknown, and “the momentum takes you” (line 50). The generalised ‘you’ denotes that it would be the same for anyone in the same situation (cf. Chapter 7, extracts 7:1.1-7:1.5). Throughout the extract, Dee relates her own experiences in terms of what anyone can be expected to do and feel. She went through it as anyone would.

RC aligns with this by highlighting the situation of anyone experiencing these things for the first time: “you don't know what’s coming” (lines 51-52). Dee picks up RC’s words and repeats or paraphrases them almost in overlap (lines 52-54), which is a way of acknowledging that RC is effectively voicing Dee’s own views on the matter. The slight alteration from RC’s “what to expect” to Dee’s “what’s ahead” nicely does that work, signalling close agreement while also displaying that these are Dee’s own thoughts, not just RC’s being echoed.

This focus on blindness or ignorance, on one’s first time through the treatment process, sets up a contrast with Dee’s current situation, of going through it all a
second time. There is an accountable matter here which is that, having been through the treatment and now knowing how awful it is, and indeed having consistently "always said" previously (line 57) that she would not undergo it again, Dee is now going through it all again. The account provided is that "the fight to live is huge" (line 67), and that this is something that is experienced only, or especially, when one's life is threatened (lines 69-71). Again, the account is a generalised one, a description of the human condition, "the fight to live". In accounting for her own particular experiences in terms of what anyone might experience, Dee effectively defines her own actions as not requiring any further explanation (cf. Sacks, 1992, on "everyone carries a gun", and Edwards, 1994, on the normalising functions of 'script formulations'). Dee's choice of whether to have further treatment is not merely a personal one, but one that anyone who had been through her experiences might be expected to make.

Having been offered a "five per cent chance" to live longer (line 60) she initially says no, "there'd have to be a 20% chance" (line 61) before she would consider this, but like Jo "you don't come to decisions overnight" (see extract 8:3.2a below). Dee is hedging about whether she would or would not say no, indicating that there is a constant dialogical negotiation going on. She has presented a hesitant account of what she would do, that it is still under evaluation. Note how she brings in a notion of the court room scenario, as with a 'death sentence' (see extract 8:1.1.) by laughingly saying, "I'm not sure hhhh hahh the jury's still o(hh)ut" (line 65).

The introduction of a jury resonates with evaluation, judgement, and consensus, that the decision is not just a personal one on her part. What decision Dee might take in the future is unclear, but she has opened up some scope here for going either way on it. The dilemma for Dee is that if she says no to treatment, there is a possible implication of giving up, not fighting, not being positive, and perhaps of being labelled unco-operative, and a 'bad patient'.

However, Dee offsets any such interpretation by seeking and obtaining collaboration from RC ("isn't it?", line 67; cf. "d'you know what I mean?", line 50, and the overlapped agreement noted in lines 52-54), and also by the
generalising expressions she uses throughout the extract (the uses of "you", and of formulae such as "the fight to live"). The "fight" to live, rather than merely, say the will to live, emphasises the powerful nature of the forces at play here, where even an awful and already-experienced treatment regime can accountably be undertaken a second time, in spite of earlier denials. Again, it is not death or dying that is being directly talked about, but concerns about treatment options, chances, and their relationship to living and living longer. Even the expression "you're not going to live much longer" (lines 70-71), is a way of talking about death in terms of life. Dee confronts the prospect of death by talking about the limitations on, and prospects for, carrying on living.

Excerpts 8:3.2a and 8:3.2b display many of the key concepts and devices that have been discussed throughout this thesis. They combine the notions of doing being normal and doing being positive, using devices such as rhetorical contrasts and a familiar language of cancer and an emphasis on the 'right' attitudes concerning how to live with a cancer diagnosis, which Jo glosses as "a frame of mind".

What is particularly interesting is how Jo leads us into talking about dying, and how she provides a sense of negotiating over time, and of how decisions are reached.

Extract 8:3.2a Jo 02/07a "if there isn't black you don't know what white is like"

11 Jo I mean as for me (2.0) and I don't think I'm anything (2.0) unique
12 (.) at all but the people I've met (2.0)
13 that are in the same position or worse
14 RC umh
15 Jo far worse have been so up and umh er positive and I've not met
16 anyone, I've not met a single person that has been on the down
17 side to it but er you know (.) all of us (.) y' know, well we all go to
18 bed at certain times of the night when you can't sleep
19 .
20 RC umh (1.0)
21 Jo that's normal, I mean its quite natural to sit there and think
oh well what if and what if and y'know
RC  umh
Jo  you're not necessarily being down and you're not
necessarily worrying overly about it but (2.0) you know
things will go through your mind (.) you'd be stupid not to think of
RC  umh
Jo  the possible down sides to life (1.0) but you have to think of	hose to then judge what you are going to do or what you- er
you know you have to think of (.)
I'm not going to be miserable (.) I'm not going to let this beat me
RC  umh
Jo  you have to think those things to then be a hundred per cent
positive about what you are going to do
RC  yeah, right
Jo  d'you see what I mean
RC  yeah, yeah
Jo  it's like if there isn't black you don't know what [white is
RC  [it's like a
perspective on something
Jo  totally
RC  yeah
Jo  y'know, but thinking these things and mulling them over
and y'know, it takes time
RC  umh
Jo  you- you er don't come to these decisions overnight (1.0)
and anyone that says they do is lying
RC  umh

Given the general requirement to be "positive" (line 15), Jo emphasises that she is just like everyone else, including people in a worse situation (presumably both terminal and suffering a lot of pain). Positive is universal, something for extreme case formulations: "all the people", "not... anyone", "not met a single person", "all of us", "we all" (lines 12-17) and later "a hundred percent positive" (line 34). As Pomerantz (1986) noted, and as we have seen in earlier chapters, extreme descriptions are used when rhetorical contrasts are being made. In this case, Jo is at pains to emphasise the strong positivity that she and others universally
maintain, in spite of the fact that they do not actually always feel positive. There are negative times too, which are also universal, things that "we all" (line 17) go through, as a generalised "you" (lines 18-19), thoughts that are both "normal" and "natural" (line 21). These are not just different from positive thoughts, but the very opposite, encoded by the conventional opposites "black" and "white" (line 38). The way that Jo accommodates this general negativity alongside a universal positivity is to include it as part of the same thing; without such negative thoughts, being positive would have no meaning. People need to have something to reject.

Throughout the extract, Jo works at normalising her situation, (as someone with a terminal diagnosis) that she is no different from anyone else. Thinking about things is something everyone else does as well, so she is the same as them. She then personalises her account saying what she is not going to do "be miserable" and draws on the canonical script, that she is "not going to let this beat me" (line 31). She is actively voicing her thinking and dialogical argument, that "you have to think those things to then be a hundred per cent positive about what you are going to do" (lines 33-34).

The detail "we all go bed at certain times of the night" (lines 17-18), when these negative thoughts occur, is interesting, in that it invokes a time when a person is alone with their thoughts, away from the daily routines where positive things are routinely done (e.g. shopping, taking the dog for a walk, see Chapter 7), and away from other people. Being positive is an effort of daily life and putting on a brave face is a kind of social duty, such that the time for negativity is when one is out of sight and alone, in bed at night, when dark thoughts can come crowding in. In the expression, "you don't come to these decisions overnight" (line 46), the term "overnight" now has a richness beyond its usual conventional meaning.

By dealing with positive and negative feelings in this way, as part of the same general and universal experience, Jo is able to strongly endorse the requirement for being positive, whilst at the same time she shows that it is something difficult that takes time. In Jo's construction, there is no white without black, no up without down, such that any dark thoughts that may occur are not merely
exceptions to being positive, but a key part of it. One important issue that Jo is dealing with here is the notion that being positive might be seen as just a sham, even a lie (line 47), especially as it is not possible to be positive all the time, or immediately, and that everyone will have negative thoughts when (emblematically) they are alone at night. Jo’s version makes room for the darkest of thoughts, and the enormous difficulties of being positive when terminally ill, as part and parcel of endorsing the virtues of positive thinking. (cf. Chapter 7, extracts 7:1.6-7:1.8). Rather than positivity being something that anyone can quickly adopt, it is something that has to be forged in time, by way of some bad experiences.

In the second half of this extract, Jo continues to display her process of dialogical negotiation and generalises about normal life expectancy, this time raising explicitly the prospect of death.

Extract 8:3.2b Jo 02/07b “it's a frame of mind”

49 Jo y'know I mean it's- it's the biggest thing that can ever happen to
to anyone (2.0) y'know we're all, we're born, we live and we die
50 RC =yes, it is now isn't it
51 Jo but you know the bit in between living and dying is
52 RC normally sort of seventy or eighty years=
53 RC umh, and then when you're told that half way through that period
54 Jo (. ) no it's not going to happen you have to sit back and think
55 RC umh (2.0)
56 Jo well okay what am I actually going to do with what's left
57 RC umh
58 Jo y'know, so you're not necessarily- I would not say
59 RC I've been worrying about it (. ) I've been thinking about it (. )
60 Jo umh
61 RC I've been thinking, what's the best thing to do
62 RC umh
63 Jo for everyone concerned but (5.0) it's a frame of mind isn't it
64 RC it's the attitude (. ) it's the character and the personality (. )
65 Jo it's very easy to tip the scale and be morose about it and
66 RC give in and give up and say ah well I'm going to die
Jo displays a philosophical approach to life and death, (lines 49-52) that it is something that happens: "We're all, we're born, we live and we die", but this is based on the normality of life expectancy "of seventy or eighty years". She then indirectly addresses that she has been given a terminal diagnosis having been told "half way through that period (.) no it's not going to happen" (lines 54-55). Her response to this is not doom and gloom, but she says again, that "you have to sit back and think" (line 55). It is not the 'sit back and think' of doing nothing, but it is one of being constructive and active: "well what am I actually going to do with what's left" (line 56). She is making a feature of 'thinking' and being positive, in contrast to the negativity of worrying (line 59) and activates her thinking "what's the best thing to do" (line 61). Theoretically, worry has been defined as uncontrolled, unwanted and an aversive 'cognitive' activity that is associated with anxiety, negative thoughts and a sense of emotional discomfort (Borkovec and Lyonfields, 1992). But worry can also have a number of purposes, such as generating ways of avoiding aversive events, aiding preparation and motivating change (Borkovec, 1994). Here (line 59) Jo cites "worrying" as a rejected, negative gloss on what she is really doing, which is, more positively, "thinking" about things.

For Jo, "worrying" connotes negativity and succumbing to death. In contrast, by "thinking" about it, she is being agentive and rational (rather than emotional: cf. Edwards, 1997 on the rhetorical uses of emotion words including "worry"), that she is endeavouring to work something out, to be positive, to make some decisions. Worrying is seen as a passive and negative emotion, whereas thinking represents the opposite: active, positive and cognitive, rationally in control, rather than succumbing to emotions.
Again, concern for others is a consideration: Jo links what to do "for everyone concerned" (line 63); it is not about what she has to do for herself, but about its effects on 'everyone'. Again, her own dilemma (line 61) is worked through in a generalised manner, indicating that what follows could be a response that can be applied to anyone. She says: "it's a frame of mind isn't it", which she unpacks further as "the attitude", and "it's the character and the personality" (lines 63 and 64). In speaking in general terms applicable to anybody, Jo avoids talking specifically about her own dying. "A frame of mind" is idiomatic and dispositional, and the voiced words “ah well I'm going to die [etc.]" (line 66) are offered, not as her own actual thoughts, but as a version of what anyone might say or think if not being positive about death.

Again, however, it is not death per se about which one (anyone) has to be positive, but rather, the life that remains: what she is "going to do with what's left" (line 56). Jo then offers a strongly worded version of the options available. She highlights that there is a fine line of balance, "it's very easy to tip the scale", "be morose", "give in and give up" (lines 65-66). The last agentive act is to give up agency completely, "I'm going to die well that's it I might as well die" (line 67). The implication here is that dying is a process, that it is something that is going to happen to you, rather than something which is actively done as a consequence of an action, and therefore there is nothing to be done about it. She offers a further option whereby she could succumb and give in, "it's very easy to be that way" (line 68). But, although giving up might be easy, she then counters this by presenting yet another contrast, "it's just as easy to say the opposite and say fuck em all y'know" (line 69).

What Jo is explicating here is that there are two main options she has to deal with. Firstly that the problem is a physical one; she is dying and can do nothing about it, which leads to the notion that she may as well just be passive and let it happen, give up responsibility and lose agency. This resonates with the discussion earlier in this chapter, concerning first reactions and what other people might think about what happens when you have cancer, that you lose agency, that you just "lie down and die", "it's a death sentence". Jo acknowledges that, but does so as a platform for promoting an alternative, that she can do
something about it. Jo's second option is that, regardless of what anyone else
may think, she has a choice, to reject the "very easy" path of no resistance, and
the cultural "death sentence" script allocated to cancer, by saying "fuck em all",
which of course is a contrasting script for resistance. So, her illness and
impending death throw up two contrasting moral ways of being, two recognisable
kinds of action, reaction and ways of being.

Interestingly Jo is treating agency as optional. She highlights her options in
relation to how she thinks about it, that some kind of personality disposition is the
key factor: "personality plays the biggest role" (line 72). So even agentively,
resisting passivity and making the choice to be positive is reliant on what kind of
person you may already be. Jo identifies herself as the kind of person who does
not give in (cf. Chapter 7, extracts 7:2.1-7:2.4).

What both of these extracts (8:3.1 and 8:3.2) show is that being positive about
life when you are terminally ill is not just a simple option that can be
recommended to people. It requires experience, coming to terms with things, a
period of time involving bad times and the ability, and disposition, to resist what
may at first seem hopeless. There is a continual negotiation of the past, the
present and the 'hypothetical future'. Jo draws on and challenges numerous
cultural scripts and presents herself as someone who is being very philosophical
(in the idiomatic sense) about her illness, and retains the agency to live. Sadly,
but in line with all that she acknowledged and knew, Jo died on 20th July 1998.

8:4 Anticipating death

Another way participants talked about death and dying was to speculate about 'if
it happens', and how they are going to manage it.

In extract 8:4.1, Amy is accounting for what happened when it was discovered
she had cancer. The issues at stake here are about not having long to live. In
Chapter 4, I analysed another extract from Amy's interview in which she revealed
that it took her doctors a considerable time before they actually reached a
diagnosis of cancer. She gave this interview some months after her operation,
so not only was Amy's diagnosis delayed, but the prognosis she was eventually given was also wrong.

Extract 8:4.1 Amy 04/03 “I want to go on my own”

1   RC    umh (3.0) who was the first person you told after you knew
2   Amy   (. ) about your diagnosis
3       I don't know because I think my husband told everybody
4   RC    yes, [they told- they told him (.) you knew afterwards didn't you
5   Amy   [it was different for me ((inaudible))]
6       yeah it wasn't like, y'know you usually go into a room (.)
7       you're shocked (. ) you go home and ring your mum or
8       somebody (. ) I was just in hospital and everybody .hh
9   RC    my husband had to go in and tell everyone
10  Amy   and he was the worst, he had to drive home (1.0)
11  Amy   and then tell everybody (1.0) an' everyone was ringing him up
12  RC    umh
13  Amy   I mean I still think he had it worse than I did [even now
14  RC    [do you know
15  Amy   what he told people?
16  Amy   I think he just said, she's umh (. ) had this operation (. ) and
17  RC    they've found out it's cancer and she hasn't got long to live (2.0)
18  Amy   that was it, that's what they told him, had him in a room,
19  RC    I mean he rung up he had an ((inaudible)) he said can I come
20  Amy   and see her and she said fine ((inaudible)) she had a sister
21  Amy   ((inaudible)) would you like to come and see her –
22  Amy   oh you'd better come in, we've been trying to get hold of you
23  Amy   and he said oh my god y'know and he went in and they just said
24  Amy   er (. ) we've found (. ) she's got cancer (. ) it's widespread and we
25  RC    don't think she's got very long to live,
26  RC    she might last the night or she might last a couple of weeks
27  Amy   and we'll try and get her into LOROS (2.0)
28  Amy   and that was it
29  RC    wow
30  Amy   well- well it was me I think in the end that said
31  RC    can I go to LOROS because I'd heard how nice it was
32
Amy describes how awful it was for her husband having heard the news and that he had to tell 'everyone' (lines 1-14). There is nothing positive in this extract; all hope and optimism are absent, and the implication is that nothing more can be done. It is Amy's account of what her husband was told, what he heard and what he said, so that rather than her talking about her own death, the words are voiced as what they (someone at the hospital) and her husband had said, and had to deal with. She focuses on how he was the one who was placed in the position of having to "tell everybody" and "everyone was ringing him up" (line 11). So rather than it being awful for Amy, "it was awful really for him" (line 12) because "he had it worse than I did" (line 14).

The implication here is that having to tell people the news is an awful thing for anyone to have to do, and unlike in most of the data I have, Amy was the only
participant who did not have to break the news to family and friends. Reporting the news through the accounts of others, and saying that her husband had to do the telling, helps distance Amy from talking directly about the issue of her dying. It also enables her to say how awful things were without this being a complaint on her own behalf; it was her husband who bore the brunt of it, and our sympathies should lie with him: “I mean I still think he had it worse than I did” (line 14).

Amy found out about her fatal prognosis after her husband did, so throughout this extract, she voices what her husband said and what he was told. Note again how, rather than saying that she was going to die, this is voiced in terms of living: “we don’t think she’s got very long to live” (line 26: cf. extract 8:3.1). Amy voices that they told her husband that “she might last the night or she might last a couple of weeks” (line 27). Reporting her husband’s account provides Amy with a way of talking about the bad news of not having long to live. The suggestion to try and get her into LOROS (line 28) is also an indication of her not having long to live. LOROS is a hospice, that PWC often choose as a place to die. 5

Amy now becomes agentive in the dilemma of where she wants to go (line 32) and in so doing indirectly acknowledges her own imminent death, and the hopelessness of the news and her situation. She has heard that LOROS is “nice”, (line 32) which is a strange choice of words to describe a place where people go to die, but this is contextual (and contrastive) to what she then goes on to say. She then brings us up to date with her current knowledge that “I know now it’s not brilliant” (line 34). But it appears that at the time, this would have solved not only the dilemma of going home and being a burden to everybody else, but of being in the hospital.

Amy is reflecting here on events that occurred a year before this interview, using subsequent experiences to provide a contrastive sense of prior ones. She goes on to justify her choice of going to LOROS by producing an account of what it is

5 It has been suggested that once patients are referred to a hospice they must surely have a full insight into their diagnosis and likely prognosis (Saunders and Baines 1983) and Amy has already provided the news that ‘she may not last the night’.
like to be in hospital. In hospital, she had "been next to people who've died every time" she went in (lines 37-38) and the emphasis on 'every time' is that "somebody died". Her preference now therefore is "to stay at home" (line 39), referring back to the hospital as a place without dignity. Amy has now contradicted her earlier choice of going to LOROS to avoid being a "burden to everybody else" (line 35), which displays the normative expectation that people should not want to create additional problems for family and friends.

In going against what she had defined as her family's interests, in not being a burden on them, Amy reassures herself and RC that wherever she was, "they'd be there anyway" (line 43). Concern for others in times of trouble is a common feature in PWC's accounts of receiving the bad news and of handling the immediately relevant concerns about death. They frequently produce accounts of a range of difficulties in terms of their concerns for others, rather than for themselves (see extracts 5:1.7, 6:3.1, 7:1.3.-7:1.5). Amy's concerns about her family have been negotiated and justified and she has overcome this dilemma, such that where she dies now becomes a reasoned choice for her. She has "often thought about that" (line 46) and having considered these possible problems, Amy now attends to "if it happens" (line 46). This is the cue for a spate of irony and gentle laughter (lines 47-50), which deflects the tone away from any kind of indulgent morbidity. The scenario is like a comedy sketch:

47  Amy I want to go on my own (.) they'd find me in the corridor
48  RC trying to get out of there hhh hah ha ha
49  Amy get in the laundry basket

The final part of this extract produces a way of dealing with all of her dilemmas, that she will not be alongside people who die, that dignity will be assured, and that she will not be a burden on her family, because she would "get out of there... hhh hah ha ha in the laundry basket", an extreme and laughable notion, in order to avoid being in an awful place, where "you're just a number really". RC is able to join in with the laughter (line 47) because of Amy's brief comic scenario. Throughout most of this extract RC has said very little other than brief
acknowledgements and agreements, which probably display the difficulties for recipients making any kind of response at all when the topic of the speaker's own death is raised. But the laughter here helps Amy get off, or manage, the interactional difficulties of such a severe 'troubles telling' (Jefferson, 1988). Again the contrast with the awfulness of the hospital, where people die and where you are "just a number" (line 54) deflects attention away from the topic of Amy's dying, onto the hospital environment, 6 so any response from RC can relate to that rather than to Amy's death itself.

8:5 A deviant case: "Am I go(hh)ing to di::e?"

Whereas in extracts 8:2.1 and 8:3.1, participants attended to the possibility of dying by being "up-beat" or claiming "the fight to live is huge" and that they were "living not dying", extract 8:5.1 is an unusual account in my data. Chloe talks about it "being an awful feeling" and asks the question "am I going to die?" It would seem that this is a very different way of talking about dying, but closer analysis reveals some interesting similarities in the talk and issues of concern which echo those already discussed.

Chloe is in her early sixties and was born in the West Indies. She was diagnosed with breast cancer after attending a routine mammogram. 7 She lives alone and was not working at the time of the interview. She was interviewed with her friend Sara.

Some months had passed since Chloe first received her breast cancer diagnosis and, at the time of this interview, she had already undergone radiotherapy treatment. What follows is Chloe's account of what she remembers when the doctor first gave her the diagnosis, and how she reacted. It is a rhetorically structured account, full of contrasts.

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6 Amy's description of being on the hospital ward is in stark contrast to when Sara and Chloe talked about their treatment in radiotherapy, (see Chapter 7, extract 7:2.1) where they described the people, rather than the place, and it was just one big happy family.
7 As part of a national screening programme in the U.K., women over 50 years of age are automatically invited to have a mammogram every two to three years.
Chloe 16/01 “am I go(hh)ing to die?”

10 Chloe Yes, and then I waited two weeks for the results (. ) that was
11 the lo:ngest two wee:ks of my life
12 RC uh huh
13 Chloe and when it came (2.0) I couldn't (2.0) until this day I still
14 don't believe it (3.0)
15 RC umh
16 Chloe "I keep thinking, oh it's someone else (. ) it's not me,
17 RC umh
18 Chloe it can't be, because I didn't feel no illness (. ) nothing (1.0)
19 RC umh (1.0)
20 Chloe so I couldn't believe it but then (2.0) they- they called me up the
21 hospital (3.0) gave me a date, I can't - yes I think it was the er
22 (0.5) when did I go er ((shuffling of paper as she looks through
23 her diary)) the eighth yes I went to the hospital and the doctor
25 and the nurse took me into this little room (2.0) .hh
26 and they sat me down and (3.0) and they took a biopsy (2.0)
27 I remember that and two weeks later I got another letter to come
28 to see them (2.0) and I went up (2.0)
29 ((voice level drops - very quiet))
30 Chloe *and they sat me down again and started to talk to me (. )
31 well it was as if I weren't here y'know
32 Chloe I couldn't believe it when he says (. ) it is (2.0)
33 they'd got the results it is ca:ncer (1.0) it is (. ) ma:llignant (2.0) *
34 RC uh huh
35 Chloe but it's as if I am fa::r away still y'know-
36 [I'm not- it's not registering what he's saying
37 RC umh
38 RC You're not sort of connecting (. ) [with it at all
39 Chloe [umh umh
40 RC o:h it's an aw:ful feeling (1.0) but then I just [just floods of tears
41 RC umh
42 Chloe and all I could say to him (. ) am I go(hh)ing to die?:
43 RC .hh he he he he that's all I co(hh)uld sa:(hh)y ha ha ha y'know.
44 RC What did he- how did he react to you?
Chloe had explained earlier that she had already attended the hospital for a routine mammogram and she is now reporting on what happened next when she received another letter asking her to go back and see them. She describes and sets the scene (lines 10-28). There is an element of complainable delay here in that for Chloe, waiting for the results was “the longest two wee:ks” of her life (line 11). She begins to build her sense of disbelief on receiving the results which she reiterates three times (lines 14, 21 and 32) throughout this extract which is also expressed in her “thinking oh it’s someone else (. ) it’s not me” (line 16). She provides some grounds for that disbelief, in that she “didn’t feel no illness (. ) nothing (1.0)” (line 19).

In lines 22-26 Chloe describes what happened at the hospital, where they took a biopsy, but she provides no details of that. But she implies delay again, in that it was “two weeks later” (line 27) that she got another letter calling her to the hospital.

At this point Chloe talks very quietly, and her presentation is slow and deliberate, something also reflected by her saying “well it was as if I weren’t here y’know” (line 31). The image here is that what was happening was happening as if somewhere else, to someone else. The soft and deliberate delivery helps build the awful solemnity of the situation she has found herself in and also helps convey her disbelief at what is occurring. She says that she “couldn’t believe it” (line 32) and what she could not believe was that the doctor has disclosed some information to her: “they’d got the results (. ) it is cancer (1.0) it is (. ) ma:lignant (2.0)” (line 33).
It is not unusual for doctors to deliver a bad news diagnosis in such a pragmatic way. Research on doctors disclosing diagnostic information describes this as being delivered as a short, blunt announcement (Glaser, 1966; Taylor, 1988). This pragmatism is also a commonly reported basis for complaints made by patients, particularly people with cancer, about how the news is delivered to them, which in turn poses interactional difficulties for them (Cartwright and Seale, 1990).

Chloe's delivery of her version of events is brief although she does make reference to a 'preamble' (Taylor, 1988) when “they sat me down again and started to talk to me” (line 30). Chloe delivers the doctor's news in the form of a three-part list, a rhetorically effective way of making an impact on recipients (Atkinson, 1984a; Heritage, 1984a; Jefferson, 1990). This listing is followed by a two-second pause. Normally such a pause would be an indication that RC or Sara (the other participants) might take up the next turn. Sara, who has probably heard Chloe talk about this on other occasions, does not say anything. However, as the information being imparted is sensitive and difficult to respond to, RC does not say anything either, but merely acknowledges Chloe's announcement (line 28) and makes no comment at this point. As we noted earlier, direct announcements of serious illness or impending death can provide interactional difficulties for story recipients, such that tellers will generally manage those difficulties in various ways, such as by telling stories indirectly, or in terms of the reactions of others, or in generalised terms, or ironically.

Participants often face a problem of "realisation" when receiving bad news (Maynard, 1996), and Chloe (lines 35-39) is managing this realisation with some

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8 Jefferson (1990) noted that it was very common for lists to be delivered with three parts or items. There are various features of the delivery of lists that indicate that three-partedness may often have a conventional or normative status and are frequently used to summarise some general class of things. Atkinson, (1984a) identified various rhetorical formats one of which was the three part list, which seemed to be particularly effective at eliciting audience applause, particularly in political speeches (Heritage, 1984a).
difficulty. Her difficulty in receiving the news is expressed as feeling distant from the current proceedings.

35 Chloe but it's as if I am fa::r away still y'know-
36 RC [umh I'm not- it's not registering what he's saying
37 RC [umh umh You're not sort of connecting (. ) [with it at all
38 RC
39 Chloe

The doctor is not telling Chloe that she is going to die, nor that her illness is terminal; rather, he announces that she has cancer and that it is malignant. But as pointed out earlier in extracts 8:1.1-8:1.4, 'some people' often equate cancer with a death sentence. Chloe is managing the registration of this possibility. Her account differs from the extracts analysed earlier, where agency was attributed to the doctors delivering the news and some peoples' expectations. Here Chloe is reporting the impact her diagnosis had on her, and she is referring to a specific occasion where the difficulty is attributed to herself alone.

The talk is of a very sensitive nature, with Chloe openly displaying her feelings about the awfulness of receiving being a recipient of such bad news, and she describes how she responded and coped with this. She says "oh it's an aw:ful feeling" and that she was in "just floods of tears" (line 40). Note how the actively voiced "oh" marks her narration as an experience being told as if re-lived. Although a normatively expectable reaction to receiving such bad news might be that participants would burst into tears, as Chloe reports she did, the fact is that Chloe's account is unusual as this reaction has not been a commonly reported feature in my interview data.\textsuperscript{10}

Chloe's response to hearing the combination of results, "it's ca:ncer (1.0) it is malignant" is then to say, "all I could say to him is am I go(hh)ing to di::e?" (line

\textsuperscript{9}Kubler-Ross's (1970) stage theory of dying which has attained mythical status in the professional discourse on open awareness, construes the initial reaction as the beginning of a journey towards acceptance, but Chloe's initial reaction (line 26) is that 'she couldn't believe it'.

\textsuperscript{10}See Chapter 5 where participants' accounts of receiving the bad news focused on how the medical professional delivered the news and dealt with issues of identity, managing complaints and being positive.
42). Chloe's asking "am I go(hh)ing to di::e?" is produced interactionally as something that is an accountable thing to do and say, as "all I could say". She orients to the potential difficulty for 'him' (the doctor) of her asking such a question and, in so doing, manages to display concern for the doctor's feelings. Her repetition of "that's all I co(hh)uld sa: (hh)y" (line 43) is like an apology for being unable to say anything else at the time. Her use of the extreme case formulation 'all' is a potent way of expressing the awfulness of the difficulties she was experiencing at receiving the news. Her account for not saying anything else, is that it was all she could say.

What is interesting here is that, even when narrating the hearing of bad news from the doctor, Chloe still displays a concern for how the doctor might respond, and she remains accountable for what she says to him. This piece of talk (lines 32-43) delivers a number of actions at the same time; firstly, that the degree to which she says she was unable to do or say anything else is an indication that she has now realised and understood the severity and the significance of the diagnosis being offered to her. Secondly, she modestly displays her own lack of mastery of the situation, of the difficulty of believing it and how she cried.

To counter any potentially difficult responses from Sara or RC, Chloe also introduces laughter (lines 42-43) and the account, as we have seen many times, begins to become ironical, a comedy melodrama (line 43) where she actually begins to laugh. Again, the laughter does a number of things, including enabling Chloe to disarm any potential thought that the hearer may consider her to be being melodramatic or self-pitying.

Chloe is also the only one of my interviewees who actually raised the question (directly in this way, rather than how Amy did it in 8:4.1) of "am I going to die?" But what is quite extraordinary here is that she begins to interpolate her talk with laughter (line 43). So again, Chloe attends to the possible recipient's concerns of talking about something so sensitive, by introducing laughter. This provides the recipient with a way of hearing and participating and in turn helps signify an end to this particular part of the bad news story.
Certain types of topic pose a particular closing problem for speakers, and "to get off them and go anywhere else from them, one has specifically to do 'getting out of them'" (Sacks, 1984:191). When 'exiting' from 'troubles talk', participants cannot (normatively) simply switch to other matters. Jefferson points out that "overwhelmingly, interactions treat troubles talk as a topic after which there is nothing more to be said" (Jefferson, 1988:345). Chloe's introduction of laughter not only helps 'get off' the delicacy of Chloe's "floods of tears" but also manages any possible interactional difficulties for the other participants. She has also managed to distance herself from the expression of her emotions by attending to the difficulty for the doctor, of how he might respond to her delicate question.

Chloe recalls the doctor saying "they get scared if people just take it casually y'know" (line 44). RC then 'mirrors' Chloe's telling about the doctors getting scared (line 45). 'Mirroring,' 'echoing,' and 'repeating,' have been identified as types of repetition in the therapeutic relationship (Ferrara, 1994). Mirroring can be observed in many types of consultations where a thoughtful or attentive listener is actively pursuing the listener's role rather than demanding a next turn. For example, priests hear confessions, lawyers hear first-hand accounts, supervisors sound out advisees, chiefs or commanders hear news from the battlefront, detectives are interested in keeping a detainee talking (Ferrara, 1994:124). So, in interviews and in this particular extract, RC could be responding to the doctor's getting scared as being something interesting and worth expanding on for the interview's sake. (RC is interviewer as well as a surprised participant). What is hearable on the tape at this point is an element of questioning surprise in RC's voice, that 'they', the doctors, get scared, rather than the expectation that Chloe herself would be scared. It is hearable both as a question and also as a marker for encouragement for Chloe to go on and tell more.

Chloe's reference to the doctors being "scared" also provides a way for her to distance herself again from her feelings and emotions by placing the focus back onto the doctor's problems. A common feature found throughout this thesis is that participants frequently head off any protracted talk about themselves by invoking their concerns for others, in this case the doctor.
One might think that asking the question, "am I going to die?" is a natural enough response to receiving a cancer diagnosis, but it was a rare occurrence in the accounts given in these interviews. Asking whether one is going to die is a difficult question to ask the medical profession and is one, as the literature reveals, that is not easy for them to respond to, either factually or interpersonally (Stacey, 1997). As has been discussed, participants tend to report the difficulties for the medical profession when presenting a cancer diagnosis; medical professionals are people too, and equally have difficulties in talking about cancer, death and dying.

Summary

The analysis has shown that participants' talk about death and dying is mostly invoked by accounts of what other people are reported as saying or thinking, which resonates with the canonical script that a cancer diagnosis equates with death. When talking about the difficulties they had in coming to terms with their cancer diagnosis, they proclaim they are living, not dying, and display an optimism about the hypothetical future. Even death itself is typically broached, where it is broached, in terms of the limited life that remains.

Again, concerns about death and dying are displayed as issues that PWC have to manage for others. Other peoples' expectations, that they are going to die are denied and rejected and participants' manage to resist the cultural belief of others (and their own initial reactions), that 'cancer equates with death'. Instead, they talk about what they are going to do, and what they are not going to, which would be to just sit back and do nothing. They do this by using normative canonical contrasts (e.g. "black and white") and other idiomatic resources. Talk about morbidity and doom and gloom is avoided, and laughter is

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11 Stacey overheard an exchange between a patient and a doctor on the chemotherapy ward and she commented on being struck by the incongruity between the personal terror of death on the one hand, and the professional reduction of mortality to an inevitable mundanity on the other: "P: Am I going to die, doctor? D: We all have to die sometime". She suggests that the refusal of doctors to engage with the patient on anything other than routine terms is typical of the ways in which biomedicine frequently responds to death so inadequately and also notes that "within a system that seeks to control life, death can only be recorded as a failure, and as such must be minimised in terms of its significance." Stacey (1997:27).
used in ways that manage any potentially difficult recipient responses, whilst at the same time, indexing the speaker as not being morbidly over concerned. Any uncertainty about the future is countered by presenting a determination to live.

Talk about death and dying is managed in similar ways, therefore, to receiving the bad news and the difficulties of treatment, by maintaining an identity as a person with a positive attitude in the face of all difficulties, attending to being normal and living, not dying. This is handled through invoking the difficulties that other people face in interacting with them, and reflecting their concerns and problems, rather than dwelling on one's own.

It appears from these accounts that participants' cultural knowledge and awareness of the difficulties of interaction are a continual concern which they seek to manage, regardless of whether the person they are interacting with or reporting about is a family member, a friend, a medical carer or a social science researcher.

Chapter 9, the final chapter, summarises the findings of the analytical chapters and. I will discuss how these can contribute to our understanding of some of the problems PWC face, how a discourse analytical approach to talk about illness can reveal different ways of understanding that are beneficial, not only to people with cancer, but for those who are involved in their care and finally, make some suggestions for future research.
Chapter 9
Conclusions

This thesis has examined how people given a cancer diagnosis have to contend not only with managing a life threatening illness, with all its physical discomfort, fear and dread: they are also faced with presenting themselves as someone who is 'coping' with their illness. I have suggested that the dominant culture and language of cancer has been socially constructed and it provides for a prescriptive and normative moral order that informs how people with cancer are expected to respond.

As noted in Chapter 2, the structure and analytical content of this thesis are in themselves a construction, and the extracts were selected to examine the difficulties of talking about cancer and to highlight the interactional problems PWC encounter with the medical profession, family, friends and colleagues. I have also addressed how, in addition to living with a disruptive and life threatening illness, the pervasive cultural knowledge and language of cancer produce a diversity of moral dilemmas for the person with cancer to manage. I proposed that medical and social scientists have constructed recommended 'coping' strategies whereby the person with cancer is held morally responsible for the success of their treatment and recovery, and they have to manage that additional burden and its accompanying expectations when talking to others.

The key analytical theme throughout, and one that has escaped attention in the health and illness research literature, is how PWC make sense of their experiences in the detail of talking about their illness, where the focus is on the difficulties and interactional problems of the people that they encounter. Throughout the illness trajectory, from discovery to at best a hopeful recovery, or at worst death, a PWC constantly faces managing the problems of other people and the analytical chapters examine how this was handled in their narrative accounts.
9:1 Overview of the analysis

As soon as a person enters the domain of the medical profession, they are firstly given a new identity and are categorised as a 'patient'. As such they are expected 'to be patient', and they are morally expected to "bear or endure trouble with composure, without discontent" (OED, 1994). At the same time, this categorisation places the onus and moral responsibility on the 'patient' who should not complain about their condition but who is expected to 'cope' by being positive and 'fighting' their illness.

My concern throughout this thesis has not been with what did or did not happen at the time, but how PWC tell their stories now (in interview). Chapters 4 and 5 looked at the first normative and accountable issues arising in the first stages in the trajectory of illness, the time when their identity as a healthy individual was transformed to that of a 'patient', or a person with cancer, and their encounters with the medical profession. The analysis of the diagnostic trajectory showed how, in discovery accounts, participants first displayed their accountability in doing being responsible by going to the doctor's on discovering a symptom. I also showed how they managed any notion of being irresponsible or delaying "doing the right thing". Accounts of diagnostic delay and stories of receiving the 'bad news' were intricately linked. I did not introduce the notion of diagnostic delay as a scheduled interview topic, but the analysis revealed how, in diagnostic accounts, this was produced as an accountable issue, worked up as a participant's concern, and managed with a view to not appearing to be unduly complaining.

What was of particular interest in these accounts was who was hearably constructed as being accountable for diagnostic delay. This was achieved either by interviewees being personally accountable, or as an issue of accountability for the medical profession. Participants provided justifiable reasons for any personal involvement in a delayed diagnosis, and this justification was influenced by the contrast of "knowing" or "not knowing" that it was cancer. For example, if someone does not suspect that their symptoms are serious or indicative of cancer, they are less likely to take immediate action and more likely to attribute
their symptom to something else less threatening, and consequently are not held culpable for any delay. Any thought of 'knowing' that it was cancer, along with a delay, was accounted for by providing justifiable reasons of being overwhelmed by other dramatic life events.

Throughout these accounts the doctor-patient relationship recurs as a topic, and despite the sometimes dismissive nature of the doctor, or of the PWC not being taken seriously, accounts were constructed that presented the story teller as identifying and complying with their role of being a 'patient', of someone who was “bearing it without complaint”, “quietly awaiting the course or issue of events” and/or “exercising or possessing patience” (OED, 1994).¹

Participants for the most part avoided any direct undermining or criticism of the medical profession, or expressing any failure of confidence in it. Their expected role of being a 'patient' as passive, compliant, and uncomplaining was displayed in a pattern of rhetorical moves whereby descriptions and agency are implied rather than overtly offered, in such a way that it was left for the hearer to draw the inferences that these stories are about culpable diagnostic delay, and something to complain about. The avoidance of making direct, explicit complaints is linked to the general normative requirement for being a 'good patient', and adopting a 'positive attitude'.

I highlighted that the delay literature focused mostly on the issues surrounding the 'patient' being responsible for the delay in going to the doctor's. However, my analysis revealed that diagnostic delay accounts are constructed differently. Contrary to the way the responsible agent is reported in the literature, the culpability for diagnostic delay in these accounts invariably resided with the medical profession.

¹Note that I am not taking these connotations of the word 'patient' from the literal version used in medicine. The broader definitions I use show an interesting and relevant etymology of the term, in which medical 'patients', and other words such as 'patient' (adjective), 'passive', etc., share the same roots and semantic associations.
A discursive analysis shows how PWC attend to these issues when narrating their experiences in the particular setting of an interview. When they are with members of the medical profession they are expected to be passive and conform to their role. Participants reported that they were subjected to difficult encounters, not having their symptoms taken seriously, or with any sense of urgency. Although many argue that doctor-patient communication has improved, and efforts to reduce delays in delivering a diagnosis have improved, it appears that diagnosis and communication about cancer still remain problematic in the medical environment, and participants' accounts continue to reinforce the problems the medical profession has in talking about cancer.

We know that a cancer diagnosis is bad news. What is interesting is how the notion of a 'positive attitude', in other words doing being positive, permeates in different ways through these retrospective accounts. An additional feature is that by telling stories about the medical profession, participants are able to avoid describing the awfulness of receiving the bad news and talking about cancer itself.

These stories also consistently oriented to any difficulties the hearer might be presented with. It is the PWC who takes it on themselves to make it easier for recipients to hear and respond, by providing something else for them to respond to, such as the awfulness of the consultant or the registrar. Interactional attention is diverted from the individual telling the story in such a way that respondents can instead affiliate with the story as complainable behaviour on the part of the medical profession, rather than focusing on the difficulties of the person with cancer. The implied incompetence and culpability, along with the sometimes ironic nature of the stories, also helps insulate participants from reliving the severity of receiving the bad news. Throughout the telling of these events, participants produced an identity of someone who was 'being positive' and 'coping' with their difficulties, and not someone who could be categorised as a complainer.

Having discovered these stories as hearable matters for complaint (both at the time of hearing and in the process of analysis) I wanted to know why PWC did
not complain directly about the problems they experienced. In subsequent conversations with PWC (outside the interview situation), I asked why they did not complain directly about the way they were being treated. Their response was a ‘preventative’ and ‘protective’ one, of having to fend off other dilemmas. They told me that they feared upsetting their consultant in case this might result in not receiving the best possible treatment. Although it is not the topic of this thesis, this raises the issue of the Foucauldian view of power and the ‘top down’ asymmetry of the medical relationship. As is the case generally with ideological orders of life, such ‘top down’ structures can be held in place by the co-operative practices of the people on the receiving end.

Having received a cancer diagnosis, participants are engaged in an ongoing discourse with the medical profession. They also have to relay the ‘bad news’ to family, friends and colleagues. Consequently, they become involved in the pervasive culture and language of cancer, which in turn can become problematic, because other people may not know what to say.

In Chapter 6 I analysed how PWC accounted for the difficulties they encountered in social interactions with friends, family and the medical profession. Talking about troubles is full of complexities and contradictions, especially when they are laden with the cultural language of cancer. In contrast to the passive stance of being a ‘patient’ in the medical environment, outside, in their everyday social world, PWC are expected to be active in how they manage their illness. The expectation of ‘thinking’ or ‘being’ positive about their illness is not a constant state, and participants are placed in situations where they are held morally accountable for how they ‘cope’ positively with their illness, where not being positive becomes a matter of accountability. I showed how the expectations placed upon them are sometimes unwelcome and “rammed down their throats” and if they were not ‘positive’, this might have some dreadful, self-inflicted bearing on the success of their treatment. Category membership and entitlements were also relevant because who said what, when and where, was a consideration in whether it was considered right or wrong. Expressions of pity, or people implying they felt sorry for PWC, were constructed as being un-supportive. To counter such unwanted responses, participants ‘put on a brave
face’ to fend off the difficulties of talking about their troubles, avoiding being a worry or burden to others. Issues of identity were managed by PWC presenting themselves as ‘being positive’ and rather than the expectations of others being placed continually on them, they contrasted this by describing their own expectations of others and how they should respond.

Any conversations with someone with cancer are problematic for all concerned and the moral ascriptions of cancer produce dilemmas to be countered and managed. A strong theme of this thesis is that PWC are constantly placed into difficult social situations where invariably they are the ones who have to display understanding, and manage other peoples’ reactions to their illness.

One of the key strategies for people with cancer is to work at maintaining their identity and, as Sacks (1984a) puts it, do being ordinary or, as I propose here, do being normal and do being positive. Rather than look at the things other people say about ‘think positive’ and ‘fight it’, Chapter 7 looked at how participants accomplished doing being positive. I examined the devices employed to fend off recipients producing unwanted sympathy, or engaging in talking about their troubles, and how the cultural expectations of being in control, of ‘coping’, ‘fighting’ and being positive were accomplished in talk. The analysis revealed that being positive is not always possible, and moral judgements are overtly and covertly displayed by others, which burden the PWC with additional problems.

As previously discussed, ‘thinking’ or ‘being’ positive is considered an important ‘coping’ strategy that can impact on life expectancy. I have shown how the notion of being positive is a participant’s concern which is handled as an accountable matter. Accounts are constructed using contrasts of the active-passive stance, of taking an active role and continuing to do mundane activities, or the consequences of succumbing to it and doing nothing. I suggested that this is an interesting contrast to the notion that ‘being positive’ is simply good psychological advice and that on occasions it can be counter productive. In order to acquiesce to the demands of being positive, participants have to explain, make excuses, justify and deal with the issues of blame and moral accountability that accompany it. At the same time, they have to manage a dilemma it
produces, of not allowing others to see or hear them as someone to be pitied, not coping, or complaining.

Another device for managing this is to employ laughter and humour, which have a number of useful interactional functions. I showed how when a topic encroached on forbidden or taboo territory, laughter and humour were used as interactional devices that could avoid placing story recipients in embarrassing situations. This was achieved in three different ways. Firstly participants report events and invoke laughter; secondly participants report events where laughter occurred and goes on again in the telling; and finally, rather than the analysts' providing the meaning of laughter, the participants themselves might construct their own accounts of what laughter is doing for them. I suggested that the rhetorical construction of accounts when laughter is invoked does some identity work and can display the PWC as being positive and as someone who is 'looking on the bright side'. Again, laughter and humour help to manage the delivery of implied complaints, whereby the teller is not heard as being self-pitying, complaining or succumbing to their illness. At the same time, they avoid potentially difficult responses by recipients who could introduce their own problems into the talk.

The final analytical chapter looked at how the canonical script, that a cancer diagnosis equates with death, featured in participants' talk. I showed how when describing the difficulties of coming to terms with their diagnosis, participants proclaimed that they were living, not dying, and displayed an optimism about the 'hypothetical future', even when death was inevitable. They achieved this by invoking stories about what other people said.

Again, concerns about death and dying are displayed as issues that PWC have to manage for others. Other peoples' immediate expectations, that they are inevitably going to die simply because of the initial diagnosis, are refuted. Instead, they talk about what they are going to do, and more importantly, what they are not going to do, which would be to sit back and do nothing. They produce normative canonical constructs (e.g. black and white), contrast structures and extreme case formulations, that rhetorically maximise these
opposed positions. Talk about morbidty and 'doom and gloom' is avoided, (that is, actively avoided rather than merely absent), and again laughter is invoked in ways that manage or forestall potentially difficult recipient responses. Any uncertainty about the future is countered by asserting a determination to live.

Talk about death and dying is managed in similar ways to receiving bad news and the difficulties of treatment, by PWC maintaining their identity as people who are being positive, attending to being normal and living, rather than dying. This is rhetorically constructed by invoking the difficulties of other people interacting with them and their concerns and problems, rather than dwelling on their own.

9:2 In terms of the future: The next step

When I began to write my conclusions I asked myself the classic question, well, having written this thesis, "So what?" What conclusions have I come to? What does my analysis contribute to our understanding of how people talk about cancer? How might it be applied outside of the academic world? What relevant contribution does it make for people with cancer, their family, friends, colleagues, and the medical profession? What does it contribute to my theoretical approach in the academic world?

The cultural discourses of cancer have been socially (and medically) constructed. They are continually reinforced as they are replayed and displayed by people talking about cancer. Someone who is diagnosed with cancer is categorised as being different from the person they were before, and consequently people respond to them differently; a whole range of normative expectations come into play.

The pervading culture and language that has been constructed around cancer produces both fear and dread, but at the same time, the language of the dominant coping strategy of the 'heroic model', and 'think positive' work to counter the equation that a cancer diagnosis is a death sentence. On the positive side, it constructs a language offering other people something constructive and supportive to say. However, being positive is a double-edged
sword, and I suggest that this constant imposition and reinforcement of the *culture of cancer* can be counter-productive and dispiriting.

Throughout this thesis, I have suggested that the normative expectations this culture produces place additional burdens on the PWC. While I do not deny that for anyone experiencing a traumatic life event, *being positive* is preferable to being negative or feeling depressed, I propose that this produces moral dilemmas to be managed, especially as it entails, normatively, a bearing on recovery and survival.

The continual dilemma for PWC is that they are placed in a situation whereby it is unacceptable for them to tell others when they are feeling down, or are not 'coping' or *being positive*, without some sense of guilt. When talking to others they display their concerns for the listener's difficulties while at the same time they are having to be accountable for *not* being positive, which makes their burden all the heavier.

In terms of applying my findings to a wider arena, I suggest that everyone who becomes involved with someone with cancer (or any chronic illness) has to realise that it is not just medical and psychological problems that have to be faced. PWC have to manage the accompanying social interactional problems and work to maintain the identity of someone who is bearing their illness 'patiently', without complaint and are being 'a good patient'. They often have to divert other people from introducing their own interactional problems and at the same time they have to avoid rejecting 'positive' advice and 'support' at times when they are inappropriate. They have to manage the interactional problems that their illness poses for others, and *their* inadequacies to cope with people with cancer, together with the moral restrictions on being able to admit that they are not coping.

The principal findings of this thesis can be made available as supporting information for members of the medical profession and for counsellors and carers, and could be made available as parts of published information leaflets about cancer.
In terms of the future, the discursive approach that I have taken to analysing a variety of social interactions between PWC (or anyone who is seriously ill) and the medical profession; between PWC and their carers; and PWC and their social networks (families, friends, and colleagues) would provide rich sources for further research and discovery.

9:3 Discursive Psychology and Discourse Analysis

Every theory and method reveals some things and conceals others, but the pragmatic question here is what can be learned from a discursive analytical perspective?

Discourse is constructed to perform social actions and discourse analysis is concerned with how people construct accounts of their world in social interaction, with the upshot that these versions are produced both immediately and over time, as part of ideological practices (Edwards and Potter, 1992).

A discursive analysis identifies some of the problems PWC face in their social relationships that are otherwise overlooked or under-analysed, and provides a different insight into our understanding of how people manage their illness and their relationships. What my analysis has shown is that it is not simply a matter of people without cancer learning a set of rules about how to talk and what to say to people who have cancer, but that we have to take account of a wide range of variability. It is more a matter of being sensitive to the ambiguities and the various needs of cancer patients and their families. They may sometimes want support, sometimes not, sometimes want their illness acknowledged and sometimes require people to act cheerfully. That is surely their privilege.

The accounts throughout this thesis are retrospective and of course what actually occurred at the time of the events recounted is not known. My concern has been with how the nature and invocation of the culture and language of cancer and how when talking about cancer, PWC show that the medical profession and people in their social network constantly reinforce the prescriptive moral order of how to "do it right".
PWC are frequently faced with having to live up to other people's expectations of how they are expected to be. Hence, the moral implication of my friend Charles's question, the one I started with (see the Dedication, p. iv), "Am I doing it right?"

My answer is that there are no definitive rules for having cancer, for either the person with cancer or for those without. Rather, I suggest that we all need to recognise that people with cancer should not be made to feel as if they are continuously under pressure to conform to other people's normative and moral expectations. There is no 'right' or 'wrong' way, because people's needs are variable, across situations and occasions, and not just across persons. Again, that is surely their prerogative.

The category entitlement, of who says what, when and where, and whether it is the right or wrong thing to say, is inevitably part of the performative function of language, something variable, where accounts (or versions) are constructed in ways that perform different actions on and for their occasions. In the context of these kinds of considerations, a discourse analysis of the local contingencies and rhetorical orientations of talk is no less than a form of respect for the people talking.

So, what this thesis is about is that, by analysing what and how people talk about managing the difficulties of having cancer, we can come to another view of a relatively unexplored topic of research. I believe that discourse analysis provides us with a novel and useful understanding of the moral dilemmas faced by anyone suffering from a life-threatening illness.

This thesis began with my heightened interest and concern about the difficulties that people have in talking about cancer. The following extract, if I may introduce such a thing at this juncture in a set of 'conclusions', is taken from one of my first interviews, and it made a dramatic impression on me. I present it here, without analysis, as a piece of viva voce, and as a way of giving voice back, unanalysed to my participants, to show that people with cancer also have difficulties in knowing what to say to someone else with cancer; that is all I want to say about it.
Jan and do you remember the one night
I'll never forget this we were talking about colours
Bee Oh yes
talking about colours and what colours do for you.
Yellow is the colour of sunshine y'know and that sort of thing
and we had to close our eyes and think of a colour and
what came to our mind without thinking too much about it
and I always remember Lois (...) do you remember what she said?
Bee I can only see black
Jan I can only see black she said
and we all sat there in stunned silence
because what could we say
we couldn't say anything
RC Yes, it's very difficult to know what to say

There is no definitive answer to knowing what to say, or how to do it right, but I propose that by heightening awareness of the difficulties identified in this thesis, this research takes talking about cancer a 'positive' step forward.


Garro, L. C. (1994). Narrative representations of chronic illness experience; Cultural models of illness, mind and body in stories concerning the temporomandibular joint (TMJ) *Social Science and Medicine, Vol. 38* (6), 775-788.


London: Tavistock.


Schegloff, E. A. (1982). Discourse as an interactional achievement: Some uses of 'uh huh' and other things that come between sentences. In D. Tannen (Ed.), *Georgetown University Round Table on Language and Linguistics, 1981: Text and Talk* (pp. 71-93). Washington, DC: Georgetown University Press. [NOTE that while the Round Table was held in 1981, the accurate copyright date/date of publication is 1982, not 1981 as many people cite it!]


APPENDIX A

CONTACT TELEPHONE NUMBERS - HELPLINES

National Organisations

CANCERLINK 0800 132905 (Mon-Fri 9.30am to 1pm; 2pm to 5pm)
BACUP 0171 618 2121 or 0800 181199
BREAST CANCER CARE 0500 245 345
TENOVUS CANCER INFORMATION CENTRE 0800 526 527

Local Organisations:

COPING WITH CANCER Leicester 0116 2230055
HELEN WEBB MEMORIAL TRUST (Leicester) (Ovarian Cancer Group) 0116 2302495
LEICESTER PALLIATIVE CARE TEAM 0116 2516229
The Counselling Centre 17 Princes Road West Leicester 0116 2558801
The Samaritans 0345 90 90 90

INTERNET

BACUP http://medweb.bham.ac.uk/cancerhep/index.html
ONCOLOGY FORUM http://www.oncology-forum.org/

Researcher
Rosemary Chapman 01509 556273
2 Turner Avenue 01509 223365
Loughborough
Leicester

Dept of Social Sciences
Loughborough University
Epinal Way
Loughborough LE11 3TU
CONSENT FORM

DATE:

I, state that I am over 18 years of age and that I voluntarily agree to participate in a research project conducted by ROSEMARY CHAPMAN, a postgraduate researcher in the Social Sciences Department at Loughborough University.

The specific task I will perform requires me to participate in an interview (approximately 1-1½ hours) and I agree to the whole interview being tape-recorded.

I acknowledge that Rosemary Chapman has explained the task to me fully; has informed me that I may withdraw from participation at any time without prejudice or penalty; has offered to answer any questions that I might have concerning the research procedure; has assured me that any information that I give will be used for research purposes only and will be kept strictly confidential and anonymous. I understand that some of the transcripts of the interview may be used in research documents and may be published in scientific journals.

I have been provided with a list of contact HELPLINES.

I understand that if I so wish I may have a copy of the taped interview and/or transcript.

_________________________________  ___________________________________
SIGNATURE OF RESEARCHER           SIGNATURE OF PARTICIPANT
APPENDIX C

Part 1: Unstructured part of interview:

Can you tell me something about your experiences since being given a cancer diagnosis.

Part 2: Semi-structured Interview questionnaire

The semi-structured interview questionnaires were used as a guide for asking questions and were not adhered to strictly. Many of these topics arose in Part 1.

1. When your diagnosis was confirmed, did you feel that you received adequate emotional support from the hospital?
   YES/NO

2. Do you think the medical profession, as a whole understands your needs?
   never or sometimes often always or almost always

3. When you were first given your diagnosis did they give you any information about organisations who could give you support/information about your illness?
   YES/NO

4. Did you follow any of these suggestions up?
   YES/NO

5. After receiving your diagnosis, who was the first person you told?

6. Do you thinking talking about your illness is helpful?
   YES/NO

7. How often do you talk about your illness?
   never rarely sometimes often always or almost always

8. Who have you talked to about your illness apart from people in the medical profession?

   spouse
   friends
   Consultant
   Oncologist
   radiotherapist
   local cancer organisation
   family (who)
   GP
   MacMillan Nurse
   Chemotherapy nurse
   Breast care nurse
   LOROS
9. Who have you found it easy to talk to?

spouse
friends
Consultant
Oncologist
radiotherapist
local cancer organisation
Counsellor

family (who)
GP
MacMillan Nurse
Chemotherapy nurse
Breast care nurse
LOROS
Other

10. Do you find it easier to talk to people who have experienced cancer?

never or rarely
sometimes
often
always or almost always

11. Since your illness was diagnosed have your relationships changed in anyway? YES/NO

are they more difficult
unchanged
easier

12. Have you found any of your friends, or family have found it difficult to talk to you about your cancer? YES/NO

never or rarely
sometimes
often
always or almost always

13. Who found it the most difficult?

spouse
friends
Consultant
Oncologist
radiotherapist
local cancer organisation
Counsellor

family (who)
GP
MacMillan Nurse
Chemotherapy nurse
Breast care nurse
LOROS
Other

14. What do you think made it difficult for them?

15. How would you describe your quality of life before your illness was diagnosed?

very good
good
average
bad
very bad

16. How would you describe your quality of life now?
very good  good  average  bad  very bad

**Open-ended**

Do you think, since being given your diagnosis, your approach/attitude to life has changed in anyway?  
Yes/No

Do you think you have changed?  
Yes/No

In what ways have you and your life been affected since your diagnosis?  
Or
How has having cancer changed or affected your life?
Transcription Notation

The transcription symbols used here were derived from those developed by Gail Jefferson (see Atkinson and Heritage, 1984, p ix-xvi). They reflect the requirements of analysing talk as a social activity rather than for example as an expression of ideas, phonetics or grammar. Note that many of the symbols are familiar as ‘punctuation’ marks but here they are re-defined to signify intonation or speech delivery, rather than grammar.

(.) A micropause, hearable but too short to measure

(0.5) Numbers in round brackets measure pauses in seconds (e.g. 5 tenths of a second.

.hh A dot before an ‘h’ denotes an in-breath (inspiration). The more h’s, the longer the in-breath.

hh An ‘h’ denotes an out-breath (aspiration). The more h’s, the longer the out-breath.

Ha ha ha Hah hah hah Laughter syllables with some attempt to capture ‘colour’

Go(h)d (h) denotes ‘laughter’ within words. The more (hh) the greater the word is interpolated with laughter

[^t] dental click

((sniff)) A description enclosed in double brackets indicates a non-speech sound

cu- A dash denotes a sharp cut-off of a prior word or sound.

lo:ng Colons show that the speaker has stretched the preceding letter or sound. The more colons the greater the extent of the stretching

(guess) Material within brackets represents the transcriber’s guess at an unclear part of the tape.

(syll syll) Unclear speech rendered as approximations to number of syllables

[a hospital] square brackets enclose contextual or explanatory information

run= ‘Equals’ signs mark the immediate latching of successive talk, whether of one or more speakers, with no interval, thus the talk runs on
↑ word ↓ word  Vertical arrows indicate a rising or falling intonational shift. They are placed before the onset of such a shift. Double arrows indicate very marked shifts.

→ A horizontal arrow indicates a point of special analytical interest in the extract

under Underlining indicates vocal emphasis; the extent of underlining within individual words locates emphasis, but also indicates how heavy it is

CAPITALS Capital letters mark speech that is obviously louder than surrounding speech

°soft ° Degree signs enclose obviously quieter speech that is noticeably quieter than the surrounding talk. (i.e. hearably produced as quieter, not just someone distant). Double degree signs indicate greater softness.

> fast < ‘Greater than’ and ‘less than’ signs indicate that the talk they encompass was produced noticeably quicker or slower than the surrounding talk

[talk over] [overlap ] Square brackets between adjacent lines or bracketing two lines of talk indicate the onset [ and end ] of overlapping talk.

((....))) Material left out of the extract

😊 denotes a smiley voice
APPENDIX E

Full extracts referred to in analytical chapters

Sara 15 "A comedy of errors"

1  RC  I just want to listen to what your experiences were
2  Sara I mean er (. ) I was er (1.0) having a bath this morning (. )
3       and its something that always brings back memories (. )
4       to me (. ) because that's where I found it (. ) .hh
5       as I was soaping my bo(hh)dy (. ) .hh ha ha ha y'know (. )
6       my fingers just went over this little th(hh)ing (. )
7       just sli(hh)pped off of it and I thought (. ) oh (1.0)
8       there's something the::re (. ) y'know (. )
9       So I rubbed again and as I did- which- this is- er this is-
10      I think you can find out (. ) if you've got things on you
11      when you've got a so:ap: y bo:dy (. )
12  RC  Uh huh
13  Sara because your hand goes over it so smo:oth (. )
14       you can just feel every little (. ) y'know (. ) and then I did
15       and thought oh >yes there is and it was just about the size
16       of a pe:a (1.0)< at at er the- at the root of the breast (. )
17       and er umh and I got out the bath (. ) dried myself (. ) and
18       what have you (. ) and I went to the bath- bedroom (. )
19       and >I was fee:(hh)ling .hh everywh(hh)ere no(hh)w
20       you see> .hh ha ha ha I am looking and I thought
21       .hh (. ) yes *there is a little thing the(hh)re*
22       and so I thought straight away (. ) I couldn't care less
23       whether it was beni: gn or ma: lignant (. )
24       I am going straight to the doctor because (. ) I know from
25       experience .hhh that you don't put these things off (. ) y'know-
26       and er I'm not going to be sort of bashful or shy
27       say well (. ) I'm .hh not going to the doctor with this y'know
28       I'll- I'll wait and see what happens (. ) I didn't (. )
29       In the same we: ek I made an appointment
30       as a matter of fact my husband came into the bed-
31       walked into the bedroom (. ) and he says what are you doing?
32       (. ) he says have you got something there y'know and I said
33       yes it feels like a little lump so he says (. )
well you'd better get to see the doctor then so
and I says oh well I had thought y'know
that's what I'd do anyway.

RC umh
Sara and I made my appointment for the same we: ek (. )
to go and see my doctor
Sara and as I got there umh (1) he had a
look at me ( . ) and he couldn't find it ( . )
I mean it was that little ( . )
RC umh
Sara that he just couldn't find where it was and I had to take
his finger and more or less guide it on to the spot y'know
.hh wh(hh)ere this li(hh)tle th(hh)ing was and er
he says oh yes there is there is a little thing there ( . )
he says er but er ( . ) I don't think it's anything to worry
about but I'll still send you to see the er specialist
RC umh
Sara I'll make an appointment for you ( . ) so I says ( . ) ri::ght.
RC umh ..hh
Sara so er ( . ) eventually an appointment was made and er a
letter came through the door ( . ) a few months after and
er ( . ) knowing me, I'm usually so busy I I er just looked
at the date of when I was supposed to be there
RC umh
Sara and I thought, oh right, I'll be there for that date but I
didn't look to see what department. I didn't read every
single thing on the paper
RC right
Sara all I did was just look, for, y'know, I saw the date, that
I have to be there and, and er y'know well I thought right
that's good enough for me er because er I mean
what more is there to er ( . ) know, y' know, until I get there
so of course the day came ( . ) I went down, ( . )
I was in the wrong department.
So he didn't send me to the right place ( . ) so the doctor who was
there and I I er noticed it as well as I looked up I thought oh ( . )
I'm not supposed to be here
RC [where was this?]  
Sara [but this is where he sent me, where you go for umh, er a hysterectomy and so on y'know]
RC Oh
Chloe gynecology
Sara gynecology, [gynecology department]
RC [right, right]
Sara and umh the doctor says to me, but I'll still look at you she says, because she called my name up you see, my name was called
RC she was expecting you?
Sara yes she was expecting me and my name was called so I thought well I'm there I might as well go so I explained to her, I says, look I'm er I'm not here for any gynecology, y'know er problem I says what I came in for is a lump in my breast (. ) at the side of my breast so she says well you're in the wrong department she says but do you want me to have a look at you (. ) So I says, I don't mind. So she examined me down there as well and er she says er, you're fine, nothing to worry about and then she says I'll have a look at your lump and she did and she says I should go back to your doctor immediately and tell him to get you to the right department as soon as possible it may not be anything, it may be something, she says, but lumps are not supposed to be (. ) there you take them out (. )
RC u::mh
Sara so I had to go back to him, and ask him (. ) to send me to the right department
RC how long had you waited?
Sara this was, well about three months had gone already from my first appointment, (. ) then er I went to him and er (1.0) a week had passed and I happened to be there again for er, I think it was for Jason, something to do with his asthma and umh I asked the Nurse, did Dr D send off my letter to the right department and she looked up and says oh no it's still here it's not gone yet
Chloe [((gasps))]
RC: [((gasp))]

Sara: She says I'll get it off as soon as possible.

RC: So there was no sense of urgency at this stage?

Sara: So there was no urgency there at all. The only time the urgency happened was when I went again.

In the meantime, I had, a letter came from the right department then, for me to go and they tried to do a biopsy and they couldn't because it was too hard, and he couldn't get in and then it was bleeding and so an and so I thought, right well I know what that is anyway. I didn't need anybody else to tell me what was wrong. But umh still you've got to wait for confirmation. You need that little bit of thing saying oh well. It's probably nothing you know.

RC: Umh

Sara: So even he himself says, umh I'm sorry I can't get there any sort of er umh. Is this the consultant?

RC: Is this the consultant?

Sara: Not the tissue, the liquid, he was trying to draw some fluid out of it.

RC: Umh

Sara: He couldn't get any fluid out, there was blood coming.

This is er the specialist.

RC: Uh huh

Sara: But he says I tell you what, he says umh, it's probably nothing to worry about, he says I don't think it's any er malignant umh tissue that's here. Hhh he says but I'll make an appointment, he says can you come in at any time? Y'know, at short notice, whenever, sort of like, er when they've got a bed? So I says, yes I can. He says because lumps aren't supposed to be there y'know. If they're there then we take them out.

So I said right, fair enough. Then umh I went again. The next week to for Jason to have another check up with his asthma but I mean they don't do check ups on asthma every five minutes.

RC: Umh
Sara: So you know there's a space between and while he was there, the nurse said to me who does who was doing the asthma and the check up how's your lump coming on Sara?

So I say oh it's growing nicely so she says ha ha ha can I have a look. She says can I have a look so I say yes of course so she took one look at it so she says oh I better let Kevin come in and have a look at this so in comes the doctor and he has a look at it and the next thing I know they've forgotten Jason was there for his asthma, and he was on the phone trying to get to the doctor, then he was on the phone trying to get to pathology to see if they had the results of this stuff that they'd tried to get out of me pathology wouldn't give him any news at all of what's going on, the doctor, the consultant was in theatre so he couldn't get through to him and he's flinging around like a whatsis, you know. He couldn't get through to the hospital or to pathology department so he says pathology wouldn't tell me anything about the results and he says what I can make of it.

Then you know it has got to be cancer because if it was clear and it was nothing they'd probably say to me it's all well, everything's fine but they wouldn't let me know anything so all I can presume it is. I thought oh my God, Jesus, Chloe ... Sara: I said. Whose going to look after Jason? And just the only time I had a little weep and a cry and what have you you know.
181 Sara .hhh because I thought to myself (. ) what er y'know I-
182 the thought of not being able to look after Jason (.)
183 to see him grow up (.). hh he says (.)
184 o:h don't worry about it you'll live lo:ng enough to see
185 Jason grow up to be a fi:ne you::ng man he says
186 we'll get rid of that y'know (. ) it was so:: la::id back it [was
187 RC [umh
188 Sara so:: (. ) o::ka::y (. ) y'know so ca:stial (.)
189 oh it's o::nly ca::ncer y'know .hh ha ha ha .hhh
190 but he did say to me that er umh if there was a prob-
191 if I ever I feel I need to talk to him or (. ) for anything at all
192 he says (. ) he'll be the:re for [me
193 RC [umh umh
194 Sara just come to him (.)
195 RC Oh that's good
196 Sara Yes (. ) Oh he is a very nice doctor (. ) he is really nice
197 and I wouldn't change him
198 RC This is the doctor at the hospital or er the GP
199 Sara No this is my GP (. ) y'know the o(hh)ne who sent me to the
200 wro(hhh)ng pla(hh)ce in the fi(hhh)rst pla: (hh)ce
201 y'kno(hh)w but I wouldn't change him for the world
202 RC sure
203 Sara and this is how I look at it. I mean my husband, was
204 RC umh
205 Sara y'know, I says (. ) people can't see what's in side of you (.)
206 RC umh
207 Sara unless they do tests but he says but he shouldn't, y'know
208 RC umh
209 Sara I says umh, well yes we all should've (. ) done lots of
210 Sara things and everything happens for a reason I says just let it go
211 and umh Dr D, like I said, I wouldn't change him for the world
212 he's been very very good to me(,) anyway he says to me (.) if I
213 don't get a lett- if I don't hear from them to go in by Monday
214 come back to him .hh but fu(hh)nnily enou:(hh)gh ..hh ha ha
wh(hh)en I go(hh)t home I had a letter asking me if I could
come in (.) er a phone call in fact if am I free and I said
yes and then a letter came on the Friday saying
can I come in on the Mo(hh)nday (.) er to have this operation to
remove this lump from my breast (.) and er umh I went in
and as I was lying th(hh)ere y'know I was sort of feeling
oh hh ha ha I've got two big ones under my(hh)rm y'know
and they're be:::auties .hh ha ha hah hah hah hh
so as the doctor came through to examine me: (.) in the
hospital I says oh by the way, I says (.) I know they
always check anyway (.) they check your arm pit (.)
but I says oh there's two big ones under there two nice ones
beneath there as well .hh y'know .hh ha ha and
he says oh yes the(hh)ere is and er I just sort of (.) lie there
waiting for them to er remove this er foreign thing .hh ha ha
that was inside of me(.) y' know but umh (.)
but that was only up until the operation so:rt of thing y'know
RC umh

Ann 09/01 “there's always the o:ne”

1  Ann you know they- they (.) the-there's always the o:ne that you get
that rings you up and says
Ξο::h dear what are you going to do ξο::h dea:::r what areΨ
and that is the last thing that you want
5  RC yes, yeah
6  Ann and (0.2) I er (.) in the end I had to tell this lady er don't- please don't phone me again because (.)
8  I didn't want to hear it (.) she was so ne:::gative
9  [I couldn't believe it you know
10 RC [umh
11 Ann oh well (.) what are you going to do you know (.)
you've got this (.5) er terrible disease and er (.) y'know (.)
↑oh I'm so sorry I'm sorry for you and ↓
13 RC umh
15 Ann ↑but you want people to that are positive at the side of you (.)
you don't want negative people↓
yeah, I was gonna ask you- actually its one of the questions
yeah
er but whether any of your- your relationships have changed (.)
with you know family, friends or
u::mh, [yes
[you know whether some people have found it
difficult or moved away or
[oh yes people walk over the road er so that they-
its like a bereavement=
you have experienced that?
yes () I definitely have yes
where people () cross the road?
yes, they've crossed the road and umh
people you know?
yes (0.5) they're talking- they're quite happy to talk to me now,
but that was two years ago (0.5) and er at the time this girl was,
she lives round the corner from me and she was working with
me at BG at Linkboy and she er umh (1.0) she just couldn't look
at me when she ta::iked to me (1.0) and I said to one of the girls
that work with her (. ) I said why is Dawn like she is? and I- I
hadn't even thought about it- that it was because of what had
gone on said, what- what is wrong with her? I said I've not said
anything to her (. ) she said I think its because of your problem↓
(. ) I says what problem, I haven't got a problem (. )
My problems GONE [hahh and that's why I remain positive is
[umh
is because I- I er, its gone, its not there
[I haven't got cancer its gone]
[umh umh umh]
So why do you think er she () found it er difficult then
or she couldn't look at you or
[why do you think she crossed the road?
[wel I think because she er- its that is sheer ignorance of (. )
people with breast cancer, she- she doesn't realise,
she probably thinks that when you've got breast cancer
no matter how bad it is, you're gonna die with it anyway
so she couldn't face me (. ) she trea::ed it as if it was a- its was
a bereavement (1.0) you know an- and umh er
I think it was just because of her ignorance (.)
she didn't realise that yes there is light at the end of the tunnel
so er she didn't know what to say to you?
no, no she was embarrassed by it (3.0)
RC umh I mean that is one of the er difficulties that a lot of people
have, of not knowing what to say
Ann umh
RC but its like, I know from my own experience when I say things
you know, talking about my brother or my friend .hh er y' know
some people know y, know how to say, or to respond or say you
know or can er speak to you but other people are er er y' know,
there's just, [they haven't got a clue what to say
well they annoy me a bit really because I think well
I- I-
well they can't help it though can they?
no, this is what I say but that it- it gets, it does get at you
yeah
that people are like that I mean when I'd got this Jo on the phone
saying "oh dear, oh dear what are you going to do"

hh hhhh you know, well I'm I'm gonna live

RC umh
Ann you know that's the first thing I'm gonna do, I'm going to live=
RC =yeah=
Ann =Yeah- and I'll be alright you know, but why should I be the one
telling her that I'm gonna be alright (.)
she should be the one telling me!
yeah
Ann where's the support?
yeah
Ann you know, no support from them

Ann 09/02

you just don't know what is around the corner
no, exactly I mean er (1.0) you just (.) don't know (2.0)
but people do react very differently to you
yeah, so people who- would you say that if people (1.0)
umh (2.0) well I mean you've mentioned the lady who-
who was negative to you (2.0)
basically you didn't communicate with her
Ann well I couldn't, I- I wasn't in er, in er sit- I wasn't in the position
that I felt that I (1.0) I was quite tearful at that particular time
because I'd just recently been diagnosed with a serious illness
RC yeah
Ann and I couldn't (. ) I couldn't be bothered with her
I just didn't want to know, I didn't want this woman telling me
oh I'm so sorry (. ) I'm so sorry (. ) I wanted someone to say (. )
Ann (. ) you're gonna be fine (. ) don't worry about it (. ) you're
going in you're gonna have your operation (. ) you will get over it
RC umh
Ann that's what I wanted to hear and any woman that's going in for an
operation an- and er got that kind of illness,
I'm sure they would agree with me
RC yeah did you, I mean er [in the people that you spoke to
Ann [I try- I try to carry myself not to carry
someone along [with me
RC [yes, yes
Ann an- and this is what she was trying to do

Dee Extracts 7:1 –7:5 Dee 08 and Sandra 3A 343-358

1 Dee she's tackling it the second time round
2 much better than she tackled it the first, it's strange isn't it?
3 RC umh
4 Dee she was the one out of all of us who (.2)
gave up walking her dogs (.)
didn't go down the garden because she couldn't
get that far, (.2) stopped shopping (.1)
didn't go out in her car (.1)
didn't go out to dinner,
she stopped living really in the terms she had before (.)
during the treatment
12 RC uh huh
13 Dee the re(hhh)st of us sta(hh)ggered ro(hh)und the water works
14 you know with two dogs that were raring to go
and you'd think oh hhh dear I cant go any more
I carried on doing my shopping,
that was very important to me (.)
the one thing that's very important to me is
that I could do the wee:kly [Sainsburys
RC [Yes
Dee now isn't that silly but it was very important
RC yeah absolutely
Dee it's norm- the only se- sense of normality
RC yes
Dee I wash my own car still (1) and I drove all the while (1)
Sandra did nothing, she sort of (2) let the disease (2)
dictate to her really I suppose in a way .hhh umh
and I met her (.) after about six months
I hadn't seen her for about six months-
I met her in the clinic at County a year and a bit ago (.)
Dee and I was sitting in clinic and thinking the only person I haven't
seen recently is Sandra and a person grabbed my arm and said
Dee (.) I said d'y'know I was just thinking about you
it's strange, it's eerie (.) and I went to say and I did say
how are you? and I looked at her and as the words came out
I thought oh what a silly thing to say you can see what she's like
(.) ((voice lowers to a whisper))
but y'know (.) it's a natural reaction
RC umh, umh
Dee and she said "I'm very ill", umh yeah you look very unwell
(.) and I said, what's the problem?
she said I've got metastatic lung cancer (1.0)
and we sat (.) for about half an hour
because the consultant was so far behind
and you could see the people in the clinic becoming very
unhappy about two patients sitting discussing (.) one
patient's terminal disease (.)"they were so uncomfortable"
RC umh
Dee and I said look Sandra I said this is causing a few problems
in clinic I said why don't we go to the coffee shop and
say to them we're in the coffee shop how long do you think we
will be before we're needed

and we did that in the end (1.0) umh (2.0)
and she was so feisty and she's been (.) I mean Zoe will tell you
she doesn't know her very well, she's met her once but (.)
she's just been wonderful this time and
I wonder sometimes if she couldn't have input so much
effort the first time what would have happened? (2.0)

RC umh

Dee she's so, I mean I take my hat off to her this time I don't
know how she keeps going (.) and she does (1.0)
that this is the third time that she's lost her hair (.) hhh
Dee umh but I often wonder if she'd kicked in like feisty like
now before, would it have made any difference, isn't it
strange? (1.0)

RC umh

Dee because she did actually give up (1.0) not give up but
she just stopped living
RC but was she very poorly umh?
Dee no I don't think she was as poorly as the rest of us really (.)
she just thought that that's how she should behave (2.0)
and (1.0) it used to annoy me because I used to want to
shake her and say "come on"
I'd say where have you been this week?
you know you meet in chemotherapy (.)
where oh where have you been this week?
"oh I've not been able to go anywhere"
I said have you not been shopping? (1.0)
"No, I cant drive, she said I just cant- I cant drive"
I said you could go to Fosse Park you could park outside
(1.0) ha ha because if I was fed up I'd get in the car
go to Fosse Park for half an hour it sounds silly but that's my (.)
form of therapy
RC umh
Dee just have a won- a wonder round and I still walked my dogs
RC so, what, what was it about her then you think
that stopped her from doing anything
any ideas about that

I think she just became totally unempowered by the disease it overtook her whole reason for living and she had a strange thing is she had a husband like perhaps who would have suited me in a way but I suppose it wouldn't have done because I'm not that sort of person she had a husband who made it very easy for her to negate her responsibilities right he took over the shopping, he took over the chores he took over everything, he would drive her to every appointment so she, so the NEED for her to do these things right was taken care of, so that made her, it made it very easy for her- he would walk her dogs, their dogs yes now if she had a husband who said oh come on were going up, wherever, you can walk half the way because I only used to walk half the way at one stage I couldn't get round the reservoir umh I'd go half ha ha the funny thing is the dogs were younger then and they could walk for ever, now I'm, I could walk for ever they're too old to walk ha ha its not fair ha ha ha ha but she had somebody who made it very easy for her to do that right she didn't do any gardening, she didn't do anything and what do you think moved her out of that? the realisation that she didn't have long and the inordinate will to live that she admits that she didn't know she'd got (1) I wonder where it comes from I don't know
RC I mean how would you describe your quality of life before (. ) umh
(...) er you had your diagnosis?=
Zoe =I thought it was very good (. ) I thought it was (. )
you know, nothing particularly wrong with it but er I think you-
you value your time more .hh I've a lot less pati- I've a lot-
I've absolutely no patience with (. ) er, with er wasted time
RC umh
Zoe .hhh umh (0.5) and that sort of stuff (. ) and you- you sort of look
at things and I think you appreciate things (. ) and er (. ) the thing
that's (. ) quite striking about the whole issue is that er (. )
I- I think most people when they go, when- as- as they go
through their lives experience sort of some form of (1.0) er
depression be it mild or be it (. ) chronic or whatever
RC umh
Zoe .hh thinking o:::h god (2.0)
RC uh huh (1.0)
Zoe I'm not going to carry on and all the rest of it
but when you're life is threatened .hh what amazed me was just
just how much you swing the other way (. ) I suppose it comes
back to control doesn't it?
RC umh umh (1.0)
Zoe you er, sort of er, you fight bloody tooth and nail (4.0)
RC yeah (1.0)
Zoe for the control
RC yeah
Zoe I don't- I don't believe that you fight the disease, I think that's
absolute crap, but you- you er fight for the control and you- you
fight (3.0)
RC can you tell me more about that?
Zoe what?
RC fighting the disease being crap (4.0)
Zoe well what do you want to know? how do you- how do you- you
well you tell me how you physically fight a disease, mentally?
RC umh
Zoe what do you class as fighting it? Denying it? (2.0)
RC denying it? (. ) did you say?
Zoe do you think- do you think that maybe denying it is-
is fighting it? (. )
RC well it depends what you- meaning you put on these words,
that are attached around it isn't it?
Zoe [well this is what it is exactly, yeah yeah
RC I mean, I think er what you said about er (. ) control (0.5) I think
that's really very interesting because that's (0.5) er in relation to
taking control (0.5) of- of yourself and your life is a very, very
different way of er (. ) [looking at it
RC very different
Zoe I am going to do this and I will do this today
RC yes
Zoe sod the fact that I was po::isoned yesterday (. ) I'm going to do it
today
RC yes
Zoe but that isn't fighting the di::se::ase (. )
RC right
Zoe no, its er, it pisses me off (. ) you know it does anyway
RC yeah, but I mean, you think you know, its like, you know, you talk
about, people talk about coping (0.5) I mean not just with cancer
but I mean coping is a- is a word which is common in our
vocabulary=
Zoe =yeah well I don't like the word coping you see
RC I don't like it very much but I'm also wondering about what does it
mean? You're coping?=
Zoe =I don't know=
RC =or you're not coping=
Zoe =I haven't got the faintest idea
RC And I think, I mean I feel its something to do with control
because when it happens to me, when I'm oh I'm not coping with
this it means I'm not in control
Zoe umh
RC .hh and umh
Zoe not necessarily of the situation but of yourself (3.0)
er yess (2.0) yes (1.0) I mean it works both ways but I think (2.0)
if I'm not coping, yeah I'm not er (.) yeah its very much (.)
it's an internal thing

Zoe yeah

RC its not (.) what's going on out there or anything else, its how I'm
actually dealing with things

Zoe yeah, so, so you know, you're talking about self-control
rather- rather than con- controlling something's that's objective
that's out there, its the situation

RC yeah yeah

Zoe this is what it is, this is what it comes down to (1.0) the coping
stuff

RC if you're in control of things then=

Zoe =its not about coping with the disease, its about coping with you

RC yeah

Zoe full stop, this is- this is partly why this- this fighting stuff and this-
this heroic image and er this er (0.5) you know (1.0) brave bit
makes me so cross because it is just absolute total bollocks

RC umh

Zoe I think its rubbish (0.5)

RC umh

Zoe and its rammed down your throat (0.5) and I don't care what
anybody says, there is an expectation that that is the way you
should be, its what people expect (.)

RC yeah, and I think that's er=

Zoe =and I think that's where the strain comes in on the er individual
coping, because, you're trying to do that for (.) other people and
for you