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# Talking about cigarettes: conversational narratives of health and illness

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**ABSTRACT** In this article an argument is put forward that narratives of health and illness that are drawn from conversational rather than textual sources require a particular type of analysis. In common with other research on talk, it is argued that conversational narration is a joint activity and that the form and context of its telling can tell us as much about lay understandings of health as can the content of its stories. Analyses of narratives co-told during an interview are presented to consider how narration is used to rehearse plausible and implausible past, current and future actions and to bring off an entitlement to an unhealthy habit. The empirical material is drawn from a single interview selected from a collection of interviews on the subject of smoking. Only one interview is drawn upon to allow the narrative rather than the semiotic structurings of the material to be represented and analysed in depth.

**KEYWORDS** *causation; health; narrative; risk; smoking*

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## Introduction

[L]ay respondents tend rather to move back and forwards between concepts of cause which seem opposed, but which individuals can keep in equilibrium – belief in the responsibility about health behaviour and the importance of healthy mental attitudes on the one hand, and concepts of chance, luck and inevitability on the other. (Blaxter, 1997: 750)

Harry: Well I can't say that it's . . . we know what happens to most smokers. I mean tomorrow I could walk out into my car and that's it. But I keep wondering if it'll change as I get older but at the moment I'm mid twenties, it seems an awful far way off and there's a lot of things could happen before then. And, I think, I've seen quite a few people die of cancer and things like that. My gran died of leukaemia and she was a smoker. And my mum and dad have both been smokers. And my dad's got cancer through his family, and not through smoking. They've had bowel cancer things like that. (Interview excerpt: Harry.tape13 (326/332))

Telling stories is a fundamental human attribute. In the telling, a subject folds past and future into the present, or as Blaxter (1997) puts it above,

telling stories about health allows a 'lay respondent' to move back and forwards 'between concepts of cause'. In these movements the very logic of cause – as one thing directly leading to another thing – is created, questioned and worked upon not just by the teller but by their audience. As 20-something, married, male and middle class interviewee 'Harry' responded to an inquiry about his regular smoking as a risky behaviour during my interview with him, 'we know what happens to most smokers. I mean I could walk out into my car and that's it' [he could die in a crash]. The topic of this article will be found in working out why Harry should continue beyond this quite reasonable assessment of mortal risk based on random accidents to the seemingly irrational position of suggesting to the interviewer that his family experiences of cancer actually suggest a calculably greater health risk from smoking, and yet this entitles Harry to continue smoking.

Narrative creates multiple ways of knowing the world as a place in motion, as defined by change and yet as renderable, agreeable as a story but not necessarily as a story of precisely specified causes and effects. The brief oral stories told during health research interviews are contingent articulations which make sense out of that situation, they are accounting stories or stories of accountability (Radley and Billig, 1996): in this case Harry has to account for his smoking. Much has been written on lay accounts of illness and narrative (Mishler, 1984; Williams, 1984; Radley, 1993; Mattingly, 1994; Mogensen, 1996; Hydén, 1997) perhaps because it is a period in life when people struggle to account for how they came to be in their present position of suffering and what future might now lie ahead of them. A great deal less has been written on lay accounts of health and narrative since by a similar turn, it is understood in part as the absence of illness, the lack of a tellable event (Pierret, 1993). However being called to account for one's health still produces stories and is in turn a by-product of those stories, though as the following article will suggest, this account is likely to be more fragmentary since it is infrequently plotted and still tends to rely on relating health as normal life's 'background' to illness as an event: 'Health becomes tangible in being breached, where beforehand it might have been just an absence of bodily symptoms' (Radley, 1994: 46).

A second and important question that narratives and accounts of health raise is whether health should ever be treated, as Pierret (1993) and others have suggested, entirely as if it were a separable system of interpretation rather than a glossing practice (Garfinkel and Sacks, 1986). Blaxter's (1990) work in the Health and Lifestyles Survey demonstrated the heterogeneous nature of health beliefs which varied widely not only in what they represented but also in how her respondents reflected upon experiences in different contexts. What her work further emphasized was that other rationalities than that of 'theoretical coherence', or indeed biomedical expertise, were at work in accounting for health beliefs.

Picking up the lines of argument advanced by conversational analysts (Polanyi, 1989; Sacks, 1992), social psychologists (Shotter, 1993; Murray,

1997) and ethnomethodologists (Garfinkel, 1967; Lynch, 1993) this article will question the broad sweep of narrative analysis by reflecting on narratives gathered during interviews which are situationally co-constructed. In answering this question it will argue that a degree of caution should be exercised in treating 'stories about health and illness [that] are everywhere in books, in magazines, on television and in everyday conversation' (Murray, 1997: 17) as amenable to the *same* forms of analysis and interpretation.

If asking about health does not always lend itself to a good story since it often lacks an event to recount, asking about something else might end up turning into a revealing story about health. When Billig (1992) interviewed a series of respondents about the Royal Family, he ended up with a very rich collection of stories of nationalism, gender and the meaning of family life, a collection that would have probably been considerably poorer had he asked about nationalism, gender and the family directly. In a similar way, the complex reflections and partial narrations on life, death and health which this article will discuss arose out of interviews that were understood to be about smoking. Like the Royal Family smoking is a publicly charged topic, and is frequently the focus of argumentative stories which invoke health as one of several formal structurings to everyday behaviours, not least of course in conversational tales about what happened when for instance one person asked the teller to put their cigarette out or to smoke elsewhere. That tellable moment of argumentation about cigarettes and conduct may seem trivial but the importance of argumentation as it is told, and as it is used as part of another argumentation according to Billig (1992) is that we can learn about what it is that constitutes common sense about smoking and health and it is generally such common sense that sets the rules around what *doing being healthy* consists of. Smoking is interesting in a further way since it sets up a *problematic relation to health* for the smokers (and perhaps a temporary resolution for the ex-smoker). As long as someone is smoking they are indeed breaching the ordinary conduct of being healthy and are likely to reflect upon what doing being healthy means and how it might be extended (or not) to their unhealthy habit.

## Situating narratives

In this section I will sketch a brief history of narrative to consider whether more attention needs to be paid during analysis to the situated nature of stories gathered during research interviews. My sketch pencils in the early outlines of narrative analysis in the practices of folklorists and literary critics, where the object of their analysis was printed texts. Although any attempt to make a once and for all division between narrative achieved through writing and narrative achieved through talk is both misguided and unfeasible since each constitutes the other, infects the other and to divide them is to risk creating the kind of oppositional logic heavily critiqued by deconstructive approaches to speech and text (i.e. Derrida, 1979). Each is

engaged in a scriptural economy, they are 'social actions embedded in social worlds' (Plummer, 1995: 17).

Early work on the analysis of narratives is associated with the Russian Formalist school who studied folk tales and children's stories to establish a typology of possible patterns in the construction of a story (Propp, 1968). They divided narrative into two elements *fabula* (story) and *szjuhet* (plot). The story is the sequence of events and actions as they actually happened and the plot is the sequencing of events and actions as they are told. Formalism has some major drawbacks for analysing the content of any narrative since it was predominantly concerned with the uncovering of universal or meta-structures underlying all story-telling. Ricoeur (1991), one of the most important contemporary theorists of narrative, simplifies the confusing Formalist labels of story and plot into life and plot, and narration as the activity which struggles to bring the two together. Although a phenomenologist and arguably still in search of underlying unchanging essences to story-telling, Ricoeur's analyses of narratives are less reductive than Formalist approaches and offer greater possibilities for researchers interested in the form *and* content of narratives. Apart from his more philosophical speculations on the relations between life and narrative, Ricoeur's main objects of his analyses are narratives drawn from textual sources, in particular from literary novels. Indeed as noted by Potter and Wetherell (1987) there are plenty of textual sources such as novels, magazine articles, newspaper stories and autobiographies where health and illness are narrated and these have provided a rich source of material for tracing the ways in which health and illness are storied.

At its simplest, shifting narrative approaches from texts to talk involves holding on to a definition of narrative as 'an entity that is distinguishable from the surrounding discourse and has a beginning, a middle and an end' (Hydén, 1997: 50). The Formalists suggested that the sequential ordering of events is of critical importance since it is by such ordering that other orders are created by the narrator. Shifting away from a simple sense of language as a transparent medium which 'tells it as it is' there is a double emphasis on *how* the story is constructed and at the same time *what* it is representing, which becomes 'it is as it's told'. In the representational notion of narrative there is one problem worth highlighting which is that the narrative is still treated as a *reflection* of the real world of 'lay respondents'. Narrative is treated as a distorting mirror held up to a world in motion, held up by storytellers to reflect reality as it approaches, passes them by and recedes into the distance. If we are willing to accept 'it is as it's told', then this is to say that narration is the realizing, interpretation and organization of health and illness. Narrative in talk although not detachable from its present situation is part of a shifting out of a narrow and strongly contingent present tense of a conversation to a wider time span that may embed other stories directly or may borrow their formal structurings. In conversational situations a constant activity is cross-referencing, validating, looking for mistakes and inconsistencies in a

performance, so creating an agreed upon real is a normal part of the work of being involved in a conversation, reality is brought off by the conversation-ists rather than being an entirely given and determining structure. Even telling a lie about health or illness, if it has to remain hidden has to be constructed from appeals and references to a shared set of assumptions, so the narrative analyst will still be left with relevant material on appealing to everyday discourses of health and illness (Goffman, 1974). The central point that I wish to assert about conversational narrative, is that it is a negotiated and dialogical process for making up what is healthy and what is not.

The shift, as I noted earlier, that I wish to assert here is between kinds of narrative analyses still based in literary theory and the potential of a narrative analysis arising out of a conversational situation (Mishler, 1986; Sacks, 1992). Where in unstructured conversation 'every story is so full of comments and interruptions, negotiations and discussion' (Polanyi, 1989: 107) and as a result does not have the discrete bindings of a book. As Ochs et al. (1996) succinctly put it, 'stories often do not come in neat packages'. Telling is an action carried out interactively through turn-taking in the conversation, though not necessarily more 'democratically' as Polanyi (1989) suggests when it is in an interview situation. Oral stories are situated and situating activities. They are produced by and productive of who tells, how and what they are telling, who is listening and where and when it all happens (Shotter, 1993). Beyond their situated or contextual nature, narratives produced in conversation have a multitude of oral qualities such as variations in accent, pitch, pausing, intonation and the use of overlaps and silences which for the trained linguist provide endless fascinating data and for the ordinary participants provide important clues in the interpretation of often very brief stories (Gee, 1991).

## **A brief story about the project**

Research projects have their own guiding stories and the one related to this project that the grant-holder and the researcher told each other was about inheritance, disciplinary differences and competencies. The project was designed by a psychologist with an expertise in statistics venturing into 'qualitative methods' in health for the first time and it drew on a statistically powerful but fairly reductive model of addiction and behavioural change. It was designed drawing on her experience of statistics and psychology, but also of the interests and assessments of a funding body. A funding body that urged ever greater number of interviews to be carried out to ensure a representative population was created so that statistical analysis could be carried out on the interview data. When during the first quarter of the project the designer, and the main researcher, left for other jobs it was inherited by another member of the disciplinary team, a sociologist, and the author of this article, a cultural geographer, was appointed as the new researcher on the project.

To summarize from the grant proposal document, what was inherited was: to provide a degree of stratification interviewees were sampled from three different socio-spatial zones: one inner-city, one affluent urban district and one mixed suburban rural. With the co-operation of local GPs (UK doctors providing primary healthcare) a list of around 400 smokers and ex-smokers between ages 18 and 40 was generated and they were invited by letter to participate in the study. All of this had been completed and was thus inherited when the research project underwent a shift in its personnel. The legacy of the earlier stage of the project was that each interview – of which only around 50 were agreed to – was a one-off encounter between an interviewer who had been identified in advance in the letter of invitation as coming from a ‘health centre’ which while helping in accessing interviewees simultaneously caused an entrance-strategy obstacle since the interviewer was then assumed to have a medical role (and potential expertise), the interview was then associated with the power-laden role definitions of medical encounters (see Mishler, 1984, 1986). In the brief time left available the project underwent a process of (limited) adaptation by the inheritees which attempted to shift it towards explanations and understandings of smoking more firmly rooted in the interview-derived accounts of its ex-smokers and smokers rather than the numerical development of a model of behavioural change and addiction.

As the interviews were actually carried out certain perhaps unsurprising social trends in the 25 percent of the original ‘sample’ who had agreed to be interviewed on the subject of smoking, health and behavioural change, became apparent: the majority of the respondents to the mailshot were middle class, women were more likely than men to respond and homeowners than renters. However the project which had initially been concerned with statistical representativeness was now seeking out the shared and divergent discourses between a variety of individuals. Moreover in common with many ethnomethodological responses to discourses around the statistical sampling populations it retained a suspicion of a particular statistical use of terms such as ‘representativeness’ (Mishler, 1986; Lynch, 1993)

Pre-specified by the original project investigators and contractually agreed with the funding body, the interviews were to last an hour, they were to be semi-structured around a list of topics identified in advance by the senior researcher, the principal investigator (again see Mishler (1986) for a critique of the semi-structured interview). They were mostly carried out by the author of this article, as was the case with Harry’s interview which is drawn upon here. What should be borne in mind is that the interviews were not designed to elicit extended stories about smoking and health, though fortunately the interview provides a highly suitable occasion for co-telling of stories and it was the interviewer’s aim to attempt to reframe the interview as more conversational, informal and less medical. Each interview was thus prefaced by the interviewer introducing himself as a social researcher and not a medical doctor (see quote 1 below). It was during the post-fieldwork analysis of the

interview transcripts that a narrative approach was brought to bear on suitable empirical material. Part of the logic behind exploring the transcripts through narrative was derived from the interviewer's gradual substitution of question prompts such as 'when did you first start smoking' with stories about 'when my brother first started smoking' which led to an exchange of information via a more collaborative interview rather than a structured, controlled and well-defined list of questions from the interviewer and correspondingly limited responses from the interviewee. As a consequence of the interview inescapably being framed as an interview (that was the invite to which the respondents answered) (Phillips, 1993) the number of well-formed narratives produced was fairly limited. In choosing what transcript material to represent the interviews any kind of selection process inevitably silences numerous other possible stories about health and cigarettes and leads into questions as to 'why choose this respondent and not others?' Choosing just one narrative has even further ramifications, some of which are picked up later on in this section, at this point though it is the selection of Harry that has to be justified and not just on the grounds of typicality, since, though not a house-working mother, he was a middle class home-owner. For the interviewer Harry was one of the least intimidated of the interviewees, and importantly, was one of the quickest to reposition the interviewer as a social scientist rather than a medical doctor. Part of the explanation for this lies in the similarities in the social backgrounds of the interviewee and the interviewer (two white, male, middle class, young professionals). Nevertheless Harry's skill in bringing off stories during the interview should not be underestimated since he provided a particularly rich source of plots, which in the empirical space of an article can only be skimmed over. What is perhaps of greatest interest in Harry's interview material is his frequent use of humour to achieve a number different aspects of his performance as someone competent in managing his health while also allowing some of the moralistic and mortal charge surrounding cigarettes to be played with.

Excerpts from several interviews rather than solely Harry's might have been extracted from the project's data archive via coding, which is a method for tracing commonalties across large numbers of narratives and by that means revealing various shared discursive structures (Goodwin et al., forthcoming). In the interviews on smoking for instance, there was the 'walking under a bus' (Harry's 'I could walk out into my car . . .' [and have a fatal accident]) discourse of mortality and chance, where several interviewees either said directly they might die of cancer from smoking in later life but on the other hand they might be knocked down by a bus the next day. The possibility of a bus tomorrow weighed against cancer in a distant future, being one of those ways of sharing out the cause of their death to maintain an 'equilibrium' (as Blaxter might put it).

A dilemma inherent in reading across narratives to gather together shared discursive structures is that it is the interpreter that is creating one order out of all the chaotic instances, as the Formalists sought to do with



folk tales and children's stories. A further and more fundamental dilemma is whether speakers who often only uttered parts of that discourse in their narrative would follow that order or whether their very disorderliness offers alternative orderings of the world. In a critique of the work of Bourdieu and Foucault, it is de Certeau (1984) who most forcefully argues against this totalizing tendency in making everyday practices and everyday speech fit into theoretical structures. This critique is played out closer to the concerns of this article in Riessman (1993) and Polkinghorne's (1995) suggestions for a different practice of dealing with transcribed narratives than coding them (see also Psathas, 1990; Lucas, 1997). Beginning with Polkinghorne (1995) first, he distinguishes narrative analysis from analysis of narratives, which is to contrast looking for paradigmatic elements (i.e. codes) across narratives, with looking at the unfolding of one plot in all its complexities (what the semiotician would call the syntagmatic). What is lost in the abstracting of coding is 'the flow and flux of experience . . . the uniqueness and diversity of each experience' in favour of categorizing, ordering and abstracting. Polkinghorne and Riessman do not discount such approaches, instead they argue for their supplementation, in part to restore a sense of human subjectivity which is often diminished in grounded-theorizing.

Riessman's work on the practicalities of dealing with transcribed narratives are to consider 'how' interviews are 'transformed into a written text' (hence the earlier comments about the coding of the interviews) and whether during the process of determining the narrative meanings the narrative analyst leaves open the possibility of alternate meanings being derived from the narrative. Polkinghorne is more explicit in his demands, the number of narratives being dealt with have to be dramatically reduced. Riessman, as she closes her guide to narrative analysis, reminding the reader that sometimes only one narrative may be all that is required, citing Breuer's 'Anna O.', Garfinkel's 'Agnes' and Piaget's children.

In what follows, it is thus Harry's narrative that will bear the weight of an argument around the analysis of conversational narratives, one of their potential methods of interpretation and indeed about what kind of ordinary narratives of health emerge from discussing smoking. There are several complex systems for transcript notation (Atkinson and Heritage, 1984) used to mark up various important phenomena that occur such as speaking simultaneously, overlapping speech emphasis, doubt over transcribed words and non-verbal elements. For two reasons the quotes from the transcript of Harry's interview that is used throughout this article are simplistically transcribed. The first is a banal legacy of the research process, wherein the large quantity of interviews were transcribed for thematic coding and isolated quotation rather than for conversation or/and narrative analysis. Interview tapes were also reused thus erasing the original audio recordings, and so Riessman's (1993) warning to always keep the original interview tape for later more detailed transcriptions was learnt the hard way, through experience rather than foreshadowing. The second reason, however, is of a more

conceptual nature since it is one which is in sympathy with the overexamination of formal properties of conversation. Just as the Formalists were heavily criticized for their inattention to context, as well as content in favour of form (Hodge and Kress, 1988; Holquist, 1990), so it is that this article seeks to still address the transformations achieved by tellers of their situations and their lives. What this has meant during the analysis is still paying attention to *how* the stories are told (jointly, singly, heavily interrupted, ironically) yet balancing that with attention to *what* is being told, though clearly the two can never be truly separated anyway.

In practical terms this means that all non-verbal comments are put inside square brackets, lengthy pauses are indicated by three dots and the speech is uncorrected but partially punctuated for the sake of easier comprehension. The role of the researcher in this case has been in part interpretation and in part translation (Bauman, 1989), shifting understandings from one interpretative site (the interview) to another (the academic article). So my apologies to the conversational analysts for oversimplifying their method and to the interviewees for both oversummarizing their arguments and lifting them out of their common-sense situation (Radley and Billig, 1996).

### Doing 'being healthy'

What I want to use Harry's tale to examine is just how his conversational narrative diverges from a novelistic narrative since it is not directed to the same ends. As Sacks (1992: 215–21) suggests narratives worked upon for a novelistic text or autobiographical text will spend a lot of space and time describing objects and characters, motivations and feelings and often thereby achieving a great deal of precision, while narratives worked upon during a conversation with a stranger or even an acquaintance will often be remarkably unremarkable, frustratingly vague (though not for participants) and indeed stray towards the banal. Sacks argues that there is in effect a struggle between the tellability of daily events as worthy of interest and the tendency towards '*non*-production of stories' (p. 216) since speakers in demonstrating the 'utter usualness' (p. 219) of their lives (i.e. 'what's been happening?'/ 'just the usual') follow one rule which then demands special manoeuvres during the telling of unusual events such as Harry's panic attacks (quote 2) and brother's death (quote 3). When a conversational story is told it may well be to demonstrate with extraordinary economy a knowledge of how far an event deviated from the usual run of things and how it might still be recuperated to show an awareness of the correct conduct of being healthy.

It needs to be remembered at this point that one critical framing operating during the interview, was the overdetermined public narrative of the relationship between smoking, illness and health which disrupts doing 'being healthy' for an interviewee since they were already identified as either smokers or ex-smokers. Why this is of even greater importance in this

case, is the interviewer's projected role as a representative of health promotion and biomedicine (and perhaps the shared drive on his part to perform his utter usualness rather than an exceptional expertise) which was thus even more likely to elicit narratives that demonstrated competence in saying what being healthy is, while somehow balancing out smoking's position in this.

Interviewer: I see you've been decorating . . . [the kitchen is half-way through being wall-papered]. Right, you're a smoker is that right? Some things I'd like to make clear before we begin. I'm not here with a health message.

Harry: You're the first doctor that hasn't been then.

Interviewer: Well this is the other thing I have to explain I'm not a doctor of medicine, it's kind of research. I don't know very much about medicine at all . . .

Harry: Apart from Benlylin or something like that . . .

Interviewer: Exactly Aspirin, Nurofen . . . Okay, I mean, how many do you smoke? (Quote 1)

Harry was ironic throughout the interview, his overall mocking style – doctors without a health message, a doctor who only know about Benlylin – frequently disrupting the earnest tone of the interview (Stallybrass and White, 1986; Hutcheon, 1994; Burnard, 1995). Harry's disruptive tactic actually assisted the interviewer in shifting his presumed role as health professional and connotatively health promoter, to a more ambiguous and sympathetic role. Again echoing Billig's (1992) research on the Royal Family, where his speakers often used humour to make their point, a humourless retelling of their narrative risks both the subordination and occulting of their voices (Ahearne, 1995). It is too often assumed that interview situations are dominated by the structuring of the interviewer. Narrative, even in a disjointed form, is one of the key ways in which interviewees can argue their accounts in the face of 'semi-structured' interruptions from the interviewer. To recapture a sense of the economy of narrative requires some interpretative work on the part of interviewer to replace the conversation in its context where arguing may occur through less immediately apparent disagreements, being rendered instead by the interviewee's skilful use of the multiple levels of conversational understanding, where what seems to be agreeing may be quite the reverse (Boden, 1994) and indeed irony provides a richness to short exchanges that allows a conversation to explore the edges of the everyday knowledges it is unsettling (Hutcheon, 1994). In everyday conversation direct challenges to and from a story's recipient are rare, though there may be requests for technical (i.e. mishearings) or topical clarifications (i.e. misunderstandings) (Goffman, 1981; Schegloff, 1992), and during interviews where the interviewer is trying to maximize the comfort of the interviewee, direct challenges are even less likely (Kleinman and Copp, 1993), wherein irony again is important since it may provide a kind of challenge which is indirect. During

face-to-face conversation irony can be invoked in a multitude of ways since facial and manual gestures can be used to ironicize what is being said, as can altering the delivery of certain phrases though pausing mid-way through or before taking a turn, and through particular emphases on certain words or phrases. Yet I find for all Billig's (1992) examples of the skilful rendering of the humour of his interviewees, that though I can remark on Harry's use of irony I have found it hard to do justice to it in the transcription process.

Earlier in the interview Harry had firmly tied his smoking to coping with, alternately, periods of boredom and high intensity at work. His job had been with an electricity supplier, initially in their operation department where he had to work a shift system, sometimes in solid slots of 24 hours 'if the system went down', and at the time of his interview much to his relief he had finally been moved off the shift system. During his shift work he was frequently working alone at night and used the cigarettes to break up the long eventless hours, equally when work got really busy he hardly smoked at all, until there was a break when again he would have a cigarette. Smoking was, like narrative, a device for the marking of an otherwise blank passage of time, or dividing up the ceaseless rush of experiences during a busy stretch of work. Accounting for his 'bad habit' went beyond this kind of emotional time management to its importance as a tool in establishing friends at work and in fact acquiring a wider spread of social connections within his workplace than non-smokers. Ostracized from their workplace, the smokers ended up with feelings of solidarity and even some degree of, as Harry put it, 'wildness' signified in not only their labelling of themselves as the 'ravers' but the adoption of this label by other people at their workplace.

The 'style' as 'frame' (Riessman, 1993) of the interview changed, becoming more serious, as the conversation moved on to Harry's panic attacks (quote 2). Over the past two years Harry had been 'ill', suffering from stomach pains when he went out for a meal, symptoms which had been diagnosed by his GP as a stomach ulcer. He had been unhappy with this diagnosis, since Harry suspected his doctor was making the diagnosis on the basis of smoking and ruling out all other factors:<sup>1</sup>

- Harry:  
[frame] He thought, I was a smoker and *so* I had a stomach ulcer,  
[problem] so he actually did misdiagnose because he put 2 and 2 together  
because I was suffering like I was feeling sick  
[complication] . . . But . . . I was explaining to the other doctor that I was all right  
when I was at home. I could drink, I could eat curries, chillies  
things like that but when I went out I couldn't go out. Or you  
know I just didn't feel comfortable being out, and that was . . .  
[evaluation] I tried to tell him that as well but he just didn't listen to it. He  
just, I think he just said, do you smoke?  
[2nd problem] And that was the answer and he gave me ulcer tablets. Which

made no difference. I ended up just as bad. And getting more worried because I was thinking this must be in my mind sort of thing.

[resolution] And now we've got the hang of it, or we've got a hold of it, or it's a long medication to just try and stop these attacks. Once I get over that, and you know, it is working. (Quote 2)

In the brief story my interpretation (though I hope there is room for disagreement) is, as broken-down on the left-hand side, that Harry was situating and evaluating causes and effects. Harry was, I would like to argue, attributing his, what might be better called ill-health, back to his work situation (which he mentioned in an earlier dialogue) where he was under particular stress, frequently working 17-hour shifts, and at the same time helping plan and organize his sister's wedding. Blaxter (1997) makes the point that the middle classes use more mental terms in describing the experience of health or ill-health and 'indeed, "stress" is seen by both the working class and middle class as associated with managerial and professional jobs' (Blaxter, 1997: 754). However, what Harry was telling in his narrative was not opposing concepts of cause from his own understanding of his health, but opposing causes from on the one hand the overestimation of smoking's causation of ill-health by his doctor, who too quickly put 'two and two together', and his own attribution to external factors such as overwork and a life event (his sister's wedding), rather than smoking. The second point to pick up here is Harry's reference to his own understanding and experience of his condition which helps him question the doctor's diagnosis, and yet the more that an expert disagrees with him, the more that he is pushed towards 'thinking this must be in my mind'. Curiously then the more that Harry's health and his doctor's diagnosis is put into question by his experience, the more that he is willing to give jurisdiction and understanding of his body to medical knowledge and question his own reason. It is at the moment when after a year and a half of being treated for stomach ulcers that another doctor suggested Harry might be suffering from 'these [panic] attacks' that there is a return to his embodied understanding: 'got the hang of it, got a hold of it' rather than just 'thinking about it'.

Harry though not actually quitting smoking had cut down and changed to a lower tar brand during the last two years as one 'responsible' response to his ill-health even though he remained sceptical about its role. Importantly the story Harry is telling as quoted here and as told in other parts of the interview is about his illness interview with his doctor – it is a play within a play. And to return to the central argument about the importance of situating this narrative within its conversational context. Harry is, by its close, making an excellent display of his own competence in restoring and restoring his health and managing his illness. Being respectful of the authority of the doctor even though he and I, in the story he is telling me, know that the doctor will probably be wrong, which we know by the way Harry puts

emphasis on: I was a smoker *so* I had a stomach ulcer, and then as he evaluates what is going on later: 'I tried to tell him that as well but he just didn't listen to it . . . he just said, do you smoke? . . . and that was the answer' and also in his shifts from a distant past tense at the opening of his story to an involving (yet also contingent, indicating his optimistic scepticism) present tense by the end (for comparable material on recounting panic attacks, see Capps and Ochs, 1995). However, remain inside the summarized and labelled narrative of quote 2 and there is a risk of losing the contextual play within which this story is being told. This is a story about medical authority being wrong, it is further a story about the pre-selection of smoking cigarettes as the cause of any 'sickness', it is being told mid-way through an interview in which the interviewer has deliberately distanced himself from medical authority and yet still wants to know about the reasoning behind starting, stopping and restarting smoking. Talking about health and smoking has provided the occasion for a story about ill-health and smoking, that posits smoking as non-causative. That a doctor should suggest cause and be proved wrong adds to the strength of the reasonableness of Harry continuing to smoke even while suffering different kinds of ill-health.

What I would like to suggest is that Harry during quote 2 and once again in quote 3 is using short conversational stories to build up his entitlement to smoke. As mentioned earlier Harry already reported several different sources of stress: his hours of work, the content of his work, the arrangement of weddings, his stress-related illness and, in the following quote, the death of his brother. In the face of all this stress his health is not simply a *given* it is an *achievement*. It is an achievement that might well have failed without Harry's cigarettes, which is one thing that the panic attack story skilfully demonstrates to the interviewer. Part of this entitlement to smoke is constructed by Harry through the stories he is in turn entitled to tell as his own experiences as in quote 3, rather than an embedded story of someone else's experiences where the interviewer would on their part be entitled in turn to express some degree of disagreement. Of the many smokers interviewed during the project there were few who did not produce stories about smoking and early death. However it was very different to state succinctly that one could fall under a bus the next day compared to telling a story about the experience of actually seeing your brother crushed by an oncoming lorry.

Harry: Go to work on an egg and come back in an ambulance as they say . . . I mean I had a brother who was diabetic. And he died about 26 of a diabetic coma, that's when my parents found out that I smoked, obviously that's quite a stressful occasion for all concerned and I just turned round and said, look I need a fag. I'm sorry, if you're disappointed in me. And my mum said, at least we know now. It doesn't really bother us.

Interviewer: How old were you then?

Harry: I was twenty when John died.

Interviewer: So you were quite a lot younger than him?

Harry: Yeah, but eh I'm not a diabetic so it kind of takes away that edge of it from me. It's not immediate to me in that way, but it makes you realise that it can happen any time. You know that's really the attitude. Why worry about it, it comes to us all. (Quote 3)

This brief extract comes close to not seeming like a story at all, yet it does still report an event which it marks out as tellable and is prefaced by the 'go to work on an egg' common saying and then closed by second common saying, 'why worry about it, it comes to us all'. Harry's brief narrative of the funeral, as an encounter with family loss, became the stage to introduce his own mortal habit in front of his parents, as guardians of his health, and risk their disappointment. And what did it mean there, in the unavoidable confrontation with the potential mortality of children, mortality which has been excluded from most other realms of everyday life in the West?<sup>2</sup> As Harry explains the situation, he receives tacit acceptance from his parents of his unhealthy, 'immoral' and mortal habit in the face of greater loss. He is entitled within the story to let go of the responsibility for and duty towards his health that the gaze of his parents normally demands, because of what he has directly experienced of suffering and death. 'It' haunts this tale, 'it' is death, it is life and death signified by smoking a cigarette, and it is several other experienced rather than reported deaths which Harry mentioned during his interview: grandmother, brother and friend's mother. And in the depiction of smoking a cigarette during the funeral scene is perhaps rendering of the death of immortal, health-laden childhood.

My gloss here is that Harry's story produces his entitlement to assess the experience of death against the duty to be healthy (Lupton, 1995). If he were telling someone else's story about having a sibling die young of a death unrelated to smoking then it would be fairly close to the simple truism of the possibility of being run over by a bus the next day and be open to challenge. As it is through Harry's entitlement to tell this story to the interviewer he also staked a claim on his entitlement to smoke in several different ways: by allowing his parents to witness him being unhealthy for the first time and by having 'realise[d] that it comes to us all'. A realization based on experience not on a reported and so more distanced less authoritative awareness of the mortality of the self and significant others.

## Conclusion and discussion

Narrative endings are changeable, mobile and may even be used to reshape the beginning, yet the expected endings are not quite as limited as the Formalists would suggest through their analysis of the possible narrative patterns and as conversational analysts would suggest through their attention to the requirements of ordinary conversation. I introduced this article by quoting Blaxter (1997) on lay respondents moving back and forth between opposing concepts of cause of health and illness, one which emphasizes

agency – a person's behaviour and attitude – and the other which emphasizes external forces – luck and inevitability. Without overt theorizing and without a high degree of competence in medical knowledge, lay respondents use narratives to move back and forth between their own and others' past experiences and potential futures. Interviewees are, it would seem, hard at work attributing responsibility, stressing their entitlement to break certain codes of healthy behaviour and assessing past, present and future suffering in their dialogues with the interviewer. More than that though they are using their stories to demonstrate their competence in establishing the important aspects of doing being healthy. Cigarette smokers begin from a disadvantaged position with demonstrating the work they are doing to be healthy, as Harry's story about his encounter with his doctor demonstrated, their competence to act healthy is under question because they have already acted unhealthily. To balance out his account Harry shows how cigarettes assisted in achieving health in the face of a highly stressful job which had caused him to be ill and moreover he displayed his entitlement via the experience of death and loss to disregard the social duty to be healthy.

The curiosity with smoking cigarettes as Klein (1993) frequently remarks is why should people continue with their habit even when they know how bad it is for them socially and in terms of their life expectancy and indeed when they know how much damage it does to their moral career (Goffman, 1964). Smoking then is a classic narrative complication (a breach of health norms, an immoral behaviour and an anti-social habit), endlessly productive of narratives offering resolutions (giving up), evaluations (improving health or not, more or less stress, whose moral judgement and whose responsibility) and further complications (allowing parents to witness it, restarting, having health researchers knock at the door). What is specific to the conversational narrative is the situation in which it emerges, so in this case during an interview with a researcher associated with health, in such a situation smoking is not simply a narrative complication it is actually a reason for shifting out of the usualness and non-storyability of life.

As was noted at the outset of this article when one tries to consider health as a narratable event in its own right there is very little to tell since *being* healthy is almost by definition a non-event, it is what is taken for granted, as against *becoming* healthy or *becoming* ill. Health then tends to be shifted into being active, being as well as others and (in this case narratively) ready for illness. Health is treated as the ordinary state into which illness enters as a complication, yet even health as ordinariness requires work to bring it off. Narration offers the possibility of dealing with major and minor breaches in doing being healthy, so that smoking among other things can be the complicating issue which requires repair work for the smoker's reputation. The reasonableness of smoking can then be resolved narratively in a variety of different ways which will be shaped by who such a course of conversational narrative as social action is co-performed with.



Harry, like other interviewees in the study, tried out several rich and economical conversational narrative logics in his account, none of which I could discount as either true or false, especially when they were delivered ironically. They are rather several sense-making attempts which can be taken as situated dialogues (in the interview) while also attempts to create, sometimes actions, and always endings, good and bad, beyond the interview: for Harry to retain his remarkable unremarkableness and for my understanding of what constitutes a reasonable account of continuing to smoke. However there are strong limits on what can be said during a one-off interview since it is a public account (Radley and Billig, 1996) and equally importantly on *how* things can be said, to fail to perform those limits would be to display an unacceptable level of socio-situational incompetence. What doing being healthy in a conversational narrative sense means with a professional interviewer may be considerably more restricted than the narration of health for kith and kin. Explorations of the varying conversational narratives produced in familial and friendship and other non-interview situations would be a worthy area of future research into understandings of health and unhealth (and it may be worth considering why unhealth seems such a strange category even though unhealthy is not such an odd description).

Returning to the importance of the difference between narrative theory which draws on textual and visual sources (novels, autobiographies, films, etc.) and conversational sources, the importance of timing of the conversation is a more fundamental activity in a conversational narrative (Lucas, 1997). An inscribed source comes to an end whether it be an arbitrary cut-off point implying no real resolutions or alternatively a virtuoso tying up of several plots into a fantastical resolution. The smoking plots told by Harry and other interviewees are picked up and put down many times, new evaluations are linked in and old ones discarded. That such moves are carried out banally hides the complex symbolic and discursive work going on in conversation in a way that tends not to occur in the narratives of magazines, films and advertising (though they have their own styles of banality). As Radley and Billig (1996) emphasize conversational narratives are told jointly and under 'real-time' interactive conditions which normally engage participation via various frameworks: people having already had many conversations about and with cigarettes and the interview providing a particular occasion for revisiting and remaking those conversations. As conversations are continued elsewhere beyond the interview, tellers and audiences are attributing and checking with their co-tellers felt probabilities – 'there's more chance of me giving up than you', 'you're at greater risk than I am' – yet they are also perhaps highlighting how smoking itself can be a vital part of that joint activity of their conversations.

### Notes

1. The labelling and summarization method used below borrows from Riessman (1993), to look for the stating of problems and solutions in a section of extended

narrative which although created out of a conversational situation does not rely on any more than affirmative prompting from the interviewer.

2. For a rich account of mortality's banishment from western societies see Bauman (1994).

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