
Solicited audio diaries in longitudinal narrative research: a view from inside

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ABSTRACT The use of solicited audio diaries in longitudinal qualitative enquiry is rare. Moreover, an understanding of the unique insights that these diaries might give the qualitative researcher has largely been absent in our consideration of appropriate methods for data collection. This article aims to address this deficit by providing a critical reflection on the use of solicited audio diaries in longitudinal narrative research from practical, theoretical and analytical perspectives. The data is drawn from a longitudinal study investigating medical students' professional identity formation. In an attempt to reach the broadest audience, both structural aspects and communicative elements of talk within the data are considered alongside ethical issues and emotional work that the longitudinal audio-diary researcher might encounter. In addition to presenting extracts from a variety of diary entries, a single event narrative is presented in full, alongside an analysis, in order to demonstrate the powerful utility of this underused method.

KEYWORDS: *identity formation, longitudinal, narrative analysis, selves, professionalism, solicited audio diary*

Introduction

Stories enable us to make sense of events and actions in our lives. They are powerful social tools that we use to construct an identity of ourselves in the world: who we are, who we were and who we might be (Holstein and Gubrium, 2000; McAdams, 1993; Ricoeur, 1992; Sarbin, 1986). It is not surprising, therefore, that researchers interested in understanding identity formation have been drawn towards narrative methodologies (Diaute and Lightfoot, 2004). By attending closely to the way in which we narrate our stories, in addition to the content of those stories, insights can be gained into the rich cultural resources that are drawn upon in this sense making process (Diaute and Lightfoot, 2004; Holstein and Gubrium, 2000).

While Atkinson and his colleagues have argued for the need to broaden our methods of data collection, the preferred choice of method for the narrative

researcher frequently remains the semi-structured interview (Atkinson, 2005; Atkinson et al., 2003; Atkinson and Silverman, 1997). Occasionally, unsolicited diaries and focus groups have been employed. However, the use of solicited diaries in narrative enquiry is relatively rare (Milligan et al., 2005). Moreover, while audio diaries have been used in a limited way within qualitative research (Hislop et al., 2005) there have been no studies to date that have used the audio diary method within a narrative enquiry. Part of the problem is that a deeper understanding of the unique insights that solicited audio diaries might give the researcher has largely been absent in our consideration of appropriate methods with which to understand identity formation.

I aim to address this deficit by providing a critical reflection on the use of solicited audio diaries in longitudinal narrative research from practical, theoretical and analytical perspectives. In doing so, I not only wish to illustrate the rich seams that this novel research method opens up, but I also wish to embed this method within a wider perspective of symbolic interactionism and the work of Mead (1934). The data is drawn from a study investigating medical students' professional identity formation over time and was designed to examine how individuals narrated their developing medical identities as they negotiate their way through medical school.

It is acknowledged that there is no single definition of 'narrative' nor what it means to analyse a narrative. So, in an attempt to reach the broadest audience, both the structural aspects (i.e. the macro level) and the communicative elements of talk (i.e. the micro level) within the data obtained using this method will be considered. At the same time, other considerations of the longitudinal solicited audio-diary method including ethical issues and emotional work for the researcher will be commented on, and extracts from a variety of diary entries will be presented in order to give breadth to this discussion. Before more detailed aspects of the talk from this audio diary data are presented, although not exhaustive, a number of key points about narrative structure, grammatical and interactional resources used in identity work will be briefly outlined in order to allow a comparison between traditional forms of data collection and the audio diary method. It should be noted, however, that while the focus here is towards the narrative researcher, other qualitative researchers will hopefully recognize the utility of the solicited audio diary method for use within their own research methodologies.

Narrative structure

Although we experience events, the events themselves are not stories. We choose which aspects of those events we wish to convey and which to omit, we create plots from disordered experience and give meaning to events. Moreover, the interplay between how we convey a story and how each narrative unfolds sheds light onto the development of self coherence and diversity (Holstein and Gubrium, 2000). Ochs and Capps (2001) contrast the concept of a 'narrative'

with the understanding of a 'conversational narrative.' The first is a cognitive and discursively complex genre typically containing a description, chronology, some evaluation and an explanation. Indeed, Labov and Waletzky (1967) suggest that narratives typically have a formal structure comprising six common properties: a summary of the essence of the narrative (the abstract), an indication of the time, place, people etc. (the orientation), the sequence of events (the complicating action), the meaning and significance of the events and what the speaker thinks about them (the evaluation), what finally happened (the resolution) before the speaker returns the story to the present situation (the coda).

Conversational narrative, however, is an interactionally discursive complex genre that includes additional genres of discourse: description questions, chronology challenges, evaluation clarifications and explanation speculations (Ochs and Capps, 2001). Furthermore, Ochs and Capps (2001) identify a number of narrative dimensions and a continuum of possibilities that may characterize narrative which might shift during the process of a single narrative's telling. These dimensions are Tellership (from a single active teller to multiple active co-tellers), Tellability (whether they provide sequential reportable events and make rhetorically effective points), Embeddedness (the extent to which they are detached or embedded within the turn-taking activity of conversation), Linearity (from a closed to an open temporal and causal order) and a Moral stance (from a certain and constant stance to an uncertain and fluid stance). In research settings these conversational narratives are frequently found in interviews with a researcher or group facilitator.

Grammatical and interactional resources

Some theorists comment on the grammatical resources we use within our narrative structure that can be evoked as a form of rhetorical persuasion. Consider Burke's (1945) notion of an attitude *frame*: through talk, we can stir attitudes in ourselves and in others and even take on the *attitude of the other*. Indeed, closely related to Burke's idea of an attitude frame, the presence of *the other* in the way in which we narrate our own identity is crucial to a relational view of communication and has immediate relevance to the notions of *footing* (Goffman, 1981) and *face* (Goffman, 1967). Footing refers to the shifts in 'alignment, or set, or stance, or posture, or projected self' (1981: 128) as demonstrated in the way we present our selves to others through talk. Whereas face refers to those positive social qualities individuals lay claim to during interaction. For both footing and face work, narrators may draw on a number of different resources in order to construct an identity of themselves for others. For example, quoting the words of others (direct reported speech (DRP), cf. Holt and Clift, 2007) to stress an idea or opinion, or to take an opposing stance is commonplace. Furthermore, it has been argued that DRP is a rhetorically powerful device in story telling that enables the hearer to draw their own conclusions regarding the message conveyed by the speaker (Labov,

1972). Similarly, reporting the inner thoughts of one's own mind during the narrating of personal events can act as a way of presenting a positive face. While the notions of footing, frame and face have long been considered in talk-in-interaction contexts, to my knowledge these have not been explored within the context of a spoken monologue.

Holstein and Gubrium (2000) highlight how coherence and meaning are developed through the linkages made from the biographical resources of the narrator and into the narrative construction of the self. So, there is an element of sequentiality and 'making a point' in the composition of a good story (Gergen and Gergen, 1986; Labov, 1972). Such linkages can also be made retrospectively, giving rise to further ways in which the narrative plot might develop and providing hints of 'alterative selves.' Sometimes speakers display a type of slippage between the way in which they story themselves and the culturally accepted way in which prototypical storylines develop (Holstein and Gubrium, 2000). Furthermore, in conversations with another, the trajectory of storytelling shifts to ensure that specific points have been made and heard, speakers explicitly talk around the processes involved in their telling and the others' interpreting of a story; they 'step out' of their stories attending to the hearer's perspective and edit their stories to adopt different viewpoints (Riessman, 1990). Thus, attending to the discourses developed around such narrative linkages, slippages and editing can further advance our understanding of identity construction. Additional linguistic resources open to the narrator (and thus to the analyst) include changes in pitch, tone, pauses, false starts, laughter, anger and other emotional work (Antaki and Widdicombe, 1998; Atkinson and Heritage, 1984; Cutting, 2000).

So against this background a number of questions emerge. For example, does the act of telling our stories, away from others, differ greatly from telling stories to another who is present? Who is the audience: ourselves or others – or are they both for the personal and the social (Mead, 1934)? Do we structure those stories differently? Are these stories like the conversations we hold with ourselves which have a single 'teller,' (Labov and Waletzky, 1967) or are they like the conversations we hold with others with potential multiple 'co-tellers' (Ochs and Capps, 2001)? When narrating events in the quiet of our room would we laugh out loud and use paralinguistic aspects of language such as intonation and pitch in order to convey further meaning? And what of other linguistic devices such as reported thoughts and direct reported speech that link to footing, frame and face work (Burke, 1945; Goffman, 1967, 1981)? Finally, what can these stories tell us about the developing professional identity of tomorrows' doctors?

Context of the research

In October 2005 I began a longitudinal research project with a clinician-researcher colleague, Dr Kieran Sweeney. We are particularly interested in

how medical students arrive at medical school with an essentially 'human' gaze on the world, and leave a number of years later, with a predominately 'medical' gaze on the world. Building on previous work looking at medical students' epistemological talk (Knight and Mattick, 2006), our main questions in this study centred on the following issues: what is the nature of medical students' epistemological talk during medical school and how do medical students narrate their developing professional identity?

The setting for this research is a newly developed medical school which places an emphasis on developing 'patient-centred' doctors. The first two years of the 5-year curriculum is delivered from two main university sites and utilises a problem based learning (PBL) method with the emphasis across all years on self directed learning. During the last three years, learning is predominately based in clinical sites situated across a large geographical area within the South West of England. During these years students work in pairs and rotate around different clinical departments.

The researchers involved in the project (LVK & KS) had minimal involvement with medical students at the school and no involvement in the assessment of any participants in the study. LVK was responsible for some workshops in Evidence Based Practice at one university locality, delivering a number of non-compulsory human science plenaries that were telematically linked across two main geographical locations and was also personal tutor to a number of students (not in the study). KS had no direct or indirect teaching involvement with students in the first two years and runs Special Study Units for small groups of students in years 3–5. The medical school ethics committee gave approval for this research.

Seventeen first-year medical students accepted our invitation to participate. We met in groups at the beginning of the study and gave them one request: 'Please tell us a story about something that has happened to you since the last time you left a message and how it has affected the way you think about yourself now and your future role as a doctor.' While data is also collected through individual interviews and group discussions, this article we will only consider data from the primary method of data collection: the audio diary.

Fifteen of the seventeen participants use the audio diary as their preferred method of recording. Participation in the recording of diary entries differed both across and within individuals. For example, some participants make regular weekly recordings, although these tend to stop during university vacation times. Other participants leave longer intervals between recordings and, at times, make more than one recording in a day. For the purpose of this research therefore, a 'diary entry' is defined as 'a recording or group of recordings by any one individual participant in a single day.' In the first 18-month period between 15 October 2005 and 15 April 2007 we received 255 diary entries which comprised 408 recordings. The recordings varied in length from a short as 20 seconds, to longer, discursive recordings (up to 13:57). Short recordings typically highlighted difficulties individuals were having at the time and often in the form of a 'rant.'

When looking at this data it was hard not to be impressed with the richness and diversity of the recordings, the ways in which the everyday and the extraordinary events experienced by these medical students became plotted into evocative constructions of their own developing professional narratives. Additionally, we are also struck by the positioning of researched and researcher, even within these apparently undirected and 'solo' narratives. My aim in the following section of this article is not to provide a full and comprehensive analysis of these factors. This is beyond the scope of the present article. Rather, I wish to provide brief insight into various aspects of the ways in which these messages were composed, and the narrative elements that embodied them, before presenting a single diary entry which brings these elements together in one narrative. As you read on, you are invited to take on the perspective of a researcher using this method for the first time, trying to make sense of the data before you. Additionally, consider the context within which you listen to these audio diary recordings: just as these recordings are made in solitude in the quiet of a room, so they are listened to in a similar context.

Positioning of the researcher

In conversation, appropriate linguistic devices are used in order to introduce a story, to mark the ending of a story and to demonstrate relevance of the story to the listener (Jefferson, 1978). In an audio diary recording, however, there is no listener present. So how do participants introduce their stories? How do they conclude their stories? Who are they talking 'to' in their narratives and what does the entrance and exit talk reveal about the role of the researcher?

One of the most notable aspects of the beginnings and endings of the recordings themselves is the way in which participants frequently directed their diary entry to the researcher through their opening and closing utterances¹:

'Hi Lynn- Doug here (.) uh (.) uhm (.) no-nothing major- just sort of funny development (.) I- just now when I was searching some information on the internet I found myself- uh I found myself...I just immediately dismiss it without reading any further- uh (.) and it seems to be working- it's quite strange that (.) okay (.) thanks (.) bye.' (Doug, 9 November 2005)

As the project went on, and more diary entries were made, a further development in the framing of beginnings and endings of the diary entries became apparent. This shift in alignment (cf. Goffman, 1981) highlighted the way in which the relationship between myself and individual participants was beginning to develop: many recordings continued to begin with a *hello*, but then often went into a recognition of time passing, and the diary entries had the feeling that I was about to 'catch-up' on their news and events. At times, participants apologized for the absence of diary entries and some felt the need to give detailed explanations for this. Additionally, continuing the longitudinal feel to the diary entries and the developing relationship between researched and researcher,

there were frequent exits within which participants returned to their marking of time with statements of intent to be in touch again in the future – in doing so they frequently qualified this statement of intent with the word *probably*:

'Right- hello (.) it's the 5th of February and it's been a week and a bit since I last left a message so I thought I'd just- you know- catch- fill you in on what's going on (.) and yeah (.) after the AMK²...I'll probably get back to you in about a week or so- right (.) bye-bye.' (Paul, March 2006)

One further notable aspect of entrance talk in these examples above is the way in which participants introduced the story part of their diary entries with *yeah* or *right*. In conversations with another the introduction of a newsworthy event can be generated interactionally and mutually though a sequence of talk beginning with an initial topic elicitor (Button and Casey, 1984). However, in these diary recordings, there is no opportunity for this mutual acceptance of a story. Indeed, participants often reported during catch-up interviews that they sometimes felt awkward speaking to no-one and this often led to avoidance in recording diary entries or to a certain difficulty in getting started with the story: the use of words such as *yeah* therefore took on a signifying role suggesting that a topic was about to be discussed and were used both at the beginning of recordings and also part-way through messages to identify a shift in footing or storyline (cf. Goffman, 1981).

However, while the majority of diary entries began with this welcoming *hello* introduction, significant others took on a more direct tone, thus framing the subsequent narrative differently (cf. Burke, 1945):

'My mother died a few days ago (1.0) she died during the night between the [date] and the [date] and she'd been an alcoholic for a very long time (.) and her liver finally failed on her... there had to be an autopsy (.) and I haven't seen the autopsy report (.) and at first I thought I wanted to- I thought I wanted to know exactly what the report said... the conflict between the idea that as a DOCTOR I need to understand but as a member of the FAMILY it's all very well to know this stuff in the abstract but to actually think of it as happening to someone who's such a large and important part of your life is- um (1.0) I'm not sure that I really wanted to know that much about it (.) so I just thought I'd mention that conflict as well.' (Katie, 6 January 2006)

A number of issues, both analytically and ethically, became apparent upon the receiving and listening to a diary entry framed in this way. Rhetorically, this message begins with a noticeably different footing to that of previous messages from this participant, both in what is said and in the paralinguistic aspects of pitch and tone (Cutting, 2000), thus making demands on the hearer to take particular notice. This message is intended to convey important issues of conflict that the speaker wished to highlight as directly relevant to her developing professional identity.

Furthermore, while the audio diary method appears to comprise an essentially one-way conversation, in practice this is not the case. The longitudinal nature of the study in combination with personal disclosure

through a narrative monologue (sometimes conveyed in a highly intimate manner through paralinguistic aspects of talk) entails an engagement with the participants that is different from other forms of research which, in turn, brings forth different ethical issues. For example, the researcher-participant relationship can develop to include a heightened feeling of responsibility of care on the part of the researcher and with little opportunity to negotiate this *in the moment*. Further aspects of the audio diary method that develop and define this relationship for the researcher are discussed in the next section, but on listening to this particular message in which the emotional frame of the narrative had been set in the first breath, a number of conflicting and difficult thoughts and feelings emerged for me. Some were situational whereas others were of an ethical nature.

Firstly, in this study, whenever a diary entry is received, it is acknowledged within 24 hours by an e-mail to the participant, thanking them for sending the recording and informing them that I will be in touch over the next few days once I had listened to the message. This aspect of the study provides an important contact between the participants and researcher and acts as a form of closing the feedback loop between participants and researchers, acknowledging the contribution that the participant has made and aiding their continued involvement in the study. Occasionally, however, it is not possible to listen to the message immediately resulting in a week or two passing before it is heard. Unprepared for this message, and for the immediate feelings of sadness and helplessness that resulted, led to an emotionally difficult time personally as a number of ethical and practical aspects of the situation came into play. For example, this temporal lapse makes it more difficult to go back to the participant to let them know their story has been heard. Moreover, there can be a tension between the idea that contact should be in the dispassionate role of a researcher – thanking them for their interesting reflection – and the desire for it to be in the impassioned humanistic role of someone who was touched by their story and the inner conflict they reported. Since receiving this diary message, a number of other emotionally difficult diary entries on subjects such as death, illness and divorce have been recorded. The relationship between researcher and participant that the solicited audio diary method develops, therefore, can become an intimate association: one in which participants feel comfortable to share their most difficult and intense experiences. Researchers contemplating the use of this method should take this aspect into account.

Lists, prototypical narratives and small stories

Not all diary entries were constructed by way of a canonical narrative. Some comprised brief up-dates of what had happened, effectively taking the form of a list or brief description. The vast majority of recordings, however, took the form of *prototypical narratives* and *small stories*

(Bamberg, 2006). Thus, prototypical narratives are personal stories of the tellers' past experiences that have not been shared by the current interlocutor. An example of a prototypical narrative is presented in the latter part of this article. Such narratives can be contrasted with small stories that include tellings of on-going events, future or hypothetical events, shared (known) events, re-tellings, allusions to tellings, deferrals of tellings and refusals to tell (Georgakopoulou, 2007). To date, there have been no examples of refusals to tell within our data, which can be partly explained by the absence of an interlocutor and thus the absence of direct requests to tell. However, the longitudinal audio diary method does appear to capture a number of other types of *small stories*:

'It's going to be a tough week (.) I've got about six maybe seven days to my SSU-well- just over six (1.0) I need to get my priorities in the right order- less socialising (.) more working (1.0) This [SSU] research has been really difficult for my SSU- I'll have to stay on top of it- well I'm off to the IT suite now so I'll chat to you later.' (Anwar, 20 March 2006)

'I sort of talked about- in the past (.) the pressure that other people's good wishes put you under and in the last week I've heard from an old friend...' (Katie, 2 February 2006)

'Hello Lynn- a couple of things- three things I think this week (.) anyway I'll start (1.5) the first thing is that (1.0) first occurrence actually was during your lecture early this week about the psychological development of children- I don't know if I've ever told you...' (Charles, 20 October 2006)

Through these diary recordings, and in particular the receiving of small stories, a relationship has developed (at least on the part of myself) whereby participants are identified with, known and intimately personalized. This goes beyond what typically happens in the one-to-one interview and group settings that have comprised the interactional settings of my previous qualitative work. These small stories evoke the feeling of knowing a person and the developing of an intimacy that might bring forth further emotions. For example, as time goes on, sometimes participants suffer personal difficulties such as parental divorce, personal or family illnesses and even the death of a loved one. These occurrences, whilst 'outside' the research context are often narrated within the research arena. This might be particularly so because of the nature (longitudinal, personal incident narratives) and the context of the research (medical settings and the development of a medical professional identity). So, following the sense of familiarity that small stories foster, when I later listen to a 'troubled' *prototypical narrative*, feelings of sadness, unease, confusion, helplessness and sometimes joy may rise. However, even when not directly narrated within the audio diaries themselves, sometimes these difficulties are discussed within the participant-researcher relationship. Once again, these stories evoke personal feelings within me and my role as a researcher that need to be considered and negotiated.

Humour and laughter

'one funny thing that happened earlier this week that I thought I'd mention it because it sort of- it is funny...I was sitting in the life sciences private study room and [laughs] I was just doing stuff...' (Katie, 2 February 2006)

The elegantly timed rendition of events accomplished through the strategic and skilfully managed pauses, repetitions, humour and the outcome of actions give some of the diary entries a light-hearted frame (Burke, 1945). Such rhetorical framing can be felt early on in some diary recordings. In others, rhetorical framing shifts and changes with the use of humour developing as participants negotiate their way through difficult stories. Indeed, humour is not necessarily about making people laugh, it has psychological and relational functions and can be used as a mechanism for dealing with difficult situations such as stress, uncertainty and pain (Hay, 2000; Martin, 2004). Moreover, within the context of medicine, *gallows humour* has been identified as a coping mechanism for dealing with traumatic and difficult events (Crawford, 2003; Saraglou and Anciaux, 2004; Sinclair, 1997). One participant in particular displays a continual use of humour and laughter in his diary entries, this sometimes is achieved through his choice of words, intonation in his voice, the pitch of his voice and his own laughing out loud:

'Just been watching that anatomy of 'life of death' thing on Channel 4- it's now about five-past midnight and- it's really odd... he's talking about the infarctions and how the blood stops flowing into different organs... there's a sort of part of me that thinks- this should- you- you should find this really ugly- you know this man is up to his wrists in people's organs and entrails but then a huge part of me finds that [deepens voice] *really fascinating* hummm (.) I dunno- it- it but it somehow feels wrong and another part of it feels *soo* good and looks *so* interesting so- I dunno, it's weird (1.0) I wonder if that's what- all doctors should feel like [laughs].' (Rory, 17 January 2006)

'The next person I meet with high blood pressure- hypertension- is going to die- I'm going to put my hand round their throat and choke them until every last drop of life is gone (2.0) if I have to learn one more diuretic somebody's gonna catch it from me.' (Rory, 9 February 2006)

What is particularly difficult, therefore, is knowing how to 'read' some of these diary entries. There were obvious rhetorical devices used by some participants that included the use of irony, sarcasm and 'dead-pan' humour. However, the circumstances within which this humour was used was far from typical: as previously demonstrated, the researcher is clearly an interactional partner in the minds of the participants, yet unlike face-to-face situations the researcher has no role in negotiating how and what is said. This therefore entails that the participants have no opportunity to 'repair' any misconceptions and misunderstandings that sometimes occur in the moment. Occasionally, concerns regarding the mental health of participants, the potential danger to other students or, indeed, patients are raised when listening to a recording in which

participants have used humour in this way. Sharing concerns with a second researcher, negotiating strategies to ensure the wellbeing of participants and of others with whom we, as researchers, have responsibility has become an essential aspect of the audio diary method.

Reported thoughts and reported talk

We continually use talk in interactions when reporting the speech of ourselves and others, attempting to mimic the voice of the other and often reflecting emotional affect (Holt and Clift, 2007). While reported speech and reported thoughts have been identified as a set of linguistic and discourse practices for talk-in-interaction, this is the first time it has been highlighted as an important aspect of diary making:

'...just suddenly got this really huge wave of fear thinking 'oh my god- what have I missed out on the last four case studies?' you know what...' (Jeff, 6 February 2006)

'...well (.) a lady came in and she was pregnant- heavily pregnant in fact she's er- er due next week and we were allowed to er- touch uh- well feel for the- for the fundus of the uterus...and it was pretty pretty impressive and GREAT- really makes you feel like "YES, this is definitely what I want to do"...' (Andy, 21 October 2005)

'...we had a teacher who's talking about voice production...our voices are distinctive because of the shapes of the passages in canals within our head and face and the sinuses and they affect the way the sound comes out and er- but he actually said something like 'STUPID SINUSES' or 'they're pretty USELESS apart from voice production' and that kind of annoyed me because...' (Tre, 19 November 2006)

The participants' strategic use of reported thoughts and reported speech, with the intonation, pitch and pace of their own and other's voices helps them to set up, maintain and sometimes reinforce the attitudinal framing of their narratives.

Kath's narrative

While it is important that we deconstruct the audio diary recordings to gain an understanding of the detailed way in which participants produce their narratives, it is also important that we consider the bigger picture: how it all fits together in the telling of a single event narrative and what that provides for the researcher interested in narrative identity formation. To this end I now reproduce in full one single event narrative that was recorded as part of a diary entry. In order to provide a holistic experience for the reader, the narrative is presented in full, before I offer a brief interpretation to demonstrate the powerful utility of the audio diary method for narrative researchers. As this interpretation is necessarily incomplete (for reasons of both space and of focus) as you read this excerpt you are invited to bring forth your own rich understanding of the unfolding narrative.

The event concerns a medical students' first experience of witnessing death: something that all doctors encounter at some point during their training. This

event was narrated by Kath and the extract presented lasts 10:48 (the full recording lasts 13:55). At the time of the recording, Kath was nineteen-years-old and had been at medical school six months. She begins her message with a brief and solemn summary sentence, establishing a footing reminiscent of Katie's narrative of her own mothers' death:

TABLE 1

1	I've recently had a profound experience (1.0)
2	I was visiting my friend- erm- yeah my friend- he's an [job] I mean I've had
3	time off for- doing my SSU and I was visiting my friend who's an [job] in
4	A & E of all places [softly laughs] and I was waiting for him- erm- this was
5	up in [city]and I was waiting for him to finish his shift
6	and he was about to go and everything seemed fine
7	when they brought in- there was like a car accident or something and they
8	were bringing in- sorry it wasn't a car accident it was motor vehicle
9	accident- there was a guy- a collision involving a motorbike and I think it
10	was some sort of a big truck or lorry and as you can imagine very (.) kind of (.)
11	messy and anyway what happened was (.) of course- my friend was like- kind
12	of- he couldn't really leave so he asked me would I mind waiting around and
13	because- you know- I'm doing medicine I was kind of interested (.) so I kind
14	of stood back and I asked him like- well can I d- well I asked them- well I
15	asked him not really his superiors because they were very very busy- would
16	he mind if I just waited and like kind of- not sure if it was proper that I
17	stayed there but I did anyway and like he just said (.) basically (.) if I kept out of
18	the way I wouldn't get in trouble or whatever- but I- the point of my little
19	story is that erm (.) there was- I- I saw someone die-
20	and I mean I've seen- I've seen autopsies done and I mean I've seen like
21	people who are dying and I've seen people who are like a few hours from
22	death- erm- but I've never actually seen the act of it itself (.) and I mean I'd
23	always thought that- actually- I don't know what I actually had thought (.)
24	I mean I hadn't exactly expected it to be like fireworks or anything and
25	screams and you know a very big excitement but I mean it wasn't like all
26	that spectacular and the closest really I can describe it as it would be like a
27	drift (.) kind of a deflation and I mean I know a deflation (.) okay well they've
28	stopped breathing and that it makes- you know they're gonna- well deflated
29	the air's literally expired from their chest- but I think it's more than that it's
30	just- I mean i-it it seemed so empty- I mean the guy who died today was a
31	young chap
32	he'd just been thrown off a motorbike and he had- erm (.) suffered a
33	subarachnoid brain haemorrhage- and I mean (.) the team had thought they
34	had stabilised him and I was standing maybe 10- 15 feet away from the bed
35	watching and sort of looking straight at his face- he's kind of- he's kind of

(Continued)

TABLE 1 (Continued)

36 semi conscious and when the ECG monitor started bleeping and [long
 37 breath out: 2.0]
 38 it honestly it seemed almost like as if the doctors were disturbing him by
 39 attempting the resuscitation (.) it was almost like someone disturbing a
 40 child's sleep (.) really it was such a profound experience but I think (.) since
 41 I was so unprepared to see it and honestly I've not really encountered death
 42 in such close proximity (1.0) I- I- I wasn't fully alive to the mystery
 43 unfolding before my eyes (.) I mean I've seen like- I've seen- well- I've had
 44 close members of my family die but I was never actually there when they
 45 did the actual moment of death (.) it was- I mean- a-as doctors we can
 46 define and limit- I mean the miracles of the womb and a lot of the processes
 47 of the body and all these marvellous things it does- but after that (.) the
 48 second of that release I mean (.) we don't know (.) we can describe the
 49 deterioration of the physical body but (.) I'm not a spiritual person but it seems
 50 so empty just to be there and gone (1.0) and I mean where does it begin and
 51 where does it end? That second (.) that release (.) like does it exist? I mean
 52 they were there for like half an hour trying to resuscitate him and I mean (.)
 53 when is enough enough? He looked so young- so healthy he was a kid (.) it's a-
 54 one of his arms was- was like hurt- it was bleeding and it looked- I think
 55 they suspected it to be broken and they were about to wheel him down to-
 56 they were waiting for the x-ray department to free up or get him in quickly
 57 to check his arm (.) but they really had thought he was okay (1.0) he was semi
 58 conscious and like they were moving onto more extreme cases and just- just
 59 the alarm started- well the alarm- the beeping of the ECG started to say that
 60 basically he's dead and- well his heart had stopped
 61 I mean he just looks like any sort of guy who I'd chat to in a club or bar and
 62 it seemed- it seemed- it almost seemed like a theft (.) a robbery of his youth
 63 (2.0) I think that there's something that as a doctor I'll encounter a lot but it
 64 such a profound experience that I don't think one can ever really come to
 65 terms with it (.) I mean its something that happen- will happen to every one of
 66 us but I've always thought of it as kind of an abstraction (.) I mean I know a
 67 lot of people they say (.) okay (.) they want death to become- "oh" they say "oh
 68 I wish I was dead-" "I'd rather be dead than do this exam-" "I'd rather be
 69 dead than (.) like go to that club" or- really like it's fine to talk about death as
 70 an abstraction but as soon as he's in the next room (.) if his touching you he
 71 becomes so- so- so solid and it's frightening (2.0) people get scared (2.0)
 72 and other members of my family who work with death a lot (.) like they work
 73 with patients who are like [disease] sufferers and stuff like that- one of my
 74 [family] (.) she's a doctor who works with- like what I say infectious disease
 75 and that's her specialty and she works on the [disease] ward- well semi

(Continued)

TABLE 1 (Continued)

76 infectious disease ward but obviously she sees a lot of people with [disease]
77 and stuff like that and the high mortality rate on her ward (.) and I see with
78 her (.) even her she's worked for the best part of 25 years and like- well 20- 25
79 years [softly laughs] sorry better flatter her (.) but it doesn't seem to get any
80 easier for her- it's just- its like as if I want to be climbing this mountain that
81 I'm not sure that I'll ever be able to fully reach the top and (.) then again
82 would I ever want to reach the top? would I ever want to accept death that
83 much that I'd be so desensitized to it but- I just- wouldn't be totally affected
84 (1.0) and I think that is (.) it is a subject that we all have to encounter but I
85 mean it's so taboo (.) I mean we can talk about things that happen everyday (.)
86 but like when death comes it just- people like shut up (.) they just clam up-
87 they just don't talk about it (.) and I mean you know it's something that's
88 going to happen to us all- like I mean- you know (.) they've no problem about
89 joyously celebrating the fact that someone's had a baby- like "a baby is
90 born" and "ooh" like they don't- when I die I know myself I don't want
91 people to be mourning the fact that I'm dead (.) I want them to celebrate my
92 life- don't want people to cry-
93 like I saw that- that boy (.) his mother- well mother- I- to be honest I don't
94 know if his mother but somebody obviously who had a strong bond with
95 him possibly or someone who is strongly affected by his death at any rate (.)
96 like she could have been his mother- his Aunt- I don't know (.) but the point is
97 she was so gutted about it
98 I mean how can you as a doctor be so upset about this person dying (.) seeing
99 death in front of you and you have to go on and still be strong like tell
100 people "look (.) the person you love so much is dead" and they'd be angry
101 and hurt and upset and I know there's a good chance that they'll take it out
102 on you and you have to take that- I mean where does the doctor- who
103 doctor's the doctor? you know and all these emotions that are being fired at
104 you and your own emotions topping them all up- I mean where? I mean like
105 I'm not a system and I like to believe I'm a fountain (.) I'll probably overflow
106 and in what direction? I mean you can't keep bottling these things up (1.0) I
107 know there's help lines and stuff like that for doctors but it's not really
108 enough- I mean they give people counselling for- you know if you see
109 someone shot (.) that- you know if you're a witness to a murder they often
110 give people like- oh they give them free counselling or whatever to
111 overcome it but I mean (.) as a doctor you'll encounter death an awful lot
112 more frequently but you're supposed to be able to keep so strong inside and
113 cold and hard against the onslaught of emotions (1.0) unsure of a death
114 world (3.0)
115 and speaking of difficult [softly laughs] well SSUs and all (.) they're just

(Continued)

TABLE 1 (Continued)

116	Over(.) well I've just- I submitted yesterday and that's the reason why I
117	haven't been able to get back to you Lynn with this tape recording and well
118	because I've been hell bent on SSUs- I did mine on [medical condition] and
119	I found it was very- again emotive ..." Kath, 27 th March 2006

Following her brief summarizing sentence (line 1), Kath makes an immediate shift in tone as she provides a short orientation to her story, drawing on a shared understanding between researcher and participant as she acknowledges illegitimate 'time off' during an element of her undergraduate programme, while softly laughing at the irony of the setting she is describing to her as-yet untold story. She then provides a signifying sentence (line 6) alerting the listener that she is about to disclose the 'complicating action' (lines 7–19). In doing so, she invites further shared understandings of the event by drawing on cultural images of '*a motor vehicle accident*' arriving at an accident and emergency department: '*as you can imagine it was very (.) kind of (.) messy*' (lines 10–11) encouraging the listener to conjure up an image of the event, thus drawing us emotionally closer into her own experience. At this point in the narrative, and throughout the initial stages as Kath discloses the complicating action, the researcher is clearly present and affecting the way in which Kath constructs both the content and the telling of her story. Indeed, she feels the need to legitimize her being (and remaining) present in the accident and emergency department at this point in time (when a non-medical would have been asked to leave) directly to the researcher '*because- you know- I'm doing medicine I was kind of interested*' (line 13). Moreover, it appears that Kath's desire to legitimize her presence and to establish her behaviour as ethical in the eyes of the researcher led to momentary incoherence in her story, displaying confusion regarding the issue of consent '*he asked me if I'd mind waiting around*' (line 12) '*and I asked him like- well can I d- well I asked them- well I asked him...would he mind if I just waited*' (lines 14–16). Thus, when narrating her story, Kath appears to closely consider her audience even when the listener is not present. Moreover, Kath continues with further justification '*he just said (.) basically (.) if I kept out of the way I wouldn't get in trouble*' (lines 17–18), suggesting that she was aware of her limited legitimacy at the scene. Kath's choice not to narrate this interaction using reported speech (which would have entailed a shift in prepositional use from *I* to *you*) gives the impression that this is what happened (rather than just a request for it to happen) and that she did just watch and stay 'out of trouble'. At this point, however, rather than continuing with the frame and situating her story around consent issues and the ethics of her own actions, Kath shifts footing from impression management and legitimizing her own position to, once more, that of storyteller as she quickly gets to the point of her '*little story*'; her witnessing of a man's death. At this point Kath makes another shift (signalled by the phrase '*and I mean*' line 20) into an evaluative frame as she begins an attempt to make sense of the act of death.

As Kath embarks on her sense-making activity, she does so for the other in an attempt to explain why this event was so significant in comparison to other events she has experienced. However, we can see how her sense-making moves between an explanation for the other, and sense-making for herself, as multiple shifts in footing occur. The most prominent shift begins as Kath realizes that she had never really considered the actual moment of death before '*actually- I don't know what I actually had thought*' (line 23). We can see from this section of her narrative how the audio diary method appears to be capturing Kath's own sense-making-in-the-moment, as she struggles to find a reference within herself for this 'moment of death.' It is acknowledged that other qualitative methods, such as semi-structured interviews, when employed by a skilled narrative researcher do allow space for such 'ponderings.' However, the possibility for prompting, questioning and directing the thoughts of participants (and indeed, the expectation on the part of the interviewee that they might come) ultimately makes this sense-making process, driven purely by the narrator, hard to capture outside the audio-diary method. Thus we can see how, through her further use of the phrase '*I mean*' – indicating her struggle for meaning – Kath's explanation begins to take on a feeling of exploration as she considers both the literal and the metaphorical aspects of the act of taking one's last breath (lines 27–30). Moreover, she contemplates this act as situated in another, and not her own last breath, with her continual use of 'they' (lines 27–29). Through the use of the third-person pronoun, individuals can mark social distance between themselves and others or depersonalize others (Dyer and Keller-Cohen, 2000; Fortunet, 2004). Here, it seems that Kath is clearly contemplating the act of death in the *other* – that of the generalized patient. Following this brief contemplation, Kath brings her narrative back to the particular: '*the guy who died today*' (line 30).

On a conceptual level the main shift that occurs at this point in her narrative is between Kath's contemplation of the metaphysical (lines 24–31) and her sudden transition to more concrete, biomedical matters (lines 32–37) – drawing on the dominant discourse of medical professionalism that includes a detached voice of authoritative certainty comprising technical medical terminology, objective descriptions of physical symptoms, and the classification of these within a reductionist biomedical model (Mishler, 1984). This shift in footing brings her back into her description of the complicated action (line 32), filling in more detail around the events surrounding the young man's death. In doing so we can see the interplay between Kath's developing professional identity which calls for a clinical and emotionally detached self and which is developed and maintained by her careful use of medical terms (Mishler, 1984): '*he had suffered a subarachnoid brain haemorrhage, and I mean, the team thought they had stabilized him...*' (lines 32–33), and her identity as a person with emotions and a vulnerable body of her own (lines 40–43).

With her evocable use of the metaphor 'death as a sleep' we can see how Kath gently shifts her narrative back into evaluation talk (lines 38–40). The

contrasting unexpectedness of the present death event is powerfully narrated as Kath steps back into the moment, describing her own state of awareness during the event '*I- I- I wasn't fully alive to the mystery unfolding before my eyes*' (lines 42–43). As she continues to make sense of these unexpected events, Kath uses narrative linkage to make a further temporal shift (line 43) by contemplating her own experiences with death in the past, one within which she had an element of control over her interactions with death. Throughout her narrative, as Kath grapples to make sense of events, she contemplates her personal relationship with death itself whilst simultaneously reinforcing her medical professional identity. Here, Kath's use of the inclusive pronoun *we* orients her firmly within the medical profession, whilst simultaneously returning her narrative to the present time '*I mean, a-as doctors we can define and limit*' (lines 45–46).

Kath continues her sense-making within this narrative with her potent use of rhetorical questions about the moment of death: '*where does it begin and where does it end? That second (.) that release (.) like does it exist?*' (lines 50–51). Her comments on the man's youth and health clearly define him as someone who she finds hard to associate with death: '*a kid*' (line 53). Although Kath doesn't say how old he is, she herself is only 19 at the time. Immediately following these rhetorical questions, Kath makes a further temporal and conceptual shift as once again she abruptly moves her narrative from a consideration of the meta-physical to a description of the biomedical, returning once again to the complicated action (within evaluation), and ultimately the start of his death (line 54).

Kath's abrupt shift in frame back to a biomedical description suggests a tension within her sense-making process. It suggests a need for her to bring her narrative back to the known and the knowable. What is interesting here is how she corrects herself to say his heart had stopped, rather than he was dead: the very issue she was struggling with, the question concerning point at which death begins '*the alarm started- well- the alarm- the beeping of the ECG started to say that basically he's dead and- well his heart had stopped.*' (lines 59–60). Immediately following this declaration of his death, Kath makes another temporal shift in frame (to another phase of evaluation) as she talks about the man using the present tense '*he just looks like*' (line 61) highlighting her own present identity: that of a young medical student, frequenting clubs and bars, and destined to become a doctor who will inevitably need to cope with the death of patients and ultimately of her own demise.

During this phase of evaluation, Kath repeats her powerful opening statement that this had been '*such a profound experience*' of death (line 64). One which she contrasts, through her rhetorical use of reported speech, as she mimics different voices, with death as an abstraction (lines 67–69). Following this change in frame, Kath proceeds to shift frame once more, elegantly bringing us deeply and intimately into a world where death is a person rather than an abstraction: a person in the next room, touching you (line 70). The reality of this death event is, for Kath, frightening: '*people get scared*' (line 71). Kath then skillfully uses narrative linkage, bringing in her personal cultural history to

further develop her construction of herself as a doctor and her future coping abilities as she draws on her Aunt's experience of working with terminally ill people: *'it doesn't seem to be getting any easier for her'* (lines 79–80). Here, we witness Kath struggle with her future professional identity as she develops a potent metaphor of 'emotional detachment as the summit,' something to be reached as an ultimate achievement for a doctor and one which is culturally defined (lines 80–83). However, in developing this metaphor she begins to question her own desire to reach that summit: she's climbing it in her pursuit of a medical career, yet as a person she is unsure that she truly wishes to adopt that aspect of the medical professional persona. Thus we can see how Kath contests the dominant discourse of emotional detachment within medicine.

Kath then pauses for a brief moment before she develops her narrative to question a wider discourse in society – that death is a taboo subject – thus broadening her sense-making beyond herself as a future doctor. She draws on cultural rituals whereby death can be mourned or death can be celebrated (lines 91–92). At this point Kath makes an abrupt temporal shift once again back to the event, and another aspect of the complicating action, to reveal one further dimension to her story: there had been a member of the boy's family present around the time of his death and Kath had witnessed her distress (lines 93–97).

During this final stage of evaluation, Kath returns to her future role as clinician and the process of breaking bad news. Once again we can see her narrating her identity as a future clinician *'seeing death in front of you and you have to go on and still be strong...'* (lines 98–99) and her identity as she is now and how she talks about coping *'I like to believe I'm a fountain (.) I'll probably overflow and in what direction?...'* (lines 105–106). Kath continues by considering what life will be like as a doctor, although here she is using the pronoun *you* rather than *we* as she did earlier, thus suggesting at this moment she prefers to distance herself with this professional identity *'as a doctor you'll encounter death...you're supposed...'* (line 112). Indeed, Kath demonstrates her predicament as she evocatively draws both on the cultural demands of a clinical professional identity *'strong inside and cold and hard against the onslaught of emotions'* and of her own personal self *'unsure of a death world'* (lines 112–114). Pausing for a few seconds, Kath's voice changes tone and pace as she enters into a coda (line 115): bringing herself and the listener back to the here and now, she softly laughs, apologizing for not getting back with her recording, before continuing on with a second story that she also found personally emotive.

Discussion

If we now theorize about this narrative, its meaning and its contribution to Kath's personal and professional development we are drawn to the following observations. First, one can see her story oscillating between the literal and the more elaborate metaphorical, between the diagnostic and the reflective, between the physical and the metaphysical. Thus, Kath informs us about the

man's subarachnoid haemorrhage and his abnormal ECG before reflecting on his child-like disturbed sleep and describe the events as 'a mystery unfolding'; she talks of his broken arm and the need for an x-ray before mulling over the 'robbery of his youth.' She then returns to the implication of the event for her as a person. At this point her reflections are strictly personal, devoid of any technical competence in this context. The metaphor she uses here is stark: climbing, reaching a (probably unachievable) summit. Finally, this incident invites her to reflect on her own death, visualized as a celebration rather than a cause for sorrow. Thus, within this narrative, we witness a young girl contesting a number of dominant discourses within medicine and society in general, in order to reconcile her inner feelings and thoughts evoked by the event she had just experienced with her future identity as a doctor.

For clinicians, these insights are reminders of the indisputability of their personal and professional selves, of the elusiveness of 'professional detachment' or even 'scientific objectivity'. They exemplify the two ways of gazing on the human condition – biomedical and narrative – that doctors constantly oscillate between. Finally, they confront us with what Polanyi explained to clinicians nearly half a century ago: the inseparability of the knower from all acts of comprehension and the reciprocity, in all acts of knowing, of thinking and feeling (Polanyi, 1958).

Conclusion

The solicited audio diary methodology is a powerful tool for researchers interested in narrative enquiry. It opens up new insights into the way in which we make sense of the world of telling our stories to another and to ourselves. One interesting question regarding the narratives found within our solicited audio diary data is to what extent they typify *narratives* (Burke, 1945; Labov, 1972; Labov and Waletzky, 1967) and to what extent they can be described as *conversational narratives* (Ochs and Capps, 2001). While it is possible to see from Kath's narrative that this method of data collection gives participants the opportunity to tell their stories in a classically structured way, with the key elements of summary, orientation, complicating action, evaluation and coda (Labov and Waletzky, 1967), aspects of these narratives reveal an element of conversational mindfulness. Indeed, when recording a diary entry the narrator has the opportunity and space for editing and repairing their narrative structure. So we see Kath's narrative contains embedded additions to the complicated action within her evaluation talk. This recursive aspect of these narratives is interesting for a number of different reasons including the insights it provides regarding the process of sense-making and narrative identity formation in action. For example, Kath describes and evaluates the events surrounding the man's death, what happened and what it means to her as a medical student and a doctor of tomorrow, she returns to the scene to provide more information about the complicating action three times: the first time was

to give us details of the actions of the medical team and of herself at the very moment that the ECG started to beep, the second time she returned once more to this key moment in time to further embellish on what was happening to the man himself and the medical team's actions, later she returns to the complicating action but moves on from this moment, bringing a new protagonist to the scene, the grieving relative. These key moments that Kath returns to, further enhance our own understanding of the event, whilst at the same time enables Kath to establish a clearer understanding of the meaning as she makes sense of these events.

Additionally, data collected using the solicited audio diary method contains further dimensions of conversational narrative (Ochs and Capps, 2001). So, although there is a single active teller in the narratives collected using solicited audio diaries it is clear from the data that the stories are directed at a known individual. While there is essentially no turn-taking, it is interesting to see how these solitary narrators take both sides in a conversation: taking on the role of the other, asking questions and then providing an answer. As participants in the study narrate their stories they are mindful of who the researcher is and what she stands for. At times it seems that they treat the researcher as a co-narrator, addressing their comments in order to answer anticipated questions from the other. For example, Kath included an explanation of why she was present in the accident and emergency ward of a hospital without consent. As such, there remains the *feeling* of a co-narrator actively influencing the construction of these narratives.

On the dimension of tellability (Ochs and Capps, 2001) the longitudinal audio diary method enables a broad spectrum of forms from the highly tellable events with profound consequences (such as Kath's narrative) to relatively uneventful 'ordinary' events with low tellability (such as Anwar's brief diary entry on his SSU). Therefore the longitudinal nature of the study, in addition to the audio diary method, enables participants to leave a variety of tellable stories that give the narrative analyst a deeper understanding of identity in formation and practice. Ochs and Capps (2001) also point out that narratives may differ on the dimension of linearity whereby 'highly linear narratives link events within a plot structure with a beginning that builds to a middle, then resolves into an ending' (p. 83). While some solicited diary entries are more-or-less linearly structured, others are nonlinear (like Kath's narrative). Such non-linearity reflects the spontaneous and recursive nature of sense-making in practice. Capturing this process gives a deep and unique insight into identity formation: this discursive think-aloud process is an unintended, yet profound insight into an individuals' sense-making activity. Indeed, we can see from Kath's narrative how she shifted from narrating one event to another, to this process of pondering and wondering about her own expectations of what death was and how the events she had experienced had affected her. In doing so, a noticeable shift in the framing of her talk was apparent: it took on a more pensive and questioning tone. Similarly, stories solicited via the audio diary

method invariably have a moral stance. This is typically uncertain and fluid as individuals narrate their developing personal and professional identities.

We have also seen how the solicited audio diary method captures talk that is highly conversational in nature from the perspective of micro analysis. Thus, we notice reported talk and thoughts, paralinguistic aspects such as the use of tone and pitch, the use of humour and even laughter are all apparent. While it is beyond the scope of this article, further research into understanding just how these compare to examples found in talk-in-interaction would be advantageous. Questions such as whether they perform the same function in narration when the audience is not physically present would be of importance here for the narrative analyst.

The ethical dimension for the researcher employing this methodology also needs to be taken into account when considering its use. As we have seen, the solicited audio diary method encourages both prototypical narratives and small stories. Each of these narrative forms brings with it an ethical dimension. Small stories bring the researcher closer to the everyday life of the participant and with it a feeling of knowing someone that other methods do not. Prototypical narratives can be difficult to hear and may comprise highly eventful stories that are deeply significant in the lives of the participants. Accordingly, the researcher should expect the unexpected: while we may solicit the telling of stories using the audio diary method, we can never know which stories will be told and how the narrators will tell them, until the moment of listening. Sometimes the emotional or the ethical tone of the narrative entails that the researcher consider further action following the receipt of a diary entry. At all times, however, the world into which the solicited audio diary method brings us is brimming with a multitude of ways in which to understand how our participants make sense of their world and the manner in which they narrate their developing identities.

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NOTES

1. All names have been changed to preserve anonymity. The notation for these excerpts is as follows: SMALL CAPITALS = spoken loudly; Underlined = emphasized; <words in sharp brackets> = spoken faster than typical speech for individual;

Dash- at- end- = running on speech; [words in square brackets] = further information or substitute words; (words in single brackets) = probably word spoken; (...) = inaudible speech; (1.5) = pause to nearest half second;... = omitted speech.

2. The AMK (Applied Medical Knowledge) is the main form of assessment at the School and is in the form of 125 multiple choice responses to a clinical scenario.

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