Article

Feeling Rule Management and Relational Authority: Fostering patient compliance in palliative care consultations

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Abstract
Once conferred by jurisdictions, hierarchies, or credentials, professional authority is now considered relational and probabilistic, drawing attention to actions that professionals can take to encourage client compliance. In this paper, we use ethnographic observations of palliative care consultations to show that professionals suggest feeling rules that correct patients' lay understandings and in doing so facilitate compliance. Palliative care professionals suggested three corrective feeling rules that validate patients' emotions and reattribute them to circumstances aligned with professionals' expert recommendations for care: that patients should fear curative treatment, that patients should hope for pain relief, and that patients and family members should feel guilty for prolonging misery. We argue that authority depends, in part, on professionals' ability to manage broader feeling rules instead of individual emotions. Given that feeling rule management involves altering meanings of what is considered appropriate, we contend that professionals' symbolic power and emotional capital underpin their authority in the professional–client encounter.

Keywords
emotional labor, emotional regulation, feeling rules, health care, palliative care, physician, professional–client relationship, relational authority, symbolic power

Introduction

Traditional theories of the professions claim that professional authority is conferred by jurisdictional control (Abbott, 1988), position in hierarchies (Weber, 1946a), or attaining credentials (Collins, 2019). In these accounts, authority is taken for granted or assumed to follow from professionals'

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elevated social status. However, skirmishes with clients illustrate skepticism, distrust, or hostility toward professional authority or expertise (Craciun, 2016; Cross & Swart, 2021; Sandholtz, Chung, & Waisberg, 2019; Toth, 2015). Segments of the population deny facts agreed upon by scientific professionals, including evolution and climate change (Porter, Kuhn, & Nerlich, 2018). Parents and patients contest providers' diagnoses (Barker, 2008; Gengler, 2014). Some members of the laity challenge infectious disease experts regarding mask-wearing and vaccination to prevent the spread of Covid-19.

A relatively recent turn in theorizing about professions—the relational perspective—argues that professional authority can no longer be assumed. Viewing authority from a relational lens brings into focus its probabilistic character, where relational authority is defined as clients' voluntary compliance with professionals' commands (Huising, 2015). In other words, professional authority is neither assumed nor automatically granted but dependent on interactions with clients and the relationships professionals build with them. As such, scholarly attention is turned toward the actions that professionals can take to facilitate client compliance and therefore establish their authority. In this vein, we ask: *How do members of a profession establish relational authority with skeptical clients?*

Research has investigated this question in terms of professionals' work to maintain their jurisdictions (Bechky, 2003; Norris, 2001; Timmermans, 2006) and the taken-for-granted institutions that undergird their power (Currie, Lockett, Finn, Martin, & Waring, 2012; Lawrence & Suddaby, 2006; Rojas, 2010). Here, we focus on emotions, which are specific components of the professional–client encounter and fundamental elements of human relationships (Collins, 2004). In previous research, emotional strategies that are used to influence others often involve regulating or managing one's own emotions or strategically expressing them to affect another person's behavior (Grandey, Diefendorff, & Rupp, 2013; Hochschild, 2012). In this paper, we show that professionals manage feeling rules (i.e., "the socially shared. . .guidelines that direct how we want to try to feel" (Hochschild, 1979, p. 563)), a concept from the emotional labor perspective that has been identified as ripe for further development (Meanwell, Wolfe, & Hallett, 2008).

We use data from an ethnography of palliative care consultations with terminally ill patients in an American hospital. Client compliance is difficult to earn in palliative care settings in part because patients can be skeptical of palliative care and in part because providers cannot make unilateral decisions on behalf of the patients; patients, their families, or other designees must voluntarily choose palliative care. Based on our data, we argue that providers encourage patient compliance by suggesting alternative feeling rules that correct patients' lay understanding of palliative care, part of what we call *feeling rule management* (i.e., the ability to influence the social guidelines that direct people how to feel). The feeling rules that providers suggest center on three emotions that patients and their families tend to feel about palliative care: fear, hope, and guilt (Collins, McLachlan, & Philip, 2018). Instead of trying to change these emotions or direct clients away from them ("don't be afraid"), professionals validate patients' emotions and reattribute them to circumstances that can be addressed by complying with professionals' recommendations. The feeling rules that providers suggest are fearing the negative side effects of curative treatment, hoping for pain relief, and associating guilt with prolonging misery. Data suggest that patients warm to a palliative course of treatment, and voluntarily comply with providers' expert recommendations, after hearing professionals recommend corrective feeling rules.

Broadly, we direct the theoretical, analytical, and practical focus away from managing individual feelings and expressions and toward the broader, socially constructed, symbolic elements of the situation. Much of the emotional labor literature focuses on workers' efforts to invalidate their emotional experiences to conform to company or professional feeling rules, either through surface acting (invoking a change in their emotional expression) or through deep acting (invoking a change

in their internal affective state) (Grandey, 2003; Hochschild, 2012; Voronov & Weber, 2017). Workers' efforts to manage their own expressions or emotions are aimed at creating or sustaining an advantageous relationship with a customer or client. Here, we show that validating a client's emotion and suggesting a feeling rule that reattributes the client's emotion to a different circumstance leads to voluntary compliance and relational authority.

Our study posits that relational authority in professional–client encounters is underpinned by intertwined emotional and symbolic dimensions. Given that feeling rules dictate what is appropriate for a situation, and that symbolic power is the ability to determine what is considered appropriate (Bourdieu, 1991), feeling rule management is an instance of professionals' symbolic power centered on emotions. Because the strategies we outline are fundamentally emotional, and because symbolic power is stratified according to distributions of capital (Bourdieu, 1986), an implication stemming from this research is the need to develop professionals' emotional capital (Cottingham, 2016) to facilitate client compliance and generate relational authority.

Our plan for the paper is as follows. First, we review how current research understands professionals' efforts to navigate the probabilistic nature of authority and encourage client compliance. Next, we provide examples from our data of the three alternative feeling rules and how they validate and reattribute clients' emotions; in doing so, they encourage patient compliance with providers' expert recommendations for care. Then, in the discussion section, we theorize feeling rule management as an extension of emotional labor theory and as an exercise of symbolic power buttressed by emotional capital. Furthermore, we suggest the opportunities for achieving client compliance through validating emotions. Finally, we discuss possibilities of using feeling rule management to achieve professional goals in other settings.

Professional Authority as Probabilistic

A common understanding of professional authority is that it is derived from expertise, training, or status. The assumption is that because professionals are members of an occupational group that has secured public trust and the backing of the state to treat client's problems (Abbott, 1988; Freidson, 1970), clients would therefore voluntarily defer to professionals' expertise. In other words, authority would automatically flow from a professional's "duty of office," a position that echoes Weber's (1946b) rational-legal authority. This is evident in Parsons's (1951) formulation of the sick role, where an expectation of the patient is to seek treatment from a credentialed physician and comply with "doctor's orders."

However, there is a growing understanding that professional authority is neither predetermined nor assumed but instead probabilistic (Huising, 2015; Sandholtz et al., 2019), evidenced in examples of clients who challenge professionals' expertise and undermine their authority. For example, anti-vaccination movements mistrust medical knowledge (Reich, 2016), and psychiatric patients hesitate to accept clinical diagnoses as valid (Craciun, 2016). In some cases, client noncompliance is associated with outcomes that present challenges to professions or their members. Lackadaisical adherence to antibiotic prescriptions accelerates bacteria resistance, which contributes to the spawn of "super bugs" such as methicillin-resistant *Staphylococcus aureus* (MRSA) (Yu, Jiang, Shi, Ye, & Lin, 2019). Client noncompliance can include resistance against medical doctors, as in the case of fibromyalgia sufferers seeking self-help treatment options within their own community when the medical establishment provides them with insufficient pain relief (Barker, 2008). Examples of clients' resisting professional authority extend beyond medicine into law (Shalleck, 1993), education (Smollin & Arluke, 2014), computer programming (Kellogg, Orlikowski, & Yates, 2006), and social work (Cingolani, 1984), signaling that professional authority should no longer be taken for granted by virtue of professionals' education, credential, or professional status.

Scholarly attention is thus turned toward actions professionals can take to establish or re-establish authority. Professionals can take action at the levels of jurisdictions, institutions, organizations, and professional–client encounters. Professionals engage in jurisdictional maintenance to shore up the boundaries of their control and signal their authority to clients (Bechky, 2019; Timmermans, 2006). They can also maintain their authority by underscoring the taken-for-granted assumption (i.e., institution) that professionals have rational-legal authority (Currie et al., 2012; Lawrence & Suddaby, 2006; Rojas, 2010). Work arrangements of the physical space of an organization (Kellogg, 2009) or the orientation to a specific set of technical tasks (Huising, 2015) can also generate authority. Finally, professional authority can be created, re-asserted, or maintained in interactions with clients. Interactional strategies include incorporating clients' lay expertise in decision-making concerning the appropriate treatment of clients' problems (Eyal, 2013), identifying and using efficacious communication strategies (Broschak, 2015), packaging their expert knowledge so that clients can identify how it will benefit them (Maack, 1997), and redefining the meaning of a client problem using symbolic power (Parnaby, 2009).

At the level of professional–client interactions, professionals can work to build relational authority, where professionals build relationships with clients and develop "the capacity to elicit voluntary compliance with commands" (Huising, 2015, p. 267). In Huising's study, professionals (i.e., health physicists) developed relational authority with their clients (i.e., researchers) by performing menial tasks. Doing the "scut work" put the professionals in a similar position as the clients. In this way, the professionals could better understand their clients and build a relationship with them on the basis of shared work tasks. Additional research finds that professionals can build relationships with clients by fluidly segueing among multiple roles depending on the professionals' interactional partners (Cross & Swart, 2021), by capitalizing on windows of opportunity that allow for interacting with certain groups such as powerful, non-technical experts (DiBenigno, 2020), and by amplifying or suppressing their emotions in interactions with clients (Rafaeli & Sutton, 1987).

Shared emotions bind people together (Collins, 2004; Cottingham, 2012; Durkheim, 1995). When interactional partners are not on the same page emotionally, emotional regulation occurs. Emotional regulation is the "modification of feelings or expressions" (Grandey & Gabriel, 2015, p. 325). For example, patient advocates in hospitals modify their own emotions to mirror their patients', generating empathy that helps them better support their clients (Heaphy, 2017). Many examples can be found in service work, where employees seek to regulate their emotions and better serve customers (Niven, 2016). When emotional regulation happens at work, it is part of emotional labor, wherein workers and professionals manage their expressions (i.e., surface acting) or their internal, felt emotions (i.e., deep acting) to conform to organizational feeling rules, defined as the "socially shared, albeit often latent. . .guidelines that direct how we want to try to feel" (Hochschild, 1979, p. 563).

Often, in situations where emotions are used to persuade, emotions themselves are regulated or managed. For example, leaders model positive emotions to encourage their followers to suppress negative feelings and feel happy instead (Barsade & O'Neill, 2016). People can show anger in an attempt to alter another's behavior (Crawford & Dacin, 2021). Suppressing emotions prevents individuals from "boiling over" and consequently alienating the person they are trying to persuade (Jarvis, Goodrick, & Hudson, 2019). In these situations, the individual's own emotions or expressions are altered to manage other people's feelings.

In this paper, we argue that professionals foster client compliance by managing broader feeling rules rather than their own or their clients' emotions. Professionals manage feeling rules by suggesting alternative feeling rules that correct clients' understandings of the situation. Rather than trying to change their own emotions or others' emotions, professionals instead validate clients' emotions and then reattribute those emotions to circumstances that can be addressed by complying

Table 1. Data Summary.

Type of Data	Number of Observations
Providers' interactions with patients newly referred to the palliative care team	64
Providers' interactions with family members when patient was absent	9
Providers' interactions with patients who had previously received a palliative care consultation	10
Providers' interactions with each other	22
Total interactions	105
Interviews with care team members	5

Note: The care team consisted of five members (two doctors, one physician assistant (PA), one social worker, and one chaplain). Interviews occurred at the end of the fieldwork.

with professionals' recommendations. Our study directs attention toward professionals' ability to manage the feeling rules of a situation, and by implication, professionals' symbolic power and emotional capital, when establishing their authority in interactions with clients.

Data and Methods

To answer the question of how professionals develop relational authority and to advance the concept of feeling rule management, we draw from ethnographic observations of palliative care consultations with terminally ill patients and in-depth interviews with palliative care team members. Ethnography and interviews have often been used in studies of the professional–client relationships and emotions (Cain, 2012; Gustafsson, Swart, & Kinnie, 2018). A benefit of ethnographic fieldwork is that researchers can observe the negotiation of meaning in real time, and the method is well-suited to uncovering new analytic concepts (Glaser & Strauss, 1965). We pair in-depth interviews with ethnographic observations to provide a participant-check on our interpretations of the data.

The observations took place at a hospital located in a small midwestern American town. The hospital was part of a non-profit, academic medical system. The palliative care team at the hospital included two medical doctors, a physician assistant, a social worker, and a chaplain. In hospitals such as the field site, palliative care is the domain of interdisciplinary consultation teams comprised of medical professionals and complementary workers. Observations happened once or twice per week, for a total of 40 days over a six-month period. During the study period, the first author observed over 100 interactions between team members, patients, and their families and attended approximately 80 team meetings. We treat interactions as the unit of analysis. Refer to Table 1 for a full accounting of the interactions observed and the interviews used as a participant check on our interpretations of the ethnographic observations.

Shadowing was the primary technique for data collection during ethnographic observations. McDonald (2005, p. 456) defines shadowing as "a research technique which involves a researcher closely following a member of an organization over an extended period of time." The researcher goes where the research subject goes: to meetings, to consultations, even to get coffee. The first author shadowed palliative care team members during their consultations and team meetings. A typical day in the field began with a team meeting at 9:30am. During the meeting, the team discussed the health status of new referrals from oncology and other departments, as well as the ongoing treatment of patients who had already accepted pain management. After morning meetings,

team members would consult patients and/or their families in patients' rooms, sometimes as a team and sometimes solo. Care was taken to distribute time equally among the team members to the extent possible. Team members reconvened around noon to discuss morning rounds and how to move forward with their suggestions for reluctant patients. Throughout these observations, the first author took jotted notes, which include pieces of conversation and key words as the interaction unfolded in real time (Emerson, Fretz, & Shaw, 2011). As a rule, these jotted notes were converted into full field notes within 24 hours of leaving the hospital for the day.

After completing field work, the first author conducted semi-structured interviews with members of the care team. Interviews were included as part of the data collection strategy to allow for member validation of the processes that arose from preliminary analysis of field notes (Hammersley & Atkinson, 2007). Care team members spoke about strategies for negotiating with recalcitrant patients and the emotional nature of their work. Example interview questions included "What is the role of hope in palliative care?" and "What is the biggest challenge in managing the emotions of your patients?" and "How do you handle situations where patients or families are sensitive about the notion that it is time to give up curative treatment and focus on comfort care?" All interviews were audio-recorded, transcribed, verified, and lasted 30 minutes, on average.

Data analysis

The initial idea for this research concerned providers' emotional strategies for discussing end-of-life treatment options. Checking field notes against the literature during data collection indicated the promise of concepts related to emotion regulation and management (Grandey & Gabriel, 2015; Hochschild, 2012) and the issue of obtaining clients' voluntary compliance in the professional–client relationship. This type of conversation between data and existing theory follows the abductive approach to data analysis (Timmermans & Tavory, 2012). A key part of the abductive approach is surprise, when an opportunity to make a theoretical contribution with the data reveals itself. In our case, the abductive surprise occurred when we were able to substantiate a new concept that emerged in our coding of the data. Our coding unfolded through iterative rounds and writing analytic memos, as suggested by Saldaña (2014).

First round of coding: emotions. The first round of coding was very general, occurred early in the research, and focused on central concepts initially guiding the project, as suggested by the abductive method. Initial readings of the field notes revealed the prevalence of emotions in end-of-life discussions and identified specific emotions, noting in broad strokes examples of fear, guilt, and hope.

Second round of coding: strategies. The second round of coding was more specific. We looked at instances of emotions in the data and identified how these emotions were used in consultations. Observed discussions were frank, in accordance with prior research on prognosis (Christakis, 1999). However, we noticed that providers' recommendations often were subtle and couched in emotional terms. Some example codes from this round included: "using the guilt card" and "listening to patients' worries."

Third round of coding: reviewing emotions. Our third round of coding was more focused and coalesced the codes from the first two rounds into patterns (Timmermans & Tavory, 2012). In reviewing our initial coding, we found that our first codes oversimplified the emotions in our data. The most striking realization was that what we identified as emotions were not obvious expressions of those emotions. For example, patients were not showing signs of being afraid in excerpts coded as "fear." Instead, providers were hinting at what should make patients afraid, guilty, or hopeful.

Example codes from this round include: "fear of side effects," "guilty of being a burden," and "palliative care as hopeful." These focused codes prompted us to return to the literature.

Abductive surprise: feeling rule management. In our rereading of the emotion regulation literature, we noticed that the target of regulation is usually one's own or another person's emotions or expressions. People know to perform emotion regulation when they receive rule reminders, but we noticed an incongruity between rule reminders and what was appearing in our data. Rule reminders indicate that a person's emotions are inappropriate (Hochschild, 2012), but the interactions in our data did not show this. Providers did not say to patients, "Don't feel sad" or "You mustn't feel angry." In other words, the providers were not sanctioning patients' emotions, as one would expect if the providers were issuing rule reminders. Instead, the providers were validating and reattributing patients' emotions. We concluded that our data could propound a new theoretical concept—feeling rule management, which we theorize below.

Final round of coding: voluntary compliance. After discovering our concept of feeling rule management, we asked ourselves "To what end is this concept beneficial?" We then returned to the literatures on professional–client relationships and compliance. Our reading informed us of relational authority and the probabilistic nature of client compliance. Thus, our final round of coding was to establish when patients complied with providers' recommendations and whether these instances were linked with feeling rule management. Piecing these codes together revealed the pattern that we present in our findings section—that providers manage feeling rules to encourage voluntary compliance.

Feeling Rule Management and Voluntary Compliance

Healthcare providers tend to perceive palliative care differently from patients and their families. They have divergent priorities, views of a palliative course of treatment, and perceptions of feeling rules governing the provider–patient encounter. Generally, palliative care providers at our field site want to work with terminally ill patients to develop a treatment plan that limits pain and provides comfort as they approach the end of life in accordance with the best practices of palliative care outlined by the American College of Surgeons (2017). On the other hand, patients tend to approach palliative care with apprehension, viewing it as accepting death and therefore something to fear or a choice worthy of guilt (Collins et al., 2018). Differences in the norms and understandings around death create a need for patient and family socialization to death and dying (Prigerson, 1991). Providers' and patients' discrepant perceptions of palliative care are outlined in Table 2.

There were many instances of patient resistance in our data. For example, team members visited a patient to discuss palliative care options at end of life, and the patient did not engage with the team members. He sat on his bed, watching a baseball game. Instead of acknowledging the care team's request to talk about palliative care, he simply said, "The game's on." The palliative care team left the room. This example, one of many in the data, shows that some patients are reluctant to engage with palliative care professionals, let alone comply with their recommendations. Other times, patients or their families are overtly hostile about palliative care. A patient's son was pushing for continuing curative treatment, so much so that he transferred his mother out of a hospital where the palliative care team advocated too strongly for pain management. The son was angry that palliative care team members at the previous hospital suggested that pain management was better for his mother than curative treatment. He said, "What is [the hospice nurse] doing in that hospital to start with? She was pushing for 'let go.' She was saying, 'Do you want to go home? Do you want to speak with Jesus?'" The son was evidently angry that the staff thought his mother was likely dying, and his anger was an impediment to providers' ability to recommend what they think is best for the patient—accepting a palliative course of treatment.

Table 2. Discrepant Perceptions in Palliative Care Consultations.

	Providers	Patients
Priorities	Pain management; increase quality of life	Cure through medicine; sustain life
View of palliative care	Legitimate treatment plan	Failure; accepting death
Feeling rules	Fear side effects of curative treatment; hope for better quality of life; feel guilty for prolonging misery	Fear death; hope for a cure; feel guilty for accepting palliative care and therefore death

Note: It is certainly the case that some patients will share providers' feeling rules. However, this is not always the case. This table summarizes the differences in viewpoints about palliative care, including relevant feeling rules when there is discrepancy between providers and patients.

The question, then, is what can palliative care professionals do to encourage compliance with their recommendations? During palliative care consultations, professionals cannot make unilateral decisions about patient care. Patients, their next of kin, or those holding power of attorney must consent to palliative treatment. Thus, voluntary compliance is a necessary, yet difficult to elicit, component of the professional–client relationship in palliative care consultations. We argue that palliative care professionals foster patient compliance by managing the feeling rules surrounding the palliative care consultation. Providers suggest three feeling rules that correct patients' lay understanding of palliative care: that curative treatment should be feared, that patients should hope for pain relief, and that patients and their families should feel guilty for prolonging misery. Feeling rule suggestions validate patients' emotions and seek to reattribute them to circumstances that can be addressed by complying with professionals' recommendations. When patients and their families hear providers' suggestions of corrective feeling rules, they tend to voluntarily cease insistence on curative treatment and accept palliative care in the form of hospice or another kind of pain management plan. In what follows, we provide examples of each corrective feeling rule, explain how they operate, and then provide extended instances of feeling rule management and voluntary compliance. Our argument is illustrated in Figure 1.

Suggestion that patients should fear curative treatment

Many, if not most, patients think that they should fear death, a worry amplified near the end of their lives (Collins et al., 2018). Here, we show that providers suggest a feeling rule to correct patients' lay understanding of death: that *curative* treatment should be feared. Frequently in the data, providers discuss the side effects that will likely result from continuing curative treatment. An initial step toward palliative care and away from curative care is a "do not resuscitate" (DNR) order—a common legal arrangement giving providers permission not to perform cardiopulmonary resuscitation (CPR) if a patient's heart stops. Providers encourage DNRs for patients who will suffer from the commotion and physical intensity of resuscitation attempts (Alpers & Lo, 1995). In an interview, a physician assistant (PA) mentions that many patients do not understand what medical professionals do when a patient's heart stops:

> We sometimes present information [such as] all the interventions that we have to do when somebody is in the process of dying, to restart the heart and break ribs and put people on ventilation. All those things people don't necessarily understand very well. So, we go into some detail about that. (interview transcript)

An important point in the quote above is that resuscitation can break a patient's ribs. Bodily injury is something that many people fear, including elderly people and otherwise frail patients, and providers are aware of this when they supply such information.
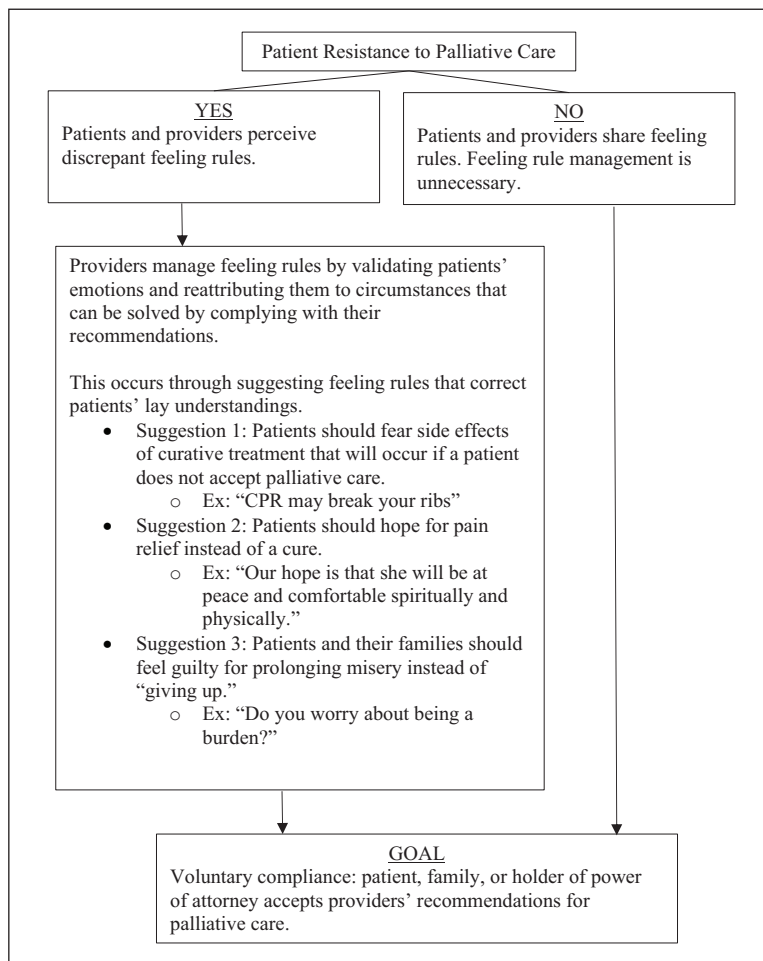
Figure 1. Outline of Argument.

The following excerpt illustrates the suggestion that fear should be reattributed to curative treatment and its side effects. When an elderly patient expresses timidity about agreeing to a DNR, the social worker begins describing scary side effects of resuscitation, including the possibility of broken ribs. Note that the social worker could have ended the conversation or given the patient time to think. Instead, she begins talking about frightening consequences of not signing a DNR and the low likelihood of successful resuscitation.

Social worker:	Can I ask you one more hard question? If your heart stops, do you want us to pump your heart?
Patient:	I don't know. . .
Social worker:	I am worried we will *break your ribs*. I am not saying it will happen, but it can happen. If a patient is young, then it is very successful. But when someone is sick, it may not be. (field note, emphasis added)

The next excerpt focuses on side effects of intubation, another aspect of curative treatment. Intubation creates an artificial airway for patients who cannot breathe on their own in the form of

a plastic tube inserted down the patient's throat. Intubation raises the likelihood of pneumonia. The patient in this excerpt has meningitis in her brain. The family asks about their mother's possibility of leaving the hospital and returning home, to which the doctor responds:

> The big question is, I can't answer how much she will come back [from intubation, if it is done]. The neurologist says she has meningitis in her brain. She had pneumonia and has risk of getting it back [if we continue]. [Intubation means] there is a good chance she may need to go to a nursing home. I don't want to give false hope of recovery. She may have to end up in a nursing home for the rest of her life. (field note)

In this interaction, the doctor communicates to the patient's family members that curative treatment can result in side effects that are worthy of fear and references the patient's previous experience with pneumonia to underscore the negative effects of intubation. The provider suggests that the negative physical side effects are something to fear, and he raises the possibility of dying in such a way that goes against the patient's wishes. The patient was afraid of being transferred to a nursing home, a worry for many people at the end of life (Mattimore et al., 1997). The doctor underscored those fears by suggesting that electing to revive her and continue curative treatment may put her "in a nursing home for the rest of her life." Accepting hospice, on the other hand, would mean that the patient could return home to live the remainder of her life with her family. In reattributing what should be feared, providers suggested a corrective feeling rule—that curative treatment should be frightening.

Suggesting the feeling rule related to fear is a tool that providers can use to encourage voluntary compliance. In the following example, the patient's wife is struggling with the decision to transition her husband to palliative care.

> Doctor: In his condition, if his heart stops a ventilator has to be used, most likely, which increases the risk of pneumonia.
> Wife: (pause)
> Doctor: It is also painful.
> Wife: I don't want a ventilator. (field note)

After pausing to consider the frightening side effects that her husband would experience (i.e., pneumonia, pain), the patient's wife complies and decides against a curative measure by accepting the DNR, a step toward palliative care.

Taken together, the excerpts in this section illustrate providers offering a feeling rule during palliative care consultations to correct patients' understanding of where to place their fear. Providers essentially suggest that patients should fear curative measures instead of death. It is important to note that providers did not admonish patients or their families for feeling afraid; instead, they redirected their fear to a different threat. We will discuss the importance of validation and reattribution in more detail below, but first we provide examples of providers correcting patients' feeling rules regarding hope and guilt at the end of life.

Suggestion that patients should hope for pain relief

Providers often sought to correct patients' perception of what should be hoped for. Providers suggested that patients should hope for the pain relief and improved quality of life that palliative care brings rather than hoping for a cure through life-sustaining treatment. For example, in the following excerpt, the PA suggests to the patient that there is reason to have hope when accepting hospice.

> We want to get some feedback about your opinion on hospice. It is for patients who have six months or less of time left, patients who have life-limiting illnesses. It is for pain management for you, and they have family support programs. Lots of people think it is for the last couple of days. But it is not that. Some people live in hospice for years. Some even graduate from hospice. (field note)

The PA leaves open the possibility of "graduating" from hospice, which suggests that patients need not completely surrender hope of "getting better" but that they can instead adopt the corrective feeling rule that such hope should be reattributed to palliative care.

The next quote demonstrates a similar instance of providers suggesting the hope feeling rule.

> Social worker to patient: There have been studies that patients, especially lung cancer patients, who are in hospice actually live a bit longer. (field note)

Although the social worker references "studies" that show patients in hospice live longer than similarly afflicted patients who stay in the hospital, she does not provide any concrete evidence. The intention of the comment is to suggest that hope should be attributed to comfort through hospice instead of to a cure.

Suggestion that patients and family members should feel guilty for prolonging misery

A lay understanding of palliative care is that patients think they should feel guilty for choosing palliative care because it means they are "letting go" and consequently causing pain to their loved ones (Werkander Harstäde, Roxberg, Andershed, & Brunt, 2012). Providers seek to correct this feeling rule by suggesting that patients and their family members should feel guilty for prolonging misery. Take, for example, an instance during a group meeting where the team discussed a difficult case. The patient was incapacitated, and her daughter was unwilling to move forward with palliative care. The doctor proposed a direct strategy to encourage the daughter to accept pain management for her mother. To all team members present, the doctor said, "Maybe we can try the guilt card with the daughter" (field note). The providers in the room affirmed that this would be an effective strategy, suggesting agreement among providers concerning appropriate practice related to feeling rule management. In the remainder of this section, we demonstrate how the "guilt card" suggests a feeling rule in which continuing life-sustaining treatment is worthy of guilt.

In interactions with patients, the "guilt card" can be subtle. The underlying suggestion is an alternative feeling rule that patients should feel guilty for "being a burden" to their caregivers and should transition to hospice or palliative care to eliminate that hardship for their caregivers. The feeling rule suggestion is illustrated in the following example:

> The patient lamented, "I have run out of steam. I cannot dress or undress myself." The PA replied, "*Do you worry of becoming a burden?* I think it will be a good idea to get support from hospice." (field note, emphasis added)

Immediately after this conversation, the patient asked the PA to call for the hospice nurse to arrange his transition to palliative care, a strong indicator of his compliance.

In the following conversation, the doctor and PA talk about CPR with a woman who was struggling with the decision to accept palliative care for her husband. Choosing CPR means that, should a patient's heart stop, much commotion will occur around the patient, and there is mixed evidence concerning the efficacy of CPR, especially for elderly, terminally ill patients (Sundar, 2016). The

PA and doctor subtly indicate to her that she might feel guilty about choosing CPR because it will not result in the peaceful death that her husband had envisioned.

Doctor:	One last question. If his heart stops, will you want him to be resuscitated?
Wife:	Hard question.
PA:	It is a hard question. If he is dying, CPR is to bring him back. . .(pause). . .Some people die peacefully. (field note)

Key in the above interaction is the intimated contrast with a peaceful death. The PA suggests that "people die peacefully" when they choose palliative care instead of continuing life-sustaining treatment, which includes CPR. The providers hinted that the patient's wife can adopt an alternative feeling rule that says she should feel guilty for putting her husband through the commotion and trauma of CPR instead of accepting the ease and peace of pain management.

It is important to reiterate that the providers are not admonishing the clients for feeling guilty. Rather, they are casting the situation in a new light by suggesting a corrective feeling rule—that patients and their families should reattribute guilt to prolonging a difficult life. In the next section, we provide more examples of how feeling rule suggestions operate through validating emotions and reattributing them to circumstances aligned with professionals' goals.

Feeling rule suggestions validate and reattribute emotions

When providers proffer corrective feeling rules to patients, they attempt to validate patients' emotions and reattribute those emotions to circumstances that can be solved by complying with professional recommendations. One of the doctors explained:

> [Part of the work is] trying to bring out the emotions and encouraging people to talk about the emotions *behind things* because that's kind of [an] art in itself so that people feel safe to talk about emotions. (interview transcript, emphasis added)

Notice that the doctor does not say that patients are experiencing incorrect emotions for the situation. Rather, his work is to encourage patients to feel safe to talk about their emotions. This is what we mean by validating emotions. Providers seek to communicate to patients that their emotions are valid, and that they should realign those emotions with other circumstances. Another doctor explains the reattribution aspect of feeling rule suggestions in the following quote when discussing how providers seek to correct patients' understanding of hope:

> I think a lot of times we're trying to help patients hope for something different than a cure. Hope can still be part of how they manage, how they cope, but we're helping them look at hoping for something else. You know, [there's hope for] time to say goodbye or time to be at home or a chance to finish the last project, as opposed to hoping for a cure. (interview transcript)

As seen in the quote above, providers are not saying that it is wrong for patients to have hope. Rather, providers direct patients' feelings of hope away from life-sustaining treatment and toward what can be achieved through pain management.

The following field note excerpt illustrates the reattribution of hope in action. The excerpt begins with the patient asking an ambiguous question.

Patient:	How long will it last?
Social worker:	Are you asking how long it takes until you get better or how long before God takes you home? I don't think I have an answer to it. How long do you want it to last? We can keep the machines running, [but] it's easy to get wrapped up in technology. . .In

> the hospital, you did turn around, but your body is still struggling. [I'm] not sure your body made as much progress as we hoped. (field note)

The social worker suggests that the patient and her daughter should not place their hope in the machines that are keeping her alive. Shortly after this, the patient and her daughter decide to accept palliative care.

In a separate field note excerpt, the chaplain shows that the reattribution of patients' emotions is aligned with the care team's goal of client acceptance of palliative care. Leading a prayer with the family of a patient suffering from metastatic cancer, he prays: "Our hope is that she will be at peace and comfortable spiritually and physically" (field note). The chaplain suggests to the family members that they should hope for their loved one's peace and physical comfort. He could have said something like "Let's hope for God to guide the doctors' hands" or, more directly, "Let's hope for a cure." While he acknowledges that patients and their families can feel hope, the chaplain intimates that their hope should be placed in the relief that comes from choosing palliative care.

In the following excerpt, a provider validates and reattributes fear. A doctor consults with a patient, who is so ill she can barely speak, and her daughter about a feeding tube. Feeding tubes can be very painful (McClave et al., 2016), and the doctor seeks to discourage the patient from accepting a feeding tube by validating her struggles and redirecting her fear toward curative treatment.

Doctor:	What is your idea of a feeding tube?
Patient:	No.
Daughter:	But maybe you can. . .
Doctor:	People can get pneumonia with feeding tubes. You are fighting a lot and that's not easy. I want to help you all decide because it's hard for the family to let go of you. (field note)

As shown in this quote, the patient begins to go along with the provider's recommendations by refusing a feeding tube, but her daughter asks her to reconsider. Before the conversation can continue, the doctor intervenes to explain the negative side effects that can result from this procedure and to intimate that a feeding tube would add fears. By noting these side effects, the provider suggests a corrective feeling rule to the patient and her family—that continuing curative treatment should be frightening. Providers use feeling rule suggestions to encourage voluntary compliance by directing patients' emotions toward circumstances that can be solved by complying with professional recommendations. In the next section, we provide extended vignettes from the data to show in more detail how providers gain voluntary compliance through feeling rule management.

Obtaining voluntary compliance: vignettes and counts

The first case we present, from start to finish, features a patient and her family who were reluctant to accept palliative care but ultimately complied with the team's recommendations for a palliative treatment plan. The patient is a 79-year-old woman with metastatic lung cancer. She was admitted by her oncologist to the field site hospital to receive a pacemaker. The hospital cardiologist recommended against a pacemaker due to her advanced cancer, but the family continued to push for it instead of palliative care. After asking about the patient's general plans for the end of her life, to which the patient said, "I don't know," the PA asks her about her cancer.

PA:	What is your understanding of your cancer right now?
Patient:	It is slowly growing.
Doctor:	Treating a malignancy that we can't cure *can affect other things such as pneumonia.*

Here, the doctor hints that continuing curative treatment may lead to pneumonia (i.e., by suggesting a corrective feeling rule related to fear). The family ignores the doctor's mention of pneumonia and talks about how the whole family takes care of their mother. They perform chores that she used to do, such as cooking and washing the dishes. They sleep in the same room in case she has trouble breathing or otherwise needs assistance. After hearing this, the PA inquires about and the doctor validates the patient's unwelcome experience of feeling like a burden:

PA:	Are you worried of being a burden?
Patient:	Yes.
Doctor:	Nobody wants to be [a burden.]

As the meeting continues, the social worker joins the conversation as the discussion seeks to reattribute the family's emotions to circumstances that align with providers' goals.

Social worker:	[To the family] Also, think, if her pneumonia gets bad and she needs a ventilator, *how good will she be when the ventilator is taken out?* What will be the quality of life?
Son:	[To his mother] Do you understand about the tube that goes into the throat?
Social worker:	[Before the patient responds] *You can't eat or drink.*
Doctor:	Yes. *And there's a chance that you may not come out of it.*
PA:	Just because we *can* do this or that doesn't mean we *should*.
Doctor:	I would like to share my medical opinion. If it's so bad that she needs a ventilator, *it will be hard for her to recover and have a good life*. If she wants to die peacefully, going on the ventilator will be hard to have any comfort of life although she can live a little longer. (brief pause)
Patient:	I want to die peacefully and quietly. (field note, emphases added)

Providers repeatedly note scary or uncomfortable side effects, emphasized in the excerpt above. In doing so, they suggest to the patient and her family that they should attribute their fear to continuing curative treatment. Before hearing suggestions of negative and fearful consequences, she was not ready to cease a curative course. After the feeling rule suggestions, the patient decided that she wanted to die "peacefully and quietly." She opted against the ventilator and complied with the palliative care plan. The feeling rule suggestions appear to encourage voluntary compliance.

The second case features a mixture of feeling rule suggestions. The chaplain visits a patient who recognizes that he is dying but has yet to accept a pain management program.

Chaplain to patient:	What's going on?
Patient:	I am dying.
Chaplain:	Liver failure? How long has it been happening?
Patient:	Year and a half.
Chaplain:	Is it going anywhere?
Patient:	They are trying everything.
	Patient discusses how he enjoys fixing different things at home.
Chaplain:	Sounds like being active is important for you. (pause)
Chaplain:	You tried a transplant, but your body did not accept it. There is a *chance of stroke and becoming a vegetable.* (pause)
Chaplain:	So, you are not interested about hospice, yet?

Table 3. Feeling Rule Management and Voluntary Compliance.

	Compliance	Non-compliance	Total
Feeling Rule Management	37 (73%)	14 (27%)	51
No Feeling Rule Management	13 (46%)	15 (54%)	28

Note: The total number of interactions here is lower than the total number of interactions in Table 2 because interactions were limited to provider–patient interactions in which a decision was reached about palliative care.

Patient:	Not yet.
Chaplain:	*How many tubes going into your abdomen now?* Two or one?
Patient:	One.
Chaplain:	*How long will it stay?*
Patient:	As long as I live.
	Patient starts crying.
Chaplain:	Would you like a prayer?
Patient:	Yes
Chaplain, in prayer:	We cherish life. Lord, *there will come a time when life comes to an end. We can draw strength and comfort from you.* We pray in Jesus's name. Amen. (field note, emphases added)

The chaplain suggests that continuing curative treatment is frightening when he mentions the risk of stroke and the patient becoming a vegetable. The suggestion that the patient should reattribute hope occurs at the end, during the prayer, when the chaplain hints the patient should hope for relief, strength, and comfort rather than a cure through medicine. The patient agreed to accept palliative treatment shortly after hearing these feeling rule suggestions.

We present a count of our interactions to support our claim that patients voluntarily comply with recommendations for palliative care after experiencing providers' feeling rule management. Table 3 compares the rates of patients' accepting palliative care after hearing suggestions of corrective feeling rules versus not hearing them. Although caution must be exercised when interpreting counts developed from qualitative research, the data are suggestive. When consultations included feeling rule management, patients complied with providers' suggestions for palliative care 73% of the time. The compliance rate was 46% when providers did not manage the feeling rules governing the consultation.

Discussion

Motivated by the understanding that professional authority is performed and earned when it was once assumed or guaranteed (Anteby, Chan, & DiBenigno, 2016; Bourgoin, Bencherki, & Faraj, 2020; Huising, 2015), we investigated the strategies that professionals use to encourage client compliance with an eye toward emotional strategies, in particular. Based on our ethnography of palliative care consultations, we claim that professionals manage broader feeling rules surrounding palliative care, and in doing so, manage client compliance. In this section, we more formally define the concept of feeling rule management, explain how the concept interfaces with and expands existing literature, and propose the conditions associated with professionals' use of feeling rule management to foster client compliance and generate relational authority.

We define feeling rule management as the ability to influence the norms or social guidelines that direct how people should feel. We have shown that one way professionals manage feeling rules is by suggesting alternative rules that correct clients' lay understandings of the situation. Making

feeling rule suggestions validates clients' emotions and reattributes them to circumstances aligned with professionals' goals. We extend the literature on emotional labor in that feeling rule management encompasses more than feeling rule reminders, defined as sanctions that result when a person's emotions or expressions are incongruent with the emotion norms governing the situation (Hochschild, 2012). Given that enforcing norms or rules is part of management, feeling rule reminders are instances of feeling rule management. However, feeling rule management extends beyond reminders and enforcement of rules into suggesting corrective feeling rules, as we have shown here.

To illustrate the difference between feeling rule suggestions and feeling rule reminders, consider this. Feeling rule reminders encourage a change in a person's underlying emotion (deep acting) or in a person's expressions (surface acting). A classic example of a feeling rule reminder is receiving a nudge to the ribs when expressing emotions other than grief or sadness at a funeral, which communicates that a person's emotions or expressions are inappropriate for the setting. If providers were issuing feeling rule reminders in our data, they would have said "You shouldn't feel guilty about choosing palliative care." Instead, providers suggested that patients and family members could feel guilty and said that they should feel guilty about sustaining their own or their family's misery rather than choosing palliative care. Rather than negate patients' and family members' emotions or seek to change them, providers validate and reattribute them. Thus, we argue that feeling rule management is a contribution to emotional labor theory and that feeling rule management encourages client compliance, thereby reinforcing professional authority.

Feeling rule management directs empirical and theoretical attention away from the alteration of individual emotions or expressions to the broader feeling rules governing the situation. This shift brings into focus a different set of strategies that professionals can draw upon to generate authority. Given that feeling rules are largely symbolic, by which we mean they are social elements that shape meaning in a situation, feeling rule management is an instance of professionals' symbolic power. Symbolic power is the ability to alter meanings of what is considered appropriate in a situation (Bourdieu, 1991; Hallett, 2007). Professionals are well-positioned to exercise symbolic power. Symbolic power can stem from a position of rational-legal authority, legitimacy, or deference (Hallett, 2003, 2007). While we are not the first to suggest that professionals use symbolic power to gain compliance (e.g., Parnaby, 2009), we contend that a novelty of our study is showing that professionals use symbolic power to perform emotional strategies to encourage compliance.

Symbolic power is available to people who possess capital that is valuable in their sector of society (Bourdieu, 1991). For professionals, such capital is usually education and specialized knowledge (Abbott, 1988; Larson, 1977). Here, we draw attention to another form of capital that can be advantageous for professionals: emotional capital. Emotional capital is "composed of emotion-based knowledge, management skills, and capacities to feel" (Cottingham, 2016, p. 452). The knowledge, skills, and capacities are dependent on social location, such as hierarchies, occupational roles, organizational contexts, race, class, and gender (Cottingham & Erickson, 2020; Stacey, 2011; Wingfield, 2010). The professionals in our study have experience dealing with the emotional nature of palliative care work. As determined by the American Academy of Hospice and Palliative Medicine, a core competency for palliative care professionals is the "ability to recognize and respond to [providers'] own emotions and those of others" (HPM Competencies Project Working Group, 2009, p. 13). Here, the providers were able to draw on their emotional capital to suggest corrective feeling rules and win compliance. Thus, we posit that professionals' relational authority has symbolic and emotional roots.

Emotional capital can be developed through early-life socialization (Cahill, 1999) or through socialization later in life, such as through occupational training programs. For example, managers train salespeople in how to process rejection from potential buyers and in doing so build a set of

strategies and a base of knowledge that salespeople can use to manage their emotions on the job and clinch the sale (Schweingruber & Berns, 2005). Professional training programs socialize members to the feeling rules of the profession (Cahill, 1999; Smith & Kleinman, 1989). Often, these training programs teach the necessity of emotion regulation when a professional's own emotions would inhibit their work, as is the case of mortuary students learning how to suppress anxieties related to cadavers (Cahill, 1999). Our study suggests a need for training programs that teach professionals to harness emotions to address another impediment to their work—noncompliant clients. A hypothetical training program could be organized around Abbott's (1988) tripartition of professional work. In the diagnosis stage, professionals canvas patients' emotional states and identify which emotions the patients are feeling. In the inference stage, professionals decide how to package those emotions and how to suggest feeling rules that reattribute them to circumstances aligned with professional goals. In the treatment stage, professionals suggest alternative feeling rules to clients. Such training could be advantageous for managers who seek to create an emotional culture without invalidating employees' emotions. This type of training would go beyond management of professionals' or clients' emotions toward management of feeling rules. The value added of feeling rule management is that it is a tool that professionals and managers can use to build relationships with clients and employees and establish authority in their eyes. Importantly, our study shows that using feeling rule management builds relationships with clients on the premise of validating clients' emotions rather than on the premise of asking clients to change or otherwise regulate their feelings.

Though our setting is unique in its emotional intensity, we contend that feeling rule management could be used by professionals in other fields to foster client compliance and generate relational authority. For example, financial advisors use symbolic power to manage their relationship with clients, namely to assert the normalcy of market volatility and establish reasonable expectations for investments (Parnaby, 2009). It is possible that financial advisors manage feeling rules, too, and future research could investigate how feeling rule management differs in this field. A possibility is studying how financial advisors might validate and reattribute clients' feelings of anxiety related to risk. Another field that could be fruitful for studying feeling rule management is insurance. It is possible that agents encourage clients' purchase of insurance with a strategy akin to: "Don't worry about the effect of the insurance premium on your family's finances. Worry about what would happen to your family if something happens and you don't have insurance" (i.e., feeling rule management through suggesting a corrective feeling rule that validates and reattributes clients' emotions to a problem that the professional can solve). Such strategies may also be useful for neo-professionals seeking to establish legitimacy, such as self-employed management consultants (Cross & Swart, 2021), who could use feeling rule management to develop relationships with clients. Moving forward, we anticipate that feeling rule management will be most effective under two conditions: when performed in situations where professionals and clients have divergent perceptions of the emotional expectations of the encounter and when performed by people with a reservoir of emotional capital. Future research could investigate how feeling rule management does or does not achieve client compliance in these fields.

It is also possible that feeling rule management could be used to secure professional goals beyond those within the client encounter. We have focused on one type of relation (i.e., clients) and one type of interaction (i.e., professional–client encounters), but the relational perspective captures relationships with other stakeholders, such as legislators and organizational leaders. A promising example is how a nursing professional association, the American Association of Nurse Practitioners (AANP), advocated for expanding the scope of practice laws, and thus expanding professional autonomy, for nurse practitioners during the Covid-19 pandemic. In the early days of the pandemic, healthcare workers were rightly worried about the biological effects of the novel

coronavirus on patients, such as suffering and death. The AANP used what could be considered feeling rule management to argue that governors should lift or temporarily suspend laws that require physicians to oversee nurse practitioners' work. The tenor of the conversations about the healthcare workforce and Covid seemed to be, "Yes, we should fear what Covid will do to patients' bodies. At the same time, we should fear Covid patients overwhelming the healthcare system." The suggestion seemed to be that fear is valid and should also be attributed to a problem that the AANP could solve—a shortage in the healthcare workforce. Governors expanded the scope of practice laws for advanced practice nurses in 22 states to ward off fears that too few healthcare workers would be available to provide adequate care (Thomas, Feyereisen, McConnell, & Puro, 2021). By validating fears and attributing them to a problem the profession could solve, the AANP managed feeling rules and achieved the professional gain of expanded autonomy for nurse practitioners. Future research could investigate how, for example, professionals use feeling rule suggestions to win other professional gains beyond client compliance.

While our data suggests that feeling rule management increases compliance, our study is limited in that we cannot identify how patients have come to the decision to accept palliative care after hearing professionals' feeling rule suggestions. Doing so would have required in-depth interviews with patients, which our Institutional Review Board would not approve. We suspect that a kind of cognitive reframing occurs, where clients experience a shift in perception and re-evaluate their situation (Robson & Troutman-Jordan, 2014). Future research could use cognitive reframing as a starting point for investigating how clients interpret professionals' feeling rule management and subsequently comply with professional expertise.

Another limitation is that the size of the care team prevents us from making propositions about variations in emotional capital and feeling rule management strategies. These limitations do not prevent us from advancing the concept of feeling rule management, but they do point toward opportunities for future research. Future research could investigate whether individuals with different levels of emotional capital are more or less successful in feeling rule management. Another possibility is studying the differences in feeling rule management across occupational groups, which we were unable to do with only one or two representatives from each professional group in the care team at our field site.

In conclusion, how professionals establish their authority is important when their credentials, status, and expertise are no longer taken for granted. Given that jurisdictional control depends on the public's trust and confidence in professionals (Abbott, 1988; Freidson, 1970), it seems particularly urgent to study how professionals can act to reassert or maintain their authority through building relationships with clients. Professional work is as much about properly practicing professional knowledge as it is about developing a relationship with the client that aligns with a power dynamic in which professional knowledge is perhaps more applicable and more appropriate to the client's situation than the client's own lay understanding. Here, we have shown that professionals can do this by validating clients' emotions and suggesting a reattribution of those emotions to circumstances aligned with professionals' goals, a process we call feeling rule management.

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