**Radiotherapy:**

**Death Talk on Primetime National Radio—The Steve Hewlett Interviews**

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**Abstract**

Between October 2016 and February 2017, BBC Radio 4 broadcast a series of interviews with presenter Eddie Mair and journalist Steve Hewlett, following Hewlett’s diagnosis with esophageal cancer. These interviews, which became compelling listening—and for a brief moment, part of public conversation—provide the focus for this article. Three broad but overlapping themes are identified from analysis of the interviews: 1) the subjective lived experience of illness, and specifically, esophageal cancer; 2) the experience of navigating UK cancer care, and debates about the organisation and delivery of UK healthcare; and 3) the function of talk in mediating the experience of living with/dying from cancer. Two further strands are woven into the discussion: the specificity of male cancer talk; and radio as a medium for facilitating first-person narratives of illness/dying.

**Key words**: Cancer, Talk, Pathography, Public Dying, Radio

**Introduction**

In October 2016, journalist, broadcaster and media consultant, Steven Hewlett, began writing a diary in the *Observer* newspaper documenting his experiences following his diagnosis earlier in the year with esophageal cancer. In the five months between October 2016 and his death in February 2017, Hewlett also appeared as a regular guest on the early evening flagship British Broadcasting Corporation (BBC) Radio 4 news and current affairs programme, *PM*. In these weekly pre-recorded interviews with the programme’s host, Eddie Mair, Hewlett spoke candidly about his experiences of living with cancer, updating listeners on how he and his family were coping with his illness, on his treatment and care, and his selection for clinical trials using immunotherapy. The manner and tone of the interviews won plaudits from journalists and reviewers, who commended the combination of the two men and the way in which this had “made for gracious, realistic and very touching radio” (Sawyer, 2017).

For a brief period, this extraordinary piece of radio became part of public conversation. What made it so extraordinary was not just the subject matter—the lived experience of illness and dying in the middle of a news and current affairs programme—but that here were two men talking about a topic, and attendant issues and emotions, that has traditionally been considered decidedly “unmale” terrain. Once closeted and repressed, death in the 21st century is not only huglely accessible and visible (Woodthorpe, 2010) but also clearly audible. Death talk of this sort affirms that death in the second decade of the 21st century is, in fact, “having a moment” (Clark, 2018). What is also extraordinary, and marks this out as landmark radio, is the audience response and engagement with Hewlett’s very public journey. As part of the data analysed in this article, listeners’ feedback also provides a useful measure of audience response to the interviews as media text.

Public dying of the sort considered here reflects, and is the product of, a number of interrelated tendencies and trends. This includes growing general interest in death and dying both inside and outside of academia reflective of a so-called “death turn” (Davies, 2020) in the last 30 years or so. More specifically, it reflects media interest in death and dying and—in addition to long-standing media interest in death and dying as making good editorial copy—provides a corollary of media interest in public mourning (Woodthorpe, 2010). More specifically still, public dying—or more accurately, “public mediated dying” (Penfold-Mounce, 2020)—is very much part of an evolving genre of “pathography” first identified and documented by Hawkins (1984, 1990, 1999) as “a form of autobiography or biography that describes personal experiences of illness, treatment, and sometimes death” (Hawkins, 1999, p. 1). Modern media are thus central to these first-person narrative accounts of illness, dying and bereavement, providing the tracks on which they run as well as the platforms by which they are viewed.

As an evolving genre, publicly mediated pathographies span a range of media, new and old, forming part of a contemporary media landscape or ecosystem that symbiotically feeds off itself. Publicly mediated stories of dying that originate in social media (on YouTube, Facebook or Instagram) are routinely reported by mainstream news media—in print, online, on television and radio, and in news channels’ own use of social media. By the same token, stories of publicly mediated dying that originate in more “traditional” mainstream media are often widely reported and shared, and given added currency, in the orbit of social media.

As Walter (2009) has argued, this appears to challenge the long-established thesis of sequestration in sociology (Giddens, 1991; Mellor, 1993; Mellor & Shilling, 1993) charting the process by which death and dying have become hidden or concealed from public view. As a subset of debates around death denial (Becker, 1973) and death-as-taboo (Lee, 2008; Kellehear, 1984; Walter, 1991, 2014), claims that death and dying have been banished from the public sphere appear all the more absurd in light of burgeoning public interest in all things mortiferous, not least in the publicly mediated dying of the sort discussed here.

As a genre, “pathography” has been largely confined to the written (published) word; to books, and first-person musings of newspaper columnists (e.g. Diamond, 1998; Picardie 1998; Rabinovitch, 2007), and more recently, to magazines and blogs. Less common have been oral accounts of illness and dying broadcast on radio as audio diaries or conversational one-to-one interviews: exceptions being the audio diary of BBC Radio 4 journalist Nick Clarke in 2006; the conversational interview between comedian-actor-writer, David Schneider, and writer Jenny Diski, in 2015 (Schneider, 2015); and the weekly chats between Steve Hewlett and Eddie Mair considered here. As Karpf (2013) notes, pathographies are the terrain of those already in the business of writing for a living; using their illness—usually cancer—as material for their work, and their writing as therapy. Karpf also notes how few writers-come-pathographers use therapy to process and work-through the grief generated by their dying, but that their writing itself functions as therapy. I want to extend this by suggesting that Hewlett’s radio interviews also function as therapy—as radio therapy.

**From Pathography to Public Mediated Dying: Evolution, Uses and Growth**

It is now more than a decade since the death of reality television celebrity, Jade Goody, from cervical cancer in 2009. The appetite for first-person narratives (or “pathographies”) of this sort has grown steadily since Hawkins (1990) first claimed that ours is a culture in search of an *ars* *moriendi*, and more rapidly in the 21st century, as new technologies have provided a multitude of platforms in which to share one’s experiences. Goody’s very public dying, documented chiefly in television and popular magazines, can be seen as a “watershed” moment in public dying equivalent to the “high water” moment in public mourning provided by the death of Diana, Princess of Wales in 1997.

The proliferation of public dying in the 21st century has been enabled by modern media technologies. While still largely the preserve of middle-class writers and professionals with the networks, literary means and wherewithal to publicly document their experiences of terminal illness, the “democratising” impulse of social media has helped turn a steady trickle of pathographies into a veritable stream (Karpf [2013] notes the rejection letter *Guardian* columnist Dina Rabinovitch received from a prospective publisher for her book proposal for a cancer memoir on the grounds that it was already a crowded market). The second decade (or “tens”) of the 21st century has borne witness to a number of high-profile instances of public mediated dying: of well-established public figures and celebrities, plus individuals who have come to public prominence through using social media to document their illness and/or dying.

Too numerous to list here in full, notable examples of public mediated dying in the last decade include writers, journalists and broadcasters such as Christopher Hitchens (1949-2011), Jenny Diski (1947-2016), Rachael Bland (1978-2018), and Clive James (1939-2019)—whose dying became notable for the prospect that he might outlive his own pathographic material (James lived almost a further decade following his diagnosis with leukemia in 2010 and his public pronouncement in 2012 that his death was “immanent”). Examples of ordinary members of the public who came to public attention because of their public mediated dying include Yorkshire-born family doctor, Kate Granger (1981-2016), and personal trainer and vlogger, Emily Heyward (1993-2018). Granger used Twitter to not only document her experiences of cancer but also to fundraise for a local cancer charity (raising £250,000 for Leeds Cancer Charity Centre), and launch a campaign, “Hello, my name is,” to help reform and improve the ways healthcare professionals treat patients with terminal conditions (Granger was treated brusquely by a doctor who informed her that her cancer had spread but did not introduce himself or make eye contact with her).

The public dying of individuals in the “tens” is marked by the variety of media by which their experiences are shared (television, radio, newspapers, podcasts and social media) and the interaction between them. Heyward’s YouTube videos and Instagram posts following her diagnosis with malignant melanoma in 2011 were widely reported in the UK tabloid press and news websites, and Heyward’s story—especially her positive defiance in the face of cancer—was taken up by the fundraising campaign, Stand Up To Cancer (in association with Cancer Research UK and Channel 4).

Another recent tendency has been for clinicians to document their own and others’ experiences of dying (e.g. Gawande, 2014; Kalanithi, 2017). Other clinicians (Aronson, 2000; Hudson-Jones, 2006) and sociologists (Frank, 2000, 2013) have advocated the utility of first-person narratives of illness and dying as a vehicle by which medical practitioners may gain greater insight into patients’ experiences, closing-up the gap between patients and healthcare professionals. Further uses of public dying lie in its *mediated* experience, facilitating grieving (McQuire, 2021) by allowing individuals to reflect—at a remove (Walter, 1991)—upon their own experiences. Public mediated dying of this kind may help to stimulate conversation about end-of-life issues in ways that fit with the agenda and mission of the Dying Matters Coalition established in the UK in 2009 to promote greater public awareness, challenge preconceptions, and normalise public openness around death, dying and bereavement (see http://www.dyingmatters.org).

As a genre, however, pathography is not without criticism. In addition to criticisms of pathography—for its alleged narcissism (Burchill, and Aitkenhead, cited in Small, 1998); tendency to sanitise or omit less savoury bodily aspects of illness and dying (Aarons, 2014; Woodthorpe, 2010); and monitise or “commodify” intimate experiences of illness and dying (Armstrong-Coster 2005; Woodthorpe, 2010)—there have been other dissenting voices who have challenged the dominant motifs that underpin it. These criticisms round on pathography for purveying an overly positive view of cancer as either redemptive or transformative (Ehrenreich, 2009; Segal, 2007).

This article sits within a small but significant, and very specific, body of literature that has emerged to track first-person narratives of illness and dying (Bingley et al, 2006), to analyse and compare the textual content of contemporary (and historical) pathographies (e.g, Armstrong-Coster, 2001, 2005; Brennan, 2018; Frank, 2000; Hawkins, 1984; Seale, 1998), and to assess their wider significance for the culture within which they reside and that helped give rise to them (Karpf, 2013, Small, 1998; Walter, 1994, 2009, 2010; Woodthorpe, 2010).

**The Steve Hewlett Interviews**

Data for this article is drawn from interviews with Eddie Mair and Steve Hewlett first broadcast on the BBC Radio 4 *PM* programme between October 2016 and February 2017, and subsequently archived, stored, and available on the Eddie Mair podcast as “Steve Hewlett’s Cancer Journey” (<https://www.bbc.co.uk/programmes/p04p07t7>).[[1]](#footnote-1)

Analysis of the data was arrived at by the following process. First, the interviews were listened to in their entirety, without note-making, so as to acquire an intimacy and familiarity with the data. Second, the interviews were transcribed using speech-to-text transcription software. Transcribed material was then checked against the podcast recordings for accuracy, and where necessary, corrections made (as transcription software that relies on artificial intelligence and machine learning often betrays, and is not entirely faithful to, the speech being transcribed). Third, once transcribed, the interviews were listened to again—as part of a recursive process—in combination with the printed transcripts.

Following this, data was then coded: first, “indigenously” by attaching “labels” and “tags” to particular phrases and utterances; and secondly, using “focused” or “axial” coding by which data were “disaggregated” and organised under a rubric of concepts, issues and/or broader thematic categories. As part of this process, brief notes were made in the margins of the transcripts by “coding the record” (Hammersley & Atkinson, 1995, p. 185). Following this, and the first cycle of “in vivo” coding, a summary and description of each interview was made while material was still fresh in the mind.

Perhaps the most salient feature of the Hewlett interviews is that—aside from the occasional intervention or question from Eddie Mair—the interviews consist mainly of Hewlett: speaking at length, speedily, and uninterrupted. Another is the matter-of-fact nature of the way in which cancer is discussed, especially Hewlett’s treatment for it and the way in which he (and his family) are dealing with it. Hewlett’s attitude throughout the interviews is overwhelmingly positive, hopeful and upbeat—a reason perhaps why his death in February 2017, after 5 months of weekly updates, came as something of a shock to listeners, who had developed an intimacy with Hewlett and his cancer journey.

The interviews also reveal an intimacy between Hewlett and Mair, marked in large part by humour and joviality. They are also concentrated, allowing Hewlett free rein to provide listeners with weekly updates on his condition and treatment, and unlike similar “one-off” or “stand alone” pathographic interviews (such as those between Melvyn Bragg and Dennis Potter in 1994; Jeremy Paxman and Christopher Hitchens in 2010; or Mary Beard and Clive James in 2018), do not dwell on Hewlett’s life, career and achievements.

**1. Cancer as Lived Experience**

A clear thread running throughout the interviews is the focus they give to Hewlett’s first-hand, everyday lived experience of cancer. Much of this is storied and involves providing a narrative of events: of what happened, when, and to whom. As a sequence of storied events, the weekly interviews begin with Hewlett’s own account of his first feeling ill and being diagnosed with cancer—a “discovery story” common to cancer pathographies. The first interview in the series in September 2016 begins in typically forthright fashion:

Mair: Steve Hewlett is a well-known voice on radio for presenting *The Media* *Show* and he regularly pops up on *PM* and other programmes, making sense of complex media stories. Steve is here tonight to talk about something more personal. We’re going to talk about your health.

Hewlett: Indeed.

Mair: What’s happening?

Hewlett: Well, I’ve got cancer. I’ve got cancer of the esophagus, near where the esophagus joins the stomach.

(Mair, 2016a)

Hewlett goes on to explain how he first recognised something was wrong during a meal with his sons at the Asian food restaurant chain Wagamama, recounting how he had to interrupt his meal and leave the restaurant in a fit of coughing and retching in the street outside. As part of the interviews, Hewlett’s three sons—Freddie (24), Billy (21), and Bertie (18)—also appear (once near the beginning of the series of interviews and again following their father’s death) and are routinely invoked in Hewlett’s updates and reflections on his experiences. Auto/biography invariably involves writing or speaking about others (Brennan & Letherby, 2017) and the Hewlett interviews are no different in this respect. The Wagamama “origin story” is a storied account (and memory) shared by participants to this event and journey. Other people, in this way, are part of the weft and weave of the personal stories we tell others, clearly imbricated in a person’s own identity and sense of self, and cannot be so easily disentangled.

Following this, the interviews illustrate how emotions for Hewlett are triggered not by his diagnosis or lived experience of cancer as such, but rather at the thought of telling others about his cancer and how they will cope with the news. Hewlett discusses on a number of occasions throughout the series of interviews how he has not been “crushed” or “cowed” by his diagnosis, experience of cancer, or treatment for it. As “complexes” (rather than “things”) (Burkitt, 1997), this illustrates how emotions can be understood as constituted through, and precipitated by, interpersonal relational bonds.

Hewlett: I didn’t feel down, honestly, about any of it, nor really particularly emotional. The only emotional bit—and forgive me if I don’t quite get through this bit intact. The really hard thing I found was telling people that are close to you, my children especially. And what it was, I think, is you know what they mean to you, but you don’t really know [...] *what you mean to them* (emphasis added). And it’s the look in their eyes when you tell them […] they’re slightly scared [...] So actually, I think all of this has been easier for me to deal with, actually, than it is for anybody close to me.

(Mair, 2016a)

If stoicism, betrayed only by Hewlett’s emotional response to significant others, is one feature of his lived experience of cancer, then several others are also represented in the interviews. As part of regular updates on his treatment, one such aspect of Hewlett’s lived experience of cancer centres on the “little things”—on “everyday real life things”, as Hewlett puts it (Mair, 2017a); things that don’t really seem to matter but, in fact, seem to matter a great deal. Here on separate occasions Hewlett talks about the side-effects of various treatments: splitting nails, dry mouth, the discomfort from eating, and fluctuating appetite. He does so in characteristically sanguine fashion, and in ways that provide genuine insight—as a “very small price to pay”, as Hewlett puts it (Mair, 2017a), if the treatment is working.

Like many other cancer pathographies, chemotherapy figures prominently in Hewlett’s day-to-day experiences of living with cancer. Hewlett’s experience of using the “cold cap” intended to prevent significant hair loss on the head gives some insight into the treatment itself, as well as the gendered experience of such treatment—as a treatment not usually taken up by most men. If mediated lived experience is about allowing others to see the world from another’s perspective, Hewlett’s description of the “chemo bubble” (as if “seeing the world through some weird perspex helmet” [Mair, 2016c]) will affirm the experience among those who have undergone or are undergoing chemotherapy, and allow others who are not, to see it through the eyes of those who are.

As lived experience, Hewlett’s interviews bear the imprint of his professional identity, revealing the journalistic impulse to research forensically and meticulously his condition and treatment for it. This impulse, as part of lived experience, extends to and overlaps with his experiences of navigating cancer care in the UK National Health Service (NHS), which I discuss presently below.

**2) Cancer Care, the NHS and Patient Advocacy**

A recurring theme throughout the interviews is a focus on the treatment and care Hewlett was receiving from the NHS. For the most part, Hewlett’s appraisal of the treatment he is receiving is overwhelmingly positive, describing it in one interview as “utterly faultless” (Mair, 2016b). Hewlett spoke in praise on a number of occasions about staff at the Royal Marsden Hospital in London where he was being treated, and in particular about the consultant medical oncologist, Dr Naureen Starling, supervising his care. Dr Starling later appeared as a guest with Eddie Mair on the *PM* programme following Hewlett’s death, where she talked about her relationship with Hewlett and how his speaking publicly about his cancer had helped her, as a clinician, reflect upon the patient experience.

Far less flattering was Hewlett’s appraisal of how NHS care is organised and delivered. Specifically, Hewlett describes the circuitous (and at times tortuous) journey by which he eventually arrives at the Royal Marsden through a seemingly arcane system of referral. Talk here centres on how Hewlett needed to rely upon his own investigative skills and assertiveness as a journalist (having a “thick brass neck”, as he put it [Mair, 2016b]), in order to successfully navigate what would otherwise be impossible for many others—comparing this to his own 86-year old mum, whom Hewlett suggests would have struggled to achieve what he did.

Similarly, Hewlett spoke also about the challenges of pursuing and of being accepted on clinical trials for immunotherapy—of how “getting onto this trial [was] quite a trial” (Mair, 2017b) in and of itself; of waiting to find out if he could join the clinical trials or not as anxiety inducing in ways that produced a physical reaction to stress: “it actually produces pains in my stomach and my esophagus” (Mair, 2017c). Talk here is of patient advocacy: of being actively involved and informed about one’s own care—as crucial to the standard of care one receives and to eventual health outcomes.

**3) Cancer Talk**

Another theme that emerges from analysis of the interviews is a focus on the value of talk. As social scientists have attested (ethnographers, anthropologists, sociologists and conversation analysts among them), talk is both a ritual practice and social institution that helps structure interaction, validate identity, and affirm membership of a community. Here several voices are identified—Hewlett’s own; patients and carers of people with cancer; and clinicians and healthcare professionals with responsibilities for treating people with cancer.

For Hewlett, as patient and primary participant, talking openly about his cancer is described in utilitarian terms—as “useful” and hopefully as “helping other people talk about some of these things” (Mair, 2016a). In one interview, Hewlett explains the satisfaction that comes from knowing he has made a connection with listeners; from helping others talk about issues that previously they may have been unable to talk about.

Hewlett: But the sense of connection that it’s created with the audience...I don’t think I’ve felt before...To feel that you have this kind of relationship with an audience, albeit about something that’s quite difficult, and that they are genuinely interested in what you’ve got to say about it...partly because many of them are going through it, and many of them went through it, and couldn’t talk about it for whatever reason at the time. So I think for me, but more importantly, for me personally, I have to say, it’s been a pretty positive experience. My abiding hope is that it’s been as positive for people who’ve listened to it.

(Mair, 2017d)

Emphasis here centres on the positivity that comes from Hewlett talking openly about his experiences, and from the sense of comfort he takes from knowing his sharing is helping others, not least from the opportunities his talk may have opened up for interpersonal—or intersubjective—shared experiences. That it does so suggests that it is not simply repression or reserve (as a typically British trait) that prevents people from talking openly about their experiences of cancer, but that hearing these experiences echoed in another allows opportunities for third-party reflection otherwise absent from one’s first-person experiences. Thus in another interview Hewlett says: “I hope that my experience will help other people talk about some of these things...and I hope that they may see elements of what happened to me in what’s happening to them” (Mair, 2016a). In yet another, Hewlett says:

I just think people don’t talk about it enough. There’s not enough in that sense of informal public dialogue between patients, public [...] experts, clinicians…

(Mair, 2016c)

Much is made in the interviews of listener engagement with Hewlett’s experience. In one episode (Mair, 2016d), the words of a listener—named only as “Marcus (aged 51”)—diagnosed with colon cancer are read out to illustrate ways in which Hewlett’s talk, and openness with his teenage sons about his condition, may have helped others, like Marcus, to discuss their own feelings with others closest to them (in this instance, with Marcus’ own three teenage sons). The implication here is that Hewlett’s stoicism, but also his willingness as a middle-aged man to talk openly about issues men have traditionally shied away from, may have helped in opening the door to other men in similar situations. This is caveated by the suggestion that Hewlett’s positivity about his cancer was leading Marcus to have unrealistic expectations about his own prospects in ways that belied his own sons’ genuine concerns about his condition.

In another episode, listeners’ voices are used as testimony to the impact Hewlett’s cancer talk has had on them. One listener speaks of the benefit Hewlett’s talk has been in helping them navigate the best patient care for their mother with advanced bowel cancer, and the way his frankness about cancer and death “diminishes the unknowingness [and] fear of it” (Mair, 2016e). Another describes how helpful it was to hear someone else express how they *feel* when presented with a terminal diagnosis, while another (named only as Amanda) described how helpful Hewlett’s talk has been in learning how to break the news they have cancer to others (Mair, 2016b). Another still describes how it is Hewlett’s “courage to face illness, to talk about it and be honest, that allows those close to a person to feel they can face it together” (Mair, 2016b).

Finally, the third set of listeners engaged by Hewlett’s cancer talk are clinicians and healthcare professionals, including some of those treating Hewlett himself. Among the voices represented in support of Hewlett’s willingness to speak publicly about his experiences are surgeon and esophageal cancer specialist, Professor Tim Underwood, from Southampton University, and a student nurse named only as Deidre.

Underwood: Quite a few of my department and from outside have been listening to Steve on *PM*, and we’ve all been really impressed with what he’s been talking about ...We’re pleased that people are prepared to talk about cancer and prepared to talk about esophageal cancer in particular. We deal with a disease that is the fastest growing disease in the UK...and yet no one knows about it, and Steve talking so well, so openly, so honestly, really helps us get our message out that we need to do better...So really, we’re really pleased that Steve’s talking about it.

(Mair, 2016f)

Deidre: The way Steve has spoken about it has affected me as a nurse in that I won’t give up. I’m more relentless in pursuing these patients and getting them to talk to me.

(Mair, 2016f)

Following Hewlett’s death, the consultant specialist treating him, Dr Naureen Starling, spoke also about Hewlett’s journey, about the dynamic between them as doctor-patient, and the very public dimension that his radio interviews introduced to their relationship. The following segment between Eddie Mair and Dr Starling provides a glimpse into the impact Hewlett’s interviews had in helping her to reflect on the patient experience:

Starling: It’s been a journey, and I think I’ve learned many things. Actually, it’s made me reflect more on the patient experience. I think we should always do that. But this has definitely made me do that.

Mair: Did you listen to his [Hewlett’s] stuff?

Starling: Early on I didn’t. But then as I realised there was such a public interest around what he was saying, I did start, and if I’m honest, it took me a couple of days to muster the courage to listen to them. I’m glad I did...I think his portrayal of the patient experience was really, really important.

(Mair, 2017e)

Dr Starling goes on to speak about the importance of talking with others about one’s health, especially cancer, but that such talk is also a very individual thing that can also be “terribly complicated and sometimes very difficult” (Mair, 2017e). Such difficulty, Starling acknowledges (as also discussed in one of the interviews with Hewlett), can come from a desire on the part of the patient with cancer to protect family members, for whom the fear of death and associated anxieties may be harder to deal with than for the person with cancer themselves. Talk, nevertheless, and more of it, Starling suggests, is a starting-point for breaking down the many fears surrounding cancer.

**Discussion: Talk, Radio, Men**

The Hewlett interviews provided a useful glimpse into how talk-based pathography operates. Here in particular I want to pull out and discuss three interlinked strands that emerged from my analysis: 1) the interpersonal dynamics of public mediated talk about illness/dying and the way it may function as both coping mechanism and defence; 2) the specificity of radio as a medium that facilitates intimacy but has hitherto been under-utilised and under-explored as a vehicle for pathography; and 3) the gendered nature of male cancer talk embodied in the Hewlett interviews.

**Mediated Talk: Conductor, Coping Mechanism and Defence**

Talking about the end of life has in recent years been almost universally championed as a personal and public good. The UK’s Department of Health-funded Dying Matters Coalition, and globally manifested Death Cafe movement, are but two examples (Walter, 2017), each with their exhortations to talk about death and dying as a means of improving patient care and increasing awareness of death so that people might live their (finite) lives more fully. Talk, as Seale (1998) has illustrated, is a social institution that may be utilised by people to reorient themselves towards life in the face of death. Drawing upon the work of anthropologists, conversation analysts, ethnomethodologists and interactionist sociologists, Seale shows how talk-as-ritual works by affirming membership of a community (albeit, often imagined), in ways that are crucial to creating meaning and sustaining social bonds. Talk, in this way, can be understood as “a concrete procedure...for the maintenance of reality” (Danforth, cited in Seale, 1998, p. 202).

The talk underpinning the Hewlett interviews operates very much in this orbit. The weekly pre-recorded interviews can be understood as helping to give routine and purpose to a life suddenly disrupted by serious illness. Like writing, talk—especially when expressed as narrative—is a resource for getting coherence and creating meaning, particularly when meaning and taken-for-granted expectations about life have been cruelly shattered following a terminal diagnosis. The public response to Hewlett’s interviews helped generate a sense of community, however fleeting, affirming Hewlett’s place within a community of well-wishers and others who, through his radio talk, he was deemed helping.

Talk is also central to the therapeutic domain—the “talking cure” by which we process, ventilate, and work-through painful emotions and experiences. It occupies a central place too in the “revivalist” discourses and “expressivism” that has underpinned the bereavement counselling tradition since the 1960s (Walter, 1994). In the context of the Hewlett interviews, mediated talk functions by permitting Hewlett to articulate feelings and thoughts that might otherwise be problematic to express in direct face-to-face encounters with loved ones. As we have seen, Hewlett talked about the one thing he found “really hard…[which] was telling the people that are close to you” (Mair, 2016a). There are parallels here with Lisa Lynch’s cancer blog—later the basis for a book (2010) and made-for-television film—which she uses as both a distraction from cancer and means of communicating her experiences to family and friends (Karpf, 2013). In this way, Hewlett’s radio talk provides a “meta solution” to the delicacies of broaching difficult topics, like cancer, with those closest to him.

From the perspective of his family, especially Hewlett’s sons, his radio interviews led to greater openness and transparency, allowing him to say things—from “behind the radio” (Mair, 2017f), as his youngest son, Billy, put it—that he could not talk about directly to them, making him, as Billy suggested in an interview with Eddie Mair following his father’s death, “more emotionally available” (Mair, 2017f). The utility of Hewlett’s interviews, however, extends beyond simply facilitating conversations at a micro-level with his family. Rather, Hewlett’s interviews are of much wider public value, serving as a conductor or lightning rod for others—be that for people with cancer in a similar situation to Hewlett who are struggling to talk to their loved ones; or for those caring for people with cancer who might benefit from Hewlett’s insights.

From a psychoanalytic perspective, Hewlett’s interviews and talk, like that of other cancer memoirists (Karpf, 2013), can be seen as both coping-mechanism and defence for dealing with the existential plight generated by terminal illness. Hewlett’s diligent search for optimal treatment, his forensic analysis of drug regimes, and journalistic impulse to hold care providers’ “feet-to-the-fire” can all be seen as characteristically middle-class attempts to exert mastery and control over a process (including illness progression) which, in reality, they have very little or none. Nevertheless, such activity, including writing/talking about cancer, can be seen as attempts to “confine the catastrophe” (Broyard, 1992, p. 21), to distance oneself from the awfulness of the situation (Want, 2011), transforming pain into journalistic (or academic) practice by turning one’s own “precarity into words and work” (Steinberg, 2016).

**Radio: The Intimate Medium**

With the exception of Nick Clarke’s audio diary, oral/aural pathographies are relatively rare. This is somewhat surprising given radio’s reputation as the intimate medium (Orfanella, 1998) or “theatre of the ear” (Fargher, 2014). Radio’s special power lies in its ability to speak simultaneously to millions of people but often, and paradoxically, in ways that feel as if the listener is being spoken to directly as an individual (Crisell, 2002). As a sound-only medium, and one which is typically enjoyed alone in personal or private spaces such as the kitchen, car or through intimate in-ear technologies of the phone, the uniqueness of radio may stem from the structural properties of the medium as much from the content it conveys. Radio, it would appear, has the ability to speak to us in ways that other mediums cannot.

This makes it ideally suited to pathography and helps explain the appeal and traction generated by the Hewlett interviews. Radio’s special power lies not just in its ability to create a feeling of intimacy but also to generate a sense of community and shared experience (Hendy, 2013). More critical analyses suggest that intimacy is not inherent within the medium of radio but is constructed and must be actively produced as part of the “fiction” of radio by which the listener is invited to *imagine* the characters and world it reports/creates (Crisell, 2002, p. 10). The purchase of the Hewlett interviews—like Nick Clarke’s cancer diary as “unswitchoffable” radio (Elmes 2009, p.xv)—lies, I would argue, in a combination of factors that include content, style and medium.

The weekly format of the chatty, informal updates from Hewlett on his prognosis, his cancer treatment, and accompanying anecdotes, helped foster not only a community of well-wishers but also a sense of companionship that is a staple of the radio-audience relationship. Intimacy, as Kirkpatrick (2013, p. 117) notes, drawing upon the theoretical work of German sociologist, Niklas Luhmann, is firmly related to intersubjectivity (or “interpersonal interpenetration”), often in ways connected to “privacy, personal space, dialogue, privileged self-revelation, affinity and domesticity, not to mention love, passion and sexuality”. To these we can add the sense of intimacy created between speaker and listener so successfully harnessed in the Hewlett interviews through his personal disclosures relating to illness and dying (one interview was even recorded from Hewlett’s bedside in the Royal Marsden Hospital in London where he was being treated). It is this, then, especially radio’s immersive qualities (in which audiences do not just listen but “bathe and sit in its sound” [Schwartz, 1974, p. 75]), allied to the deeply personal subject matter, that give the Hewlett radio interviews their distinctiveness.

**Men’s Cancer Talk**

The Hewlett interviews are mainly men talking—chiefly, Steve Hewlett, to a lesser extent Eddie Mair (who provides occasional questions/interjections), Hewlett’s three sons (Freddie, Billy, and Bertie), and John Newlands, a male senior Macmillan Cancer Support nurse. The only female voice featured is that of Dr Naureen Starling, the specialist consultant oncologist treating Hewlett. Hewlett’s partner (identified only in the interviews as “Rachel”)—who he later marries in hospital shortly before his death—is not featured.

Much of the public discourse around men’s health, cancer in particular, focuses on men’s reticence to talk—a feature both of Macmillan Cancer Support campaigns and of the Hewlett interviews (especially episodes that featured contributions from Newlands). Here an explicit goal has been to address the barriers that prevent men from talking openly about, and acting on, cancer. At one point in the series of Hewlett interviews, Newlands suggests the “strong silent type” embodied in John Wayne-style Hollywood Westerns has “a lot to answer for” in explaining men’s reluctance to talk (Mair, 2016a).

The Hewlett interviews, as one might expect, both reflect and are inflected by the socio-demographic characteristics of their participants (by class, age, ethnicity, and gender). The tone is—for the most part—jovial, upbeat, interspersed with occasional humour, and mild banter; as if two men talking over a pint in the pub. Conversation rarely verges on the emotional and Hewlett’s matter-of-fact stoicism (often considered a specifically male characteristic) appears to be the order of the day. There is little of the “heroic warrior” so often seen in tropic representations of cancer as a “battle” or “fight”.

**Conclusion**

As media event, bounded within a particular time and space, the Hewlett interviews garnered considerable traction. While clearly not of the magnitude of Jade Goody’s public dying almost a decade earlier, Hewlett’s interviews drew widespread media interest, prompting—unusually for an event of this sort—a *Guardian* newspaper editorial on public dying following his death (*Guardian*, 2017).

The Hewlett interviews provided an opportunity to hear a person talk openly about a topic we have been told we need to talk about more, prompting wider conversations about cancer, cancer treatment, and the end of life. In the last decade or so in the UK, media and campaign groups such as Dying Matters have begun promoting a message that those within thanatology and bereavement circles have been telling us for decades—that talking about death and dying can have both therapeutic and practical value: helping to alleviate fears and anxiety generated by the end of life, while also managing uncertainty about estate planning, funerary arrangements and end-of-life preferences. The Hewlett interviews and BBC Radio 4 series, “We Need to Talk about Death”, first broadcast in 2016, clearly fit within the talk agenda promoted by the Dying Matters coalition to encourage conversation around death, dying and bereavement.

The Hewlett interviews also sit within a wider cluster of contemporary resources and events—including Death Cafe and media interest in death—that speak to a renewed cultural interest and engagement with death in the 21st century. As facilitator of further talk, the Hewlett interviews carried a clear public health message: that talk is good—with regular appearances from a Macmillan Cancer Support nurse, and details of telephone helplines and web addresses on where to find support for people dealing with cancer provided at the end of each interview. This clearly was public service broadcasting.

Alongside helpful advice on how to navigate cancer care within the NHS, talk in the Hewlett interviews provides a basis for intersubjective communication. Several important things coalesce here to produce a powerful effect. The first is that of lived experience. Much research on the lived experience of people with cancer appears to operate without fully defining the term conceptually. In the way it is used here, lived experience refers to the focus given to ordinary, everyday events, privileging subjective experiences as a way of knowing the world (Boylorn, 2008). As someone *with* cancer, Hewlett’s experience gives voice and moral authority to the storied accounts he provides in ways that resonate with listeners—be they clinicians, people with or caring for people with cancer, cancer survivors, or people with little or no first-hand experience of cancer.

In a secular age in search of authenticity (Taylor, 2007), the Hewlett interviews are compelling not because they are conclusive but because they are believable (Bochner, 2002). The validity of Hewlett’s story-telling resides too in its ability to evoke emotion, which encourages therapeutic experiences for both teller and listener. As teller, Hewlett acknowledges at various points in the interview series the positive impact that messages of support—which his telling helped initiate—have had on his experience; while listener testimonials attest to the impact Hewlett’s narrativised accounts have had in validating their experiences. The storied, and therefore, mediated nature of Hewlett’s accounts are important here: for it is Hewlett’s telling—from experience to story—that helps create the listener experience as “an experience of the experience” (Denzin, 1997, in Bochner 2002, p. 89).

It is also the ordinariness of experience that helps give the Hewlett interviews their extraordinary power and purchase. Cancer is clearly an extraordinary event, eliciting high levels of physical and mental distress among people diagnosed with it. But it is also extraordinarily commonplace and will, over a lifetime, affect one in two of us. A significant feature of the Hewlett interviews is the way in which everyday, storied talk between two men serves to render, and thereby disarm, cancer talk as ordinary, normal and thereby accessible. Hewlett’s typically understated British salutations (Hewlett’s stock response in each interview to Mair’s opening question “how are you?” was usually “not bad”, signing off each interview with a cheery “see you next week”—sometimes undercut by a slightly macabre “hopefully”) reinforces such ordinariness, as do the coping strategies by which the Hewlett family reported dealing with the news of Hewlett’s cancer diagnosis: where the institution of the pub provides solace. In one particular interview with Hewlett that included his three grown-up sons, each report the experience of how they first heard of their dad’s diagnosis: Bertie reporting that “we went to the pub” (Mair, 2016d) following his dad’s disclosure that he had Stage 4 cancer; Freddie too that he joined them (his dad and Bertie) at the pub after having heard the news. At this point, Mair asks: “And did the pub help?” To which Billy responds wryly: “The pub always helps” (Mair, 2016d).

As a social institution, talk helps structure interaction and give meaning to everyday experiences. Talk, narrative in particular, serves to help crystallise what are often chaotic and inchoate experiences and events, giving them a structure and meaning that they would not otherwise possess. As a vehicle of lived experience, narrativised forms of talk are also part of ritual practice that help sustain human bonds, and what it means to be human, by helping to place individual life “within a much broader, sometimes cosmic, interpretive framework” (Seale, 1998, p. 29). In this way, Hewlett’s storied accounts and updates on his health help resist the sense of social “fading” sometimes common among people with terminal conditions, while also affirming the humanity of the story-teller (Frank, 1997)—some of which may be diminished or lost during aggressive cancer care such as chemotherapy.

As well as helping to initiate wider public dialogue about death and how care within the NHS is organised, delivered and funded, the Hewlett interviews also illustrate how knowledge about the lived experience of cancer and cancer care may be co-produced. As others have demonstrated (e.g. Brennan & Letherby, 2017), auto/biography and the stories we tell ourselves and others are rarely, if ever, only about the self doing the narrating, instead invoking significant others as formative of our experiences. Here the Hewlett interviews demonstrate a complex and triangular relationship: between teller, interviewer and audience. Hewlett’s own telling is thus constructed and negotiated in and through other social relationships: with his sons, his physician, and wider public audience. Those about whom Hewlett talks—his family and physician—are also his audience, become part of the story, and are impacted and changed by Hewlett’s telling.

The Hewlett interviews represent one particular “moment” within contemporary culture by which death and dying become public property. By sharing his experiences of illness (and dying), Hewlett continues a trend towards de-sequestration, lifting accounts of experiences that were previously private, marginalised or hidden and placing them firmly in the public domain.

The dynamic between Hewlett and his audience illustrates the potential benefits to both self and others that may come from talking openly about one’s experience of illness and dying. At a social level, Hewlett’s decision to talk publicly about his experiences may simply have given encouragement to others to do likewise. It may also have prompted people—men in particular—to seek medical attention for symptoms discussed by Hewlett. Within his own family network, Hewlett’s mediated sharing created a positive space in which to face cancer together. As self-care, the benefits of sharing of this sort come not just from catharsis, as such, but from the social support it generates; from the sense of meaning and purpose of organised telling, as well from the knowledge that such activity might provide benefit and comfort to others.

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1. All 23 interviews were downloaded from the BBC Sounds app, ranging from the shortest (5:59 minutes), to the longest (26:12 minutes), with the average interview lasting approximately 14 minutes. In total, over 331 minutes (5 hours, 36 minutes) of interview material was harvested for analysis. [↑](#footnote-ref-1)