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The social construction of lung cancer: An analysis of representations of lung cancer in UK media

by

Sally Ann Moore

Thesis for the degree of Doctor of Philosophy

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ABSTRACT

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Lung cancer is a commonly occurring cancer in the United Kingdom. However, little attention has been directed at understanding meanings in relation to the disease, and how these are socially constructed. This thesis examines representations of lung cancer in media stories to explore how the disease is constructed and with what effects.

Drawing on a social constructionist approach, media stories are understood as public places or sites in which meanings about the world are produced and reproduced through language and discourse. Media portrayals of lung cancer are examined for their content and how they may function to construct meanings and knowledge about lung cancer and people who develop the disease. Media portrayals of breast cancer are used to compare and contrast how the two diseases are portrayed in order to identify differences that may have implications for the construction of meanings.

The analysis identifies that media stories draw heavily on discourses that associate lung cancer with death and smoking. It is suggested that stories also draw on wider cultural discourses in which health and dying are constructed as moral issues. As a consequence, lung cancer is constructed as a potentially blameworthy death and thereby unworthy of public attention and support. In contrast, media stories about breast cancer draw on discourses that associate the disease with survival and factors that suggest women as 'at risk' rather than the cause of the disease. As a consequence, breast cancer is constructed as an indiscriminate threat and, as such, worthy of public attention.

The thesis argues that media representations are illustrative of the social processes and conditions involved in the production and sustenance of lung cancer stigma.

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DECLARATION OF AUTHORSHIP

I, Sally Ann Moore, declare that the thesis entitled 'The social construction of lung cancer: An analysis of representations of lung cancer in UK media' and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission.

Signed: ……..

Date:……

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1. Introduction

1.1 Introducing the study

This research stems from an interest in how meanings in relation to lung cancer are socially constructed, and the effects of these constructions. Lung cancer is a commonly occurring cancer affecting around 43,000 individuals each year in the UK (Cancer Research UK (CRUK) 2014a). Most of these individuals will die of the disease within one year of diagnosis (CRUK 2012a). Recent and ongoing initiatives aimed at increasing survival from lung cancer include efforts to streamline diagnostic and treatment pathways, increase public awareness of the disease, and promote the importance of early diagnosis. However, little attention has been directed at understanding the social context in which the disease is experienced, diagnosed and treated. In particular, there has been little research undertaken to examine the social processes in which meanings about the disease are produced.

The term media is used in this thesis to refer to any form of public communication. Media comprise a multitude of artefacts (for example, newspapers, magazines, television and radio broadcasts, advertisements, film, art, mobile telephone and internet-based content) that influence understandings in all areas of public life within modern contemporary societies (Philo 1990). Health and illness are frequently represented in media stories, and media are cited as sources of information about health and illness for lay people (Petersen 1994; Kitzinger et al. 1999). However, media not only inform audiences; they also produce meaning and create culture (Hall 2013; Miller et al. 1998; Petersen 1994; Lupton 1992). This conceptualisation of media draws on a constructionist understanding in which media are viewed as representational activities or practices in which meanings about the world are constructed through shared language use and discourse. In this perspective, therefore, media are meaning-making processes and media products can be examined for their constitutive activity.

Drawing on this social constructionist conceptualisation of media, the study presented in this thesis was devised to explore how media processes act to construct meanings in relation to lung cancer. Media texts in which lung cancer

is represented are examined, paying particular attention to their constitutive and action-orientation properties; that is, how they function to construct lung cancer and individuals who develop the disease. Media texts that represent breast cancer are also examined. These act as a point of reference from which to identify differences in how the two diseases are portrayed, and speculate on the consequences these may have in relation to how meanings and knowledge about lung cancer are constructed.

Within a constructionist approach, meanings and knowledge in relation to lung cancer are understood to be produced through activities and interactions within the particular cultural and historical contexts in which the disease is situated and experienced. In adopting this approach, the constructed and situated nature of the meanings and knowledge produced in this thesis is acknowledged. The purpose of the study, therefore, is not to present a single objective truth in relation to how lung cancer is constructed, but rather to offer one (my) reading or interpretation of the media texts examined – which, it is hoped, will open up discussion and further critique.

1.2 Situating myself as the researcher

As suggested above, adopting a social constructionist approach draws attention to the researcher's own role in the production of knowledge. The research presented in this thesis and the accounting of it is not a neutral process; it is a situated one, which is culturally, socially and historically specific to my position as researcher, author and PhD candidate, among other roles. For this reason I present a brief biographical account to situate myself within the research.

The study and this thesis build on my thirty-year career as a nurse, a cancer nurse and, for the ten years prior to undertaking this doctoral study, a lung cancer nurse specialist. My interest in lung cancer has lasted almost as long as my nursing career. I remember the first individual with lung cancer that I cared for – a gentleman in his early fifties whose diagnosis had prompted his return to the UK from abroad where he had been living and working. This initial 'contact' with lung cancer was on my first ward as a nursing student. His stay on the ward was almost as long as my eight-week placement there. He had been admitted to hospital for radiotherapy and pain control, and he died on

the ward the week before I finished my placement. Caring for this gentleman created an interest in cancer and lung cancer in particular, born I sense now, from a feeling of being useful to him, despite my novice status, at a difficult time in his life. Since qualification as a registered nurse I have worked mainly in oncology; during the last fifteen years prior to my PhD study I have specialised in lung cancer, initially in an inpatient setting and latterly in an outpatient hospital setting. Three of these years were spent working as a researcher involved in the day-to-day running of a randomised controlled trial comparing nurse-led follow-up of patients with lung cancer with conventional follow-up care. The most recent ten years were spent as a lung cancer nurse specialist at Guy's and St Thomas' NHS Foundation Trust, London and the Royal Marsden NHS Foundation Trust, London and Sutton. My interpretation of this role is to provide support for patients and their family members during the period from diagnosis through to recovery or end of life.

Undertaking full-time study at PhD level is the realisation of a long-held ambition. For me it represents a privileged opportunity to study an issue in depth, having 'time out' to think and reflect about healthcare in a way that is seldom possible in clinical practice. I am fortunate to have been awarded a fellowship from my employer in order to study full time. Initially, when I enrolled on to the MPhil/PhD programme I planned a very different research study, which explored experience through the use of interviews with patients and family members. However, my supervisors encouraged me to spend a little time reflecting on what I wished to gain from PhD study, and perhaps to use this opportunity to 'think outside my comfort sphere' (my interpretation of their words) in terms of the different ways to attain knowledge through research. My supervisors are Professor Jessica Corner and Dr Lucy Brindle; both have a research interest in lung cancer, and both work at the University of Southampton. Professor Corner is Dean of Health Sciences and Chief Clinician for the charity Macmillan Cancer Support. Professor Corner has an international reputation for her work in relation to cancer nursing and cancer care, and she was the Chief Investigator for the nurse-led follow-up study mentioned earlier. Dr Brindle is an epidemiologist and social scientist and is experienced in conversation analysis and discourse analysis.

After a few months of reading and thinking about their advice, I decided on the study presented in this thesis. However, at that stage the epistemological and

theoretical implications of the study were not as apparent to me as they are now. My understandings of these aspects have developed through the conduct of the study and the writing of the thesis. Indeed, I am sure they will continue to develop and become still clearer after the PhD process is over.

This brief biography is intended to situate myself as the researcher within the thesis, recognising that personal and institutional contexts, as well as the epistemological, theoretical and methodological choices discussed later, will have shaped the research process and the knowledge produced.

1.3 Structure of the thesis

There are seven chapters in this thesis, of which this is the first. **Chapter 2** is titled 'Describing the research' and it comprises three main parts. In the first part the rationale for the research is presented. I describe the initial thoughts that prompted the research and the decisions involved in selecting the design of the study. A review of the literature that has examined the reporting and representation of cancer in media is presented in this chapter, since this literature provided a rationale for the study and informed its design. In the second part of the chapter the theoretical and methodological approach of the study is presented. I position the research within a social constructionist framework whereby representation is conceptualised as a culturally and historically situated process in which meaning is constructed through language and discourse. Media are conceptualised as social practices involved in the activity of representing aspects of the world. In the third part of the chapter I describe the methods used to conduct the study in relation to the retrieval and analysis of media texts. The word 'text' is used to mean any media artefact, including written, visual and audio materials. I also discuss issues of validity that have guided the conduct of the study and the construction of the thesis.

Chapter 3 is titled 'Contextualising the research'. The purpose of this chapter is to situate the research within a historical and social context. The importance of this positioning of the research draws on the theoretical approach to the study, which conceptualises representation as a social activity in which meanings are constructed through interaction with the wider cultural context. In this chapter I attempt to trace social understandings of lung cancer from when the disease first seemed to 'emerge' as a significant health problem to

the present day context. Inevitably, this representation of lung cancer is a situated one; subject to the perspectives that I bring to the research.

Chapter 4 is titled 'Examining representations of lung cancer and breast cancer'. In this chapter, the results of a broad exploratory thematic content analysis of all the media texts retrieved for the study are presented. Initially, I describe the grouping and coding of texts in relation to what they are predominantly about and the most prominent themes of their discussion of lung cancer or breast cancer. Then, I present a thematic content analysis of the two datasets in which the most prominent themes identified are used as a framework to compare and contrast how the two diseases are portrayed in relation to each of the themes.

Chapter 5 is titled 'Personal stories of lung cancer and breast cancer: Narratives of dying and survival'. In this chapter the analytic lens narrows to examine texts that contain a personal account of lung cancer or breast cancer. These texts are selected because they provide an opportunity to examine in greater detail how the personal experience of lung cancer, in particular, is portrayed. Texts are examined for their content and action-orientated function; that is, a search for pattern in the data in terms of features that are shared by texts or variability and differences between them, and the potential social consequences of this patterning. Previous sociological studies that suggest that the experience of cancer is constructed as a heroic event (Seale 1995a, 2001a, 2002) are used to inform the analysis presented in this chapter.

Chapter 6 is titled 'Examining personal stories for evidence of blaming activity'. Personal stories of lung cancer are examined and compared with personal stories of breast cancer to develop an emerging theory regarding the function of texts in relation to blaming activity. A model of blame proposed by Malle et al. (2012) is used to examine personal stories of lung cancer and then personal stories of breast cancer. Differences in how individuals with lung cancer and breast cancer are positioned in relation to blame are identified and discussed.

Chapter 7 is titled 'Discussion'. In this chapter I present the implications of the study in terms of its contribution to existing knowledge in relation to how lung cancer is socially constructed. I suggest that representations of lung cancer may be constrained by wider social and cultural discourses in relation to dying

and individual responsibility for health. This activity contributes to the stigmatisation of the disease in that it acts to marginalise some representations of the disease. I go on to outline some of the lessons that I have learned during the conduct of the study and discuss some of the study's limitations, before concluding the thesis with some final thoughts.

2. Describing the research

This chapter situates the study in relation to previous research and within a methodological and epistemological approach. First, the rationale behind the research and study design is discussed. This discussion includes a review of the literature surrounding media reporting and representation of cancer. Next, the theoretical and methodological concepts that have guided the study design and its conduct are presented. Finally, I describe how the study was carried out in terms of the methods of data retrieval and data analysis.

2.1 Rationale for the research and study design

2.1.1 Initial ideas

The research stems initially from reflections on an issue within my professional practice area, namely the late diagnosis and poor survival of people with lung cancer. Only a third of people diagnosed with lung cancer in the UK survive beyond a year and less than one in ten people survive for five years or more (CRUK 2012a). Late diagnosis is cited as one of the main reasons for poor survival and promoting earlier diagnosis is a key target of current national initiatives (Richards 2009; Walters et al. 2013). To date, initiatives have approached late diagnosis from two perspectives: Firstly, the problem has been tackled from an individual perspective aimed at understanding the factors that prevent people with potential symptoms of the disease from presenting early for healthcare advice. For example, work has recently been carried out to examine levels of public awareness of symptoms and risk factors of the disease (Simon et al. 2012). Secondly, the issue has been approached from a service provision perspective to understand factors within the healthcare system that delay diagnosis and treatment once people have presented for medical advice. For example, there have been initiatives aimed at improving referral pathways into specialist teams, cutting hospital waiting times, establishing specialist multidisciplinary teams and reconfiguring surgical services (Richards 2009; NHS Executive 1998).

However, there is a third perspective aimed at understanding the wider social context in which diagnosis takes place, which has been largely been ignored.

2. Describing the Research

Corner et al. (2006) and Corner and Brindle (2011) suggest a need to examine the disease from a broader perspective in order to identify how the social context may influence the illness experience and contribute to the timing of diagnoses. In the study by Corner et al. (2006), and also in a further study by Moffat (2006), individuals diagnosed with lung cancer describe the initial attribution of potential early symptoms of the disease to benign, everyday causes such as ageing. The two studies suggest that lung cancer does not seem to feature in people's consciousness as a possible interpretation for bodily changes. Corner et al. (2006) draw attention to the disease's lack of social prominence and contrast it with breast cancer where media and public health messages have led to a 'near universal acknowledgment' of the need to seek medical attention for a breast lump (p1389). Moffat (2006) suggests that lung cancer's lack of social prominence may influence individual behaviour in relation to diagnosis since there is no social narrative of lung cancer – no story or plot-line for people to identify with and place themselves in.

These thoughts regarding the lack of social prominence of lung cancer and its consequent lack of influence on the timeliness of diagnosis formed the starting point of this research. They led me to reflect generally on how the social context in which an illness is experienced may influence the personal experience of it, and the ways in which health and illness are socially defined and constructed. I became interested in the meanings and knowledges about lung cancer that are socially available for people generally to draw on in order to make sense of the disease within the context of their everyday lives. My thoughts then turned to how this issue might be explored further. A possible research approach would be to use interviews with individuals and/or groups to access public understandings of the disease and perceptions of the source of these understandings. This approach positions individuals as 'active knowers' (Brown 1995, p45) and presupposes they are fully aware of their experience of the social world and are able to articulate this within a research context (Fischer 2009).

However, I was also drawn to arguments made in two reviews of sociological research, encouraging researchers to look beyond the micro to the macro level of social analysis, moving beyond the research interview and the individual perspective to examine wider social structures and their potential impacts on health and illness (Lawton 2003; Pierret 2003). Pierret (2003) draws on Bury

(1991) to define the social structure in this context as health policy and the roles played by patients' associations, consumerism, charities and media. Pierret particularly singles out the role of media for evaluation arguing that media diffuse values and norms in relation to health matters. These arguments led me to consider examining media representations of lung cancer as a way of approaching the research since these are publicly available discussions in which meanings are produced and circulated. At this stage my interest was in understanding how media might shape public understandings of the disease.

2.1.2 Media and health

People construct their understanding of the world, including their beliefs about health and illness, from their personal interactions with others and with cultural artefacts in the world around them (Lupton 2003; Hall 2013). Media are fundamental components of mass culture, playing a seemingly ever-increasing role in the everyday lives of most people living in modern, capitalist societies like the UK. Media are argued to have a strong influence on what and how things come to be defined as issues in society (Philo 1990; van Dijk 1991; Hall 2013). Representations of health and illness are a common feature of media and these can be influential in a number of ways including setting agendas within society for the discussion of health issues, presenting images of 'typical' diseased persons, suggesting causes of illness and disease, pressuring governments to act, and influencing funding for health and research (Lupton 1994; Henderson & Kitzinger 1999; Philo 1999; Petersen 2001; Williams et al. 2003; Sare 2011). Thus, media are thought to have become major sources of public information about health, and people's behaviours in relation to health and illness are thought, in turn, to be profoundly influenced by media representations (Chapman & Lupton 1994; Bunton 1997; Miller et al. 1998; Henderson & Kitzinger 1999; Lupton 2003; Seale 2003). For example, media coverage of celebrities' experience of cancer, or screening for the disease, has been correlated with an increased demand for services by the general public (Nattinger et al. 1998; Cram et al. 2003; Chapman et al. 2005; Kelaher et al. 2008).

Media representations are subject to many determining influences. They represent interpretive choices made by journalists and other media producers in constructing a particular version of the world in line with political or

ideological affiliations and how audiences are perceived. Typically, media producers are attracted to stories that are characterised by drama, controversy, human interest and simplicity (Williams et al. 2003; Kitzinger et al. 1999). They also favour topics relevant to societies' élites, stories about common or unusual things, and stories which are negative (Lupton 1994; Nelkin 1996; Kitzinger et al. 1999; Henderson & Kitzinger 1999). Within news media, for example, journalists select items which they believe are sufficiently newsworthy to report. They then construct how the item will be presented, making choices about headlines, images, the use of experts and links to web-based material. Increasingly, financial and practical constraints mean that stories are produced in highly routinized ways, often with a reliance on, and reproduction of, press releases authored and supplied by interested parties such as government departments, medical and scientific institutions, pharmaceutical companies and charitable organisations (Freimuth et al. 1984; Rowe et al. 2002; Benelli 2003). Therefore, these external parties also have a significant influence on the production and content of media stories. In this way, media practices serve to perpetuate and reinforce the views, perspectives and preferred discourses of these dominant external parties (Freimuth et al. 1984; Singer & Endreny 1987; Kitzinger et al. 1999).

In the UK, from the 1960s onwards media have been enlisted as a public health tool to warn the public about health risks (Berridge & Loughlin 2005). This practice is based on the assumption that public awareness of the risks involved in certain activities will lead to avoidance of those activities. However, despite the influence of medical and scientific professionals in the production of media stories, the reporting of issues relating to health and illness is often criticised for errors of omission, over-generalisation, sensationalism, bias and changed emphasis (Singer 1990; Molitar 1993; Nelkin 1996; Berry et al. 2007; Bomlitz & Brezis 2008). Conflict arises because of differing views regarding the role of media in relation to health and illness information, and what is deemed newsworthy and of interest to the public (Johnson 1963; Peters 1995; Nelkin 1996).

Ultimately most popular media seek to entertain and they are driven by what sells. Therefore, in creating a story, media do not necessarily prioritise the risks and concerns that are judged to be the most important by so-called experts in health (Johnson 1963; Kitzinger et al. 1999; Clarke 1999a). For

example, news media are often biased towards emerging health hazards, so that the public may consider these to be more serious and pose more of a threat than equally serious but under-represented hazards (Young et al. 2008). Also, different media formats may prioritise different agendas and representations because of perceptions about their different audiences. In the UK, for example, 'broadsheet' or 'serious' newspapers often focus on the scientific aspects of a health story (sometimes referred to as 'hard' news) while 'tabloid' or 'popular' newspapers may focus on the 'human interest' aspects of a story such as a personal account of illness (sometimes referred to as 'soft' news) (Kitzinger et al. 1999). These choices are based on assumptions about the educational level and interests of a specific newspaper's readership.

2.1.3 Studies of media representations of cancer in the literature

A literature review was undertaken to inform the study design in two ways: first, to explore how other researchers have approached examining representations of cancer in media; and second, to identify the types of understandings and knowledge derived from different research approaches and studies. During 2010, I conducted a search of the following databases: PsycINFO, Medline, AMED, CINAHL, Web of Science, and the search engines Google Scholar and Google. Key search terms were 'cancer' and 'lung cancer' and these were linked to 'media' 'representation', 'portrayal', 'discourse', 'social construction', 'news', 'magazines' and 'television'. No time frame was used to restrict the search. Only English language papers were retrieved. In addition, an electronic search of the content lists of a number of journals was carried out, and content page e-mail alerts were set up for a number of journals to access newly published material (Appendix 1). Additional papers were identified from reference lists. Further searches using the OVID, Google Scholar and Google search engines were undertaken throughout the study to identify further studies.

Literature was retrieved from journals representing a range of disciplines including medicine, public health, sociology, psychology, communication studies, cultural and media studies, reflecting the wide and cross-disciplinary interest in media portrayals of health and social issues. The studies identified were conducted in the US, Canada, Australia and the UK. Most of the studies examine representations in newspapers, and to lesser extent on television and

in magazines. Only a small number of studies were identified that examine representations in visual arts and internet-based media.

A variety of methodological approaches are used in the studies identified. Some authors use approaches that draw on positivist assumptions about objectivity to examine the frequency of media reporting in relation to different cancers, and in some of these studies comparisons are made between the reporting of cancer and the reporting of other illnesses. Positivist assumptions about objectivity also inform some examinations of the content of stories. These studies categorise and quantify manifest messages or themes contained within stories. Manifest content refers to that which is explicitly stated (Altheide 2002). Other authors, whilst also examining the content of stories, draw on more interpretative research approaches to investigate deeper and perhaps unintended messages and themes. In some studies, authors combine positivist and interpretative approaches, by first quantifying the manifest content of media stories and then exploring the content further for more 'latent' meanings (for example, Clarke 1999b, p63). The studies identified from the literature search that examine media reporting of cancer (other than lung cancer specifically) are summarised in Appendix 2.

In studies that examine the frequency of media reporting of cancer, a consistent finding is the disproportionately high number of media stories about cancer relative to stories about other diseases (Gerlach et al. 1997; Blanchard et al. 2002; Berry et al 2007). For example, in a study examining the reporting of cancer in US women's magazines during the period from 1987 to 1995, over one third of health-related articles were about cancer compared with only 16% about cardiovascular disease despite cardiovascular disease causing more deaths in the US (Gerlach et al. 1997). Authors raise concern that over-reporting of cancer, particularly where messages contain contradictory or inflated claims, may lead the public to exaggerate the risk of developing cancer and under-estimate the risk of other illness (Blanchard et al. 2002; Berry et al. 2007).

In the studies that examine the frequency of media reporting of specific cancers, breast cancer is identified as being discussed more frequently than other cancers, even in comparison with cancers that have comparable or greater impact in terms of incidence and mortality, such as lung, colorectal and

prostate cancers (Saywell et al. 2000; Hoffman-Goetz & Friedman 2005; Clarke & Everest 2006; Berry et al. 2007; MacKenzie et al. 2008; Slater et al. 2008; Lewison et al. 2008; Jensen et al. 2010; Konfortion et al. 2014; Hurley et al. 2014). For example, in a study conducted in the US, breast cancer was mentioned in one in four newspaper articles about cancer, in comparison with lung cancer which was mentioned in one in ten articles and bowel cancer which was mentioned in one in twelve articles (Jensen et al. 2010). In a further study conducted in Australia, breast cancer was mentioned in 43% of cancer-related television reports compared with bowel cancer which was mentioned in 5% of reports and lung cancer which was mentioned in 3% of reports (MacKenzie et al. 2008). Authors raise concern that the amount of media discussion of breast cancer may cause women to over-estimate their personal risk of the disease and underestimate their risk of other cancers (MacKenzie et al. 2008; Hurley et al. 2014). MacKenzie et al. (2008) also suggest that the over-representation of one type of cancer may distort public and political perceptions about which cancers are the most deserving in terms of government and community support and research investment.

In the studies that categorise and quantify the content of media stories about cancer medical issues, risk factors and personal stories are identified as commonly discussed topics, although no standard categorisation schema is used by the authors involved (Gerlach et al. 1997; Clarke & Everest 2006; Lewison et al. 2008; Slater et al. 2008; MacKenzie et al. 2008; Jensen et al. 2010; Hurley et al. 2014). 'Medical issues' are variously described as treatment (particularly new or aggressive treatments), cause and risk factors, prevention, screening and detection/diagnosis. For example, a study examining cancer research stories on the British Broadcasting Company (BBC) internet site between 1998 and 2006 identified that the two most commonly discussed topics were new or improved drugs or vaccines (20% of stories) and risk factors (12% of stories) (Lewison et al. 2008). Lifestyle behaviours such as diet, smoking, sexual activity and sun exposure are identified as the most commonly reported risk factors for cancer (Brown et al. 2001; Clarke & Everest 2006; MacKenzie et al. 2008; Jensen et al. 2010; Bell & Seale 2011). Environmental, occupational and social factors are identified as less commonly discussed. For example, in a study examining the reporting of cervical cancer in UK newspapers, number of sexual partners and early sexual intercourse

were commonly identified as risk factors, with little mention of the relationship between the disease and social deprivation (Bell & Seale 2011).

Personal illness narratives are identified as being more frequently presented in cancer stories than in stories relating to other diseases (Berry et al. 2007) and personal accounts of cancer of famous people are identified as being particularly common (Kitzinger et al.1999; MacKenzie et al. 2008; Jensen et al. 2010; Hurley et al. 2014). In the study of Australian television news reporting mentioned earlier (p13), a fifth of all cancer stories focused on well-known individuals with the disease (MacKenzie et al. 2008). Authors suggest that while increased media attention in relation to celebrities with cancer may improve public awareness and present opportunities to improve public health, it may also serve to over-emphasise or under-emphasise certain types of health messages, and adversely impact the appropriateness and cost-effectiveness of services (Chapman et al. 2005; MacKenzie et al. 2008). For example, a study examining the use of breast cancer services in Australia following the singer Kylie Minogue's breast cancer diagnosis identified not only a dramatic increase in demand for mammography in previously unscreened women in the target age group, but also an increase in demand from young women who are at low risk of the disease (Chapman et al. 2005).

Some studies that categorise and quantify the content of media stories also identify that prominent commentators within cancer stories tend to be academics, politicians, and charity and advocacy organisations (Kitzinger et al.1999; MacKenzie et al. 2007; Lewison et al. 2008). For example, in the analysis of BBC website stories mentioned previously (p13), the authors identified that commentators from cancer research charities were more prevalent that other commentators (Lewison et al. 2008). Other authors, however, suggest that different media outlets prioritise different commentators within cancer stories reflecting perceived audience preferences (Henderson & Kitzinger 1999; Bell & Seale 2011). For example, Henderson & Kitzinger (1999) identified that tabloid or 'popular' newspapers, magazines and TV soap operas contain more 'soft' human interest stories and feature individuals affected by the disease. Whereas, broadsheet or 'serious' newspapers, science magazines and TV documentaries present more 'hard' science stories featuring more scientists, doctors, academics and politicians.

In the studies that adopt a more interpretative approach to examine the content of media stories about cancer, some authors draw attention to the gendered nature of reporting cancer (Lupton 1994; Lantz & Booth 1998; Clarke 1999a; 1999b; Clarke & Robinson 1999; Saywell et al. 2000; Seale 2005; Halpin et al. 2009). Lupton (1994) and Lantz and Booth (1998) examined media portrayals of breast cancer and argue that discourses in relation to femininity are drawn on in ways that function to blame women for the development of the disease. Lupton (1994) examined breast cancer representations in Australian newspapers and women's magazines between 1987 and February 1990. Lantz and Booth (1998) examined breast cancer representations in US popular magazines between 1980 and 1995. In both of these studies, the authors identify that media accounts associate the development of breast cancer with women's lifestyles particularly in relation to reproductive choices and careerism – for example, pointing to factors such as delayed childbearing, not having children and the use of oral contraceptives.

Clarke (1999a) also examined media portrayals of breast cancer, in US and Canadian magazines between 1974 and 1995, and suggests that these reinforce cultural stereotypes about women, their bodies and doctors. In her reading of the stories, women are portrayed as weak and emotional, preoccupied with their sexual attractiveness and worried about their health and about breast cancer in particular. In this analysis, breast cancer is portrayed as the '*most dread disease*' (p118) which is caused by everything, particularly women's '*traitorous' bodies*' (p119). In contrast, Clarke suggests, doctors are presented in typically masculine terms; as objective and rational in their response to and treatment of cancer. Cartwright (1998) and Saywell et al. (2000) are also critical of the way in which women with breast cancer are represented in media accounts. Cartwright (1998) argues that, in general, mainstream media representations of breast cancer not only repress images of the unreconstructed breast but also differentials of class, cultural identity, ethnicity, sexuality and ageing. Saywell et al. (2000) argue that media's focus on the breast obscures other dimensions of the illness experience such as other bodily effects of the disease and its treatments.

Authors of studies examining media portrayals of male cancers and men with cancer also suggest that gender stereotypes are reinforced in these stories (Clarke 1999b; Clarke & Robinson 1999; Halpin et al. 2009). For example,

Halpin et al. (2009) examined representations of prostate cancer in Canadian newspapers between 2001 and 2006. The authors suggest that stories typically draw on traditional masculine ideals within which stoicism, money, success, virility and heterosexuality are privileged. They also identify that recovery and biomedically-derived cures are emphasised, and discussions of the personal experience of prostate cancer, the negative effects of treatment and explicit references to marginalised forms of masculinity are absent from stories. Seale (2005) examined discussions on cancer charity internet sites in relation to decision-making and identified that these differ in accordance with cultural gender stereotypes. He identifies that women are portrayed as having a network of relationships that have to be managed and needing to consult with others when deciding on treatments. He suggests that, in this way, media portrayals emphasise women's family obligations, their right to take non-medical factors into account, and their need to make decisions about other matters such as childcare and whether to start or end a pregnancy. In contrast, Seale suggests, the stress of decision-making for men is not discussed. Rather, men are portrayed as more isolated and obliged to take charge of decision-making using information gained from medical sources, with minimal consultation with family and friends.

Authors adopting a more interpretative methodological approach also draw attention to the use of metaphorical language in media stories of cancer in which the disease experience is constructed as a battle or a fight (Lupton 1994; Lantz & Booth 1998; Clarke 1999b; Clarke & Robinson 1999; Wilkes et al. 2001; Clarke & Everest 2006; Halpin et al. 2009; Hilton & Hunt 2010). In a study identified earlier in relation to breast cancer (p15), Lupton (1994) draws on earlier work by Sontag (1991/1978) to suggest that militaristic language constructs cancer and its treatments as a form of punishment, and positions individuals with the disease as responsible for both their illness and their recovery. Both Lupton (1994) and Clarke and Everest (2006) argue that this type of metaphorical language draws on a dominant masculine rhetoric associated with medicine that acts to disempower and demoralise individuals who are diagnosed with cancer. Clarke and Everest's (2006) study examined media portrayals of cancer in general, rather than solely breast cancer, in Canadian and US magazines published in the years 1991, 1996 and 2001. These authors suggest that metaphors of war serve to heighten and reinforce

ideas that the appropriate reaction to a cancer diagnosis is fear and a reliance on medicine.

Seale (2001a, 2002) suggests an alternative interpretation with regard to how media portray cancer in relation to gender and metaphorical language. He examined reports of the life or death of an individual with cancer in English language newspapers (mainly from North America and the UK) published during the first week of October 1999. With reference to gender, Seale (2002) suggests that rather than being portrayed as weak as Lupton (1994) and Clarke (1999a) have argued, women are presented as having extraordinary powers in their response to cancer; as able to transform the devastation being diagnosed into a positive event. In his analysis, Seale suggests that men's emotions are not as visibly described as women's, but where they are portrayed it is within a narrative of stoicism, strength and wanting to return to normal (working) life. However, he argues that media stories are constructed to present cancer as a meaningful event and show that it is possible for both men and women to influence their experience of it. With reference to the dominance of war metaphors, Seale (2001a) suggests that these could alternatively be characterised as 'struggle' language within a sporting context (p309). He argues that in a sporting context cancer is portrayed in a more positive light; as a heroic endeavour in which the individual concerned is able to progress towards a satisfying resolution or goal. He argues further that in this context, 'even losing can be understood, in some way, as winning if psychological gains are made on the journey' (p326). Therefore, in Seale's analysis, media representations of cancer portray the disease as a meaningful event in which both men and women are able to exert considerable control and become 'ordinary heroes'. Rather than being oppressive and harmful, he suggests that media stories of cancer are likely to be experienced as inspiring and supportive by people who develop the disease.

Differences in how media representations of cancer are interpreted are likely to reflect authors' epistemological and philosophical perspectives. They may also reflect differences in the type of media examined. For example, Seale (2001a, 2002) examined media stories in which there was significant reporting of the life or death of an individual with cancer. He excluded stories that did not include an individual with cancer (for example scientific reports) from his analysis. In contrast, in the studies that argue that media portrayals are likely

to be oppressive to people with cancer because of their gendered nature of reporting and the dominance of military metaphors (for example Lupton 1994, Clarke and Everest 2006), a range of cancer stories were examined. It is possible that different aspects of cancer are emphasised in different types of stories. For example, scientific reports may be more likely to present stories about the latest medical breakthrough in the fight against cancer and the role of lifestyle behaviours in the development of the disease whereas personal stories may be more likely to position individuals within inspirational narratives of heroism.

Some authors suggest that media stories are organised to shield audiences from some of the more material aspects of the cancer experience (Cartwright 1998; Clarke 1999a; Saywell et al. 2000; Armstrong-Coster 2005; Walter 2010; Woodthorpe 2010; Frith et al. 2012). In particular, authors identify that images of pain and suffering are largely absent in personal accounts of cancer (Armstrong-Coster 2005; Frith et al. 2012) and bodily deterioration is concealed in stories that portray individuals as dying of the disease (Armstrong-Coster 2005; Walter 2010; Woodthorpe 2010). These authors suggest that, typically, individuals with cancer are presented as being largely in control, with an emphasis on what they are able to do rather than what they are not. For example, in recent studies, authors have examined the way that the British television celebrity Jade Goody's dying of cervical cancer was reported in various media outlets (Walter 2009, 2010; Woodthorpe 2010; Frith et al. 2012). In these studies, the authors identify that although the reporting was unusual in the direct way that Jade's dying was portrayed, few images of physical suffering and bodily deterioration were presented. Walter (2009) observes that although Jade was described as being in agony, photographs depicted her as smiling and without visible signs of suffering.

Therefore, in the studies that draw on a more interpretative research approach there is consistency and variation in authors' reading of media representations of cancer. In some analyses, cancer is presented as a potential meaningful experience and individuals are portrayed as heroic in their influence over the course of the disease. In other analyses, the disease is thought to be portrayed in ways that may have more problematic effects; for example reinforcing cultural stereotypes, positioning individuals as responsible for the

disease and their recovery, and repressing some aspects of the disease experience.

2.1.4 Studies of media representations of lung cancer in the literature

In the previous section, it was identified that a number of studies that examine the amount of media reporting of cancer suggest that representation of lung cancer is low in relation to its incidence and mortality, and in relation to stories about breast cancer (pp12-13). Two of these studies were conducted in the UK. For example, Konfortion et al. (2014) examined newspaper reporting of the four commonest cancers (lung, breast, prostate and colon) in the UK in 2011. In this analysis of texts, lung cancer was identified in 19% of stories, compared with breast cancer in 46% of stories, prostate cancer in 19% of stories and colorectal cancer in 16% of stories. Stories of lung cancer were more common in months that were distant from Lung Cancer Awareness Month. In contrast, the highest number of stories about breast cancer coincided with Breast Cancer Awareness Month. The other study examining the amount of cancer reporting in the UK was the one discussed earlier (pp13-14) that retrieved cancer research stories from the internet archive of the BBC (Lewison et al. 2008). The authors of this study examined the number of stories in relation to different cancers and in relation to the burden of each cancer calculated using a disability-adjusted-life-years measure (rather than mortality rates, as used by some of the other studies). They identified that breast cancer was more commonly featured in media stories than other cancers (34% of stories), although the burden of the disease was calculated as relatively low (13%). Lung cancer was identified in 10% of stories although its burden was calculated as high (20%). Colorectal cancer was identified in 9% of stories and its disease burden was calculated as 12% and prostate cancer was identified in 8% of stories while its disease burden was calculated as 5%.

Two further studies conducted outside the UK illustrate similar patterns. Slater et al. (2008) examined newsprint, magazine and television reporting of cancer in the US between 2002 and 2003. The authors of this study identified that lung cancer accounted for 9% of all cancer stories. This compares with breast cancer at 30%, colon cancer at 11% and prostate cancer at 10%. A further study examined coverage of cancer in mainstream newspapers and ethnic minority newspapers in Canada in 2000 (Hoffman-Goetz & Friedman 2005). In this

study, the authors identified that lung cancer accounted for 3.9% of cancer coverage in mainstream newspapers, but it did not feature at all in ethnic newspapers. This contrasted with breast cancer accounting for 20.1% of coverage in mainstream and 33.3% in ethnic newspapers, prostate cancer accounting for 7.4% of coverage in mainstream and 8.6% in ethnic newspapers, and colorectal cancer accounting for 3.9% in mainstream and 3.7% in ethnic newspapers. However, in an earlier study by Freimuth et al. (1984) that examined newspaper coverage of cancer in the US during 1977 and 1980, the proportions of news stories about lung cancer and breast cancer were identified as largely in keeping with the relative incidence of the two diseases. In most studies, therefore, and particularly the most recent ones, lung cancer is identified as less commonly represented in media stories than breast cancer, despite the two diseases being common cancers.

The study by Slater et al. (2008) discussed above, which examined newsprint, magazine and television coverage of cancer in the US, also examined the content of stories in relation to eight categories: treatment, cause, death, survivors, funding, detection/diagnosis, industry and prevention. The authors identified that lung cancer is most commonly discussed in relation to death (31%), detection/diagnosis (25%), cause (19%) and survivors (11%). Breast cancer, in comparison, is most commonly discussed in relation to treatment (21%), cause (20%), survivors (16%), funding (15%) and detection/diagnosis (14%). Death accounted for only 5% of breast cancer discussions, 2% of colon cancer discussions and 8% of prostate cancer discussions.

Only one study focussing specifically on media representation of lung cancer was identified by the literature search. In this study, the authors examined all reports of lung cancer in television news programmes broadcast in Sydney, Australia over a four-year period between May 2005 and August 2009 (MacKenzie et al. 2011). The study formed part of a larger project examining television news coverage of cancer in Australia (Mackenzie et al. 2008). The study is described as '*an exploration of whether media coverage of lung cancer was consonant with, and therefore contributory to, prevalent attitudes that hold smokers responsible for their illness*' (p67). In their analysis, the authors grouped all statements made in relation to lung cancer into the following categories:

- Incidence: references to the number of new cases of lung cancer and any demographic characteristics of these cases
- Celebrity cases: any famous or well-known person, including family members of such persons
- Treatment: any statement about treatment modalities, success rates, access or cost
- Prevention: causes and risk factors for lung cancer, including genetic factors
- Profile: any mention of the experience of having lung cancer or efforts to give lung cancer (and research into it) a higher public profile
- Diagnosis: statements about diagnosis or screening for lung cancer
- Regulation and control of tobacco: statements about controlling smoking which explicitly refer to lung cancer.

In addition, the authors identified all statements made in relation to the smoking status of individuals with the disease.

In this analysis, lung cancer was identified in forty-five television broadcasts during the study period. This accounted for 2% of all references to cancer during that time. The authors identified that the forty-five television reports contained 157 separate statements about the disease. The frequency of statements in relation to the categories listed above and the smoking status of individuals mentioned in the reports is reproduced in Table 1.

Table 1: Focus of statements in forty-five television reports mentioning lung cancer. Reproduced from MacKenzie et al. (2011, p67)

1. Categories and main examples found	2. Statement frequency	3. Number of statements specifying smoking status of subjects	4. Proportion of statements in column 3 specifying subject was a non-smoker
Incidence: Primarily rising incidence in non-smoking women	42 (27%)	36 (86%)	31 (86%)
Celebrity cases: All but one in relation to Dana Reeves' diagnosis and death	33 (21%)	24 (73%)	24 (100%)
Treatment: Poor prognosis of disease and government funding	33 (21%)	9 (27%)	0 (0%)
Prevention: Risks/causes including genetic predisposition to smoke	18 (11%)	16 (89%)	3 (19%)
Profile of lung cancer: Stigma, support, fundraising	12 (8%)	9 (75%)	9 (100%)
Diagnosis: New methods, current situation	12 (8%)	6 (50%)	0 (0%)
Regulation and control: Reports on tobacco control policy referring specifically to lung cancer	7 (4%)	7 (100%)	2 (28%)
Total	157 (100%)	107 (68%)	68 (63%)

Table 1 illustrates that the authors identified that most discussions of lung cancer were in relation to: i) the incidence of the disease (particularly that it

was about to become the leading cause of cancer death among Australian women); ii) a celebrity who developed and died of the disease; iii) treatment (particularly in relation to its poor prognosis and funding); and iv) prevention (particularly in relation to risk). A smaller number of discussions related to the profile of the disease, diagnosis and tobacco control policy. Two-thirds of statements referred to the smoking status of individuals with the disease, and of these, almost two-thirds referred to individuals who were non-smokers. The authors also observed that non-smokers with lung cancer are portrayed sympathetically within stories as tragic victims, implying that they are not responsible for their condition. Within the report, extracts are presented from data to illustrate this point. For example: '*Dana Reeves, Christopher Reeve's wife, diagnosed with lung cancer but she's never smoked*' and '*tragic victims of the fact that they have a disease that is associated with smoking*' (p68).

The authors argue that their data illustrate that lung cancer is under-reported in Australian television news media given the number of deaths from the disease and given also its association with smoking, which is a leading focus of health news reports in Australia. They argue further that the sympathetic focus on non-smokers with lung cancer and the relative absence of individuals with the disease who have smoked imply an element of victim-blaming directed at individuals with the disease who have smoked, and that this may contribute to them being subject to stigmatisation.

2.1.5 Implications of the literature review for the study and study design

From this examination of the literature, it seems that media representation of lung cancer is a largely unexplored area. Only two studies were identified that examined the content of media portrayals of the disease (Slater et al. 2008; MacKenzie et al. 2011), and only one of these focussed specifically on lung cancer (MacKenzie et al. 2011). In both studies, the authors identify that media reporting of lung cancer is low compared with that of breast cancer. This is identified in other studies that examined the reporting of cancer in general, one of which also identifies that the amount of media reporting of lung cancer does not increase in response to the Lung Cancer Awareness Month initiative. The two studies that examined the content of lung cancer stories, like the studies of cancer in general, categorise the data using different coding

schemas and draw different conclusions regarding the categories that are most commonly discussed in relation to lung cancer. One study identifies that lung cancer is commonly discussed in relation to death, detection/diagnosis and cause (Slater et al. 2008). The other study identifies that lung cancer is commonly discussed in relation to incidence, celebrity and treatment (MacKenzie et al. 2011). In this latter study the authors were particularly interested in how individuals are portrayed in relation to their smoking status. They identify that non-smokers with the disease are represented more frequently and are more likely to be portrayed sympathetically than individuals who have developed the disease and have smoked. They argue further that this activity may contribute to the stigma associated with lung cancer by marginalising smokers in favour of non-smokers.

The lack of research specifically examining media representation of lung cancer suggests that a study addressing this area would be timely. The literature review also forced me to think carefully about exactly what I was attempting to do in setting out to examine how lung cancer is represented in media texts. It raised questions regarding the knowledge that each of the studies produced and the implications of that knowledge in terms of how cancer and lung cancer in particular are constructed. Research approaches that seek to quantify the reporting of cancer are useful in that they identify which cancers are most frequently represented in various media texts. In terms of this study, it seems that lung cancer is less frequently represented in media than breast cancer and perhaps also other cancers relative to their respective mortality rates. This may imply that lung cancer is less attractive to media producers and images of the disease are less publicly available than is the case for breast cancer which in turn, as suggested by Corner et al. (2006), may hamper efforts to raise awareness of the disease. However, drawing further interpretations from these studies in relation to how media stories may function to construct meanings and knowledge about lung cancer is difficult.

Research approaches that seek to categorise and quantify the manifest content of texts are useful to the extent that they suggest topics areas or themes that may be commonly portrayed in relation to cancer and lung cancer. In terms of understandings for this study, it seems that lung cancer may be commonly discussed in relation to factors such as detection/diagnosis, incidence, risk factors/cause, death, and individuals diagnosed with the disease particularly

celebrities and/or non-smokers. However, the significance of these categories and their frequencies in terms of how they may function to construct meanings, and the social impact these may have, remain largely unexplored in these studies. Furthermore, although these studies draw on empiricist and realist epistemological approaches in that they attempt to objectively categorise and quantify the content of media stories, differences in the descriptive categories used to code the data illustrate that a whole set of interpretative choices are involved in the selection and application of categories. The studies therefore draw attention to the 'ever-present possibility of alternative categorisations' (Potter & Wetherell 1987, p3) and the assumption that the categories applied have a fixed and pre-existing structure that reflect a reality or truth in relation to what is being represented; in this case cancer and, in some studies, lung cancer.

Rather than treating media representations as reflections of fixed categories that pre-exist in the social or natural world, in the studies that adopt a more interpretative methodological approach media texts are conceptualised as actively constructing versions of the world. Furthermore, just as media representations do not merely describe the world and things in the world, the authors of these studies do not claim to merely observe and objectively describe the content of texts. Rather, there is an acknowledgement (in varying degrees) that they too are involved in an active process of construction in relation to understandings about the object of interest, and the possible social and political implications these proposed understandings may have.

Given that in this study I am interested in how understandings in relation to lung cancer are socially constructed and the effects these may have for individuals who develop the disease and the social response to the disease, these theoretical concepts in relation to media as a constitutive process are adopted in this study. In conceptualising media practices and also the research process as constitutive, therefore, I am positioning the study within a social constructionist epistemology. Both are conceived as social practices involved in the construction of knowledge and meanings in relation to the world and objects (things, people, events) within the world (Burr 1995). This epistemological approach is discussed next.

2.2 Theoretical and methodological approach

2.2.1 Social constructionism and the social construction of illness

Social constructionism is a conceptual framework that emphasises the historical and cultural aspects of phenomena widely thought to be exclusively natural (Conrad & Barker 2010). In this approach, meanings in relation to objects in the world (things, people, events) do not inhere in the objects themselves nor are they fixed by individual users of language, rather meaning is constructed through social interaction in specific historical and cultural contexts. Burr (1995) suggests that a social constructionist position draws on one or more of the four following key assumptions:

1. A critical stance towards taken-for-granted ways of understanding the world: A social constructionist approach is critical of positivist and empiricist approaches in which it is assumed that the true nature of the world can be discovered by objective, unbiased observation, and that what exists is what we perceive to exist. In this approach, therefore, the 'natural' ordering of the world, and the concepts and categories that are taken for granted as 'real' are questioned.

2. Historical and cultural specificity: In a social constructionist approach, all knowledge and ways of understanding the world relate to particular cultures and periods of history. Therefore, the concepts and categories that we use to understand the world are historically and culturally specific. They are viewed as artefacts of the social arrangements prevailing in that culture at that time, and not necessarily any better in terms of being nearer the truth than other concepts and categories produced in other cultural and historical contexts.

3. Knowledge is sustained by social processes: In a social constructionist approach, common ways of understanding the world are constructed through the daily interactions between people in the course of social life. These social interactions or the everyday 'goings-on' between people are viewed as practices, in which shared versions of knowledge are constructed through language use. In this perspective, therefore, language use or communication is viewed as a social practice; involved

in the construction of meanings about the world and objects (things, people, events) in the world. Therefore, what is regarded as 'truth' (i.e. current knowledge or accepted ways of understanding the world) is a product not of objective observation of the world but of the social processes and interactions involving people and their use of language.

4. Knowledge and social action go together: These 'negotiated' understandings deriving from social processes and interactions between people may take different forms so that it is possible to conceptualise multiple social constructions (or knowledges) of the world, each bringing or inviting a different kind of action. Burr uses understandings of drunkenness as an example. In the past, drunks were considered entirely responsible for their behaviour and a typical social response to drunken behaviour was imprisonment. In more recent times, drunkenness has been defined (constructed) by some as a disease (alcoholism) that warrants medical and psychological treatment rather a crime deserving of imprisonment. In a social constructionist perspective, therefore, different knowledges about the world may act to sustain some patterns of social action and constrain others.

In drawing on these four assumptions, a social constructionist approach opposes a naïve realist and empirical epistemology that claims the existence of essential 'truths' and that knowledge simply reflects or mirrors what is 'out there' in the world. Instead, knowledge is conceptualised as the product of social relations within specific cultural contexts and periods of time, and is subject to change rather than fixed. Moreover, language use in all its forms is viewed as a constitutive activity rather than a reflective one. As Potter (1996) suggests: 'the world is not ready categorised by God or nature in ways that we are all forced to accept. It is *constituted* in one way or another as people talk it, write it and argue it' (p98, emphasis in the original). A social constructionist epistemology, therefore, examines how 'reality' is constructed, rather than explaining one true 'reality'.

Critics of social constructionism (for example Bury 1986) have argued that the approach can descend into relativism if taken to its logical conclusion. That is, that if all knowledge is socially constructed, then the claims made by social

constructionists are also socially caused and therefore cannot be afforded the state of knowledge. In response, Nicolson and McLauglan (1987) suggest that the approach does not dismiss or devalue the knowledges that we presently possess but rather argues that we cannot claim any more of them than what they are – the products of a specific time and place. This reflexive awareness of the problematic status of knowledge claims draws attention to the constitutive and situated nature of this research and thesis.

A social constructionist perspective of illness emphasises how knowledges and meanings in relation to specific diseases and conditions are shaped by cultural and social practices, rather than solely the biological properties and physical effects of the disease or condition. In adopting this approach, I am not questioning the reality of illness states or bodily experiences. Rather, my understanding is that these states and experiences are known and interpreted through social activity within the context in which the disease is situated and experienced. How a disease is understood or constructed may take a variety of different forms, so that it is possible to conceptualise multiple understandings or constructions of the disease. Moreover, how a disease is constructed will have an impact on how it is experienced and the social response to it, including what practices and policies are created concerning it. Therefore, as Brown (1995) suggests, in examining how an illness, in this case lung cancer, is socially constructed I hope to elucidate some of the social forces that shape our understandings and actions towards it.

In drawing on a social constructionist approach media, in the widest sense of the word to mean any form of public communication, are viewed as cultural and social practices involved in the activity of representation. They use language (e.g. written words, talk/sound, images) to represent aspects of the world (e.g. objects, people, events) to their audiences (i.e. the public). In a social constructionist approach, this practice of representation does not function as a mirror to simply reflect the object that is being portrayed. Nor does it act to merely convey the intentions of the producer or author of the representation. Rather, representation is understood as a constitutive practice; actively involved in the construction of the object being represented through its use of shared systems of language. In this perspective, the products of this particular activity – media texts – are viewed as cultural artefacts that can be

examined for their representational function and the social actions that may be achieved through this particular practice.

2.2.1.1 Reflexivity and validity

As mentioned above, a social constructionist approach draws attention to the position of researchers as producers of knowledge. In this perspective all forms of knowledge, including scientific knowledge, are constructed through social interaction and language use. This requires a reflexive awareness of the problematic status of one's own knowledge claims (Potter and Wetherell 1987). Therefore, like all research, this study is acknowledged to be constitutive. It is historically and culturally specific, drawing on socially available resources to promote one version of the world over many possible others in order to achieve certain things. It cannot aim to reveal or discover a 'truth' about the subject area, since this would be in opposition to its epistemological framework. Instead, the study aims to provide a novel representation of the subject area that will serve to create discussion and further critique. Drawing on this perspective, I aim to make visible areas which have hitherto been outside discussion, and in doing so contribute additional perspectives to public debates in relation to lung cancer. In this understanding, the production of this thesis is conceived of as part of a process of questioning, challenging and demystification (Pujol 1999).

In order for others to be able to consider its value, Jørgensen and Phillips (2002) propose that research accounts should be characterised by the following principles: 1) the research steps taken are made as transparent as possible; 2) the argumentation is consistent; 3) the theory and method form a coherent system; and 4) empirical support is given for the interpretations presented. They also suggest that researchers should position themselves explicitly and cast light on the social and historical circumstances under which their knowledge has been produced, although they acknowledge that it is impossible to transcend the contingent conditions of production to give a complete account. These principles have guided the construction of this thesis in an attempt to facilitate evaluation by the reader. Ultimately, however, its value will be in its utility – whether it does indeed open up further discussions in relation to how lung cancer is socially constructed and the possible consequence of this for people with the disease or who may be at risk of it.

Therefore, this study draws on a social constructionist epistemology to examine how lung cancer is represented in media. Media are understood as social practices in which meanings and knowledge about the world are created. Media texts are treated as sites of representational activity; places in which public discussions about the world (objects, people, events) take place and where meanings about those the world are created, circulated and exchanged. The word 'texts' in this context is used to mean any product of media activity including not only what is written but also visual and audio content. Media texts that contain representations of lung cancer are examined to identify how they construct meanings and knowledge about the disease and individuals who develop it, and also to speculate on the broader social effects of this particular activity.

In the next section, I describe the methods used to conduct the study in relation to the retrieval and analysis of media texts.

2.3 Methods

So far, this chapter has discussed the study in terms of its rationale and theoretical approach. This final section outlines the practical aspects of the study in terms of how texts – the data of the study – were retrieved and analysed. Although media texts may be thought of as naturalistic data in the sense that they are naturally occurring and have not been created deliberately for the research process (Potter & Wetherell 1987), decisions about what to retrieve and analyse are influenced by the researcher, and in this sense, as in any study, the data are constructed. This section attempts to show transparency, as far as is possible, with regards to the decisions that were made in relation to what data to retrieve and the methods that were used to examine it.

2.3.1 Data retrieval

The aim of the study is to examine how lung cancer is constructed in media texts and with what effects. Decisions about what texts to retrieve were informed by my initial thoughts in planning the study but also by practical considerations involved in retrieval. Since the rationale for the study stemmed from an interest in understandings of lung cancer and the impact of these on

public behaviours in relation to the disease, I was keen to be as inclusive as possible and draw on representations from a wide range of media that might be considered to form a 'backdrop' to everyday social life. However, given that the definition of media in the widest sense includes any form of public communication, it was necessary to make decisions regarding what media to retrieve, and over what time period. These decisions were informed by an initial exploratory phase in which I examined the practicalities of retrieving media texts which feature discussions of lung cancer. In the writing of this exploratory phase I have artificially separated decisions regarding the 'what' and 'how' of data retrieval. In practice, the 'what' and the 'how' were co-dependent and the decision-making process was more seamless than the writing may suggest.

2.3.1.1 What media to retrieve?

Three early decisions were made in relation to what texts to retrieve following examinations of various media sources. These decisions inevitably narrow the scope of the study. The first decision was to retrieve contemporary media texts rather than a historical sample. This decision was made partly because I am interested in current representations of the disease, although current knowledges in relation to phenomena draw on contemporary and historical discourses, and partly because of the practical difficulty of retrieving a historical sample of texts across a range of media. No single archival source of a wide range of media could be identified, and accessing texts from a number of sources was perceived to be too time-consuming within the resources available. I also thought at this early stage that it would be possible to retrieve a selected sample of historical texts later if the retrieval process or analysis suggested it might be useful to do so.

The second decision was to exclude social media technologies such as internet forums, blogs and social network sites. This was in part because it was unclear how often these technologies discussed health issues and partly because of an anticipated difficulty in locating materials in relation to lung cancer from these media sources. The third decision in relation to what media to retrieve was to exclude specialist medical and scientific journals and textbooks, and newswires concerning pharmaceutical industry business activity (for example, about share price fluctuations). This decision was made because these media

are less oriented to a general readership, although it is acknowledged that readers of these are also members of the general public and that discourses in these types of media are likely to influence wider public discourses.

A further decision was taken at an early stage in relation to what media to retrieve, and this decision may be considered to have broadened the scope of the study. During this exploratory phase, examination of various media texts highlighted that lung cancer is not often a focus of stories. Often references to lung cancer are brief and contained in stories that are not about the disease. At this point, therefore, it was necessary to make a decision about whether to only retrieve texts in which the disease is a main or prominent focus, or to retrieve all texts that mention the disease, no matter how brief the discussion. At this stage, given the frequency of brief mentions, I felt that limiting the search to texts that focus specifically on lung cancer would narrow the perspective of the study too early and risk excluding an important way that the disease is represented. I therefore decided to collect all references to lung cancer in order to gain a broad sense of how the disease is represented in media discussions in the knowledge that decisions regarding what data to sample for in-depth analysis could be made at a later stage.

Prior to data retrieval, no decision was made with regards to the quantity of material to retrieve. An initial retrieval period was planned to include Lung Cancer Awareness Month[1] and two non-awareness months. Decisions regarding the retrieval of further texts would be made following an initial analysis of the texts retrieved.

Further decisions regarding what media to collect were dependent on the practicalities involved in identifying and retrieving representations of lung cancer. These practicalities are discussed next.

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[1] November was designated Global Lung Cancer Awareness Month in 2001 by the Global Lung Cancer Coalition (Baird 2003). Awareness month initiatives are used by groups and organisations to raise awareness and funds for specific issues, commemorate a group or event and/or celebrate something. Apart from cancer awareness months, other examples include Black History Month and National Poetry Month.

2.3.1.2 How to retrieve media?

Retrieval methods used by other researchers interested in aspects of health and illness in media include manual searches of newspaper and magazine archives (for example, Jones 2004), electronic searches of databases that archive newspaper content such as Nexis® UK (for example, Seale 2001a), prospective recording of television broadcasts (for example, MacKenzie et al. 2011), and engagement of a media monitoring service to retrieve newspaper, magazine and television content (for example, Lupton & McLean 1998). However, the practicalities involved in using these methods are not discussed in detail in any of the studies reviewed. Therefore, I investigated a number of methods in order to assess the utility of each. These included: 1) manual searching of newspapers and magazines; 2) monitoring TV and radio broadcasts; 3) searching electronic databases, search engines and websites such as the Nexis® UK, Google™, Yahoo™ the BBC, ITV, Sky News, Roy Castle Lung Cancer Foundation, Cancer Research UK, Macmillan Cancer Support and British Lung Foundation; 4) engaging a media monitoring service; 5) subscribing to Google™ and Yahoo™ news alerts; and 6) searching public areas (for example libraries, bookstores, premises providing health services and products). Table 2 presents a summary of the learning gained from this investigation.

Table 2: Exploration of retrieval methods and lessons learned

Search strategy	Main learning
Manual search of newspapers and magazines	• Too time-consuming for one person to conduct for any length of time. • Easy to locate lung cancer in titles but not in the body of text. • Not a practical retrieval method.
Monitoring TV and radio programmes by searching programme guides	• Difficult to identify potential data sources (easy to locate if lung cancer in programme title but often only brief information given regarding content of programmes). • Not a practical retrieval method.
Search of Nexis® UK database using the search term 'lung cancer'	• Identifies a number of relevant texts from newspaper sources. Other types of media not identified. • Easy and free to use. • Able to save text and export to a database. • Able to limit search to UK media. • Does not retrieve images/photographs. • Does not retrieve as wide a range of media as media monitoring service.
Media monitoring service using the search term 'lung cancer'	• Identifies a number of relevant texts. • Largest number and widest range (newspaper/magazines/TV & radio). • Retrieves images • Able to limit search to UK media. • Financial cost. • Not comprehensive (some texts retrieved using other methods were not retrieved by the service).
Internet search using Google™ search engine	• Identifies a number of relevant texts, mostly internet news sites.

using the search term 'lung cancer'	• Many items from US. Not possible to limit to UK media. • Retrieves images. • Not comprehensive (some texts retrieved using other methods were not retrieved by the internet search).
News alerts from Google™ and Yahoo!™ using the search term 'lung cancer'	• Identifies a number of relevant texts, mostly internet news sites. • Retrieves images. • Range of media. • Most items are from US. Not possible to limit to UK media. • Not comprehensive (some texts retrieved using other methods were not retrieved by the alert services).
Internet search using BBC, ITV, Sky News websites using the search term 'lung cancer'	• Identifies a small number of relevant texts. • Retrieves images. • BBC seems to be most comprehensive in terms of UK items.
Search of charity websites for press releases and promotional materials (Roy Castle Lung Cancer Foundation, Cancer Research UK, Macmillan Cancer Support, British Lung Foundation)	• Identifies a small number of press releases and posters.
Search of bookstores (including Amazon UK) and libraries	• No books found that mention lung cancer in the title (other than medical books).
Search of local GP and healthcare public waiting areas	• No leaflets/posters identified.
Search of local chemists and health food stores	• No leaflets identified.

This investigation of search and retrieval methods suggested that using a media monitoring service was likely to yield the most media texts from the widest range of media. However, some texts retrieved from other search

strategies were not retrieved by the media monitoring service suggesting that a combination of methods, if time permitted, would yield the greatest number of texts from the widest range of media. Therefore the following combination of methods was chosen:

a. A media monitoring service (Durrants®) would be the main method of retrieval. Media monitoring services are companies that use digital search and scan technologies to identify and supply a range of media coverage relating to key words that are of interest to clients. They are also known as press or media cutting agencies, information logistic services and media intelligence. Durrants® retrieve texts from a range of media sources including national and regional newspapers, popular and trade magazines, and local and regional television and radio broadcasts (http://durrantsmedia.com/step-ahead/gorkana-group/).

b. A search of the Nexis® UK database for all UK publications using the search term 'lung cancer'. This database provides full text access to national and regional newspapers, press releases, transcripts of TV broadcasts, magazines and trade journals. It is updated daily. Nexis® UK does not retrieve any graphics or illustrations that may have been published as part of the media text.

c. A subscription to Google Alerts™ and Yahoo! Alerts™ for the term 'lung cancer'. These are free notification services by the internet search engine companies Google™ and Yahoo! ™. They notify subscribers by e-mail (or as a web feed, or displayed on the user's iGoogle™ page) when new items are identified on the internet that match the search terms selected.

d. A weekly search of the BBC and ITV internet sites using the search term 'lung cancer'.

e. Weekly internet searches via the Google™ and Yahoo!™ search engines using the term 'lung cancer'.

f. A search of local public areas during Lung Cancer Awareness Month including libraries, health service public waiting rooms (GP surgeries and local hospitals), health shops and bookstores.

Using these methods would potentially retrieve data from national and regional newspapers, trade and popular magazines, national and regional television and radio broadcasts, and internet sites with the possibility of retrieving other media such as health promotion materials, books and films.

2.3.1.3 A comparative dataset

A further decision during the exploratory phase was to collect media texts that discuss breast cancer for use as a comparative dataset during the analysis. One way to build an impression of a text is to compare it with another text to identify similarities, differences and absences in how the object of interest is represented that may have implications in terms of how the disease is constructed. Using comparison as a strategy may also facilitate the process of distancing oneself from the material examined in order to identify what might be taken-for-granted assumptions. Breast cancer was chosen because of its similarity to lung cancer as one of the most common cancers in the UK and also because of its media prominence. An initial decision was made to retrieve texts during Breast Cancer Awareness Month and one other month, using the same retrieval methods as used for the lung cancer texts.

2.3.1.4 The actual process of data retrieval

The overall purpose guiding data retrieval was to collect a sample of texts that represent lung cancer in some way from a wide range of publicly available media in the UK. Within the scope already defined, the emphasis at this stage was to be as inclusive as possible.

During the three-month period from 1st September 2010 to 30th November 2010 the media monitoring service (Durrants®) was requested to retrieve all media published in the UK that make a reference to 'lung cancer' anywhere in their text. No further exclusion was placed on this search. The retrieval period included Lung Cancer Awareness Month (November 2010). Additional material was retrieved during the period using the search strategies described above (p36).

Durrants® was also requested to retrieve all media published in the UK that referred to 'breast cancer' anywhere in their text during October 2010 (Breast Cancer Awareness Month). A further month of data retrieval for breast cancer

did not go ahead as planned because of the volume of texts retrieved during one month alone.

2.3.2 Data generated

The retrieval process described above generated a dataset of 2176 different media texts in which lung cancer was discussed. The dataset comprised texts from the domains of news, entertainment and promotional media. Most (84%) of the texts were retrieved from newspapers, particularly regional newspapers. Smaller amounts were retrieved from other sources such as magazines (7%), internet sites (5%) radio broadcasts (3%) and television broadcasts (1%) (see Table 3).

The texts were retrieved in a variety of formats. For example, texts retrieved by the media monitoring service from newspapers and magazines were reproductions of the original texts in which the words and graphics (if any) were 'cut and pasted' from the original source onto A4-size sheets of paper and copied in black and white print. The texts retrieved from the Nexis® UK database from newspapers and magazines were transcripts of the original words printed onto A4 paper. These texts did not reproduce any graphics from the original source. Texts from internet sites were printed out in colour onto A4 paper. A small number of newspaper and magazine texts, and health promotional materials identified by the author were retrieved in their original form. Some texts from radio and television broadcasts were available in CD-ROM and DVD form. Others were available via an internet link for a week only and a written transcript with a number of screenshots was stored.

Table 3: Lung cancer dataset

Media format	Number of texts retrieved			
	Sept	Oct	Nov	Total (% of total)
Newspapers	**574**	**638**	**607**	**1819 (84%)**
• National	100	124	74	298 (14%)
• Regional	444	427	454	1325 (61%)
• Online	30	87	79	196 (9%)
Magazines	**24**	**67**	**66**	**157 (7%)**
• Popular	12	40	40	92 (4%)
• Trade	12	27	26	65 (3%)
Internet site	**43**	**48**	**23**	**114 (5%)**
Radio	**16**	**21**	**24**	**61 (3%)**
• National	3	4	8	15 (<1%)
• Regional	13	17	16	46 (2%)
Television	**8**	**6**	**9**	**23 (1%)**
• National	3	2	5	10 (<1%)
• Regional	5	4	4	13 (<1%)
Other (health promotional flyer & cigarette packet)	**1**		**1**	**2**
Total	**666**	**780**	**730**	**2176 (100%)**

The retrieval process also generated a dataset of 2568 media texts in which breast cancer was discussed. All but six of the texts were retrieved using the media monitoring service. The six texts not retrieved via this method were identified and retrieved by the author. The breast cancer texts are also mainly

from newspapers (see Table 4). Most texts are in the 'cut and pasted' format where text and accompanying images from the original are cut and pasted onto an A4 sheet of paper.

Table 4: Breast cancer dataset

Media format	**Number of texts retrieved (Oct) (% of total)**
Newspapers o National o Regional o Online	**2221 (86%)** 171 (7%) 1940 (76%) 110 (4%)
Magazines o Popular o Trade	**200 (8%)** 135 (5%) 65 (3%)
Internet site	**26 (1%)**
Radio o National o Regional	**74 (3%)** 11 (<1%) 63 (2%)
Television o National o Regional	**45 (2%)** 16 (<1%) 29 (1%)
Poster	**2 (<1%)**
Total	**2568 (100%)**

Therefore, the overall data corpus[2] comprises media in various forms and formats. However, for the purpose of this study they are treated similarly – as publicly available representations of lung and breast cancer. As such, they draw on the various discourses in relation to the two diseases that are in circulation at the particular historical and social moment when they were produced.

2.3.3 Data analysis

A thematic content analysis was selected as the method of analysis. Green and Thorogood (2004) describe thematic content analysis as essentially a comparative process, in which various accounts are compared with each other to classify themes that recur or are common in and across the data. The method is not theoretically bounded and is compatible with both essentialist and constructionist approaches. It can be used with a wide range of research questions, different types of data, and applied to produce data-driven (inductive) or theory-generated (deductive) analyses (Braun & Clarke 2006).

In this study, the analysis is guided by a social constructionist epistemology in which knowledge is conceived as socially produced. This epistemological approach was discussed earlier (pp26-30). The overall purpose of the analysis is to examine how knowledge about lung cancer is constituted through the practice of media representation and develop theories in relation to the potential effects that may be achieved through this particular activity. The analysis does not attempt to identify the conditions under which the texts were produced or the actual meanings that audiences derived from the texts. The main focus of the analysis is the lung cancer texts. Texts from the breast cancer dataset act as a reference point for the analysis, that is, they enable a process of comparison to identify alternative possibilities for how cancer may be represented.

The analysis involved an initial examination of the entire data corpus to identify broad themes, patterns, variations and areas of interest in and across

[2] 'Data corpus' refers to all the texts that were retrieved. 'Dataset' is used to refer to all the texts retrieved for each of the two different cancers.

the texts. This examination prepared the way for a more focussed analysis of a subset of texts that contain a personal story of lung cancer or breast cancer. The more focussed analysis was both inductive and also deductively driven in that two themes that emerged as potentially important in the data were explored using theoretical concepts from Seale's (1995a, 2001a, 2002) analyses of accounts of the personal experience of cancer and Malle et al's (2012) step model of blame.

The analytic process can be summarised as having three main phases:

- **Phase 1**: Exploratory thematic content analysis of the entire data corpus involving:

    i. A simple grouping and coding of all of the texts to identify:

        - The main focus of the text i.e. what the text is predominantly about.

        - The dominant theme of the discussion in relation to lung cancer or breast cancer.

    ii. A comparative thematic content analysis of the two datasets using the themes identified as a framework to examine how each of the two cancers is portrayed in relation to each of the themes.

Phase 2: In-depth thematic content analysis of texts containing a personal story of lung cancer or breast cancer:

    i. Texts that contained a personal story of lung cancer and breast cancer were examined and compared in relation to:

        - Content: Features that are shared by texts or variability and differences between them in relation to how they portray the two cancers and individuals with the disease.

        - Action: The potential social consequences achieved by these portrayals.

- **Phase 3**: Theoretically-informed content analysis of personal stories:

    i. Personal stories of lung and breast cancer were examined using theoretical concepts regarding:

- The construction of cancer as a heroic event.
- Attributions of blame.

This schema presents a retrospective account of the analysis. In presenting it in this way I do not intend to suggest the analysis was an entirely pre-planned, smooth and linear process, or that it is one that is necessarily complete. In practice, the analysis developed in response to both the characteristics of the overall dataset and also to repeated readings and interpretation of the data and, importantly, in the writing, reviewing and re-writing of the analysis. During the analysis and in particular the writing, there was constant movement between the phases outlined above, particularly in relation to the latter two phases, sometimes because of new insights gained and sometimes because of problems and difficulties raised. Moreover, it is recognised that focussing on certain areas of interest has left other areas only partially explored.

To illustrate some of the decisions and procedures of the analysis in more detail, a fuller account of each of the three phases is presented next.

2.3.3.1 Phase 1: Exploratory thematic content analysis

This phase of analysis involved a simple coding and grouping of all the texts in the data corpus to initially identify what each of the texts was predominantly about, and then to identify the dominant theme of the discussion in relation to lung cancer or breast cancer. This coding process prepared the way for a thematic content analysis (Green & Thorogood 2004; Braun & Clarke 2006) of the entire data corpus to examine how each of the two diseases is portrayed in relation to the themes identified.

The analytic method was not only shaped by the aim of the study, it developed in response to the specific characteristics of the overall data corpus which in turn were shaped by the method of data retrieval. For example, media texts had been retrieved if they made any reference to ‘lung cancer’ or ‘breast cancer’ regardless of whether either disease was a main or prominent focus of the stories presented within the text. This method of retrieval generated two large datasets: a lung cancer dataset of 2176 texts from a range of media sources and a breast cancer dataset of 2568 texts from a similar range of sources (see Tables 3 and 4, pp 39-40). Although both the lung cancer and breast cancer datasets are large and derived from similar types of media, they

differ in ways that had implications for the analysis. The first of these differences is that the lung cancer dataset consists of texts produced during the Lung Cancer Awareness Month as well as non-awareness months, whilst the breast cancer dataset consists of texts produced during the Breast Cancer Awareness Month alone. (Data retrieval for the breast cancer dataset was halted at the end of one month because of the sheer volume of texts retrieved and the implications this posed for managing and analysing the data as well as the cost of further retrieval.) This difference between the two datasets limits the claims that can be made in relation to how breast cancer is represented in media outside of Breast Cancer Awareness Months and therefore presented potential problems with regards to the comparisons that could be made between the two datasets.

The second difference between the two datasets is related to the first and was immediately apparent when the texts were being retrieved and stored. Most of the texts in the lung cancer dataset, even those retrieved during the Lung Cancer Awareness Month initiative, are not about lung cancer in particular. Rather in most texts, the disease is mentioned only briefly in a story that is about something else. In contrast, most of the texts in the breast cancer dataset are about breast cancer, mainly in relation to the Breast Cancer Awareness Month initiative. These features of, and differences between, the two datasets are explored in greater detail throughout the analysis presented in Chapter 4. However the challenge they presented was in determining how the texts might be examined and compared in a systematic way that would enable plausible insights to be produced.

Given the size of the data corpus and the differences between the two datasets, the overall aim of the first phase of analysis was three-fold: i) to become familiar with the breadth of the data retrieved; ii) identify where and how each of the two diseases is represented in texts; and iii) prepare the way for further analysis by identifying areas of interest to explore in greater detail with a smaller and more manageable sample of data. The first task involved coding the texts in relation to two simple characteristics: First, the main focus of the text (i.e. what the text is predominantly about) – this would provide a context for the representation of each of the cancers. Second, the main theme of the discussion in relation to each of the cancers – this would focus the analysis on the relevant cancer even where it is mentioned only briefly, and

enable a comparison of how each cancer is portrayed in relation to similar themes. Practically, this entailed first reading each of the texts and asking the following question:

- What is this text predominantly about? Is it about lung cancer/breast cancer or something else?

The codes or labels applied to the texts at this stage were developed inductively from examining the texts and deductively from examining other content analyses identified in the literature review. As texts were examined, the codes were refined to reduce overlap and repetition between them, and then grouped into broader descriptive categories that summarised what the text was predominantly about (e.g. a story about lung cancer/breast cancer, a story about cancer in general, a story about fundraising). The frequency of texts coded to each of the broad categories was recorded.

Next, each text was re-examined asking a second question:

- What is the dominant theme of the discussion in relation to lung cancer/breast cancer?

The themes identified in this coding of the data were developed inductively from repeated readings and comparison of texts. Where coding the discussion of the cancer to a single theme was difficult, a 'best fit' was applied and copies of the text were made and filed under each of the alternative themes that could be applied (these copies were not included in the frequency counts recorded). Although this process is inevitably reductionist, it provided a way of organising representations of each of the two diseases into broadly similar themes or 'bodies of instances' (Potter and Wetherell 1987, p167) that could be compared, whilst also retaining the context of each representation.

The results of this initial coding of the data corpus are presented in Chapter 4 (Table 5, p96 and Table 6, p98). However, caution should be applied regarding what can be interpreted from the frequency counts since coding is itself a constructive process involving both selection and exclusion (Potter and Wetherell 1987). The categories and themes chosen are not solid and defined, and a different researcher may have produced different categories, themes and frequency counts. Moreover, there is a danger that in the process of coding and 'wielding' the data into (mostly) single, 'prominent' categories and

themes, the variation and discursive subtlety of stories may be lost. This was evident in the coding of both datasets, but particularly in relation to the breast cancer dataset where although in most texts discussions of the disease are coded to the 'awareness initiatives' theme, other themes are also prominent particularly 'individuals with the disease', 'fundraising activities' 'risk factors' and 'epidemiological factors'. For this reason, and to assist with further analysis (rather than for the purpose of further quantification), breast cancer texts coded to 'awareness initiatives' were also grouped and filed according to whether other themes were prominent.

Following this grouping and coding of the texts, the themes identified in relation to the discussions of lung cancer and breast cancer were used as a framework to undertake a thematic content analysis of the two datasets. These themes relate to:

- Death of an individual
- Awareness initiatives
- Risk factors
- Individuals living with the disease
- Epidemiological trends
- Biomedical initiatives
- Fundraising activities.

Texts were examined to compare how each of the two cancers is represented in relation to each of the seven themes. So, for example, texts that portray the 'death of an individual' from either lung cancer or breast cancer were examined and compared. The same was then done for 'awareness initiatives' and so on. The volume of texts meant that the analysis at this stage was inevitably broad. The aim was to search for pattern in the form of variation and consistency, and areas of interest in and across texts in terms of how the two diseases are portrayed. In particular, texts were examined and compared in relation to the prominence of representations (including frequency and length, situation within the text, and use of symbols and persuasive language), the manifest messages about each of the two cancers and how individuals with

each of the two diseases are portrayed. The findings from this phase of analysis are presented in chapter 4.

2.3.3.2 Phase 2: In-depth content analysis of personal stories

In this phase, texts that present an account of an individual's experience of having lung cancer or breast cancer were selected for an in-depth thematic content analysis. Personal stories were selected because in the previous phase of analysis, differences in how the experience of lung cancer and breast cancer are represented were identified. Portrayals of the personal experience of lung cancer were identified as relatively absent in the texts examined. However, where they are presented, it appeared that they differ from portrayals of breast cancer in that they are less likely to portray individuals within a heroic narrative of personal triumph over the disease (Seale 2002). This was deemed worthy of closer inspection to understand more fully how texts are organised to construct the experience of lung cancer and breast cancer, and the potential consequences of this activity.

A social constructionist conceptualisation of media as a constitutive practice informed the analysis of personal stories. This perspective is discussed earlier (pp26-30). The analysis comprised two closely-related activities: First, an in-depth search for, and comparison of, patterns in relation to how each of the two diseases is portrayed in the form of either features that are shared by texts, or variability and differences between texts. Second, forming hypotheses about the potential consequences of what was observed. That is, how these representations may work to construct knowledge in relation to each of the two cancers and individuals who develop the disease. This process was informed by earlier studies of media representations identified in the literature review, accounts of how to approach thematic content analysis (Green & Thorogood 2004; Braun & Clarke 2006) and also other accounts of textual analysis (for example, Potter and Wetherell 1987; Widdicombe 1993; Carabine 2001). The process also developed inductively from examining the data. Practically, it meant examining the texts using the following linked and overlapping 'interrogative' strategies:

a. Attempting to distance myself from the natural qualities of the texts – that is their taken-for-granted ways of portraying things, particularly given my professional closeness to cancer and lung cancer. Potter and

Wetherell (1987) suggest constantly asking: 'Why am I reading this passage in this way? What features produce this reading?' (p168).

b. Examining the narrative content, structure and sequencing of texts and the language and metaphors used.

c. Comparing representations of individuals in relation to social differences such as age, gender and ethnicity, and factors such as physical appearance, and emotional response and adjustment to the experience of cancer and treatment for it.

d. Looking for absences and silences. What is not present in texts that might be expected to be?

e. Paying attention to the constructive dimension of texts by asking: What are texts doing? How do they construct lung/breast cancer and individuals with the disease? What are the effects and consequences of these constructions and do they vary across texts/contexts? What opportunities do they open up or close down and whose interests are being served?

f. Paying particular attention to examining texts in which there are exceptions to the patterns identified, since these may be more informative than texts that lie within the patterning, and asking if these exceptions or 'deviant cases' can be explained (Green & Thorogood 2004, p183).

g. Identifying the rhetorical organisation of texts (Billig et al. 1988) and contradictions or oppositions in relation to constructions of lung/breast cancer and individuals with the disease by asking what is being argued for and what is being countered or resisted. Billig et al. (1988) suggest that talk and texts are argumentative, drawing on socially available arguments and counter-arguments (or discourses and counter-discourses) and pointing to a view of social life as dilemmatic in nature. They argue that the 'lived ideologies' of a society or culture, that is its beliefs, values and practices are characterised not by consistency and coherence, but rather inconsistency, fragmentation and contradiction (p27). Therefore, the rhetorical and dilemmatic elements of texts are indicative of the discourses that are available within the particular social

contexts in which they are produced. In examining what is being promoted and undermined as a consequence of media activity is likely to point to the live ideologies of the social context in which they (media) operate.

h. Widdicombe (1993) suggests regarding the ways in which things are discussed as being 'a solution to a problem' (p97). For her, the analyst's task is to identify the problem and look for the ways in which what is said constitutes a solution.

In order to explore and develop explanations for findings from this comparative analysis of the two datasets, theoretical understandings from other studies in the social science literature were drawn on. This is presented as the third analytic phase although in practice this and the current phase developed as a merged activity.

2.3.3.3 Phase 3: Theoretically-informed content analysis of personal stories

In examining and comparing the personal stories, the observation made during the initial phase of analysis in relation to a relative absence of a 'heroic' narrative in representations of individuals with lung cancer was identified as more complex than originally understood. In the analysis of personal stories, a heroic narrative similar to the one described by Seale (2002) and discussed earlier in the thesis in relation to the review of existing studies examining media portrayals of cancer (pp17-18) was identified as dominant in many of the breast cancer accounts. In this narrative, individuals with cancer are portrayed as being in a dramatic struggle in which they are able to influence their experience of the disease through acts of determination and courage. However, although some individuals with lung cancer are positioned within a heroic narrative, particularly those portrayed as dying of the disease, the characteristics of this narrative differs somewhat from the one identified in the breast cancer accounts. The dominant narrative in these stories is more in keeping with the 'heroic death' narrative that Seale (1995a) describes in an earlier study of interview accounts of dying (rather than media accounts of cancer). A heroic death narrative, however, appeared to be relatively absent from the personal stories of breast cancer, even where individuals are portrayed as having been given a terminal diagnosis. To explore these

differences further and the possible consequences they may have in terms of how the two diseases are constructed, Seale's studies examining media accounts of cancer and interview accounts of dying were examined more closely and used as a framework to re-analyse the personal stories.

Using Seale's work in this way drew attention to how accounts of cancer are often constructed within a moral discourse in which the social worth of the individual concerned is at stake. This is identified in other studies examining accounts of cancer, and accounts of health and illness in general (for example Williams 1993; Radley & Billig 1996; Frith et al. 2012; Walter 2010). Moral accountability in relation to having caused one's illness was then theorised as a possible explanation for why a narrative of heroism was identified as less prominent in personal stories of lung cancer, particularly accounts in which the individual concerned was identified as having smoked. This led to a further analysis of the personal stories to examine if, and if so how, stories were organised to position individuals in relation to cause and blame. To inform this analysis, a model of blame proposed by Malle et al. (2012) was used. This model was selected as useful because in it, blame is conceptualised as not only a cognitive phenomenon but also a social activity involving language and communication. The model outlines a series of informational steps or components involved in the process of making evaluations and judgements of blame. These components were used to examine the personal stories for evidence of blaming activity.

The analyses described in Phases 2 and 3 are presented in Chapters 5 and 6. Chapter 5 describes the personal stories and presents an analysis of them using Seale's work in relation to the construction of cancer as a heroic event. Chapter 6 presents the analysis of personal stories using the model of blame proposed by Malle et al. (2012).

2.3.4 Validation

Validity is concerned with the standards that research must meet to count as a qualified piece of academic research (Jørgensen & Phillips 2002). Validity in a positivistic epistemological sense of research capturing a reality is not relevant to a social constructionist approach since this perspective maintains that what we know about the world is constructed through language and discourse. This

concept has been discussed earlier in this chapter in relation to reflexivity and the positioning of analysts as producers of knowledge (pp29-30). Also discussed at that point in the chapter were a number of principles that Jørgensen and Phillips (2002) suggest researchers should follow to aid accountability and assist the reader to make an evaluation about the validity of the research. One of these principles is that the reporting of studies should provide empirical support for the interpretations made. Extracts from the texts examined are presented in the three analytic chapters (Chapters 4 to 6) to provide a degree of transparency and enable the reader to make a judgement in relation to the validity of the claims made and to minimise the extent to which the reader has to take the interpretations on trust. Rather than 'decontextualised snippets' (Frith & Kitzinger 1998, p307), extracts are lengthy at times in recognition that the local context, that is the ordinary language sequences in which statements are embedded in texts, is important in evaluations of meaning. This strategy has inevitably lengthened these chapters.

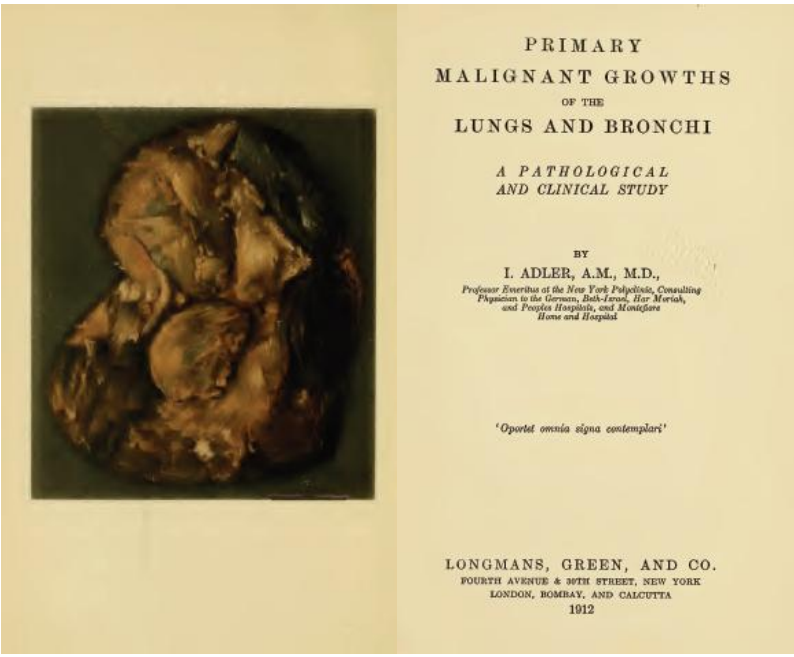
This chapter has described the overall design of the research including the rationale for the study, its theoretical and methodological approach, and the methods used to carry it out. With the study now situated in relation to existing research and within a theoretical framework, the next chapter aims to situate the study within its social and historical context by offering a perspective on how lung cancer has become an object of varying degrees of scientific and political interest.

3. Contextualising the research

This study draws on a social constructionist approach in which meanings and knowledge about the world, including health and disease, are understood to be historically and culturally specific. This theoretical approach is discussed in the previous chapter. The purpose of this chapter is to situate the study within its historical and social context. In this chapter, I provide one particular narrative of the development of social understandings of lung cancer from the time when the disease seemed to 'emerge' as a consequential phenomenon to the present time. However, in keeping with the overall theoretical perspective of the study, the situated and context-specific nature of this narrative of lung cancer is acknowledged, particularly given my professional association with the disease.

The material used to inform this chapter has been drawn from a variety of sources. A number of authors have written short historical accounts of the disease, either as discrete papers or within texts about other subject areas – for example, texts relating to smoking and public health policy. In addition, a history of lung cancer has recently been published by Carsten Timmermann (2014) and Carsten kindly allowed me access to two draft chapters from this text. These texts informed the early sections of the chapter in particular. From these sources a number of medical texts were identified and accessed. Examination of these publications and their reference lists added further texts for the review. Where I have drawn on these texts directly, I have referenced them as source documents. Finally, a number of media texts from the internet and materials already in my possession are also used to illustrate some of the claims made in this chapter.

3.1 From insignificant beginnings



PRIMARY
MALIGNANT GROWTHS
OF THE
LUNGS AND BRONCHI

A PATHOLOGICAL
AND CLINICAL STUDY

BY
I. ADLER, A.M., M.D.,
Professor Emeritus at the New York Polyclinic, Consulting Physician to the German, Beth-Israel, Har Moriah, and Peoples Hospitals, and Montefiore Home and Hospital

'Oportet omnia signa contemplari'

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LONDON, BOMBAY, AND CALCUTTA
1912

> *'Is it worth while to write a monograph on the subject of primary malignant tumours of the lung? In the course of the last two centuries an ever-increasing literature has accumulated around this subject. But this literature is without correlation, much of it buried in dissertations and other out-of-the-way places, and, with but a few notable exceptions, no attempt has been made to study the subject as a whole, either the pathological or the clinical aspect have been emphasized at the expense of the other, according to the special predilection of the author. On one point, however, there is nearly complete consensus of opinion, and that is that primary malignant neoplasms of the lungs are among the rarest forms of disease.'* (Adler 1912, p3)

This extract, written just over a hundred years ago, is taken from the opening paragraph of the introduction to one of the first medical textbooks devoted to the subject of lung cancer. It illustrates that although lung cancer is currently thought to be one of the commonest types of cancer in the UK and worldwide, this was not always the case. Lung cancer was thought to be a rare disease until the beginning of the twentieth century and of little concern to most doctors. Another medical textbook, this time published in 1850, described the

disease as a 'medical curiosity' and 'too rare to be of much practical importance' (Pepper, cited in Horn and Johnson 2008, p3268).

However, Adler suspected that the true incidence of lung cancer was masked by physicians' and autopsy technicians' readiness to diagnose most respiratory disease as tuberculosis (TB), a disease which was highly prevalent at the time. At this time, lung cancer was diagnosed primarily at autopsy and rarely in life Rather than being rare, Adler (1912) argued that lung cancer was more common than generally suspected, and moreover, it was likely to be increasing in incidence.

Alton Ochsner, a thoracic surgeon in the US, was a medical student in 1910 and recalls:

> '*During my junior year in medical school at Washington University at St Louis, a patient with cancer of the lung was admitted to Barnes Hospital, the teaching hospital of Washington University, and, as usual the patient died. Dr George Dock, who was an eminent clinician and pathologist, asked the two senior classes to witness the autopsy because, as he succinctly said, the condition was so rare he thought we might never see another case as long as we lived*.' (Ochsner 1973)

Ochsner comments further that he saw his second case seventeen years later, and in the subsequent six months saw a further eight cases, all in men who smoked heavily and had began doing so during the First World War (Ochsner 1973).

Ochsner's experience reflects the apparent emergence of lung cancer during the first half of the twentieth century in Western Europe and the United States from a seemingly insignificant and rare condition to one that demanded greater attention because of a dramatic increase in the recorded mortality from the disease. During this time in England and Wales, a roughly fifteen-fold increase in the number of deaths from lung cancer over a twenty-five year period was reported, from 612 deaths in 1922 to 9,287 in 1947 (Doll & Hill 1950). Before 1920 lung cancer was thought to account for 1.5% of all cancer deaths in men. By 1947 this figure was reported as 19.7% (Anon 1950). Writing at the time, Doll and Hill (1950) described the increasing death rate as 'one of the most striking changes in the pattern of mortality recorded by the Registrar

General' (p4682) and noted that similar patterns were being recorded elsewhere in the world, in countries such as Germany, Switzerland, Denmark, the US, Canada and Australia.

In the UK, the number of deaths from lung cancer was initially overshadowed by even higher death rates from other cancers and respiratory illnesses including TB, bronchitis and pneumonia, all of which were common and attributed with having caused greater mortality and morbidity over a longer period of time (Smithers 1953; Royal College of Physicians (RCP) 1962). This 'overshadowing' of the death rate from lung cancer is illustrated in Figure 1.

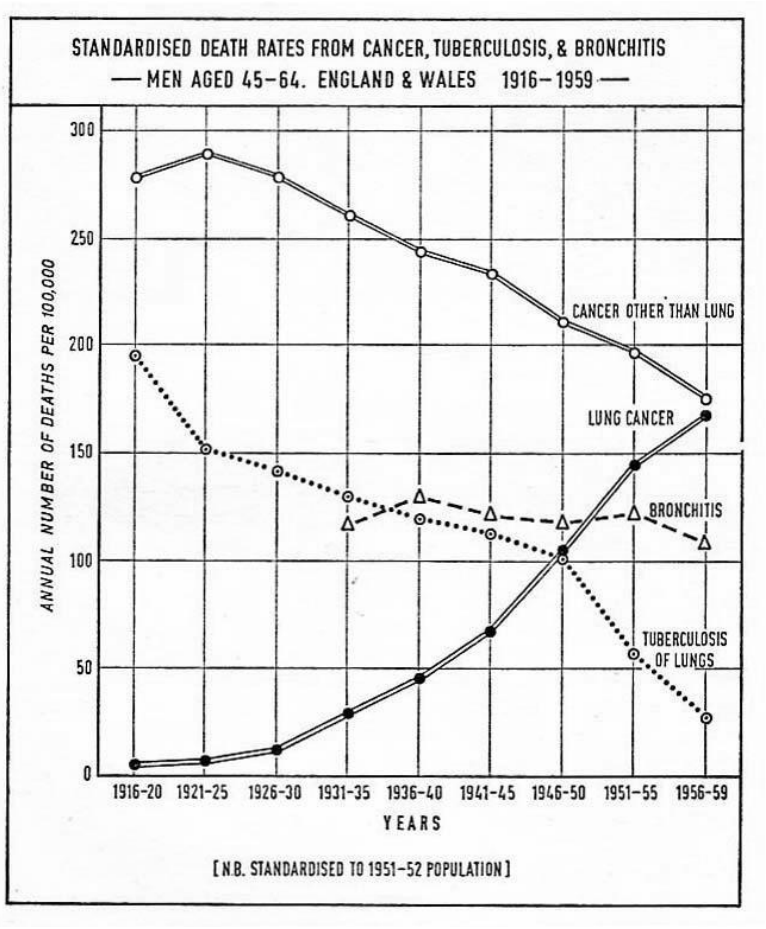


Figure 1: Death rates from cancer, tuberculosis and bronchitis, 1916–1959. Source: Royal College of Physicians 'Smoking and Health' report (1962)

At the time, there was debate about the 'true' extent of the increasing death rate and whether the recorded rise could be accounted for by factors such as increased longevity of the population and improvements in the diagnosis and recording of the disease, particularly since there had been increased medical specialisation during this time with the emergence of specialised chest clinics, as well as improvements in thoracic surgery and diagnostic techniques such as

radiography (X-ray in particular), bronchoscopy (a technique for visualising the airways), biopsy (removal of tissue from the lungs), and cytology and pathology (microscopic examination of cells from sputum, fluid and tissue) (Smithers 1953; Talley et al 2004; Berridge 2007a). Two extracts from the medical literature of the time illustrate the debate:

> *'It is doubtful whether the higher incidence of cancer of the lung observed in recent times is real or only apparent. When studying the statistics it must be remembered both that diagnosis has become more precise and that man's average span of life has lengthened. Cancer of the lung is by no means rare.'* (Anon 1942, p672)

> *'If the results from Copenhagen can be generalised, it seems that the apparent increase in lung cancer mortality is, to a very large extent, conditioned by improvements in diagnostic means, and it can be expected to continue until the sex ratio amounts to about 8 males to 1 female.'* (Clemmesen & Busk 1947, p259)

The first extract is taken from the opening paragraph of an editorial discussion of lung cancer in the British Medical Journal (BMJ). The second extract is taken from the concluding paragraph of a paper in the British Journal of Cancer which examined Danish mortality figures between 1931 and 1945. The extracts suggest that at the time, the 'apparent' rise in lung cancer was contested by some doctors.

The editorial in the BMJ also serves to illustrate how lung cancer and the medical management of it was characterised in medical literature of the time. Lung cancer is described as being most common in people over sixty years of age and in males rather than females. Surgery was thought to be the only curative treatment for lung cancer and only effective if the disease was diagnosed early. For example:

> '*Surgeons who are aware of the good result pneumonectomy [removal of an entire lung] may offer in the early stage of the disease are now taking every opportunity to emphasise early symptoms – cough, pain in the chest, and haemoptysis or "staining". Any one of the symptoms in a middle-aged or elderly person should lead to investigations to exclude*

> *cancer unless the symptoms can otherwise be accounted for.*' (Anon 1942, p672)

The extracts and figures presented in this section suggest that over a thirty-year period lung cancer had shifted from a position of medical insignificance to one warranting interest and debate. In contrast to the beginning of the twentieth century, by the 1940s the disease was no longer characterised by medicine in terms of its rarity, but rather by its apparently dramatic and unexplained emergence and its high death rate.

3.2 Seeking an explanation

The 1950s could be conceived as marking another defining period in the history of lung cancer. It was at this time that a causal explanation for the disease was proposed, that potentially accounted for its increasing incidence. The correlation between the increase in lung cancer and the increased prevalence of cigarette smoking twenty to forty years earlier may seem an obvious one with the benefit of hindsight and history. At the time, however, a link between the two was less clear. During the early part of the twentieth century a link had been made between the disease and high levels of radon gas in the mining industry, but this did not account for the disease in most people who developed it (Greenberg & Selikoff 1993; Witschi 2001). Suspicion about the harmful effects of smoking mounted throughout the first half of the century. However, smoking was only one of a number of causes that were considered. Other factors included industrial gases and dusts, asbestos, asphalting of roads, the increase in road traffic, exposure to gas in World War I and the influenza pandemic of 1918 (Kennaway & Kennaway 1950; Proctor 1999; Witschi 2001; Timmermann 2007). The following extract taken from the British Journal of Cancer in 1950 illustrates the uncertainty:

> *'A possible connection between tobacco, and especially cigarettes, and cancer of the lung, has been suggested many times….*
>
> *During the present century very considerable changes have taken place in this country in the social distribution of the various methods of smoking. There were, of course, exceptions to any rule, but roughly one might say that in the earlier part of this period men of the richer*

classes smoked pipes, cigarettes and cigars, and men of the poorer classes smoked pipes; cigarette smoking was increasing among the richer women, while women of the poorer classes did not smoke. One never saw a woman scrubbing her front door-step, or hanging out the washing, with a cigarette in her mouth. The great change which has taken place in the later years is the general increase in cigarette smoking, and its adoption by women of classes which formerly did not smoke at all……

Some writers have contended that smoking cannot be associated with cancer of the lung, because this form of cancer has increased more among men, while the use of tobacco has increased more among women. But the sexual distribution of cancer involves unknown factors, and does not provide a very secure basis for an argument of this kind. Of course no claim is made here that the simultaneous increases in the consumption of tobacco, and in cancer of the lung, proves any aetiological connection between the two. Other changes which have taken place in the same period, which no one proposes to associate with cancer of the lung, e.g. the increase in the issue of wireless licences show a very similar curve, and such correlations are a common subject for statistical witticisms. Thus wireless licences have increased at a rate (about 10-fold in the last 20 years) similar to that shown by deaths of cancer of the lung, or from coronary disease.'
(Kennaway & Kennaway 1950, pp293-295)

Later in the same year, two large epidemiological studies were published by Wynder and Graham (1950) in the United States and Doll and Hill (1950) in the UK. These case-control studies reported a strong association between cigarette smoking and the development of lung cancer by presenting data that showed that lung cancer was rare in non-smokers, people with the disease tended to be smokers and often heavy smokers, and prevalence of the disease in men and women matched patterns of smoking behaviour. Other epidemiological studies published at the time in the US reported similar results (Schrek et al. 1950; Levin et al. 1950; Mills and Porter 1950) and successive studies, including prospective cohort studies by Doll and Hill (1954, 1956) in the UK and Hammond and Horn (1954) in the US, were reported as verifying the association.

3.3 Public health impact

Despite the wide publicity received by the studies linking smoking and lung cancer in the UK, and attention from both the medical sphere and the popular media, authors have noted that it took a number of years and many more studies for the 'evidence' to impact on health policy (White 1990; Doll 1999; Talley et al. 2004; Berridge 2007a). Although they are considered landmark studies today, at the time there was genuine scientific and public scepticism of the association between tobacco and lung cancer. For example, in 1953 the Director of the Radiotherapy Department at the Brompton Hospital for Diseases of the Chest in London made the following comments in the British Medical Journal:

> *'The startling rise in the recorded death rate from cancer of the lung and the implication of one of our favourite indulgences as chief culprit have suddenly made this a matter of public interest, which is no doubt the reason why this topic was selected for me……*
>
> *The sudden interest in this subject and the recent accumulation of many new facts has led to a fine display of fancy. The different fancies that people have about the same facts usually depend on their training and outlook. What the clinician so readily attributes to his diagnostic skill the research worker is apt to believe may well be due to the action of a specific carcinogen. Both need to take particular notice of the way their natural bias is apt to lead them and to remember their responsibility to an anxious and ill-informed public when they publish their views on serious problems of fatal disease.'*

The paper ends by stating:

> *'As a profession which speaks so much and so rightly of the need to allay the cancer fear we should beware of putting extravagant accounts of rising cancer death rates and their causes before the public especially when neither the magnitude of the one nor the degree of responsibility of the other has yet been fully established.'* (Smithers 1953, pp1235 & 1239)

Historians suggest that given the historical context, this initial scepticism was reasonable from a medical and scientific perspective (White 1990; Talley et al. 2004). The studies linking lung cancer with smoking were epidemiological in design and showed statistical associations rather than experimental proof. At the time epidemiology was generally considered ancillary to medicine, and the case-control methodology was seen as subject to a number of biases (White 1990; Talley et al. 2004). More usually at this time, cause and effect was demonstrated in laboratory studies by isolating the biological cause of a disease, usually a pathogen. Also, the epidemiological studies left a number of key questions unanswered, including the exact causative agent in smoking, the reasons for the development of lung cancer in non-smokers, and why many smokers did not go on to develop the disease. These unanswered questions made many physicians and scientists contest the findings on both methodological and scientific grounds.

White (1990) suggests there was also a general reluctance to implicate an activity that, as Smithers described in the extract above, had become a 'favourite indulgence'. By now, smoking was commonplace. Smoking rates were reported to be at their peak in Britain with 82% of men and 41% of women smoking (CRUK 2012b). Smoking was also popular across all socio-economic groups. For example, 90% of male doctors over 35 were reported to be smokers (Doll and Hill 1954). These figures contrast with smoking patterns today. Currently, about 20% of the population are reported to be smokers, with the greatest prevalence in people working in manual occupations rather than non-manual and professional groups, and in women in the 20-to-24 age group (CRUK 2014b).

The rise in the popularity of smoking in the first half of the twentieth century is attributed to the increase in tobacco production immediately prior to the First World War which made it more affordable than ever before, and also to an advertising campaign that promoted it as a glamorous, pleasurable and healthy activity (Street 2004; Gardner & Brandt 2006; Lum et al. 2008) (see Figure 2).

3. Contextualising the research

Figure 2: Top left: Magazine advertisement for Craven A cigarettes (1910s). Top right: Magazine advertisement for Players cigarettes (1930s). Bottom left: Magazine advertisement for Model cigarettes (1940s). Bottom right: Magazine plate from Women's Journal (1959). Source: The Advertising Archives, London

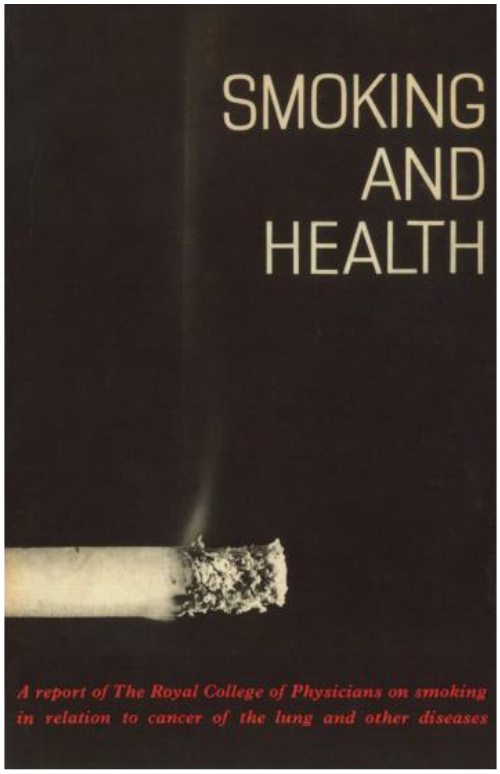
Major Hollywood stars and movie studios were signed up to endorse smoking through testimonial advertising and on-screen smoking and, it is argued, women were particularly targeted through the use of female actresses to model behaviour and increase its social acceptance (Lum et al. 2008). Doctors and nurses were also used in advertisements and smoking was recommended

by some doctors as means of controlling stress (Street 2004). By the1940s, it had become such an accepted part of everyday life that tobacco rations were distributed to solders during the Second World War, tobacco tokens for old age pensioners were issued by the Government, and the possibility of extra tobacco concessions for the disabled was discussed (Berridge 2007a).

The popularity and widespread social acceptance of smoking as part of everyday life is attributed to having led to a general reluctance in all social spheres to accept a causal association between smoking and lung cancer (White 1990; Talley et al. 2004; Berridge 2007a). As well as promoting smoking through its advertising activity, the tobacco industry is also attributed with acting in various ways to raise doubt about the veracity of the evidence linking smoking and lung cancer (Proctor 2012). Furthermore, despite pressure from a number of local authority medical officers, doctors and MPs, the Government resisted a centralised public health campaign to promote the link between lung cancer and smoking. Historians suggest that this was due in part to the contested nature of the evidence, but also due to the importance of tobacco in terms of taxation revenue and employment, concern about the electoral implications of proposing any measures to restrict a popular and normalised habit, and the nature of public health at the time whereby governments were less willing to intervene in people's everyday lives (Doll 1999; Talley et al. 2004; Timmermann 2007; Berridge 2006). Consequently, a decade passed where the studies linking smoking and lung cancer had little impact on public health policy.

A decade later the Royal College of Physicians (RCP) decided to act to bring the dangers of smoking to public attention and persuade the Government to do something about it. In 1962 it published a report entitled 'Smoking and Health' in which the evidence of two hundred epidemiological and biological studies on smoking was reviewed (RCP 1962). The report concluded that 'cigarette smoking is a cause of lung cancer and bronchitis, and probably contributes to heart disease and less common diseases' (pS7). A seven-point agenda for governmental action is recommended in the report including public education, restrictions on the sale of tobacco to children, restriction of tobacco advertising, tax increases, information on the tar and nicotine content of cigarettes, restrictions on smoking in public places, and the establishment of anti-smoking clinics. The report was launched at the first ever press conference

held by the RCP and a brief, readable summary was produced for distribution to the general public. By the autumn of 1963, 33,000 copies of the report had been sold in the UK and 55,000 in the US (Berridge 2007b). It received widespread media coverage including television current affairs and news programmes (Berridge 2007b; RCP n.d.). A copy of the cover of the report and the introductory paragraph of the report's summary are presented in Figure 3.



SUMMARY

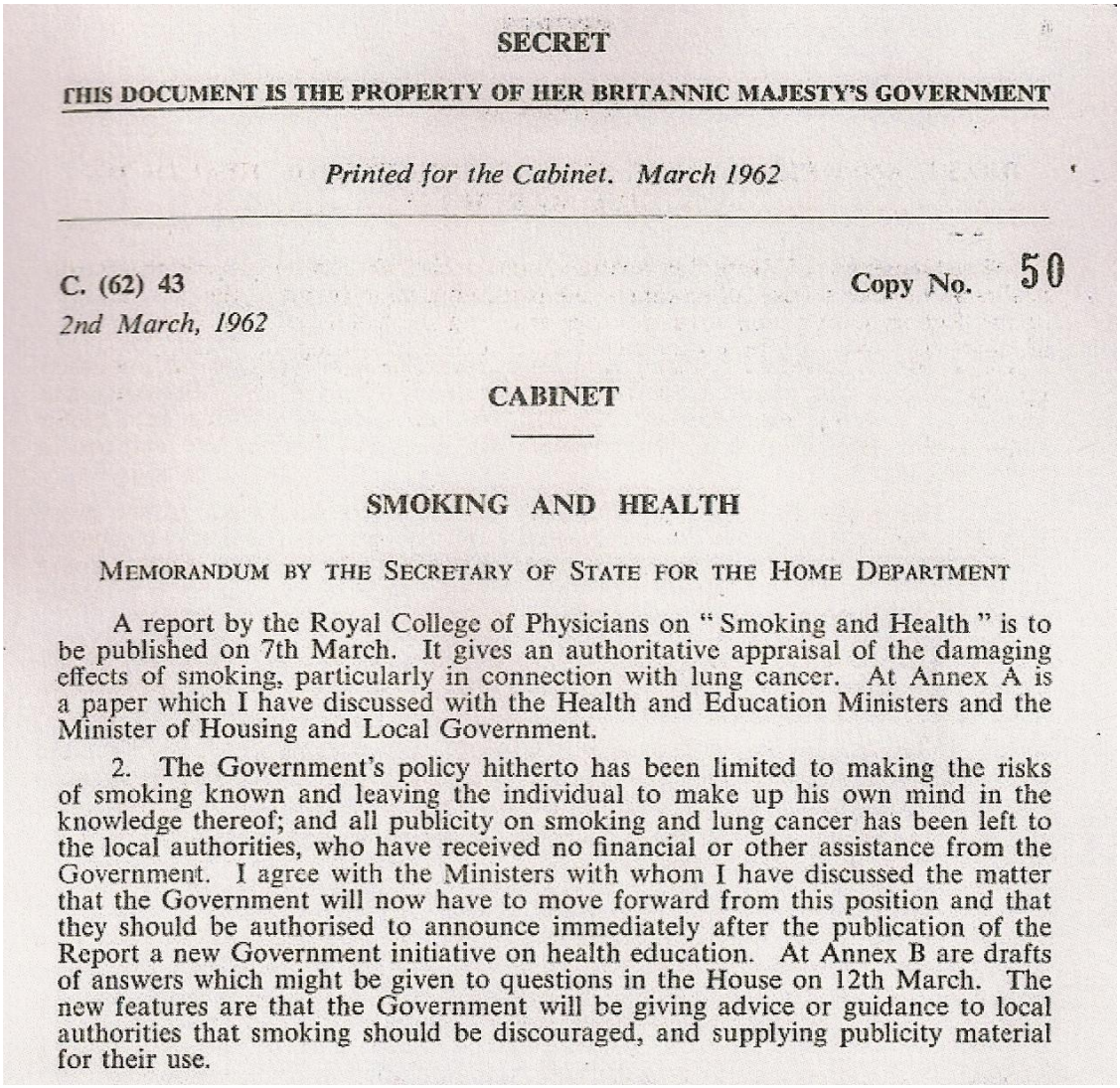
Introduction

Several serious diseases, in particular lung cancer, affect smokers more often than non-smokers. Cigarette smokers have the greatest risk of dying from these diseases, and the risk is greater for the heavier smokers. The many deaths caused by these diseases present a challenge to medicine, for in so far as they are due to smoking they should be preventable. This report is intended to give to doctors and others evidence on the hazards of smoking so that they may decide what should be done (*paras.* 1–3).

Figure 3: Cover page and introductory paragraph (pS2) from the 'Smoking and Health' report (1962). Source: Royal College of Physicians

Some historians mark this period, and the publication of the RCP report, as the beginning of a significant shift in the way that public health and health education were organised in the UK (Talley et al 2004; Berridge & Loughlin

2005; Berridge 2007a; Berridge 2007b; Cantor 2007; Toon 2007). Some suggest that up until the late 1950s the role of public health had been the responsibility of local authorities, with neither Government nor doctors assuming an overarching role or responsibility for advising the public on health matters (Berridge 2007b; Cantor 2007; Toon 2007). However, changes were occurring not only in the way that health services were being organised under the new National Health Service, but also in the patterning of disease. The traditional role of public health had been in combating infectious diseases, such as TB, cholera, scarlet fever and diphtheria, using immunization, sanitation and laboratory investigation of diseases (Berridge 2007a). As the incidence of these types of diseases declined, so non-infectious causes of death such as cancer, heart disease and strokes grew in importance. This led to a shift in the nature and focus of public health, which Berridge (2007b) suggests was exemplified by the lung cancer and smoking issue. In this new public health, the public came to be viewed as needing to be persuaded of the risks associated with consuming harmful goods and substances in order to avoid disease, doctors and scientists became more willing to speak directly to the public, and the Government adopted a new attitude regarding its public role on matters of health (Berridge & Loughlin 2005; Berridge 2007a). This shift in the Government's approach to public health can be identified in Figure 4, which presents an extract taken from a Cabinet memorandum that was produced in response to the anticipated media launch of the 1962 RCP report.



SECRET

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Printed for the Cabinet. March 1962

C. (62) 43 Copy No. 50

2nd March, 1962

CABINET

SMOKING AND HEALTH

MEMORANDUM BY THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

A report by the Royal College of Physicians on "Smoking and Health" is to be published on 7th March. It gives an authoritative appraisal of the damaging effects of smoking, particularly in connection with lung cancer. At Annex A is a paper which I have discussed with the Health and Education Ministers and the Minister of Housing and Local Government.

2. The Government's policy hitherto has been limited to making the risks of smoking known and leaving the individual to make up his own mind in the knowledge thereof; and all publicity on smoking and lung cancer has been left to the local authorities, who have received no financial or other assistance from the Government. I agree with the Ministers with whom I have discussed the matter that the Government will now have to move forward from this position and that they should be authorised to announce immediately after the publication of the Report a new Government initiative on health education. At Annex B are drafts of answers which might be given to questions in the House on 12th March. The new features are that the Government will be giving advice or guidance to local authorities that smoking should be discouraged, and supplying publicity material for their use.

Figure 4: A Government memorandum (Home Office 1962) discussing the publication of the Smoking and Health report. Source: National Archives

Media were considered central to this new style of public health. Government and medicine began to work together and use media to influence public attitudes and behaviours in relation to health and social lifestyles (Berridge & Loughlin 2005; Berridge 2007b). Persuasion, through media, became a key approach. Berridge (2007b) suggests that messages were no longer neutral, aimed at providing people with the facts and trusting them to make the right decision with regards to their health. They became imbued with moral and medical imperatives emphasising self-discipline and the avoidance of risk. Smoking became a particular target of these new-style public health campaigns. The Government, in conjunction with doctors and anti-smoking lobbyists, launched a series of publicity campaigns over the next two decades warning of the dangers of smoking. The campaigns drew expertise from advertising including the Saatchi and Saatchi agency. In this way, media,

particularly advertising, were used as a public health tool to counter the attractiveness of smoking just as the tobacco companies had previously used media to promote smoking. Smoking was variously portrayed as dirty, unpleasant, unsocial, unglamorous, nonsensical and dangerous creating what Berridge and Loughlin (2005) describe as an 'anti-aesthetic' around it (p7). This negative portrayal of smoking is illustrated in the posters presented in Figure 5 and is in stark contrast with the imagery of smoking presented earlier in Figure 2 (p62).

Figure 5: Smoking posters. Top left: England Health Education Council poster, 1975–81. Top right: England Health Education Council poster, 1971–75. Source for both: Science Museum Group. Bottom left: Magazine advert, England Health Education Council, 1970s. Bottom right: Scottish Health Education Council poster, 1970s. Source for both: The Advertising Archives, London

Media was also used in other ways to discourage smoking and children were particular targets of the campaigns (Berridge 2007b). For example, a film

called ‘Smoking and You’, aimed at the 11-to-16 age-group, was distributed to schools free of charge in 1963. The film includes a number of devices that may evoke shock and fear among young audiences including emotive footage of middle-aged smokers having problems breathing and confined to hospital beds (see Figure 6), stark warnings issued by doctors such as “cigarettes can kill, and if they don’t kill they can rot the lungs”, close-up pictures of damaged lung tissue, cigarette butts stubbed out in left-over food, and glass beakers brimming with revolting treacly tar extracted from experiments mimicking the effects of smoking.

Figure 6: A screenshot taken from the film ‘Smoking and You’ (1963). Source: British Film Institute

From this historical perspective, therefore, the period following the publication of the RCP Smoking and Health report (1962) could be said to mark a time when lung cancer became inextricably linked with smoking and the imagery associated with cigarettes and smoking. Some historians also mark it as a period in which there was a shift in medical and governmental approaches to smoking. Rather than a harmless indulgence and a matter for personal choice, smoking became regarded as a significant public health risk and as something to be actively discouraged.

3.4 Medical enthusiasm and dashed hopes

Around the time of the publication of the studies linking lung cancer with smoking, surgery was considered to be the only effective treatment for the disease. Holmes Sellors, a thoracic surgeon working at the Middlesex, London Chest and Harefield Hospitals, summarised the current state of medical knowledge in the British Medical Journal:

> *'In the treatment of cancer of the lung it is generally accepted that surgery alone offers any real hope of success. Up to the present time radiotherapy has played a part that is largely palliative, and the experiences gained by the combined use of radiotherapy and surgery are too limited to be of value'*. (Holmes Sellors 1955)

At this time, surgery usually involved removal of the whole lung (pneumonectomy). The procedure had been established after it was successfully performed for the first time by Evarts A. Graham in 1933 (Mountain 2000). Ironically Graham was a cigarette smoker, and although he stopped smoking in 1951, he was diagnosed with bilateral lung cancer in 1957 and died soon after (Baue 1984). Although offering the best chance of a cure, mortality from surgery was recorded at the time to be 10 to 15% (Bromley 1953) although it was reported to vary widely depending on the skill of the surgeon and the selection of patients (Taylor & Waterhouse 1950). Five-year survival following surgery was variously reported as between 5 to 25 % (Taylor & Waterhouse 1950; Davidson 1953; Holmes Sellors 1955). For patients not treated by surgery, the average life expectancy following diagnosis was reported as four months (Taylor & Waterhouse 1950). As the extract above states, when radiotherapy was used it was commonly to palliate symptoms, although some trials had suggested it may have a role in prolonging life and possibly cure the disease for some patients (Taylor & Waterhouse 1950). The use of chemotherapy had not been shown to improve survival from the disease (Davidson 1953).

Although surgery was the treatment of choice at this time, most people diagnosed with lung cancer were unsuitable for an operation, either because they were not fit enough or because the disease was found to be too extensive to be completely excised (Bromley 1953). Of the patients referred for surgical

assessment only 15 to 20% were operated on, and of those only 60 to 70% had disease that was resectable (Bromley 1953; Holmes Sellors 1955). Diagnosing the disease in its early stages proved difficult, and delays in diagnosis and getting to surgery were common. In the 1950s the average delay between a patient experiencing initial symptoms of the disease and being operated on was recorded as six months, although this was said to have reduced from nine months in 1940 (Holmes Sellors 1955). Earlier diagnosis was thought to be the consequence of a combination of factors, including the '*insidious nature of the early symptoms and failure of the patient to seek early medical advice, and also to procrastination by the general practitioner and a failure to have radiological and other investigations early enough*' (Taylor & Waterhouse 1950, p262).

Timmermann (2007, 2014) suggests that the increasing incidence of lung cancer, the publication of the studies linking the disease with smoking and the need to improve on therapeutic approaches sparked not only debate within the medical and scientific community but also considerable research interest. This, he suggests further, led to an increase in research activity investigating not only the aetiology and epidemiology of the disease but also areas such as screening, diagnosis and treatment. From his analysis of the UK Medical Research Council archives, he describes an active programme of research studies during the mid-1950s and 1970s in which there was little notion among scientists and the medical community that the disease would remain incurable. However, from his analysis, Timmerman (2007, 2014) identifies that the lung cancer trials proved difficult to organise and carry out, partly due to the dominance of surgery as the standard of care. The trials also failed to demonstrate significant improvements in terms of survival, which contrasted with the reported successes of trials in other cancers such as leukaemia and breast cancer. Despite considerable scientific and medical investment, survival rates from lung cancer remained unchanged and mortality rates rose to an all-time high. These difficulties and failures, Timmermann (2007) suggests, led to disappointment and frustration among scientists and doctors, and contributed to a notion of hopelessness and futility in relation to the treatment of lung cancer. A sense developed that the disease was inherently resistant to treatment. This understanding of lung cancer is evident in an editorial in The Lancet published in 1975:

'The Treatment of Bronchial Carcinoma

Bronchial carcinoma is now by far the commonest malignant tumour in men in Great Britain and most other developed countries, and is still increasing in frequency. In women its incidence is about a third of that in men but is increasing more rapidly; already in England and Wales it causes nearly three times as many deaths as carcinoma of the cervix uteri and more than half as many carcinoma of the breast…

The mortality of this disease is little affected by treatment. Survey of large unselected series suggested in 1958 that, of all patients diagnosed and treated with the best means available, the proportion who could be expected to survive 5 years was not much more than one in twenty, and there is little reason to believe that there has been much improvement since then…

Attempts to detect the disease early in its course by mass radiography have led to only minor increases in the number of long-term survivors…

It thus seems that, for the foreseeable future, only a minority of patients with bronchial carcinoma will prove to be eligible for attempted "radical" treatment, either by surgery or radiotherapy. The chief problem of management will continue to be whether life can be usefully prolonged, or its quality improved, by so-called palliative radiotherapy or by the hopeful administration of cytotoxic drugs, the alternative being to use these, among other measures, only when they are likely to relieve symptoms without producing others equally troublesome…

While every effort must be made to improve the results of treatment of bronchial carcinoma, either by the more discriminating application of existing methods, guided by increasing knowledge about the response of various histological types, or by new approaches to the treatment of malignant disease, the overwhelming importance of a preventive approach to this disease must always be emphasised. It would be a cruel deception to allow smokers to think that any improvement in treatment, or any procedure to which they might submit themselves to

> *attain early diagnosis, is likely to diminish appreciably their risk of dying of lung cancer.' (Anon 1975)*

In this extract, lung cancer is viewed as intractable and largely resistant to medical efforts to control it, and prevention is cited as the most important way of controlling the disease.

3.5 Stagnation and neglect

As the twentieth century drew to a close and the new century began, several national reports suggested that medical progress in lung cancer was stagnant, born of a sense that the disease was inevitably fatal (NHS Executive 1998; Krishnasamy & Wilkie 1999; National Cancer Research Institute 2002). At this time, approximately 10 to15% of patients were reported to receive surgery (similar to the proportion recorded in the 1950s), 10% of patients received radical radiotherapy (which was curative for a small proportion of people by this time), and 5% of patients received palliative chemotherapy (NHS Executive 1998). Median survival time following diagnosis was said to be four months, again similar to the figure recorded in 1950, and 80% of patients died within one year (NHS Executive 1998). A report by the National Cancer Research Institute (NCRI) (2002) identified that lung cancer received much less funding for research than other cancers, relative to both its incidence and its mortality rates. In this report, only 3.4% of research that was disease-specific was said to be targeted at lung cancer although the disease accounted for 22% of all cancer deaths. This may be compared with almost 18% of disease-specific research aimed at breast cancer, which accounted for only 8% of cancer deaths at the time. Within the report, it was speculated that:

> *'Lung cancer is not a particularly researchable or tractable disease to study and it may be for these reasons that lung cancer research is unattractive to many investigators.*' (NCRI 2002, p30)

In a further analysis examining the issue in greater depth, the NCRI identified that the UK's publication output for lung cancer as a proportion of the total biomedical output was low, reaching only 60% of the world average during the period between 1993 and 2003, although the quality of UK publications was reported to be high (NCRI 2006). The analysis also identified that lung cancer 'had a reputation for being difficult to study and has been associated with a

culture of nihilism'. These two reports by the NCRI led to a number of actions being taken by the organisation and its partners, including: 1) the formation of a working party to help raise the profile of lung cancer research among the pubic and professionals and young people considering a career in science; 2) the pledge of funds worth £2.25 million for research studies on symptom management; 3) support for efforts to determine the feasibility of screening for lung cancer; and 4) collaboration with disciplines working with patients to identify opportunities for research into the promotion of early health-seeking behaviour.

Data from a national needs analysis suggested that patients with lung cancer and their family members experienced multiple problems with very little help from professionals, while GPs felt unable to deal with commonly experienced problems and were hampered in their efforts by delays in the flow of information from hospital teams (Krishnasamy & Wilkie 1999). The first national lung cancer guidance document, published in 1998, was also highly critical of services and suggested a wide variation in clinical practice, poorly co-ordinated and fragmented services, and inequitable access to treatment (NHS Executive 1998). This guidance suggested that delays in diagnosing and treating patients were common, and low rates of histopathological diagnosis and inadequate patient assessment, particularly among elderly patients, led to inappropriate management, under-treatment and poor outcomes. Haward noted in the foreword of the document that:

> '*It has been apparent to those preparing this report on lung cancer that prevailing attitudes towards this disease and its treatment are characterised by a sense of pessimism, at the extreme by a degree of nihilism, amongst some professionals. To put this view crudely, it doesn't matter what you do for patients with lung cancer because they all die relatively quickly. Where, then, is the incentive to provide good care? Whilst lung cancer does carry a poor prognosis for many patients, there is ample evidence to support the view that better organisation and delivery of treatment and care can make a worthwhile difference. Health professionals, including those responsible for commissioning and managing services, need to be encouraged to adopt a more positive view of the improvements in*

> *health that can be achieved for large numbers of patients with lung cancer.*' (NHS Executive 1998, p4)

The guidance document was one of a series of tumour-specific guidelines that followed the publication of the Calman-Hine Report in 1995 (The Expert Advisory Group on Cancer 1995). Both initiatives were part of an overall strategy aimed at improving outcomes from cancer by reducing inequalities and ensuring the delivery of a uniform standard of high-quality care to all patients. As part of this strategy, cancer services were reorganised and tumour-specific teams of specialists were established throughout England and Wales. Cancer services in Scotland and Northern Ireland underwent similar reorganisation.

In contrast to the national guidance documents published at the time relating to other cancers, primary prevention through smoking cessation and tobacco control was a prominent focus of the lung cancer guidance. It was argued that: '*Prevention is the only form of intervention that can be expected to have a substantial effect on lung cancer incidence and mortality'* and the first recommendation of the document stated that '*Action against smoking should be the primary focus of efforts to improve outcomes in lung cancer*'. The document cited the Government's target to reduce the lung cancer death rate by 2010 by at least 30% in men and 15% in women, using strategies such as reducing cigarette consumption and the prevalence of smoking.

However, the guidance document was also concerned that clinical services should improve. This is evident in the extract above. Haward drew on Sir Donald Black (1984) to argue that treatment and prevention are complementary rather than oppositional and that both approaches are necessary to deal with the disease effectively. Further recommendations highlighted a need for better organisation and delivery of services as well as improved access to specialist multi-professional teams. This led to the creation of specialist lung cancer teams within hospitals, and a reorganisation of services aimed at streamlining care pathways and reducing the system delays that hampered patients' timely access to diagnosis and treatment.

3.6 A resurgence of interest

The publication of the reports discussed in the previous section could be viewed as marking the beginning of a resurgence of biomedical and political interest in lung cancer. Since their publication, a number of developments in the organisation and delivery of clinical services are reported to have taken place including: (i) greater multi-professional working with the establishment of multidisciplinary teams and better organisation of services (Naidu & Rajesh 2008); (ii) the development of the nurse specialist role in lung cancer and the creation of over 250 such posts (London and South East Lung Cancer Forum for Nurses 2004); (iii) the establishment of a national dataset and audit programme aimed at addressing variations in practice (Health and Social Care Information Centre 2012; RCP 2013); and (iv) increased numbers of patients receiving a histopathological diagnosis and some form of anti-cancer treatment (Health and Social Care Information Centre 2012). In addition, research spending on lung cancer research by the NCRI and its partners has grown from 3.4% of site-specific research (£3.5 million) in 2002 to 5.2% (£11.6 million) in 2011, although this amount remains low when compared with some other cancers (Figure 7) and relative to the impact of the disease in terms of incidence, mortality, morbidity and economic burden (NCRI 2012).

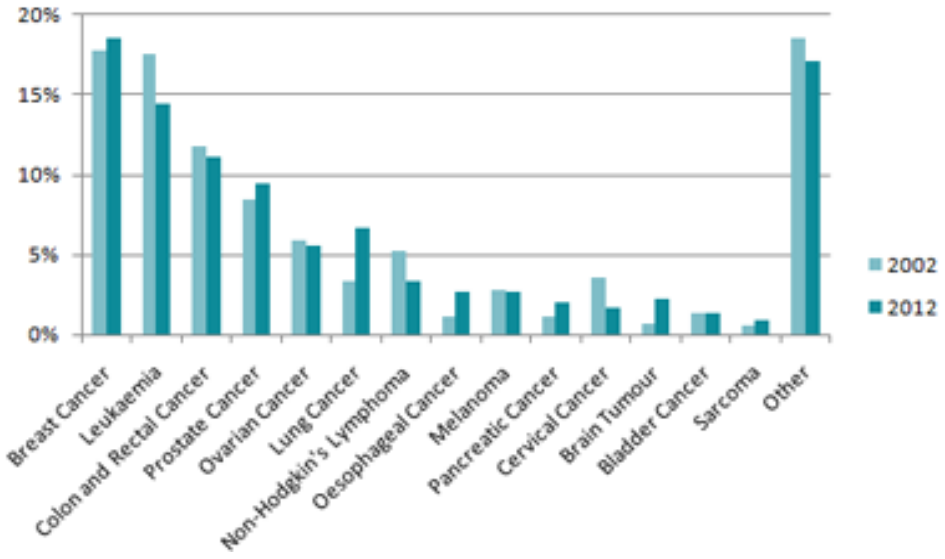

Figure 7: National Cancer Research Institute (NCRI) analysis of disease-specific funding in percentage terms. Source: NCRI (2012)

National initiatives are also focussed on improving survival from lung cancer in response to reports that rates are still low compared with those of other

cancers (except cancer of the pancreas) (CRUK 2014c, see Figure 8) and in comparison with many other counties with similar levels of economic development (Sant et al. 2009; Coleman et al. 2011; Walters et al. 2013).

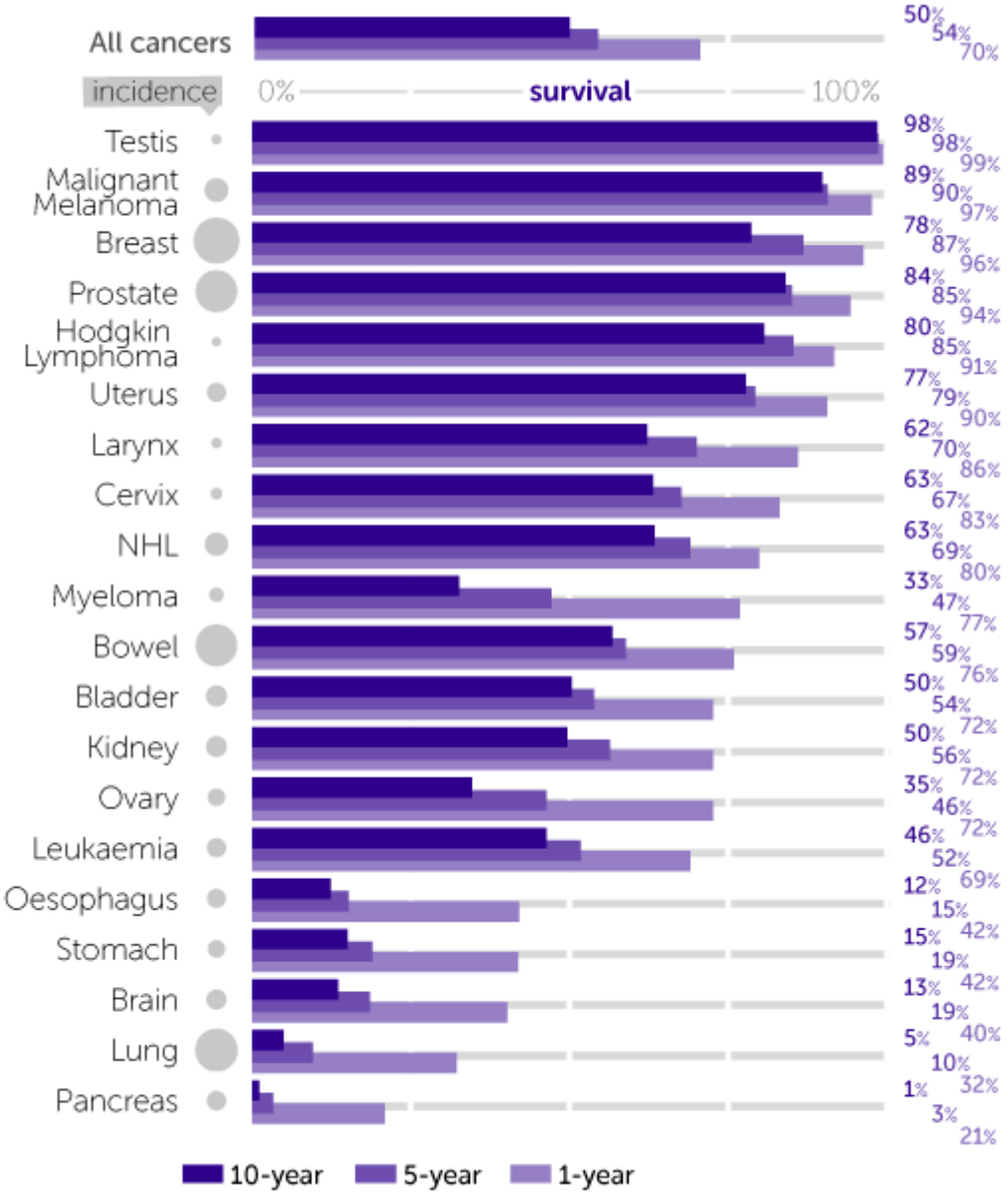

Figure 8: Age-standardised one-, five- and ten-year net survival, selected cancers, adults (aged 15-99), England and Wales, 2010-
Source: CRUK (2014c)

Low lung cancer survival rates in the UK compared with those in other countries are thought to be due to a combination of late diagnosis and differences in access to and quality of treatment (Walters et al. 2013). The issue has provoked a significant political response since comparison of survival

outcomes is used to monitor the implementation and efficacy of national cancer plans. Successive UK Governments have pledged to tackle the apparent inequalities and achieve cancer outcomes comparable to the best in the world (Department of Health (DH) 2011a; Scottish Government 2008; Welsh Assembly Government 2008; Department of Health, Social Services and Public Safety/Northern Ireland Cancer Network 2008). Strategies are targeted at addressing both late diagnosis and variations in care. With regard to late diagnosis, the National Awareness and Early Diagnosis Initiative (NAEDI) was established in England in 2008. It aims to increase public awareness of symptoms and the benefits of early diagnosis, as well as supporting primary care in diagnosing the disease earlier (CRUK 2010). In 2011 public awareness campaigns were launched to highlight the symptoms of lung cancer and increase the number of people with possible symptoms who are referred for chest X-ray. Figure 9 presents one of the materials produced for the campaign (DH n.d.). These campaigns are ongoing.

Figure 9: Lung cancer awareness campaign poster. Source: Department of Health

With regard to variations in care, recent strategies have focussed on increasing the numbers of patients receiving curative surgery. Although surgical rates have improved, variations between centres are identified, ranging from 11% in one centre to 16.5% in another (Health and Social Care Information Centre

2012). Variations between surgical rates in the UK and those in other countries are also identified. For example, the surgery rate in Teeside, UK is reported to be one third of that in Varese, Italy (7% compared with 24%) even though the proportion of potentially operable early-stage cancers was identified as greater in Teeside (Imperatori et al. 2006). As well as continuing efforts to improve surgical rates, the uptake and delivery of radiotherapy and systemic anticancer therapy is the subject of current reviews which aim to quantify and address regional variations (RCP 2013).

Recent advances in understanding the biology of cancer in general also appear to have generated a resurgence of interest in the medical management of lung cancer. Traditionally, lung cancer is said to be comprised of two main histological types: small cell lung cancer (SCLC) that accounts for between 10 and 15 % of cases and non-small cell lung cancer (NSCLC) that accounts for about 75 to 80% (Health and Social Care Information Centre 2012). NSCLC can be divided further into several sub-types including adenocarcinoma, squamous cell carcinoma and large cell carcinoma. Historically NSCLC was considered to be a single disease and treatment was not specific for the different sub-types. However, recent studies have indicated that different NSCLC sub-types have different sensitivities to chemotherapy agents and also, like many other cancers, they can be sub-classified by molecular or genomic characteristics. These findings have created the potential for personalised or stratified therapies that target specific genomic alterations. They have also led to further research activity aimed at developing technologies to detect genomic alterations effectively and efficiently (Li et al. 2013).

These new understandings and developments have not only led to an apparent resurgence of activity amongst scientists and clinicians working in lung cancer; they may also have led to a resurgence of hope that more effective therapies may soon be available. For example Schiller et al. (2013), writing in only the second Special Series on lung cancer in the Journal of Clinical Oncology since the journal's inception thirty years ago, report that they are '*optimistic about the accelerating pace of discovery and innovation in lung cancer biology and treatment*' (p982). They describe an '*explosion in the knowledge about the molecular characterisation*' of the disease and suggest the field has been '*revolutionised*' (p982). Similarly Professor Dean Fennell, an oncologist working in the UK, recently suggested that '*looking to the future, it's clear that after*

many decades of frustration, there's a bright future ahead for lung cancer research – in treatment and care, and in spotting patients early – and the possibility of substantial progress in the coming years' (CRUK 2013a; see Figure 10).

Figure 10: Cancer Research UK (CRUK) Science Update blog (2013a). Source: CRUK

This level of scientific and government activity and enthusiasm is in distinct contrast to the abject nihilism described by Haward (NHS Executive 1998) at the end of the last century where he suggested that many health care professionals felt there was little to be gained from investment into the disease

because it its inherent resistance to treatment. The current display of interest and optimism around the disease echoes the past in some ways, when the dramatic rise in related deaths and the establishment of the link with smoking seemed to spark a similar surge of interest from science, medicine and government. In doing so, it perhaps opens alternative discourses in relation to lung cancer, in which prevention is not the only course of action that is promoted in order to tackle the disease.

3.7 Public understandings

In studies involving both people diagnosed with lung cancer and the general public, authors suggest that awareness of symptoms of the disease is low and this is cited as a major contributor to delays in diagnosis (Bowen & Rayner 2002; Corner et al. 2006; Tod et al. 2008; Robb et al. 2009; Simon et al. 2012). For example, the most recent study identified conducted by Simon et al. (2012) surveyed almost 1500 people in the UK and identified that unprompted recall of symptoms of lung cancer was low. For example, less than 37% of respondents correctly identified breathlessness, 21% correctly identified coughing up blood, and only 5% correctly identified a cough that doesn't go away. However, when prompted with a list of symptoms for identification, recall was much higher (83% identified breathlessness, 92% identified coughing up blood and 63% identified a cough that doesn't go away). In this study also, although respondents' unprompted and prompted recall of smoking as a risk factor for lung cancer was high, their unprompted recall of other risk factors for the disease (such as exposure to asbestos and radon, air pollution, family history of lung cancer, history of lung disease) was much lower than their prompted recall. In the 'key messages' section of the paper, the authors suggest that the 'bottom line' of their research is that '*lung cancer could potentially be diagnosed at an earlier stage if patients had better symptom and risk factor awareness that led them to present more promptly in primary care*' (p426). In this study, judgements on public understandings of lung cancer place more importance on individuals' ability to recall symptoms without being prompted. However, how individuals make sense of these symptoms in context is unexplored.

A small number of reports are identified that present results from opinion polls and surveys in relation to public attitudes towards people with lung cancer. For

example, a global 'attitude survey' conducted in 2010 asked members of the public which cancer causes the greatest number of deaths in their country and how sympathetic are they towards individuals with lung cancer (Ipsos MORI 2010a). The survey was commissioned by the Global Lung Cancer Coalition (GLCC) and involved 16,000 people in sixteen countries. Of the 1000 respondents taking part in Britain, 54% correctly identified that lung cancer causes the greatest number of cancer deaths, a figure somewhat lower than the ones for most other countries (Ipsos MORI 2010b). A further 37% of respondents cited breast cancer. When asked if they have less sympathy for people with lung cancer given its association with smoking, 54% of respondents disagreed and 24% agreed (Ipsos MORI 2010b) (see Figure 11).

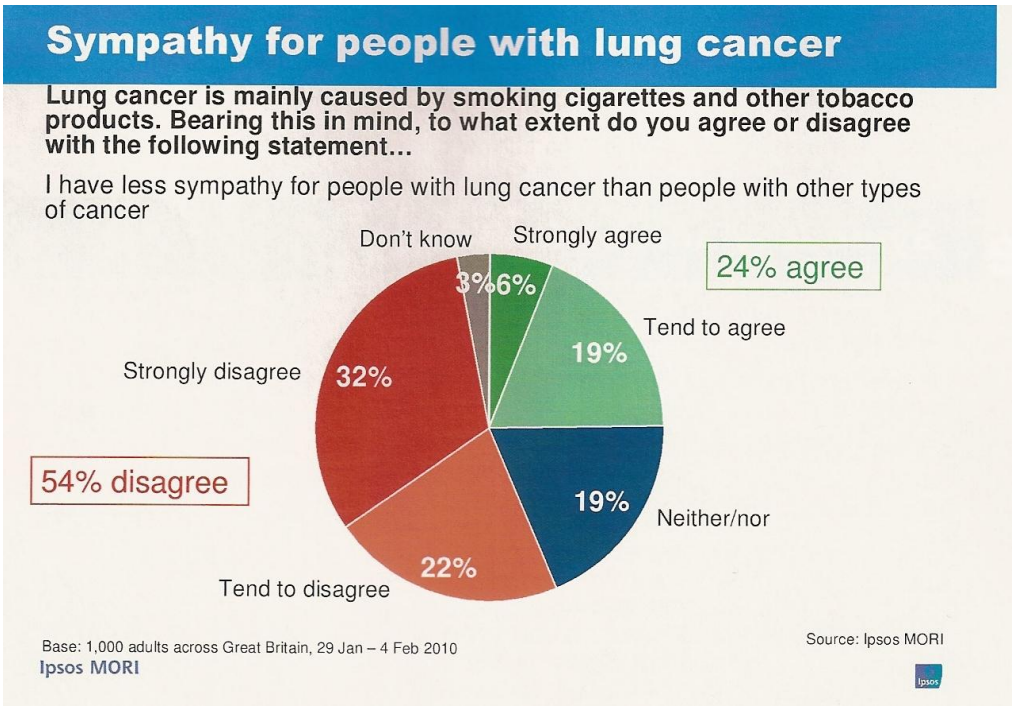

Figure 11: Chart from Ipsos MORI survey showing results for 'Sympathy for people with lung cancer'*. Source: Ipsos MORI

*The sum of the two percentages for 'Strongly agree (6%)' and 'Tend to agree' (19%) is at variance with the label of '24% agree'. However, 24% is also the figure presented in the report of the findings of the global survey (Ipsos MORI 2010a)

Compared with other countries, British respondents are reported as less sympathetic than respondents in many of the other nations polled. Across countries, sympathy levels were generally greater in countries with higher smoking levels, although in Britain the level of sympathy is relatively low

despite having relatively high smoking rates. The results of this survey were used by the GLCC to portray people with lung cancer as stigmatised because of the association of the disease with smoking. Figure 12 presents a screenshot from the GLCC's website to illustrate this portrayal.

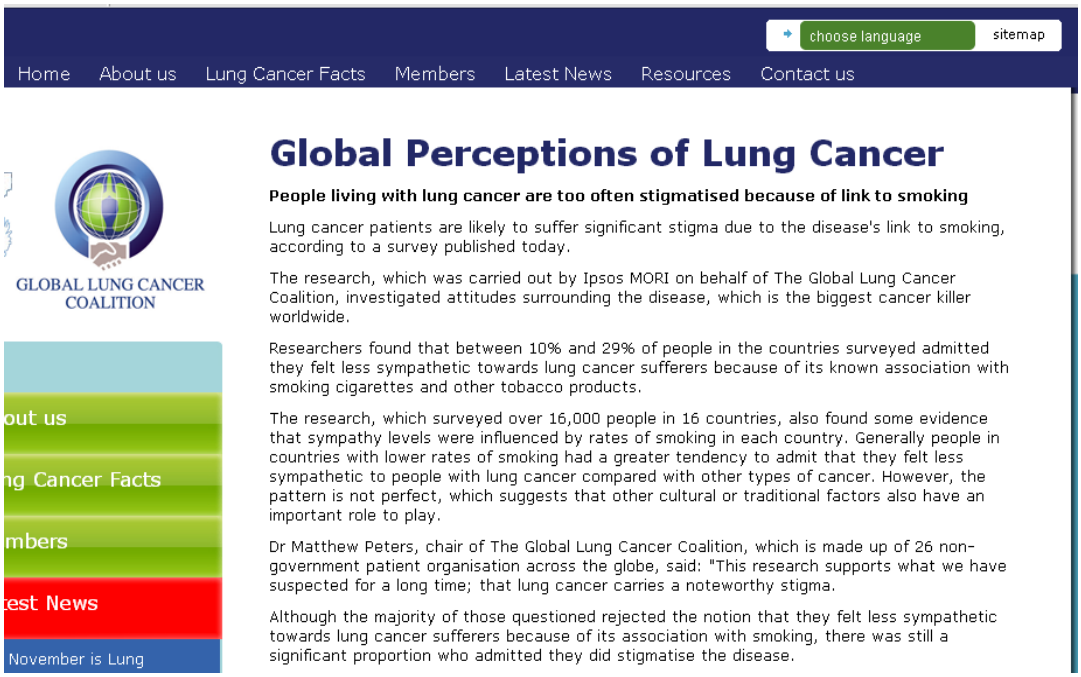

Figure 12: Global Lung Cancer Coalition (GLCC) internet report of survey conducted in 2010. Source: GLCC

An earlier opinion poll, conducted in 2000 in the UK on behalf of the Cancer Research Campaign (CRC), questioned 2000 people about their attitudes in relation to people with lung cancer (Ipsos MORI 2000). The report identified that 70% of respondents agreed that smokers who develop lung cancer have brought the disease upon themselves. However, 84% of respondents agreed that people with lung cancer are as deserving of NHS treatment as other people with cancer. The poll was used by the CRC to publicise lung cancer as 'the invisible cancer', which lacks 'public attention' because of its association with smoking (Ipsos MORI 2000). Figure 13 shows a screenshot from the BBC news internet site presenting the results from the poll in Scotland.

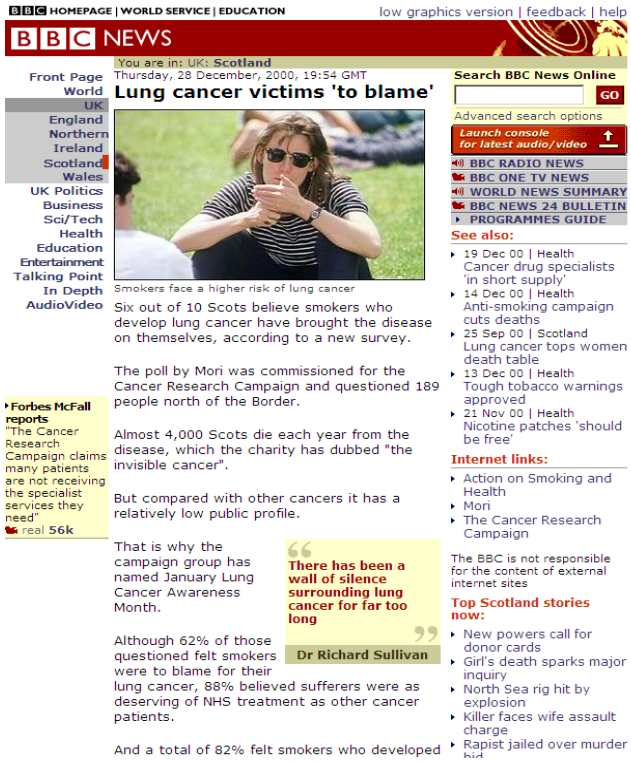
BBC HOMEPAGE | WORLD SERVICE | EDUCATION
low graphics version | feedback | help
BBC NEWS
You are in: UK: Scotland
Front Page
World
UK
England
Northern Ireland
Scotland
Wales
UK Politics
Business
Sci/Tech
Health
Education
Entertainment
Talking Point
In Depth
AudioVideo
Thursday, 28 December, 2000, 19:54 GMT
Lung cancer victims 'to blame'
Smokers face a higher risk of lung cancer
Six out of 10 Scots believe smokers who develop lung cancer have brought the disease on themselves, according to a new survey.
The poll by Mori was commissioned for the Cancer Research Campaign and questioned 189 people north of the Border.
Almost 4,000 Scots die each year from the disease, which the charity has dubbed "the invisible cancer".
But compared with other cancers it has a relatively low public profile.
That is why the campaign group has named January Lung Cancer Awareness Month.
There has been a wall of silence surrounding lung cancer for far too long
Dr Richard Sullivan
Although 62% of those questioned felt smokers were to blame for their lung cancer, 88% believed sufferers were as deserving of NHS treatment as other cancer patients.
And a total of 82% felt smokers who developed
Forbes McFall reports "The Cancer Research Campaign claims many patients are not receiving the specialist services they need" real 56k
Search BBC News Online
GO
Advanced search options
Launch console for latest audio/video
BBC RADIO NEWS
BBC ONE TV NEWS
WORLD NEWS SUMMARY
BBC NEWS 24 BULLETIN
PROGRAMMES GUIDE
See also:
19 Dec 00 | Health Cancer drug specialists 'in short supply'
14 Dec 00 | Health Anti-smoking campaign cuts deaths
25 Sep 00 | Scotland Lung cancer tops women death table
13 Dec 00 | Health Tough tobacco warnings approved
21 Nov 00 | Health Nicotine patches 'should be free'
Internet links:
Action on Smoking and Health
Mori
The Cancer Research Campaign
The BBC is not responsible for the content of external internet sites
Top Scotland stories now:
New powers call for donor cards
Girl's death sparks major inquiry
North Sea rig hit by explosion
Killer faces wife assault charge
Rapist jailed over murder

Figure 13: BBC report of the Cancer Research Campaign opinion poll conducted in 2000. Source: BBC Scotland

Drawing meaningful interpretations in relation to public understandings of lung cancer from the studies and surveys identified is difficult given their small number and limited methodology. However, the studies and surveys illustrate how this activity in itself (i.e. research and canvassing public opinions/attitudes) is involved in the construction of lung cancer by feeding into discourses that associate the disease with smoking, and associate late diagnosis with low levels of public awareness and agency in relation to symptoms. The activity, turn, feeds into wider discourses that construct blame by emphasising personal responsibility for maintaining and monitoring health and avoiding risks that may lead to ill-health and diseases such as cancer (Lupton 1995).

Interview studies conducted in the UK and the US with patients with lung cancer and professionals working with the disease report that the disease is stigmatised (Chapple et al. 2004; Tod et al. 2008; Tod & Joanne 2010; Conlon et al. 2010; Maguire 2011; Brown & Cataldo 2013). In an interview study involving forty-five people with lung cancer in the UK, the authors state that the subject of stigma was often raised spontaneously by participants and emerged as an important theme in their analysis (Chapple et al. 2004).

Regardless of their smoking status, individuals reported feeling stigmatised because the disease is associated with smoking, dirt, and a particularly '*dreadful death*' that draws on images of '*gasping for air*' and '*drowning*' (p1471). Participants reported that their experience is coloured by perceptions of the disease held by others; namely family members, friends, and health professions, and also by representations of the disease in the press and on television.

Similar themes are reported in a study conducted in the US exploring social workers' perceptions of the lung cancer experience (Conlon et al. 2010). In interviews, social workers reported that people with lung cancer are stigmatised because the disease is linked with smoking and a poor prognosis. They suggested that these factors lead to material effects for people with lung cancer including feelings of low self-image, poor social interaction with families, friends and health care professionals, and a reluctance to seek support (for example by attending support groups and seeking financial assistance). Stigmatisation was also identified as a contributory factor in delays in seeking medical help, as well as in the low levels of funding and advocacy for the disease. Three further studies conducted in the US used various tools to measure levels of stigmatisation and psychological outcomes, and identified that people with lung cancer have higher levels of perceived stigmatisation than people with breast or prostate cancer, and that high levels of perceived stigmatisation are associated with depression, symptom burden and poor quality of life (LoConte et al. 2008; Cataldo et al. 2012; Gonzalez & Jacobsen 2012).

In the interview study discussed above conducted in the UK by Chapple et al. (2004), people with lung cancer identified anti-smoking campaigns and the media as sources of lung cancer stigma. Public health measures have increasingly sought to denormalise and marginalise smoking in order to stimulate behaviour change (Bayer & Stuber 2006; Bell et al. 2010). Brandt (1998) suggests that these measures draw on a moral discourse to connect smoking cessation with notions of progress, civilisation and cleanliness. As a consequence, the cigarette has been transformed from 'an object of pleasure, consumption, autonomy and attraction to a symbol of personal disregard for health, addiction and weakness' and the smoker has become an 'object of infamy and disgust' (Brandt 1998, p165 and p177). Furthermore, smoking is

no longer depicted as a behaviour affecting only the individual. It has been reconstructed as a threat to society because of the dangers of second-hand smoke particularly to children, and the economic burden of smoking-related illnesses and lost productivity (Lupton 1995; Brandt 1998). Figure 14 presents examples of how smoking has been portrayed in recent smoking cessation campaigns and Figure 15 presents portrayals of smoking in recent newspaper media.

Figure 14: Smoking cessation advertisements from 1995 to 2013. Source: NHS Smokefree Resource Centre

Figure 15: Recent newspaper items involving smoking. Source: MailOnline

In these portrayals, smoking is associated with both a rapid and slow death, as well as a painful death, disgust and censure.

3.8 Lung cancer advocacy

Unlike breast cancer and HIV/AIDS, where activists have resisted messages of stigma and marginalisation and lobbied for greater public attention and investment, lung cancer has lacked a similarly strong advocacy voice until recent years, despite its significance in terms of incidence and mortality (Corner et al. 2006; NCRI 2006; Timmermann 2007). Corner et al. (2006) draw on Brown (1995) to suggest that lung cancer has lacked the key factors necessary for a disease to gain social prominence, namely lay initiation in seeking help, a social movement demanding action, professional agendas that seek to champion a particular disease, and strong organisational or institutional backing. In the past both breast cancer and HIV/AIDS have been able to draw on an existing activist element within their membership that was already engaged in fighting for equal rights in society (i.e. the women's movement and homosexual men). This has not been the case in relation to lung cancer. The high morbidity and mortality associated with the disease inevitably means that many people who have the disease are not well enough to engage in lobbying. Moreover, the stigma associated with the disease

because of its links with smoking may actively discourage survivors of the disease from making demands of society. It may also inhibit others to advocate on their behalf.

Advocacy groups for lung cancer are a relatively recent phenomenon. In the UK, the Roy Castle Lung Cancer Foundation (RCLCF) was established as a charity in Glasgow in 1997. Its stated aims are '*to fund research, provide support, help people quit smoking and give a voice to all those affected by lung cancer through our campaigning*' (RCLCF 2013). In 2005 the UK Lung Cancer Coalition (UKLCC) was also established to '*help bring lung cancer out of the political, clinical and media shadow*' by raising political and public awareness of the disease, empowering patients to take an active part in their care, and improving lung cancer services (UKLCC n.d.). This organisation comprises lung cancer experts, senior NHS professionals, charities and healthcare companies.

Awareness campaigns, other than those associated with smoking cessation, are also a recent phenomenon. The first campaign took place in 2002 following the designation of November as Lung Cancer Awareness Month by the Global Lung Cancer Coalition (Baird 2003). The campaign aimed to emphasise the importance of early diagnosis and awareness of coughing as an early symptom of the disease. It used a number of media materials depicting the Daily Mirror newspaper cartoon character Andy Capp to advertise the event (Figure 16).

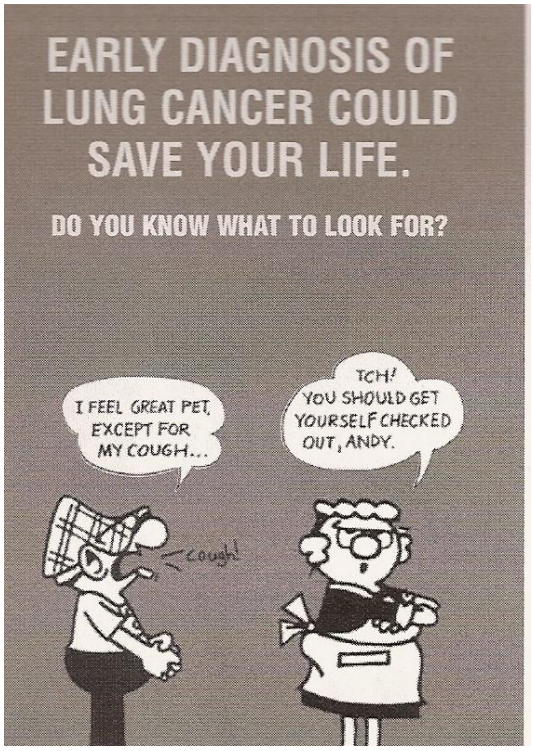

Figure 16: Poster produced for the Lung Cancer Awareness Month campaign in 2002. Source: Roy Castle Lung Cancer Foundation/Baird 2003

It could be argued, however, that the imagery used in this campaign material reinforces stereotypical discourses that serve to stigmatise lung cancer and people who smoke. The cartoon character Andy Capp is a working class figure from the North East of England who is work-shy, and who smokes and drinks to excess. The poster depicts him in a familiar pose with a cigarette hanging from his lower lip. At the start of the campaign the Daily Mirror's Medical Correspondent wrote the following:

'*ANDY'S PET PROJECT: Mirror cartoon in smoking crusade*

Legendary layabout Andy Capp is finally doing something positive with his life.

The Mirror's heavy-drinking, chain-smoking cartoon character is spearheading a campaign to increase awareness of lung cancer. And he is doing it in his favourite haunt, the pub, with his image printed on millions of beermats nationwide.

His battle with long-suffering wife Flo over his "smoker's cough" also features on thousands of leaflets. Doctors hope the involvement of flat-capped Andy will help to spread the message that a long-term cough

> *could be the first sign of lung cancer. The cartoon strip on the leaflet shows Andy listening to Flo for the first time in 40 years and going to the doctor.*' (Daily Mirror, 30 October 2002)

Subsequent Lung Cancer Awareness Month campaigns have also focussed on early diagnosis and cough but they have not used this type of imagery to do so.

Awareness campaigns draw on the strategies developed in the 1960s in response to the Royal College of Physicians' Report on Smoking and Health (RCP 1962). That is, they rely on media producers to voluntarily take up and promote messages about the disease to the public. However, the literature reviewed in the previous chapter identified that although cancer is a common feature of media stories, lung cancer appears to be less attractive to media producers and is featured less frequently than other cancers (Gerlach et al. 1997; Kitzinger et al. 1999; Hoffman-Goetz & Friedman 2005; MacKenzie et al. 2008; Slater et al. 2008; MacKenzie et al. 2011; Konfortion et al. 2014). Further, in one study the frequency of lung cancer reports was not seen to increase during Lung Cancer Awareness Month. This apparent low media profile, therefore, has implications for the effectiveness of advocacy and awareness-raising initiatives. It has the potential to further stigmatise lung cancer by marginalising the disease from public view.

A recent initiative by the Lung Cancer Alliance (LCA) in the US could be interpreted as a measure to counter this apparent marginalisation of the disease. The organisation ran its own advertising campaign aimed at confronting the issue of stigma. Bold imagery was used to attract public and media attention. The campaign comprised six posters stating that cat lovers, crazy aunts, hipsters, the genetically privileged, the smug, and the tattooed all '*deserve to die, if they have lung cancer*'. These sentiments were then modified with a further statement that '*many people believe that if you have lung cancer you did something to deserve it'*. Figure 17 illustrates one of the posters.

Figure 17: Lung Cancer Alliance (LCA) 'No one deserves to die of lung cancer' campaign (2012). Source: LCA

Lung cancer advocacy is a recent phenomenon in the UK, with broad aims to raise the public and political profile of the disease, increase research activity, improve services, support people with the disease and reduce smoking (UKLCC n.d.; RCLCF 2013). However, these aims present an inherent challenge: smoking cessation initiatives may serve to perpetuate stigma by reinforcing discourses that construct lung cancer as a self-inflicted disease which, in turn, may serve to hamper initiatives to raise awareness and increase public support of the disease.

3.9 Conclusion

This chapter has presented a historical and social perspective of lung cancer. This perspective is one that is inevitably shaped by culturally available dominant narratives and my clinical perspective. There are, inevitably, other perspectives that may construct this history very differently; one drawn from representatives of the tobacco industry for example, or from a sociology of science or critical theory perspective.

In the perspective presented, lung cancer was traced from a position of apparent obscurity at beginning of the twentieth century through a number of key events that are perceived to have shaped the current context of the disease, including: i) a gradual awareness of a dramatic rise in lung cancer mortality during the first half of the century; ii) a realisation and slow acceptance of a causal link between tobacco and the disease; iii) a shifting nature of public health whereby doctors and government formed an alliance to influence individual lifestyles and educate the public about risk; iv) an initial enthusiasm and subsequent failure of biomedicine to control the disease; v) a period of scientific and medical neglect; and vi) an apparent resurgence of interest associated with a political imperative to address poor survival rates and a scientific optimism regarding the possibility of new treatment approaches.

In this largely biomedical perspective lung cancer is characterised by a high death rate and poor survival, a resistance to treatment other than surgery, a tendency for the diagnosis to be made too late for surgery and a strong causal association with smoking. These characteristics construct lung cancer within a discourse of inevitable but nevertheless preventable dying which, in turn, may act to stigmatise the disease by positioning individuals who develop it as responsible for the disease and, potentially, their dying. However, discourses that question the inevitable fatality of lung cancer and its stigmatised status are also identified. Rather than focussing on smoking cessation as the only means to control lung cancer, some discourses suggest that survival may be improved by new treatment approaches and increased research activity. Other discourses have arisen to counter the argument that individuals who develop the disease do not deserve to be stigmatised.

4. Examining representations of lung cancer and breast cancer

This study set out to examine how lung cancer is constituted through media, and with what effects. The texts gathered for the study provide a 'snapshot' of the ways in which lung cancer is represented in media, taken at a particular moment and in a specific social context. This first analytical chapter is a scene-setting one. In it, results of the initial examination and exploratory thematic content analysis of the entire data corpus are presented. As discussed in Chapter 2 (pp 43-47), the aim of this first phase of the analysis was essentially to prepare the way for a more interpretative analysis by identifying patterns, variations and areas of interest in and across texts that could be explored further and in greater depth in a more focussed analysis of a subset of texts. Therefore, the focus of the analysis presented in this chapter is broad and, given the size of the dataset, its depth limited. First the results of the initial examination and coding of the data, to identify what each text is largely about and the dominant themes of the discussions in relation to lung cancer and breast cancer, are presented. This is followed by a summary of the analysis that describes how the two diseases are commonly portrayed in relation to each of the dominant themes identified. Extracts from the texts are presented to give the reader a sense of the materials examined and facilitate judgements in relation to the validity of observations and claims made. Inevitably, however, this undertaking can provide only a partial view of the materials examined.

4.1 Initial examination and coding of data

4.1.1 Media sources

In Chapter 2 (pp39-40), the lung cancer and breast cancer datasets are described in relation to the source of the texts retrieved. Texts for the two datasets were retrieved from roughly similar media sources. Most (84%) lung cancer texts were retrieved from newspapers. Other sources included magazines (7%), internet sites (5%), and radio and television broadcasts (4%). Most (86%) breast cancer texts were also from newspapers, with 8% from magazines, 5% from radio and television broadcasts and 1% from internet sites.

The relatively low percentage of breast cancer texts from internet sites is probably a consequence of using only one retrieval method – the data monitoring service – to collect all but a few of these texts. (This method alone generated a dataset that was sufficiently large for the purpose of the study.) Most of the lung cancer texts from internet sites were retrieved by searches conducted by the researcher rather than the data monitoring service.

4.1.2 Number of texts retrieved

One of the most striking differences identified in the initial examination of the lung cancer and breast cancer datasets is in relation to the number of texts retrieved for each disease. During the three-month data retrieval period for lung cancer and using a variety of different search strategies, 2176 texts containing the phrase 'lung cancer' were retrieved; 666 of which were produced during September, 780 during October and 730 during November (Lung Cancer Awareness Month) (see Table 3 in Chapter 2, p39). This compares with 2568 texts containing the phrase 'breast cancer' retrieved during one month alone (October – Breast Cancer Awareness Month) and using a single retrieval source; the data monitoring service (see Table 4 in Chapter 2, p40). This represents more than a three-fold difference in the number of texts retrieved that refer to breast cancer during Breast Cancer Awareness Month compared with the number of texts that refer to lung cancer during Lung Cancer Awareness Month.

4.1.3 What are the texts about?

Also striking in the initial examination and coding of the texts, is in relation to differences in the manifest orientation of texts that mention lung cancer and those that mention breast cancer; that is what the overall text is largely about and whether either disease features as a prominent focus. The results of this coding process are presented in Table 5 (below) and the coding categories that were applied to the data are described in greater detail immediately below the table in Box 1. Lung cancer was identified as a prominent focus of approximately one in eight (12%) of the texts retrieved and between one in four and one in five (22%) texts produced during Lung Cancer Awareness Month. More commonly in the texts retrieved, lung cancer is discussed in stories that are about something other than the disease, for example in stories

about fundraising initiatives, obituaries, stories about cancer and other health issues, and profiles of individuals. In many of these texts, lung cancer is mentioned only briefly, for example in obituaries to identify cause of death, without further discussion of the disease. In contrast, breast cancer was identified as a prominent focus of most (89%) of the texts retrieved for the breast cancer dataset with relatively small numbers of texts in which the main focus of the overall story was about something other than the disease.

Table 5: Coding of texts in relation to what the overall story is about

	Lung cancer dataset		Breast cancer dataset
What is the text about?	**Number of texts All texts**	**Number of texts Awareness month**	**Number of texts Awareness month**
The cancer (lung/breast)	255 (12%)	158 (22%)	2279 (89%)
Health issues (other than cancer)	420 (19%)	185 (25%)	51 (2%)
Fundraising activities and charity events	360 (17%)*	99 (14%)*	20 (1%)*
Obituaries and death reports	319 (15%)	69 (9%)	29 (1%)
Cancer (other than lung/breast)	253 (12%)	62 (8%)	32 (1%)
Profile of an individual (public or non-public)	170 (8%)	65 (9%)	75 (3%)
Media review	101 (5%)	20 (3%)	10 (<1%)
Local issues and events	84 (4%)	11 (2%)	9 (<1%)
Healthcare services (other than lung/breast cancer)	65 (3%)	14 (2%)	22 (1%)
Business news	21(1%)	7 (1%)	8 (<1%)
Other	128 (6%)	40 (5%)	33 (1%)
Total	**2176 (100%)**	**730 (100%)**	**2568 (100%)**

Percentages rounded to nearest whole number so that the sum of the percentage figures may not add up to 100

*This figure excludes texts in which fundraising is discussed explicitly as a lung/breast cancer awareness initiative; these texts are coded to 'The cancer' category.

Box 1: Coding categories in relation to what the overall story is about (Table 5)

The cancer: Where either lung/breast cancer is identified as a main topic of the overall story, including stories about raising awareness, risk factors, personal experience, epidemiological trends, screening, treatment and services.

Health issues: Stories about health concerns other than cancer, for example stories about other illnesses, environmental and lifestyle health risks, initiatives to improve health and reduce levels of illness.

Fundraising activities and charity events: Stories about fundraising and charity events where the activity is not explicitly oriented to raising awareness of lung/breast cancer.

Obituaries and death reports: Where the main topic of the story is the reporting of an individual's death.

Cancer (other than lung/breast): Stories about another cancer or cancer in general.

Profile of an individual: Stories about individuals (not diagnosed with lung/breast cancer) and their endeavours including the famous and not-so-famous.

Media review: Reviews of television programmes, plays and books.

Local issues: Reports of local events, issues, disputes and crime.

Healthcare services (other than cancer): Reports of new and existing services, standards of care, funding of services, malpractice and negligence claims.

Business news: Reports about pharmaceutical business activity and share price.

Other: Miscellaneous and varied stories that do not easily 'fit' into one of the above categories, for example a magazine article in the lung cancer dataset about spiritualism in which lung cancer is mentioned as the cause of death of the husband of a woman featured in the story ('Touched by the spirit world', My Weekly, 30th October 2010).

4.1.4 Dominant themes in relation to the discussion of lung cancer and breast cancer

Texts were also examined asking the question: What is the most prominent theme of the discussion in relation to each of the two cancers? In this examination, seven prominent themes were identified. These are: 1) Death of an individual; 2) Awareness activities; 3) Risk factors; 4) An individual living with the disease; 5) Epidemiological trends; 6) Biomedical initiatives, and 7) Fundraising. This data is presented in Table 6 (below) and a coding schema for the themes identified is presented in Box 2 immediately below the table.

Table 6: Prominent themes in relation to the discussion of lung cancer and breast cancer

What is the most prominent theme in relation to the discussion about lung cancer/breast cancer?	Lung cancer dataset		Breast cancer dataset
	Number of texts	Number of texts	Number of texts
	All texts	Awareness month	Awareness month
Death of an individual	781 (36%)	186 (25%)	88 (3%)
Awareness activities	299 (14%)	151 (21%)	1972 (77%)
Risk factors	333 (15%)	106 (15%)	78 (3%)
Individual living with the cancer	249 (11%)	79 (11%)	99 (4%)
Epidemiological trends	203 (9%)	67 (9%)	38 (1%)
Biomedical initiatives	157 (7%)	82 (11%)	232 (9%)
Fundraising	108 (5%)*	34 (5%)*	21 (1%)*
Other	46 (2%)	25 (3%)	40 (2%)
Total	**2176 (100%)**	**730 (100%)**	**2568 (100%)**

Percentages rounded to nearest whole number

*This figure excludes texts in which fundraising is discussed explicitly as a lung/breast cancer awareness initiative.

Box 2: Coding schema in relation to the prominent themes identified in the discussion of lung/breast cancer (Table 6)

Death of an individual: An individual's death from lung/breast cancer is the main reason for and focus of the discussion about the disease.

Awareness activities: Reports of awareness month activities, and other initiatives to improve public awareness and survival from the disease.

Risk factors: Discussion of lung/breast cancer in relation to factors that either increase or decrease the risk of developing the disease.

Individual living with the disease: An individual who has lung/breast cancer is the main reason for and focus of the discussion about the disease.

Epidemiological trends: Discussion of lung/breast cancer in relation to trends in incidence, mortality and survival.

Biomedical approaches: Discussion of lung/breast cancer in relation to screening and diagnostic tests, treatment, research and/or service provision.

Fundraising: Stories about fundraising for lung/breast cancer (where fundraising is the main reason for the disease to be discussed rather than raising awareness of the disease).

Other: Miscellaneous and various reasons for lung/breast cancer to be discussed that do not 'fit' into one of the above categories, for example a magazine story about a digital media awards ceremony in which one of the judges was a social media manager at the charity Breast Cancer Care. In this story, no further mention to 'breast cancer' is made ('Use of digital media' Third Sector, 5 October 2010).

The data presented in Table 6 shows that in this coding of the texts, roughly a third (36%) of discussions of lung cancer in the texts retrieved is identified as being in relation to an individual who had died of the disease. This contrasts with the breast cancer dataset in which most (77%) discussions of breast cancer are in relation to awareness initiatives and an individual's death is less commonly identified as a prominent focus of discussions about the disease. Awareness initiatives are identified as a prominent theme in 14% of the texts in the lung cancer dataset overall, and in 25% of texts produced during the Lung Cancer Awareness initiative. Even during Lung Cancer Awareness Month, a death from lung cancer is still identified as a prominent reason for the disease to be discussed in many of the texts retrieved (i.e. in 25% of texts).

As discussed in Chapter 2, the main purpose of coding the texts in this way was to develop a broad overview of the data and organise it into similar bodies of representation that could be examined and compared, rather than to make too many claims about differences in the frequency of categories observed. Organising the texts in this way focussed the analysis on how each of the two cancers is portrayed, particularly in the lung cancer dataset where most of the texts are about something other than the disease. However, the thematic categories selected for this coding process are not mutually exclusive and at times it was difficult to apply a single category. For example, texts in which 'awareness activities' was identified as the main theme of the discussion about the disease often included discussions, in varying degrees of prominence, in relation to an individual living with the disease, risk factors, epidemiological trends and fundraising, for example. A notable exception is the category 'death of an individual' in relation to the lung cancer texts. Where lung cancer is discussed in relation to the death of an individual from the disease, often little further discussion of the disease in relation to the other categories was observed.

The seven themes identified were used as a framework for the thematic content analysis that is presented next.

4.2 Exploratory thematic content analysis

This phase of the analysis involved examining texts from the two datasets to compare and contrast how each of the two cancers is portrayed in relation to the prominent themes identified in the coding process. As discussed in Chapter 2 (pp26-29), the analysis draws on a social constructionist conceptualisation of media as a social and constitutive practice. It comprised two closely-related activities: First, a search for pattern in the data in the form of either features that are shared by texts, or variability and differences between texts. Second, forming hypotheses about the potential consequences of what is observed, i.e. how this particular representational activity may work to construct knowledge about each of the two cancers and individuals who develop the disease. Where comparisons are made and conclusions drawn, they are done tentatively; mindful of the limitations of the breast cancer dataset and in the knowledge that there may be other explanations than the ones proposed.

4.2.1 Death of an individual

In the texts examined, an individual's death from lung cancer is identified as a prominent theme in relation to discussions of lung cancer. Unsurprisingly, this is a common feature of obituaries and obituary-type stories, and in these the individual with lung cancer is prominent. However, a death from lung cancer is also a common reason for the disease to enter into other stories too, for example in stories about fundraising activities and profiles of individuals including the famous and not-so-famous. In these texts, the individual who has died may have varying degrees of prominence; sometimes entering into the story only very briefly and at other times commanding a greater narrative focus.

In contrast, the death of an individual is less commonly identified as a prominent theme of discussions of breast cancer (i.e. in only 82 (3%) stories in the breast cancer dataset compared with 781 (36%) stories in the lung cancer dataset and 186 (25%) stories during Lung Cancer Awareness Month). This difference between the two datasets may be unsurprising given that death rates for breast cancer are much lower than those for lung cancer. In the UK, just less than 12,000 individuals die of breast cancer each year compared with just over 35,000 individuals who die of lung cancer (Cancer Research UK 2013b). However, what creates a striking impression when examining and comparing the two datasets is that an individual's death from lung cancer is so often the main and only reason for the disease's presence in texts, even during Lung Cancer Awareness Month. During Breast Cancer Awareness Month, however, it is activity in relation to raising awareness rather than an individual's dying of the disease that is the main reason for breast cancer to be discussed in the stories examined.

A common pattern in the texts that report an individual's death from lung cancer is that, often, very little is presented in relation to disease or the individual's experience of it. As commented on earlier in this chapter (p95), usually in these texts lung cancer is featured only briefly to identify the cause of death. Occasionally the individual is described as having been 'suffering' from lung cancer or having 'lost their fight' against the disease but further details relating to their personal experience of being diagnosed, treated and dying of it are often absent. This patterning of stories is observed across texts

regardless of their length or how prominently the individual is featured. This contrasts with the breast cancer texts. Although deaths from breast cancer feature less frequently in the dataset, an account of the individual's personal experience of the disease is more likely to be presented. For example:

Extract 1:

'Dad's Charity Challenge

A former SAS soldier from Norfolk is hoping to be the first Briton to complete the world's most extreme endurance event. Tremaine Kent from Great Yarmouth is taking part in the Four Deserts Challenge, racing in the hottest, windiest and driest places on earth, and he's doing it all in the name of his young wife, Carla, who died of lung cancer leaving him to bring up their two children. He says as a single dad he has to be strong but running allows him to grieve.' (ITV Anglia Tonight, 28 September 2010)

Extract 2:

HEALTH

Son struggling with loss of his mother has dedicated himself to fundraising for charity

'When my mum died of cancer I felt I just had to do something'

by TOM FOOT

LIFE has not been the same for Rob Seddon since his mother died from cancer two years ago. The 32-year-old telecoms consultant has struggled to cope with the loss. At times overwhelmed he found himself compelled to "do something".

"She was always so strong," he explained. "She always had a smile. When she was in oncology, the nurses told me they would put the ladies who were scared of dying on the same ward as her because they knew she would look after them.

"My mum was 57 when she died – I was 30. You just should not lose a mother at my age.

dad's house. I can't bear to think of him on his own – it kills me."

Rob's mother Susan was diagnosed with breast cancer in July 2003.

She was in remission for four years until the cancer spread to her spine in April 2008 and her liver not long after. She passed away in December 2008.

Rob, who lives in Finsbury Park, said his family had a history of breast cancer but that tests for a cancer gene proved negative.

He began pouring his energy into volunteering for Breakthrough Breast Cancer (BC) and has become an ambassador for the charity.

He has raised thousands of pounds through long dis-

their mum and aunt's names engraved on a wall at the charity's headquarters.

Now the charity has rewarded Mr Seddon for his efforts by screening an image of his mother on one of the famous electronic advertising boards in Piccadilly Circus.

The image is of Susan playing golf in Cyprus, where she lived at the end of her life with her retired RAF husband.

It is also included in a work of art by British artist Samira Harris. The recreation of Botticelli's *Birth of Venus* includes 1,096 images from the BC network – 1,096 is the number of women diagnosed with

information visit www.breakthrough.org.uk

Susan Seddon in Cyprus

'Life has not been the same for Rob Seddon since his mother died from cancer two years ago. The 32-year-old telecoms consultant has struggled to cope with the loss. At times overwhelmed he found himself compelled to 'do something'.

"She was always so strong", he explained. "She always had a smile when she was in oncology, the nurses told me they would put the ladies who were scared of dying on the same ward as her because they knew she would look after them.

My mum was 57 when she died – I was 30. You should not lose a mother at my age."'

Further in the story:

'Rob's mother was diagnosed with breast cancer in July 2003.

She was in remission for four years until the cancer spread to her spine in April 2008 and her liver not long after. She passed away in December 2008.' ('Son struggling with loss of his mother has dedicated himself to fundraising for charity: "When my mum died of cancer I felt I just had to do something"', Camden New Journal, 21 October 2010)

These two extracts present similar stories of individuals who are fundraising because a family member has died of cancer. Extract 1 is taken from a television broadcast. Tremaine Kent is fundraising in memory of his wife Carla who has died of lung cancer. Although Carla is not the main subject of the

story, she is prominent and presented in ways that are likely to evoke sympathy in the audience. She is portrayed as a young wife and mother leaving behind a husband and two small children to fend without her. She is also said to be the inspiration for Tremaine's '*herculean task*'; the endurance event. However, lung cancer – the cause of Carla's untimely death and the family's sad predicament – is mentioned only briefly (limited to that shown in the extract) to identify the cause of death. Details of her or her family's experience of the disease are not presented as part of the story.

Extract 2 is taken from a newspaper story. In this extract, Rob Seddon is portrayed as dedicating himself to fundraising after the death of his mother from breast cancer. Similar to the previous extract, the individual who has died is presented in relation to her family role; as a mother of a young son and, as such, too young to die. However, the two stories differ in their portrayal of the individual in relation to their cancer experience. In Rob's story, details of his mother's experience of breast cancer are presented, for example the timing of the diagnosis, the spread of disease and her personal response to the illness. She is portrayed as being emotionally strong and concerned about the welfare of others around her despite her own serious predicament of having cancer that had spread to her spine and liver. A similar account of Carla's experience of and response to the diagnosis of lung cancer is not presented.

A rare exception to the pattern identified in the lung cancer texts is in relation to the reporting of the singer Gregory Isaacs's death. Most of the fifteen texts that report the singer's death do so in a similar way to the texts described above in that they focus on aspects of his career and family life rather than his experience of having cancer. However, two texts differ in that they present, in varying depth, details of his experience of the disease and/or his dying of it. In one text, he is described as being '*surrounded by his family*' when he died. In the other text, his dying is described in greater detail and an account of his experience of being diagnosed with the disease is also presented. For example:

Extract 3:

Tributes pour in for reggae legend Isaacs

By Davina Morris

TRIBUTES HAVE poured in for reggae legend Gregory Isaacs, who died at his home in London following a battle with lung cancer. He died on Monday (October 25), aged 59.

The iconic Jamaican singer, affectionately known as the 'Cool Ruler', was famed for hits such as *Night Nurse* and *Objection Overruled*, and was revered for his unique and distinctive voice.

Isaacs' wife Linda told *The Voice*: "He died at 9.45am [on Monday]. His children and grandchildren were with him and he died in peace. He didn't suffer and he wasn't in pain, and he's gone home now to his resting place.

"The lung cancer had affected his walking and he'd suffered for quite a long time. He kept going to doctors because he was experiencing pain in his knees, and they

his money. That was last year July, at the Royal Free Hospital in London. Me and his daughter took him there, and when he got the diagnosis he said, 'Come, dem ah teef!' He wouldn't accept it.

"But this year, in Jamaica, he was diagnosed again with cancer and there was nothing they could do for him. So he came back to London and that was it. But I'm just glad he's at peace now."

Also a gifted songwriter, Isaacs' career spanned over four decades and he was celebrated for his many romantic songs including *My Only Lover* and *Lonely Lover*. He enjoyed his greatest success in the 1980s with the release of his hit *Night Nurse*, which enabled him to break through

publicised addiction to cocaine, which was said to have ravaged his vocals over the years. Still, the singer maintained his presence on the reggae scene even in more recent years, with performances both in the UK and abroad.

* *See tribute on page 29*

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Isaacs' wife Linda told The Voice: "He died at 9.45am [on Monday]. His children and grandchildren were with him and he died in peace. He didn't suffer and he wasn't in pain, and he's gone now to his resting place.

The lung cancer had affected his walking and he'd suffered for quite a long time. He kept going to the doctors because he was experiencing pain in his knees, and they kept telling him he had arthritis in his legs.

When we finally got the diagnosis that he had cancer, Gregory thought the doctors were just trying to take his money. That was last July at the Royal Free Hospital in London. Me and his daughter took him there, and when he got the diagnosis he said, 'Com, dem ah teef!' He wouldn't accept it.

But this year, in Jamaica, he was diagnosed again with cancer and there was nothing they could do for him. So he came back to London and that was it. But I'm just glad that he's at peace now."' (Tributes pour in for reggae legend Isaacs', The Voice, 28th October 2010)

This extract is taken from a newspaper story. Similar to other stories that report an individual's death, Gregory is portrayed in relation to his family and career. However, unlike the other stories reporting a death from lung cancer,

some details in relation to Gregory's personal experience of the disease and his dying are also included as part of the overall story. In this account, although Gregory's death from lung cancer is portrayed as a peaceful event; having taken place without suffering, his initial diagnosis of the disease is presented as being more problematic; as protracted and a time in which he experienced pain, and uncertainty regarding the trustworthiness of the doctors involved and the veracity of their diagnosis. This single account of an individual's death from lung cancer contrasts somewhat with accounts of deaths from breast cancer in which the individual concerned is often portrayed within a narrative of confronting the diagnosis and treatment of cancer with displays of personal courage and self-sacrifice. Another extract from the data exemplifies the difference further:

Extract 4:

Heart-wrenching True-life

Dying mum's final gift of love

My brave Gemma's such an inspiration to all of us...

By Simon Hogg, 42, from Horley, Surrey

that once the results came back clear, Gemma could finally relax.

Only, a few days later, suddenly, I wasn't so sure.

It was 5pm when Gemma's consultant rang.

'Come to the hospital tomorrow,' we were told.

We knew instantly – the news wasn't going to be good.

But even then, we weren't prepared for just how bad it

The very next day, we lost her...

'Gemma had been right. She had inflammatory breast cancer. A rare and aggressive form. But together we were determined to beat it.

Well, if anyone could, Gemma could. She was strong, determined and stubborn. There was no way cancer would get the better of her'.

Further in the story:

'*Gemma was given the drug Herceptin and, from September 2008 to February 2009, she'd have chemotherapy. "Right" Gemma said after her diagnosis. "Let's have a head-shaving party!" Losing her hair was inevitable but for the kid's sake, Gemma made it into something fun. As her sister Sam, 34, shaved Gemma's head – and mine! – the kids fell about laughing. "You look funny, Mummy," they giggled.*' ('Heart-

wrenching True-life: Dying mum's final gift of love', Chat, 4 November 2010) (Available during October 2010)

This extract is taken from a story in a women's magazine, presented over three pages. The story is about Gemma, a young mum who has died of breast cancer and is written from her husband's perspective. Although the Breast Cancer Awareness Month initiative is not explicitly mentioned, it is very possible that the story was produced in response to it. Gemma's diagnosis, treatment and final days including her dying are presented in detail. The story portrays Gemma as accepting and facing the diagnosis of cancer with extraordinary strength, courage and selflessness. She is described as a fighter, determined to do everything possible to overcome the disease and, moreover, protect her children from the harsh realities of the diagnosis – in this extract by turning her inevitable hair-loss into a fun event, and elsewhere in the story as trying to keep life as normal as possible even to the extent of having '*dragged herself out of her deathbed*' the day before she died to be at her son's first day at school (the day of the photograph presented in the extract above). Although an extreme example, the story serves to emphasise an absence of similar posthumous accounts of the experience of lung cancer in discussions of individuals who have died of the disease, even during Lung Cancer Awareness Month.

4.2.2 Individuals living with the disease

Although the most common reason for lung cancer to be discussed in the texts examined is because an individual has died of the disease, individuals living with the disease are also identified in texts and are discussed in various ways and with varying degrees of prominence. In most texts, and like those reporting an individual's death, lung cancer or the individual's personal experience of the disease is not a prominent focus of the overall story. More usually, the disease is discussed only very briefly to define the individual, often as someone who is dying by the use of words such as 'terminal' 'incurable' 'advanced' and 'inoperable'. Even where individuals with lung cancer are prominent within stories, there is often little discussion of their illness experience. For example:

4. Representations of lung cancer and breast cancer

Extract 5:

HAIR WE GO CANCER PATIENT HELPS DISABLED CHILDREN

GOING, GOING, GONE ... Hugh Wickett has his head shaved at Tutbury's New Inn by Stuart Kerry of Bespoke Barbers

A CANCER patient has raised more than £300 for disabled children after having his head shaved at his local pub.

Hugh Wickett made £356 from the event which was held at the New Inn, in Ludgate Street, Tutbury.

The money was raised to equip a sensory room for severely disabled children attending The Fountains Primary School, in Bitham Lane, Stretton.

The 65-year-old decided to hold the charity shave after being diagnosed with 'incurable but manageable' lung cancer, and expects to lose his hair anyway.

Stuart Kerry, of the villages Bespoke Barbers, sheared Mr Wickett's locks during the half time break in Wednesday's England and France international football friendly, and the New Inn donated 10p from every drink sold on the day to Fountains.

Mr Wickett said: "For a small pub to raise that much is brilliant, I had a lot of support from people but my head is freezing now.

"I want to thank 'Sweeney Todd' from Bespoke Barbers and 'Lurch' the landlord, as well as a big thank you to those who put money in the collection."

A CANCER patient has raised more than £300 for disabled children after having his head shaved at his local pub.

Hugh Wickett made £356 from the event, which was held at the New Inn in Ludgate Street, Tutbury.

The money was raised to equip a sensory room for severely disabled children attending The Fountains Primary School in Bitham Lane, Stratton.

The 65-year-old decided to hold the charity shave after being diagnosed with 'incurable but manageable' lung cancer, and expects to lose his hair anyway.' ('**HAIR WE GO** CANCER PATIENT'S IDEA HELPS OUT DISABLED CHILDREN', Burton and South Derbyshire Advertiser, 24 November 2010) (bold text and capitals as in the original)

This extract is taken from the first four paragraphs of a newspaper story in which Hugh Wickett, who has lung cancer, is raising money for a children's charity by having his head shaved. Although Hugh is prominent in this story, lung cancer and his experience of the disease is not a prominent focus. Lung cancer is described in only brief terms as '*incurable but manageable*' and something that is likely to lead to hair loss. These details serve to depict Hugh as a person who is seriously ill with cancer and present his fundraising endeavour within a heroic narrative. Despite the adversity of his own situation,

he is selflessly raising money for a good cause – in this case, disabled children. However, his experience of being diagnosed and treated for cancer is not presented.

In contrast, an individual's experience of lung cancer is presented as a prominent theme in a small number of texts. Similar to the extract above, in some of these texts the individual concerned is portrayed as dying of the disease. For example:

Extract 6:

Asbestos is killing me

Alan Desborough (right) with his colleague Jock Blain at Weatherley-Cincinnatti.

'A retired engineer is calling on former colleagues to get in touch after he was diagnosed with an incurable form of lung cancer normally caused by exposure to asbestos.'

Further in the story:

'"I am frustrated that there is no cure – the only treatment is to manage the symptoms." Now living in Conway, North Wales, Mr Desborough went to see his GP after experiencing terrible wheezing and coughing with breathlessness. He had experienced symptoms for almost a year when he had an X-ray and scans in March and was diagnosed a month later.' ('Asbestos is killing me', Biggleswade Today (online), 8th October 2010)

In this extract taken from an online newspaper story, Alan Desborough is portrayed as terminally ill with mesothelioma; a type of lung cancer that is caused by exposure to asbestos. The story is oriented to an appeal to former

work colleagues to come forward if they witnessed Alan's exposure to asbestos. However, in contrast to Hugh's story presented in the previous extract, an account of Alan's personal experience of being diagnosed and treated for cancer is presented as part of the overall story. Alan is portrayed as aware that he is dying and frustrated that there is no effective treatment for the disease.

Across the lung cancer dataset, the personal stories of twenty-two individuals living with lung cancer are identified. In half of these, the individual concerned is portrayed as dying of the disease, as in the extract above. In the remaining half, the individual is portrayed as having survived the disease or as currently receiving treatment for it. For example:

Extract 7:

Surviving lung cancer

Lung cancer is a notoriously difficult form of the disease to treat successfully. However the expertise of doctors in Leeds has given a grandma a new lease of life. **Katie Baldwin** met her and heard about the complex surgery which

'When Lynne Hughes-Jones was diagnosed with lung cancer, she was filled with fear. Her ex-husband had died of the disease and she was aware that in the majority of patients the outlook is not good. "I was devastated and absolutely terrified," she said.'

'Lynne had adenocarcinoma of the lung, the most common type of cancer in lifelong non-smokers, although she had been a smoker in the past. She was told it was also one of the easiest forms of cancer to treat if it is diagnosed early enough. In many lung cancer cases, the disease is already advanced when it is picked up so can be impossible

to cure. Only around 10 in every 100 lung cancer patients are alive five years after diagnosis.'

Further in the story:

'November is Lung Cancer Awareness Month and the Roy Castle Lung Cancer Foundation is promoting the message that early diagnosis saves lives.

- *Lung cancer is the second most common cancer in the UK after breast cancer and more people die of it than any other cancer.*
- *The incidence of lung cancer in men continues to fall as a result of the fall in smoking among men, but is still rising in women.*
- *Smoking and passive smoking causes nine out of 10 lung cancers.*
- *Five-year survival rates for lung cancer are less than 10 per cent.*
- *In the last 20 years there has not been any discernable improvement in survival rates as by the time most patients are diagnosed, the disease is advanced*.' ('Surviving lung cancer', Yorkshire Evening Post, 10 November 2010)

This extract is also taken from a newspaper story. Lynne Hughes-Jones' experience of being diagnosed with lung cancer and having survived the disease following complex surgery is presented within an overall account aimed at raising awareness. The text is unusual; not only because the personal experience of lung cancer is a prominent theme within the overall story as in the previous extract, but also because the individual concerned is portrayed as surviving rather than dying of the disease. This story is one of only eleven in which the personal experience of surviving lung cancer is presented. Like Lynne's story, all of these eleven stories are presented in texts in which raising awareness is also a prominent theme, and all but one was produced in response to the Lung Cancer Awareness Month initiative.

Common to all portrayals of an individual living with lung cancer however, regardless of whether the individual concerned is depicted as surviving or

dying, is that the risk of death from the disease is explicit. This is evident in the extract above in which Lynne's personal story of surviving lung cancer is situated within an account that also constructs dying as the more usual outcome of the disease. Lung cancer is identified as the cancer that '*more people die of than any other cancer*', and a '*notoriously difficult form of the disease to treat successfully*', and Lynne's ex-husband is said to have died of the disease.

In examining the breast cancer dataset, although some discussions in relation to individuals with breast cancer are also brief and present few details in relation to the illness experience, where individuals are featured prominently an account of their experience of the disease is more likely to be presented particularly, but not exclusively, in stories oriented to the awareness month initiative. In these stories, women living with and surviving breast cancer are frequently portrayed as keen to take part in awareness-raising and fundraising events. These discussions are likely to prompt details of how the individual came to be diagnosed, the treatment they received and the impact the disease has had on their lives. As a consequence and in contrast with the lung cancer dataset, where individuals with breast cancer are portrayed, their personal experience of the disease is a more common and prominent feature of the texts examined. For example:

Extract 8:

Woman has head shaved – and husband gets a pink mowhawk

Bald facts of cancer wife's fund-raising

By ROSS ROBERTSON
ross.robertson@northeast-press.co.uk

THESE are the extreme hair cuts which helped a mum struck twice by cancer raise hundreds of pounds for research into the disease.

Lorraine Anderson, 36, from Red House, shaved her head and husband Michael got a pink mohawk to raise £700 for Sunderland Royal Hospital's chemotherapy unit.

The mum-of-two underwent a mastectomy after being diagnosed with breast cancer last February, but discovered this year the disease had spread to her chest and bones.

Doctors say the condition is incurable, but brave Lorraine has vowed to continue with treatment.

"I'm just really over the moon with how much it raised," said Lorraine.

"We've still got money coming in, but the total is about £700."

Lorraine said she was very thankful to everyone at Tricolorgi in Windsor Terrace, Grangetown, for helping her reach the fund-raising total – and shaving off her locks.

"They did a collection in the shop for me and even one of their little girls made cakes. I'm really, really pleased," she said.

Lorraine, who lives with Michael, a spraypainter at Hashimoto, and daughters Beth, 13, and Leah, six, was just about to complete a course of herceptin when doctors discovered she had secondary cancer.

The former care worker said she wanted to raise money for the chemotherapy unit because staff there had been so wonderful, and she wanted to show she was full of the fighting spirit.

"They're fantastic and they don't get a lot of money given direct to them. That's where I get my treatment and the girls there are brilliant. My Macmillan nurse is great too," she said.

She added: "You've just got to keep on fighting and fighting. If you give up, then I think that's when it gets you.

"You've just got to get up every day and keep pushing on."

HEAD FOR CHARITY: Cancer sufferer Lorraine Anderson, who had her hair shaved off for charity, with her husband Michael who got a new hairstyle to show his support.

> *'These are extreme haircuts which helped a mum struck twice by cancer raise hundreds of pounds for research into the disease.'*
>
> And further in the story:
>
> '*The mum-of-two underwent a mastectomy after being diagnosed with breast cancer last February, but she discovered this year the disease had spread to her chest and bones. Doctors say the condition is incurable, but brave Lorraine has vowed to continue with treatment.'*
>
> And further in the story:
>
> *'She added: "You've just got to keep on fighting and fighting. If you give up, then I think that's when it gets you. You've just got to get up every day and keep pushing on."'* ('Bald facts on cancer wife's fund-raising', Sunderland Echo, 5 October 2010)

This extract is taken from a newspaper story in which an individual with breast cancer, Lorraine, is raising money by having her head shaved. In this way, the story is similar to the one presented in Extract 5 in which Hugh Wickett has shaved his head to raise money for charity. Like Hugh, Lorraine is portrayed as having incurable cancer. However the texts differ in that an account of Lorraine's experience of cancer is presented as part of the overall story, including details of her diagnosis, the treatment she received, the extent of her disease, and her attitude and approach to being ill. Lorraine is described as '*brave*' in her determination to keep '*pushing on*' with treatment. In contrast to Hugh, therefore, this presents Lorraine as heroic not only because of her fundraising effort but also in her response to cancer; despite the terminal nature of the diagnosis she is determined to fight the disease in order to carry on living.

The extract above is one of only a few texts in which an individual with breast cancer or the disease is described as 'incurable'. Although the breast cancer dataset contains stories about individuals who have died of the disease, very few depict individuals as actively dying even when the cancer is defined as incurable as in the extract above, or where individuals are described as having secondary breast cancer. Instead, individuals with breast cancer are portrayed as able to carry on living a full and meaningful life in spite of the diagnosis. In this way, and in contrast to the lung cancer dataset, the risk of dying is less

apparent in discussions of individuals with breast cancer even though almost 12,000 women die of the disease each year in the UK (CRUK 2013b) and more women are living longer with secondary (and thereby incurable) disease. In the last decade in the UK, criticism that people living with metastatic breast cancer are a marginalised group led to the establishment of the Secondary Breast Cancer Taskforce and a concerted effort to increase awareness of this form of the disease (Breast Cancer Care 2008). Within the dataset, some texts reflect this initiative and present a personal account of an individual who has secondary breast cancer. However, rather than confronting their dying, these women are portrayed as engaging in active living and encouraging others in similar circumstances to do likewise by promoting messages such as '*there is life after a diagnosis* [of secondary breast cancer] *and it is possible to live with it'* (Birmingham Mail, 20 October 2010).

Across the breast cancer dataset, stories of individuals living with breast cancer often share a similar narrative in which (mainly) women are portrayed as having battled against the adversity of the diagnosis to emerge from the experience as triumphant; able to exert control, get on with their lives largely without ill-effects, and keen to share their story to inspire others that they can do the same if diagnosed with the disease. For example:

Extract 9:

'BEAMING Bernie Nolan punches the air as she reveals how she won her battle with breast cancer and declares: "I'm so glad they've cut the bastard out of me!" The feisty Nolans star has been given the all-clear following gruelling chemotherapy and a mastectomy.

> *Surgeons reconstructed her left boob and she is so delighted with it she's planning a spectacular return to showbiz – by STRIPPING OFF on stage in Calendar Girls – the play she was forced to pull out of when she was diagnosed. Brave Bernie, 50, said: "It feels like cancer has been an interruption in my life. Now it's gone. I'm back. And I'm just so happy I've beaten it."' ('EXCLUSIVE: BERNIE ON HER INSPIRATIONAL CANCER BATTLE. YES! I've won my fight with the Big C..they cut it out and I'm free of it', News of the World, 24 October 2010) (capitals as in the original)*

This extract is taken from a newspaper story and is one of a number of texts that discuss the singer Bernie Nolan's breast cancer diagnosis. Although the story does not explicitly mention the Breast Cancer Awareness Month initiative, the timing of the story may well have been influenced by it. Bernie Nolan is one of a number of women with a public profile who are portrayed in the texts examined as willing to talk about their breast cancer diagnosis or a breast cancer scare in order to raise awareness, and help others who may be in similar circumstances or at risk of the disease. This contrasts with the lung cancer dataset where, although a number of individuals with a public profile such as Ricky Gervais[3] (see Extract 13, p125), Katherine Jenkins[4] and Sir Alex Ferguson[5] are depicted as raising awareness of the disease, usually because a relative has died of it, only one story is identified in which an individual with a public profile is portrayed as willing to share their experience of being diagnosed with lung cancer, even during the Lung Cancer Awareness Month initiative[6].

In the extract above, Bernie is portrayed as having successfully beaten breast cancer following recent chemotherapy and pioneering surgery. In this way, the story is similar to the extract discussed earlier in this section in which Lynne

---

[3] An actor and comedian

[4] A singer of classical and popular music

[5] Ex-manager of Manchester United Football Club

[6] This is an autobiographical account written by the journalist Cassandra Jardine and discussed in Chapter 5

Hughes-Jones is portrayed as having survived lung cancer following complex surgery (Extract 7, pp110-111). The two stories share other similar narrative details: The women are described as initially scared when diagnosed with cancer; they are portrayed in relation to their careers and family roles, and the treatment they received is discussed in detail. However, the inspirational and heroic narrative that is evident in the portrayal of Bernie is not as apparent in Lynne's story. Bernie's story draws heavily on fighting imagery and she is portrayed in more active terms; as '*feisty*', punching the air and happy to have '*won her battle*' against the disease[7]. In contrast, similar fighting imagery is not as apparent in Lynne' story and, in comparison, her portrayal is passive and constructed as less of a personal triumph. Lynne is described as having been '*given a new lease of life*', and feeling '*so lucky to have been able to undergo such a rare and complex operation,*' and '*very lucky that they were willing to take it on*'.

The inspirational narratives of individuals living with breast cancer are similar to those identified in the posthumous accounts of breast cancer in which although individuals have died, they are nevertheless portrayed within a heroic narrative of having battled against the disease with courage and determination, and leaving a legacy to inspire others (see Extract 2, p103 and Extract 4, p106-107). These 'heroic' narratives of the experience of cancer share similarities with the ones described by Seale (2001a, 2002) discussed earlier in the thesis (p17). Seale (2001a, 2002) suggests that media accounts of cancer construct the experience as a meaningful event involving displays of heroic resistance and, for some, a conquest of the limitations of the body. Heroic narratives may be a particular feature of representations of breast cancer produced during Breast Cancer Awareness Month. Indeed, the media accounts retrieved by Seale were also produced during Breast Cancer Awareness Month and a large proportion of these featured individuals with breast cancer (i.e. 46% compared with 6% of accounts featuring individuals with 'lung or throat cancer'). However, similar heroic narratives are not as evident in portrayals of individuals living or dying of lung cancer, even during Lung Cancer Awareness Month. In comparing the two datasets, fewer accounts of the personal

[7] Bernie Nolan died of breast cancer in 2013

experience of lung cancer are identified and where they are presented they appear to draw less on a heroic script. These apparent differences between the two datasets are intriguing and warrant closer scrutiny.

4.2.3 Awareness initiatives

Where raising awareness initiatives are discussed in relation to lung cancer, stories tend to be oriented in one of two ways: Either they are aimed at directly informing the public how the disease can be avoided by not smoking and survived by being diagnosed early enough for treatment to be successful, or they report on the funding of national or local awareness campaigns. Both types of stories convey similar messages about lung cancer. It is presented as a disease that both affects, and is the cause of death for, large numbers of people in the UK. Surviving the disease is promoted as possible with the help of specialist treatment but contingent on early diagnosis. Poor survival is presented as the more usual outcome of lung cancer and a consequence of individuals failing to recognise and act on symptoms, so that the disease is diagnosed too late for treatment to be effective. Finally, smoking is identified as the main reason that lung cancer develops and other risk factors for the disease are not discussed. A number of these characteristics are evident in Extract 7 presented in the previous section (pp110-111) in which Lynne Hughes-Jones is portrayed as having survived the disease following complex surgery. This story is one of a small number in which a personal story is used to raise awareness of lung cancer and exemplify the message that surviving the disease is possible. In these stories, the personal account of lung cancer follows a similar narrative structure in which individuals are portrayed as having been diagnosed early enough to be able to receive successful treatment, usually surgery, and as able to resume their lives with little adverse effect from the disease or treatment. Most individuals are identified in relation to their smoking status; most having smoked. Factual-type information about the disease is woven through the individual's personal story and/or presented in sections separate from the main narrative. This information typically describes lung cancer in terms of its high incidence, high mortality and stubbornly poor survival and, in doing so, it acts in opposition to messages that aim to promote the disease as one that can be survived.

4. Representations of lung cancer and breast cancer

The following extract provides an illustration of texts that, in contrast, present a story about the funding of awareness initiatives:

Extract 10

Don't let that persistent cough carry you off...

A NEW campaign warning people about the early signs of lung cancer and encouraging them to get checked out is to be launched across the county.

NHS Cornwall and the Isles of Scilly, NHS Devon and the Torbay Care Trust have jointly

By BEVERLEY COUMBE
e-mail: bcoumbe@c-dm.co.uk
01872 247564

cer Network, some work has already been done to better understand people's attitudes to lung cancer and how the

it can lead to earlier diagnosis and treatment and help improve their prognosis.

Felicity Owen, director of public health for NHS Cornwall and the Isles of Scilly, said: "This new funding should help to encourage changes in be-

'*A NEW campaign warning people about the early signs of lung cancer and encouraging them to get checked out is to be launched across the country.*

NHS Cornwall and the Isles of Scilly, NHS Devon and Torbay Care Trust have jointly been awarded £320,000, with £80,000 awarded to Cornwall and Scilly by the Department of Health for their innovative campaign.

The new campaign, to be rolled out early next year, will target particular population groups with high incidence of the disease and take account of smoking as the most common cause of lung cancer.

Evidence shows that if people go to their GP soon after recognising a persistent cough it can lead to earlier diagnosis and treatment and help improve their prognosis.' ('Don't let that persistent cough carry you off…', Cornish Guardian, 13 October 2010) (Capitals as in the original)

This extract is also taken from a newspaper story. A similar story is identified in a number of texts in both national and regional newspapers published during September and October 2010. Similar to Extract 7 (p110-111) discussed above, the extract illustrates how lung cancer awareness initiatives are presented as opportunities to educate the public, particularly smokers, in relation to monitoring their bodies for symptoms of the disease and reporting

early for medical advice, in order to improve survival and prevent early death from the disease.

A compelling impression from examining texts in the breast cancer dataset, especially after examining the lung cancer texts, is not only in relation to the frequency of stories that focus on breast cancer awareness but also the prominence of these in and across texts. Initiatives aimed at promoting breast cancer awareness are prominently featured within the composition of texts; often presented early (for example on front pages of magazines and in newspaper headlines and subheadings), denoted by the use of the pink ribbon symbol and the colour pink, and often discussed at considerable length. Additionally, and in contrast to discussions in relation to lung cancer awareness, breast cancer awareness is presented as more than simply a public health activity directed at educating the public about the disease and the benefits of early detection. It is presented as an opportunity for the public to engage with and become part of a mass campaign aimed at combating the disease by raising money for further research. For example:

Extract 11:

'This issue of Stylist is dedicated to the women fighting breast cancer – the army of patients, survivors, relatives, researchers, scientists, doctors and surgeons all looking for a long-term solution to this terrible illness.

4. Representations of lung cancer and breast cancer

> *It is a stark truth that breast cancer is still the most commonly diagnosed form of cancer in the UK, and the second most common cancer diagnosed in women aged under 35. Sadly, not many of us can say we don't know someone affected by it.*
>
> *Which is why in this issue we wanted to do something special to support Breast Cancer Awareness Month, which runs from 1 October. Every year the leading charities work together for a month to raise the profile of this illness. So you'll notice that this edition has turned pink to support this amazing cause, plus we've showcased the items you can buy, charities you can support and the women who will inspire you to do your bit to help battle this illness.'* (Stylist: Issue 47, 29 September 2010)

This extract is a particularly clear example, but it is not an isolated depiction of how prominently discussions of breast cancer awareness are presented in and across texts. It serves to illustrate a number of features commonly observed in the breast cancer dataset. The extract presents the front cover and editorial page of a weekly women's magazine that is distributed free across several major cities in the UK. Breast cancer awareness is not only prominent in its placement on the cover and first page, the magazine is described as '*dedicated*' to the initiative. Further metaphorical language is drawn on to create a sense of a coordinated military campaign or mission in relation to initiative. Breast cancer is portrayed as a threat to everyone, either as a personal risk or a risk to someone known to us. Supporting the campaign is presented as a vital response to the threat – a fight for everyone to get involved in, in order to diminish the risk and, moreover, to defeat the disease. The magazine is depicted as philanthropically lending its support to the '*army*' of people already engaged in the fight and readers are encouraged to '*enlist*' also and '*do their bit*' to support the cause. Inside the magazine, various stories demonstrate how readers can do so, including two pages of products that can be bought in aid of breast cancer charities, exemplars of how others are participating in fundraising events, and information about the disease and advice on how to detect it early. This portrayal of breast cancer as a threat and a concern for everyone to engage with in some way, contrasts with how lung cancer is presented; that is, as a risk of smoking and thereby a concern primarily for people who smoke.

The extract also illustrates how the colour pink and/or the pink ribbon symbol are used in stories, often very early in their structure. In this story, the same shades of pink are used throughout the magazine in titles, borders and shading, even in articles that are not about breast cancer awareness. These visual features (the colour pink and the pink ribbon) have become international symbols that act to signify breast cancer awareness so much so that even the word 'pink' (without the colour being shown) is used in stories to create a similar effect. These signifiers act to unify a range of activities into an instantly recognisable and seemingly coordinated campaign.

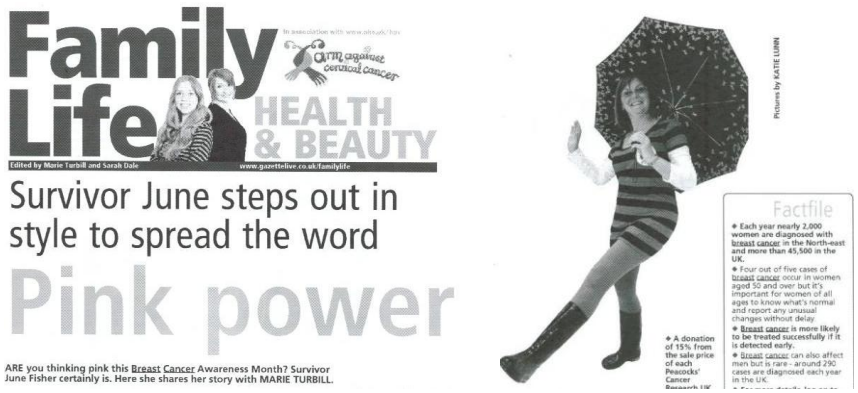
Indeed, in and across the breast cancer awareness texts, there is a real sense of activity and movement; a campaign 'in action'. Numerous people including individuals with the disease, survivors, family and friends, the bereaved, the general public, politicians, celebrities and health professional are portrayed as 'doing their bit'; energetically involved in a myriad of activities that constitute 'breast cancer awareness'. As evident in the extract above, these activities include not only raising awareness of the disease and promoting early detection, but also and equally raising money through charity events, fundraising and the merchandising of 'pink products'. Lobbying for improvements in breast cancer services is also portrayed as an awareness activity in some stories. This representation of mass public support promotes breast cancer as a popular and worthy cause; one that attracts the loyal following of many including the famous and powerful – even the American White House which in some texts is shown to be supporting the campaign by being lit up in pink during October.

Not only is breast cancer promoted as a worthy cause, it is also associated with fun, glamour and femininity. Marketing, media and advertising are used to associate the campaign with celebrity, fashion and other lifestyle accessories and activities. Numerous images of individuals (both the famous and not-so-famous) seemingly having fun whilst participating in and promoting the campaign are presented in texts. Other commentators (for example Cartwright 1998, Kitzinger et al 1999, Mckay and Bonner 2004) have noted that these features of media stories are likely to appeal to a young female audience whereas the disease occurs more commonly in older women. In the texts examined for this study, images of individuals involved in breast cancer awareness activities are also predominantly of young white women. However

children, older and non-white women, and men are also shown as participating in activities and events in support of the disease.

As discussed in the previous section, individuals living with breast cancer are a frequent feature of texts oriented to raising awareness. They are often a prominent focus of stories, and portrayed as keen to be involved in events and activities to raise awareness and money for research, and to share their experience of the disease to inspire others. This personal involvement in the awareness campaign is often presented as a way of 'giving something back' and moving on from the experience of breast cancer. In contrast, although some individuals with lung cancer are prominent in awareness stories, they are less frequently portrayed than women with breast cancer and less likely to be depicted as taking part in events and activities to raise money for the disease. Extract 7 presented in the previous section (pp110-111) is a typical illustration of how individuals with lung cancer are portrayed within awareness stories and can be compared with the following extract from one of the breast cancer texts:

Extract 12:


Family Life

HEALTH & BEAUTY

Edited by Marie Turbill and Sarah Dale www.gazettelive.co.uk/familylife

Survivor June steps out in style to spread the word

Pink power

ARE you thinking pink this Breast Cancer Awareness Month? Survivor June Fisher certainly is. Here she shares her story with MARIE TURBILL.

Pictures by KATIE LUNN

Factfile

- Each year nearly 2,000 women are diagnosed with breast cancer in the North-east and more than 45,500 in the UK.
- Four out of five cases of breast cancer occur in women aged 50 and over but it's important for women of all ages to know what's normal and report any unusual changes without delay.
- Breast cancer is more likely to be treated successfully if it is detected early.
- Breast cancer can also affect men but is rare – around 290 cases are diagnosed each year in the UK.

A donation of 15% from the sale price of each Peacocks' Cancer

'Be pretty in pink this Breast Cancer Awareness Month just like Middlesbrough mum June Fisher. She is one of Teeside's survivors and is happy to do her bit to help spread the word. Today that means modelling some of Peacock's charity products in our own fashion shoot.'

Further in the story:

> *'After facing her own breast cancer battle, her aim now is to "live life to the fullest. "What would I say to anyone going through something similar is to try and stay positive."*
>
> *She was diagnosed in 2008 after being called for her first routine mammogram. Treatment involved a lumpectomy followed by a four-week course of radiotherapy.*
>
> *She strives to do her bit for all the good causes that have touched her and her family's lives – including taking part in the Cancer Research UK's Race for Life and supporting Breast Cancer Awareness Month.*
>
> *"I am living proof that research into breast cancer leads to effective treatments and does save lives."' (Survivor June steps out in style to spread the word: Pink power', Evening Gazette (Family Life Health & Beauty), 5 October 2010)*

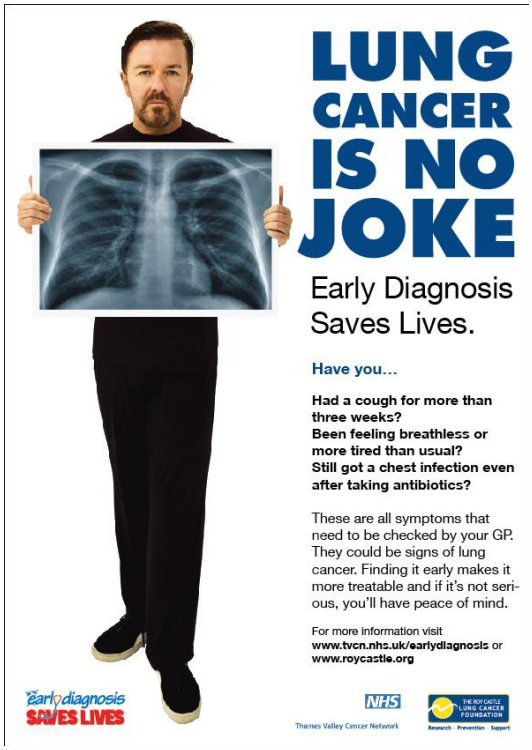
This extract is taken from a story in a newspaper supplement. It is typical of many of the breast cancer awareness texts that portray individuals who have developed the disease. Similar to the awareness texts that present a personal account of lung cancer, the individuals concerned are portrayed as keen to share their experience of the disease in order to raise awareness and act as exemplars for specific messages about the disease; in this extract the benefits of screening and research. However, in contrast to the lung cancer texts, individuals with breast cancer are often portrayed as taking a more active role in relation to raising awareness initiatives; as participating in associated events and activities aimed at raising money for research rather than acting solely as messengers for public health advice and warnings in relation to the disease.

The message that breast cancer can be survived is a dominant one in stories that discuss awareness initiatives. Similar to the lung cancer texts, individuals are commonly portrayed as survivors and exemplify messages regarding the need to detect the disease early; in the case of breast cancer by taking advantage of the national screening programme and being 'breast aware' (i.e. being familiar with what is normal and abnormal in the look and feel of their breasts so that new lumps can be detected easily and quickly). In contrast to the lung cancer texts however, where factual information and advice about

breast cancer is presented, survival rates are said to be persistently improving and the disease is portrayed as one that most will survive.

In comparison, therefore, there are distinct differences in how the two diseases are portrayed in relation to awareness initiatives. Across the lung cancer texts, raising awareness is promoted as a health education activity aimed at persuading the public, mainly those who have smoked, to amend certain behaviours in order to avoid the disease and increase their chances of survival if they develop it. In these texts, the tone of the overall message is didactic and serious. In contrast, the tone of many of the texts promoting breast cancer awareness is less didactic. Instead, breast cancer awareness is presented as a mass popular event in which everyone is encouraged engage with and, moreover, have fun whilst doing so. In these texts, raising awareness of the disease is one aspect of the event. However, raising money for further research into the disease is promoted as a vital component also. The following extract is presented to illustrate this distinction further:

Extract 13:



(NHS Thames Valley Cancer Network/The Roy Castle Lung Cancer Foundation, November 2010 and Breast Cancer Care, October 2010)

This extract presents two promotional materials; one produced for Lung Cancer Awareness Month (top) and one produced for Breast Cancer Awareness Month (bottom). The lung cancer poster was displayed in London Underground

stations and on buses in a number of cities in the UK. It features the actor and comedian Ricky Gervais supporting a campaign by the Roy Castle Lung Cancer Foundation to promote early diagnosis of lung cancer, particularly drawing attention to cough as an early symptom of the disease. The poster is one of a number of texts in the dataset featuring Ricky Gervais and in many of them Ricky is reported to be supporting the campaign because his mother died of lung cancer. Most of these texts draw attention in some way to the fact that in contrast to Ricky's more familiar public role, his message in relation to lung cancer is a serious rather than humorous one. The breast cancer leaflet was produced by the charity Breast Cancer Care, and made available to the public and also professionals via the organisation's internet site. It illustrates the distinction identified between how the two diseases are portrayed in relation to raising awaress in that it shows how breast cancer awareness is promoted as an opportunity for the public to have a good time whilst also raising awareness and money for the disease. In comparison, lung cancer awareness lacks the colour, vibrancy and sense of fun that is created in the text promoting breast cancer awareness.

The distinction between how lung cancer and breast cancer are represented in relation to awareness-raising initiatives illustrates a difference in how the two diseases are constructed, and also how the public is positioned in relation to them. In texts that discuss breast cancer awareness, breast cancer is constructed as a worthy cause and the public is presented as part of the solution to defeating the disease. In contrast in the texts that discuss lung cancer awareness, lung cancer is constructed as a serious concern and the public (mainly smokers and those who present late for diagnosis), is presented as the cause of the problem.

4.2.4 Fundraising activities

As discussed in the previous section, fundraising is a prominent feature of breast cancer texts aimed at raising awareness of the disease. In the lung cancer texts, however, although fundraising is a common and prominent feature of some stories, it is seldom identified as being in support of lung cancer and often the disease is mentioned only briefly. This is evident in the first extract presented in this chapter in which Tremaine Kent is reported to be undertaking a Four Deserts Challenge in memory of his wife, Carla, who died

of lung cancer (Extract 1, p102). As discussed previously, details about lung cancer or Carla's experience of the disease are not presented and although Tremaine's fundraising efforts were inspired by his wife's death, he is raising money for the creation of a garden at a local palliative care unit rather than for lung cancer specifically. This story represents the most common way that lung cancer is portrayed in relation to fundraising, that is, briefly and because an individual has died of the disease. Texts that discuss fundraising activities in support of lung cancer form only a small proportion of the dataset and the prominence of the disease in these stories is variable. In some stories lung cancer is one of a number of cancers to benefit from events, in others it is a main beneficiary. Often, however, discussion regarding the disease is brief.

Even in the small number of stories that portray individuals with lung cancer as taking part in fundraising, their activities are often in aid of something else and little is presented about the disease or their experience of it. This is evident in another extract discussed earlier (Extract 5, p108) in which Hugh Wickett is portrayed as having his head shaved for charity. As discussed previously, lung cancer enters into the story only briefly to describe Hugh as having been '*diagnosed with incurable but manageable lung cancer*'. No further details are presented about Hugh's experience of the disease and his fundraising is in aid of disabled children rather than lung cancer. In the texts examined, only two stories are identified that portray an individual with lung cancer raising money specifically for the disease.

In contrast in the breast cancer dataset, most fundraising activities are in support of breast cancer and individuals with breast cancer are commonly portrayed as taking an active part in events and activities to raise money for the disease. This is evident in some of the extracts presented in earlier sections, for example Extract 8 (pp112-113) and Extract 12 (pp122-123). As previously discussed, raising awareness and raising money are inextricably linked in stories aimed at raising awareness of breast cancer. Moreover, fundraising in the context of breast cancer awareness is promoted as both a worthwhile and a fun activity; one that engages and entices the active and enthusiastic support of not only those affected by the disease but also the wider public at large.

4.2.5 Risk factors

Both lung cancer and breast cancer are discussed in relation to factors that are thought to increase or decrease the risk of developing the disease. Unsurprisingly given the strength of the causal link, lung cancer is commonly discussed in relation to smoking. Where this occurs, smoking is presented as an unequivocal cause of the disease rather than a risk factor. For example:

Extract 14:

('Royals Kingsize' cigarette packet, front and back. Manufactured by Rothmans of Pall Mall. Retrieved 3 October 2010)

This extract presents a commonly available medium in which the risk of developing lung cancer from smoking is portrayed. Lung cancer is one of a number of health consequences that are depicted on cigarette packets sold in the UK and elsewhere. In this extract, the risk of lung cancer from smoking is explicit and unambiguous; smoking causes lung cancer and, moreover, death is presented as a consequence of both smoking and lung cancer. The picture contained in this extract is presumably intended to represent the actual effect of smoking on the lungs; changing them from white (not the natural appearance of lungs) and presumably clean and healthy, to dark, blood-stained, presumably fatally diseased and, by comparison, unclean. This imagery is similar to that described in Chapter 3 (see Figure 5, p68) in which smoking is associated with dirt and unpleasantness. In other texts across the dataset where smoking and lung cancer are discussed together, they are portrayed similarly; as killers of large numbers of people and, in the case of passive smoking, innocent non-smokers particularly babies and children. These

portrayals serve to perpetuate and sustain associations between lung cancer, smoking and dying.

Lung cancer is particularly discussed in relation to smoking in texts aimed at raising awareness of the disease (see for example Extract 7, pp110-111, and Extract 10, p118). Many of these stories are identified as being organised to construct lung cancer as primarily a smoking-related disease and downplay the possibility of other causes. Often smoking is presented as the cause of most lung cancers and where individuals with the disease are portrayed they are usually identified in relation to their smoking status. Phrases such as '*Smoking and passive smoking causes nine out of 10 lung cancers*' (Extract 7, p111) and '*Although some people who have never smoked get lung cancer, smoking causes nine out of 10 cases*' (Evening Chronicle (Newcastle) (Your Health), 29 November 2010) function as extreme case formulations (Pomerantz 1986). That is they are structured to maximise the significance of smoking in the development of the disease and minimise the significance of non-smoking-related disease. The positioning of the word '*although*' in the second phrase above prior to the first clause (that the disease occurs in non-smokers) works to subordinate this idea in favour of the second clause (that smoking is the main cause of the disease). Other phrases such '*nine out of 10 cases*', '*nearly all*', '*in most people'* and '*almost 90%'* are also commonly used to describe smoking prevalence in lung cancer populations. They imply 'almost always', and as such they too function as extreme case formulations. They emphasise the magnitude of smoking-related lung cancer, and minimise the counter-argument; that lung cancer occurs in non-smokers. Arguably, if the actual number of people who develop lung cancer never having smoked was presented within stories (approximately 4,000 people in the UK each year), the persuasive effect of messages might be altered. These linguistic devices, in conjunction with an absence of information about other causes or risk-factors for lung cancer and the presentation of smoking cessation as the only way to avoid lung cancer, all serve to construct the disease as *almost always* a consequence of smoking, and place an effective limit on discussion of other reasons why individuals may develop lung cancer.

Although smoking is presented as an addiction in some texts, it is also portrayed as a personal choice and one that can be given up if people have the will to do so, and accept the help and support that is readily available to them.

4. Representations of lung cancer and breast cancer

In this narrative, developing lung cancer and dying of it are presented as consequences of individuals choosing to smoke in the first place, and then choosing not to give up. Lung cancer is thus constructed as a problem that stems from indulgent personal behaviours and a lack of self-control to protect not only one's own health (and life) but also that of others.

In contrast in a smaller number of texts not explicitly oriented to the awareness month initiative, lung cancer is discussed in relation to certain environmental hazards and foods that are thought to either increase or decrease the risk of developing the disease. Across these texts, factors that are portrayed as increasing the risk of lung cancer include cannabis use, pollution, dust, radon, asbestos, silica and cooking fumes. Factors that are portrayed as decreasing the risk of lung cancer include a high intake of fruit and vegetables, Madiran wine, chocolate, pistachio nuts, pumpkin and watercress. For example:

Extract 15:

SCHOOL CLOSED IN RADIOACTIVE ALERT

Radon levels found above 'action level'

A DANGEROUS gas alert has closed a primary school on Portland.

Pupils were told not to return to Grove Infants School after high levels of the colourless, odourless radioactive gas radon were detected in parts of its building.

Around 70 children were hastily relocated to two classrooms and a school hall at St George's Primary School at Easton.

It is hoped that the contaminated school will reopen after half term in early November. In the meantime emergency work is being carried out to ventilate the building in Grove Road.

Radon can cause lung cancer if it is inhaled over a period of time.

Headteacher Jane Hurdiss of Grove Infants School said it was 'all a bit of nightmare' but that radon are very long term and accumulative but it can contribute to lung cancer.

"The children are fine but I was concerned for the staff who have worked there for years. Any sort of risk isn't worth it.

"It's all been a bit of a nightmare but we've been really lucky to get accommodated all together at a large school close by.

"The children have seen it as an adventure, they only had two closure days while we moved everything over from the school.

"Obviously behind the scenes there's been a lot more work for staff, governors and myself."

Mrs Hardiss thanked St George's and Royal Manor Youth Club, which is accommodating the after-school club, her 'magnificent' staff

space so we said we could fit them in our activities room, learning centre and small school hall."

A Dorset County Council spokesman said the radon testing was part of routine health and safety assessment of school premises.

The results for Grove School on Portland showed levels matched

'*It is hoped that the contaminated school will reopen after half term in early November. In the meantime emergency work is being carried out to ventilate the building in Grove Road.*

Radon can cause lung cancer if it is inhaled over a period of time.'
('School closed in radioactive alert: Radon levels found above 'action level'', Dorset Echo, 10 September 2010)

This extract is taken from a newspaper story that identifies that high radon levels in the environment can increase the risk of developing lung cancer.

The discussion in some lung cancer texts of risk factors other than smoking draws attention to the absence of similar discussions in other texts,

particularly those aimed at raising awareness of the disease. This omission is, perhaps, an intentional and understandable public health strategy aimed at targeting a cause that is likely to have the greatest effect in reducing the number of people who develop and die from the disease. However, this strategy works to sustain and perpetuate the strength of the association between lung cancer and smoking so that the disease is constructed as one that affects primarily smokers rather than a risk for the population as a whole. Additionally, the strategy may act to suppress awareness and investigation of other factors that may increase or decrease the risk of lung cancer.

Discussions of risk factors in relation to breast cancer differ in that a single causal explanation is not identified. The disease is more commonly associated with intrinsic rather than extrinsic factors; ones associated with a woman's inherent biology including female gender, ageing and family history. Across the breast cancer texts, where lifestyle choices and behaviours are discussed either to identify or refute them as risk factors for the disease (such as taking the contraceptive pill, breast feeding, being overweight, working nights, drinking alcohol and exercise), they are presented with less certainty than factors such as gender, age and genetics. Furthermore, an individual's risk of developing the disease is presented more as a matter of chance where even specialists are unable to provide an adequate explanation. For example:

4. Representations of lung cancer and breast cancer

Extract 16:

Advice on... Breast cancer

Breast cancer affects thousands of women in the UK but many are still able to live long lives after they have been diagnosed. Breast Cancer Care's **Jackie Harris** offers advice on how to make teenagers aware of the disease

Q What is breast cancer and how many people are affected each year?

Breast cancer starts when a cell in the breast starts to divide and grow in an abnormal way. There are several types of breast cancer, which can be found at different stages of development and can grow at different rates. This means that people can be given different treatments, depending on what will work best for them.

It is the most common cancer in the UK. In 2007, around 45,600 women and approximately 250 men were diagnosed with the disease. The majority of cases occur in people aged over 50, but around 8,800 women under 50 are also diagnosed each year.

Breast cancer does not occur when the breasts are developing – and it is extremely rare for anyone under the age of 20 to be affected.

If someone in your family is diagnosed with breast cancer, it does not necessarily mean that they are going to die. Better treatments mean that more and more people are now living long and full lives after breast cancer. It is thought that around 550,000 women are alive in the UK who have been diagnosed with breast cancer.

Q What causes breast cancer and how can teenagers reduce their risk?

Although there is lots of research on breast cancer, we still don't know what causes it. There doesn't seem to be one single cause, but rather a combination of lots of different things.

There are three main risk factors for breast cancer and are things that we

age of 50)

- Having a family history of breast cancer

Most cases of breast cancer happen by chance. Only around five to 10 per cent of breast cancers run in families. Because breast cancer is so common in the UK, it's not unusual to have one family member with breast cancer, and this doesn't mean that you are at a higher risk of developing it.

For teenagers, eating a healthy, balanced diet and taking regular exercise are good ways to reduce your risk of developing breast cancer and other diseases in later life.

Q What is a good way of making young people aware of breast cancer and how to be breast aware?

We know that teenagers and young adults worry about the changes their bodies go through and that they can find discussing these changes difficult. Many teenagers and young adults worry about their breast shape being different to others of the same age and worry this could suggest a medical problem or increase their risk of breast cancer.

Breast Cancer Care is a national charity that has been providing information and support for more than 30 years. In 2008, we produced a workshop resource pack to help teachers, school nurses and other professionals working with young people run information sessions on breast health called Breast m8s: Know and ❤ your Breasts.

The free resource pack includes details on how breasts develop, what is

tion. The website includes advice on bras, breast development and facts on breast cancer. It also debunks some of the more commonly held myths about the disease, such as using a deodorant, or having your nipple pierced gives you breast cancer.

The website includes a frequently asked questions section that addresses issues such as whether it is normal to experience sharp pains in your breasts at times and the likelihood of you developing the condition if a grandmother or other close relation has been treated for the condition.

Jackie Harris is clinical nurse specialist at Breast Cancer Care

MORE INFORMATION

- To order a free copy of the Breast m8s resource, or to find out more about breast awareness and breast cancer, visit **www.breastcancercare.org.uk** or call the freephone helpline **0808 800 6000** (open 9am to 5pm Monday to Friday and 9am to 2pm on Saturday)
- Breast m8s: Know and ❤ your Breasts is designed to provide information on breast health and bras for girls aged 11 to 16: **www.breastcancercare.org.uk/breast-cancer-**

'*Q: What causes breast cancer and how can teenagers reduce their risk?*

Although there's lots of research on breast cancer, we still don't know what causes it. There doesn't seem to be one single cause, but rather a combination of lots of different things.

There are three main risk factors for breast cancer and they are things we can't do anything about.

They are:

- *Gender (being female)*
- *Getting older (80 per cent over the age of 50)*

- *Having a family history of breast cancer.*

Most cases of breast cancer happen by chance. Only 5 to 10 per cent run in families. Because breast cancer is so common in the UK, it's not unusual to have one family member with breast cancer, and this doesn't mean that you are at a higher risk of developing it.

For teenagers, eating a healthy, balanced diet and taking regular exercise are good ways to reduce your risk of developing breast cancer and other diseases in later life.' (Children and Young People Now (Youth Work Now), 5 October 2010)

This extract is taken from a youth-worker magazine and said to be written by a nurse specialist from a breast cancer charity. It can be compared with Extract 14 presented earlier in this section (p128), and also Extract 7 (pp110-111) and Extract 10 (p118) in which lung cancer is discussed in relation to awareness initiatives. The extract above illustrates that causal factors for breast cancer are presented with less certainty than is the case for lung cancer. Breast cancer is constructed as largely a matter of chance with only limited things that women are able to do themselves to avoid developing the disease. The extract also illustrates that even though ageing is presented as a main risk factor for the disease, stories about the risk of breast cancer may be oriented to young audiences. In this way, breast cancer is presented as a risk for all females, regardless of age.

Therefore in the texts examined, differences are identified between how lung cancer and breast cancer are portrayed in relation to risk. Lung cancer is portrayed as a consequence of external factors that pollute and damage the body rather than an intrinsic biologically-driven process. As such, lung cancer is constructed as an avoidable risk; one caused through social and environmental practices rather than the internal workings of the body that are beyond personal control. Moreover the dominance of portrayals of smoking as the main cause of the lung cancer and the relative limited discussion of other risk factors, constructs the disease as one that generally occurs in people who choose to put themselves at risk. Unlike individuals with breast cancer who are cast as victims of their disease, individuals with lung cancer are positioned as the likely perpetrators of their disease and its consequences.

4.2.6 Epidemiological trends

As well as risk factors, both lung cancer and breast cancer are discussed in relation to other epidemiological factors. For example, Extract 7 presented earlier (pp110-111) illustrates how lung cancer is commonly portrayed in relation to incidence, survival, mortality and smoking rates, particularly in texts that are aimed at raising awareness of the disease. As previously discussed, these epidemiological factors characterise lung cancer in problematic terms in relation to the large number of people who develop and die from the disease, mainly as a consequence of smoking. For example, in Extract 7 (p111), lung cancer is identified as: *'the second most common cancer in the UK after breast cancer and more people die of it than any other cancer*'. In a number of texts examined, as in Extract 7 also, incidence rates are presented as increasing in women (due to the delay in their smoking cessation rates compared to those of men), and survival rates are portrayed as not having improved in 20 years. As discussed earlier, these messages may act to undermine other messages aimed at promoting survival as a potential consequence of the disease, and also perpetuate the association between lung cancer and smoking.

In some texts, epidemiological trends in relation to lung cancer are prominently portrayed. For example:

Extract 17:

Lung cancer killed 916 in seven years

LUNG cancer killed over 900 people in the Western Trust over the past seven years.

Last year 152 people were admitted to hospital with a diagnosis of lung cancer in this area. 916 have died from lung cancer since 2003.

Health Minister Michael McGimpsey outlined the number of lung cancer deaths in response to an Assembly Question.

The amount of deaths in 2009 was 149 - the highest in the Western Trust in the last seven years - but the lowest amount recorded in any trust last year. Across Northern Ireland 906 people died of lung cancer whilst in the United Kingdom the figure was 35,071.

Lung cancer rise in women

BRITAIN Lung cancer rates in women have soared as efforts to persuade them to quit smoking appear to have failed.

While the number of cases in men has fallen, a report shows the disease is claiming more female victims – up 10 per cent between 1987 and 2006 to 35.4 cases per 100,000 women. The report, by the South West Public Health Observatory, says efforts to encourage people to give up cigarettes has focused on men, with rates down from 70.4 per 100,000 in 2000 to 59.4 per 100,000 in 2007. It says women must be targeted in the anti-smoking drive.

Cancer rate 'is legacy of cheap cigarettes'

By Dolores Cowburn

dcowburn@jerseyeveningpost.com

LUNG cancer rates are nearly 30 per cent higher in Jersey than the south-west of England, and the rise is blamed on the legacy of cheap tax-free cigarettes.

Figures released for 2007 by the South West Cancer Intelligence Service show that Jersey had an average of 49.1 people with lung cancer per 100,000 population, compared with 38.1 in south-west England.

Despite Jersey having an estimated popula-

Historic duty free sales are blamed for latest figures

('Lung cancer killed 916 in seven years', Londonderry Sentinel, 3 November 2010; 'Lung cancer rise in women', Manchester Evening News, 29 November 2010; 'Cancer rate 'legacy of cheap cigarettes'', Jersey Weekly Post, 14 October 2010)

This extract is compiled from three newspaper stories. The stories are unusual in the lung cancer dataset in that the disease is presented as headline news. Each of the stories was written in response to the release of epidemiological information by a public health organisation or a government official. Although the Lung Cancer Awareness Month initiative is not mentioned in the stories, the texts are identified as having an awareness-raising function and were produced in or near to the awareness month. In these texts, lung cancer is constructed in similar ways as in previous texts discussed; as a major killer and a public concern particularly for local populations and women, and a

consequence of the availability of cigarettes and a failure of people to act on smoking cessation advice.

Similar to discussions in relation to the role of smoking in causing lung cancer, statistical information about the disease is presented in dramatic terms to achieve the maximum negative impact. Words and phrases such as: '*highest rates'*; '*deadliest cancer*' and '*biggest cancer killer*' function as extreme case formulations (Pomerantz 1986) and emphasise the magnitude of what is being discussed i.e. the burden caused by lung cancer. Similarly, phrases such as '*less than 10 per cent'*, '*fewer than 10%*' and '*only around 10 in every 100 lung cancer patients*' emphasise how insignificant the number of people who survive the disease is compared with the magnitude of those who do not.

Epidemiological trends in relation to lung cancer are also used in some texts to illustrate, contextualise or act as a comparison for some other aspect of the story. For example, the incidence and/or mortality of lung cancer is used to rank breast cancer as the most common cancer and prostate cancer as the second highest cancer killer in men (after lung cancer). This ranking of cancers into the commonest and/or most fatal is particularly identified in stories aimed at raising awareness of different cancers but it is also a feature of stories about other diseases and conditions, or in other stories in which a comparator for death rates in particular is needed to contextualise what is being discussed. These narrative practices serve to define lung cancer as one of the most common and most lethal of all diseases and cancers.

In the texts examined in the breast cancer dataset, breast cancer is also presented as a common disease; one affecting many women (commonly cited as one in twelve) at any time of life. However, in contrast to the lung cancer texts, survival rates for breast cancer are presented as improving due to increased awareness, early detection and improvements in treatment. This is identified earlier in this chapter in relation to awareness raising stories (see pages 123-124). Death rates from breast cancer are less commonly discussed but where they are, they are presented as falling and of a smaller magnitude than the number of women who survive the disease. For example:

Extract 18:

Simply the breast news for sufferers

More women surviving cancer

By LISA SALMON

editorial.cumbernauldnews@jnscotland.co.uk

BREAST cancer is the most common cancer in the UK — and it's every woman's nightmare.

But fresh figures show treatment and survival rates have radically improved,.

compared with a 52 per cent five-year survival rate between 1971 and 1975.

Such encouraging survival rates are reflected in a substantial drop in breast cancer deaths in the UK.

Rogers, a clinical nurse specialist for Breast Cancer Care, says: "While the incidence is going up, people are surviving for longer, which is the positive message we'd like to get across."

"There are lots of

'Breast cancer is the most common cancer in the UK – and it's every woman's nightmare.

But fresh figures show treatment and survival rates have radically improved.

While nine out of 10 people referred to a specialist with possible signs don't actually have the disease, 46,000 people every year find out they have. In fact, one in every three cancers in females is breast cancer.

But huge advances in knowledge and treatment mean that breast cancer survival rates have increased dramatically.

The latest figures from Cancer Research UK show that 82 per cent of people diagnosed with breast cancer will be alive half a decade later, compared with a 52 per cent survival rate between 1971 and 1975.

Such encouraging survival rates are reflected in a substantial drop in breast cancer deaths in the UK.' ('Simply the breast news for sufferers: More women surviving cancer', Cumbernauld News, 20 October 2010)

This extract from a regional newspaper presents statistics released by Cancer Research UK. In this story and in contrast to the lung cancer texts, statistics are used to present breast cancer as a good news story. Although the linguistic devices used in this story also emphasise the large number who develop the

disease ('*most common*', '*46,000*' '*every woman's nightmare*', '*one in three cancers in females*'), they also present the disease in more optimistic terms; as one where progress is being made ('*huge advances*', '*survival rates have increased dramatically*', '*substantial drop in deaths*'). In this way, although breast cancer is presented as a significant threat (for women), it is portrayed as one that most women can survive. Lung cancer, by comparison, is constructed as a bad news story, one in which most people who develop the disease will die of it.

4.2.7 Biomedical initiatives

Each of the two cancers is discussed in relation to a number of overlapping topics that are grouped under the theme of 'biomedical initiatives'. These topics include screening and diagnostic procedures, treatment, service provision and research. Some of these topics are discussed in relation to earlier themes. Across both datasets, early diagnosis is equated with successful treatment and survival, and is presented as a consequence, in part, of the vigilance of individuals (mainly women) in monitoring their bodies for symptoms. In many of the breast cancer texts aimed at raising awareness, women are both encouraged and shown to be active in checking their breasts for abnormalities. In contrast in many of the lung cancer awareness texts, public awareness and monitoring for symptoms of the disease is presented as lacking and in need of improvement. A further obvious difference between the two datasets in relation to how diagnosis is portrayed is that mammography (usually referred to as 'screening') is discussed in many of the breast cancer texts. In most of these texts, screening is presented as an effective diagnostic procedure; one that has led to improvements in survival and one that women should undergo if invited to do so. In a smaller number of texts, breast cancer screening is discussed in more controversial terms; as a cause of missed diagnosis and/or over-diagnosis of lumps that may not be life-threatening, and as not available to all women who are at risk of developing the disease (in the UK screening if offered to women aged between 50 and 70 years). In the lung cancer texts, discussions of the disease in relation to screening are identified in a small number of texts only. In these stories, screening is presented as something that may lead to earlier diagnosis of the disease in the future rather than a present reality.

These differences in how the two diseases are portrayed in relation to screening show that breast cancer is constructed as an easy disease to detect. In contrast, screening and detecting lung cancer is constructed as more difficult. The difference can be illustrated by two extracts from texts that report new screening initiatives:

Extract 19:

'IT APPEARS easy. Screen patients for a deadly disease; pick it up early and save lives. Sadly, medicine is never that simple.

Early diagnosis does not always mean a better outlook. And lung cancer, which kills more than 35,000 people ever year in the UK and accounts for more than one in five of all cancer deaths, is one disease where screening and early detection has been disappointing.

But recent research in America has suggested that maybe, just maybe, an effective screening programme might just be possible eventually.

Sorry for the lack of hyperbole. There is no talk of a 'breakthrough' – just a glimmer of hope. Up to now attempts to devise a screening test for lung cancer have been disappointing.' ('Lung cancer research asks more questions than it answers', *www.thisisplymouth.co.uk/news*, 28 October 2010) (Capitals as in the original)

Extract 20:

*'*Reporter*: "It's a DIY scanner. The portable kit can instantly detect tumours allowing women at risk of the disease to carry out their own instant checks. This is the radio-frequency scanner that could make it happen. This is the first to give results in real time."'*

And further in the report:

'Prof Wu: "*What we have here is a tool that could have the potential to help millions of women in the world to have early diagnosis of breast cancer.*"*'* ('Scientists unveil latest weapon in the fight against breast cancer', Sky News, 28 October 2010)

These two extracts illustrate the difference identified in how the two cancers are represented in relation to screening and detection. In the first extract,

taken from an online newspaper account, the results of a screening trial for lung cancer are presented with caution; as raising more questions rather than providing an immediate solution to the problem of late diagnosis. Moreover, early diagnosis of lung cancer is presented as *'not always mean[ing] a better outlook*'. In the second extract, taken from a television broadcast, the diagnosis of breast cancer is presented as something that women may soon be able to do for themselves, instantly at home using a simple scanning device. In comparison therefore, detecting lung cancer is presented as a complex matter in which even research into sophisticated scanning techniques do not readily provide answers whereas detecting and diagnosing breast cancer is portrayed as a relatively straightforward activity.

Treatment of each of the two cancers is also discussed in relation to themes presented earlier in this chapter, particularly 'awareness initiatives' and 'individuals living with the disease'. In relation to these themes, treatment for lung cancer is presented varyingly; in some texts as ineffective and aimed at symptom control rather than cure, and in other texts as potentially effective if the disease is diagnosed early (see for example Extract 6 (pp109) and Extract 7 (p110-111). Treatment for breast cancer is more likely to be presented as effective; able to cure or at least control the disease so that individuals are able to continuing living with it (see for example Extract 8, pp 112-113, Extract 9, pp114-115 and Extract 12, pp122-123).

Both cancers are discussed in relation to the availability of, access to and research into, novel and existing treatments. In both datasets, texts are identified that report these topics in both positive and problematic terms. For example stories about new drug developments in each of the two diseases are identified; some to report successes, others to report failures. Other stories refer to individuals being given or denied access to new and existing treatments for each of the two diseases. In the breast cancer texts, however, advances in breast cancer treatment are commonly linked with research activity and improving survival rates.

Both diseases are also discussed in relation to service provision, for example in stories about new and existing services to diagnose and treat the disease and/or support individuals who have the disease. Texts in which services are reported as successful or deficient are identified in both datasets. A particular

difference is noted, however, in the number of stories reporting local support services for each of the two cancers. Thirty-four texts present details of a support service for people with breast cancer; twenty-four of these advertise a support group. The other texts present details of a range of services including: bra and prosthetic advice (2 texts), hair loss advice (2), exercise class (2), drop-in centre (1) telephone helpline (1) a nurse specialist (1) and a 'special lunch' organised by hospital staff (1). This compares with five texts that present details of a support service for lung cancer, including a 'fatigue, anxiety and breathlessness programme (3 texts), a support group and a nurse specialist (one text each). In the UK, support groups in particular are more common for breast cancer than for lung cancer (Macmillan Cancer Support 2007). This difference in the number of texts promoting support services for the two diseases may reflect differences in the services available for each of the two diseases, although there may be other explanations.

4.3 Bringing the analysis together

This broad examination of texts has identified differences in how lung cancer and breast cancer are represented in media. Not only is breast cancer more commonly discussed, it is also highly visible across texts; prominent in headlines, titles, and in the use of the word and colour pink and the pink ribbon logo to signify discussions of the disease. In addition, breast cancer is often a prominent focus of texts and is commonly discussed at length. In comparison, lung cancer is noticeably less prominent. In most of the texts retrieved, it is less commonly identified as a prominent focus of stories and often discussed only briefly, even during Lung Cancer Awareness Month where it is possible to make a direct comparison between the two datasets.

The contrast between how the two diseases are discussed in relation to awareness initiatives is particularly striking. In the breast cancer texts the volume, prominence and structure of stories serve to promote breast cancer awareness in a way that is not evident in the lung cancer texts. Across the breast cancer texts, breast cancer awareness is constructed as a social movement i.e. a collective activity organised through shared goals, values, actions, slogans and symbols (Marshall and Anderson 2008). Within stories, breast cancer is promoted as a worthy social cause; one that attracts the attention of many including the most powerful and famous and one that is

deserving of public support because of the disease's impending and indiscriminate threat to women and society in general. Moreover, the public is offered a clear invitation to engage with the movement, by taking part in a range of events and activities aimed at raising awareness of the disease and also money for further research. Supporting the disease in this way is presented as a worthy and worthwhile activity providing social benefits as well as personal gains.

In comparison, in texts that promote lung cancer awareness there is little sign of a public or media galvanised in support of a worthy cause, and little in the way of an invitation for the public to get involved in the initiative other than to heed the advice on offer. Fundraising, although a common feature in the lung cancer texts, is not promoted as an awareness-raising opportunity for the public in the same way that it is in the breast cancer texts, and where it is discussed it is seldom in support of the disease. Instead, lung cancer awareness is presented as a serious public health activity, directed at educating the public of the risk of dying from the disease and persuading people to modify their behaviours in relation to smoking and presenting late for diagnosis. In this didactic narrative, lung cancer is constructed as a less appealing concern; one targeting mainly people who smoke rather than one that is worthy of wider public engagement and support.

Further differences in how the two diseases are portrayed are identified. Breast cancer is commonly discussed in relation to survival, whereas lung cancer is commonly discussed in relation to death and dying. Women with breast cancer are frequently depicted as surviving the disease, and they and their personal experience of it are often a prominent feature of stories. In these stories, breast cancer is presented as a transformational experience in which individuals are portrayed as heroic and inspirational in their response to the disease, and as able to live full and meaningful lives. Individuals who have died are less commonly presented but where they are, they too are portrayed within a similar heroic narrative of having lived a full and meaningful life right up until their death from the disease. Epidemiological information about breast cancer, where discussed, reinforces this image of the disease in that it emphasises the large number of women who develop and survive the disease rather than the proportion who die of it.

In contrast where individuals with lung cancer are presented, they have usually died or are portrayed as dying, and little is said about the disease or their experience of it. Individuals living with or surviving lung cancer appear less frequently in texts, and often, little is said about their experience of the disease either. Where the personal experience of surviving lung cancer is discussed, it is usually in relation to awareness initiatives and in these stories messages that survival from the disease is generally poor and the risk of death high are also prominent. Moreover, in these texts and across the lung cancer dataset in general, a heroic narrative similar to the one identified in relation to portrayals of individuals with breast cancer texts is less apparent.

These distinctions between how the two diseases are commonly discussed draw attention to how discourses, identified in Chapter 3, that construct lung cancer as an inevitably fatal disease are sustained and perpetuated in media stories. The distinctions also draw attention to the relative absence of discussions in relation to the personal experience of lung cancer. This absence may serve to construct lung cancer and people who develop the disease as unworthy of public attention. It may also reinforce discourses that construct cancer, and in particular lung cancer, as a dreaded disease; one that is too awful to speak openly about, and therefore, not suitable for public discussion.

A further distinction in how the two diseases are discussed is apparent in relation to risk. When risk is discussed in relation to breast cancer, chance and intrinsic factors such as age, female gender and genetics are implicated. These factors construct breast cancer as an unavoidable risk for women; they are ‘at risk’ of the disease rather than the cause of it. In contrast, in discussions of risk in relation to lung cancer, smoking is usually identified as the main cause of the disease, particularly in texts discussing awareness initiatives. Other risk factors for lung cancer, or the development of the disease in non-smokers, are less commonly presented. Therefore, in contrast to breast cancer, rather than being ‘at risk’ of lung cancer, individuals are positioned as being the likely cause of the disease. This distinction between how the two diseases are portrayed in relation to risk illustrates how discourses identified in Chapter 3 that construct lung cancer as a smoking-related disease and, thereby, largely self-inflicted are sustained and perpetuated in media portrayals.

4. Representations of lung cancer and breast cancer

Following this broad examination of texts, the next two chapters present a more focussed and in-depth analysis of a smaller set of texts that contain a personal story of the experience of lung cancer or breast cancer. These texts are selected to enable a more detailed examination and comparison of how individuals with lung cancer and breast cancer are portrayed, particularly in light of the observation that the personal experience of lung cancer is less likely to be presented than that of breast cancer and less likely to be portrayed within a heroic narrative.

5. Personal stories of lung cancer and breast cancer: Narratives of dying and survival

As discussed briefly at the end of the last chapter, in the next two chapters the analytic lens is narrowed to examine texts that contain a personal story of the experience of lung cancer or breast cancer. Personal stories are selected because, from the broad overview of the data, it appears that where the experience of lung cancer is portrayed it differs from portrayals of the experience of breast cancer. Individuals with breast cancer, whether living or dying, are often presented within narrative similar to that described by Seale (2001a, 2002) in which individuals with cancer are portrayed as heroic. Similar heroic narratives in portrayals of individuals with lung cancer are less evident. Personal stories are also of interest because of their potential to influence public perceptions and behaviours towards the disease. Kitzinger et al. (1999) identified that women's perceptions of breast cancer are profoundly influenced by personal stories in media texts. Such stories were vividly recalled by women and used to 'make sense' of breast cancer, as well as influencing their own sense of risk from the disease. Therefore, texts that contain a personal story of lung cancer or breast cancer have been selected to allow a more focused and detailed analysis of how each of the two diseases, and individuals diagnosed with them, are constructed. As in the previous chapter, the main focus of the analysis is the lung cancer texts. Texts from the breast cancer dataset are used as a reference to identify similarities and differences that might elucidate the social processes involved in the construction of lung cancer.

All the texts that portray a personal account of the experience of lung cancer were examined in detail. Texts, in which an individual with lung cancer is discussed with no details of their disease experience, were excluded from the examination. For example, the story discussed in the previous chapter (Extract 5, p108) in which Hugh Wickett is raising money for charity by having his head shaved is not included since it does not portray him in relation to his cancer experience (although this absence of detail becomes pertinent to the analysis). Some stories pertaining to the same individual are presented in a number of texts. For example, eleven of the personal stories from newspaper sources were retrieved in both print and online formats and the accounts presented in

each of these are often very similar. Another individual's personal story is presented over twelve episodes of a television soap-opera. Where a personal story is presented in more than one text, the 'unit of analysis' is the individual's story rather than each individual text. In this way, the analysis is based on twenty-three personal stories, retrieved from sixty-two texts, and presented in twenty-seven newspapers (twenty-one regional, six national), eighteen internet sites, fifteen television broadcasts (fourteen national, one regional), one regional radio broadcast and one magazine. Fourteen of the internet sites relate to regional newspapers, and twelve of the national television broadcasts relate to one individual's story presented as part of a soap-opera.

The stories present the lung cancer experience of sixteen women and seven men. In the UK population, lung cancer is slightly more common in men rather than women with a male:female ratio of approximately12:10 (CRUK 2014d). Visual images of the individual are presented in 21 stories and from these, 20 individuals appear to be white and one individual is black, from Jamaica. In general in the UK, lung cancer is more common in white men and women than non-white. For example in one analysis from South East England (including London), between 1998 and 2003 the rate of lung cancer in black men was about half the rate in white men (Jack et al. 2011). The age of the individual is stated in 20 stories and ranges from 31 to 91 years. Approximately two-thirds of individuals are under 65 years. This age distribution contrasts with that of lung cancer in the UK population where three-quarters of diagnoses are made in people over 65 years (CRUK 2014d). Other analyses of media accounts of people with cancer also note a bias towards portrayals of younger age groups (McKay & Bonner 1999, Seale 2001a).

The twenty-three personal stories of lung cancer are compared with one hundred and nineteen personal stories of breast cancer. This difference in the number of personal stories between the two dataset relates to the observation made in Chapter 4 that although individuals with lung cancer, particularly those who have died, are present in media texts their personal experience of the disease is often not discussed. The personal stories of breast cancer were retrieved from ninety-five newspapers (seventy-six regional, nineteen national), twenty magazines, fourteen internet sites, four television broadcasts and three radio broadcasts. All but one of the stories relate to women. (In the UK less

than 1% of breast cancers occurs in men.) A visual image of the individual is presented in 95 stories and in 91 of these the individual is white. Although in the UK non-white women are less likely to develop breast cancer than white women, the difference in risk is only thought to be between 15 to 18% (Gathani et al. 2014). The age of the individual is given in 113 stories and ranges from 23 to 107 years. Sixty-six individuals are aged below 50 years (i.e. 55% of all stories and 64% of stories in which the age is given). These percentage figures contrast with the age distribution of breast cancer in the UK in which only 20% of women diagnosed with the disease are under 50 years. However, given that the number of individuals developing breast cancer each year is just over 50,000, around 10,000 women will be aged below 50 at diagnosis (CRUK 2014e). These characteristics in relation to media representations of individuals with breast cancer are in keeping with the findings of other authors who also report a greater portrayal of young white women (Cartwright 1998; McKay & Bonner 1999; MacKenzie et al. 2010a).

The analysis presented in this chapter combines elements of the second and third analytic phases described in Chapter 2 (pp47-50). In the second phase, personal stories were examined for their constructive and action-oriented features i.e. focussing on what the text is doing, accomplishing and constructing, rather than treating it as merely as a report or description of real events. However, as this analysis progressed, questions were raised in relation to the observation made earlier that a heroic narrative is absent in stories of individuals with lung cancer. Therefore, Seale's analyses in relation to accounts of the experience of living and dying of cancer were examined in detail and provided a framework for the analysis of the personal stories of lung cancer and breast cancer. It is the analysis from these two merged phases that are presented in this chapter. First, however, an understanding of Seale's conceptualisation of cancer as a heroic event is presented.

5.1 Heroic cancer narratives

In the literature review presented in Chapter 2, Seale's (2001a, 2002) analysis of mainly North American and UK newspaper accounts of people with cancer published in 1999 was discussed. In this analysis, Seale suggests that individuals with cancer, whether living or dying, are portrayed as able to influence their experience of the disease through efforts of will, emotional

labour and displays of moral character. Extending the view of Sontag (1991/1978) that the language of cancer is dominated by imagery of warfare, Seale argues that in a '*cancer heroics*' narrative (2002, p107) sporting connotations evoked through the use of military metaphors position individuals within a dramatic 'struggle' for life. In this narrative, cancer is portrayed as controllable or at least influenced by acts of determination and courage on the part of the individual concerned (2001a). Seale (2002) suggests further that these heroic displays of resistance act as a defence of the individual's moral character in the face of life-threatening illness and, for some, their death.

Countering suggestions made in earlier studies (Lupton 1994, Clarke 1999a) that the use military metaphors in media accounts of cancer is oppressive and positions the individual concerned as emotionally weak and devoid of power, Seale (2001a) argues that in a heroic narrative both men and women are portrayed as possessing considerable agency over their reactions to cancer, either through emotional labour or emotional steadfastness. He suggests that for women in particular, cancer is presented as a transformative experience resulting in something of benefit, for example emotional development, new understandings and/or changed priorities. In his analysis, women with cancer are identified as skilfully working on their own distressed emotions in response to the diagnosis by drawing on the supportive help of others, so that initial bad feelings are transformed into better ones or into a sense of mission to help others who may develop the disease. For men, on the other hand, cancer is presented as a setback that, with the right character, can be got through and overcome. Seale (2001a) suggests that men are less likely to be portrayed in relation to a transformation of emotions. Instead, they are shown as exhibiting pre-existing strengths of character in response to the cancer diagnosis such as stoicism, altruism and an unruffled attitude that enable them to withstand emotional trauma. Either way, he suggests, media portrayals construct cancer as a meaningful experience in which both men and women are presented as having heroic qualities of courage and determination, and as able to exert considerable control.

Seale (2002) also suggests that in a '*cancer heroics*' narrative the experience of cancer is portrayed as a psychological and spiritual journey in which the individual progresses towards a satisfying resolution, even if death lies at the

end of it. In this narrative even 'losing' the struggle can be understood in some way as 'winning', if psychological and/or spiritual gains are made on the way (p326). In a further discussion specifically in relation to media accounts of dying of cancer, Seale (2004) suggests death is '*made good*' in these accounts by images of individuals largely in control of driving their story (i.e. their cancer experience) forward, and surrounded by a loving family, a wide circle of friends and (on the whole) excellent medical and nursing care (p973). This notion of death being 'made good' draws on a discourse particularly linked to the hospice and palliative care movement in which facilitating a 'good' death is a central goal for professional practice. In this discourse, a good death is largely characterised by: i) open awareness and communication; ii) a sense of having lived a long and successful life; iii) having support from family and friends; iv) having some control over decision-making; v) a settling of one's affairs; vi) living life to the full right up until death; and vii) an absence of suffering and pain (McNamara et al. 1995; Payne et al. 1996; Kitch 2000; Pierson et al. 2002; Seale & van der Geest 2004; Costello 2006; Frith et al. 2012). In contrast, 'bad' deaths are distinguished by opposite characteristics, namely: i) non-awareness, non-acceptance and/or non-communication; ii) a lack of preparedness; iii) suffering; iv) loneliness and dying alone, and v) a failure to actively pursue living until the final stages (Seale 1995b; 2004; McNamara et al. 1995; Costello 2006). The ideology of a good death, however, is viewed by some commentators as a form of social control over dying people in which their choices are shaped, controlled and constrained (Hart et al. 1998).

Some of the characteristics of a 'good' death narrative were also identified by Seale in an earlier study in which he examined accounts produced during interviews with individuals in the UK who knew someone who had died (1995a). In this study, Seale identified that accounts of dying of cancer in particular, like those of dying of AIDS and in contrast to accounts of sudden deaths, often drew on a heroic narrative in which the individual is portrayed as having initially struggled to '*know the truth*' about their prognosis and thereafter had courageously come to terms with and faced their dying in open awareness, acceptance and sacrifice (p602). In this '*heroic death*' narrative, Seale suggests that both the individual who had died and their carers are portrayed in a '*beatific state of emotional accompaniment*' in which there is a

ordering and reordering of relationships, and an affirmation of love through emotional talk and caring practices (p597).

This '*heroic death*' narrative contrasts somewhat with the '*cancer heroics*' narrative identified by Seale in his later analysis of media accounts of cancer. In the '*heroic death*' narrative, although the individual who has died may have struggled initially to learn of their dying they are not portrayed within a narrative of heroic resistance (2001a, 2002). Rather, it is their acceptance and selfless courage in the face of dying that demonstrates their strength of character and warrants admiration. Both narratives, however, suggest an active process in the construction of accounts of dying of cancer to depict the individual concerned as brave and heroic; either in their resistance or their acceptance of death.

In summary, Seale has argued that personal accounts of the experience of cancer often take the form of a heroic narrative in which the individual concerned is portrayed as facing the disease with extraordinary displays of personal courage and strength of character. As such, he suggests that accounts act as moral tales of 'good' ways for the public to confront life-threatening illness and the possibility of dying. In the analysis that follows, the concept of cancer as a heroic event in which the moral character of the individual concerned is at stake is drawn on to examine the personal stories of lung cancer. Personal stories of breast cancer are drawn on to identify similarities and differences that may have implications for how understandings of lung cancer are constructed.

5.2 Patterning of personal stories

Two distinct narratives are identified in lung cancer personal stories. Twelve stories present an account of an individual who is portrayed as dying or having died of lung cancer. These stories are grouped as 'accounts of dying' for the purpose of the analysis presented in this chapter. In contrast, eleven stories present accounts of individuals who are described as survivors or who are currently receiving treatment for lung cancer. These stories are grouped as 'accounts of survival'. These two narratives are examined in turn and compared with accounts of dying and survival in the personal stories of breast cancer.

5.2.1 Accounts of dying

In ten personal stories, individuals living with lung cancer are explicitly portrayed as dying. In most of these, the individual's dying status is a prominent focus of the story; often referred to in the headline or early in the story. This is evident in an extract discussed in the previous chapter in which Alan Desborough is appealing for former work colleagues to come forward after he was diagnosed with mesothelioma (Extract 6, p109). This story carries the headline: '*Asbestos is killing me'*, and Alan is described as having '*an incurable form of lung cancer*' and as '*terminally ill*' (not shown in the extract presented). In these stories, death is presented as an inevitable consequence of lung cancer and treatment, where discussed, is described as ineffective in controlling the individual's disease. In some stories a prediction of the individual's remaining life-span is also given. For example:

Extract 21 Christine J's story:

'*This month the doctors have told her that her body cannot take any more radiotherapy, and she has been told once again she has just two months left to live*' ('I've held on to see Jessica born: Gran's brave battle against cancer', Daily Post (Liverpool), 24 November 2010)

This extract is taken from a newspaper story in which Christine Jones is presented as having just two months left to live after being told that further treatment for her lung cancer is no longer possible. Elsewhere in the story Christine is described as making the most of what time she has left; preparing for her funeral, and buying gifts and writing mementos for her family.

5. Personal Stories

The ten stories that portray individuals as dying draw on elements of the 'heroic death' narrative described by Seale (1995a) in that they present accounts of individuals courageously facing their death in open awareness, acceptance, self-sacrifice and emotional accompaniment. In contrast however to the accounts examined by Seale, the individuals in these stories are not portrayed as having struggled to obtain confirmation of their dying. They are depicted as fully aware of the terminal nature of their illness and seemingly calm and accepting of the situation. Moreover, they are able to talk about and make plans for their death. This presents the individuals as emotionally strong; able to face and come to terms with their dying. For example:

> Extract 22 Liz's story:
>
> *'When Elizabeth Jones was given the devastating news that she had lung cancer – at the same time as her husband was diagnosed with the disease – she could have been forgiven for giving up.*
>
> *But the 59-year-old mother of five and grandmother of 13 instead focussed on a good cause – and organised a sponsored walk from Maerdy to Porth in aid of Macmillan Cancer Care.'*
>
> Further in the story:
>
> *'"She decided that she doesn't want to have a funeral, and instead wants to donate her body to science", said Tina, who lives in Cymmer with her husband Glan and their daughters.*
>
> *"It's something she feels really strongly about. And she didn't want presents either – she asked everyone to donate to Macmillan."'* ('Brave Liz helps to raise funds for Macmillan', Rhondda Leader, 2 September 2010)

This extract is taken from a newspaper story in which Liz is described as having terminal lung cancer and has '*just three months to live'* (not shown in the extract above). Liz is portrayed as fully aware and seemingly accepting of the situation and not resisting or denying her fate. Instead, she is focussing her energy on 'good causes' and preparing for her dying. This selfless concern for others is a common feature in the stories of dying. Despite the adversity of their own situation, individuals are able to put aside their suffering to protect

their family and friends from pain and suffering, and also help others by fundraising, donating their bodies to medical science and issuing warnings about the dangers of smoking and asbestos. In this way, their dying is presented as a meaningful event. Making death meaningful is discussed explicitly in another story. For example:

Extract 23 Mitzy's story:

Photo source: Backtothebay

'*Mitzy* [in purple]: *"Its funny how the idea of dying is something you can get used to."*

Marilyn: "Well, I suppose sooner or later your mind catches up with what your body's going through."

Mitzy: "Ever the pragmatist, the human brain. I was planning so many things with the time I had. Now I'll have to get used to a new fact. All those months have turned into days, maybe hours. So much for seeing another Christmas."

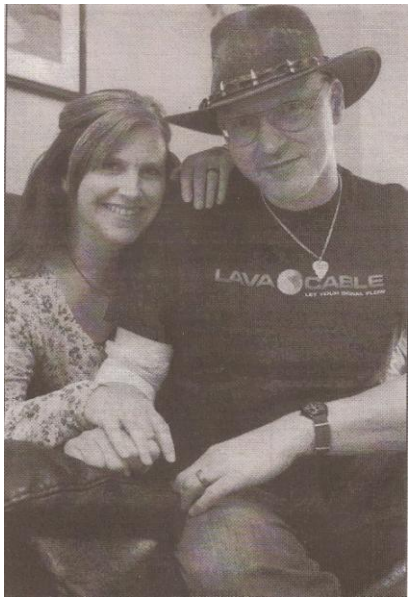
Marilyn: "Well you could still make a start on those plans you had."

Mitzy: "It wasn't really a list of things to do. More a decision to make a difference to people's lives. I'm scared of dying, Marilyn. What if I haven't made an impact in this life? What a waste that would be."'
('Home and Away', Channel 5, 8 November 2010)

This extract is taken from a fictional television story in which Mitzy has told her friends that she is dying of lung cancer after treatment has failed to halt the progression of the disease. In this extract, the need to construct death as a meaningful experience is put into words. Mitzy admits to being scared of dying. However, this fear appears not to relate to the physical aspects of dying but rather to the possibility of not having made an impact in life. In this narrative, a meaningful death is characterised by a life that has not been wasted; one that can be judged to have been worthwhile. Dying, therefore, has implications for how the individual concerned has lived their life; in particular, that they have not wasted it.

Characteristics of what has been described as a ‘good’ death (see p149) are prominent in the stories of dying and those associated with a ‘bad’ death are largely absent. Not only are individuals aware, accepting and selflessly concerned for others, they are portrayed as making the most of their remaining time, able to sort out their affairs in accordance with their wishes, and well-supported by loving family members and friends. Moreover, even though individuals are said to be within weeks and months of their dying, descriptions of physical suffering and bodily deterioration are minimal. In particular, photographs show few if any effects of illness or physical frailty. For example:

Extract 24 Gary H's story:



'But everyday I play my guitars and try to learn some new songs. Music lifts my spirits and I am continuing to play gigs.

I cherish every minute I spend with my children, and as a family we're just trying to lead a normal life. I have decided to leave my guitars to them.

I've had to churn out a will and when we arranged my funeral, it was just surreal, and making light of it made it easier to deal with. But then there are moments when the reality hits me and it makes me sad.

When people ask what music I will have at my funeral, Fiona [Gary's wife] *and I laugh. I am a mad Pink Floyd fan so, of course, it had to be one of their songs – Comfortably Numb.*' ('I've only got months to live', Daily Gazette (Colchester) (Online), 14th September 2010)

In this extract, Gary is portrayed as making full use of his remaining time and making appropriate plans for his dying. Although elsewhere in the story his cancer is described as '*now ravaging my body*', the photograph presented as part of his story does not suggest a significant loss of bodily control or deterioration. Other than a bandage on his right arm perhaps indicating the presence of a chemotherapy infusion device and possible hair loss as he is wearing a hat, little in the way of any physical impact of cancer is portrayed. This structuring of stories to present individuals who are dying of lung cancer

with few, if any, signs of physical suffering or bodily deterioration is evident in all stories of dying. An extreme example is the fictional account of Mitzy in the television soap opera (see the photograph in Extract 23, p153). Throughout most of the story Mitzy appears remarkably well showing no physical limitations or signs of bodily deterioration. Visual signs of illness are limited to when she collapses – once due to a seizure, with the cancer subsequently being found to have spread to the brain, and once due to a stroke that leads to her death. However, following the first seizure and just prior to the stroke, Mitzy is portrayed as functioning normally. She is shown at various times walking along a beach, walking up stairs, carrying baskets of shopping and cooking for friends. Similarly, her death is presented without visible bodily deterioration. Instead, its imminence is indicated by her lying in a hospital bed attached to oxygen tubing and a heart monitor. A few moments prior to her death she is able to speak rationally, albeit in whispers and with fragmented speech, and settle a dispute between friends. Following this, death is signified by the closure of her eyes and a change in the sound of the heart monitor from an intermittent beep to a continuous 'flat-line' beep. In presenting dying in this extremely sanitised form, Mitzy's story suggests an active choice on the part of media producers to shield audiences from images of suffering and bodily deterioration in relation to portrayals of dying of lung cancer.

One story of dying differs from the ten stories discussed so far in that dying is not explicitly discussed but rather implicitly implied. This story is unusual in that it is autobiographical, written mainly in the first person by the newspaper columnist, Cassandra Jardine. Most of the other personal stories of lung cancer are the products of media producers presumably unconnected personally to the individual concerned. The only other exception is a story of survival in which an individual with lung cancer telephoned in to a radio station and gave an account of his experience of the disease as the programme was being broadcast.

Cassandra's story presents a detailed account that charts her near-to-current experiences of living with the disease and its effects on aspects of everyday life. As well as describing the diagnosis and treatment experience, Cassandra is portrayed as contemplating the personal impact of the disease; how it affects her as a person, the adjustments she has had to make because of it, and how her own experience compares with that of

contemporaries who have also discussed their cancer experience in public. Cassandra is also portrayed as contemplating the impact of the disease on her family. She describes the practicalities involved in trying to keep her five children informed as she underwent investigations and the challenge that the disease imposes on her natural parental instinct of trying to protect her children from distress. In essence, therefore, the narrative focus of this story is the everyday 'ups-and-downs' of being diagnosed and living with cancer, rather than surviving or dying of the disease. For example:

Extract 25 Cassandra's story:

'Halfway through a regime of chemotherapy, which makes me feel ironed to my bed one week in three and below par the rest of the time, I am adjusting to a new, less robust reality. Like fellow cancer travellers Michael Douglas and Christopher Hitchins, I am one of many being injected with expensive poisons, hoping to beat the statistics.

In a recent interview Douglas said he was convinced that his throat cancer would make him "a better person". I suspect that's a sentimental notion. All those I've known who have fallen ill have retained exactly the same faults, interests and sense of humour (or lack of it) as before. While I don't expect to become a better person, I am rapidly becoming a better delegator. For that I must thank all those who have uttered the words: "Let me know if there is anything, I mean anything, I can do?"

"Actually, there is," I have learned to say. What started with a tentative "yes" to a dish of lasagne to feed the family is rapidly becoming a habit. Responding to "anything", I've had my freezer defrosted, a sobbing child brought back from a holiday, my clothes darned and

> *ironed, and plenty of new nighties and pillowcases. (I hadn't anticipated my post-chemo yearning for constant clean clothes and bed linen.)* ('THE DAY MY LIFE CHANGED FOREVER', The Telegraph (Weekend), 16 October 2010) (capitals as in the original)

This extract serves to illustrate the narrative focus of Cassandra's story and how it differs from the stories discussed thus far. In the ten stories previously discussed, the experience of lung cancer is described mainly in terms of how individuals are confronting their impending death. There is less scrutiny of the actual impact of the disease on individuals and their everyday lives. However, although not explicitly discussed, dying from the disease is nevertheless implicit in Cassandra's story. It is suggested by an absence of discussion about survival. Unlike '*her fellow cancer traveller*', the actor Michael Douglas, who suggested in public around a similar time that his chances of surviving advanced head and neck cancer were 80% (Brooks 2010), Cassandra's story does not present the chances of her surviving lung cancer. Instead, she is portrayed as '*hoping to beat the statistics*' which suggests that the odds of surviving the disease are not in her favour[8]. The possibility of dying is suggested in other ways elsewhere in the story: in presenting the diagnosis as one that will '*change her life forever*'; in describing her immediate response on hearing the diagnosis as '*What's going to happen to the children*?'; in foreseeing that telling the children would deliver *'such a blow that is bound to send them reeling without being able to, in any obvious way, 'kiss it better'*, and in phrases such as '*seriously ill',* and '*grim diagnosis*'. These ways of discussing the diagnosis draw on discourses that construct a diagnosis of lung cancer as a potential death sentence, so that dying rather than surviving the disease is presented as the more likely outcome for Cassandra.

Cassandra's story draws on a similar narrative to the other stories of dying in that her dying is 'made good'. Indeed, this requirement for the individual concerned to be portrayed as 'dying well' is explicitly expressed:

[8] Cassandra died in 2012.

Extract 26 Cassandra's story:

'"*What's going to happen to the children?" I thought when I heard the bad news. Concern for their future was swiftly followed by worries about the present, principally the need to behave well. My fear was that I would never be able to enjoy anything again – no joke, meal, holiday or gossip with an old friend*.'

And further:

Basking in all this attention, spending leisurely time with friends and relatives, I have, to my amazement, hugely enjoyed the past few weeks. I have also laughed uproariously, which seems a bit unfair as my illness has been horrible for my husband and children.' ('THE DAY MY LIFE CHANGED FOREVER', The Telegraph (Weekend), 16 October 2010) (capitals as in the original)

In this extract, the requirement for individuals faced with a terminal diagnosis to be portrayed as dying well is explicit. Indeed, Cassandra's unfolding story presented over two newspaper magazine supplement articles, recount a counter-narrative to the one she initially feared on hearing the diagnosis. Rather than never being '*able to enjoy anything again'*, an image of life carrying on, even humorously so at times, is presented with her doing the very things she feared she would not be able to do following a diagnosis of lung cancer. In the two extracts above and throughout Cassandra's story, humour is drawn on to present her illness experience. Drawing on humour presents Cassandra as self-effacing rather than self-indulgent and not outwardly courting sympathy or awe for her plight. In doing so, it conforms to the conventions of a heroic narrative similar to the other stories of dying – that of an individual able to face and rise above the adversity of their situation with courage and sacrifice and, moreover, able to retain a sense of humour and fun. Similar also to the other stories of dying, displays of dread and suffering are largely absent. Instead, a narrative of everyday life continuing through the illness experience is presented. This narrative works to normalise the experience of lung cancer, presenting it as endurable and meaningful rather than insufferable and devoid of meaning.

Humour is also identified in the extract presented from Gary H's story above (Extract 24, p155) in which he is portrayed as making a joke about having to

choose songs for his funeral. It is also a feature of other published accounts of journalists' cancer experience of incurable cancer, for example the works of Christopher Hitchens (2012), Ruth Picardie (1998) and John Diamond (1998), and also of interview accounts of men with mostly curable testicular cancer (Chapple & Ziebland 2004). Chapple and Ziebland (2004) identify that humour was used by the men in their study as a device to restore levity, and maintain normality and an equal status, particularly when talking about sensitive or emotive issues or facing potentially difficult or embarrassing situations. In similar ways, humour is identified in the stories of Cassandra and Gary H as a way of reducing the tension and normalising the situation when portraying difficult issues like dying.

Therefore, the overwhelming impression from the stories discussed so far is of an idealised form of death in which individuals are presented as dying 'well'; bravely facing the prospect of death from lung cancer in a state of calm acceptance, showing concern for others rather than themselves and largely in control – not of the cancer and their inevitable fate – but of their essential qualities and in their preparation for death.

In examining the personal stories of breast cancer, similar portrayals of individuals facing their dying whilst they are still living are less evident. Only two women with breast cancer are portrayed within a narrative of imminent dying. In these two stories, although the word 'dying' is not used specifically, one woman is described as 'brave', 'terminally ill', in hospital and too ill to attend a fundraising event that her twin sister who also has breast cancer is participating in as part of Breast Cancer Awareness Month. The second story draws on a similar narrative of dying in open awareness, acceptance and selflessness to the one identified in the stories of dying of lung cancer. For example, the woman's diagnosis of breast cancer is defined as terminal, and she is portrayed as having told her young daughter that she *'was poorly and wasn't going to get better*', and as having made arrangements for her daughter to be looked after '*when the time comes*'.

Where women are described as having incurable or secondary breast cancer, they are more likely to be portrayed within a narrative of actively living with the disease rather than imminently dying of it. This narrative is evident in Extract 8 presented in the previous chapter (pp112-113) in which Lorraine is described

as having incurable disease but has '*vowed to continue with treatment*', saying: '*You've just got to keep on fighting and fighting. If you give up, then I think that's when it gets you. You've just got to get up every day and keep pushing on*'. It is also evident in the following extract taken from a story about a woman who has been diagnosed with secondary breast cancer:

Extract 27:

'Melaine Gardner works in a breast screening unit – but that did not stop her feeling confused and alone when she was told she had developed secondary breast cancer.

The 40-year-old, from Handsworth, Birmingham, was shocked to learn breast cancer cells had spread to another part of her body.

Further in the story:

'"This happens to lots of people everyday, so this campaign is important for people like me who have been diagnosed to realise the support available and remember that life goes on.

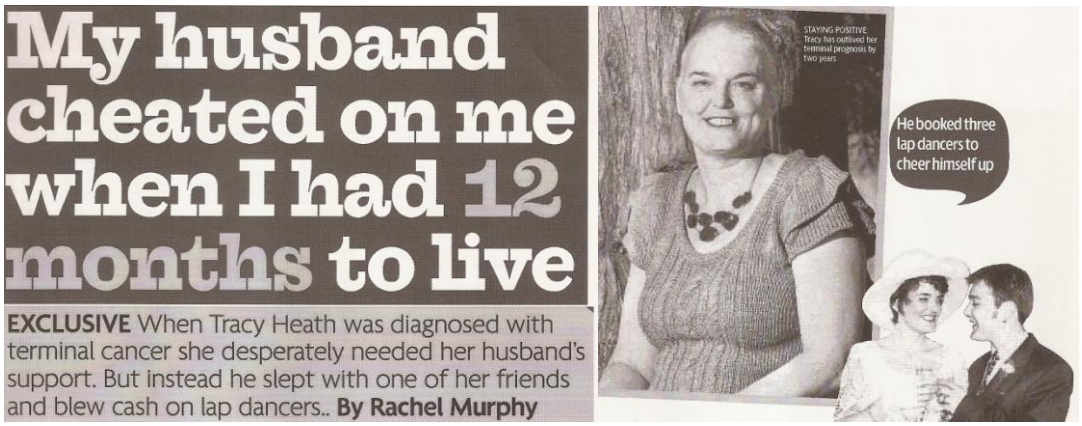
I hope my poster raises awareness for other people to realise there is life after a diagnosis and it is possible to live with it."' ('MELAINE THE NEW FACE OF CANCER CARE', Birmingham Mail, 20 October 2010) (capitals as in the original)

This extract is taken from a newspaper story and is one of number of stories organised to raise awareness of secondary breast cancer as part of the Breast

Cancer Awareness Month initiative. The extract serves to illustrate how this form of breast cancer is presented as an emotional challenge but one that women are able to live with. This contrasts with the construction of lung cancer in the stories of dying in which the disease is portrayed as inevitably and often imminently fatal, and individuals are portrayed as dying of the disease rather than able to carry on living with it. This story is one of only four that present a personal story of a black woman with breast cancer.

In contrast also to the portrayals of individuals dying of lung cancer, only one individual with incurable breast cancer is presented as having been given a time-frame in relation to their remaining lifespan. In this story also, however, the emphasis is on living rather than dying. For example:

Extract 28



'"*It's more than three years since my terminal diagnosis. I am convinced my positive outlook has kept me alive. I'm having chemo to tackle the tumours on my liver, but I don't think I'm going to die soon."*

My oldest daughter has had a beautiful baby girl and I'm a very proud granny, something I never thought I'd live to be. I'm back at work full-time and loving it. I've been on holiday to Las Vegas and the Grand Canyon, moved home and had a couple of enjoyable relationships."' ('My husband cheated on me when I had 12 months to live', Daily Mirror, 27 October 2010)

This extract is taken from a newspaper story. It illustrates that despite an awareness of the incurable nature of her disease and a limited prognosis, Tracy is portrayed as able to live life to the full and resist dying by maintaining a positive outlook.

Therefore, in the personal stories examined, women diagnosed with incurable or secondary breast cancer are more likely to be portrayed within a narrative of actively living with the disease rather than of dying of it. In some stories, being able to live with incurable breast cancer is portrayed as a consequence of the individual's personal determination and strength of character as illustrated by Tracy in the extract above and Lorraine in the extract previously discussed (Extract 8, pp112-113). In other stories the diagnosis of incurable breast cancer itself is constructed as one that women are able to live with rather, than signifying an imminent death. Common to all these stories is that individuals are portrayed in what Willig (2011) has termed 'a cultural imperative to think positively' in the face of cancer even where a terminal diagnosis has been given (p898). Willig suggests that positive thinking in response to a cancer diagnosis is mandatory and death as a possible outcome is not to be acknowledged or talked about, and to do so is constructed as a morbid preoccupation; something unhealthy and illegitimate. Similarly, in the personal stories of individuals with incurable breast cancer, death is constructed as something that individuals can resist by maintaining a positive outlook and concentrating all their resources on living rather than dying. This resistance in the face of life-threatening illness draws on elements of the 'cancer heroics' narrative described by Seale (2002) rather than the 'heroic death' script (Seale 1995a) identified in the stories of dying of lung cancer. In these stories of individuals with breast cancer, and in contrast to the stories examined that portray individuals with lung cancer as dying, it is the individual's resistance in the face of a terminal diagnosis that portrays them as heroic rather than their courage in accepting its inevitability. In a 'cancer heroics' narrative, therefore, accepting one's dying as inevitable and without resistance could construed as 'giving up' and may, thereby, weaken the individual's moral standing.

One remaining lung cancer story of dying contrasts with the previous ones discussed thus far in that it presents a posthumous account of an individual's experience of lung cancer. The account was discussed in Chapter 4 (Extract 3, p105) and reports the death of the Jamaican reggae singer Gregory Issacs. This account contains similarities and also contrasts somewhat with the other portrayals of dying of lung cancer, although it is limited in the amount of detail it presents in relation to Gregory's experience of the disease. Unlike the other stories of dying, a narrative of having faced death in open awareness and

acceptance is not presented. Instead, Gregory is depicted as not having initially accepted the diagnosis and mistrustful of the doctors in London who took a long time to diagnose the disease. He is also depicted as having died following a '*battle*' with the disease. Similar to the other stories of dying, however, lung cancer is portrayed as untreatable and although Gregory is described as having suffered with pain in his knees prior to the diagnosis, his actual death is said to have taken place without pain or suffering and surrounded by his children and grandchildren. In this story, therefore, there is an emphasis on presenting death as a peaceful and calm event; '… *he died in peace. He didn't suffer and he wasn't in pain, and he's gone now to his resting place*', rather than portraying the individual as accepting their diagnosis and preparing for death.

Drawing interpretations from variations identified in a single and relatively brief account is difficult. This story differs from the other accounts of dying in that it presents a posthumous account of an individual's experience of lung cancer – the only text in the lung cancer dataset to do so. Also, it is the only story that presents an account of a black individual's experience of lung cancer, presented in The Voice, a newspaper serving Britain's black community (see: http://www.voice-online.co.uk/). Photographs presented in all but one of the other personal stories of lung cancer show white individuals. Therefore, the variation identified in how death is represented in this story may reflect differences in how posthumous accounts of lung cancer are constructed. It may also reflect cultural variability, both within and between cultures, in how death and dying are sometimes constructed. Depicting death as returning to one's resting place may be a religious reference in which dying is constructed as a spiritual journey rather than a psychological one as in Seale's analysis (2002). When Seale examined his media accounts for religious themes he found that these were rare, particularly in UK media (Seale 2001b). In his analysis, he suggests that generally media portray secular women and men finding strength within themselves to face cancer and the possibility of their dying rather than in religion. However where religious themes were present, they were more likely to be confined to particular social and ethnic groups. In contrast, an analysis of personal stories of cancer published in magazines directed at a predominant readership of African-American women, identified religion as a dominant narrative theme (Hoffman-Goetz 1999). In this study, language used to invoke military or struggle imagery was identified as being

metaphorically linked with a spiritual quest, for example in the depiction of a breast cancer survivor as a '*courageous Christian crusader*' (p43). A further theme identified in this study was 'negative interactions with the medical system' particularly in relation to European-American medical institutions and communication of the cancer diagnosis – a finding that may be consistent with the portrayal of Gregory's diagnosis experience in the extract discussed above and presented on page 105 (Extract 3). A further study, this time of interview accounts of individuals with advanced cancer in South East London, identified that religious beliefs were drawn on by some people to understand and transcend their experience of pain and suffering, and this was more evident in the accounts of Black Caribbean individuals than White British individuals (Koffman et al. 2013). Therefore, accounts of individuals from different cultural and social groups are likely to construct the experience of cancer differently. However, in the stories examined for this thesis, most individuals dying of lung cancer are not identified as being portrayed in relation to their religious beliefs and, as suggested by Seale (2002, 2001b) it is their inherent strength of will and the support of their family and friends rather than their religious beliefs that are depicted as enabling them to face and accept their dying.

In examining the breast cancer dataset, although individuals with breast cancer are less likely to be portrayed as dying whilst they are alive, posthumous accounts of the experience of the disease are more commonly identified than in the lung cancer dataset. This was observed in the previous chapter (pp101-107). There are twelve such stories identified in the breast cancer dataset compared with the one story in the lung cancer dataset. As discussed briefly in the previous chapter, these posthumous accounts portray women with breast cancer within a heroic narrative of having courageously fought against the disease and their dying, concerned more for the welfare of those around them than their own plight and leaving a legacy to inspire others. This is identified in Extract 4, presented in Chapter 4 (p106-107) in which Gemma is portrayed as fighting the disease with determination and courage, and doing everything she can to protect her children from the harsh realities of the diagnosis and her dying. Similar to the portrayal of individuals with incurable breast cancer discussed above, displays of calm acceptance of the inevitability and imminence of dying are not a feature of these stories. Instead, individuals are more likely to be portrayed within a narrative of resisting their dying for as

long as they possibly can. This is also evident in the extract from Gemma's story in which she is defined as: '*… strong, determined and stubborn. There was no way cancer would get the better of her'*, and also in the portrayal of her having '*dragged herself out of her deathbed*' and '*hauled herself out of her wheelchair with her last ounce of strength*' in order to attend her son's first day at school. This portrayal of women stubbornly fighting against the inevitability of dying is also illustrated by the following extract:

Extract 29 Alison's story:

MUMMY WITH ANGELS NOW

Alison loses 3rd fight with cancer

By Dan Charles
dan.charles@gloscnedia.co.uk

"MUMMY'S body is broken and she has gone to live in a castle in heaven with the angels".

That was how four-year-old Amelia learnt her darling mum Alison Edgcumbe had lost her battle with breast cancer.

Alison, 44, was crowned as *The Citizen*'s mum of the year in March 2008.

Last night her partner Tony Bullock, 46, said: "She put everyone else first with never a thought for herself."

"Only two weeks ago we took our daughter Amelia to Blackpool to see the lights, because that's what Alison did when she was a girl and she wanted Amelia to see them too.

"It's so sad for everyone."

Alison, who was a catering manager for Busy Bees childcare Ltd, was battling her third bout of cancer when she succumbed to the disease.

She had endured chemotherapy, radiotherapy and surgery in her fight against the disease.

She first detected a problem in 2007 but recently was told it had returned. This time it was incurable.

"She battled through and

one who has had cancer will know how awful it is.

"But she lost the battle."

He added that the pair of them, along with Amelia, had a busy year as Alison put together a list of things to do when she realised her cancer was untreatable.

Tony said: "We spent 10 days going around Scotland, which was lovely, and we had Amelia christened on September 4 at Down Hatherley Church, which was also really nice.

"We had a really great time. Although she was ill, she wasn't exactly poorly with it, or she didn't show it at least. When it happened it came really suddenly."

Her son Jamie, 16, spoke of the pride he had for his mum who he put forward for our Mother's Day Special awards last year.

He said: "I nominated without her knowing, and she was overwhelmed when she found out.

"She was so loving and warm, and she was always looking out for other people."

Alison, from Cheltenham Road in Longlevens, died on October 7.

She leaves Tony, her two

Tuesday at 12.30pm.

Friends and family are welcome.

Alison's the bravest of the brave

WINNER: How we told Alison's story last year

'*Alison, who was a catering manager for Busy Bees Childcare Ltd, was battling her third bout of cancer when she succumbed to the disease. She had endured chemotherapy, radiotherapy and surgery in her fight against the disease.*

She first detected a problem in 2007 but recently was told it had returned. This time it was incurable. "She battled through and through, and dealt with whatever was thrown at her," added Tony, who had spent the last five years by her side. "She had chemotherapy three times, and anyone who knows anyone who has had cancer will know how awful it is. But she lost the battle."

He added that the pair of them, along with Amelia [their daughter], *had a busy year as Alison put together a list of things to do when she realised her cancer was untreatable.*' ('MUMMY WITH ANGELS NOW: Angela loses 3rd fight with cancer', Gloucester Citizen, 16 October 2010)

In this extract taken from a newspaper story and similar to the findings of Seale (2002), metaphorical language is used to portray Alison within a dramatic struggle for life. Despite being aware of the terminal nature of her disease, she is shown as having done everything possible to avoid dying of it; enduring numerous treatments and '*whatever was thrown at her*' rather than accepting the inevitable without a fight. Similar to the stories of women living with incurable breast cancer, therefore, individuals who have died of the disease are presented within a narrative of heroic resistance; as bravely battling to continue living their lives to the full, rather than giving into the disease and accepting their dying.

Across the personal stories of dying, 'struggle language' (Seale 2001a) (for example, 'fighting', 'battling', 'beating') is more prevalent in accounts of breast cancer than lung cancer. In the breast cancer stories, eight of the thirteen individuals are described as having battled or fought against the disease. In contrast, the use of struggle language is apparent in only four of the thirteen lung cancer stories and in two of these is not used to directly position the individuals as fighting to overcome the disease and their dying. Rather, in one story, the individual's fundraising efforts are described as helping to '*fight against the disease*' and in the other story Gary H, the man depicted in Extract 24 (p155) who has 'churned' out his will, is said to be '*determined to beat this disease mentally*'. One of the two remaining stories is the report of Gregory Isaacs death discussed above and in Chapter 4 (Extract 3, p105). Gregory is portrayed as having '*died following a battle with lung cancer*'. As discussed previously, this is the only posthumous account of the experience of lung cancer and it draws less on a narrative of dying in open awareness and acceptance. The remaining story is also unusual in that although the individual is portrayed as confronting her death in open awareness and acceptance, she is also portrayed as not accepting its imminence as inevitable. For example:

> Extract 30 Christine J's story:
>
> '*A brave grandmother, given just two months to live after a tumour was found on her lung more than two years ago, has spent that time raising more than £14,500 for cancer charities.*

> *Instead of accepting her fate, Christine, from Pentraeth on Anglesey, set about raising awareness of cancer and with family and friends raised thousands of pounds to ease the suffering of fellow patients. That battling spirit ensured she was around for the magical moment of the birth of her second grandchild Jessica*.' ('I've held on to see Jessica born: Gran's brave battle against cancer', Daily Post (Liverpool), 24 November 2010)

An extract from this story is also presented on page 151 (Extract 21). In the extract above, Christine J is portrayed as having initially resisted the inevitability and imminence of her terminal diagnosis in order to raise awareness and money for cancer and, as a consequence, has managed to 'hold on' long enough to witness the birth of a second grand-daughter. This is the only personal story that portrays an individual with lung cancer as both dying and battling against their prognosis. As such, it contrasts with most of the other stories of dying of lung cancer in which individuals are portrayed as having calmly accepted the inevitability of their fate and it shares similarities with the accounts of breast cancer in which displays of heroic resistance are common. However, elsewhere in Christine's story and unlike the stories of breast cancer, her acceptance of the imminence of her dying is reinforced. Christine is presented as having arranged her funeral, and written cards and letters to her family for birthdays and significant events after her death. She is also described as having been given just two more months to live and not able to '*escape the fact that the disease will finally kill her*'.

In summary, in the stories that are grouped as 'accounts of dying' an individual's personal experience of lung cancer is presented in terms of their dying of the disease. In these stories, medical efforts to control lung cancer are presented as ineffective and death is constructed as an inevitable consequence of the diagnosis. The individuals concerned are mostly portrayed within a 'heroic' death narrative similar to the one described by Seale (1995a) in which they are depicted as confronting their dying with courage and self-sacrifice. In two stories, variations to this narrative are identified. In one of these, the individual is portrayed as not only facing her dying but also as having resisted it for a considerable length of time, managing to stay alive to raise money and awareness for cancer and see the birth of a grand-daughter. In the second account, a narrative of acceptance is less evident. Instead, the individual is

portrayed as initially resisting the diagnosis and death is reported to have followed a battle with the disease. This story is also unusual in that it is the only posthumous account of the experience of lung cancer identified in the dataset. It is also the only account of an individual who is black. In the other accounts where images are shown, the individuals are white.

In contrast, individuals (mostly women) with breast cancer are less likely to be portrayed as dying whilst they are living with the disease, or to be portrayed as accepting death as an inevitable or imminent consequence of their diagnosis. Where women are identified as having incurable breast cancer, they are presented as determined to carry on living their life to the full by not giving into the disease, adopting a positive mental attitude and continuing on with treatment. In this way, the stories draw on elements of the 'cancer heroics' narrative described by Seale (2002). Only two stories portray women as dying of breast cancer. In one of these, dying is implicit. In the other story, a 'heroic death' narrative similar to the one in the lung cancer stories is identified in which the individual is facing her death in open awareness, acceptance and sacrifice (Seale 1995a). In contrast also with the lung cancer stories, posthumous accounts of the experience of breast cancer are more commonly presented. These stories also draw on a 'cancer heroics' rather than a 'heroic death' narrative, in that the women concerned are portrayed as only having succumbed to the disease and their dying following a courageous battle to do everything in their power to avoid doing so.

Despite the differences identified between the two datasets, personal accounts of dying of lung cancer and breast cancer share similarities in that they both position the individual concerned within a heroic narrative; either to portray them as brave in their confrontation and acceptance of death or as brave in their resistance of it. Both also portray the individuals as well-supported by family and friends with little sign of the physical suffering and bodily deterioration that might be associated with advanced cancer. In these accounts, therefore, dying of either disease is constructed as a 'good' death. In contrast, however, death is constructed as an inevitable fate for individuals diagnosed with lung cancer but something that can be resisted for individuals diagnosed with breast cancer.

5.2.2 Accounts of survival

In contrast to the twelve personal stories of lung cancer examined so far, the remaining eleven personal stories present an account of an individual who is portrayed as having survived lung cancer or as living with the disease rather than dying of it. These stories all share a similar narrative structure in that they present a personal account of being diagnosed and treated for lung cancer within an overall story aimed at raising awareness of the disease. All but one of the stories is identified as being in response to the Lung Cancer Awareness Month initiative. This contrasts with the accounts of dying; only one of which is identified as being in response to the awareness initiative.

Whereas the accounts of dying associate a diagnosis of lung cancer with an inevitable death, the accounts of survival are organised to persuade audiences – the public – that death is not necessarily an inevitable or imminent consequence of the disease and that surviving it is possible. In this narrative, the account of lung cancer is presented as a 'good news' story. Diagnosis and treatment are portrayed in a positive light; as efficient, effective and well-tolerated, and individuals who develop the disease are shown as being able to resume active lives once treatment is completed, with little in the way of adverse effects from either the cancer or the treatment. Extract 7 (pp110-111), discussed in the previous chapter, provides a typical example. In this story, Lynne Hughes-Jones' experience of surviving lung cancer following complex surgery is presented. The overall account is organised to persuade readers that despite what they may think (i.e. that '*lung cancer is a notoriously difficult form of the disease to treat successfully*'), it is in fact possible to survive the disease as long as '*it is diagnosed early enough*'. Lynne provides living proof of this message. Her cancer was diagnosed early enough to be suitable for surgery, she has survived and is back enjoying her role as a grand-mother. At the end of the story, Lynne is presented as directly advising the public of this message: '*I want to let people know that cancer is not necessarily a death sentence and there are those dedicated people who are prepared to go the extra mile to help you.*' This portrayal serves as a final rallying call and summarises the overall message of the story.

Two stories present accounts of individuals who are currently receiving treatment for the disease. These differ from the other accounts in that the

individual is not portrayed as a survivor and cure is not explicitly presented as a potential outcome. In one account in particular, the cancer is described as inoperable and incurable. However, both follow a similar narrative structure to the other accounts of survival in that they are oriented to promoting public health messages in response to the Lung Cancer Awareness Month initiative, and portray the disease as being effectively controlled so that the individual is able to get on with their life with minimal effects. In this narrative, therefore, the two accounts differ from the 'accounts of dying' in which the outcome for individuals with incurable or terminal lung cancer is portrayed as certain death rather than life continuing on. For example:

Extract 31 Gary T's story:

SO MUCH HELP IN MY CANCER BATTLE

Gary praises wife and specialist care staff

by Katie Bond
kbond@swindonadvertiser.co.uk

WITH LUNG Cancer Awareness Month now upon us, pensioner Gary Turner has spoken of his battle with the life-threatening disease.

The 76-year-old, of Shrivenham, was diagnosed with the disease in August 2007, and has since undergone radiotherapy and four cycles of chemotherapy, which proved successful in shrink-

for three months at Oxford and then visited Jane Gray, Macmillan Lung Cancer Nurse Specialist at the Great Western Hospital to ensure his illness was closely monitored.

"After the radiotherapy I was fit as a flea," he said.

"I had no pain at all and that lasted about three months before the pain crept back, I had regular visits to Jane but I was fighting fit.

with, my wife has been an absolute brick, I have stayed positive and we have got through it together."

Mrs Turner, also 76, added: "The nurses and doctors, especially Jane Gray, have been absolutely brilliant - Jane was always there on the end of the phone if you had any worries, you could always call her with any questions you may have had."

Lung cancer nurse specialist Jane Gray added: "Gary's cancer has shrunk, he has had a very good response to the chemotherapy and he looks fabulous. He is back to enjoying his life."

EVERYTHING TO LIVE FOR Gary and Jane Turner
Picture: SIOBHAN BOYLE

'With Lung Cancer Awareness Month now upon us, pensioner Gary Turner has spoken of his battle with the life-threatening disease. The 76-year-old, of Shrivenham, was diagnosed with the disease in August 2007, and has since undergone radiotherapy and four cycles of chemotherapy which proved successful in shrinking his cancer.

The father-of-three said he originally visited the doctor with chest pains but lung cancer never occurred to him, despite smoking since he was 17.

My doctor broke the news to me, cancer had never crossed my mind to be honest but I wasn't surprised. "My wife Jane broke down when we were told, but I just thought I had to get on with it."'

Further in the story:

'"I was quite nervous about having chemo but I was very lucky. Jane [his specialist nurse] *was very specific about what reaction you could*

> *have, but I had nothing apart from being quite sleepy and that is what everybody gets, I responded very well to it.*
>
> *I'm feeling fine now and I'm back to enjoying life.*
>
> *It was a traumatic time to start with, my wife has been an absolute brick. I have stayed positive and we have got through it together."'* ('So much help in my cancer battle: Gary praises wife and specialist care staff', Swindon Advertiser, 11 November 2010)

This extract is taken from a newspaper story. The account follows a similar narrative pattern to the other accounts of survival of an individual being diagnosed and effectively treated for lung cancer within an overall story aimed at raising awareness of the disease. Despite the diagnosis of '*life-threatening*' disease, following treatment Gary is described as '*feeling fine*' and '*back to enjoying his life'*. Therefore, unlike the accounts of dying, Gary is portrayed within a narrative of being able to live with lung cancer rather than inevitably and imminently dying of it. In this way, the account shares similarities with the breast cancer accounts discussed in the previous section of this chapter in which women diagnosed with incurable disease are also portrayed within a narrative of living rather than dying. Similar to these portrayals, rather than engaging with dying Gary is shown to be able to carry on with life, despite the diagnosis, by continuing on with treatment and staying positive. Therefore, the stories of surviving lung cancer, like most of the breast cancer stories, draw on a restitution-type narrative (Frank 1995), in which a trajectory from health to sickness and then recovery is plotted.

Within these stories, individuals with lung cancer are positioned as exemplars and spokespersons to promote specific public health messages about the disease. These messages present smoking as the main reason that lung cancer develops, and awareness of symptoms and seeking medical advice promptly as behaviours that lead to early diagnosis and survival. Public ignorance and negative perceptions of the disease are presented as factors that lead to late diagnosis and poor survival. These messages act to place power and agency with individuals to prevent the disease, bring about their own earlier diagnosis and avoid early death. However, in doing so, they present surviving the disease as largely contingent on individuals amending aberrant behaviours in relation to smoking and presenting late for diagnosis.

Factual information about lung cancer is also presented as part of these stories, either woven into the individual's personal stories or presented in stand-alone sections within the overall text. This information is didactic in quality and, as discussed in the previous chapter in relation to stories oriented to raising awareness in general, it constructs lung cancer in largely problematic ways; emphasising its associated high incidence and mortality, poor survival, links with smoking, and relative neglect in terms of research activity. Whilst these messages provide a rationale for the need to improve awareness of the disease, they may act to undermine the 'good news' message promoted in the stories, particularly in relation to survival since they emphasise the large number of people who do not survive and the persistently poor survival rates associated with the disease. Therefore, an overwhelming impression from examining the stories of survival is the dominance of a public health discourse in which dying of lung cancer is presented as a consequence of smoking and presenting late for diagnosis, and survival is portrayed as largely a victory of medical effort. In this discourse, survivors of lung cancer are positioned as the lucky few; lucky to have survived the odds particularly if they have caused the disease to develop in the first place by having smoked.

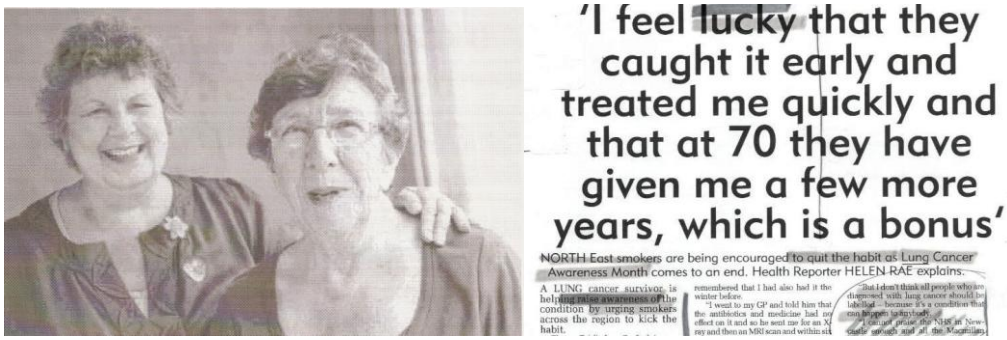
Some of these narrative features are illustrated by the two extracts discussed in this section so far. For example, in Extract 7 presented in Chapter 4 (pp110-111), Lynne is portrayed as having survived lung cancer. However, her survival is presented as a consequence of the '*expertise of doctors*' and the '*complex surgery*' she received. Further into the story (not shown in the extract) a detailed account of the '*nine-hour procedure*' requiring '*two surgeons backed up by an eight-strong team'* is presented, including comments from the doctors involved. Within this account, it is the medical team rather than Lynne who are portrayed in heroic terms; as technical experts who were '*prepared to go the extra mile to help*' her. In contrast, Lynne is positioned as having potentially caused the disease to develop by having smoked in the past and her role in having survived is portrayed in more passive terms; as that of a grateful patient who has been '*given'* a new lease of life by the team of specialists looking after her. Elsewhere in the story she is credited as saying: '*I think I was very lucky that they agreed to do it, that they were willing to take it on. I can't find the words to thank him* [the surgeon] *enough*'.

The extract from Lynne's story also illustrates how messages that lung cancer can be survived are countered by epidemiological information that portrays the disease as one that '*more people die of than any other cancer*' and where '*there has not been any discernable improvement in survival rates'* in the last 20 years. This information, as well as details within the story that present lung cancer as notoriously difficult to treat successfully and the cause of her ex-husband's death, also works to position Lynne as lucky in having survived the disease.

In the extract from Gary T's story above (Extract 31, pp171-172), although elements of a heroic narrative are drawn on to portray Gary as being in a *'cancer battle*' and as having got through his cancer experience by staying positive, the account is also shaped by a narrative of having caused his disease to develop through smoking from a young age and having survived with the help of others around him. Near to the beginning of the story Gary, like Lynne discussed above, is identified as a smoker and, moreover, as lacking in agency in his initial response to the disease since he did not associate his symptoms with the possibility of lung cancer '*despite smoking since he was 17*'. The use of the word '*despite*' followed by details of the length of his smoking suggests this was something he should have foreseen and presents him as somewhat negligent in health matters rather than heroic. In this story also, the role that others played in Gary's survival is prominent. In the headline of the story Gary is portrayed as praising his wife and specialist care staff in helping him in his battle with cancer. Further, a detailed account (within the main narrative of the story and also in a separate text box) of the role his Macmillan nurse played in ensuring that '*his illness was closely monitored*' and that '*patients get their investigations and treatment as urgently as possible*' is presented (not shown in the extract above).

Another extract from the data is used to illustrate further how the stories of surviving lung cancer are shaped by the public health messaging function of the overall account:

Extract 32 Eleanor's story:



'I feel lucky that they caught it early and treated me quickly and that at 70 they have given me a few more years, which is a bonus'

NORTH East smokers are being encouraged to quit the habit as Lung Cancer Awareness Month comes to an end. Health Reporter HELEN RAE explains.

A LUNG cancer survivor is helping raise awareness of the condition by urging smokers across the region to kick the habit.

remembered that I had also had it the winter before.

"I went to my GP and told him that the antibiotics and medicine had no effect on it and so he sent me for an X-ray and then an MRI scan and within six

But I don't think all people who are diagnosed with lung cancer should be labelled — because it's a condition that can happen to anybody.

I cannot praise the NHS at Newcastle enough and all the Macmillan

'NORTH East smokers are being encouraged to quit the habit as Lung Cancer Awareness Month comes to an end. A lung cancer survivor is helping raise awareness of the condition by urging smokers across the region to kick the habit.

Eleanor Fairlie from Gosforth is supporting NHS North of Tyne mark Lung Cancer Awareness Month this November by reminding smokers of the vast free stop smoking services available.

Former civil servant Eleanor has been in remission for a year and nine months having the cancerous lower lobe of her left lung removed.

The mother-of-one had been a light smoker for 50 years but had visited her local chemist for support to quit with the use of patches (nicotine replacement therapy).

Eleanor had successfully quit for a year when she developed an unusual cough.' ('I feel lucky that they caught it early and treated me quickly and that at 70 they have given me a few more years, which is a bonus', Evening Chronicle (Newcastle), 29 November 2010) (capitals as in the original)

This extract is taken from the opening paragraphs of a newspaper story in which Eleanor's personal experience of lung cancer is presented in an account aimed at encouraging the public to stop smoking as part of the Lung Cancer Awareness Month initiative. The first half of the story presents Eleanor's experience of the disease and the second half presents detailed information about local smoking cessation services. The extract above illustrates how the account of Eleanor's personal experience of cancer is organised to promote the overall smoking cessation message. Eleanor is cast as a human exemplar for

the message. She provides living proof of the consequences of smoking and also that cessation is possible even after 50 years of smoking. Elsewhere in the account other details of her experience of lung cancer are presented. These include her early diagnosis after she attended the GP as soon as she developed an '*unusual cough*', her successful treatment with surgery and chemotherapy, and her return to health and active living. These aspects of Eleanor's experience (smoking history, being diagnosed promptly after experiencing symptoms, receiving swift and effective treatment by specialists, and life resuming) characterise the personal stories presented in these accounts.

In the accounts of survival, therefore, it is a public health discourse aimed at instructing the public how to avoid developing and dying of lung cancer that is dominant and shapes how the individual's experience of the disease is portrayed. In this discourse, displays of personal heroism are less evident. This is particularly apparent in examining the personal stories of surviving breast cancer. These stories share similarities with the ones of surviving lung cancer in that they recount how the individual concerned was diagnosed and treated, with life resuming or carrying on alongside treatment, within an overall account oriented to raising awareness of the disease. Also similar is that individuals surviving breast cancer are portrayed as grateful recipients of efficient and effective treatment, and as exemplars and spokespersons for public health messages about the disease, particularly in the case of breast cancer in relation to the need for early diagnosis and presenting for screening if invited. However, in contrast, individuals with breast cancer are often presented in ways that suggest a more active and energetic response to the disease, and a personal role in their survival. For example, woman are frequently portrayed as being in a state of high alert with regards the possibility of breast cancer and quick to recognise the significance of a lump or breast changes; quicker sometimes than their GPs when medical advice was initially sought. This presents women as cognisant of their risk from breast cancer and proactive in detecting the disease, contrasting with a message commonly promoted in stories of surviving lung cancer (and evident in Extract 31, pp171-172 from Gary T's story) that suggests a general lack of public awareness of the disease and a reticence in reporting symptoms which, in turn, may hamper medical efforts to diagnose and treat the disease effectively.

Also in contrast, 'struggle language' (Seale 2001a) is used more frequently in the breast cancer stories, not only to portray women as actively battling or fighting the disease but also to position them as having personally triumphed over it. Treatment for breast cancer, unlike lung cancer, is presented as a tough ordeal in terms of both its physical and emotional impact, so that 'getting through it' is portrayed as a heroic achievement in itself. Having got through the ordeal, as Seale (2002) identifies, women are also portrayed as keen to make sense of the experience and create something positive from it – either in terms of their own personal development so that they become a 'better' person, or to help others by raising awareness and money, or both. These narrative features observed in the breast cancer stories act to present the individuals involved, mainly women, as more than passive recipients of expert care and exemplars for public health messages. Women with breast cancer are portrayed as having greater agency in their response to the disease; battling to ensure their own personal survival, working hard to transform a negative event into something positive and meaningful, and participating in wider activities aimed at eradicating the disease in general. In comparison, portrayals of individuals surviving lung cancer lack a similar degree of agency.

Some of these features of the breast cancer stories are evident in extracts previously presented. Extracts 8 (pp112-113) and 9 (pp114-115) in Chapter 4 illustrate how individuals with breast cancer are portrayed in ways that suggest an active and heroic response to their cancer diagnosis and can be compared with extracts from the lung cancer stories discussed above. For example, Extract 8 (pp 112-113) from Lorraine's story can be compared with Extract 31 (pp171-172) from Gary T's story as both extracts present individuals who are depicted as living with cancer rather than having survived it. Despite a diagnosis of terminal breast cancer, Lorraine is portrayed as '*brave*' in her avowal to continue with treatment and as '*fighting and fighting*' and '*pushing on*' rather than giving up and letting the disease '*get*' her. Elsewhere in the story, she is described as wanting to raise money for the disease to show that she is '*full of the fighting spirit*'. This imagery presents a physical and energetic response to the diagnosis of breast cancer; Lorraine is fully engaged in efforts to control her own cancer as well as participating in the wider fight against the disease. The portrayal of Gary T's battle against lung cancer is passive in comparison. Rather than full of fighting spirit, he is described using

less vigorous language – as initially '*quite nervous about having chemo'* and having got through his cancer experience by staying positive, and with the support of his wife and specialist nurse.

Extract 9 from Bernie's breast cancer story (Chapter 4, pp114-115) can be compared with the extract from Lynne's lung cancer story discussed above and presented in Chapter 4 (Extract 7, pp110-111). Both stories share a similar overall narrative of an individual receiving complex surgery and being cured of their cancer. However, Bernie is portrayed in ways that suggest a more spirited response to the experience of having breast cancer and her survival is presented as a personal achievement. For example, she is depicted as '*feisty*', using expletives, punching the air and '*so glad*' to have '*won her battle*' against the disease. She is also described as '*inspirational*', helping others by filming a candid video diary of her illness experience, planning to resume her career where it left off by '*STRIPPING OFF*' for the stage-show Calendar Girls and proud to show her surgical scars to her daughter and publicly on stage. In this extract and elsewhere in the story, the ebullient narrative acts to emphasise Bernie's emotional transformation from being initially scared and apprehensive of the diagnosis and prospect of surgery, to taking control of her survival and future, and able to reconcile the experience as merely an '*interruption*' in her life that has enhanced rather than diminished her character. In contrast, Lynne's story recounts a much quieter and less animated experience in relation to her survival from lung cancer, and similar imagery of a personal victory over the disease is not drawn upon. Although Lynne is also portrayed as being '*filled with fear*' and '*very scared'* on learning the diagnosis, a large proportion of her story relates to the surgery she received and the professionals looking after her rather than her own actions and emotional response to the cancer experience, and her survival is characterised by portrayals of gratitude rather than personal triumph.

An additional extract from the breast cancer data is presented to illustrate further the differences observed between the two datasets, particularly in relation to how individuals with breast cancer are portrayed as having influenced their diagnosis, experience of and survival from the disease.

Extract 33: Catherine's story:

Mum will use her cancer battle to raise awareness

Real life

This week marks the start of Breast Cancer Awareness Month, a yearly campaign which aims to promote understanding of the disease. **Zita Collinson** meets mum-of-four Catherine Bennett who was diagnosed with the illness in 2009

Catherine Bennett, second from right, with daughters, from left, Hannah , aged 25, Liz , aged 16, and Rebecca , aged 13.

EVERY year nearly 46,000 women find out that they have breast cancer.

toddler group, she is a governor at Churnet View Middle School and

down. My legs went to jelly.

"My husband and I were both

'*Mum-of-four Catherine Bennett is only too aware of the importance of self-examination. Over a period of nine years, she found seven lumps in her breasts. All were benign except for the last, which was cancerous.'*

And further:

'"My husband and I were both shocked and frightened. But my children have known everything from the word go. Nobody could speak to them and tell them something that we haven't informed them of already. If I hadn't told them the truth, would they ever believe me if I tell them anything now? We decided that Team Bennett would beat it."

Catherine had 12 doses of chemotherapy over 8 months. This was followed by radiotherapy, which she finished in May. "I really did feel ill with the chemotherapy," says Catherine.'

And further:

'Now recovering from the past year and gradually regaining her strength, Catherine has begun to think about how she could use her own experiences to help others. In August, at the Leek Show, she filled a Mini car with bras and asked people to guess how many there were in return for a £1 donation. So far she has raised £2,070 for Breakthrough Breast Cancer. "I felt all along that if I've been given this cancer, I've been given it for a reason," she says. "That reason was probably to raise awareness and money for charity."' ('Mum will use her cancer battle to raise awareness', Sentinel (Stoke-on-Trent), 5 October 2010)

This extract, taken from a newspaper story, presents a small part Catherine's account of breast cancer which, like the stories of surviving lung cancer, provides details of her diagnosis, treatment and recovery within a story aimed at raising awareness of the disease. In this extract, Catherine is portrayed as highly aware of the potential risk of breast cancer and the need to detect the disease early in its course; she has been keeping a watchful lookout and over a period of nine years has detected seven lumps in her breasts. She is also portrayed as having quickly taken control of her cancer experience. Despite the initial shock and the fear created by the diagnosis, she and her family decided they were going to beat the disease. Finally, having recovered from being really ill from the treatment, Catherine is depicted as keen to use her experience of cancer to create something that will benefit others. These narrative features present Catherine as an active agent in response to the physical and emotional threat posed by cancer. They serve to illustrate how the stories of individuals surviving breast cancer draw on elements of Seale's (2002) 'cancer heroics' narrative in which individuals are positioned in '*a self-willed victory over cancer*' (p107) involving displays of personal courage and emotional transformation.

In his analysis of media stories of people with cancer, Seale (2002) identified that women surviving breast cancer were often portrayed within a narrative of having changed priorities and being on a mission to raise awareness and money in response to their diagnosis and experience of the disease, as if '*led by* a *mystical higher power to their calling*' (p116). In contrast, he identified that men with cancer were less likely to be shown as getting involved in charity or awareness raising events, or experiencing changed priorities as a result of their experience. Elements of these features of texts are identified in the personal accounts of breast cancer examined for this thesis particularly in relation to the portrayal of women as illustrated by the extract above. Catherine is depicted as having been '*given*' cancer for a reason; that of raising awareness and money for charity. In contrast, where women or men surviving lung cancer are identified as developing new understandings and/or undergoing self-transformation as a consequence of their cancer experience, it is more likely to be portrayed in terms of correcting behaviours in relation to smoking, and monitoring their health more closely and warning others to do the same. For example:

Extract 34 Janet's story:

'*Janet is now in remission and her positive outlook helped her live life to the full. "I used to have a cigarette and a coffee instead of lunch," she said. "Now I'd rather have a sandwich!"'*

Janet said: "There are lots of reasons why you might get any of the symptoms. If it's not serious, you will have peace of mind. If it is lung cancer, it needs treating quickly. It is worth getting yourself checked out – make an appointment with your GP straight away."' ('How Janet has beaten lung cancer', Rugby Advertiser, 11 November 2010)

This extract is taken from a newspaper story. It provides a comparison with the previous extract from Catherine's story (Extract 33, p179) in which the experience of cancer is portrayed as a transformative one; inspiring Catherine to raise awareness and money for charity. The extract above is taken from one of the lung cancer accounts that draws on 'struggle language' and elements of a heroic narrative to position the individual as having agency in relation to surviving the disease. Janet has beaten lung cancer and her positive outlook has helped her live life to the full. However, the dominant public health discourse that runs through the account acts to undermine this heroic positioning. For example in this extract, Janet's personal transformation from the experience of cancer is presented in terms of developing an understanding of the importance of not neglecting her health as she has done in the past. Elsewhere in the story, details of her smoking from the age of 15 until the diagnosis is presented as a decision that '*would nearly cost her her life*' and when her symptoms developed, including a persistent cough and chest

infections, she is described as being unaware of the risk of lung cancer and credited with saying: '*not for one minute did I think I had lung cancer*'. This portrayal contrasts with the account of Catherine's experience of breast cancer in which she is depicted as fully aware of the risk of breast cancer and diligent in surveying her body for signs of the disease. Furthermore, although Janet is portrayed as taking part in the Lung Cancer Awareness Month initiative by telling her story to raise awareness in relation smoking cessation and early diagnosis, unlike Catherine, she is not shown as having been inspired by her experience of the disease to participate in and/or initiate activities in support of the wider fight against the disease. Only one of the accounts of survival presents an individual with lung cancer as participating in activities to raise money for research. This is the story of Herbie, a 91-year-old gentleman who has survived lung cancer for twenty-five years. Following his recovery, he is said to '*go to fundraising events for Cancer Research UK*' (rather than lung cancer specifically). This feature of the accounts of surviving lung cancer not only contrasts with the accounts of breast cancer (whether individuals are living or dying), it also contrasts with the accounts of dying of lung cancer in which some individuals are portrayed as fundraising in response to being diagnosed with the disease (see for example, Extract 22, p152 and Extract 30, pp167-168) thus portraying them as heroic in their dying. Similar to Herbie's story, however, the individuals concerned are portrayed as raising money for cancer in general rather than lung cancer specifically.

Accounts of women with breast cancer formed a large proportion of Seale's (2001a, 2002) dataset of media stories (i.e. 46% of texts overall and 73% of those involving women with cancer). In his analysis, Seale argued that women were frequently portrayed in relation to their emotions; engaged in what he describes as 'emotional labour' to turn their initial negative feelings in response to the diagnosis of cancer into positive ones that could be used to move on from the experience/and or benefit others through raising awareness and charitable acts. Men, on the other hand he suggested, were more likely to be portrayed as drawing on existing strengths of character such as altruism, courage, determination and stoicism to help them rise to the challenges that cancer posed. In the personal stories examined for this thesis, portrayals of women unsurprisingly dominate the breast cancer accounts. In these accounts and similar to Seale's analysis, women who have survived the disease are

presented as having been initially overwhelmed with shock and fear on learning the diagnosis but as able to transform these emotions in their response to the disease and treatment for it. However, accounts of women who have died of breast cancer are more likely to position the individual within a narrative of having been strong in their response to the disease, similar to how Seale describes portrayals of men i.e. as able to draw on their existing strength of character in response to cancer. For example, in Extract 2 in the previous chapter (p103), Rob Sneddon's mother is described as being '*always so strong*' and in Extract 4 (Chapter 4, pp106-107) Gemma is said to have been '*strong, determined and stubborn*' in her response to the diagnosis'.

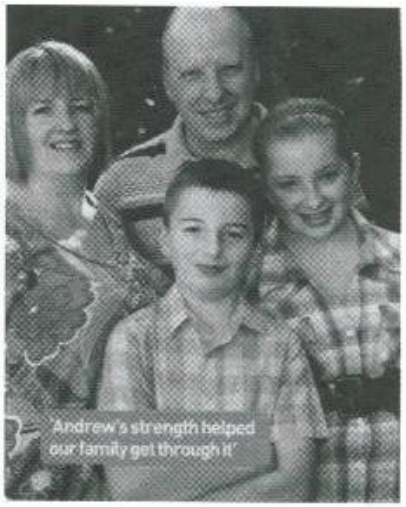
The single account of a man's experience of breast cancer shares similarities with Seale's analysis in that his inherent masculine stoicism and strength of character is identified as helping him and his family get through the experience of cancer, although a momentary display of emotion in response to the diagnosis is also presented. For example:

Extract 35 Andrew's story:

REAL LIFE

BEING A MAN ABOUT IT

Amanda's husband may have had a 'woman's disease', but he was going to fight it like a bloke...



'The phone rang and I rushed to get it. I'd been waiting for this call all day. 'Andrew?' I said. 'It's me,' he replied. 'I've got breast cancer.'

He sounded totally calm, yet I didn't know how to respond. It was such a terrible shock.

All I could think was I wished I was there to hold him. But not wanting to upset me, Andrew, 45, had insisted on going to the hospital by himself. In fact, at every stage that had lead to this awful diagnosis, he'd been a typical man.'

And further:

'It was only once they [the children] *were lying in bed that we cried, lying on our duvet in our room, arms wrapped around one another. "How could this be happening to us" Andrew wept.*

It was the only time I saw him cry. After that, he was determined to cope. So when we sat the kids down, Andrew told them straight what was going on. "I'm going to fight this, don't you worry," he assured them. His strength kept them positive. And it helped me be strong, too. But I had a deeper, inner fear. My mum had suffered breast cancer 13 years earlier and I'd seen how much she'd suffered.'

And further:

'Soon after, he started his chemo treatment and lost his full head of dark brown hair. "It's so typical," he said. He'd always been proud that he hadn't gone bald naturally.

Staying positive

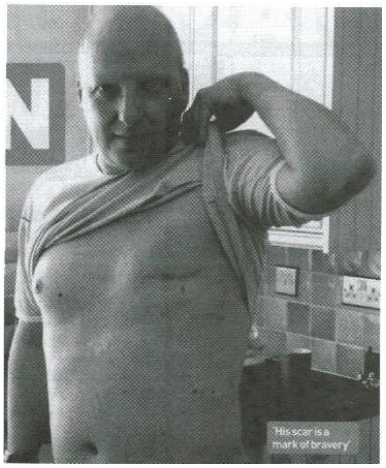
But he just laughed it off and it helped the kids adjust to it, too. "You're lucky you've got a nice shaped head, Dad," Charlie teased.

'Three months on, Andrew's now having radiotherapy, but we're hoping that will be the end of his treatment and he'll be in remission by Christmas. Breast cancer is a terrible disease. But I think Andrew's story is an inspiration to any sufferer – whatever their sex.' ('REAL LIFE: BEING A MAN ABOUT IT', Love it! 4 November 2010*)* (capitals and bold text as in the original)

This extract is from a women's magazine story in which an account of Andrew's experience of breast cancer is written from his wife's perspective. The account is similar to many of the other survival stories examined in that it recounts the experience of being diagnosed, treated and potentially surviving breast cancer. However, in this account, there is an emphasis on presenting Alan's response to the diagnosis as a typically masculine one, despite the feminine nature of the disease. Alan is presented as calm, strong, determined to fight and mindful of the emotional vulnerability of those around him – his wife and children. These characteristics are identified as helping his family adjust to and live with the diagnosis, particularly his wife who is portrayed as having '*a deep and inner fear*' because of her greater insight into the suffering that breast cancer can cause. Where Andrew's emotions are shown, it is a shared expression of tears with his wife, hidden from the children and presented as an isolated occurrence following which he was determined to get through the experience by '*staying positive*' and 'making light' of the situation.

In contrast to the accounts of women with breast cancer examined, Andrew's mastectomy scar is described and displayed. For example:

Extract 36:



'It was only later, back home, Andrew showed me the scar.

I stared at the smooth, nipple-less area of skin. I knew the trauma women could face losing a breast, so I guess it helped knowing this didn't alter Andrew's appearance as a man.'

Although photographs of women with breast cancer are a common feature of the stories examined and in common with that of Andrew in the extract above

these may depict hair loss, in contrast they usually show covered and 'normal' looking breasts with little sign that a breast may have been removed. In the extract above, despite Andrew having a '*woman's disease*', the experience of it – in this case mastectomy surgery and its effect on the body – is presented as less of a threat to masculinity than to femininity and thereby less emotionally traumatic for men than for women. Therefore, this story presents a similar heroic narrative to the one described by Seale (2002) in which the cancer experience is portrayed as an emotional challenge, particularly for women, but one that men are able to face up to and overcome by drawing on their inherent (male) character traits.

In the personal stories of lung cancer, a less clear distinction than the one described by Seale (2002) is identified in terms of how woman and men are portrayed in relation to their response to the cancer diagnosis. Whilst some stories of survival depict women as being overwhelmed with emotions and shocked by the diagnosis, other stories portray women's initial response to the disease in less emotional terms. For example, in Chapter 4, Extract 7 (pp110-111), Lynne is described as: '*filled with fear*' and '*devastated and absolutely terrified*'. Elsewhere in the story she is said to be: '*in tears*' and *'just very scared*'. In two further accounts, one woman is described as going '*into shock*' on hearing the diagnosis and not knowing '*what to think other than it's cancer*'. The second woman is depicted as saying '*I thought oh my God, I'm going to die'*. However, in three further stories, women's responses are presented as: '*I just sat there and asked him* [the doctor] *what the next step was*', '*It all happened so quickly, so I don't think it fully registered that I had cancer*' and '*I just thought to myself how inconvenient'.* These responses are not dissimilar to how the three male survivors of lung cancer are portrayed. For example, in Extract 31 (pp171-172), Gary T's response to being told his diagnosis is described in stoical terms; as thinking that he '*just had to get on with it*'. In the second account, on being told the diagnosis, the man is described as '*lying on a trolley looking dazed*' without further reference to how he was feeling. In the third account the man's emotional response to the disease is also not described.

Examining the accounts of dying of lung cancer also identifies a less clear distinction between how men and woman are portrayed in relation to their emotional response to the diagnosis. For example in Extract 24 (p155), Gary H

is said to have '*moments*' when the reality of the disease really '*hits*' him and makes him '*sad*'. Elsewhere in the story and despite '*fighting to stay mentally strong*' and not mope around '*feeling sorry*', he is presented as getting upset at '*the prospect that I will not be here to see my little 'uns through school. That is what breaks my heart*'. Another man is described as '*shocked*' and '*devastated*' by the diagnosis and the lack of effective treatment for the disease. (This is the account of Alan D who is dying of mesothelioma presented in Chap 4, Extract 6, p109). Where women are depicted as dying of lung cancer, although some are presented in emotional terms; as sad and sorry to be dying, generally they are portrayed as emotionally strong rather than overwhelmed in confronting death, and more concerned about those around them than their own feelings. This was discussed earlier in this chapter and is illustrated by several extracts in which the women concerned are portrayed as immediately turning their attention to the welfare of others (for example, Extract 22, p152, Extract 26, p159, and Extract 30, pp167-168).

In summary, in this examination and comparison of texts, personal accounts of surviving lung cancer are identified as drawing heavily on a public health discourse oriented to raising awareness of the disease. In this discourse, lung cancer is constructed as a disease that can be avoided by not smoking and survived if diagnosed early enough for treatment to be successful. Conversely, therefore, developing and dying of lung cancer are constructed as unnecessary events and, moreover, a consequence of lax and inattentive personal behaviour in relation to safeguarding one's health. Within these stories, individuals' personal accounts of cancer act as human exemplars of the behaviours necessary for avoiding death and surviving the disease; namely smoking cessation and early presentation for medical advice as soon as symptoms arise. The accounts follow a similar narrative of how the disease arose, and how it was successfully diagnosed, treated and controlled – largely by others, with few adverse effects for the individual concerned. Although in some accounts elements of a heroic cancer narrative are identified, it is less dominant than in the personal accounts of breast cancer and less likely to position the individual concerned as having survived the experience of cancer through personal efforts of will. Instead, the diagnosis of lung cancer is constructed as more of a 'wake-up call' (Willig 2011); one that forces the individual to amend their ways with regards to looking after their health. Having been woken by the diagnosis

and threat of death, individuals are portrayed as having learned the error of their ways and, as a consequence, are keen to warn others so that they may avoid the same predicament. This presents them as previously flawed but now morally responsible.

In contrast, although the personal accounts of surviving breast cancer also draw on a public health discourse to promote awareness of the disease, a 'cancer heroics' narrative similar to the one described by Seale (2001a, 2002) is dominant in these stories. In particular, individuals – mainly women – are portrayed as having more agency than individuals with lung cancer in their response to the disease; active in ensuring its early detection and their survival from it, and also in using the experience to help in the wider fight to eradicate the disease for all women. In these accounts therefore, and unlike most of the lung cancer accounts, survival is presented as not only a consequence of medical efforts and good fortune, but also a consequence of women's personal endeavours.

5.3 Bringing the analysis together

In this analysis, media accounts of the personal experience of lung cancer take the form of two dominant narratives. In the first of these, individuals are portrayed as dying of lung cancer. These stories draw on elements of a 'heroic death' narrative (Seale 1995a) in which the individual concerned is portrayed as courageously facing their dying in open awareness, acceptance and self-sacrifice. In this narrative, lung cancer is constructed as a disease that is difficult to control and invariably fatal. In the second dominant narrative, the individual concerned is portrayed as surviving lung cancer. In these stories, a public health discourse oriented to raising awareness is dominant and lung cancer is constructed as a disease that can be avoided and survived, rather than an inevitable death.

At a literal level these two narratives appear to construct lung cancer in ways that are diametrically opposed. At a more interpretative level, however, both narratives draw on discourses that associate the diagnosis of lung cancer with a death sentence. The accounts of dying draw on this discourse to position individuals as imminently and inevitably dying of the disease. However, these accounts are also organised in relation to discourses that associate dying of

cancer with dread and suffering. They work to oppose these discourses by presenting lung cancer as a 'good' death in which individuals are dying well; able to face and accept the adversity of their situation, make the most of their time with family and friends, with few if any signs of physical suffering and bodily deterioration.

In contrast, the accounts of survival are organised in rhetorical opposition to discourses that construct lung cancer as an inevitable death. That is, they counter them by drawing on a public health discourse in which surviving the disease is shown to be possible. However, these stories are dilemmatic in that they also present factual information about lung cancer that acts to reinforce discourses of inevitable dying by constructing the disease as one characterised by persistently high mortality and poor survival. In the accounts of survival therefore, because death is presented as a common and usual consequence of lung cancer, individuals surviving the disease are positioned as lucky to have done so.

This activity of arguing for and against familiar discourses of lung cancer, acts to perpetuate and sustain their circulation. In presenting images that are congruent with the discourses, texts reinforce commonplace understandings about the disease. However, in arguing against the discourses, texts draw attention to the counter-arguments, the very claims they are opposing. This interpretation draws on the concepts discussed in Chapter 2 in relation to the rhetorical function and dilemmatic character of text and talk (Billig 1987; Billig et al. 1988, see pp48-49). These rhetorical and dilemmatic features of the stories examined are indicative of the social resources available within the context in which they are produced, and also the processes that contribute to their continued existence.

In contrast, the personal stories of breast cancer are not organised to argue for and against discourses of inevitable dying. In these stories, although most are also oriented to raising awareness and contain public health messages about the disease, a 'cancer heroics' narrative (Seale 2002) is dominant. In this narrative, breast cancer is constructed as a disease that, for most individuals, can be survived or lived with by adopting a positive stance and focussing on survival and active living, rather than dying. Individuals who develop breast cancer – mainly women – are portrayed as having actively engaged in the fight

to overcome the disease and the challenges posed by it even when faced with a terminal diagnosis. Similar to the lung cancer accounts, however, personal stories of breast cancer are also organised to counter discourses that associate dying of cancer with physical suffering and bodily deterioration so that where deaths are presented, a sanitised version of dying is portrayed. These features of the breast cancer stories are also indicative of the social context in which they are produced and suggest a cultural imperative for individuals who develop breast cancer to be shown as active agents in influencing their experience of and ultimate outcome from the disease.

This difference between how the two diseases are socially constructed provides an explanation for why accounts of dying of breast cancer are more likely to draw on a 'cancer heroics' narrative rather than the 'heroic death' script identified in the lung cancer accounts of dying. In the context of breast cancer where survival rather than death is constructed as the most likely outcome of the disease, portraying individuals within a narrative of open awareness and acceptance of the possibility of their dying could present them as not taking responsibility for their survival and as giving up. Indeed in a recent study in the UK exploring the experience of living with metastatic breast cancer, women spoke of feeling constrained by an imperative to think positively and adopt an identity of carrying on as if normal, rather than engage with their suffering and mortality (Reed 2012). In this social context, therefore, for a death from breast cancer to be portrayed as heroic requires the individual concerned to be shown to be actively fighting against dying rather than accepting its inevitability. However, despite these differences in how individuals dying of lung cancer and breast cancer are portrayed (i.e. either in open awareness and acceptance, or as resistant), the accounts share a commonality in their positioning of individuals as heroic. In this way, dying from lung cancer and breast cancer are constructed similarly – as meaningful events in which the individual concerned is able to face death with courage and sacrifice.

This similarity between the two datasets in relation to portrayals of dying draws attention to differences identified in portrayals of survival. In privileging a public health discourse rather than a heroic narrative, the accounts of surviving lung cancer achieve different things. In these accounts, rather than a heroic event, dying of lung cancer is constructed as an event that is avoidable through not smoking and, as such, is devoid of meaning and commensurate

with a ‘bad’ death. Rather than a heroic narrative, these stories of lung cancer draw on a didactic narrative in which individuals are positioned as the likely cause of their situation rather than the hero of it. This positioning has implications for the moral character of individuals who develop lung cancer as it presents them as irresponsible in risking not only their health but, potentially, their life.

This explanation in relation to the moral positioning of individuals with lung cancer in the accounts of survival draws attention back to the individuals in the accounts of dying most of who, in contrast, are not identified as having caused their disease to develop through smoking. Indeed, although smoking is thought to cause most lung cancers and most people who develop the disease will die of it, accounts of individuals who are portrayed as both dying and as having smoked are relatively absent in the data examined. This patterning of the personal stories of lung cancer in terms of portrayals of survival in the presence of smoking and portrayals of dying in the absence of smoking is worthy of further examination, since it suggests that media representations of the experience of lung cancer may also be shaped by discourses of cause and blame. Given that there are so few portrayals of dying in the presence of smoking, the patterning of stories may also point to an explanation for the relative absence of the personal experience of lung cancer compared with that of breast cancer in the analysis of texts presented in Chapter 4.

In the next chapter, these emerging interpretations are explored further. The personal stories of lung cancer are examined and compared with the personal stories of breast cancer to identify how accounts are organised in relation to cause and blame.

6. Examining personal stories for evidence of blaming activity

In this chapter, the patterning of stories identified at the end of the last chapter in relation to how individuals with lung cancer are positioned in relation to cause and blame is explored further. This is of interest as it may provide an explanation for the disparity between the two diseases in terms of the prominence afforded to individuals identified in the initial broad analysis of texts. Positioning individuals in relation to cause and blame may actively work to lessen their appeal and apparent social worthiness so that they attract less public attention.

In order to examine this issue further the personal stories of lung cancer are examined for evidence of blaming activity. Insights from this analysis are then used to examine the personal stories of breast cancer, to identify differences and similarities in how individuals are presented in relation to cause and blame. Finally the two analyses are brought together to develop an understanding of how stories are constructed in relation to blame and the potential consequences of this particular activity.

6.1 Understanding blaming as a social practice

In order to examine texts for evidence of blaming activity, the analysis draws on a model of blame proposed by Malle et al. (2012). In this model, blame is understood as a moral judgement about whether an individual or group has caused a negative event to occur by deviating from a social norm; i.e. an acceptable way of behaving. Blame is conceived as both a cognitive and social activity. It is cognitive because it involves processes that lead up to a judgement of blame, and social in that it also entails observable acts of blame that require language and communication. The analysis presented in this chapter aims to identify whether media texts are locations where the social practice of blaming takes place.

The major function of blame is to regulate social behaviour and pass on cultural values (Malle et al. 2012). Blame judgements are described as moral because they are directed at individuals or groups of individuals who are

presumed to be capable of following socially-shared norms of conduct. The model proposes that a number of steps are involved in the practice of blaming (see also Figure 18). These are:

- The identification of a negative event or outcome that has deviated from a social norm
- An assessment of whether the negative event was caused by the actions or behaviours of an individual or group
- A decision as to whether the individual or group acted intentionally to cause the event, and
- A grading of blame dependent on whether the act was intentional or unintentional. Acts of intentional norm violations are blamed more severely than unintentional ones, as follows:
    - If the act was intentional, the individual's reasons for acting are considered. Blame may be reduced if there are reasons that provide justification for the action
    - If the act was unintentional, an assessment is made as to whether the negative event could or should have been foreseen:
        - Blame is reduced if the individual or group lacked the *capacity* to have avoided the event from happening (for example, because of lack of knowledge or ability)
        - Blame is amplified if the individual or group is judged capable and therefore had an *obligation* to have prevented the event.

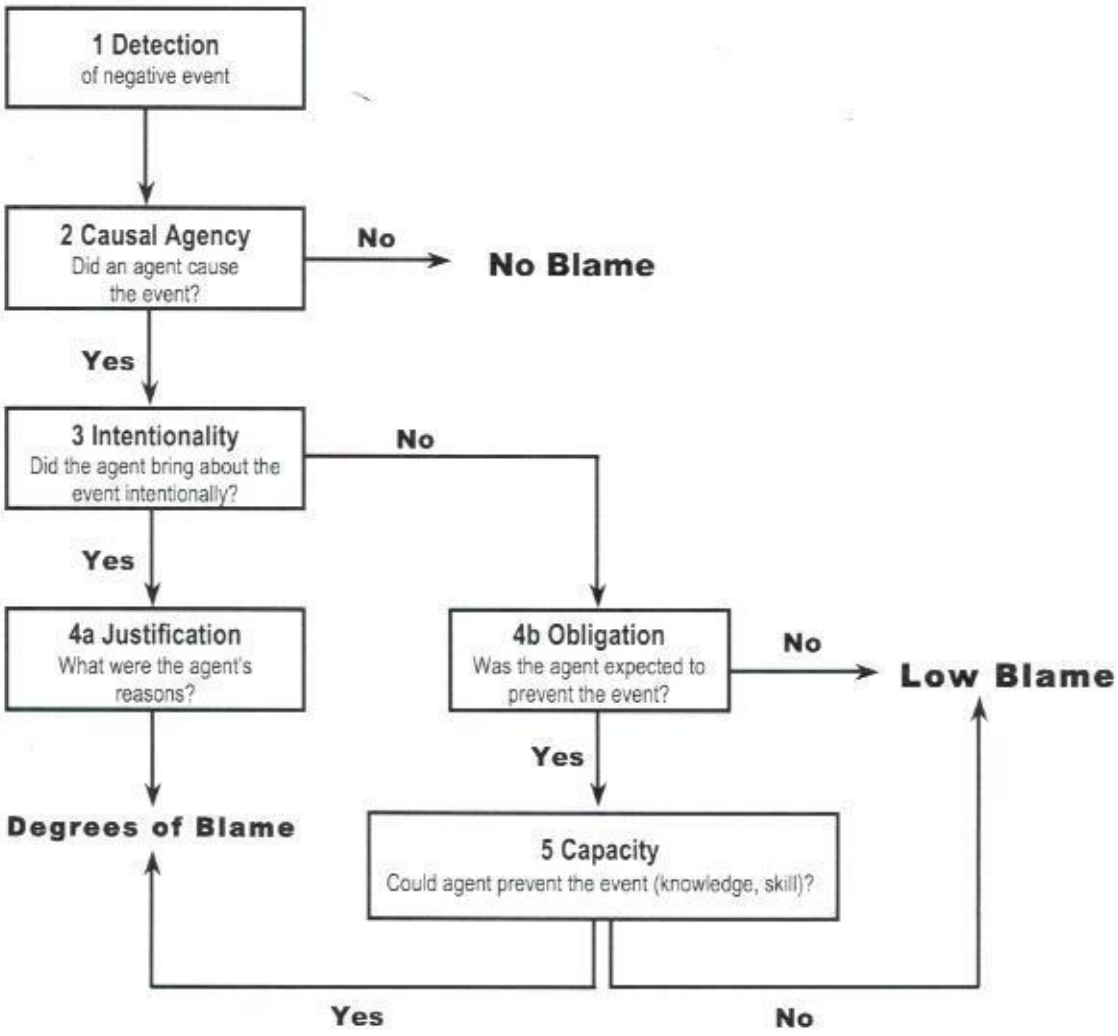


Figure 18: Step model of blame (taken from: Malle et al. 2012, p315)

In simplified form, the model suggests that blame evaluations involve identifying: i) whether an individual or group caused a negative event to occur by deviating from acceptable behaviour; ii) whether it was done intentionally; iii) whether the action was justified in any way; iv) whether they *should* have prevented it from happening; and v) whether they *could* have prevented it from happening.

In the analysis that follows, this model provides a lens through which to examine media texts. It identifies the kind of information used in making judgements of blame – that is, the occurrence of a negative event and an individual or group's causal involvement, intentionality, obligations and mental capacity in relation to the event.

6.2 Lung cancer as a blameworthy event

In examining the personal stories of lung cancer, there is clear evidence of the components of blaming activity as described in the model proposed by Malle et al. (2012). Most texts feature explanations for how the individual's disease arose, and in doing so they actively work to position the individual in relation to blame; as either blameworthy or blameless for their situation. Where the individual concerned is positioned as blameworthy, other details are presented that address issues of intentionality, capacity and obligation. These additional details work to either amplify or mitigate the level of blame. This activity within texts, therefore, suggests that lung cancer is an event that triggers an evaluation of cause and a judgement of blame. The analysis that follows explores this activity in detail by examining first the stories in which individuals are positioned as blameworthy and, second, the stories that work to position individuals as blameless.

6.2.1 Assigning blame

Individuals with lung cancer are most likely to be positioned as blameworthy for having caused their cancer to develop in the stories that portray them as surviving and living with the disease. In Chapter 5, these accounts are identified as drawing largely on a public health discourse in which smoking is emphasised as the main cause of lung cancer. Messages about smoking are commonly embedded in the narrative of the personal story and/or situated in separate text-boxes within the overall text. In this narrative structure, therefore, lung cancer is presented as usually a consequence of individuals having smoked. It was also observed in Chapter 5 that in most of the accounts of surviving lung cancer the individual concerned is portrayed in relation to their smoking status and most are identified as having smoked. This activity of identifying whether the individual has smoked or not reinforces the association between the two things i.e. lung cancer and smoking, and works to position the individual in relation to blame for having caused their disease. For example:

Extract 37 Janet V's story:

'When Dunchurch woman Janet Varney took her first puff on a cigarette at the age of 15, she had no idea the decision would nearly cost her her life.

Hearing the devastating news she had lung cancer, the 60-year-old mother said 'I thought oh my God, I'm going to die.'

Janet smoked between 20 and 30 cigarettes a day until her diagnosis in 2002.' ('How Janet has beaten lung cancer', Rugby Advertiser, 11 November 2010)

This extract is taken from the first few lines of a newspaper story in which Janet is portrayed as having beaten lung cancer. The extract is illustrative of how some individuals with lung cancer are positioned as potentially blameworthy for having caused their disease to develop by identifying them as having smoked. In presenting Janet's decision to smoke as one that '*nearly cost her her life*', smoking is presented as the direct cause of her lung cancer. An extract from the end of Janet's story was discussed in the previous chapter (Extract 34, p181) in relation to how public health discourses may act to undermine the positioning of survivors of lung cancer as heroic. Focussing the analysis on the positioning of individuals in relation to blame for having caused their disease to develop illuminates this point further. Although Janet is described in the headline of the story as having '*beaten*' lung cancer, identifying her smoking behaviour at the start of the story presents her in less

heroic terms; as someone who has developed cancer as a consequence of her own actions.

The extract illustrates a narrative structure that is shared by many of the accounts in which individuals are identified as blameworthy. Details of how the individual came to be diagnosed with lung cancer are closely followed by descriptions of their smoking behaviour. This sequencing works to associate the two things in a reverse cause-and-effect narrative, which implies the one has been caused by the other without the need for an explicit explanation, as well as assuming a social understanding of the causal link between them. This sequencing of accounts enacts the initial steps in the model of blame proposed by Malle et al. (2012). It suggests that the diagnosis of lung cancer is constructed as a negative (rather than heroic) event that triggers an evaluation to identify if the individual concerned has caused the disease to develop through having smoked.

Although the positioning of individuals as blameworthy is particularly evident in the accounts of survival, two individuals in the stories of dying are also identified as having smoked. In these stories, a similar narrative sequence to the accounts of survival is presented in that details of the individual's diagnosis of lung cancer are followed by details of their smoking status. For example:

> Extract 38 Christine J's story:
>
> *'Three weeks later Christine returned to hospital where she was given the bad news it was terminal. "It's related to smoking I'm afraid so it's self-inflicted. If I hadn't smoked I wouldn't be dying. I just didn't listen to the warnings, it wasn't going to happen to me."'* ('I've held on to see Jessica born: GRAN'S BRAVE BATTLE AGAINST CANCER, Daily Post (Liverpool, 28 November 2010) (Capitals as the original)

In this extract, blame is explicit. Christine J is portrayed as blaming herself not only for causing her cancer but also her dying through having smoked. This story, like most of the accounts of survival, was produced during Lung Cancer Awareness Month.

In the model of blame proposed by Malle et al. (2012), the activity of blaming involves not only establishing whether an individual or group may have caused

a negative event to happen but also a judgement as to whether they acted intentionally and whether they could or should have avoided the negative event. Intentional acts, where an individual or group is judged to have been in a position to avoid the event happening, are deemed more blameworthy than if the act was unintentional or if the negative event could not have been foreseen. A judgement of blame also takes into account an individual's reasons for acting, and their moral character. Undesirable, selfish or vengeful reasons for acting are likely to be judged severely. However, other reasons may provide justification for the action and cast it in a less blameworthy light.

In the stories examined, where individuals are positioned as blameworthy, regardless of whether they are portrayed as survivors or dying, a similar grading-of-blame activity is identified. Information is presented in relation to the individual's smoking behaviour and their character, which acts to negotiate the severity of blame warranted by either amplifying or mitigating blame. Amplification and mitigation activity are often identified in the same story. In the following two sections evidence of this activity is examined, starting with strategies that work to amplify blame.

6.2.1.1 Amplifying blame

In the model proposed by Malle et al. (2012), individuals who develop lung cancer potentially warrant a high level of blame if they are identified as having smoked since they have voluntarily acted in a way that is known to have serious consequences. The harmful effects of smoking are well-publicised on the packaging of tobacco products (see for example Extract 14, p128) and in media generally. Therefore, although individuals who smoke may not be acting intentionally to bring about ill-health, the risk of it happening is something that can be foreseen and so there is an obligation to not smoke.

Some stories are organised in ways that reinforce smoking as a risky behaviour and cast it in a negative light. This works to amplify blame by positioning individuals who smoke as taking unnecessary risks with their health. This activity is identified in some of the extracts presented earlier. For example, Extract 32 (p175) taken from Eleanor's story, illustrates how some individuals with lung cancer are presented in accounts in which messages about smoking are dominant. Over half of Eleanor's story is about smoking. In this account, smokers are '*reminded*' of the '*vast free stop smoking services'* that are

available to help them '*kick the habit'*. This narrative presents people who continue to smoke as knowingly participating in an unhealthy and unnecessary behaviour, despite plenty of opportunities and resources on offer to help them act otherwise.

A further example is Extract 37 (p197) in which Janet is described as having smoked since she was 15 and smoking between 20 and 30 cigarettes a day until her diagnosis. These details allow judgements to be made about the nature of the individual's smoking behaviour. In this case, the amount of cigarettes smoked and the length of smoking could be considered heavy and habitual, and may act to portray Janet as having been persistently neglectful of her health until checked by the onset of illness. Similar activity is identified in the following extract:

> Extract 39 Sue C's story:
>
> '*Sue, who has five sons between the ages of 33 and 41, began smoking when she was 28 and was puffing on four cigarettes a day before she was diagnosed.'* ('You have to stay positive and fight', Swindon Advertiser, 10 November 2010)

This extract also positions the individual in relation to the number of cigarettes smoked and the duration of smoking which is again depicted as continuing right up until the diagnosis. In this story, information about smoking is presented alongside details of Sue's children and their ages. This sequencing suggests not only a disregard for her own health but also, potentially, the welfare of her children. Also similar to the previous extract, negative imagery ('*puffing on*') casts smoking in a particular light, so that although the number of cigarettes smoked might be seen as quite low, the image created is one of self-induced and unnecessary risk rather than low risk.

The extract from Christine's story presented earlier in this chapter (Extract 38, p198) also illustrates how blame is potentially amplified by portraying individuals as knowingly having taken risks with the health and their lives. In this extract, Christine is portrayed as aware and accepting that the fault with regards to the development of cancer and her imminent death lay with herself because she '*just didn't listen to the warnings, it wasn't going to happen to* [her]'. Elsewhere in the story she is portrayed as saying: '*If you are going to*

play roulette, don't play it with your life. It's not just lung cancer, smoking causes all kinds of cancers'. This gambling metaphor reinforces the image of smoking as a high-risk behaviour and people who smoke as risk-takers; reticent in relation to their health and, moreover, their lives.

Portraying smoking as a wilful and risky behaviour with known and serious consequences acts to demonstrate a degree of intentionality in relation to the actions of individuals with lung cancer who have smoked in the past; not necessarily to bring about disease but in disregarding their health. In doing so, the severity of the blame that may justifiably be apportioned is potentially amplified.

6.2.1.2 Mitigating blame

Malle et al. (2012) suggest that evaluations of blame also involve considering an individual's reason for acting, and that sometimes explanations may provide justification for the action that cast it in a less negative light. In examining the personal stories, explanations are identified that work in a similar way; they provide reasons for the individual's smoking behaviour that potentially work to mitigate the full force of blame and restore the individual's moral worth. For example, some stories draw on familiar scientific and social explanations for smoking that act to justify the individual's behaviour to varying degrees. For example:

> Extract 40 Sheila's story:
>
> *'Sheila Warburton's life changed four years ago when her beloved husband, Allen, died suddenly in the street outside their Swinton home. He was 61, a former policeman, and the couple had been happily married for 40 years. The shock triggered a downward spiral, emotionally and physically. She became depressed, stopped eating properly and looking after herself, and was losing weight. Sheila – a mother of two, grandmother and great-grandmother – had also, after a break of 15 years, started smoking again.'* ('Ask the experts: Lung cancer case study', Manchester Evening News, 7 October 2010)
>
> Extract 41 Eleanor's story:
>
> *'"I started smoking at 18 or 19 – then it was seen as sophisticated if you smoked – you were grown up when you had a cigarette in your*

> *hand. What you don't realise when you are young is that it is also incredibly addictive. Throughout my career at the civil service, I didn't smoke during the day as you couldn't there, instead I had an occasional cigarette when I got home or out socialising*."' ('I feel lucky that they caught it early and treated me quickly and that at 70 they have given me a few more years, which is a bonus', Evening Chronicle, 29 November 2010)

The first extract from Sheila's story works to deny agency in relation to the individual's smoking behaviour. Sheila is portrayed as becoming depressed following her husband's sudden death. This presents her as having diminished capacity which serves as an excuse for not taking care of herself and taking up smoking again. This explanation draws on a discourse that identifies smoking as something people turn to in response to difficult personal circumstances: a reliever of stress that is commonplace among people who suffer hardship (Graham 1987). The explanation also positions Sheila in a more sympathetic light by evoking sympathy for her personal ordeal. Both narrative devices work to repair the individual's moral character and reduce the severity of blame.

In the extract from Eleanor's story, smoking is presented as a social norm of a bygone age when it had a sophisticated, even elevated, status and its ill-effects and addictive nature were less well-known. This era of smoking is discussed in Chapter 3 (pp61-63). The regulated nature of Eleanor's smoking is also emphasised in that it was '*light*' and restricted to certain social occasions. Elsewhere in the story, Eleanor is portrayed as having '*successfully quit*' a year prior to her diagnosis. Although smoking is described as addictive in this story, these images suggest a degree of personal control. They present Eleanor's smoking as a matter of personal choice in response to an accepted fashion at the time rather than a heavy dependency, and a past rather than current behaviour. This portrays Eleanor as has having taken responsibility for her health on her own initiative rather than being forced to by the diagnosis. The imagery in this story, therefore, contrasts with the imagery identified in the extracts presented earlier from Janet and Sue C's stories that associates the two women with habitual and heavy smoking (Extract 37, p197 and Extract 39, p200). In the extract above from Eleanor's story, the addictive nature of smoking, the ignorance of youth and a bygone era are used to justify smoking behaviour and divert blame. In Janet and Sue C's stories, the amount and

duration of the women's smoking potentially works to amplify blame by presenting their behaviour as an uncontrolled dependency.

Portraying smoking as a former rather than current behaviour may also work to mitigate blame as it presents the individual concerned as having recognised the error of their ways and amended their behaviour accordingly. An extreme example of this is evident in Extract 38 (p198) in which Christine is portrayed as blaming herself for not only having caused her cancer to develop through smoking but also her imminent death. An additional extract from Christine's story as well as one from another story illustrates further how these features may act to mitigate the severity of blame.

Extract 42 Christine J's story:

'"I hate myself for what I have done. I will never forgive myself for smoking – I have inflicted this awful mess on my family. My family are going to lose me and I am going to lose my life. If just one person stops and that means it really did save that person's life, then it won't have been in vain."

And further:

'"I can't apologise enough to my children and grandchildren that I have to leave them. I'm just so sad and so sorry," she said. "I've written letters for my children and my brothers and sisters, and I've written 18th birthday cards for Jack and Jessica. These children mean all the world to me to the moon and back, and it was just amazing to see Jessica for the first time. I've done my Christmas shopping and bought everything so if I get ill now they're there for them. I've done all my funeral plans, everything's done, they just have to turn up and have a party. I don't mind what day I die on but I've said I want to be buried on a Saturday so people don't have to lose a day's pay."' ('I've held on to see Jessica born: Gran's brave battle against cancer' (Daily Post (Liverpool), 24 November 2010)

Extract 43 Herbie's story:

'"I was also a fairly heavy smoker and I smoked right up to the last night before the operation. I remember when I was in the Royal (Victoria Hospital, Belfast) I went out on the veranda and smoked my

> *last cigarette and I have never smoked since then. I didn't really find it hard to give up. I was just thankful to be through the operation and be doing well. I was determined to stop because in my mind it was the smoking that was causing the trouble."*
>
> *Dr Dean Fennell, a lung cancer specialist and Cancer Research UK scientist, said: "Our objective is for patients to live their lives out as fully as possible but to be 91 and to have beaten lung cancer so long ago is a fantastic example of survivorship."'* ('At 91, I'm living proof lung cancer is beatable' Belfast Telegraph, 29 September 2010)

In these two extracts, the individuals concerned are portrayed as recognising and accepting responsibility that smoking is the cause of their cancer. This is reinforced by the use of direct speech. Acceptance along with the renouncing of past smoking behaviour works to restore the moral worth of the individual concerned by presenting them as formerly flawed but now reformed, having seen the error of their ways.

The two extracts also serve to illustrate a significant difference in the work required to repair the moral worth of individuals who have caused their cancer to develop and have survived, compared with those who are dying. This difference is identified as more than merely a consequence of the difference identified by Seale (2002) in relation to how men and women are portrayed with regard to their response to cancer. Taking the extract from Herbie's story first, Herbie is presented as having survived for twenty-five years after his diagnosis. In this story, acceptance of blame is described in a very 'matter-of-fact' and rational way. Herbie recognised that smoking was the problem and reformed his behaviour accordingly. Elsewhere in the story, further details provide evidence of an otherwise moral character including a belief in God and wholesome activities such as gardening, learning to play the fiddle and supporting cancer fundraising events. Having lived to an admirable age following the diagnosis, Herbie evolves from the position of a flawed risk-taker to someone who now provides a '*fantastic example of survivorship*'. The force of blame is also reduced in this account by presenting details of Herbie's smoking behaviour near to the end of the story, rather than near to the beginning when details of his diagnosis are discussed. This distance between details relating to the diagnosis (effect) and smoking (cause) contrasts with

most of the other stories that position individuals as blameworthy (see for example Extract 37, p197), suggesting that a less severe evaluation of blame is taking place.

The extract from Christine J's story is in direct contrast to the one from Herbie's story in terms of the force of blame assigned and the amount of 'repair work' (Laurier 1999, p203) required to restore her moral character and worth. Whereas Herbie has survived lung cancer, Christine is one of two individuals in the stories examined who is identified as having smoked and also as dying. Therefore, the consequences of Christine's smoking are far more serious than Herbie's. In contrast to Herbie's story, details of Christine's smoking immediately follow on from the details of her terminal diagnosis (see Extract 38, p198). This information is then followed by her acceptance of blame. This sequencing of negative event, cause and acceptance of blame, works to reinforce Christine's blameworthiness and the severity of blame that is potentially warranted. However in contrast to Herbie's story also, Christine's acceptance of blame is suffused with remorse, regret and emotion. She is presented as begging forgiveness for having caused her death through smoking. In this extract and elsewhere in the story, selfless acts are described that work to present her death in a more favourable light; as meaningful despite its needlessness, and as less burdensome for those around her. As well as arranging her funeral (on a Saturday to ensure that people attending do not lost a day's pay), and birthday and Christmas presents for the family, she is portrayed as raising money for charity, raising awareness of the disease and battling to stay alive for two years beyond her three-month prognosis. Indeed, as discussed in the previous chapter (pp167-168), Christine is the only individual who is portrayed as dying and also as having battled against the disease to stay alive beyond her prognosis. In the other accounts, individuals who are dying are portrayed as facing their death without resistance. These narrative devices work to atone for Christine's role in bringing about her death and, in doing so, they act to mitigate the severity of potential judgements of blame. Therefore, the contrast between the two stories with regards to the level of mitigating activity observed is identified as an indication of the intensity of potential judgements of blame for causing one's own death through smoking, and the work required to restore the moral character of the individual concerned in this context.

6. Evidence of Blaming Activity

The only other account of dying in which the individual is identified as having smoked is also organised to mitigate blame. However this story, in sharp contrast to Christine's story, is organised to question the significance of the individual's smoking in the development of the disease rather than accept its causal role and atone for it. For example:

> Extract 44 Cassandra's story:
>
> *'"It's very bad luck" said my consultant at Guy's Hospital as he outlined a chemotherapy regime to control the proliferating cells, which, on the CAT scan, made my lung resemble a furred-up kettle.*
>
> *While the heavy smokers' cancer (squamous cell), which chiefly strikes older men, is declining, my cancer, as I must now call it, has become more prevalent. Increasing numbers of youngish, often female, former light smokers, such as myself, are falling victim to adenocarcinomas, as well as people (mostly from the Pacific Rim) who have never touched tobacco.*
>
> *Research has linked the increase to low-tar cigarettes. My oncologist, however, ascribes the rising incidence to the greater awareness of an often hidden disease; I, like most sufferers, was almost symptom-free until a late stage.' ('Cassandra Jardine on her cancer diagnosis: The day my life changed forever, The Telegraph (online), 15 October 2010)*

This extract draws on a number of devices that work to raise uncertainty about whether the lung cancer Cassandra has developed is related to smoking. The text presented in this extract follows a description of Cassandra being informed of her diagnosis in which the disease is described not as 'lung cancer' but as '*adenocarcinoma of the mucus producing cells in my right lung*'. Indeed, the term 'lung cancer' is not used in the article from which this extract is taken. This description of Cassandra's disease works to differentiate it from the more usual type of lung cancer that is generally thought of – that is, the disease that is usually just referred to as 'lung cancer'. Cassandra's diagnosis is also described as a matter of chance ('*It's very bad luck*'). This claim is legitimated by presenting it as expert opinion (a consultant from a well-known London hospital) rather than her own. Following this, a scientific style of narrative is used to describe the disease and position it in relation to smoking. Using scientific language creates an impression that the claims made are

science-based and factual rather than the result of speculation or her own opinion. The disease is described as more common in young, female, former light-smokers and non-smokers. It is contrasted with '*squamous cell*' which is described as a disease of heavy smokers and mainly older men. These descriptions work to align Cassandra's personal characteristics (evident in both the body of the article and the accompanying photographs, see for example Extract 25, p157) and her smoking behaviour ('*three secret "ultra-low tar" cigarettes')* with the demographic profile of individuals who develop adenocarcinoma rather than the type of lung cancer that is associated with heavy smokers. In addition, Cassandra is presented as '*falling victim*' to the disease (rather than having caused it to happen).

The extract illustrates a difference between the scientific explanation of lung cancer drawn on in this account to that observed previously in the examination of stories oriented to raising awareness of the disease, particularly in relation to Lung Cancer Awareness Month (for example see Extract 7, pp110-111). In this instance, the story is organised to portray the lung cancer that Cassandra has developed as an emerging form of the disease that is not yet fully understood by doctors and to cast doubt on whether smoking is the cause of all forms of the disease. In these ways, therefore, the story functions to not only mitigate blame but also resist it.

Three other stories in which individuals are identified as smokers also draw on explanations that lung cancer is not necessarily related to smoking behaviour. However in these stories the explanation is presented with less force than is observed in Cassandra's story and the effect in terms of mitigation is also identified as less. For example:

> Extract 45 Janet V's story:
>
> *'Janet smoked between 20 and 30 cigarettes a day until her diagnosis in 2002.*
>
> *Her older sister, Betty, a non-smoker, did lose her battle against the disease.*
>
> *Janet, of Critchley Drive, said: "Although the major risk is smoking, ten per cent of people diagnosed with lung cancer have never smoked.'*

6. Evidence of Blaming Activity

('How Janet has beaten lung cancer', Rugby Advertiser, 11 November 2010)

Extract 46 Eleanor's story:

'"But I don't think all people who are diagnosed with lung cancer should be labelled – because it's a condition that can happen to anybody.

I cannot praise the NHS in Newcastle enough and all the Macmillan nurses too. They really were amazing and they didn't judge me – I just love them!"' ('I feel lucky that they caught it early and treated me quickly and that at 70 they have given me a few more years, which is a bonus', Evening Chronicle (Newcastle), 29 November 2010)

The first extract from Janet V's story follows on from the one presented earlier (Extract 37, p197) in which Janet is described as having taken her first '*puff*' on a cigarette at the age of fifteen, a decision that had '*nearly cost her her life*'. This description of Janet's smoking is how the story begins. Therefore, in this narrative sequencing smoking is presented as the cause of Janet's disease. The fact that Janet had a sister who also developed the disease despite being a non-smoker and the information that ten per cent of people diagnosed with the disease have never smoked are presented as secondary explanations and as such, are not as prominently linked to her own diagnosis as the details of her smoking.

In the second extract Eleanor is portrayed as arguing against blaming individuals for the development of lung cancer because '*it is a condition that can happen to anyone*'. This claim is legitimated by the suggestion that the professionals involved in her care did not '*judge her*' and follows the justifications for her smoking behaviour presented in Extract 41 (pp201-202). In this way, the claim acts as a mitigating device to position the individual concerned more favourably with regards to blame. However, similar to the other stories oriented to raising awareness, it is undermined by a more dominant discourse that presents smoking as the main cause of lung cancer for most people. For example, Eleanor's story begins by announcing that '*North East smokers are being encouraged to quit the habit as Lung Cancer Awareness Month comes to an end*' and Eleanor is identified as having smoked for fifty years (see Extract 32, p175 in the previous chapter).

In summary, the extracts presented thus far in this chapter illustrate how some personal stories of lung cancer are organised to assign blame to the individual concerned by identifying them as having smoked. In these stories, additional explanations regarding the individual's smoking behaviour is presented that enable judgements to be made in relation to the level of blame warranted. Some explanations are identified as acting to amplify blame by portraying the individual as neglectful of their health and having knowingly taking risks with their life. Other information may act to reduce the intensity of blame by presenting justifications for smoking and presenting it as a former behaviour that is now renounced. These mitigations portray the individual in a more favourable light and work to restore their moral character. Often activity to amplify and mitigate blame was observed in the same story.

Positioning individuals with lung cancer as blameworthy for having caused their disease is identified as a particular feature of the stories that are oriented to raising awareness in which all but one of the individuals is portrayed as having survived the disease. As discussed in the previous chapter, these stories draw heavily on a public health discourse in which smoking is presented as the main cause of lung cancer for most people. A further story in which the individual is portrayed as dying also identifies the individual as having smoked. In contrast to the awareness raising stories described above, this story positions the individual within a narrative in which lung cancer is presented as a disease that is increasingly occurring in the absence of smoking or where the amount of smoking has been negligible. These explanations are identified as ones that work to counter blame.

In the next section, further activity in relation to countering blame is examined.

6.2.2 Absolving blame

In other stories, individuals with lung cancer are portrayed in ways that present them as blameless either for having caused the disease to develop or for their dying. This activity is particularly evident in stories that portray individuals as dying of lung cancer although it is also observed in relation to one individual who has survived the disease. In all but two stories, blame is countered by

identifying individuals as non-smokers or presenting an alternative explanation for why the disease may have developed. For example:

Extract 47 Sue E's story:

'Sue: "I can't describe how awful it is to be diagnosed with something like that'".

'Huw (husband of Sue): "There's a massive gap in the research because everyone thinks lung cancer, that's smokers. Sue is not a smoker. This isn't a smoking-related disease. Now research will actually get answers. But research is such an expensive thing. More and more young women are presenting with this disease and we don't know why. Something out there, whether it's fumes from vehicles or whatever, something is causing this."' ('Captains' Climb', ITV Wales, 16 September 2010)

Extract 48 Donna's story:


Fairytale day

...but tinged with tears for cancer mum

'Donna, who was a psychiatric nurse before her illness, began suffering from recurrent chest infections when she was pregnant with Jack. However, because she was expecting, doctors were unable to undertake too many tests.

But, even after she gave birth to Jack, it was unclear what was causing Donna's chest problems – until April last year when doctors did a biopsy of her lung which revealed she had cancer.

Donna said: "Because of my age, I feel that doctors did not consider lung cancer was the cause. By the time it was eventually diagnosed, the cancer had spread to my other lung and it is now inoperable.

"Lung cancer is very rare in someone of my age. Doctors think it was probably caused by a hereditary condition. There is nothing doctors can do. I rely on my mum, Barbara, a lot to care for the children as I go into hospital quite a lot. I am really happy and proud to have seen Phoebe start school and I just hope I am around to see Jack go to school too."' ('Fairytale Day … but tinged with tears for cancer mum', Lancashire Evening Post, 4 September 2010)

6. Evidence of Blaming Activity

The first extract from Sue's story is taken from a television broadcast. It illustrates a similar narrative sequencing as the stories that position individuals as blameworthy. That is, discussion of the diagnosis of lung cancer prompts the identification of the individual's smoking status. In this story, however, smoking status is identified in order to position the individual as blameless in relation to having caused the disease to develop. In this way, the account is organised to counter discourses in which lung cancer is always caused by smoking. Alternative possible causal explanations are presented in order to strengthen the claim that lung cancer is not only a smoking-related disease. These suggestions include external factors such as car fumes, environmental tobacco smoke and '*something out there'*. They act to divert attention away from behavioural causes of disease towards causes that are outside personal control.

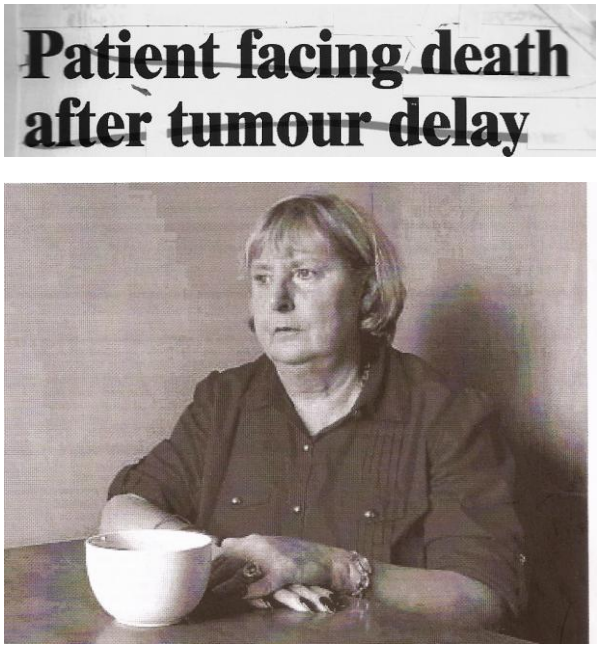
The extract from Donna's story is taken from a newspaper story. In this account a young girl is awarded a special day out as a treat because her mother is dying of cancer. Similar to the previous extract from Sue's story, the diagnosis of lung cancer triggers an evaluation of cause. However, in contrast to Sue, Donna is not identified in relation to her smoking status. Instead, her lung cancer is presented as a consequence of a hereditary condition. The authority of this claim is warranted by attributing its source to Donna's doctors. It is the opinion of experts, rather than Donna or the author of the story. In other stories where an alternative cause for lung cancer is presented, the disease is said to be a consequence of a pre-existing medical condition, exposure to asbestos in the workplace and exposure to cigarette smoke from having played in a band in pubs and clubs.

The two extracts above also illustrate that where an alternative causal explanation for lung cancer is given, additional information is presented to strengthen the claim further. For example in the extract from Donna's story, the occurrence of lung cancer is described as '*very rare in someone of my age'*. This presents the disease that Donna has developed as unusual and atypical, and works to differentiate it from the more usual type of lung cancer that most individuals develop, i.e. the type that develops in older people after years of smoking. Sue's story is organised in a similar way in that it describes the disease that Sue has developed as not smoking-related, not fully understood by science and one that '*more and more young women are presenting with*'.

These alternative descriptions of lung cancer are similar to the ones presented in Cassandra's story discussed in the previous section (Extract 44, p206-207). They work to differentiate the type of lung cancer Sue has developed from the type that is more usually thought of – the type that is fully understood, caused by smoking and affecting, in particular, older men.

The extract from Donna's story also illustrates how the stories of dying draw on a discourse in which lung cancer is portrayed as a difficult disease to diagnose and control. This was discussed in the previous chapter. In the analysis for this chapter, this discourse is identified as working to absolve individuals from blame for what is happening to them; their dying, by presenting them as victims of a recalcitrant disease. In doing so, it acts to counter the discourse identified in the stories of survival in which lung cancer is portrayed as a disease that can be diagnosed and treated efficiently and effectively, if individuals present early for medical attention when symptoms arise. In the extract above, Donna's diagnosis is portrayed as having been delayed because her pregnancy meant that her symptoms could not be initially investigated fully and also because doctors failed to consider the possibility of lung cancer because of her young age. This narrative, therefore, works to position Donna as a victim of circumstances beyond her control – she has been diagnosed with incurable cancer and is dying not because she was reticent in reporting symptoms but because they were not properly investigated by others. A similar narrative in which individuals are positioned as the victim of medical failure to diagnose and control the disease effectively is observed in the three remaining stories of dying that do not present a causal explanation for the disease. One of these is the posthumous account of Gregory Isaacs' death in which his diagnosis was said to be delayed by the doctors treating his pain as a symptom of arthritis rather than cancer (see Extract 3, p105). The following two extracts are taken from the other two stories:

Extract 49 Janet H's story:



'A woman with terminal cancer who has just weeks to live has been awarded £75,000 compensation after doctors spotted her lung tumour three years ago, but failed to act.'

Further in the story:

'"Two years ago, the tumour was very operable and I was younger and stronger – I would have had a chance. The hospital is responsible for so many lives and I just want something to be done so that other families don't have to go through this.

Like most other people, I had put my full trust in the hands of the hospital and for two years had thought I was fine. All that time a tumour was growing on my lungs and they could have stopped it."'
('Patient facing death after tumour delay', Western Daily Press, 4 September 2010)

Extract 50 Mitzys story:

'Mitzy: "I've got lung cancer. It's inoperable. There's nothing they can do for me. I'm dying, Marilyn."

Marilyn: "Are you sure chemo won't be effective?"

Mitzy: "It hasn't been, and it won't be. The specialists have given up on that front. And it's not going to be hoped or wished away, not for the want of trying, believe me."

Marilyn: "I can't believe how fast this has all come on."

Mitzy: "It has been fast but I've kept it from you for a while."

Marilyn: "Here I am worrying about … Have you gone for a second opinion?"

Mitzy: "I've been given the same prognosis by three separate oncologists. It's been confirmed within an inch of its life."' ('Home and Away', Channel 5, 5 November 2010)

The first extract is taken from the beginning of a newspaper story. Janet H has been awarded compensation because doctors failed to diagnose lung cancer when it was first apparent. As a consequence the disease has progressed to the point where it is inoperable, and she is dying. In this story Janet, like Donna in the previous extract (Extract 48, p211), is not identified in relation to smoking. Neither is an alternative cause of the disease presented. Instead, a detailed narrative identifies Janet as a victim of medical negligence, a position which is ratified by the legal system which has awarded her compensation. Janet is portrayed as having fulfilled the obligations expected of a patient. However, she has been let down by those responsible for her life ('*the hands of the hospital*'). This narrative, along with the absence of any discussion of what may have caused the cancer to develop initially (as is typically presented in the stories of survival), works to divert blame away from Janet for having caused her current situation. She is dying of lung cancer not through any fault of her own but as a consequence of medical negligence.

The second extract is taken from the television soap opera discussed previously in Chapter 5 (see pp153-154). Mitzy is described as having inoperable lung cancer which is beyond the help of medical treatment and beyond the power of positive thinking. Like Janet, Mitzy has fulfilled the obligations expected of her. She has consulted with specialists but they have failed to control the disease and she is dying. Therefore, this narrative also serves to deflect any criticism from Mitzy that, having accepted her fate, she is not doing everything she can to fight the disease and prevent her death. In

particular, it counters the 'cancer heroics' narrative described by Seale (2002) and discussed in the previous chapter in which individuals with cancer are seemingly able to influence the course of their disease by personal efforts of will. Instead, Mitzy is presented as the victim of a disease that '*even three separate oncologists'* are unable to control.

The two extracts from Janet and Mitzy's stories, therefore, illustrate further how medical failure and inability to treat emerge as explanations for dying in the stories examined. In Chapter 5, narratives of unsuccessful and ineffective treatment were identified as a feature of the stories of dying. The analysis in this chapter identifies them as strategic devices used to absolve blame from individuals for having brought about their dying. They provide alternative reasons to explain deaths from lung cancer – that is, reasons other than smoking.

Therefore, the extracts presented in this section illustrate how some personal stories of lung cancer are organised to counter attributions of blame and portray the individual concerned as blameless for what is happening to them. This activity is observed mainly in relation to individuals who are portrayed as dying of lung cancer. In some stories, blame is absolved by identifying the individual as a non-smoker. In other stories, the smoking status of individuals is not identified and an alternative explanation for the individual's predicament is offered.

6.2.3 Summary of the lung cancer analysis in relation to blame

Using the model of blame proposed by Malle et al. (2012) as a framework to examine media texts, the analysis presented in this section suggests that personal stories of lung cancer are replete with blaming activity. Lung cancer is identified as an event that triggers an evaluation in order to position individuals in relation to blame for having caused their disease through smoking. Most stories provide an explanation for how the individual's lung cancer arose and, in doing so, position the individual as either blameworthy or blameless for their situation. In the stories oriented to raising awareness and promoting messages in relation to smoking cessation and early diagnosis, most individuals are positioned as blameworthy. As discussed in Chapter 5, these stories draw heavily on a public health discourse in which smoking is

presented as the main cause of lung cancer and individuals with lung cancer are positioned as human exemplars aimed at instructing the public on the behaviours necessary to avoid developing and dying of the disease. In these stories, all but one of the individuals concerned is portrayed in relation to their smoking status. However, where individuals are identified as having smoked, additional information is presented that acts to mitigate the level of blame they merit. This mitigating activity is identified as a way of restoring the moral worth of the individuals concerned by presenting them as previously flawed but now morally reformed, having realised the error of their ways in having smoked.

Most of the stories that position individuals with lung cancer as blameworthy also portray them as surviving the disease. Only two stories of dying identify the individual as having smoked and, thereby, as potentially blameworthy for not only their disease but also their death. One of these stories draws on the raising awareness narrative described above. The other story is organised to resist blame. In this story and the remaining stories that portray individuals as dying of lung cancer, blame is actively countered by identifying the individual concerned as a non-smoker and/or by presenting alternative explanations for the development of lung cancer and for their dying. As identified in the previous chapter, in contrast to most of the stories that portray individuals as surviving the disease, most stories of dying are organised in rhetorical opposition to public health discourses that construct lung cancer and dying of the disease as solely a consequence of individual behaviour. In these stories, individuals are positioned within a narrative that presents lung cancer as a more complex disease; one that is not fully understood by science and difficult to effectively control.

This activity of positioning individuals with lung cancer in relation to discourses of blame for having caused the disease to develop through smoking acts to perpetuate and sustain their circulation. Narratives in which individuals with lung cancer are portrayed as smokers act to reinforce the discourse and may repress investigation and discussion of other causes of the disease. However, narratives that work to position individuals as blameless draw attention to the discourse by opposing it and, in doing so, act to reinforce the disease as one that is usually worthy of an evaluation of blame.

6.3 Breast cancer as a non-blameworthy event

Comparing the personal stories of breast cancer with those of lung cancer reveals a striking difference in the way that stories are organised in relation to blame. Blaming activity is hardly evident in the personal stories of breast cancer. In contrast to the personal stories of lung cancer, most (79%) of the stories of breast cancer do not feature explanations for how the disease arose and, therefore, they are not organised to address cause or blame. For example:

Extract 51 Anne's story:


Nightmare that made us bosom buddies!

Breast cancer - warning signs

Cancer Research UK recommends that if you have any of these symptoms you should contact your GP:

» A change in the size, shape or feel of your breast

» A new lump or thickening in one breast or armpit

» Puckering, dimpling or redness of the skin

» Changes in the position of the nipple or nipple discharge

» New pain or discomfort that is only on one side

'Legal secretary Anne was diagnosed with breast cancer after she found a lump in April 2006 while in the shower.

She had suffered from a cyst on her breast during her 30s, which was treated by antibiotics, and she initially assumed this lump would be something similar.

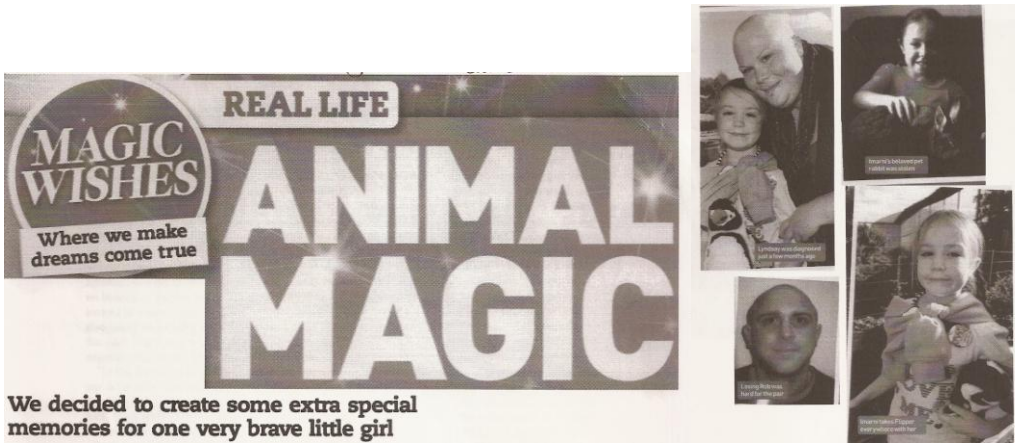
But Anne recalled how she was "absolutely floored" when tests showed she had an aggressive form of breast cancer.

Anne underwent an operation to remove the lump in May 2006, which is when she met Gillian, who was on the same ward and had the same operation the day before.'

And further:

'*We are really good friends now but we would never have met if it hadn't have been for the cancer. So in our case something good came out of something bad*.' ('Nightmare that made us bosom buddies!' Lancashire Telegraph, 20 October 2010)

Extract 52 Lindsay's story:



'After noticing a strange rash and a swelling on her left breast, Lyndsay went to see the nurse at the local GP surgery and was referred for tests.

"A week later, the doctor asked me to come in for the results, so I knew it was bad news," she explains.

Lyndsay was diagnosed with an aggressive form of breast cancer and further scans showed it had also spread to her lymph nodes and lungs. The cancer was terminal.

"I was scared and worried how Imarni [daughter] *would take it as she'd been through so much," she says. "But I had to be honest with her.*

"We sat together on my bed and I explained that I was poorly and wasn't going to get better. Imarni didn't even cry – she just wanted to get me a cup of tea before hopping back on the bed to keep me company."' ('ANIMAL MAGIC: We decided to create some extra special

> memories for one very brave little girl', Love it! 28 October 2010) (capitals as in the original)

These two extracts are illustrative of the personal stories in which discussions relating to an individual's diagnosis and/or their dying of breast cancer do not prompt a causal explanation for the disease. The first extract is taken from a newspaper story produced in response to the Breast Cancer Awareness Month initiative. It portrays how Anne was diagnosed and treated successfully for breast cancer, during which time she forged a supportive friendship with Gillian who was also being treated for the disease. In contrast with stories of individuals surviving lung cancer produced for the awareness month initiative (see for example Extract 37, p197, and Extract 39, p200), discussion of Anne's diagnosis of breast cancer does not trigger a causal explanation for the disease and she is not positioned in relation to lifestyle behaviours that are identified as risk factors for the disease. In addition, where advice and factual information about breast cancer is included as part of the story, as in the extract from Anne's story above, causes of the disease are less likely to be presented and, where they are, they are less likely to emphasise lifestyle factors. This is identified in Chapter 4 in relation to discussions about risk factors across all the texts in the breast cancer dataset (pp131-133).

The second extract is taken from a newspaper story in which the individual is portrayed as dying of breast cancer. This extract can be compared with Extract 48 (p211) from the lung cancer personal stories since both share a similar narrative of a young mum dying of cancer and her daughter being awarded a special day out. Also similar is that neither story is explicitly oriented to the awareness month initiatives. In contrast, however, in the lung cancer story the young mum is portrayed as having developed cancer as a consequence of an inherited condition and is dying after doctors failed to investigate her fully because of her young age and her pregnancy. In the extract above, Lindsay's diagnosis of terminal breast cancer is presented without an explanation of why she may have developed the disease and her dying is presented as a consequence of the disease alone – its aggressive nature and extent of spread – rather than the consequence of the actions or inaction of any individual or group of individuals.

The two extracts above serve to illustrate the contrast identified between the two datasets in that most portrayals of the experience of breast cancer, unlike those of lung cancer, are not organised to address cause and, therefore, do not work to position individuals, whether living, dying or having died, in relation to judgements of blame.

Where causal explanations are discussed in relation to an individual with breast cancer, most draw on external factors that are outside of the individual's control rather than personal behaviours. For example:

> Extract 53 Angela's story:
>
> *'Ironically, it turned out the lump she had found was not cancerous but in the course of tests, cancer was detected in Angela's other breast. She said: "It completely took the floor out from under me. We just didn't expect that."*
>
> *Angela's oestrogen levels were feeding the cancer, so initially treatment was to artificially induce a sudden menopause with all its worse effects.'* ('Think pink and help: Angela's ordeal prompts cancer appeal effort', Annandale Observer, 22 October 2010)
>
> Extract 54 Christine B's story:
>
> *'Then, when Christine was 32, she was diagnosed with breast cancer. Emma was seven and Scott, five.*
>
> *"The diagnosis was a terrible shock," admits Vincent* [husband]*. "There was no family history of breast cancer and she was so very young."*
>
> *Christine had a mastectomy and chemotherapy and the family thought she had recovered. But four years later, she began to find walking increasingly difficult.*
>
> *"It was the worst possible scenario," says Vincent, "because the cancer had spread to her bones. Doctors explained they couldn't cure it – we knew it was terminal."'* ('Nothing can prepare you for being dad … and mum', Daily Mirror, 22 October 2010)

In these two extracts and similar to the personal stories of lung cancer, discussions in relation to the diagnosis of breast cancer are followed by an

evaluation of what may have caused the disease to develop. The first extract is taken from a newspaper story about a woman who has survived breast cancer. This story is oriented to the Breast Cancer Awareness Month initiative. In this extract, the development of breast cancer is presented as a consequence of the woman's hormone levels. The second extract is taken from a newspaper story about a young mother who has died of the disease. This story is not explicitly linked with the awareness month initiative and it is the only account of an individual dying or having died of breast cancer that discusses cause in relation to how the disease may have arisen. In the extract presented above, the absence of a family history of the disease and the individual's young age present the development of breast cancer as a random event. Therefore, although in both stories the diagnosis of breast cancer has triggered an evaluation of cause, this activity is limited to an exploration of factors that are outside of the personal control of the individual involved. Unlike the accounts of lung cancer, particularly those oriented to raising awareness of the disease, the individual's lifestyle is not scrutinised in order to position them in relation to blame for having acted in a way that may have influenced the disease to develop.

However, eight personal accounts of surviving or living with breast cancer do discuss lifestyle behaviours in relation to the individual's diagnosis. In four of these, details are presented that work to position the individual as blameless. These stories draw on a similar narrative structure to that identified in the accounts of individuals surviving lung cancer: Details of the individual's diagnosis triggers a discussion of specific lifestyle behaviours. This discussion works to position the individual in relation to cause and potentially blame. However, in each of the four stories the individual is portrayed in opposition to factors that might be considered risk factors for cancer and ill-health generally. For example:

> Extract 55 Linda's story:
>
> *'"When I found my lump, I was quick to act. I knew if it had happened to Kate, it could happen to me. It was great having Kate one step ahead of me, we could discuss our fears together. When Sarah was diagnosed it was a real shock – none of us smoked or were overweight, and Sarah had breast-fed four children, which is supposed to reduce your risk. It's as if the three of us were in an exclusive club."'* ('FIGHTING BACK:

> Three friends facing one battle: WHEN KATE LEARNT SHE HAD BREAST CANCER, SHE TURNED TO LINDA AND SARAH. THEN THEY, TOO, WERE DIAGNOSED', Woman, 1 November 2010) (Available during October) (capitals as in the original)

> Extract 56 Vicky's story:
>
> *'You expect to get cancer when you're 60-plus. To get it when you're 30 is a shock to the system.*
>
> *"I didn't have any problem with my diet or lifestyle and just randomly got it."'* (Vicky, 31, wins cancer battle', Birmingham Mail, 4 October 2010)

The first extract is taken from a story in a woman's magazine and the second from a newspaper story. The extracts are illustrative of four of the stories in which individuals and positioned in opposition to behaviours that might be considered to have influenced the development of their breast cancer. Generally in these stories the individuals concerned are presented as having healthy lifestyles; in the two extracts above in relation to diet, not being overweight and having breast-fed, and in the other two stories also in relation to taking exercise and not having smoked. Three of the stories are explicitly oriented to the Breast Cancer Awareness Month initiative.

In contrast, the remaining four stories discuss lifestyle factors that potentially position individuals as blameworthy for the development of breast cancer and within these stories, similar to the lung cancer accounts, there is activity that functions to contest and/or negotiate the level of blame that may be warranted. For example:

6. Evidence of Blaming Activity

Extract 57 Jo and Mandy's story:

'*Q: "Did your consultant explain why you had developed breast cancer?"*

Jo: "I went to the forum to find out. Right at the beginning of the talk, there was a slide called 'Reasons for breast cancer'. The first one said 'Bad luck'."

Mandy: "You become like a detective picking over your life. Was it because I was on the Pill? Is it because I ate too much dairy? We all search the internet and leap on new studies as they're reported. It's not always helpful as research is often conflicting, but it gives you a sense of control when the consultants can't give you an answer."' ('OUR BREAST CANCER SURVIVAL CLUB', Red, 1 November 2010) (Available in October) (capitals as in the original)

Extract 58 Ellie's story:

'"Tom and I were taken to the consultant's room there and then, where I was told I had cancer in my left breast and it had already spread to my lymph nodes. I'd believed I was healthy, fit and strong. I went to the gym twice a week and ate my five-a-day. I didn't drink any more vodka that the average 27-year-old. But my body had let me down."'

Further in the story:

'"I Googled "survival rates for breast cancer" and my diagnosis gave me only a 50 to 70% chance. Shaking, I poured myself a glass of wine that

> *I knew wouldn't help my body at all."'* ('I thought I was too young to get breast cancer. I was wrong', Grazia, 11 October 2010)

Both of these extracts are taken from magazine stories oriented to raising awareness and portray the women concerned as having survived breast cancer. The first extract is taken from a story that is organised in a question and answer format in which four individuals take turns to answer questions posed to them. In this extract, two of the individuals are presented discussing possible causal factors for breast cancer. Taking the contraceptive pill and '*eating too much dairy*' are offered as possible explanatory behaviours. However, these explanations are sandwiched between others that work to oppose them by presenting the disease as poorly understood and a matter of chance. Moreover, these alternative explanations are warranted by official sources – 'consultants' and the 'forum'. The forum is described elsewhere in the story as a group run by the charity Breast Cancer Care. This narrative structure therefore weakens the force of blame attributions. The weakness of blaming activity is also evident in the lack of grading-of-blame activity within the story. Unlike the stories of lung cancer in which blame is amplified and/or reduced by portraying individuals within narratives that serve to explain, justify or contest their smoking behaviour, similar strategies to account for the personal behaviours identified (taking the contraceptive pill and eating too much dairy) are absent. This lack of accounting suggests that these particular risk factors for breast cancer do not invoke the same level of blame as smoking. This is understandable given that the risks to health involved in taking the contraceptive pill are socially sanctioned as acceptable, since access to the pill is dependent on it being prescribed by health professionals. Similarly, although eating too much fat is known to carry health risks and has been implicated as a risk factor for breast cancer, fat is an acceptable part of a healthy diet. How much fat is 'too much' is unclear, and the photographs of the individuals concerned do not suggest over-indulgence if a judgement may be made based on body size.

The second extract contrasts somewhat with the first in the blaming activity observed. In this extract although Ellie is portrayed as blaming her body for the development of the disease ('*my body had let me down*') and in relation to some personal behaviours that present an image of a healthy lifestyle (a diet high in fruit and vegetables and regular exercise); the description of her

alcohol consumption potentially presents her lifestyle less favourably. Alcohol is increasingly associated with the development of breast cancer (Parkin et al. 2011) and the phrase '*I didn't drink any more vodka than the average 27-year-old*' could present her consumption as problematic in the context of contemporary media coverage of young women who 'binge' drink (Day et al. 2004). Furthermore, Ellie is portrayed as having a glass of wine after her diagnosis despite '*knowing*' that it would not help her body. The narrative, therefore, positions Ellie in relation to behavioural factors that may be considered unhealthy and in doing so it invites a judgement of blame. The presence of continued drinking in this story, however, may suggest that alcohol consumption is a less blameworthy risk factor than smoking behaviour since none of the individuals with lung cancer is portrayed as continuing to smoke following their diagnosis.

In one of the four stories, although the individual is positioned in relation to lifestyle behaviours that potentially warrant blame, the narrative sequence works to reduce the intensity of blame. In most personal stories whether in relation to individuals with lung cancer or breast cancer, causal factors tend to be presented near to discussions relating to the individual's diagnosis of cancer. However, in the following extract, this is not the case. Details regarding the individual's lifestyle are presented at the very end of the story. For example:

> Extract 59 Brigid's story:
>
> *'As expected, the appointment came and went and three days later her worst fears were confirmed. Unfortunately for Brigid and the McDermotts, her variation of breast cancer was aggressive and following the complete removal of the tumour, chemotherapy and radiotherapy loomed.*
>
> *"This was a knock for me because at the time, I thought that anyone who gets chemo is only doing so to stay alive a wee while longer. The chemo was rough, very rough. You can't really explain it to someone who has never had it. From the tip of your big toe to the top of your head, you feel rough – it's pure poison."'*
>
> At the end of the story:

'Currently, Brigid regularly attends the Breast Cancer Support Group in Enniskillin where she and former cancer patients talk about everything apart from cancer, although it does get a mention from time to time. She likes the camaraderie, she says and the fact that cancer isn't a taboo subject around survivors.

"My life hasn't changed a lot," Brigid adds. "I always had a decent enough diet. I was a smoker when I was diagnosed but I've given them up, though I have fallen by the wayside a few times.

"A doctor told me once that they don't know what causes breast cancer, but I think personally, it has a lot to do with diet. I think we all eat too much processed food.

"It was a battle but it worked out OK. These days, I thank God for every day that comes along."' ('Brigid McDermott: 'From the tip of your toe to the top of your head, you feel rough – it's pure poison'. Brigid, cancer and Tyrone', Ulster Herald, 21 October 2010)

In this extract, Brigid is described as a smoker. This is the only personal story of breast cancer examined that identifies the individual as having smoked. Identifying Brigid as a smoker portrays her as someone who has put her health at risk and, in contrast to the stories of lung cancer, who continues to do so occasionally ('*I have fallen by the wayside a few times*'). In this context, the description of Brigid's diet as '*decent enough*' contrasts with the '*healthy*' and '*five-a-day'* diets identified in other stories that are organised to absolve or mitigate blame. Therefore, these details in relation to Brigid's lifestyle position her as potentially blameworthy in having acted in ways that may have contributed to the development of cancer. In this story also, expert opinion is drawn upon to suggest that the cause of breast cancer is unknown and an alternative extrinsic explanation for the disease ('*too much processed food*') is presented. These details work to reduce the force of blame, suggesting further that blaming activity is taking place.

The extract also illustrates that a 'cause and effect' narrative sequence is not presented in this story. Instead details of Brigid's lifestyle are presented at the end of a lengthy narrative (only a small part of which is presented above) that draws on a heroic narrative to position her as having battled in the face of an

aggressive form of breast cancer and treatment that is so rough that it is difficult to describe to anyone who has not experienced it. The narrative structure of this story shares similarities with the one observed in the personal stories of lung cancer in which Herbie, a ninety-one-year-old gentleman, has survived the disease for twenty-five years (see Extract 43, pp203-204). In this story and in contrast to the other stories of individuals surviving lung cancer, discussion of Herbie's smoking behaviour occurs near the end of the story, at a distance from the discussion of his diagnosis and after he has been portrayed as an inspiration to others by having survived the disease for so long. This narrative sequencing in which evaluations of cause are subordinate to portrayals of heroism suggests that less forceful attributions of blame are taking place in these two stories.

Brigid and Herbie's stories share another similarity in that both individuals are portrayed as religious and attribute their survival to God. Identifying individuals as religious may act to confirm their moral goodness and function also to mitigate judgments of blame. However, it is not a feature of the other personal stories that are identified as portraying individuals in relation to cause and blame. Similar to Seale's (2001a, 2002) analysis of media representations of the experience of cancer, in most of the personal stories examined for this thesis religion is not a dominant theme (see also Chapter 5, pp163-165).

In summary, personal stories of individuals with breast cancer are less likely than personal stories of lung cancer to be organised to address issues of cause and blame. In most stories, the diagnosis of breast cancer does not trigger an evaluation of cause in the same way that lung cancer does. Where causal explanations are presented, most stories draw on discourses that associate the disease with intrinsic risk factors that are outside personal control such as family history, age and hormone levels. Only a small number of stories portray the individual in relation to discourses that associate cancer with personal behaviours. In these stories, diet, alcohol consumption, smoking, obesity, exercise and breast feeding are factors that are implicated in either increasing or reducing the risk of breast cancer. Often, these accounts are structured in ways that work to reduce the level of blame these behaviours warrant, so that the overall impression of blame within the stories is less intense than in the stories of lung cancer.

Therefore in this analysis, developing and/or dying of breast cancer is not identified as an event that warrants an evaluation of cause in the same way that developing and/or dying of lung cancer appears to do. As a consequence, individuals who develop breast cancer, whether living, dying or having died, are less likely to be positioned in relation to a discourse of blame.

6.4 Bringing the analysis together: Addressing discourses of blame

A distinct difference in the way that personal stories of lung cancer and breast cancer are organised in relation to blame has been identified in this examination. The lung cancer texts are suffused with blame and blaming activity. In comparison, the breast cancer texts are not. Lung cancer is identified as a negative event that triggers an evaluation of blame because of its association with smoking. Explanations for how the disease has arisen and/or how individuals have come to be dying of the disease are presented, working to position individuals as either blameworthy or blameless for having caused their situation. In some stories blame is attributed by identifying individuals as having previously smoked. In these stories, further details are presented that act to negotiate the degree of blame that individuals merit. In other stories blame is absolved, either by identifying individuals as non-smokers or by presenting alternative explanations for the disease and the individual's dying. In comparison, blaming activity of this nature is barely evident in the personal stories of breast cancer. The diagnosis of breast cancer is far less likely to trigger a causal evaluation, and individuals with the disease are rarely positioned in relation to lifestyle behaviours that are considered to be risk factors for the disease.

This difference in the structuring of personal stories in relation to blame illustrates the strength of the causal association between lung cancer and smoking. It also illustrates that smoking is more strongly linked with blame than behaviours that are identified as risk factors for breast cancer. Chapter 3 draws attention to the inherent moral character of social discourses in relation to smoking. Smoking is not only a symbol of personal disregard for health; it is also perceived as a social problem, a risky activity that needs to be curbed in the interests of the wider public health (Lupton 1995). Public health strategies,

exemplified by the smoking cessation campaigns that followed the publicising of studies linking smoking and lung cancer, have increasingly and successfully sought to denormalise smoking, making it undesirable and socially unacceptable (Lupton 1995; Poland 2000; Graham 2012). As a consequence, individuals who continue to smoke are represented as uncontrolled, irrational and self-indulgent, and are increasingly socially marginalised (Poland 2000; Graham 2012). They merit little public sympathy and are deemed to have only themselves to blame if they develop ill-health (Brandt 1998; MacKenzie et al. 2011). The analysis in this chapter illustrates how media draw on this moral discourse of smoking in their representations of individuals with lung cancer. As a result, lung cancer is constructed as a blameworthy event, and individuals who develop the disease are positioned as potentially blameworthy and, thereby morally flawed.

Breast cancer is less likely to trigger evaluations of cause and judgements of blame. This is likely to be for a number of reasons. Unlike smoking and lung cancer, a similar single risk factor for breast cancer associated with personal behaviours has not been identified. A number of lifestyle factors are implicated in the development of the disease, including exogenous hormones (hormone replacement therapy and the contraceptive pill), obesity, exercise, alcohol, fat intake, shift work, age at first birth and lack of breast feeding (Parkin et al. 2011). However, each of these factors implies only a small increase in the risk of breast cancer, compared with the risk of smoking which is identified as the cause of between 85 to 90% of lung cancers (Parkin 2011; Parkin et al. 2011). In addition, compared with the link between smoking and lung cancer, lifestyle factors associated with breast cancer are only recently becoming understood, and they have not been subject to the same degree of public health campaigning. If they become increasingly implicated in the development of breast cancer, social discourses in relation to them, particularly in light of the prevalence of the disease, may change in the same way that discourses in relation to smoking have changed. Indeed, obesity (which may imply poor diet and lack of exercise) and female alcohol consumption are already associated with a lack of personal control and disregard for health (Lupton 1995; Day et al. 2004; Gilman 2010), and there is some evidence of positioning individuals in relation to these lifestyle factors in a small number of the breast cancer stories examined. Reducing levels of obesity and alcohol consumption in

general, rather than specifically in relation to breast cancer, are the targets of ongoing public health initiatives in the UK. Like those targeting smoking, these initiatives are constructed within a moral discourse that highlights their health risks and social burden, as well as personal responsibility for regulating behaviours (DH 2013a, 2013b). Conceivably, failure to regulate these behaviours may lead to increasing judgements of blame in the context of a breast cancer diagnosis, as has occurred with lung cancer since the health risks of smoking have become more widely accepted and been the subject of targeted public health campaigns.

An intriguing pattern can be identified in the personal stories of lung cancer in relation to blaming activity. Blame is more likely to be attributed to individuals in the stories of survival. Most of these stories are organised in relation to the lung cancer awareness month initiative, and position the individuals concerned as having survived the disease or actively living with it. Attributing blame in this context functions as a public health tool to regulate and reform social behaviour in relation to smoking. Individuals with the disease serve as exemplars; they warn others of the dangers of smoking and the blame that is likely to be incurred if they too jeopardise their health and life as a consequence of poor lifestyle choices. In contrast, most stories of dying are organised to absolve blame. In some stories this is achieved by identifying individuals as non-smokers. Other stories require a multifaceted construction in order to position individuals as blameless for their dying in the context of a lung cancer diagnosis. This pattern in relation to blaming activity creates stories of 'blamed' survivors and 'blameless' dying, and draws attention to what is largely absent from the dataset that might be otherwise expected. Given that smoking is the main cause of lung cancer and most individuals have a form of the disease that is incurable, it is unexpected that so few stories portray individuals as both blameworthy and dying or, in other words, dying as a consequence of having smoked.

However, close examination of the two texts that deviate from this pattern provides a potential explanation for this absence. The first of these texts is Christine's story, in which Christine is portrayed as blaming herself for having caused her dying through smoking. Like the stories of survival, this story is identified as being produced in response to the awareness month initiative and Christine acts as a public exemplar; warning others of the dangers of smoking.

6. Evidence of Blaming Activity

However, Christine's story contrasts with the stories of survival in the intensity of the blaming activity that occurs in it. Blame is expressed explicitly: '*It's related to smoking I'm afraid so it's self-inflicted. If I hadn't smoked I wouldn't be dying.*' This contrasts with attributions of blame in the stories of survival, which are implicitly achieved but not explicitly expressed. Activity to mitigate the severity of blame is also more intense in Christine's story than in the stories of survival. Unlike the stories of survival, no justifications are presented for Christine's smoking behaviour. Instead, Christine is portrayed as fully accepting responsibility for having caused her predicament; she is both remorseful and apologetic.

The intensity of blaming activity in this story indicates the severity of blame warranted, and the level of 'repair work' required to restore the moral character of individuals who cause their dying through smoking so that their death can be 'made' good. The difference in the level of blame and mitigation activity in Christine's story in comparison with the stories of survival suggests that judgements of blame are not only guided by assessments of cause and intentionality, as in the model of blame presented by Malle et al. (2012); they are also guided by the seriousness of the negative event that has occurred. In this analysis, causing one's illness and subsequent death through smoking appears to attract a more severe judgement of blame than causing one's illness and surviving it.

The second story that deviates from the patterning of texts in which individuals dying of lung cancer are positioned as blameless is Cassandra's story. This story has already been identified as a variation in relation to the other texts in that it is largely self-authored and focuses more on the experience of living with the disease rather than of surviving or dying of it. Although dying is not an explicit focus of the story, as it is in the stories of the dying individuals, it is nevertheless an implicit 'taken-for-granted' aspect of the narrative. However, Cassandra's story differs from Christine's story. Although it identifies the narrator as a former smoker, it is actively constructed to resist blame for having caused the disease through smoking. Instead of presenting a narrative of acceptance, remorse and atonement as in Christine's story, Cassandra's story is organised to undermine the construction of lung cancer as solely a smoking-related disease. It draws on various techniques to raise uncertainty as to whether smoking is the cause of Cassandra's cancer. These

techniques include presenting lung cancer as more complex and less uniform disease than is generally thought of, and a chance occurrence for some people. Also, Cassandra's smoking is presented as minimal and light, in contrast to heavy smoking. Therefore, in different ways Christine and Cassandra's stories illustrate the level of activity required to position individuals who are dying of lung cancer and have previously smoked in a worthy light; that is, representing them as worthy of media/public attention. Christine's story illustrates the level of repair work required to restore individuals' moral and social worth in the context of smoking. Cassandra's story illustrates the level of activity required to position individuals who have previously smoked as potentially blameless in the context of developing lung cancer and potentially dying of it.

The level of activity in these two stories in relation to addressing blame appears to be greater than in the other personal stories, pointing to a potential conflict posed by representations of individuals with lung cancer who have smoked and are dying. That is, the difficulty of portraying dying from lung cancer within a heroic narrative in the context of the individual having caused the event through smoking. The absence of similar stories coupled with the way that the remaining stories of dying, in contrast to the stories of survival, are organised to counter blame and portray individuals as blameless, suggests that this conflict may more usually be resolved by exclusion. In this reading of the data, only the worthy dying are presented for public view. The unworthy – those who have caused their dying through smoking – are excluded, unless their death can be 'made' good by presenting alternative explanations that act to absolve blame, or their blame can be used as a public health tool to warn others of the dangers of smoking. Since individuals with lung cancer are, or are expected to be, dying because they have smoked, this practice is likely to remove most representations of the experience of lung cancer from public view. This interpretation of how media practices function to exclude some representations of lung cancer may present an explanation for the claims made in Chapter 4 in relation to the relative absence of the personal experience of lung cancer in texts and the relative lack of prominence of the disease in comparison with breast cancer.

7. Discussion

This thesis set out to examine representations of lung cancer in UK media. Within the social constructionist framework adopted, media representation is viewed as a social practice in which meanings and knowledge about the disease are produced, reproduced and circulated within particular cultural and historical contexts. In adopting this approach, the research process and the production of this thesis are also acknowledged to be constitutive practices and are, therefore, specific to my particular social location.

Over two thousand media texts containing representations of lung cancer were retrieved and examined, all published during a three-month period in 2010. Texts were retrieved from a range of sources including newspapers, magazines, television and radio broadcasts, the internet and health promotion materials. A similar number of texts containing representations of breast cancer were also retrieved and examined. These were published in similar types of media over a single month during 2010, and were used as a comparative dataset. Texts were treated as cultural artefacts that can be examined for their representational activity and the social actions that may be achieved through this particular practice.

Analysis comprised three phases. A first phase set out to gain a broad overview of the content of texts and identify how lung cancer and breast cancer is commonly represented in them. In the second phase of analysis, texts that contain a personal story of the experience of lung cancer or breast cancer were selected for a more focussed examination. Personal stories were selected because during the initial broad comparison of the two datasets the personal experience of lung cancer was identified as relatively absent in most representations of the disease. Additionally, where the personal experience of lung cancer was portrayed, the individual concerned appeared less likely than individuals with breast cancer to be portrayed within a heroic narrative (Seale 2001a, 2002). Therefore, focussing on texts that contained a personal story would allow an in-depth examination of how the experience of lung cancer is portrayed compared with that of breast cancer. The analysis of personal stories focused on content and action, i.e. examining features that are shared, and also variability and differences in how the two diseases are portrayed, as well as speculating on the potential consequences achieved by these portrayals.

7. Discussion

Theoretical understandings from other studies in the social science literature were drawn on to develop the comparative analysis further. This is presented as the third analytic phase, and involved using Seale's (1995a, 2001a, 2002) conceptualisation of cancer as a heroic event and Malle et al.'s 2012 model of blame as theoretical frameworks to guide the analysis.

What was immediately striking from the initial examination of all the data retrieved was the difference in the volume of texts and the prominence of the two diseases in and across texts. During the awareness months, where a direct comparison may be made, breast cancer was identified in over three times as many texts as lung cancer, and was prominent in most of the texts retrieved for the breast cancer dataset. In contrast although lung cancer was present in texts, it was often mentioned only briefly and was less prominent in and across texts, even during Lung Cancer Awareness Month. This distinction in the volume of texts and the prominence of the two diseases suggests a greater social willingness to discuss breast cancer and a relative reticence to discuss lung cancer, at least in relation to raising awareness initiatives.

The prominence of breast cancer drew attention to differences in how the two diseases are portrayed in relation to raising awareness activities and the potential consequence of these portrayals. Breast cancer awareness is highly visible in and across texts, and is presented as a widely-supported social movement aimed at not only raising awareness but also raising money for further research into the disease. Texts are organised to mobilise audiences/the public to join in also. In comparison, lung cancer awareness is presented as a solemn and serious health education activity directed mainly at those who smoke so that they may avoid needlessly developing and dying of the disease. These differences in how the two diseases are represented in relation to awareness-raising initiatives draws attention to how breast cancer is constructed as a worthy and popular cause while lung cancer, in comparison, is not.

A further striking difference in how the two diseases are represented is in relation to death and survival. The most common reason for lung cancer to be discussed in texts is because someone has died of the disease, or else in relation to the high death rate associated with the disease. Where survival is discussed it is identified as persistently poor and images of individuals

surviving the disease are less commonly portrayed. In contrast, breast cancer is less frequently discussed in relation to death and dying, despite over 11,000 women dying of the disease each year in the UK (CRUK 2013b) and an estimated 36,000 living with secondary disease of which 12,000 are estimated to be potentially in the last year of their life (Maher & McConnell 2011). Rather, breast cancer is presented as a disease of improving survival and one that most people will survive. In addition, individuals living with and surviving the disease are frequently and prominently presented in stories. This distinction in how the two diseases are commonly represented reinforces the close association of lung cancer with an inevitable death.

Although individuals with lung cancer are present in media texts, mostly in relation to having died of the disease, representations of their illness experience are relatively absent. In contrast where individuals with breast cancer are portrayed, an account of their personal experience of the disease is also commonly presented. These personal accounts of breast cancer often portray individuals within a heroic narrative similar to that described by Seale (2002) in which they display extraordinary feats of personal courage in the face of life-threatening illness, mostly having survived the experience. In the broad overview of texts, a similar heroic narrative was less evident in representations of individuals with lung cancer.

Also noticeable during the initial examination of all the texts was a difference in how the two diseases are represented in terms of risk. Lung cancer is presented as a disease caused by mainly by smoking and other risk factors are less commonly discussed particularly in texts aimed at raising awareness. In this representation, lung cancer is constructed as a disease that people put themselves at risk of by choosing to smoke. In contrast, breast cancer is presented as a risk that is difficult for women to avoid because of intrinsic factors such as age, gender and family history. Therefore, women are presented as inherently *at* risk of breast cancer rather than being the cause of it. This distinction between the two diseases highlights how lung cancer is constructed as a self-inflicted disease and a concern mainly of people who smoke.

Therefore, the broad examination of the texts identifies how the discourses identified in Chapter 3 that associate lung cancer with death and smoking are

sustained and perpetuated in media portrayals of the disease. It also suggests how, compared with breast cancer, lung cancer is constructed as a cause that is less worthy of public support particularly in relation to raising awareness activities.

Focussing the analysis on texts that contain a personal story and using Seale's (1995a, 2001a, 2002) concept of cancer as a heroic event allowed a closer examination of how the personal experience in relation to each of the two diseases is portrayed. This examination identified that personal stories of lung cancer take the form of two dominant narratives. In the first of these, elements of a 'heroic death' narrative (Seale 1995a) are drawn on to portray individuals as bravely dying of lung cancer in open awareness, acceptance and self-sacrifice. In the second dominant narrative, a public health discourse is drawn on to portray individuals as having survived the disease. However in this discourse, individuals are positioned as lucky rather than heroic, particularly if they had caused the disease through smoking and given that survival from the disease is generally poor. In contrast in most of the personal stories of breast cancer the individual concerned, whether surviving or having died, is positioned similarly within a 'cancer heroics' narrative (Seale 2002) in which they have actively battled to overcome the disease, even when faced with a terminal diagnosis.

These differences in relation to how individuals are portrayed in relation to their survival and dying are indicative of how the two diseases are socially constructed. As identified in the broad overview of texts, lung cancer is associated with a discourse of inevitable dying. Texts either draw on this discourse to portray individuals as dying of the disease or they actively work to oppose the discourse and present survival as a possible outcome of lung cancer. In contrast, breast cancer is associated less with inevitable dying and more with a discourse in which survival is presented as the norm. Therefore, personal stories of breast cancer are more likely to position individuals as doing everything possible to survive the disease and avoid dying.

The differences observed between stories in relation to whether individuals are portrayed within a heroic narrative suggested that accounts of the personal experience of lung cancer are also shaped by discourses that associate lung cancer with smoking. Using a model of blame proposed by Malle et al. (2012)

to examine the personal stories for evidence of blaming activity identified that a diagnosis of lung cancer is an event that triggers an evaluation of cause in order to position the individual concerned in relation to blame. Texts function either to assign blame by identifying individuals as smokers, or to absolve blame by presenting alternative explanations for the disease and/or individuals' dying. A similar examination of personal stories of breast cancer identified that the activity of positioning individuals in relation to blame for having caused their disease and their potential dying was uncommon. Discussions of individuals with breast cancer are less likely to activate evaluations of cause and judgements of blame in the texts examined. As a consequence, and in stark contrast to the personal stories of lung cancer, few individuals with breast cancer are positioned in relation to blame.

A distinct patterning was observed across the texts that present a personal story of lung cancer. On the one hand there are stories that argue that survival from lung cancer is possible, wherein individuals with the disease are positioned as blameworthy. These are mainly stories organised to raise awareness of the disease. On the other hand there are stories of inevitable dying of lung cancer, in which most individuals with the disease are positioned as blameless. These stories are less likely to be organised in relation to raising awareness of the disease. This patterning of texts drew attention to what was absent, but might have been expected – i.e. personal stories of individuals who are dying and have smoked. The absence of these stories suggested that media processes may function to permit some representations of lung cancer and repress others. In this interpretation, representations of individuals with lung cancer who have caused their disease through smoking are permitted in the context of awareness-raising initiatives and in the context of survival. However, they are less likely to be permitted in the context of dying unless they serve to promote public health messages about the disease during awareness raising initiatives.

The contextual specificity of this patterning of texts (i.e. awareness stories of blameworthy survivors and non-awareness stories of blameless dying) suggests that this seemingly paradoxical representation of lung cancer is not random but a consequence of the social context in which the texts are situated, and the 'lived ideologies' (Billig et al. 1988) that are drawn upon in the production of texts. In drawing on a heroic narrative the personal stories of dying of lung

cancer, like those portraying deaths from breast cancer, are organised to construct dying of cancer as a 'good' death. However, portrayals of surviving lung cancer differ from those of breast cancer even though both are largely oriented to raising awareness. Rather than drawing on a heroic narrative, the lung cancer accounts draw more heavily on a public health discourse in which responsibility for maintaining health and avoiding ill-health is located with individuals (Lupton 1995; Petersen & Lupton 1996). Within this discourse health is an important signifier of moral worth, and individuals who adopt behaviours that jeopardise their health warrant blame and shame (Lupton 1995). Because of the strength of the causal association between lung cancer and smoking, the diagnosis acts as signifier of moral unworthiness, connoting a lack of personal and social responsibility. In this discourse, individuals who develop lung cancer having smoked are positioned as morally lacking and lucky if they subsequently survive the disease. Therefore, discourses that construct lung cancer as a blameworthy event are potentially in opposition to discourses that construct dying of cancer as a heroic event, since they raise questions regarding the moral character of the individual concerned. The patterning of the texts observed in this analysis suggests that the tension between the two discourses is usually resolved by repressing representations of blameworthy dying unless blame can be absolved in some way or used as a public health messaging tool.

In summary, in treating media representations as sites in which meanings are produced and reproduced, this study has traced how lung cancer is socially constructed. From the examination of media texts, I argue that lung cancer is constructed as a blameworthy event that usually results in death, i.e. a blameworthy death. As a consequence of this construction, individuals who develop the disease are positioned as potentially blameworthy for their dying. Wider cultural discourses in relation to dying (particularly dying of cancer) and responsibility for health function to permit some public representations of the disease and exclude others. In particular, representations of individuals dying of lung cancer in the context of having smoked are largely repressed. Given that most people with lung cancer will have smoked and are potentially dying, this practice is likely to marginalise most representations of the personal experience of the disease. In doing so, this practice constructs lung cancer and individuals who develop the disease as unworthy of public attention.

In suggesting how media practices function to repress representations of lung cancer, the thesis builds on and potentially extends the knowledge gained from the only other study identified that specifically examines media representations of the disease. The study by MacKenzie et al. (2011) (discussed in Chapter 2, pp20-23) examined forty-five television news reports of lung cancer that were broadcast in Sydney over a four-year period. In contrast to the study presented in this thesis, MacKenzie et al.'s study drew mainly on a quantitative content analytic approach. The authors identified that television reporting of lung cancer is low in comparison with the reporting of cancer in general (2% of all cancer-related reports). They also identified that reporting of non-smoking related lung cancer was more frequent than reporting of smoking related disease. The authors suggest that the emphasis on reporting non-smoking related cases of the disease implies '*an element of victim-blaming directed at smokers with the disease*', and that this feature of reporting may contribute to the stigmatisation of lung cancer (p68).

In examining texts for their social action as well as their content, and by drawing on media representations of breast cancer as a comparative dataset, this thesis provides data that support MacKenzie et al.'s claims. It does so by identifying the process in which blame is enacted in media texts, and suggesting how this activity may function to exclude certain representations of the disease. Moreover, it potentially extends the claims made by MacKenzie et al. by suggesting that it is not only discourses of smoking that function to exclude representations of lung cancer, but also cultural discourses in relation to dying and dying of cancer. It is the mobilisation of these two discourses in relation to lung cancer that operates to exclude most representations of the disease, thereby contributing to its stigmatisation.

In suggesting how media practices operate to exclude representations of lung cancer, this thesis potentially supports and extends the work of authors who draw attention to the material effects of stigma in relation to the disease (for example Chapple et al. 2004; Moffat 2006; Corner et al. 2006). One of these effects of stigma formed the starting point of this thesis, namely the concern that the social context may pose a significant barrier to effective public awareness campaigns and hinder public health efforts to improve the earlier diagnosis of lung cancer. Researchers raising this concern identify that prior to diagnosis, lung cancer does not feature in an individual's consciousness as a

possible interpretation for bodily changes associated with the disease (Moffat 2006; Corner et al. 2006). Moffat (2006) suggests that this may be due to the absence of a social narrative of lung cancer – that is, a socially-available story or plot-line that people can identify with and place themselves in relation to. Corner et al. (2006) argue that the lack of social prominence of lung cancer means that the disease is not defined as an important public concern, contributing to assumptions about the inevitability of late diagnosis and incurability.

This thesis provides support for these two arguments in that it demonstrates that representations of lung cancer and narratives of the disease experience are not prominent in media texts, particularly in comparison to representations of breast cancer. It also potentially extends the arguments by suggesting *how* media practices function to reduce the prominence and availability of representations of the disease. In the analysis presented in this thesis, it is not just that representations of lung cancer appear less frequently, as identified by the study by MacKenzie et al. (2011) and in the studies identified in the literature review that quantify media representations of cancer in general. Representations of lung cancer are less prominent than representations of breast cancer because they are less oriented to attract audiences/the public, particularly in relation to awareness-raising stories. Representations of lung cancer do not interpellate in the same way that representations of breast cancer do; that is, they do not call out to recruit the audience to get behind the messages that are being promoted (Althusser 1971). Nor do they create appealing subject-positions for people to place themselves in relation to, either as supporters, people at risk or sufferers of the disease.

This interpretation, that media representations of lung cancer do not interpellate audiences and create subject-positions for individuals in the same way as representations of breast cancer, draws on theoretical concepts discussed earlier in the thesis that construct representation as a social activity in which meanings and knowledges about the world are produced through language and discourse. Meaning is derived both from the literal message contained in representations and also from the symbolic messages contained in them, drawn from wider cultural themes, discourses and ideology. Althusser (1971) uses the word 'interpellate' to describe how ideology functions to recruit individuals as its subjects by hailing them – 'Hey, you there!' – with its

message (p.31). In the texts examined for this thesis, representations of breast cancer awareness draw on broader cultural themes, discourses and ideologies associated not only with health and responsibility for monitoring one's own health, but also ones in relation to charitable giving, consumerism, entertainment, fashion and celebrity. These construct breast cancer awareness as an attractive, popular social event; an opportunity to demonstrate one's moral worth and make a difference, whilst also having fun and being entertained. Therefore, the texts function not only to convey a literal message about breast cancer awareness but also to 'hail' and recruit audiences/the public to their broader ideological messages. In doing so, they create a place or position with which the public can choose to align themselves or not. In this way, representations of breast cancer reinforce and perpetuate discourses that construct the disease as a worthwhile cause to support, thereby raising its social prominence, social worth and public support further. Moreover, representations of the personal experience of breast cancer are also organised in ways that are likely to interpellate audiences. They are prominently presented and construct the disease as a common event that can affect any woman at any time. They also construct the disease as a heroic event that most can survive and even derive personal gains from. These discourses in relation to breast cancer therefore create potential subject positions for everyone, since they construct the risk of being affected by the disease, if not personally then by association, as high, while reducing the dread associated with cancer as an inevitably fatal and meaningless event.

In contrast, discourses that associate lung cancer with smoking and dying construct the disease as an inevitable and potentially blameworthy death. In this interpretation, lung cancer is constructed as more of a moral concern than a worthy cause. Therefore, representations of lung cancer that draw on these discourses are less likely to be as successful in hailing audiences/the public, since they create subject positions that are less attractive for people to align themselves with; positions that have little social value, are unlikely to make a difference, and potentially associate individuals with blame and a meaningless death. Moreover, the marginalisation of representations of the personal experience of lung cancer acts to reduce not only the social prominence of the disease but also the available subject-positions for the public to align with.

In this understanding of lung cancer, the thesis also supports and potentially extends the work of authors who draw attention to the effects of stigma for people who develop the disease. In Chapter 3 (pp84-85), stigma is identified as an integral part of the experience of lung cancer. Individuals living with the disease, whether they are smokers or not, expect to receive blame and stigma (Chapple et al. 2004; Tod et al. 2008). Some studies suggest further that blame and stigma are internalised, leading to high levels of guilt, shame, anxiety and depression, low self-image, poor quality of life, poor social interaction with families, friends and health professionals, and a reticence to seek support (Chapple et al. 2004; Tod et al. 2008; Lo Conte et al. 2008; Carmack Taylor et al. 2008; Else-Quest et al. 2009; Tod & Joanne 2010; Conlon et al. 2010; Maguire 2011; Cataldo et al. 2012; Gonzalez & Jacobsen 2012; Brown & Cataldo 2013). The expectation of stigma is also identified as a factor that may delay people reporting symptoms of lung cancer (Corner et al. 2006; Tod et al. 2008; Conlon et al. 2010).

Family members and lay caregivers of people with lung cancer are also subject to the effects of stigmatisation. Caregivers who blame individuals with lung cancer for their disease report anger and less engagement with the person concerned particularly with regards to empathetic helping behaviours and in the context of continued smoking after diagnosis (Carmack Taylor et al. 2008; Siminoff et al. 2010; Lobchuk et al. 2012). Family members also experience poorer psychological and relationship functioning, including higher levels of depression (Carmack Taylor et al. 2008; Siminoff et al. 2010). These material effects demonstrate the burden that stigmatisation places on those who are already disadvantaged by the disease.

Individuals with lung cancer and clinicians, researchers and members of advocacy groups working in the field report that the disease is stigmatised because of its association with smoking and death (Baird 2003; Chapple et al. 2004; Tod et al. 2008; Conlon et al. 2010). People with the disease cite images in the press and health promotional materials as sources of stigma (Chapple et al. 2004; Tod et al. 2008). The examination of media texts presented in this thesis supports these claims, tracing how some media representations of lung cancer draw on and perpetuate discourses that associate the disease with smoking and death, and suggesting further how these discourses may function to marginalise the disease. In demonstrating how media texts actively position

individuals with the disease in relation to blame and dying, the study presents a possible explanation for why the disease is experienced as the cause of stigmatisation. This explanation draws on the concept that discourse produces the subjects of which it speaks. For example, Willig (2011), in writing of her experience of being diagnosed with cancer, describes this concept as being '*captured and positioned*' by the prevailing discursive constructions of the disease (p898). In media representations of lung cancer, individuals with the disease are made into the subjects of a discourse that captures and positions them as potentially blameworthy for having caused their disease, and for most also their dying. This positioning is stigmatising since it marks them out as having deviated from acceptable cultural norms and expectations with regards to looking after their health. This raises questions about their moral worth, leading to the material effects identified in the literature in relation to their own experience of the disease and that of their family members. This positioning contrasts starkly with that of individuals with breast cancer who are more likely to be portrayed as victims of their disease and heroic in their response to it.

Stigmatisation occurs when a society labels someone as tainted and less desirable on the basis of an attribute that marks them out as different (Goffman 1963). Stigmatisation is often understood on the basis of a difference or deviance inherent in the individual. However, in a constructionist perspective, stigmatisation is viewed less as a static attribute and more as a constantly changing social process that operates in specific contexts to produce and reproduce social inequality, causing some groups to be devalued and others to feel they are superior in some way (Link & Phelan 2001; Parker & Aggleton 2003; Burris 2008). To date, much of the research examining stigmatisation has been approached from an individualistic perspective focussing on the perceptions of individuals and the consequences of these perceptions for social interactions. How some individuals and groups come to be socially excluded, and the forces that create and reinforce exclusion in different settings, have been less frequently examined (Parker & Aggleton 2003; Stuber et al. 2008).

By suggesting how media practices function to repress representations of lung cancer and position individuals within a discourse of blame, this study potentially broadens understandings of stigmatisation as a social process

linked to the reproduction of inequality and exclusion. It draws attention to the social conditions in which lung cancer-related stigma is constructed, i.e. the dominance of cultural discourses in relation to smoking and dying of cancer. In terms of smoking, since the scientific evidence linking tobacco and lung cancer became common knowledge, smoking has progressively moved from a social norm to a health risk. Tobacco control policies are increasingly oriented toward denormalising and marginalising smoking behaviour, and stigmatisation of smoking is perceived as an effective public health tool to reduce tobacco consumption and its associated morbidity and mortality (Brandt 1998; Chapman 1998; Bayer & Stuber 2006; Bayer 2008). The strategy has been highly successful in shifting social norms. It has led to a decline in smoking and a social climate in which smoking is less accepted. In turn, this has led to a dramatic fall in the number of deaths from lung cancer, particularly among men. However, a social cost of this strategy is that it has also led to the stigmatisation of those who smoke (Lupton 1998; Graham 2012). Studies identify that people who smoke are identified by others as malodorous, selfish, unattractive, outcasts and excessive users of public services (Farrimond & Joffe 2006; Chapman & Freeman 2008) and, moreover, they are aware of these negative depictions and report unfair stigmatisation judgements of them as people (Louka et al. 2006).

Tobacco control policies are situated within wider discourses which call upon the individual to demonstrate agency and self-determination in various regimes of body monitoring, body maintenance and body improvement (Petersen 1994; Petersen & Lupton 1996). Within these discourses there is an ever-increasing focus on health and the avoidance of health risks, which Lupton (1993) argues functions to blame individuals for ill-health. Health and avoiding risks to health have thus become moral issues. People are expected to take responsibility for the health of their bodies by engaging in various preventive actions, particularly in relation to appropriate lifestyle behaviours (Lupton 1993). However, while this approach to health may seek to place agency with individuals, it also constructs ill-health as something that can be actively avoided and a failure to take care of one's body. Illness is then indicative of a flawed individual, one who is potentially lacking self-control and due vigilance. In this discourse, given the strength of its association with smoking, lung cancer acts as a signifier of irresponsible behaviour. Moreover, because of its

close association with death, lung cancer also acts as a signifier for an avoidable death; one that could and should have been foreseen and prevented.

Public health policies in which health is constructed within moral discourses that focus on individual behaviours and ignore the wider structural conditions that underlie smoking and other health and social inequalities are subject to criticism. Graham (2012) argues that smoking has become synonymous with an underclass that is stripped of social respectability and self-worth. She warns that policies based on middle-class values of rational behaviour are likely to be ineffective, and will do little to reduce class prejudice and promote social cohesiveness. Rather than reducing smoking in areas of economic deprivation, stigmatisation may instead encourage resistance and reinforce social and cultural norms (Thompson et al. 2007; Bell et al. 2010; Graham 2012). Lupton (1995) suggests further that promoting smoking as deviant may work to reinforce smoking patterns rather than discourage them, intensifying the enjoyment of smoking by rendering it a 'sin' (p155). In addition, policies that focus on individual behaviours are criticised for taking only a short-term perspective on health, which has to be repeated for each generation (Proctor 1995; Gilbert 2008). Proctor (1995) argues for long-term approaches that address health and illness from a broader social perspective, focussing on structural and environmental effects on health.

The moral acceptability of utilising stigmatisation as a public health tool is also subject to debate (Bayer & Stuber 2006; Bayer 2008; Burris 2008; Burgess et al. 2009; Bell et al. 2010; Courtwright 2013). Burris (2008) argues that stigmatisation is dehumanising and therefore can never be justified. Bayer (2008) counter-argues that stigmatisation may be morally defensible if the potential public benefit outweighs any stigmatising side-effects; he argues that this is the case for tobacco policies. Courtwright (2013) also argues that stigmatisation is sometimes permissible but he adopts a different position. He suggests that public health policies should be assessed not by whether they promote aggregate well-being or violate moral boundaries, but by whether they can be justified to reasonable people who do not know whether they will be affected or not.

While issues of morality remain contentious, the material effects of stigmatisation are clear and demonstrate that policies to improve health,

particularly those that focus on behavioural change, may have negative as well as positive outcomes. In the context of lung cancer and smoking, what began as an enterprising initiative to reduce the burden of death from smoking-related disease and combat the strength of tobacco advertising can now be interpreted as an action that constrains representations of lung cancer and materially disadvantages people who develop the disease, whether they are smokers or non-smokers. While tobacco policies have undeniably reduced the overall death rate from lung cancer and may continue to do so, their legacy in terms of the personal and social effects for people who go on to develop the disease are significant and ongoing. Similar material effects of stigmatisation have been noted in relation to other conditions. In the context of HIV/AIDS the expectation of stigma, combined with actual experiences, is identified as having affected choices about being tested and seeking assistance for physical, psychological and social needs (Herek 1999; Parker & Aggleton 2003). In the context of obesity, despite having higher rates of gynaecological cancers, overweight women say that they avoid gynaecological examinations because of expectations of stigmatization by health professionals (Amy et al. 2006). These wider social effects of public health policies may need to be taken into account when evaluating their overall effectiveness.

The legacy of stigma in relation to lung cancer raises a concern in relation to other diseases and conditions, especially given the particular focus of current health policies on healthy lifestyles and behaviour change. Taking breast cancer as an example, the literature review presented in Chapter 2 discussed studies of media representations in which women are portrayed as responsible for the disease because of their adoption of non-traditional behaviours that are associated with an increased risk of the disease, particularly in relation to reproductive choices such as delaying childbearing, not having children and the use of the contraceptive pill (Lupton 1994; Lantz & Booth 1998). These studies were conducted in the US and Australia. In contrast, in this study conducted some twenty years later and examining UK media, I argue that while these behaviours are identified as risk factors, blaming activity is seldom triggered in portrayals of women with breast cancer. Women are more likely to be positioned as victims of the disease rather than perpetrators of it. This interpretation is more in keeping with that of Clarke (1999a), who examined media representation of breast cancer in the US and Canada between 1974 and

1995, and Seale (2002) who examined media representations of cancer in English-language media (mainly North American and UK). Both of these authors argue that women are portrayed as victims of their bodies and its natural biological processes, and of the disease in its capacity to strike at random.

However, as personal behaviours become increasingly identified as risk factors for breast cancer, there is the potential for the disease to trigger a greater degree of blaming activity. Arguably, this may be more likely to happen in relation to personal factors such as alcohol use and obesity since these behaviours, like smoking, are less socially sanctioned than reproductive choices and are constructed as problems associated with lower social groups (Lupton 1995; Day et al. 2004; Gilman 2010). Also, as discussed previously, alcohol and obesity are subjects of current awareness campaigns that draw on a moral discourse similar to that observed in the smoking cessation campaigns (DH 2013a, 2013b). In the analysis presented in Chapter 6, there is some evidence that where discussions of breast cancer trigger an evaluation of cause and blame, personal lifestyle factors including alcohol use and factors associated with obesity, such as diet and exercise are scrutinised.

As well as discourses in relation to smoking, media discussions of lung cancer draw on discourses that govern the boundaries of what is acceptable regarding public portrayals of dying, particularly in relation to dying of cancer. In suggesting how media practices may act to marginalise some representations of individuals dying of lung cancer, the thesis contributes to understandings of how public portrayals of dying construct death as either ‘good’ or ‘bad’. Although lung cancer is commonly portrayed in relation to death in media texts, either because an individual has died or because of the high death rate associated with the disease, most representations are brief and the personal experience of dying is largely excluded. This contrasts with portrayals of breast cancer in which the personal experience of dying is more frequently represented (albeit in posthumous accounts) even though deaths from the disease are less commonly discussed.

However where the personal experience of dying of lung cancer is portrayed, similar to portrayals of deaths from breast cancer, individuals are presented as dying well, with few images of physical deterioration. This representation of dying is in stark opposition to the description cited by the participants with

lung cancer in the study by Chapple et al. (2004), in which the disease is associated with a fearful and unpleasant death, involving '*gasping for air*' and '*drowning*' (p1471). It is also in contrast with the images of disintegrating and decaying bodies described by Lawton (1998) in her observational study of dying in a hospice setting. In this thesis I suggest that dominant cultural discourses that construct dying of cancer as a 'good' death work to remove representations of dying of lung cancer that may evoke the images identified in these studies, allowing only sanitised versions to be seen.

This interpretation of media activity in relation to representations of individuals dying of lung cancer is in keeping with other studies that examine media representations of dying in the context of cancer. Armstrong-Coster (2005) argues that media accounts of cancer are organised to shield audiences from the materiality of dying bodies, presenting little of the 'mess and anguish' of the actual process of bodily deterioration (p111). Similarly, studies examining the recent media portrayals of Jade Goody's death from cervical cancer identify that while these stories were unusual in terms of the intensity and directness of their portrayal of the diseased and dying body, images of actual bodily deterioration were mostly concealed (Frith et al. 2012; Walter 2009, 2010; Woodthorpe 2010). Walter (2009, 2010) describes how textual descriptions portraying Jade as close to death and experiencing physical pain as well as emotional suffering, are undermined by glamorous photographs that depict her as smiling with few visible signs of illness or pain (other than a bald head). He suggests further that magazine photographs taken for Jade's wedding just a month before her death depict a beautified and sexualised body rather than one in the process of physical decay. This thesis supports these studies in that it provides further evidence of how cultural discourses function to sanitise media representations of dying of cancer by removing images of suffering and particularly bodily deterioration from public view. Representations of dying of lung cancer are actively made 'good' by conforming to acceptable narratives of dying, with emotions and bodies largely intact and under control. Although some aspects of the emotional and physical burdens of the disease are presented, these are limited, particularly in terms of visual images presented in photographs and on screen.

The thesis potentially extends the current literature in relation to media portrayals of cancer dying by arguing that discourses of a good death also

function to remove images of blameworthy dying. Seale (1995a) argues that a good death is not only about the experience of dying, it also involves the moral accountability of those who are dying. Cancer deaths are typically constructed as meaningful events in which individuals are portrayed as heroic, able to influence their experience of dying by efforts of will, emotional transformation and displays of moral character (Seale 2002). A judgement of blame for having brought about one's death through smoking places a question mark over the moral character of an individual, and acts in opposition to a discourse in which dying is constructed as a meaningful and heroic event. Therefore, judgements of blame construct lung cancer as a potentially 'bad' death and one that is devoid of meaning. This creates an imperative for representations of dying of lung cancer to be either made 'good' by removing blame or excluded from public view. Discourses of heroic dying are less available to individuals dying of lung cancer who have smoked, unless blame can be absolved or redeemed in some way. This activity has implications for other cancers and conditions that are associated with a poor prognosis if, as discussed above, blaming activity in relation to personal behaviours that are considered unhealthy becomes more prevalent. Rather than opening up discussions of death and dying, as is the aim of the Department of Health's current End of Life Care Strategy, this activity may serve to close some discussions down (DH 2011b).

In this thesis I identify the specific social processes and conditions that may produce and act to reproduce stigma in relation to lung cancer. I have traced some of the disease's historical associations with death and smoking, and I suggest how these associations are sustained and perpetuated by contemporary cultural practices (i.e. media representation). I then argue that dominant public health discourses and practices that promote healthy lifestyles and behaviours, and stigmatise smoking, may act to repress representations of lung cancer since they construct the disease as a potentially blameworthy death. These dominant discourses and practices are also historical and can be traced back to the public health response following the studies linking lung cancer and smoking (see Chapter 3, pp63-69). Their circulation is maintained through the activities of powerful institutions, including government and biomedicine as well as media.

It is difficult to imagine that the dominance of discourses promoting personal responsibility for health and health-related behaviour change is likely to

diminish in the foreseeable future, particularly given the latest announcement that more than 100,000 cancers every year in the UK are caused by lifestyle factors such as tobacco, diet, alcohol and obesity (Parkin et al. 2011). Therefore, smoking is likely to remain a highly stigmatised behaviour given its damaging effects on health and the extent of public measures that have been put in place to discourage it. Strategies to promote lung cancer as a disease of non-smokers as well as smokers may act to reduce the stigma of the disease by reducing its association with smoking. However, they may also reinforce stigma by sustaining and perpetuating the causal link between the disease and smoking, and create a hierarchy in which individuals with lung cancer who have not smoked are privileged over those who have smoked in the past or who continue to smoke.

In Chapter 3, however, the emergence of alternative discourses in relation to lung cancer was suggested. These discourses focus less on prevention through smoking cessation as the only means to address lung cancer, and place emphasis on understanding the complexity of the disease in terms of its molecular and genetic characteristics, and the potential for new and targeted therapeutic strategies (see pp79-81). In these discourses '*there's a bright future ahead for lung cancer research – in treatment and care*' (CRUK 2013b), and an optimism about '*the accelerating pace of discovery and innovation in lung cancer biology and treatment*' (Schiller et al. 2013). Although these discourses are not identified in the media texts examined for this study, they may hold hope for the future in terms of how lung cancer is socially defined and constructed, which may in turn act to reduce stigma and stigmatisation of individuals with the disease. If these discourses in relation to lung cancer were to become dominant and the disease were to become more associated with survival and effective treatment, as is the case for breast cancer and, in some countries HIV and AIDS, there might be more representations of the disease that are not linked with death and dying, and the disease and individuals who develop the disease may gain a greater social prominence. However, given the dominance of discourses in relation to individual responsibility for health and the avoidance of risky behaviours, individuals living with and surviving lung cancer might still not be placed within heroic cancer narratives if they have smoked.

7.1 Reflecting on the research process including lessons learned and limitations

In this study, over two thousand media texts containing the phrase 'lung cancer', all published or broadcast in the UK within a three-month period were retrieved and examined. This method of sampling permitted an examination of how the disease is portrayed when it is a focus of texts and also when it is less prominently featured. This is a perceived strength of the study. The search strategy produced a large dataset from which it was possible to observe that most media discussions in relation to lung cancer are brief and in relation to death. It also made it possible to identify that when individuals with lung cancer are presented in media texts, the disease is often referred to only briefly and details of the disease experience are seldom portrayed. Retrieving breast cancer texts to act as a comparative dataset also proved to be a methodological strength. By examining the two datasets alongside each other, differences in how each of the diseases is represented were made apparent. The most striking of these was in relation to the prominence of the two diseases in and across texts particularly in relation to awareness month initiatives. Having a comparative sample also drew attention to the relative absence of portrayals of the personal experience of lung cancer and that individuals with breast cancer were more likely to be portrayed within a heroic narrative. It also meant that it was possible to confirm or refute emerging theory in relation to meanings that were specific to lung cancer – for example, in the organisation of texts in relation to evaluations of cause and blame.

The distinction between the two datasets in relation to the prominence of the two diseases raises a further point of strength in relation to the retrieval method – that of the retrieval of visual images. Had only the Nexis® UK database been used as in other studies (for example, Seale 2001a, 2002), visual images would not have been retrieved. Although this did incur an additional financial cost (the Nexis® UK database is free to use), the data monitoring company retrieved texts and their accompanying visual images in black and white form. The images provided a valuable source of data in identifying the distinct contrast in prominence of the two diseases and also the absence of images of bodily deterioration. However, both methods of retrieval (Nexis® UK and the media monitoring company) produce reproductions of

texts that have been removed from their context rather than texts in their original form and context. Additional texts were collected using other retrieval methods (for example searching the internet and generally being aware of media representations that were in my vicinity during the retrieval period). The advantage of these texts was that they were retained in their context and the images were often in colour. However, retrieval using the Nexis® database and media monitoring companies is a more efficient and effective method of collecting large samples of texts from a range of media sources.

The method of retrieving all references to lung cancer and breast cancer also presented challenges due to the volume of texts that was generated. A dataset of over 4,500 texts in varying formats and lengths raised initial questions about how to sort and make broad sense of the material retrieved, and later questions regarding a sampling strategy in order to narrow down the sample and produce a more focused analysis. These challenges came at a time in the research project when I was developing a greater understanding of the construction of meanings and knowledge as a social practice (in contrast to assumptions of meanings and knowledge being 'already' fixed entities waiting to be discovered). On reflection, time was spent attempting to sort and categorise the data in ways that were in opposition to a social constructionist approach to examining text.

The initial challenge (how to sort and make a broad sense of the dataset) was resolved by letting go of the notion that fixing rigid and potentially endless categories to texts would lead the way to identifying how knowledge about lung cancer is constructed, and adopting an approach that treated texts as sites into which lung cancer enters into and is portrayed or discussed in relation to broad themes. This approach enabled me to undertake an examination of all the texts in the dataset to gain a broad overview of the data retrieved and compare and contrast the different ways that lung cancer and breast cancer are portrayed in relation to commonly identified themes. In adopting this approach it was possible to identify that lung cancer is usually spoken of in relation to death and dying, while discussions of individuals living with the disease, and, in particular, discussions of their experience of the disease, are relatively absent. These observations helped to resolve the second challenge of selecting a sample for in-depth analysis in that they provoked an interest in texts that contained a personal story of lung cancer, since the broad

lens examination of the data suggested that the experience of lung cancer is not only less commonly portrayed but might be constructed differently. However, the size of the dataset inevitably meant that there were other samples that could have been selected for a more focussed examination – for example the texts that were produced in response to lung cancer awareness month (rather than just those that contained a personal story), or texts that presented factual information about the disease.

An advantage of having selected personal stories for the in-depth analysis is that half of the texts were produced in response to the awareness month initiative and contained factual information about the disease. Therefore, it was possible to examine representations of lung cancer and individuals with the disease in relation to awareness-month and non-awareness-month activity, and in personal accounts as well as in factual accounts of the disease. These variations in the orientation of representations enabled the identification of differences in the way that the disease and individuals with the disease are portrayed, for example in terms of narratives of survival juxtaposed with information in which the disease is constructed as one that most people die of and few survive, and narratives of blameworthy survival in relation to awareness month stories and narratives of blameless dying in relation to non-awareness month stories.

The volume of texts generated also led to decisions regarding the duration of the retrieval period. The retrieval of lung cancer texts was stopped at three months. However, the retrieval of breast cancer texts was stopped after a month. This decision meant that only the breast cancer texts produced during an awareness month were available for examination. This difference between the two datasets limits what can be said about how breast cancer is represented at other times of the year and the comparisons that can be made between the two datasets.

The time period in which texts were retrieved is limited. Therefore, no attempt has been made to evaluate representations of the disease over time. It is possible that other time periods may have produced different stories and different representations of the disease. For example during the data collection period of the study by MacKenzie et al. (2011) Dana Reeves, the wife of Christopher Reeves, the actor who played Superman, was diagnosed with lung

cancer and subsequently died. Dana was reported to be a non-smoker and was featured in all but one of the statements in relation to the disease that were categorised as ‘celebrity cases’ in the study. In their findings, the authors identified that the most prominent discussions in relation to the disease were the rising incidence of lung cancer in women who have never smoked and discussions of a celebrity who had died of the disease. It is possible, therefore, that Dana Reeves’ diagnosis and celebrity status influenced media reporting of lung cancer at the time of this study and also influenced the findings of the study in relation to the authors’ claim that non-smokers with lung cancer are privileged in portrayals of lung cancer.

Data retrieval was limited to media produced in the UK, although it is recognised that regardless of the country of origin, media are widely available throughout the world. The retrieval method generated texts from a wide range of media. However, most texts were from regional newsprint sources. Texts from national newspapers, magazines, television and radio broadcasts, internet sites and health promotional materials are fewer in number. This suggests that representation of the disease may be less frequent in these types of media sources. A different retrieval method (for example, retrospectively or prospectively collecting media for an extended period from specific sources which are under-represented in this study) would have broadened the range of media available for examination. However, these methods would have been more time-consuming and are likely to have generated an even greater amount of data to sort and analyse unless brief mentions of the disease were omitted. Also, no books (excluding medical texts) or films that were published or broadcast during the retrieval period were identified, although some that had been published earlier were available (for example, ‘The Bucket List’, a 2007 film starring Jack Nicholson and Morgan Freeman in which the two main characters are diagnosed with terminal lung cancer, and ‘Coda’, an autobiographical book by Simon Gray (2008) that discusses his terminal lung cancer diagnosis). Because of the volume of other texts retrieved, a decision was made not to include books and films that were not published or broadcast during the retrieval period. Social media were also excluded from the retrieval process because of the anticipated difficulty of retrieving and storing this type of media. Texts from these and other media sources may represent lung

cancer in varying ways and, therefore, may have broadened the analysis and the knowledge produced.

Whether from newsprint, magazines, television and radio broadcasts, the internet or health promotion material, texts were treated similarly – as publicly available representations of lung cancer. No attempt was made to distinguish between how the disease was presented in different media formats. Also, the study examined media representations rather than their production or reception. It is recognised that media comprise only one form of representational activity and, therefore, they form only one public source in which meanings and knowledges about lung cancer are produced and reproduced.

These limitations in relation to the study are areas that could be explored in further work. Focussing on texts that are not represented (for example, social media and medical texts) or under-represented (for example, texts from broadcast media, and autobiographical and fictional accounts) in this study would allow an examination of whether different media sources and formats differ in their constitutive practices in relation to the disease. In the present study, only one autobiographical account and one fictional account of lung cancer were identified. These accounts both vary from some of the dominant patterns identified within the dataset. In the autobiographical account, more of the everyday experience of living with lung cancer is presented than in any of the other accounts and blame for having caused the disease through having previously smoked is more actively resisted. In the fictional account, and in contrast to most of the other personal stories, no causal explanation for how the disease arose is presented. Also, the individual is not identified by her smoking status.

Further studies might also explore the production of media stories about lung cancer to identify what factors internal and external to media institutions influence the nature of reporting. This type of research might take the form of interviews with media producers and their sources (e.g. public health, research and advocacy organisations), and/or it might examine how source materials are retrieved and used in the crafting of stories. Alternatively, reception studies could investigate how audiences interact with media messages about lung cancer. These studies might take the form of interviews or focus groups with

individuals to examine how they perceive media messages impact on them, how they assess what they see or hear, and how messages may influence their beliefs and behaviours (e.g. their sense of personal risk in relation to the disease). Reception studies might also examine how media messages influence professional understanding and practice (for example, among professionals working in general practice, hospitals, pharmacies, social care and charity organisations). Interviews and focus groups with lay individuals and professionals could also be used to examine how meanings about lung cancer are constructed through conversational activity within a research context. The meanings and knowledges identified in these further studies could then be compared and contrasted with those identified in this study.

In Chapter 2 I discussed the concept of reflexivity and the position of the researcher in the production of knowledge. The analysis and claims presented within this thesis are recognised as historically and culturally specific. All aspects of the study, from its inception through its conduct to the final construction of the thesis, have also been influenced by my particular social and professional location. It is impossible to transcend these conditions of production, and therefore it is impossible for me to give a complete account of them. As time passes and I move on from the research and develop greater theoretical understanding, some influences may become more apparent than they are now. However, in the construction of the thesis I have attempted to be as transparent as is possible in relation to the conduct of the study in order to allow the reader to judge the validity/worthiness of the work. As I have mentioned previously, no claims are made regarding the objectivity of the research. Within a social constructionist framework, the aim of the study has not been to identify an objective truth, but to offer one possible reading of the texts examined. By doing so I hope to have illuminated some of the ways in which lung cancer may be socially defined and constructed, and identified how these social processes may act to disadvantage people who develop the disease.

Throughout the research process and particularly during the analysis, I was aware that my professional familiarity with lung cancer made it difficult at times to treat representations of the disease as discourses – that is, as socially constructed meaning-making systems that could have been different. I am also aware that my clinical experience brings with it perspectives that are difficult

to combat and/or transcend. Therefore, it will be interesting to discover the responses of others to the interpretations I have presented in this thesis.

7.2 Concluding thoughts

In seeking to examine how lung cancer is socially constructed, this thesis has identified and explored the processes involved in the production and reproduction of stigma in relation to the disease. It presents an account of how lung cancer has become inextricably linked with death and smoking and, through an examination of media representations of the disease, suggests how these links are sustained, strengthened and reproduced by contemporary social practices. The thesis suggests further, that within the current social and cultural context in which health has become a moral issue and dying is constructed as a morally accountable event, lung cancer is constructed as a disease that signifies a blameworthy event, connoting individuals who may have deviated from acceptable cultural norms, thereby rendering themselves unworthy of public attention and support.

Addressing lung cancer related stigma, therefore, may require social change in relation to how health and dying are constructed as moral issues, with individuals who develop ill-health being positioned within hierarchies of worth dependent on how they may or may not have acted to bring about their situation. Advocacy measures such as the 'No one deserves to die' campaign by the Lung Cancer Alliance in the US, as discussed in Chapter 3 (pp90-91) are targeted at achieving this sort of social change. They act to counter discourses that position individuals with lung cancer as less worthy of support. However, change of this nature may be difficult to achieve given the dominance of discourses promoting the modification of health-related behaviour as the means to prevent cancer in the UK. Alternatively, if current government initiatives aimed at improving survival are successful and recent scientific optimism regarding new treatment approaches is well-founded, then lung cancer may lose some of its association with inevitable dying and become more of a good news story than in the past. In this context, stigma and stigmatisation of the disease may diminish and the disease may attract greater public attention and support.

7. Discussion

The approach taken in this thesis illustrates the contribution that examining health and illness from a broader social perspective can make. In particular, it identifies how cultural practices within particular historical and social contexts act to shape and define diseases in ways that have consequences for how they are experienced and how society responds to them. In this way, the thesis addresses both the challenge set by my supervisors at the start of my PhD studies – to think outside of my comfort sphere in terms of the different ways to attain knowledge through research endeavour, and the challenge posed by Pierret (2003) and Lawson (2003) that future research agendas should examine broader social structures and processes that impact on the illness experience. In adopting this approach and exploring some of the implications of, and interactions between, dominant cultural discourses in relation to health, smoking and dying, not only has my perspective been broadened but new knowledge has been created that may contribute to our understanding of stigma as a social process, and the construction of lung cancer stigma.

Appendix 1: Journal contents page search and e-mail alerts

1. Electronic searches of contents pages of the following journals from the year 2000 (conducted during April 2010):
    a. Social Science and Medicine
    b. Sociology of Health and Illness
    c. Journal of Advanced Nursing
    d. Qualitative Health Research
    e. Journal of Contemporary Ethnography
    f. Sociological Research Online

2. Journal contents page alerts by e-mail set up from 19th April 2010:
    a. Social Science and Medicine
    b. Sociology of Health and Illness
    c. Journal of Advanced Nursing
    d. Supportive Care in Cancer
    e. Qualitative Health Research
    f. Journal of Contemporary Ethnography
    g. Sociological Research Online
    h. Journal of Health and Social Behaviour
    i. Health Education Journal
    j. Journal of Public Health Policy
    k. Health Affairs
    l. Family and Community Health
    m. Medical History
    n. Bulletin of the History of Medicine
    o. Psycho-oncology
    p. British Medical Journal
    q. Thorax
    r. Lung Cancer
    s. Journal of Thoracic Oncology
    t. British Journal of Cancer
    u. Journal of Clinical Oncology
    v. Lancet
    w. Lancet Oncology
    x. European Journal of Cancer Care
    y. European Journal of Oncology Nursing
    z. Seminars in Oncology Nursing
    aa. Nursing Research
    bb. Cancer Nursing
    cc. Journal of Nursing Research
    dd. Journal of Health Communication (from 16/8/10)
    ee. Discourse Studies (from 20/2/11)
    ff. Discourse (from 20/2/11).

Appendix 2 Literature review

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
Armstrong-Coster (2001)	Aim: To examine 'how two documentary films, which combined to form a series, re-presented the life of one woman with cancer' (p288). Method: Qualitative interviews with the subject, the producer and an audience of the films, and a textual analysis of the films.	• The film was edited by the producer to present the individual within a heroic and good death discourse. • Doctors are presented as objective and rational experts who seem to exist solely within the context of their work. • Individuals with cancer reported that the films did not reflect their experience of cancer. • Individuals with cancer reported that media representations of cancer create unrealistic behavioural expectations in their minds and also in those of their relatives which left them feeling guilty at failing to conform to such heroic roles. • A main message of the paper: 'Kübler-Ross's (1970) 'Good Death' thesis remains highly significant in affecting how death is managed in contemporary Western society. However, the voices of my focus group suggest that a shortfall exists between this idealized version of dying and the actual truth of the experience. … I would argue that society's implicit rules governing behaviour exercise undue and excessive demands on those with cancer. The stresses of conforming to media images such as those shown in the films place individuals, already vulnerable and marginalized, into

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
		inequitable roles at precisely the moments in their lives when they are in most need of comfort and support' (p303).
Armstrong-Coster (2005)	Aim: To explore 'when and how textual accounts of dying had originated and what conditions had fostered their development, and the motivation that drives the authors of these texts' (p99). Methodology: Comparative analysis of cancer-related pathographies ('book length personal accounts') from the mid-nineteenth and late twentieth centuries (p97).	• Identifies parallels between past and present day narratives of cancer in that they both resonate with hope: in the past because of a religious belief in life after death, and in the present because of a belief in death being, at least to a temporary extent, avoidable. • Argues that accounts of living with and dying of cancer do not detail the mess and anguish involved in the actual physical deterioration. • A main message of the paper: 'The socio-temporal conditions prevalent in present day Western society still lack sufficient strength to countenance an open confrontation with the very real traumas involved in dying' (p97).
Bell and Seale (2011)	Aim: 'To assess the extent to which UK national newspapers provide information about the risk factors, early signs and symptoms, and methods for preventing	• 685 articles that discuss cervical cancer are identified. • Promiscuity and early sexual intercourse are identified as the most frequently presented risk factor for cervical cancer. Other risk factors are mentioned less frequently and include the contraceptive pill, smoking, age,

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	cervical cancer' (p390). Method: Quantitative content analysis of UK newspaper articles published between 2000 and 2009.	deprivation, poor diet/immunity and multiple pregnancies. • The amount of coverage of early signs and symptoms of cervical cancer is greater in the tabloid newspapers than broadsheets and more common in articles about the celebrity Jade Goody's experience of cervical cancer. Pain and bleeding are the most common symptoms mentioned. • Coverage of prevention strategies is considerable in all newspapers. Human papillomavirus (HPV) vaccination is more frequently discussed in broadsheet newspapers, while cervical cancer screening is more frequently discussed in tabloid newspapers. • A main message of the paper: 'We have shown that, contrary to any expectation that broadsheets targeting a more educated readership might provide their readers with more medically relevant information, tabloid journalists succeed in providing their readers with more information about early signs and symptoms of cervical cancer. This is largely because of the popularity of stories about personal experiences of disease in the tabloids, which are particularly likely to contain this type of information' (p393).
Berry et al. (2007)	Aim: 'To examine the quantity and construction of health messages in	• The volume of health coverage is identified as highest in print media: 849 health articles in newspapers are identified compared with 165 on television, 137 on the

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	the news media' (p37). Method: Quantitative content analysis of Canadian newspaper, radio, television and internet reports on health related topics published between 1999 and 2003.	radio and 75 accessible via the internet. • There are 2.6 times more press articles about cancer than there are about cardiovascular disease (CVD). • Of the 96 stories about cancer, 44 relate to breast cancer, 6 to prostate cancer, 5 to lung cancer and 4 to skin cancer. • Across all media and health topics, there are almost two and a half times as many mentions of risk as mentions of prevention. • In general, expert sources are used to a greater extent than non-expert sources in stories. • 19% of cancer stories contain a human interest element. This aspect is not identified in CVD stories. • In articles published in 2003, there is a high proportion of articles on SARS (severe acute respiratory syndrome). • A main message of the paper: 'This research highlights how health topics are presented in the media. We know that media can play a positive role in promoting public health (Wallack et al. 1993); however some issues seem to generate a stronger response in the public, and this may be related to how media construct messages. Most often, health messages are framed in terms of risk, by expert sources using strong language…This analysis can provide a guide for further research, which should examine the characteristics of health messages in news

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
		media in conjunction with the nature of individuals who consume it' (p43–44).
Blanchard et al. (2002)	Aim: 'To conduct head-to-head comparisons of the number of articles over the previous decade in which breast cancer or cardiovascular disease (CVD) were mentioned' (p344). Method: Quantitative content analysis of US magazines published between 1990 and 1999.	• 697 breast cancer articles and 546 CVD articles identified. • The difference in the number of breast cancer articles and CVD articles widened as the years progressed. • In women's magazines, there are 286 breast cancer articles compared with 109 CVD articles. • In news magazines, there are 100 breast cancer articles compared with 79 CVD articles. • In African-American interest magazines, there are 45 breast cancer articles compared with 34 CVD articles. • A main message of the paper: 'Over-representation of breast cancer vis-à-vis CVD is pervasive in popular magazines. Future research should investigate how such disparities in the media may influence risk perceptions, adoption of preventive health behaviours and compliance with screening guidelines' (p343).
Brown et al. (2001)	Aim: To examine 'print media coverage of environmental causation of breast cancer' (p747). Method: Quantitative and	• 1232 newspaper, 142 science periodical, 126 news magazine and 207 women's magazine articles about breast cancer identified. • Environmental causation of breast cancer discussed in 5.4% of newspapers, 12% of science periodicals, 4.7% of news magazines and 10% of women's magazines.

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	qualitative content analysis of breast cancer stories in US newspapers, science periodicals, and news and women's magazines published between 1961 and 1999.	• In these articles, environmental causation is a minor element of the story and is consistently presented as uncertain. • Coverage of corporate or governmental responsibility is limited. • 49% of articles that mention environmental causation also mention at least one aspect of lifestyle or individual responsibility such as dietary intake (for example, fat and alcohol consumption) and age at birth of first child. • Genetic causation is also frequently presented (no percentage figures given). • A main message of the paper: 'The contrast between the treatment both in the scientific community and in the media of environmental factors and diet is interesting. The media and scientific community have given a great deal of attention to possible dietary factors in breast cancer despite lack of any coherent evidence from all the studies in this area. One might consider the scientific evidence about diet to be roughly similar to the evidence about environmental factors, yet diet has been a well-funded and high-profile area of research. We believe this is because, as in most health issues, it is easier to press individual responsibility than corporate and/or government responsibility' (p771).

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Cartwright (1998)	Aim: To examine 'the place of visual media in the politics of breast cancer' (p117). Method: An examination of two alternative visual images of breast cancer in light of mainstream images and media campaigns focusing on the disease.	• Argues that breast cancer is usually represented and lived through issues such as class, beauty, fashion and ageing. • Mastectomy scar tissue and breast asymmetry, hair-loss, ageing and cultural differences between women with breast cancer are usually repressed in discourses of breast cancer. • Argues that alternative media images that depict mastectomy scars (and no reconstructive surgery), the effects of ageing and cultural issues help to illustrate the ways in which race, age and beauty are key aspects in the experience of breast cancer. • A main message of the paper: 'Would it be better to bracket differentials of class, cultural identity, ethnicity and sexuality in order to underscore the shared experience of the disease? Are the effective media texts those that provide easy answers (for example prosthetic recovery) and false closure (a return to some ideal of a normal life)? I would argue that [alternative media images], difficult as it may be, perform the crucial task of widening the pool of collective images, expanding the possibilities of what can be seen beyond outmoded norms and altering historical concepts of the body beautiful to incorporate the effects of breast cancer's limited treatment options' (p136).

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations

Chapman et al. (2005)	Aim: 'To describe the main narratives in the reportage of singer Kylie Minogue's illness with breast cancer, and to asses the impact of this coverage on bookings for screening for breast cancer by mammography in four Australian states' (p247).
	
	Method: A quantitative and qualitative content analysis of Australian television news broadcasts about breast cancer during May 2005 (the month that Kylie Minogue's diagnosis was announced in the media) and mammography booking data for the 19 weeks prior to and 8 weeks following the announcement.
		• 6 news items on breast cancer (13 minutes 27 seconds) identified in the 13 days prior to the announcement compared with 74 items (147 minutes 40 seconds) in the 7 days following the announcement.
		• Dominant discourses identified in stories about Kylie:
		  ○ Her prognosis, treatment and recovery details
		  ○ Benefits of early detection for her
		  ○ She is young to get breast cancer
		  ○ Her treatment options (in detail)
		• Other discourse identified:
		  ○ Private and public support helps a cancer prognosis
		  ○ Young Australian breast cancer survivors
		  ○ Cancer is a battle
		  ○ Cancer education and prevention messages
		  ○ Personal characteristics help a cancer prognosis
		  ○ Criticism of the lack of availability of free mammograms to younger women
		• Average weekly screening bookings made in the 2 weeks following the announcement increased by 40%.
		• The increase in bookings is most prominent in women being screened for the first time.
		• The increase in bookings in the age group 40–49 years is

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		69% and 25% in the age group 50–59 years. • In the 6 weeks after the 2-week intense publicity period, bookings were 39.3% higher in unscreened women. • A main message of the paper: 'News coverage of Kylie Minogue's breast cancer diagnosis caused an unprecedented increase in bookings for mammography. Health advocates should develop anticipatory strategies for responding to news coverage of celebrity illness' (p247).

Clarke (1999a)	Aim: 'To examine the portrayal of breast cancer in the most popular circulating magazines in Canada and the US during 1974 to 1995'.
	
	Method: Qualitative content analysis of manifest and latent themes.
		• 44 US and 23 Canadian magazine articles were selected for analysis.
		• The most commonly identified manifest themes (in rank order) include: Treatment, early detection, prevalence, education/information, women's experience and risk.
		• Latent messages focus on 2 themes:
		  ○ Breast cancer is portrayed as the most dreaded disease by women; one that is potentially caused by everything, particularly a woman's own female bodily processes. Women with breast cancer are portrayed as emotionally labile, isolated and unaffiliated individuals
		  ○ In contrast, doctors are portrayed as reasonable, dedicated and much affiliated with universities and research institutions. Their medicine, science, knowledge and skill are

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		portrayed as objective, rational and considered. • Many stories begin with dramatic titles that reflect women's positioning as emotional and an optimistic tone of women triumphing over the disease. • Photographs of women are common and usually feature small-breasted, slim and young women. Absence of black, older and larger body-sized women. • A main message of the paper: 'Clearly breast cancer is not described in morally neutral, mechanical terms. Its location in a woman's breast is salient in its portrayal as a 'feminine' disease resulting in stereotypical and gendered reactions consistent with sex-role ideologies such as women's emotionalism in contrast to the rationality of men. Breast cancer is not described as a disease that may result in pain, suffering and even death at times but as a disease that affects 'femininity', self-esteem and characteristically increases the emotional volatility of women' (p126).
Clarke (1999b)	Aim: 'To examine the portrayal of prostate cancer in the most popular mass circulating magazines in Cancer and the US from 1974 to 1995' (p63).	• 36 articles about prostate cancer identified. • Manifest themes identified include: Early detection (19 stories), the growing and sizable incidence (9 stories), the importance of celebrities in advertising and educating about the disease (4 stories) and treatment/staging of the disease (4 stories). • Latent themes include:

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	Method: Quantitative and qualitative content analysis of manifest and latent themes.	○ Gender wars: concern that relative to breast cancer, prostate cancer is neglected ○ The brotherhood: men who have prostate cancer should consider themselves part of a brotherhood ○ Competition and the fight: men are encouraged to compete with or fight the disease ○ Gloved finger: men are encouraged to be fearless of the gloved finger test ○ Masculinity and sexuality: prostate cancer is portrayed as a threat to masculinity and sexuality rather than personhood more generally ○ Celebrities: lack of celebrities in early stories followed by an increased presence of celebrities in later stories. • A main message of the paper: 'The gendered nature of the disease is predominant. Articles focus on prostate cancer, not as merely a neutral, mechanical, physiological occurrence that happens to a particular organ, the prostate gland, but a disease with particularly masculine attributes and consequences. The focus, for example, is on the threat to masculinity and sexuality rather than the threat to life itself' (p70).

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations

Clarke (2005)	Aim: 'To describe and compare the frames or discourses used in the portrayal of childhood cancer in magazines' (p595).
	
	Method: Qualitative content and discourse analysis of North American English language magazines published between 1970 and 2001.
		• 101 articles about childhood cancer identified.
		• Different discourses are dominant depending on the market to which the magazine is directed. For example:
		  ○ Science magazines present stories of causation, new treatments and debates about whether incidence is increasing.
		  ○ News/special interest magazines present stories that focus on various social issues such as parents' rights in the context of medical power and financial support.
		  ○ Women's magazines focus on stories of individual children with cancer.
		• 49 stories feature a child with cancer.
		• In these stories:
		  ○ Children are portrayed in a highly idealized and stereotypical way, as heroes with attractive physical features.
		  ○ Little mention is made of difficulties with treatment or challenges posed to children's social or emotional well-being.
		  ○ School is seldom mentioned.
		  ○ Little discussion of how families cope.
		• A main message of the paper: 'The media portrayal seems to parallel the lack of research into prevention of

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		childhood cancer. … It supports the dominant emphasis on studies focusing on the refinement of treatment methods. I would argue that media portrayal, with the exception of the specialty science magazines, emphasises a medicalised individualizing and stereotyping (although paradoxically positive) view of the disease and the child with the disease' (p603).
Clarke and Everest (2006)	Aim: 'To describe and analyse the portrayal of cancer in the content of popular mass print articles' (p2593). Method: Qualitative content analysis for manifest and latent themes in English-language magazines available in Canada in 1991, 1996 and 2001.	• Increase in media portrayal of cancer over time: 29 articles identified in 1991 compared with 32 in 1996 and 70 in 2001. • Most of the increase due to an eight-fold increase in stories about breast cancer (from 2 in 1991 to 10 in 1996 to 17 in 2001). • Articles about prostate and ovarian cancer increased but the numbers are smaller. • The rank order of frequency is breast cancer, colorectal cancer, skin cancer, prostate cancer and ovarian cancer. (No mention of lung cancer is made in this paper). • The medical frame dominated stories over the time period. (In the medical frame cancer is depicted as a physiological pathology explained and discussed with biomedicine.) • The lifestyle frame grew in frequency of representation over the period. (In the lifestyle frame negative health consequences of individual choices regarding diet,

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		smoking, stress etc were discussed.) • Fewer articles discussed the political-economy frame. (In this frame, cancer is portrayed as originating outside the individual, caused by factors such as workplace dangers or environmental contaminants.) • Three latent themes identified: o The exacerbation of fear. This theme includes: The conflation of cancer with fear; the description that the disease is growing silently; an emphasis on the increase in cancer rates; the portrayal that cancer is almost inevitable; an association of cancer causation with normal experience; a correlation between fear and screening and the use of scary statistics. o Contradictions, confusion and uncertainty. This theme includes: controversy regarding the efficacy of breast self-examination, mammography and cervical cancer screening; and conflicting theories regarding prevention and cause. o Metaphors of war and battle. This theme includes: dealing with cancer is likened to a battle; cancer is described as an enemy; treatments are portrayed with metaphors of war and aggression and individuals with cancer are depicted as heroic fighters not conceding

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		defeat. • A main message of the paper: 'Explicit emphasis on fear, the elaboration of contradictions and confusion and the deployment of battle language serve to heighten and reinforce the ideas that the appropriate reaction to a cancer diagnosis, or even the threat of such a diagnosis, is fear and reliance on allopathic medicine. This emphasis on the individual obscures the evidence that isolation is harmful and social support is (usually) helpful in respect to physical and mental illness' (p2599).
Clarke and Robinson (1999)	Aim: To examine 'the portrayal of testicular cancer in the mass print media from 1980 to 1994' (p263). Method: Qualitative feminist and discourse analysis of articles that discuss testicular cancer in US and Canadian newspapers and magazines.	• 53 articles were identified –14 from the 1980s and 39 from 1990 to 1994. • The most prominent manifest themes identified are: age, social support, treatment, early detection, cause, metaphor, diagnosis and comparison to breast cancer. • Three discourses are identified: o Medical: in this discourse, early detection and treatment are emphasised. o Machismo: in this discourse, men are described in stereotypical ways, as sexually active, athletic, competitive, interested in war and battles, concerned with finances and financial acumen, and interested in cars and mechanics. There is also an emphasis on the handsome ruggedness of male bodies.

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		○ Social support: in this discourse, social support from wives, girlfriends, and other family and friends is portrayed as important during treatment and recovery from the disease. • A main message of this paper: 'Both allopathic medicine and machismo continue to dominate North America today. Both, however, are under some threat. Allopathic medicine is under threat by the increasingly prevalent utilization of complementary and alternative healthcare, and machismo is under threat as a result of the new men's movement. The dominance of such discourses, then, may serve to buttress flagging hegemony of medicine and machismo. They may reflect a reaction to these powerful and long-entrenched discourses' (p277).
Crabb and Lecouteur (2006)	Aim: 'To examine a popular media account of prophylactic mastectomy – the surgical removal of 'healthy' breasts for preventive purposes – focusing on the ways in which the account works to normalise what might alternatively be considered extreme preventive health behaviour' (p5).	• Mastectomy is accounted for and normalised in two ways: ○ The individual is positioned predominantly as a mother with responsibility for her children and, as such, she should do everything she can to remain healthy and alive. ○ Breast cancer and death are constructed as almost certain events unless a mastectomy is performed. • In this discursive context, prophylactic mastectomy is constructed as a reasonable and morally right thing to

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	Methodology: A discursive analysis of an Australian magazine article published in 2002 depicting a woman who had undergone a bilateral prophylactic mastectomy.	do. • A main message of the paper: 'Constructions of prophylactic mastectomy … draw on traditional gendered discourses and on notions of responsibility central to the new public health. Such media accounts thus promote general acceptance of the procedure, and risk management more generally, as enterprising actions that reasonable, morally responsible, 'at risk' women should undertake to maintain their own health and to care for their families' (p5).
Edsall Kromm et al. (2007)	Aim: 'To examine the types of news stories in which regular [non-celebrity] survivors [of cancer] are called upon and the perspectives they provide' (p299). Method: Thematic content analysis of US newspapers published in 2005.	• 89 articles identified that include a quote from a cancer survivor. • Most stories relate to fundraising events (n=36), survivor stories (n=25), treatment issues (n=12) and survivorship issues (n=7). • Most frequent cancer types mentioned are breast (n=27), prostate (n=16), blood (n=10) and lung (n=6). • The leading cancer type mentioned in relation to fundraising is breast cancer. • The leading cancer type mentioned in relation to treatment is lung cancer. • The leading cancer type mentioned in relation to survivor stories is prostate cancer. • Survivor quotes focus on: o Diagnosis experience – for example, discovery

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		of cancer is portrayed as a 'stroke of luck' (p302), and symptoms of cancer are portrayed as minor, innocuous and able to outsmart screening tests and health care providers. ○ Life post-cancer – for example, cancer is portrayed as giving new meaning to life, a chance to re-evaluate priorities, providing an opportunity to help others and an event that changes life for the better. • A main message of the paper: 'Discussions of the diagnosis experience often convey fear and a lack of confidence in cancer screening practices, while cancer is portrayed as a positive life event. While the evidence of a positive and hopeful portrayal of survivorship is an encouraging finding for continued efforts to decrease stigma associated with a cancer diagnosis and for public understanding of the disease, it is important to consider potential negative implications of an idealized and restricted media discourse on survivorship' (p298).
Fishman et al. (2010)	Aim: To examine 'cancer news reporting in US media to assess whether reporting emphasises survival or mortality, cures or treatment failures, and aggressive treatment or palliative alternatives'	• 436 newspaper articles identified (312 from newspapers, 124 from magazines) • Articles focus on: breast cancer (35.1%), cancer in general (20.0%) and prostate cancer (14.9%). • Articles are more likely to discuss survival or cure (32.1%) than death or dying (7.6%).

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	(p515). Method: Quantitative content analysis of US newspapers and national magazines published between 2005 and 2007.	• 57.1% of articles discuss aggressive treatments exclusively. • 13.1% of articles report that cancer treatments can fail to cure or extend life or that certain cancers can be incurable. • 30.0% of articles mention that treatments can result in adverse events such as neuropathy, pain, hair loss and nausea. • Limited discussion identified in relation to end-of-life care (only 0.5% of articles discuss it exclusively and 2.5% of articles discuss it in addition to treatments). • A main message of the paper: 'News reports about cancer frequently discuss aggressive treatment and survival but rarely discuss treatment failure, adverse events, end-of-life care or death. These portrayals of cancer care in the news media may give patients an inappropriately optimistic view of cancer treatments, outcomes and prognosis' (p515).
Freimuth et al. (1984)	Aim: 'To provide quantitative data on news coverage of specific types of cancer by body site and of various "priority cancer subjects" – cancer detection, prevention, treatment and coping with cancer' (p64).	• 2,138 news reports of cancer identified in 1977 compared with 1,466 in 1980 (i.e. less than 1977). • Most references to cancer are in relation to the disease in general in both 1977 and 1980. • In 1977, breast cancer is ranked 2nd and lung cancer 3rd in terms of frequency of reporting (after cancer in general).

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	Method: Quantitative content analysis of cancer reporting in US newspapers published in 1977 and 1980.	• In 1980, lung cancer is ranked 2nd and breast cancer 3rd (after cancer in general). • Colorectal cancer is under-represented when compared with its incidence rate. It is ranked 7th in terms of frequency of news reports in 1977 and 6th in 1980, despite having the highest incidence rate in 1977 and the 2nd highest in 1980. • Lung cancer and breast cancer reports are proportionate to their incidence rates. • Two-thirds of news reports in both 1977 and 1980 focus on three topics: causes of cancer, treatment and famous people with cancer. • Less information identified about prevention, detection and incidence. • Coverage of risk factors increased from approximately 2 out of 10 stories in 1977 to more than 4 out of 10 (47%) in 1980. In 1980 55% of articles addressing risk factors mention the environment and 41% mention lifestyle. • More than half the stories are written by a small corps of science and medical reporters at the news wire services and news syndicates. • A main message of the paper: 'Newspaper coverage of a major public and scientific concern exhibits a lack of detailed information – such as cancer incidence rates, prevention and control – that would provide perspective

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		on a fear-arousing topic and satisfy public needs' (p62).

Frith et al. (2012)	Aim: To 'situate newspaper accounts of Jade's [Goody] death in relation to debates about professional death work involved in delivering a good death in palliative care and explore how celebrities can be seen as telling instructional morality tales (Kitch 2000) about how people might live a good life and how they might die a good death' (p2).
	
	Method: Textual analysis of UK and Irish newspaper coverage of Jade Goody's death.
		• Jade's death is 'made' good in newspaper stories by drawing on discourses of:
		  ○ Being brave: Jade is presented as facing up to and accepting her dying.
		  ○ Living the good life and preparing for death: Jade is presented as actively pursuing the fulfilment of living until the final stages of death while also settling practical and interpersonal business, in particular her financial affairs and planning for the future lives of her children.
		  ○ Biographical continuity: Jade is presented as remaining essentially the same person in dying as she was in life, and as able to exercise control and make decisions right up until the last moments before death.
		• A main message of the paper: 'We examine how cultural discourses actively work to construct deaths as good or bad and to position the dying and those witnessing their death as morally accountable. By constructing Goody as bravely breaking social taboos by openly acknowledging death, by contextualizing her dying as occurring at the end of a life well lived and by emphasizing biographical continuity and agency, newspaper accounts serve to position themselves as educative rather than exploitive,

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		and readers as information-seekers rather than ghoulishly voyeuristic. We argue that popular culture offers moral instruction in dying well which resonates with the messages from palliative care' (p1).
Gerlach et al. (1997)	Aim: 'To assess the amount of cancer coverage and the content of articles about cancer in women's magazines' (p240). Method: Quantitative content analysis of cancer reports in US women's magazines published between 1987 and 1995.	• 492 articles about cancer (36.9% of all health-related articles compared with 16.3% of articles about cardiovascular disease). • Breast cancer is discussed in 33.7% of cancer articles compared with cancer in general 22.2%, skin cancer 11.4%, cervical cancer 6.1%, ovarian cancer 5.3%, lung cancer 5.1% and colon cancer 3.3%. • The percentage of articles devoted to the six most discussed cancers does not reflect either the mortality or incidence rates of these cancers. • The most commonly discussed topics include prevention (50% of the articles), risks (37.2%), treatment (34.6%) and genetics (10%). • Lung cancer articles are most likely to address risks for the disease (72%), although not all mentioned that the primary risk is smoking. • Breast and ovarian articles are most likely to provide information about treatment (44.4 % and 46.4% respectively). • Colon cancer articles are the least likely to discuss treatment (12.5%).

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		• A main message of the paper: 'The discussion of cancers in these four magazines focused mostly on breast and skin cancers and neglected two very important cancers – lung and colon. If women are indeed receiving much of their cancer information from such media coverage, these findings should alert cancer educators to the possible need to work with these media to help in the dissemination of additional information about cancers to women' (p240).

Halpin et al. (2009)	Aim: To identify 'how Canadian national newspapers portray prostate cancer' (p156).
	
	Method: A qualitative thematic content analysis of stories about prostate cancer in newspapers published between 2001 and 2006.
		• 417 articles were selected for thematic analysis.
		• Three categories are identified:
		  ○ Illness perspectives: these present information about men who have been diagnosed, treated or have died of prostate cancer.
		  ○ Medical perspectives: these focus on research, developments in treatments, screening and the healthcare system.
		  ○ Supplementary: these include articles on diet, men's health behaviours, fundraising and awareness.
		• Four themes are identified:
		  ○ Manufacturing the treatment imperative: in this theme, biomedical discourses are privileged and masculine traits are connected to health-service consumption.

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
		○ The good fight: in this theme, men's courage and stoicism is emphasized. Men are portrayed as continuing to work despite health challenges and those who have died of prostate cancer are portrayed as fallen heroes who have nobly fought the disease even in the terminal stages. ○ Money for the cure: in this theme, prostate cancer is portrayed as an opportunity to fundraise. ○ Boys' and girls' cancer: in this theme comparisons are made between prostate cancer and breast cancer in relation to inequalities regarding fundraising and research funds. At an interpersonal level, women are portrayed as looking after men's health. • A main message of the paper: 'Findings indicated a low frequency of articles that substantively discussed prostate cancer and that the descriptive content reproduced hegemonic masculine ideals, such as competition and stoicism. The presentation of a truncated illness trajectory and privileging biomedicine also depicted medicalised male bodies. Any discussion of the negative effects of treatment or explicit references to marginalised forms of masculinity was conspicuously absent' (p155).

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
Henry et al. (2012)	Aim: 'To establish the percentage of newspaper articles on the topic of cancer currently (2008) and compare it to 20 years ago', to 'compare the percentage of newspaper articles on cancer with a positive and negative valence, currently and 20 years ago', and to 'analyse the main themes in these newspaper articles'. Positive valence articles are defined as providing an optimistic cancer portrayal (e.g. scientific advances, cures, survival, support network and heroism stories). Negative valence articles are defined as providing a pessimistic cancer portrayal (e.g. deaths, suffering, stigmatization, functional deterioration, health system failures and dramatic negative stories).	• 412 newspaper articles published in 1988/1989 were examined and compared with 576 newspapers articles published in 2008. • In 2008 articles, cancer is portrayed more often in a positive valence (46.7% of articles) than in a negative valence (33.5% of articles). Neutral valence is identified in 19.8% of stories. • In 1988/9 there were similar numbers of positive and negative valence articles (39.3% and 43% respectively) and 17.5% of neutral valence articles identified. • In 2008, the most frequently reported cancers are: breast (19.8%), leukaemia 9.4%, brain (7.6%), lung (6.1%), colon (4.7%), prostate (4.7%) and skin (4.0%). • In 1988/9, the most frequently reported cancers are: breast (12.1%), lung (9.0%), skin (8.3%), liver/bile duct (5.1%), brain (3.4%) and stomach (3.2%) (Figures for leukaemia, colon and prostate cancer not presented.) • In 2008, the most common themes identified in reports are: cancer research (26.7%), risk factors (26.0%), cancer treatment (24.3%), education and/or prevention (19.8%), and fundraising events (19.4%). (Data for 1988/9 not presented.) • In 2008, the proportion of articles reporting female cancer issues is nearly double the proportion reporting on male cancer issues (14.2% and 7.3% respectively).

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	Neutral valence articles are defined as purely descriptive articles, or those with a relatively equal mixture of positive and negative valence. Method: Quantitative and thematic comparative content analysis of Canadian newspapers published in 2008 and in 1988/1989.	• In 2008, 17% of articles reported psychological cancer-related aspects, 3.9% social aspects and 0.5% spiritual aspects. • Compared to 1988/9, in 2008 there was a decrease in articles covering end of life and surgery, while there was an increase in articles portraying the senior population, male issues, individual stories depicting people suffering from cancer, the health care system, fundraising events, and ethics and law. • A main message of the paper: 'With an increase in cancer reporting also came a shift in the tone and content … cancer articles with a positive valence outnumbered those with a negative valence in both time periods, and the tone of cancer reporting has become significantly more positive and less negative with time. With this shift toward positive cancer reporting, one must be wary of an overly optimistic portrayal. Throughout both time periods, very few articles covered such topics as palliative care, bereavement, euthanasia/assisted suicide, or even recurrence despite the current 5-year cancer survival rate of only 62%' (p53).
Hilton and Hunt (2010)	Aim: 'To examine the information about cervical cancer included in newsprint coverage of Jade Goody's illness and death' (p2).	• 527 articles about Jade Goody identified. • Articles are more likely to discuss personal details of Jade's experience of cancer than include factual and educational information on human papillomavirus,

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	Methodology: Quantitative content analysis of 15 UK newspapers published between August 2008 and April 2009.	cervical cancer and cervical screening. • 40% of stories report that her illness was terminal, 36% report on her treatment and 32% report on her diagnosis. • 27% of stories report on the preparations for her children's future financial security, 21% report on her wedding, 12% on her and her children's christenings, and 12% on her own funeral. • 37% of articles claim that her illness and death would save lives by raising public awareness of the disease. • However, information about risk factors was rarely included. For example, the detrimental effect of defaulting on screening was mentioned in 4% of articles, having multiple sexual partners in 3% of articles (and only in relation to women), early age at first sexual intercourse in 2% of articles, and deprivation and smoking in 2% of articles. • Signs and symptoms of cervical cancer were mentioned in 3% of articles. • A main message of the paper: 'Newspaper coverage of Goody's illness has tended not to include factual or educational information that could mobilise or inform women, or help them to recognize symptoms. However, the focus on personal tragedy may encourage women to be receptive to HPV vaccination or screening if her story acts as a reminder that cervical cancer can be a devastating and fatal disease in the longer term' (p1).

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
Hilton et al. (2010)	Aim: 'To examine the role that newsprint media have played in HPV [Human papillomavirus] advocacy by identifying key messages about the risks and benefits associated with HPV vaccination and HPV infection, and how these stories were constructed and framed for different readership groups' (p944). Method: Quantitative and qualitative content analysis for manifest and latent themes in UK newspaper stories published between 2005 and 2008 that contain references to the HPV vaccination and/or cervical cancer/screening.	• 344 news articles identified. • 56.1% identified in 'serious' newspapers (previously called broadsheet newspapers), 22.4% in 'middle-market tabloid' (i.e. Daily Mail and Daily Express) and 21.5% in 'tabloid' (e.g. Mirror and Sun). • Coverage of HPV-related topics increased from 52 articles in 2005 to 78 in 2006, and 107 in both 2007 and 2008. • In 2008, coverage is dominated by TV celebrity Jade Goody's diagnosis of cervical cancer and the introduction of the HPV vaccination programme. • Newspaper coverage is identified as generally positive towards the HPV vaccination programme. • Tabloid newspapers are more likely to simplify messages and directly advocate HPV vaccination than serious newspapers which tend towards advocating vaccination whilst offering a critical commentary and competing views. • The vaccine is commonly presented as a scientific breakthrough (e.g. 'a genuine medical breakthrough which would revolutionise cervical cancer prevention'). • Personal testimonies are used to convey messages congruent with the dominant discourse of the risks posed by cervical cancer and the benefits of HPV vaccination. Only a few stories use interviews with

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		parents and girls to examine and debate the dilemmas about HPV vaccine decision-making. • Messages are conveyed using battle metaphors. The vaccine is presented as important to the fight against cancer and cancer is portrayed as the enemy. • The HPV vaccine is also presented as a 'green light to sex' (p948), encouraging promiscuity particularly among young girls. • HPV infection is reported as high in women. Prevalence of HPV infection in men is not reported. • A main message of the paper: 'There are two conclusions from this study. Firstly, the positive media coverage surrounding the introduction of the HPV vaccination programme is to be welcomed as it is likely to contribute towards influencing public perceptions about the acceptability and need for HPV vaccination. Secondly, the focus on prevalence rates of HPV infection among women and on women's sexual behaviours, in relation to HPV vaccination 'encouraging' sexual promiscuity, is an unhelpful aspect of media coverage' (p942).
Hoffman-Goetz (1999)	Aim: 'To evaluate qualitatively the content and context of autobiographical or fictionalised 'real life' cancer stories that appear in popular magazines targeting	• 11 stories identified. • 5 thematic categories identified: ○ Religiosity: this theme includes the importance of living through the cancer challenge, of turning to God through the cancer ordeal, and

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	African-American women' (p37). Method: Thematic content analysis of personal stories of cancer published in US magazines targeted to a predominantly African-American audience published between 1987 and 1995.	the need for prayer and faith after a cancer diagnosis ○ Cancer fatalism: this theme is conceptualised as a vector with two components: – negative (e.g. bad luck, giving up, the inevitable, submission, being singled out) and positive (e.g. survival, deliverance, hands of the Lord). ○ Quality of life after diagnosis: this theme refers to the impact of cancer (e.g. confronting one's mortality, negative emotions or reactions, pain and side-effects of cancer or treatments, positive social support and the importance of a social network). ○ Medical systems interactions: this theme relates to interactions with European-American medical institutions and includes negative judgments (e.g. racism, sexism, arrogant doctors, and high insurance and medical fees) and positive judgments such as trustworthy and caring doctors. ○ Treatment choices: this theme includes descriptions of standard medical treatments and alternative or complementary treatments. • Relationships and associations between themes include: ○ Fighting spirit in which individuals are

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		portrayed as advocates for their own cancer treatment, actively seeking information and knowledge about their disease, and supported in their fight by a circle of friends and/or family. ○ Triumph of faith over disease in which the diagnosis of cancer renews faith and calls forth personal strength to 'live life to the fullest'. ○ Faith-treatment transferral – for example, where statements link reconstructive surgery with salvation and a new outlook on life, or being a courageous fighter with the capacity to discuss mastectomy with other women. A main message of the paper: 'Cancer stories presented in popular magazines targeting African-American women place emphasis on religious beliefs and on mixed interactions with European-American medical institutions' (p43).
Hoffman-Goetz and Friedman (2005)	Aim: 'To evaluate the volume and type of cancer coverage and the readability of cancer articles in Canadian mainstream and ethnic minority newspapers, and to compare coverage of cancer with	• 748 cancer articles identified: 27 in ethnic minority papers and 721 in mainstream or provincial papers. • 7.4% (2/27) of ethnic minority and 32.2% of mainstream articles are syndicated from wire services. The remaining articles are written by freelance columnists or from unidentified sources. • In ethnic minority papers, the frequency of cancer

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	Canadian mortality' (p332). Method: Quantitative content analysis of mainstream and ethnic minority newspapers published in 2000.	reporting is: breast 9/27, leukaemia/lymphoma 7/27, cancer in general 5/27, prostate 2/27, colorectal 1/27, cervix 1/27, melanoma 1/27 and oral 1/27. • Lung cancer is not represented in any ethnic minority papers. • In mainstream newspapers, the frequency of cancer reporting is: cancer in general 28.8%, breast 20.1%, prostate 7.4%, leukaemia/lymphoma 4%, colorectal 3.9%, lung 3.9%. (Data taken from the abstract. Figures presented in body of paper differ.) • Cancer coverage does not accurately reflect cancer mortality. Breast cancer accounts for 8.4% of cancer deaths compared with prostate cancer 6.46%, lung cancer 27.2% and colorectal cancer 10%. • The average readability score of articles was senior high school grade 12.80. • Readability scores differed significantly in ethnic newspapers with the most difficult (highest readability) levels in East Indian papers and the easiest (lowest readability) levels in First Nations papers. • A main message of the paper: 'Cancer coverage in ethnic and mainstream newspapers did not accurately reflect the leading causes of cancer death in Canada' (p332).
Hoffman-Goetz et	Aim and method: 'To examine all articles between 1987 and 1994 on	• 84 magazine articles about cancer identified ('articles were counted if the content was gender neutral or

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al. (1997)	cancers in general and tobacco-related cancers in particular appearing in popular magazines whose principal reader is adult African-American women and to relate this coverage to the number of tobacco advertisements in these magazines' (US) (p262).	specifically targeted for women', p261). • Cancer comprises12.9% of all health articles. • Most (>70%) of the articles are 'short fillers' of less than one page in length. • Cancer in general is discussed in 25 articles. • Breast cancer is the focus of 24 articles compared with cervical cancer (9), lung cancer (6), throat cancer (2), bladder cancer (1) and ovarian cancer (1). • 1,477 tobacco advertisements are identified. • The number of tobacco advertisements declined from 280 in 1987 to 122 in 1994. • A main message of the paper: 'This study demonstrates the lack of coverage of tobacco-related cancers in popular magazines marketed to female African-Americans. Because tobacco-related cancers are entirely preventable and contribute to a significant cancer burden within this population, this is a missed opportunity for health promotion' (p269).
Hurley et al. (2014)	Aim: 'To detail online cancer news characteristics and trends' (p3). Method: Quantitative content analysis of online cancer news	• 862 articles about cancer retrieved. • Specific cancers were mentioned in 84% of articles (breast 33%, digestive (e.g. colon) 27%, genitourinary (e.g. prostate) 23%, gynaecological (e.g. cervical) 12%, skin 11%). • In terms of stages in the cancer continuum, treatment received the most attention (mentioned in 73% of

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	retrieved during a four-month period in 2008 from four news websites (Google News, Yahoo! News, MSNBC.com and CNN.com).	articles) followed by detection (56%), survival (45%), end of life (38%) and prevention (36%). (Articles frequently mentioned more than one stage.) • The primary focus of articles identified was: research reports (24%); person profiles (27%); event/fundraisers (10%); policy/politics (8%); awareness/education (6%). • A main message of the paper: 'In general, treatment information received the most attention in online cancer news. Breast cancer received the most attention of each specific cancer, followed by digestive and genitourinary cancers. Research reports and profiles of people (60% of which were about celebrities) were the most common article types' (p1).
Jensen et al. (2010)	Aim: To 'quantify newspaper coverage of cancer' (p148). Method: Quantitative content analysis of US newspapers published in 2003.	• 5,327 stories containing cancer information identified. • The most frequently mentioned cancers are: breast (26.0% of stories), lung (11.3%), male productive (10.4%), colon (8.5%), blood/leukaemia (8.1%), female reproductive (6.0%), skin (5.1%), and head and neck (5.0%). • The most frequently mentioned topics are: risk factors (28.1% of stories), incidence data (26.9%), treatment (24.7%), non-celebrity with cancer (11.7%), celebrity with cancer (10.7%), prevention (7.6%), detection (6.2%), mortality data (6.1%), survivorship (4.9%) and end-of-life care (1.6%). (Stories may mention more than one topic.)

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		• Lifestyle (diet and smoking) is the most frequently mentioned risk factor (in 45.9% of stories mentioning risk) followed by demographics (39.5%), genetics/heredity (22.3%), environmental/occupational (22.2%) and medical (18.8%). • The most frequently mentioned cancers in celebrity news stories are: male reproductive (19.9%), breast (16.0%), lung (13.9%), head and neck (13.1%). • The most frequently mentioned cancers in non-celebrity stories are: breast (24.4%), blood/leukaemia (17.9%), head and neck (9.5%) and lung (6.9%). • The most frequently portrayed cancers in stories about events (e.g. fundraising events) are: breast (36%), blood/leukaemia (13%), male reproductive (7.0%), female reproductive (6.5%), lung (4.2%) and colon (3.2%). • A main message of the paper: 'Breast cancer was found to be the most covered cancer site, a result that has been replicated in all but one comprehensive content analysis from 1977 to 2005'.
Jones (2004)	Aim: 'To assess the accuracy' of breast screening messages in Australian media' (p311). Method: Quantitative content	• 73 advertisements and articles about breast cancer identified. • Advertisements and articles fail to mention the age-related nature of breast cancer. True-life stories are misleading in that 80% featured young women with the disease.

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	analysis of breast cancer articles and advertisements in Australian newspapers and women's magazines published in 2000.	• Information about screening is low except in the breast screening advertisements. • Life-time risk of breast cancer is rarely reported in articles. • A main message of the paper: 'The major problem revealed by this review, both in terms of the extent of misinformation and its public health impact, was the issue of apparent age of breast cancer sufferers' (p317) …'The development of media guidelines for the presentation of information on breast cancer would greatly improve the accuracy of information presented to Australian women' (p318).
Kitzinger et al. (1999) Henderson and Kitzinger (1999) (Report and paper describing the same study)	Aim: 'To examine media coverage of breast cancer genetics and explore its implications for public understandings' (p560). Method: 1) Quantitative and qualitative content analysis of UK newspapers published between 1995 and 1997, and television and radio broadcasts, and magazines produced in 1997; 2) Interviews with media personnel and their	• 708 media texts about breast cancer identified of which 152 focus on risk, and 51 of these focus on genetics/inheritance. • Genetics features in 25 personal accounts and 21 news reports. It also appears on advice pages and fashion pages. • Most of the reporting of inherited/genetic breast cancer is in relation to one of four categories: scientific discoveries, debates about testing, controversies of patenting and human interest stories. • Human interest stories in relation to issues surrounding prophylactic mastectomy and the experience of women from high-risk families comprise 27% of stories.

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	sources; 3) Focus group discussions with ordinary women with no known interest in breast cancer and with people with a special interest in breast cancer (medical practitioners, breast cancer support workers and survivors of the disease).	• Breast cancer is identified as a 'media friendly' disease by media producers – an easy story for which editorial support is assured. • However, tensions were identified between charity and scientific personnel and press personnel regarding the reporting of stories. • Lay women over-estimate the role of genetics in the aetiology of breast cancer and were often unclear of the nature of genetic risk, e.g. 'It must be high because such a big deal is made of it'. • Human interest stories (rather than news reports) are identified by women as an important source of information about breast cancer. • A main message of the paper: 'We have shown how coverage of breast cancer genetics was influenced by the widespread nature of breast cancer and its impact on young women, combined with media efforts to target female audiences.'… 'Soft reporting [like human interest stories] may be more accessible than hard [scientific] reporting but it might mask scientific information behind emotive stories' (p575).
Konfortion et al. (2014)	Aim: 'To determine whether recent newspaper coverage [i.e. 2011-2012] of the four most common cancer types relates to their	• 9178 articles mentioning cancer identified. • 46% contain 'breast cancer', 19% contain 'prostate cancer', 19% contain 'lung cancer', 16% contain 'bowel cancer' or 'colorectal cancer'.

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	relative burden and national awareness months' (p1). Method: Quantitative content analysis of UK national newspapers published in 2011.	• The highest number of breast cancer articles was published in Breast Cancer Awareness Month (October). • 'Lung cancer' and 'bowel cancer' are most common in articles published in months that are distant from their respective awareness months. • A main message of the paper: 'UK newspaper coverage of common cancer types other than breast cancer appears under-represented relative to their population burden. Health promoting public bodies could learn from the success of Breast Cancer Awareness Month and work more closely with journalists to ensure that the relevant messages reach wider audiences' (p1).
Lantz and Booth (1998)	Aim: 'To investigate how issues related to gender norms contribute to the social construction of health problems by studying the representation of breast cancer as an epidemic' (p910). Method: Qualitative content analysis of US magazines articles that mention the increase in breast cancer incidence published	• 228 articles on breast cancer identified. Of these, 91 articles were analysed. • The number of articles on breast cancer increased more than five-fold from 20 articles in 1980 to 118 articles in 1995. • Approximately half (52%) of the 91 articles mention that breast cancer incidence has increased since 1980. • Where the increasing incidence is discussed, it is portrayed as an alarming trend (an epidemic) which cannot be explained or fully accounted for. A sense of drama and urgency is created around the premise that breast cancer rates appear to be out of control, for reasons that are eluding or not understood by scientists.

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	between1980 and1995.	• Breast cancer is portrayed as occurring primarily in young, professional women because of changes in women's behaviour such as delaying childbearing, not having children, the use of oral contraception, induced abortion, and the use of tobacco and alcohol. Women are thus portrayed as victims of an insidious disease but also victims of their own behaviours, many of which are related to the control of their fertility. • While individual behaviours are presented as responsible for the increase in breast cancer, science is presented as the means to defeat it including advances in genetics and drugs, and mammography. Cancer is portrayed as an evil enemy against which society is waging a war. • A main message of the paper: 'The portrayal of the breast cancer epidemic in the US popular press reflects a strong social desire to create order and control over a frightening disease. In the process, a common message is that the behaviours and choices of young, non-traditional women – especially those related to fertility control – have led to pathological repercussions within their bodies, which in turn may be responsible for great disorder and pathology at a social level in the epidemic of breast cancer' (p907).
Lederer (2007)	Aim and method: Exploration 'of the cultural representations of cancer in popular Hollywood films	• Representations of cancer in films are more common than previous commentators have suggested, but the precise number of films is unknown due to insufficient

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	released between 1930 and 1970' (p94). (Method not otherwise stated by author.)	cataloguing. • Films typically feature cancers that are not the most common types, e.g. brain cancer, cancer of limbs and leukaemia. • Cancer is represented as a 'clean' and non-disfiguring disease that usually ends in death (p114). • Cancers of reproductive/sexual organs are not discussed (e.g. breast, ovarian, cervical, prostate). • The diagnosis and/prognosis is frequently concealed in films, either from patients or from family members. • Death from cancer is portrayed as gracious, glamorous and quick without gross bodily transformation. • Aetiology of cancer is not a feature of films other than the link between radiation and leukaemia. No association is made in films between smoking and cancer. • Medical research is portrayed as the means that would conquer cancer. • Surgery is portrayed as the main effective treatment for cancer. • A main message of the paper: 'Popular filmmakers selectively projected some cancers rather than others, favouring those that were less offensive and more photogenic. Although the characters became weak and died, they did so without gross transformations of their bodies. This paper argues that such representations

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		nonetheless informed American attitudes about cancer and the role of medical research in overcoming the disease' (p94).
Lewison et al. (2008)	Aim: 'To describe in a quantitative manner the impact of cancer research on a major conduit of research stories – the BBC website' (p569). Method: Quantitative content analysis of cancer research reports from the BBC website health section archive from 1998 to 2006. The frequency of reports of each cancer site is compared with that cancer's burden of disease measured in Disability Adjusted Life Years.	• 240 stories identified each year, of which about 160 cite research papers. • Breast cancer is mentioned in 34% of stories compared with lung cancer in 10%, colorectal in 9%, prostate cancer in 8% and skin cancer in 6% of stories. • Breast, cervical and skin cancer are over-reported in relation to the burden they cause. • Lung cancer is identified as being the cancer that is most under-reported in relation to the burden it causes. Other cancer types that are under-reported include stomach, pancreas, oesophagus and lymphoma. • Foci of stories includes new and improved drugs (20%), lifestyle (particularly smoking and sunbathing) (12%), genetic developments (9%), and food and drink (including dietary supplements such as vitamins) (8%). • Health stories cited 1394 research papers of which 76% are in the field of cancer. • Most of the cancer research papers cited are from the UK (40%) and the US (36%). • The most frequent external commentators on stories are from cancer charities (Cancer Research UK, Breakthrough Breast Cancer and the Prostate Cancer Charity) and the

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		Department of Health. A main message of the paper: 'We have found consistently high levels of BBC cancer research stories … a strong focus on breast cancer in these stories', and 'drugs dominate research reports and the trend is increasing' (p574).
Lupton (1994)	Aim: 'To examine the discourses competing to create meaning at the site of Australian press accounts of breast cancer' (p74). Method: A critical content analysis to identify manifest and latent themes in Australian newspaper, and business and news magazine articles referring to breast cancer published between 1987 and 1990	• 960 articles identified. • Manifest themes include: the rising incidence of breast cancer in Australia; the need for early detection; the benefits of mammography; the drawbacks of mammography; the debate over the link with the contraceptive pill; funding of mammography; and the relationship between lifestyle factors and breast cancer. • Latent themes relate to: o Breast cancer and femininity: breast cancer is linked to women's reproductive choices (e.g. delaying having children, taking the contraceptive pill) and having a passive attitude. o Dominance of medical profession and medical technology in health matters: metaphors of war used to describe the roles of medicine and medical technology in the fight against breast cancer. Women with the disease are largely invisible or passive. Where they were present

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		they were portrayed as examples of how personal courage, in conjunction with medical knowledge and skill, can save women with breast cancer from death. ○ Lifestyle and responsibility for breast cancer: responsibility for preventing breast cancer is placed upon women by identifying risk factors such as lack of exercise, stress, insufficient sexual activity, excessive dietary fact, body shape and being obese. Increasing age as a risk factor is rarely discussed. • A main message of the paper: 'The analysis has demonstrated the press's valorization of medical technology, medical practitioners, public health rhetoric and medical research to the exclusion of the needs, wants, and feelings of women in the general population. Women as individuals received press attention only when they were portrayed as triumphant, brave fighters against breast cancer, living examples of the victory of medical intervention, extolling the benefits of early detection' (p84).
MacKenzie et al. (2007)	Aim: 'To examine media coverage of prostate cancer screening in Australia' (p513).	• 388 newspaper and 42 television news items identified, containing 436 statements about prostate cancer screening. • 86% of statements are identified as positive towards screening (i.e. suggesting that screening is desirable).

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	Method: Quantitative content analysis of television news and newspaper coverage of prostate specific antigen (PSA) screening from 2003 to 2006.	• The remaining 14% raise concerns about the PSA test's reliability, associated side-effects or the fact that the evidence about screening is not yet conclusive.
		• The following themes are identified:
		  ○ The imperative of testing (41%)
		  ○ Scientific progress (17%)
		  ○ Caution and concern (14%)
		  ○ Authenticity (statements by individuals with prostate cancer) (8%)
		  ○ Gender equity (with breast cancer screening) (7%)
		  ○ Reassurance about side-effects (7%)
		  ○ Attacks on critics of screening (6%)
		• Media discourse about PSA testing was dominated by a small number of individuals from cancer organisations, health care, politics and entertainment.
		• A main message of the paper: 'Australian men are exposed to unbalanced and often non-evidence based appeals to seek PSA testing. There is a disturbing lack of effort to redress this imbalance' (p513).

MacKenzie et al. (2008)	Aim: 'To test the hypothesis that television news coverage of different cancers reflects their incidence and burden, and to	• 1,319 items about cancer identified. Cancer comprises 9.4% of all health-related items and is ranked 5th in frequency among health-related topics, after injury, health care, nutrition and obesity, and medical and

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	examine the journalistic approaches used in reporting cancer' (p155). Method: Quantitative content analysis of all reports of cancer in Australia television news from 2005 to 2008.	surgical advances. • Breast cancer is identified in 43% of reports, leukaemia in 18%, melanoma in 12%, cervical cancer 12%, brain cancer in 5%, prostate cancer in 5%, colorectal in 5%, ovarian cancer in 3.7% and lung cancer in 3%. • Breast cancer, melanoma and cervical cancer are over-reported in relation to their incidence and burden. • Lung, colorectal, head and neck, bladder, kidney, uterine, pancreatic, stomach and thyroid cancers are under-reported in relation to their incidence and/or burden. • Main focus of reports include: treatment (32%), celebrity diagnosis (21%), cause/risk (smoking, sun exposure, diet) (18%), awareness (15%) and screening (9%). • Breast cancer dominates the awareness category (61% of reports) and screening category (75% of reports). • A main message of the paper: 'The current predominance of reports on breast and cervical cancer and on young women with cancer may be distorting public and political perceptions of the burden of cancer. The success of advocates in raising the news profile of breast cancer may hold lessons for agencies wishing to improve the newsworthiness of other cancers' (p155).
MacKenzie et al.	Aim: 'To test the hypothesis that young women at low risk of breast	• 421 statements about age identified from 341 reports about breast cancer.

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(2010a)	cancer are over-represented in television news' (p565). Method: Quantitative content analysis of Australian television news broadcasts between 2005 and 2007.	• 55% of statements refer to breast cancer in the under 40 age group compared with 17% in the over 40 age group and 20% not specified. • 97% of the 126 statements in relation to celebrities refer to the under 40 age group. • 60% of the 111 statements in relation to screening policy refer to the under 40 age group compared with 22% that refer to the over 40 age group. • 31% of the 43 statements in relation to fundraising refer to the under 40 age group compared with 2% that refer to the over 40 age group. • 14 (78%) of the 18 statements about cause refer to women over 40. • Where images of women are presented, 67% of individuals are known or judged to be under 40. After removing celebrity reports, images of women under 40 account for 42% of all images. • A main message of the paper: 'Over-representation of young women with breast cancer in television news coverage does not reflect the epidemiology of the disease. This imbalance may contribute to public uncertainty regarding screening policy' (p565).
MacKenzie et al (2010b)	Aim: 'To examine the coverage of colorectal cancer on Australian	• 39 news reports about colorectal cancer identified. These comprise 4.1% of all cancer reports.

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	television' (p282). Method: Quantitative content analysis of Australian television news reports broadcast from 2005 to 2008.	• The frequency of reports about colorectal cancer rank 6th behind breast cancer (507 reports), melanoma (173 reports), prostate cancer (76 reports), lung cancer (55 reports) and leukaemia (55 reports). • Reports about colorectal contain 190 statements about the disease relating to: o Treatment (38%) – mainly new treatments and surgical techniques o Screening (26%) – including the national screening programme, the awkwardness of discussing the disease and the benefits of early detection o Prevention (19%) – mainly related to lifestyle activities of exercise, diet and alcohol intake, the preventive role of aspirin and genetic issues o Prevalence (15%) – emphasising the number of diagnoses or attributable mortality, e.g. over 12,000 annual diagnoses or responsible for the deaths of about 90 Australians a week o Celebrities with the disease (2%) – three statements focusing on a former rugby player diagnosed with the disease • A main message of the paper: 'Media neglect of colorectal cancer may be an important factor in

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		explaining low participation in the Australian colorectal screening programme. Those advocating for colorectal cancer screening face ingrained cultural challenges in gaining broad media coverage, but investment in efforts to generate news and commentary would appear to be overdue' (p283).
McKay and Bonner (1999)	Aim: To examine personal narratives of breast cancer in women's magazines and compare narratives of celebrities with those of ordinary women. Method: A thematic content analysis of personal narratives of breast cancer in Australian women's magazines published between 1994 and 1996.	• 42 personal narratives identified (one in every eight or nine issues) relating to 'celebrities', 'quasi-celebrities (e.g. wife of a celebrity), public figures (e.g. a politician(and 'ordinary women'. • Typically narratives follow a similar structure: the discovery of a lump, tests, treatments and recovery interspersed with details about coping with the associated anxiety. In almost every instance, the woman involved expressed a desire that her experience should not be in vain and that by reading her story, other women would be able to comprehend the implications of the experience of breast cancer. • Young women are more commonly represented than older women and stories commonly portray women as not falling into any of the risk categories for the disease. • Health advice stresses personal control and self-help particularly through breast self-examination, fitness and controlling diet by reducing fat, and eating fresh fruit and vegetables.

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		• Narratives of ordinary women often sensationalise the experience of breast cancer; often by being highly personal and including elements of the bizarre (e.g. 'My buttocks became my breasts'). Stories typically conclude with positive statements about triumphing over adversity. During awareness campaigns themes of altruism dominate. • Narratives of celebrities are identified as less sensationalised but these also present inspirational accounts directed towards helping other women. • A main message of the paper: 'Both types of pathographies over-emphasise certain risk factors, but nevertheless provide a mechanism for women to share the experience of serious illness' (p563).
Mckay and Bonner (2004)	Aim: To identify how information and advice about breast cancer is portrayed in women's magazines, 'paying particular attention to illness narratives' and 'stories associated with the magazines' own breast cancer campaigns' (p517). Method: Thematic content analysis	• 348 magazines examined. • Magazines regularly advocate early detection of breast cancer through self-examination and mammography, and prevention through diet and exercise. • Contact details for research foundations, charitable organizations and support groups are routinely published. • Illness narratives are more likely to appear if they feature celebrities, involve sensational aspects such as multiple tragedy or are otherwise structured to evoke a strong reader response.

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	of Australian women's magazines published between 1999 and 2001.	• Illness narratives are more likely to feature young women. • Altruistic motives (i.e. an 'obligation to help other women') are commonly expressed. • Illness narratives frequently include reflections on cause in terms of how the individual did not have any of the risk factors, most often citing exercise, diet, having breast-fed her children, age and no family history of the disease. • Non-personalised accounts regularly emphasise risk reduction. • Conventional medical treatment is presented as the norm. • Women are urged to take control over their illness by developing a positive outlook and by looking after themselves by avoiding stress, eating well and exercising. • A main message of the paper: 'Magazine information on breast cancer has changed little in that personal narratives still dominate [compared with their previous study above]. While general health and diet information is still provided, the amount of this has diminished significantly. Personal narratives increasingly carry the burden of informing readers about the disease and how they can adopt techniques that will enable them to

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		manage their experience should they develop the disease, or to understand and support friends and family' (p532).
Metcalfe et al. (2011)	Aim: To examine 'newspaper coverage of Ms [Jade] Goody's illness and the extent to which articles conveyed public health messages to support prevention of cervical cancer' (p80). Method: Quantitative content analysis of UK newspapers from 2008 to 2009.	• 1203 stories including 'Jade Goody' and 'cancer' were identified. • 9.6% of articles contained information about reducing personal cervical cancer risk. • Most (85.3%) highlighted screening followed by vaccination (31.0%), limiting the number of sexual partners (14.7%), condom use (6.9%) and smoking (6.0%). (Some articles provided information about more than one risk factor). A main message of the paper: 'Only a small proportion of those [newspaper articles] reporting the story included a public health message to readers regarding methods to reduce their risk of developing cervical cancer. Of these, the majority recommended cervical screening. Fewer articles promoted the primary preventive measure of vaccination and very few identified smoking cessation, barrier protection and other lifestyle changes' (p83).
Saywell et al. (2000) This study formed part of the Kitzinger et al.	Aim: To identify how breast cancer is portrayed in media representations of the disease.	• Breast cancer is headlined four times more often than any other cancer, appearing in 133 headlines. This compares with prostate cancer in 31, skin cancer in 26, lung cancer in 18, cervical cancer in 15 and bowel cancer in 9 headlines.

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(1999) study.	Methodology: Thematic content analysis of UK newspapers published between 1995 and 1997.	• Breast cancer is referenced in texts almost twice as often as other cancers. Breast cancer appears in 1243 texts compared with lung cancer in 750 texts, prostate cancer in 466 texts, skin cancer in 362 texts, cervical cancer in 193 texts, stomach cancer in 154 texts and testicular cancer in 154 texts. • There is a disproportionate representation of young, attractive women with healthy and full breasts (as opposed to images of older women and evidence of mastectomy surgery). • Breast cancer is marketed in the UK through breast cancer awareness campaigns and fundraising initiatives. • Images and stories conceptualise breast cancer within limited definitions of femininity that focus on sexuality and maternity. Breast cancer is seen as a threat to both of these. • Women with breast cancer are positioned as stoic fighters and selfless martyrs. • Counter discourses or alternative narratives are rare. • A main message of the paper: 'Breast cancer is made newsworthy in most media reporting by focusing on the experiences of young and either maternal or sexual female bodies. This is influenced by perceptions of femininity which focus on the breast as an icon of feminine worth. The press focus on the breast obscures

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		other dimensions of the experience and polices how women should experience their bodies (for example assuming that mastectomies must be hidden and reconstruction is mandatory). It also ignores all the other bodily effects of cancer and its treatment; from swollen organs to the loss of hair. Such bodily effects may be a very important part of the experience' (p59).
Seale (2001a)	Aim: To 'investigate the proposition that a sporting context, at least in stories of personal cancer experiences (as opposed to accounts of cancer scientists' research 'breakthroughs') is now the vehicle for struggle language' (p309). Method: Quantitative and qualitative content analysis of newspaper articles appearing in the English language press during the first week of October 1999 in which there was significant coverage of the life or death of a person with cancer (PWC).	• 358 articles from 143 different newspapers were selected for analysis (62% from US papers, 26% from UK papers, 10% from Canadian papers). • 382 PWC appear in the reports; 46% have breast cancer, 7% reproductive/genital cancer, 7% leukaemia, 6% lung/throat, 5% stomach/bowel/rectal. (Articles retrieved during Breast Cancer Awareness Month.) • The language of struggle is commonly featured in reports. Common terms include for example, 'fighting', 'battling', 'winning'. • References to sport are also common. • Argues that it is more appropriate to describe the language of cancer in reports of PWC as 'struggle' language in which sporting connotations are evoked through the use of military metaphors. • Argues that, rather than being oppressive, the language of struggle may be experienced as inspiring and supportive for PWC.

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
		• A main message of the paper: 'Sports stories allow cancer to be portrayed as a psychological and spiritual journey, with progression towards a satisfying resolution even where death lies at the end' (p326).
Seale (2001b)	Aim: To 'analyse news media accounts of personal experiences of cancer paying particular attention to the prevalence of religious themes and the meanings of these where they appear' (p426). Method: 'Quantitative analysis of manifest content and more interpretative qualitative analysis of latent or more hidden rhetorical messages' of newspaper articles appearing in the English language press during the first week of October 1999 in which there was significant coverage of the life or death of a person with cancer (PWC) (p430).	• 358 articles from 143 different newspapers were selected for analysis (62% from US papers, 26% from UK papers, 10% from Canadian papers). • 382 PWC appear in these articles. • Portrayals of religious interpretations of the cancer experience are rare: only 15 (4%) of the PWC are portrayed with religious faith playing an important part of their lives (14 North American PWC, 1 South African). • In 10 stories (all North American PWC) the religious sentiments of other people are portrayed; 6 of these involve adults commenting on the situation of children with cancer. • In 10 stories (7 North American and 3 UK PWCs), there is either a passing mention of religious understanding or a quasi-religious element in the portrayal (e.g. a 20-year-old survivor of breast cancer is reported as saying 'I feel very blessed'). • Themes identified in the 15 papers in which religion is portrayed as important include: ○ The strength gained from faith to cope with cancer

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
		○ A belief in the cancer experience as an aspect of divine will ○ The power of prayer ○ The experience of a supportive fellowship • Religion is portrayed as: a marginal set of beliefs associated with membership of a minority ethnic group; an outmoded traditional authority; a matter of last resort after medicine has failed; and as childlike. • A main message of the paper: 'This study has shown that explicitly religious themes in news reports of people with cancer are uncommon. In spite of the inability of medical and scientific ideas to address existential questions of ultimate meaning or justice that often trouble people when they face a life-threatening illness, the medical expert system is presented as the preferred option when people want practical help with their cancer' (p437).
Seale (2002)	Aim: 'A study of news reports of people with cancer' … 'with particular reference to gender' (p107). Method: Quantitative and qualitative content analysis of newspaper articles appearing in	• 358 articles were selected for analysis (72% from North American newspapers and 26 from UK newspapers). • 340 adult PWC appeared in these stories; 69% were female, 73% of whom had breast cancer. 5 men also had breast cancer. (The month of retrieval was during Breast Cancer Awareness Month.) • In relation to gender: ○ Stories emphasise women's skills in the emotional labour of self-transformation

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	the English language press during the first week of October 1999 in which there was significant coverage of the life or death of a person with cancer (PWC).	○ Women are portrayed as courageous and developing altruism out of their cancer experience ○ In men, cancer is more commonly portrayed as a test of existing strength of character ○ Men are portrayed as stoic, strong and unruffled/realistic • Other themes: ○ Cancer leads to changed priorities in life ○ Something good coming from something bad ○ The cancer experience constitutes a 'lesson' and teaches the person something ○ Survivors have a mission to educate and benefit others (breast cancer stories) • A main message of the paper: 'The news reports show each gender following different paths to a common destination. This involves the construction of a narrative to show the cancer experience as meaningful in an attempt to imagine that it is possible for humans to exert control over illness' (p122).
Seale (2005)	Aim: 'To describe the messages about treatment decision-making on popular cancer websites, with particular reference to gender	• The proportion of each website devoted to information about decision-making was similar (16% breast, 14% prostate). • Website portrayals of decision-making by women with

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	differences' (p171). Method: Qualitative and quantitative comparative content analysis of two websites (Breast Cancer Care and the Prostate Cancer Charity) in 2003.	breast cancer emphasise: ○ Their family obligations ○ Their need to make decisions about other matters other than treatment (e.g. whether to start or end a pregnancy, to take part in fundraising, how to tell their children and other decisions regarding childcare) ○ Their right to opt out of decision-making, to take time, sometimes change their minds, consult with family and friends, and take non-medical factors into account • Portrayals of treatment decision-making by men with prostate cancer emphasise: ○ The obligation to be decisive using information derived from medical sources (e.g. doctors and the website), with minimal consultation with family and friends • Personal stories of breast cancer are common but largely absent on the prostate cancer website. • A main message of the paper: 'These findings show how these cancer websites reinforce popular views about differences in the behaviour and responsibilities appropriate to men and women. Women with cancer are portrayed as having a network of relationships that have to be managed and consult when deciding on treatments

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		and the consequences of disease. … Men with cancer are portrayed as more isolated, obliged to take charge of decision-making and discouraged from adopting a passive role. The stress of decision-making for men is not discussed and family and friends are said to play a limited role' (p174).
Slater et al. (2008)	Aim: 'To assess … how cancer is covered in terms of cancer topics (i.e. prevention, detection, treatment, cause, etc.)', cancer site and in relation to incidence and mortality rates. Method: Quantitative content analysis of US newspapers, television news and news magazines from 2002 to 2003.	• 677 newspapers, 57 magazines and 59 television broadcasts identified that mention a specific cancer topic. • 431 newspapers, 36 magazines and 78 television broadcasts identified that mention a specific cancer site. • Cancer topic coverage frequency varies between media formats although treatment is consistently ranked highly: o In newspapers, treatment is the most frequent topic occurring in 17.4% of stories followed by cause (16.8%), death (15.4%), survivors (14.5%), funding (10.9%) and detection/diagnosis (10%). o In magazines, detection/diagnosis is the most frequent topic (26.3%) followed by treatment (24.6%), cause (17.5%), industry (8.8%), funding (7%) and survivors (7.0%). o On television, death is the most frequent topic (29.5%) followed by treatment (20.5%), prevention (12.8%), survivors (10.3%), cause

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		(7.7%) and intervention (7.7%).
		• Breast cancer is mentioned more often than cancers of other sites across all media:
		  ○ In newspapers, breast cancer is reported in 29.6% of stories, compared with colon cancer in 11.3%, prostate cancer in 9.6%, lung cancer in 8.7% and brain cancer in 7.0% of stories.
		  ○ In magazines, breast cancer is reported in 25.0% of stories, compared with prostate cancer 22.2%, cervical cancer 11.1%, colon cancer 11.1%, lung cancer 8.3% and skin cancer 8.3%.
		  ○ On television, breast cancer is reported in 27.1% of stories compared with prostate cancer in 16.9%, brain cancer in 13.6%, skin cancer in 11.9%, lung cancer in 6.8% and stomach cancer in 6.8%.
		• Four of the five frequently discussed cancers follow a similar pattern of coverage (i.e. more coverage of treatment and cause, and less coverage of prevention and detection/diagnosis). Lung cancer differs: there is more coverage of death in stories about lung cancer (30.6% of stories compared with breast cancer 4.5%, colon cancer 2.1% and prostate cancer 7.7% and brain cancer 23.3%).
		• Breast cancer, brain cancer, leukaemia and cervical

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		cancer are over-represented in relation to their incidence and mortality. • Lung cancer and lymphoma are under-represented in terms of their incidence and mortality. • A main message of the paper: 'Results indicated that coverage reflected incidence rates more closely than they did mortality rates, but in both cases coverage under-represented the contribution of lung cancer to morbidity and mortality and over-represented the contribution of breast cancer. Of greater public health concern was the limited coverage of prevention and detection even for highly preventable or easily detected cancers' (p523).
Stryker et al. (2009)	Aim: 'To explore the frequency of articles about different types of cancer risk that are published in mainstream and ethnic newspapers, to assess the extent to which newspapers communicate risks optimally, and to determine whether portrayals differ between the two kinds of newspapers' (p2). Method: Quantitative content analysis of US mainstream and	• 5,327 cancer stories identified in mainstream newspapers and 565 cancer stories identified in ethnic newspapers. • Ethnic newspapers are more likely to report cancer risks than mainstream newspapers (61.6% and 39.3% respectively). • Ethnic newspapers are more likely to discuss demographic cancer risks (e.g. race, age, and socioeconomic status) and genetic cancer risks. • Mainstream newspapers are more likely to discuss medical cancer risks (e.g. medications, surgery and viruses or other infectious agents) and occupational or environmental cancer risks (e.g. air or water pollutants,

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	ethnic newspapers published in 2003.	pesticides/chemicals and occupational hazards). • Lifestyle risks (e.g. alcohol and tobacco use, exercise, diet, sexual practices, sun exposure and obesity) are commonly discussed in both types of newspapers. • Numeric presentations of cancer risk identified in 26.2% of mainstream and 29.5% of ethnic newspaper stories. • Of the six most commonly occurring cancers (lung, prostate, colorectal, breast, skin and female reproductive), only stories discussing prostate cancer present risk optimally (measured in terms of providing information on absolute and relative risk, and advice about prevention, screening and seeking help). • A main message from the paper: 'Information about cancer risks, in general, lacked context … and typically presented risks using non-numeric formats. These non-numeric descriptions, coupled with a general lack of contextual information may make it difficult for readers to properly evaluate their own cancer risks' (p6). 'Research is needed to understand how these non-numeric and decontextualised presentations of risk might contribute to inaccurate risk perceptions among news consumers' (p1).
Walter (2009)	Aim: 'To examine the scale of, and reactions to, print media coverage of the dying from cancer in 2009 of young British media celebrity	• Coverage of Jade is prominent, often appearing on the front page of newspapers and continuing daily to the day of her death.

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	Jade Goody' (p1). Method: Qualitative content analysis of articles in UK tabloid newspapers (e.g. Sun), OK! magazine, UK broadsheet newspaper online blogs and e-letters columns.	• Jade is portrayed as candid, open and honest in her dying, as she had been in life. • Photographs also present her in a very direct way both physically and emotionally. They depict her looking straight at the camera/audience, sometimes bald-headed, often glamorous despite her dying, in poignant situations (e.g. holding her own two young children, at her and her children's christening and at a pre-wedding photo-shoot). • Argues that the intense and high profile coverage of Jade's final weeks challenges the sequestration theory that the dying body is hidden from public view. • Public reactions to the coverage of Jade were complex with criticism of her public dying mixed with criticism of reality television in general, together with class prejudice. • Tabloid newspapers identified as generally supportive of Jade's openness and positioned her as an educator regarding conversations about dying. Other commentators found the public disclosure of her dying distasteful and difficult to avoid. • A main message of the paper: 'New media's blurring of public and private creates new arenas for publicizing the bodily, personal and emotional experience of dying, while at the same time affirming the public/private

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		boundary so that the ordinary dying of ordinary people remains substantially hidden' (p1).
Walter (2010)	Aim: To examine media coverage of the final weeks of Jade Goody's dying in UK tabloid newspapers and celebrity magazines, and her published diary. Method: Qualitative content analysis to identify narrative themes.	• Jade's dying is narrated through 4 'voices': 1) her own words and those of her intimates; 2) outsiders' words (e.g. journalists and other celebrities); 3) her publicist's words; and 4) photographs (p853). • These voices present mixed messages, Jade is presented as saying that dying can be frightening and painful, sometimes uncontrollably so. Journalists present dying as something that ordinary people can bear with courage. Photographs undermine stereotypes of how cancer ravages the body. • Two main narratives are identified: o Agency and autonomy: Jade is portrayed as struggling to retain agency and control of her dying because of the challenges of the disease. o Redemption: in dying, Jade is transformed from a physically and morally less than beautiful girl from a dysfunctional family into a physically beautiful wife and mother. In the redemptive narrative, Jade's previous liabilities are transformed into virtues – for example, her frankness is transformed into honesty, and selling her story is portrayed as an act of care for her children rather than commodification.

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
		• A main message of the paper: 'I have outlined here some key lessons that Jade Goody and her journalists taught the British public about dying from cervical cancer: it can be painful, treatment does not always ameliorate pain, it is a struggle to maintain autonomy and agency, but love can triumph and redemption is possible. Compared to the good death promoted by the palliative care movement, Jade Goody's message about pain is rather pessimistic, her message about agency is ambivalent, and her messages about love and redemption considerably more social than the inner growth in dying promoted by Kübler-Ross' (p859).
Wilkes et al. (2001)	Aim: To examine media stories 'for journalistic qualities, metaphors, narrative features and accuracy of clinical facts related to risk, early detection and treatment of breast cancer'. Method: Quantitative and qualitative content analysis of Australian women's magazine stories about breast cancer	• 60 articles identified. • 71% of articles appear in the first quarter of the magazine and a further 23% in the second quarter. • Most commonly discussed topics include: survival, screening and breast self examination, prevention such as lifestyle choices, and treatment. • Ordinary individuals with breast cancer are more commonly portrayed than celebrities. • Metaphors used include: cancer as a war or battle, cancer as an experience of redemption, breast cancer as a predator, the body as an object, breasts as femininity and people as physical/structural supports. • Themes identified in relation to risk:

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
	published from 1995 to 1998.	○ Genetic history of breast cancer means you will develop breast cancer ○ Age (as in youth) does not protect you from breast cancer ○ Breast feeding, early childbirth and low risk lifestyle choices do not lower your risk of breast cancer ○ Mammograms equal survival ○ The will to live equals recovery ○ Early detection equals survival • Clinical facts presented in stories relate to treatment modalities, early detection and risk of breast cancer. The most common risk factors presented are age, family history/genetic risk, and lifestyle factors including dietary intake of fats, vitamins and fibre, smoking, alcohol and physical exercise. • Few inaccuracies identified in the clinical facts presented. • A main message of the paper: 'The stories reflected the 'good news' editorial style of women's magazines. A dominant theme in the stories was that early detection of breast cancer is crucial and equals survival. While there were few inaccuracies in the stories, there was little detail of treatment modalities, an emphasis on lifestyle as a risk factor and a prevailing message that a genetic history of breast cancer means you will get it' (p80).

Author	Aim of study (using the author/s' own words where stated) and method/s used	Findings/interpretations
Woodthorpe (2010)	Aim: To 'examine the way in which [Jade] Goody's dying was presented' (p284). Methodology: Textual analysis of newspaper, magazine, television and online coverage of Jade Goody's dying.	• Dichotomy in how dying is presented. On the one hand, Goody's dying is highly visible. On the other hand, her final decline and death is entirely concealed. • A dramatized account of dying is presented that focuses on her relationships with her sons, her boyfriend/husband and her mother, and on her bravery. • Dying is presented as a spectacle for the consumption of others – a commodity to raise funds. • By promoting dying as a commodity to be consumed, Goody made it into a spectacle that could be ignored or rejected. • A main message of the paper: 'The coverage of Goody's dying highlights the scope for further sociological study of representations of dying in the public sphere. Largely considered to be something that is private, taking place behind closed doors (which Goody's death ultimately did), accounts of what it is like to die over a period of time and do so under the public gaze is a rich area for future study … There is much to be learnt from considering the way in which public representations of dying have developed and are consumed, to the point where dying people can now 'sell' their experience for financial gain' (p290).

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