very tired. The curtain around his bed was drawn shut and the lights in the room had been dimmed. In the semi-darkness, I went over to the side of his bed and placed the *Torah* next to him. He reached out weakly with one thin hand and stroked the *Torah*, sighing audibly. He spoke, but his words were barely audible. "Please say a prayer with me," he murmured softly.

"Let's recite the *Shema*," I suggested. I slowly intoned each word of the prayer, and the young man repeated each word after me. When we finished, he continued to hold onto the *Torah*, stroking it while his eyes remained closed. He seemed at peace. "Thank you," he said. He remained silent as did the rest of us in the room. We stayed together in profound silence for the next several minutes. As we said our goodbyes and left the room, the young patient had one request. Softly, he said: "Please come back soon, and bring the *Torah* with you."

Afterword

The preceding stories give only some idea of the wonderful "*Torah* encounters" we have on a daily basis.

Our amazing experiences have made me want to share the idea of the traveling *Torah* with as many of my colleagues as possible. I was delighted to learn that, based on a story in the *Jerusalem Post* about our experience at Cedars-Sinai, a woman named Sheva Honig donated a small *Torah* to Mount Sinai Hospital in Montreal. Several other hospitals have also contacted me to learn more about our *Torah*, and I hope that they will soon purchase similar scrolls for their facilities.

I feel honored to share this idea with my colleagues in Chaplaincy. I think that you will find this innovation to be immensely exciting and important. I will be pleased to provide information about how to contact the scribe in Jerusalem who helped us obtain our special *Torah*. Please feel free to get in touch with me if you have any further questions.

Endnote

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"Elicitation Hooks": A Discourse Analysis of Chaplain-Patient Interaction in Pastoral and Spiritual Care

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The article considers the communicative role of the hospital chaplain and maps some of the language strategies deployed to facilitate disclosure of the patients' concerns and achieve enhanced spiritual care. These include: i) involvement, ii) politeness and iii) encouraging disclosure or exploring emotion.

Spiritual and pastoral carers in health settings might well be skeptical about whether discourse analysts could usefully contribute anything to the world of hospital chaplaincy in that such analysts may have little firsthand experience of chaplains' day-to-day practices, and a secular orientation that involves little intimate appreciation of their beliefs. Such skepticism might be warranted, and it would be an unscrupulous researcher who ignored or dismissed it. However, since spiritual and pastoral care is a substantively verbal practice, an examination of chaplaincy discourse, analyzing spoken exchanges between chaplains and patients, can reveal much about its construction, patterns, and characteristics. Discourse analysis then may give valuable insights into communicative practices, enabling practitioners to change and refine their strategies as necessary.

In this article we will describe briefly the work, role, and functions of the hospital chaplain before we consider the first step in the work of chaplaincy—that of securing the relationship between chaplain and patient. We will address the enigma of how it is that a communicative frame (*i.e.*, how both interlocutors understand how the interaction will proceed context, content, permissible behaviors and social norms) is established between chaplain and client. This may facilitate the elicitation of the clients' concerns and the disclosure of issues relating to health, comfort, and, in some cases, matters of spiritual wellbeing. Verbalizing such concerns come under the rubric of painful self-disclosures (PSDs).[1] By focusing on the interactions between chaplains and patients we are venturing into relatively new territory in the study of health care communication. The process of "elicitation" in health care interaction underpins a great many subsequent

psychospiritual and physical interventions so it behoves researchers to attend carefully to the process by which it is accomplished.

Despite the centrality of health care to social, political, and economic life in developed nations, and the scrutiny which has been applied to it by many disciplines, much of the social landscape of medicine remains unexplored. Doctor-patient interaction has commanded the attention of investigators to a disproportionate extent, given that it only ever represents a small fraction of an individual's time in the health care system.[2] This contributes to a reproduction of the hierarchy within the health care professions[3] and the marginalization of the many occupational groups who provide the vast majority of the care, including nurses, occupational therapists, care assistants, pastoral carers, and a variety of volunteer service providers. The study of the language of non-medical health professionals has been a fairly recent phenomena.[4] According to Orchard, although chaplaincy is one among many disciplines allied to medicine which is poorly understood, it is perhaps the most vulnerable.[5]

The dominant approaches to the study of doctor-patient interaction have involved a preoccupation with discovering structures and processes in the consultation that are concerned with formulating and diagnosing the problem[6] and exploring how interactants use resources to achieve functional outcomes.[7] This is true both of work from a sociological perspective such as that by Maynard and Heritage, or from those seeking to characterize the consultation so as to educate novice health professionals.[8] While there are increasing attempts to explore how nurses and other health practitioners interact with clients,[9] the relative lack of attention given by researchers to practitioners other than physicians, including a neglect of spiritual and pastoral carers has had negative consequences for both researchers and practitioners. It has reduced the image of health care as distributed, multiply accountable work in a complex organizational setting[10] to a diagnostic encounter between doctor and patient. Even in the present climate of patient-centredness and increasing emphasis on holistic care, the work of the doctor is still taken to be emblematic of what takes place in health care settings.

The present study, therefore, was conceived in order to commence a new line of linguistic enquiry into the work of the chaplain. Historical links between the work of the Christian religious orders caring for the sick[11] were incorporated into the founding of the UK's NHS in 1948 and hospital authorities were advised to appoint chaplains and provide facilities for worship.[12] This has been reinforced more recently by *The Patient's Charter* and subsequent guidance.[13] Through the 1990s guidance was further refined,[14] and job descriptions were created for chaplains detailing their responsibilities for the spiritual care of patients, relatives and staff.[15] The role of Christianity in UK hospital chaplaincy services has remained predominant, with 93% of full time chaplains in the UK being Christian[16] but increasingly staff recruitment has been diversified so as to serve other faiths, depending on the client population served by the hospital. There is widespread agreement that patients, irrespective of faith group, should have a fundamental right to such care that respects their cultural, psychological, social and spiritual values.[17]

Despite the centrality of conversation to spiritual and pastoral care and the process of sustaining respect, language use in these encounters has yet to be explored. In examining the spoken interaction of chaplains and hospital patients, although this is not meant to diminish the importance of the non-verbal component, this research will begin to redress the imbalance and provide insights into the language of spiritual and pastoral care upon which more extensive research might be founded.

Discourse and Discourse Analysis

"Discourse" is a central concept in contemporary linguistics and the social sciences. However, it appears to be used variably by individual disciplines, and there is no universal agreement over its meaning and application. Social theorists typically consider discourse in terms of ways of structuring areas of knowledge and social/institutional practices.[18] In this sense discourse is conceived as an overarching concept within which we can examine how ways of talking about social and spiritual life are conditioned by the social institutions within which they occur.[19]

On the other hand, applied linguists and conversation analysts treat discourse at a more molecular level, where the discourses under study are sequences of contextually sensitive written or spoken language, usually involving more than one interactant. The emphasis is on analyzing sequences of language (spoken or written) which extend over the boundary of the sentence and which are naturally occurring. Linguistic discourse analysis uses descriptive frameworks to account for the organization (*i.e.* patterns, cohesion, regularities, irregularities) of spoken or written discourse, to examine how language functions in specific social and institutional contexts.[20] Consequently, not only can linguistic analysis describe the nuts and bolts of specific instances of communication, it can also reveal much about the interactional and interpersonal activities undertaken by the speakers. As Coulthard and Sarangi state: "discourse becomes the means through which social life is played out."[21] Contrary to the common assumption held by many people that casual conversation is a shapeless and haphazard form of interaction, analysts have demonstrated that conversation is an orderly interactional accomplishment. Despite being unrehearsed, frequently peppered with interruptions, and with more than one speaker at a time taking the floor, conversation nevertheless exhibits stable and recurring structural properties which enable participants to co-create and maintain orderly interaction. This is apparent in turn-taking, a pervasive yet tacitly agreed rule that only one person speaks at a time. As a corollary of this, a speaker who "holds the floor" can nominate a subsequent speaker to take a turn. When a speaker nominates someone else to take a turn, the addressee's response is both occasioned and constrained by the prior invitation. This is one of the simplest ways in which the phenomena we have termed "elicitation hooks" can operate, as a simple invitation to describe some state of affairs, for example as indicated in the following extract:

1	Chaplain:	How are you doing today?
2	Patient:	I'm feeling a lot better
3	Chaplain:	Are you in any pain today?
4	Patient:	No (.) no

In this sequence, the chaplain initiates the conversation by enquiring into the patient's wellbeing. The patient responds accordingly (line 2) and then at line 4 after another enquiry by the chaplain (line 3). These exchanges are structured in mutually constraining "adjacency pairs" which create an

agreeable elicitation framework. Notice too that the second is more specific than the first—a regular feature of elicitation sequences where general questions are followed up by more focused probes.

The practical relevance of these observations to those wishing to improve communication in health care settings is that by examining the *terra incognita* of what speakers actually do during conversation and how they achieve communicative success it is possible to build a systematic description of the mechanics of how this is accomplished. As Gale points out, speakers are extremely sensitive to the sequencing of talk. In the extract above, attention to the organization of adjacency pairs reveals much about the expectations of the speakers.[22] For instance, in producing his replies at lines 2 and 4, the patient indicated that he understood the chaplain's enquiry and invitation to commence interaction. Moreover, the patient's responses enable the chaplain to see that he was understood and was accepted by the patient.[23] The second question or "elicitation hook" obeys what Buttny calls conditional relevance inasmuch as it is a more specific version of the first question and its relevance is also conditioned by the hospital setting.[24] Yet when actually engaged in face-to-face conversation, we are generally unaware of the full extent of what we interactionally achieve. Conversation analysis, in detailing how social involvement is successfully realized in language, can reveal much about the state of talk and how the interpersonal relations between speakers are performed.[25]

Methodology

The research was undertaken with the co-operation of the Department of Spiritual and Pastoral Care at the Queen's Medical Centre in Nottingham, England. The data for the study were taken from tape recorded conversations between a chaplain working from the department and patients located at the Queen's Medical Centre. The conversations were recorded between October and November 2003 in various wards at the hospital. In order to obtain as authentic a discourse sample as possible, the data were taken from routine conversations conducted with patients in the course of the chaplain's regular spiritual and pastoral duties. The agreement of the hospital's ethics committee was obtained for the conduct of the study and subsequent publication. Other than obtaining patients' consent and providing them with an information sheet, no other specific demands were made of the chaplain. He was, therefore, completely in charge of the data collection process and free to select whom to engage in recorded conversation.

In any type of discourse research which analyzes spoken conversation in real social contexts, there arises the potential obstacle of what is known as the "observer's paradox." This is the phenomenon whereby speakers, knowing that they are being recorded and researched, adjust their talk so that it is different from their habitual, authentic usage. For example, by modifying their accent and vocabularies, speakers might employ a conversational style more formal than they would otherwise use. Such self-conscious language use might yield a misleading picture of the linguistic practice(s) under investigation. However, even if participants are unaware of the presence of the tape recorder, "pure natural" talk can, arguably, never be recorded. Indeed some linguists argue that completely authentic language does not exist in the first place, since all language use is a performance, the artful adoption of a particular personal and social identity contingent on the setting in which the conversation is taking place.[26]

Nevertheless, by actively involving speakers in the research, such as giving them control over data collection, it is possible to lessen the effects of the observer's paradox.[27] Since the chaplain was responsible for choosing which patients to engage in recorded conversation, as well as the actual recording process itself, this avoided the necessity of there being any external investigator on site. The recordings were replete with all the interactional quirks of live conversation—hesitations, false starts, overlapping utterances—features which, contrary to popular belief, are not necessarily associated with dysfluency and disorder but arise spontaneously in real-time face-to-face interaction.

Analysis

In total, seven conversations were recorded, yielding sufficient data to provide a preliminary analysis of how chaplains establish a relationship, achieve rapport and elicit the patients' problems. This involves describing the mechanisms through which the chaplain-patient discourse is accomplished as a constructive and supportive form of interaction, brought about by close linguistic involvement and sympathetic hearing on the part of the chaplain. Such interaction is congruent with both formal policies and individual ambitions on the part of chaplains themselves. Indeed, as Cobb points out, the role of the chaplain primarily focuses on relationships, which in turn depend on involvement and empathy.[28] Accordingly the analysis aims to provide insights into how such relationships are interactionally achieved and sustained, language influences communicative outcomes, and individuals react and respond to particular discursive strategies.

Examining the sequence of conversations as a whole, there appeared to be many salient features of communication which contributed to the constructive and empathetic character of chaplain-patient interaction. Analysis here focuses on three aspects of communication which were prominent, namely: i) involvement, ii) politeness, and iii) encouraging disclosure or exploring emotion. It is important to emphasize that these features of interaction do not occur separately but are functionally related and often operate simultaneously.

i.) Involvement

The concept of "involvement" can be applied in addressing an aspect of conversation in a specific context where more than one person is engaged in talking. For instance, the taking of a medical history is unlikely to yield the same subjective sense of emotion as talking to a close friend about the experience of illness. Thus, medical consultations, although they involve the doctor and patient verbally addressing each other, are unlikely to yield full emotional involvement.[29] Indeed, conversational involvement is achieved partly through the construction of a sense of shared emotion; an emotional connection between speakers.[30] It is this sense of emotional involvement or authenticity that the chaplain has to accomplish and regulate for the encounter with the client to be successful.

A central criticism emerging from research on doctor-patient interaction is that doctors focus on the voice of medicine at the expense of the "lifeworld" of the patient,[31] and are unlikely to explore the personal and social dimensions of a patient's illness. Consequently, a lack of conversational involvement between participants is likely to be sensed by the

patient. In sharp contrast to this, chaplain-patient interaction is a highly involving discourse in which meaning and a "structure of feeling"[32] is jointly and actively produced. For instance, in order to ensure conversational involvement, the chaplain uses what Tannen calls "involvement strategies"[33]—strategies which help create a sense of shared emotion between speaker and hearer. One effective involvement strategy is the use of verbal repetition:

Extract 1

(C = Chaplain; P = Patient)

1	C:	How are you feeling today
2	P:	I'm feeling fine today thank you very much
3	C	yeah
4	C:	Uh uh
5		(0.4)
6	P:	Yes I feel great
7	C:	Yeah
8	C:	Feel great?
9	P:	Yes (.) I've got no pain in my legs
10	C:	(N-)
11	P:	No pain whatsoever

In this extract the chaplain commences conversation with a general, opening enquiry (line 1). The query is then extended or "hooked" by means of "yeah," "uh uh" and a short pause which has the effect of inviting more commentary from the patient who at line 6 reasserts how he is feeling ("Yes I feel great"), to which the chaplain responds with a "yeah" and a repetition of the patient's words but in the form of an interrogative or question: "Feel great?" (line 8). As well as economically encouraging the patient to continue talking, and thereby further express his thoughts in his own terms, the repetition reveals a willingness to co-operatively share each other's vocabulary, an indication that not only are the participants closely listening to each other, but that they are also jointly shaping the course of conversation and thereby, as a result of the elicitation of the patient's statements about improvement, interactionally converging.

ii.) Politeness

A fundamental aspect of communication, which helps to create and maintain interpersonal relations is linguistic politeness. Linguistic politeness differs from the commonly held understanding of politeness, the well-defined and culturally specific protocols of social behavior. Rather, it is a theoretical construct which helps explain linguistic and social behavior, and their interrelationship.[34]

Linguistic politeness is dependent on the notion of "face" and "face management." Goffman argued that ritual actions in everyday life center on protecting "face" or "territories of the self," expanding the ethological concept of territory to include "areas" of visual, verbal, and informational privacy.[35] In Goffman's words: "one's face is a sacred thing, and the expressive order required to sustain it is therefore a ritual one"; the self is "a ritually delicate object"; "(w)hen a face has been threatened, face-work must be done."[36] The concept of face, of feeling valued and self-worthy, is a pervasive feature of social interaction. When engaged in conversation, individuals work hard to protect, repair and bolster their face and the face of others. Face management, therefore, is essential to the construction of social order.

In linguistic studies, face is commonly divided into positive and negative aspects.[37] Positive face relates to our desire to be liked and appreciated, to be involved with and close to others. Negative face relates to our desire to be free from imposition, not to be put upon and constrained, to have freedom to act as we would like. As Holtgraves observes, the mere act of asking someone for information could be interpreted as a threat to that person's negative face, since they are being imposed upon and are compelled to provide a response.[38] Likewise, a speaker's positive face is frequently at risk during conversation: disagreements, criticisms, refusals threaten his or her desire to be close to and appreciated by others. This is often culturally determined and knowledge of the cultural mores is very useful in professional client (or any other) interactions.

Thus, speakers work hard to lessen the potential imposition of face threatening utterances with politeness strategies.[39] In the context of chaplain-patient communication, in which speakers initiate, elicit and negotiate profoundly delicate topics, face management, through the use of politeness strategies, is skilfully accomplished:

Extract 2

1	C:	Would you able to tell me (.) a little bit about how that affects you how having
2		this having had this stroke affects you
3	P:	((slurred))
4	P:	Not (0.4) ((slurred)) it affects in (0.6) just about everything honest
5	C:	Yeah
6	P:	I can't talk properly (0.4) speech (or anything) (0.4) (got) lots of things
7	C:	Uh uh uhum
8	P:	I've got brain damage ((slurred)) the stroke
9	C:	Uh uh
10	P:	So I can't (hardly) -plain to (you) jus- (.) jus- like that
11	C:	Yes uh hu (.) I understand

On invitation by the chaplain, the patient details the effects of having recently suffered a stroke. Sensitive to the patient's potential loss of positive face the chaplain invites the patient to express how his condition affects him (lines 1-2). First, the chaplain makes use of "hedges" (words, phrases and clauses which help to lessen the force of an utterance, for example "Would you be able to tell me...," "a little bit," making the speaker sound less authoritative and imposing). Secondly, the invitation is softened and personalized ("...to tell me"), thereby helping to maintain a degree of intimacy between the participants. Thirdly, and perhaps most significantly, the utterance "Would you be able to...," though a potential threat to face since it talks of the patient's ability to respond, nevertheless provides the patient with a degree of interactional space in which he is free either to decline or accept the invitation to describe his illness effects. All these politeness fea-

tures combine to help reduce the threat to the patient's negative face—or freedom from imposition. Here it is interesting to note that an alternative utterance such as "Please tell me how having had a stroke affects you," though commencing with "please" (a token of common courtesy), is, in the present circumstances, less polite, and therefore more face-threatening, than the chaplain's invitation (despite its absence of "please") since it acts as a command, an imperative ("tell me"), without providing the patient with the option of being able to turn down the request.

When the patient details the mental and physical effects of his stroke, he unavoidably, owing to the painful nature of the disclosure, threatens his positive face (desire to be appreciated, self-image) in the process. However, the chaplain, alert to the patient's face needs, timely responds with positive politeness:

Extract 3

1	C:	But it has always seemed to me that you (.) you explain things
2		very well
3	P:	Oh! (.) if you say so [laughs]
4	C:	Uh uh yeah
5	P:	I I try to
6		(0.4)
7	C:	Yes
8		(0.4)
9	P:	explain the best I can

Praising the patient's ability to express himself effectively (lines 1-2), the chaplain counters his previously articulated self-doubt, and helps to repair his self-image. The utterance is interactionally effective not simply because of its uplifting, positive content, but also because of the way it is personally indexed. By expressly associating himself with the propositional content of the utterance ("But it has always seemed to me..."), or in other words authenticating the remark, the chaplain provides sincere encouragement and support, and avoids sounding superficially optimistic or patronizing. The success of the utterance is borne out by the patient's subsequent responses. Initially, the patient's immediate reaction (line 3) is one perhaps of apparent scepticism (the rising intonation of "Oh," followed by laughter, suggest incredulity). However, the chaplain (line 4) continues to affirm the integrity of his compliment—"Uh uh yeah" ("Yes I do say")—which leads to the patient conceding that he does "try to" explain things well, despite the effects of his illness and so he is acceding to the chaplain's frame in which he has a belief in his cognitive and linguistic abilities.

iii.) Encouraging disclosure and exploring emotion

Chaplain-patient interaction resists simple classification as a form of communication. Unlike doctor-patient discourse, which consistently exhibits predictably recurring features of interaction and can typically be resolved into a series of stages through which the participants must pass (*i.e.* complaint, examination, diagnosis, treatment),[40] the communication between chaplains and patients is much more conversationally unique and complex. It blends features of counseling and religious discourses, as well as informal conversation. This "interactional hybridity"[41] or converging of spoken formats is flexible and responsive, shaped as it is by the personal, spiritual, and social needs of the patient.

In the following long extract, the chaplain, sensitively monitoring and responding to both emotional and interactional concerns as they arise in ongoing conversation, encourages the patient to explore the emotional effects of his illness. As well as encouraging the patient to make disclosures, the chaplain helps the patient to evaluate their significance and thereby invite self-interpretation.

Extract 4

1	P:	I mean one day I was at (0.6) I was fine and er (.) the next day I (.) em got this
2		black spot on my foot (2.2) the next day (.) I was sent up here
3		for a check up (0.6) and they kept me in the same night and they
4		operated the next day
5	C:	Was it as quick as that?
6	P:	As quick as that
7	C:	Uh
8	P:	Er apparently I'd got gangrene
9	C:	Uh uh
10		(0.8)
11	C:	That must have been (.) that must have been a huge shock to you
12		for it to happen so quickly
13	P:	Well (.) it was but (.) don't forget that I'd had the previous experience
14		from the last [date]
15	C:	Yes uh uh
16	P:	of these sort of things (.) and knowing how quickly things can change
17	C:	Yes
18		(1.4)
19	P:	So erm (1.2) I was partially (0.8) partially accepted the facts straight away
20	C:	Yes
21	P:	And erm when the doctor explained that he could chop off a bit off here and a (.) off there (.) and start somewhere
22		else (0.4) whoa
23	C:	Hmm
24	P:	[laughs] no way
25	C:	Uh uhm
26		(0.6)
27	P:	He says all we can (0.6) (is) start at square one (.) chop ten inches off and have a jolly good start at clearing (.)
28		the whole thing up

29	C:	Uh uh
30	P:	So I says go for it man go for it
31	C:	That's what you said to him
32	P:	Yes
33	C:	Yeah hmm
34	P:	I said go for it
35		(1.4)
36	P:	And er (( ))
37	C:	And listen [name] (.) how long (.) how long have you been in
38		hospital now
39	P:	Since last (.) part from: a month ago I been in er twelve months
40	C:	Twelve months
41	P:	[date] last year when I (0.6)
42	C:	Came in first
43	P:	Yes (.) I had a stroke originally
44	C:	That's a long
45	P:	(( )) paralysed left hand side
46	C:	Uh uh
47	P:	And er (0.6) I got over that (.) and they sent me home for Christmas
48	C:	Yes
49	P:	I had Christmas at home (1.2) and [date] I was (.) in again
50		(2.4)
51	C:	Lord (0.6) for a man (.) for a man who's been in hospital so long
52		and has gone through so much (.) you
53		(0.6) you have a great attitude
54		(1.2)
55	P:	Well
56	C:	You have a (.) seems to me that you have a great response to being in (0.6)
57		you know [coughs] excuse me (.) in hospital
58	P:	Yes
59	C:	And and and to to being in the care of people
60	P:	I I think that's why we get on so well
61	C:	Hmm
62	P:	Er myself and the nurses because (.) they seem to think er
63	C:	Yes (very well)
64	P:	I've got that sort of attitude you know er will not be beaten
65	C:	Ya
66	P:	Will not be subdued
67	C:	Yeah
68	C:	Uh uh (.) yeah
69	P:	Will will try his damnedest

The patient produces a series of self-disclosures which are articulated with a sense of positive acceptance (lines 13-14, 16, 19, 30, 34). Disclosures are elicited by the chaplain who, as well as using questions (*e.g.*, lines 5, 11-12, 37-38) to elicit patient responses, also regularly uses what conversation analysts call "continuers"[42]—minimal responses such as "yes," "yeah," "hmm," "uh uh" (lines 7, 9, 15, 17, 20, 23, *etc.*). Continuers encourage a speaker to take another turn (continue speaking), while letting him or her know that their utterances are being registered and acknowledged. Continuers thus contribute to the running of conversation for without them fluent and manageable interaction would be extremely difficult and a framework for the elicitation of the patient's concerns would be difficult for the chaplain to construct.

Between lines 1-4, the patient discloses, with a sense of hardy acceptance, how he first became aware of his change in state of health. His account of the experience is briefly and matter-of-factly described, without any admission of the emotional effects the experience has had or is having upon him. Therefore, the chaplain's question at line 5, and subsequent turns at lines 11-12, 37-38, 40, can be interpreted as attempts to acquire purchase on the patient's feelings in relation to these traumatic events and stimulate self-interpretation. The chaplain is using a technique of emotion work called "templating"—laying out a culturally intelligible structure or "template" for the patient—"must have been a huge shock for you."[43] This the patient partly refuses, at the same time acknowledging that this answer could be seen as a "dispreferred"[44]—using terms like "well" and "but," and offering an account as to why the template is not quite applicable: "don't forget that I'd had previous experience."[45]

This attempt to elicit a more emotional discourse is followed by the patient informing the chaplain further of the circumstances of his diagnosis, describing the prospect of amputation in typically characteristic bold and euphemistic fashion (lines 21-22, 27-28, 30, 34). Responding to the disclosures, the chaplain shifts or refocuses the topic slightly, asking the patient how long he has been in hospital for (lines 37-38), a question which again can be reasonably interpreted as an attempt to elicit the extent of the seriousness of the patient's situation and encourage self-evaluation. Between lines 39-49, with acknowledgment and support from the chaplain, the patient outlines the history of his illness(es), documenting the amount of time he has spent in hospital, which the chaplain qualifies on his behalf as being "a long [time]" (line 44). The chaplain (lines 51-53) then makes empathetically explicit the extent of the patient's experiences ("a man who's been in hospital so long and has gone through so much") but completes his assessment with marked positive politeness (feeling of self-worth, positive image), promoting the patient's positive face: "you have a great attitude" and subsequently at lines 56-7: "You have a. . .great response to being. . . in hospital."

In short, this extract reveals how both participants, the chaplain in particular, interactionally manage personal painful self-disclosures. While encouraging the patient to talk freely and at length (through the use of

questions and continuers), the chaplain's responses become more probing, compelling, the patient to reconsider the import of his predominantly non-evaluative disclosures. More exactly, the chaplain helps the patient to unpack the significance of his experiences and thereby gauge the extent of his emotional recognition of, and reaction to, the serious situation he is in.[16] But as well as doing significant interactional work which enables the patient to meaningfully articulate his illness experience, the chaplain also responds to the patient's ongoing painful disclosures with sympathy and admiration. Again, face management is linked closely to disclosures, and the chaplain works hard to ensure that those which are likely to threaten the patient's face are countered by positive politeness.

In the following extract, the chaplain, having asked the patient to discuss his Catholic faith in relation to his illness, allows the patient to explore the sensitive subject of personal religious doubt and other theological concerns.

Extract 5

1	P:	In the (.) days when I was (.) arguing and saying look at this in the bible
2		and what about that (.) both of us said I think I
3	C:	Hmm
4	P:	I think I'd like to speak to a priest
5	C:	Hmm
6	P:	Now (0.5) not every priest is any good to me
7	C:	Hmm
8	P:	There are some
9	C:	Yes
10	P:	and I think (.) you are the one [laughs] who one could express these
11		things and receive sympathetic hearing
12	C:	Hmm
13	C:	Hmm
14	P:	And (.) I don't expect it all to be clearly explained and (.) fade away
15	C:	Hmm
16	P:	but I have this experience (to hold on to beliefs) you see
17	C:	Yes hmm yes
18	P:	My father-in-law (0.4) em [name] father-in-law (.) (came from a) catholic
19		family (.) everything absolutely stable
20	C:	Yeah
21	P:	and once when he was with us ( ) the conversation came round and
22		I said oh I have some doubt about something (0.8) actually
23		the incarnation funnily enough
24	C:	Yes uh uh yes hm
25	P:	And em ( ) he's totally different person to me ( )
26		he said [puts on voice] that's because you don't believe in miracles
27		(0.6)
28	P:	And there was no argument
29	C:	Hm
30	P:	He didn't there there was no discussion or sympathy or anything
31	C:	That was the answer yeah
32	P:	and [name] was somewhat the same she's got it (.) and it is firm
33	C:	Hmm
34		(1.0)
35	C:	Bu but but I think that's a huge issue within catholicism or within any (.)
36		any er form- formal religion you know
37	P:	Yes
38	C:	Er that's like er I was reared the same (.) this is the question and this is
39		the answer
40	P:	Yes yes yes yes and you don't think
41	C:	No
42	P:	Well I mean you do think but (.) to think (0.6) critically is
43	C:	( ) mm hmm
44	P:	a thing only Carmelites do [laughs]
45	C:	Yes (.) but that's the (.) but that that's
46		the healthy thing about it you know
47	P:	What about conversation yes
48	C:	Yeah and the other is is the thing that intrigues me about it is that em (1.2)
49		it's I think anyway it's hugely important
50		(.) getting the answer is not so important (.) it is at some point it is (.)
51		but what is more important I think is
52		(.) having an opportunity to talk and to and and to try and
53	P:	Absolutely
54	C:	verbalise it
55	P:	but you see not everybody does
56	C:	Hmm
57	P:	I mean not ( ) will fill the bill
58	C:	Yes yeah
59	P:	And em (.) I I thought around and I (.) I just had an idea of somebody

60 that I could hold forth to (0.6) and er
61 so it's lovely to talk to you

In a series of disclosures (between lines 1-32), the patient discusses theological issues, defining what type of priest is "good" for him (lines 10-11). The patient's reference to the chaplain ("you are the one"), and his being able to receive "sympathetic hearing" from him, can be taken as an indication and expression of intimacy, an intimacy which is reciprocated by the chaplain as the discussion about faith develops. For instance, the patient's assumption that he doesn't "expect it all to be clearly explained" (line 14) is later echoed by the chaplain: "getting the answer is not so important...what I think is more important is having an opportunity to talk" (lines 48-54). This echoes MacRitchie's characterisation of chaplaincy work as a kind of "translation"[47] which occupies a "transitional" space[48] where the interpretive work of the clergy is foregrounded.

What is further interactionally salient about the participants' exchanges at this point (and another indication of intimacy and reciprocity) is that they appear to approximate more to sequences of informal, intimate conversation than other institutional discourse formats such as counseling or therapy. The role alignments of the participants can best be typified as "acquaintance-acquaintance" rather than the more institutional "professional-client." For personal disclosure, in this instance, is not restricted to the patient (as it typically is in counseling discourses) but is reciprocated by the chaplain. For example, as well as revealing, briefly, his opinions on faith and belief, the chaplain, giving, as it were, something of himself, relates and compares his own personal experience of faith to that of the patient's (lines 38-9), an instance of what Sacks calls a "second story"[49]—a subsequent disclosure which is related to the previous speaker's. Sacks observes that second stories are frequent in casual conversation and are therefore out of place in institutional (or specifically therapy) discourses: "it is absolutely not the business of a psychiatrist, having had some experience reported to him, to say 'My mother was just like that, too.'"[50] Thus the chaplain is, arguably, eliciting further disclosure,[51] and this can be seen as a further "elicitation hook." Moreover, this kind of disclosure could be seen as reassuring or rapport-building.[52] Disclosure on the part of the professional, when used sensitively, carefully, strategically, and appropriately, can be an important means of building relationships, rapport and dealing with emotionally charged issues.[53]

The participants' interaction is therefore in an informal register with mutual self disclosures, of a kind which many formally trained health professionals might see as coming close to a violation of boundaries.[54] Yet the informal, studiously amateur approach of chaplains is argued to conceal great therapeutic skill.[55] In extract 5 the chaplain orients to the patient's accounts with a large number of "backchannel"[56] and "continuer" utterances—"hm," "um"—and those which represent accordance assessments—"yeah" and "yes" signalling accord.[57] Thus what appears to be a spontaneous and almost "instinctive" orientation to one another represents what is believed to be an important part of the work involved in spiritual care—active listening.[58] Most of the examples of continuers and accordance assessments in extract 5 serve to smoothly cede the "floor" back to the patient and, arguably, elicit further disclosures. Thus it could be said that continuers, assessments, and even the small silences (lines 27 and 34 for example) that are permitted, represent strategic means of elicitation. Thus the impression of conversing openly and intimately about issues of faith and religion in their own terms and without following a predetermined agenda is something that is artfully and strategically constructed. The chaplain then, with apparent ease, aligns himself with a further function of the ministry, that of "being there" as a companion while the patient undertakes a "spiritual journey."[59] Yet it is a journey which is jointly and locally managed, emerging in the ongoing conversation: what the patient expects, and the chaplain provides, is sympathetic hearing. There has been a good deal of acknowledgement of the way in which spiritual care should ideally be geared to the unique perspective of the individual concerned[60] and the present study begins to show how chaplains are actively accomplishing that task by eliciting the patient's concerns so as to most appropriately direct their ministry. Indeed, in the extracts we have presented here, it is possible to see that the very functional concerns that have preoccupied many studies of doctor-patient interaction[61] are less prominent here. Rather than being geared towards establishing a diagnosis or securing consent for a course of therapeutic action, as the chaplain says "getting the answer is not so important" and what is valued in these encounters is "the opportunity to talk."

Conclusion

Faber likened the chaplain's role to that of a circus clown[62]—a role which appears disarmingly chaotic or amateurish yet produces creative, spontaneous acts which require study and training.[63] Here we have revealed something of the interactional microstructure through which the roles that need to be played by chaplains in ensuring that the widely-desired high quality, appropriate and sensitive religious and spiritual care is available to all patients is accomplished. While the present study is limited in scope and focus, some salient socio-linguistic features have begun to emerge, suggesting that of more substantial research might yield useful implications for training and professional development for the chaplaincy service.

A central interactional characteristic of the discourse is that, in seeking to elicit and foreground the patient's voice, it is resolutely patient-centered. In line with the ethos of treating patients as unique individuals, it is necessary to facilitate the disclosure of their uniqueness. While patients have various emotional, social, and spiritual needs, there is a degree of interactional consistency in the way the chaplain responds to them and secures further disclosure. This is accomplished through an underpinning and pervasive reliance on an interactional strategy that is strongly reminiscent of ordinary informal conversation. Like therapy talk,[64] chaplaincy discourse constructs for the patients occasions or "slots" into which emotional expression and self-reflection can occur. But what, among other things, sets the chaplain apart from his or her counseling counterparts is the emotional and interpersonal relationship with the patient. Whereas the counselor/ therapist maintains an unpassable distance between the client and him/herself, and therefore remains a stranger,[65] the chaplain is not so institutionally and impersonally bound. Indeed, this lack of formal specification and relative independence from healthcare professionals and management has been identified as an advantage by some chaplains, who prefer to conduct their ministry without such a formal script.[66]

The distinctiveness of such interaction reflects the unique position pos-

sessed by the chaplaincy service itself within the NHS. As Swift observes, the position of the hospital chaplain is "widely open to individual interpretation, with few formal guidelines for the day-to-day practice of chaplaincy."[67] This openness and independence, or "peculiar combination of features," Swift suggests, affords the chaplain a vantage not afforded other health care workers or social therapists. Whereas the discourse between medical practitioners and patients essentially revolves around transactional talk—getting business done at the expense of personal and social understandings of illness, interaction between chaplains and patients is relational. As Swift concludes: "What spiritual care givers offer—and should be loath to lose—is spaciousness for those who may find their hopes all too often enmeshed in medical meaning."[68]

While the present article is not an instruction manual for successful communication, it is intended to begin the process of describing how the activities of chaplaincy are accomplished. In line with Iedema, *et al.*'s ideas about the "performativity" of health care[69] we have sought to identify some of the means of performance by which this disarmingly simple yet highly skilled role is performed, beginning with the means by which patients are invited to disclose their concerns. This has practical relevance too, because even though the tools are commonplace ones which we can find in everyday conversation, what is important is that they are used by a caring professional at all, because they are at odds with most kinds of institutional discourse. With this quaint naivety the chaplain goes about his or her business using commonplace conversational devices such as the elicitation hooks identified here, which are deployed to facilitate the key spiritual activities of "listening" and "being with" the client. Hence there is significant value in demonstrating how this interaction is successfully achieved in language. And if, as a consequence of these insights, practitioners at least give some extra consideration to their discursive practices and the potentials of language, then this research will have been worthwhile.

Appendix A: Transcription Conventions

The following transcription conventions were used in this article:

(.)	pause in speech shorter than a second.
(1.5)	pause of specific duration (timed in tenths of a second).
( )	word or segments that are tentatively described.
(( ))	indecipherable word or segment
[ ]	transcriber's comments
a-	word or sound cut off
<u>on</u>	emphatic
!	rising intonation in a speaker's voice.

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