Relieving Human Suffering: Compassion in Social Policy

Mary E. Collins
Boston University, mcollins@bu.edu

Sarah Garlington
Boston University, sgarling@bu.edu

Kate Cooney
Yale University, kate.cooney@yale.edu

Recommended Citation

Relieving Human Suffering:
Compassion in Social Policy

MARY ELIZABETH COLLINS

SARAH GARLINGTON

Boston University
School of Social Work

KATE COONEY

Yale University
School of Management

Human suffering is always present in society. There is general consensus that action should be taken to address suffering, but there are differing views as to the appropriate means of doing so. In this paper we utilize a classical understanding of the virtue of compassion to answer the research question: How does contemporary U.S. policy address human suffering through compassionate response? To answer this question, we conduct a critical analysis of three policy domains (hospice care, domestic violence, and disaster relief) to determine variation in response to human suffering. Comparisons among the domains suggest the various ways in which compassion can be observed within formal social policy. We discuss the implications of a compassion-focused approach to analysis of policies that address human suffering, and more broadly, the use of a virtue-oriented perspective on policy.

Key Words: *critical policy analysis, compassion, virtue ethics, human suffering*

Human suffering is always present in society. Although it may take different forms in different historical and societal contexts, there are elements of suffering even in the most advanced and prosperous societies. Indeed, modern prosperity, while reducing some forms of suffering (e.g., widespread hunger) may engender other types of suffering (e.g., alienation, social

isolation). Furthermore, although individuals may experience suffering, there are societal implications as well. Suffering "is always morally regrettable" because it clearly suggests that society is not operating at its best level (Comte-Sponville, 2001, p. 106). To address suffering as a societal problem, the question for policy makers then centers on the appropriate policy response.

Although compassion is a term widely used by both professional and lay audiences, it is more narrowly defined within moral philosophy. One contemporary philosopher (Comte-Sponville, 2001) explains that compassion is a form of sympathy; it is sympathy in pain or sadness—in other words, participation in the suffering of others. Furthermore, within some perspectives, all suffering deserves compassion; acting compassionately does not imply that one approves of the sufferer or that the reasons for the suffering have met a standard of deserving a compassionate response. Rather, to act compassionately "means that one refuses to regard any suffering as a matter of indifference or any living being as a thing" (p. 106).

In this article we use compassion as the central concept of a critical analysis of three social welfare policies that address different forms of human suffering. To provide background we first give a brief description of virtue ethics as applied to social work and social policy and we introduce some recent treatments of compassion within the policy literature.

Virtue Ethics in Social Work and Social Policy

Although the study of virtue is traced to antiquity, in modern scholarship Alistair MacIntyre (1981) is credited with providing a contemporary approach to the study of virtue and impacting the study of virtue across many disciplines. Thus, in addition to coverage in modern philosophy, there is increasing study of virtue in fields related to social policy, such as political science (Bartlett, 2002), policy analysis (Lejano, 2006; Szostak, 2002, 2005), and organizational studies (Dutton, Worline, Frost, & Lilius, 2006; Manz, Cameron, Manz, & Marx, 2008; Weaver, 2006). Social work scholars, also, have begun to examine the reality and potential of virtue frameworks. Banks and Gallagher (2009), scholars in the United Kingdom, have

provided a book-length treatment of virtue ethics in social work and health care professions. In the U.S., the attention has been more limited but appears to be growing (Adams, 2009; Chamiec-Case, 2013).

Adams (2009) notes that historically social work ethics has focused on the resolution of dilemmas in practice; he then articulates the role of virtue ethics as critical to social work. As Adams identifies, modern virtue ethics, consistent with the older tradition of Aristotle and Aquinas,

> conceive a human life as a history in which each choice we make disposes us to make similar choices in the future, so that ethical conduct becomes a matter of dispositions or character—virtues and vices acquired by practice and lost by disuse—rather than episodic, purely rational choices. (2009, p. 85)

Virtues are stable dispositions and character traits; these are what matter to social work—"how well we act, as a matter of habit and will in the professional use of self, in ways required for and developed by practice within the profession of social work" (Adams, 2009, p. 88). Chamiec-Case (2013) makes a similar case in regard to social work education and the need to move beyond the more observable practice behaviors to the cultivation of virtuous character.

Discussion of "values" is more common to social work, but values and virtues are related concepts. Chamiec-Case (2013) helpfully distinguishes virtues from values.

> Although values and virtues have some important similarities …, values are *beliefs* about what is most important to us, what we consider our priorities, and what we believe has worth. Virtues on the other hand, are the deeply ingrained *traits or dispositions* which form our character—what fundamentally makes us who we are and is manifested in our actions. (p. 259, emphasis in original)

Virtues' focus on character is also applicable at the larger macro level. Organizational mission, for example, identifies the character of the agency that will impact the deci-

sions it makes and actions it takes. Dutton et al. (2006) discuss this specifically in regard to the virtue of compassion at the organizational level. In the same way, policies can be indicative of the character of a society. One example at the municipal level is the U.S. Conference of Mayors' recent statement adopting compassion as an effective policy for their communities (U.S. Conference of Mayors, 2013).

Virtue of Compassion in Politics and Public Policy

Other virtues are more commonly articulated in policy discussions; examples include justice and mercy (especially within criminal justice systems), self-sufficiency (within welfare policy), and forgiveness (in discussions of reconciliation of national or racial/ethnic groups). Compassion does not get as much attention in policy discourse but may have a role in undergirding policies in more subtle ways. In his *Book of Virtues*, William J. Bennett (1993), typically a conservative commentator, states a belief that the virtue of compassion may have once been undergirding America's immigration policy: "Lazarus's poem [The New Colossus], like the Statue of Liberty, came to popularize America's mission as a refuge for immigrants. Here is compassion as a national policy, one of America's great national policies" (p. 179).

In the U.S., both conservative (Olasky, 2000) and liberal (Nussbaum, 2001) voices have articulated the potential for compassionate responses to relieve human suffering. Olasky sees potential for compassionate responses through community volunteers and faith-based organizations and Nussbaum through institutional structures and educational strategies.

Through compassionate conservativism, Olasky advanced a specific position, promoted by President George W. Bush, on the role of government in responding to human need that called for government action in partnership with churches, synagogues, mosques and charities to support compassionate responses delivered by friends, families, professionals, volunteers, or strangers (Olasky, 2000; Pilbeam, 2003). As compassionate conservatism became defined by the 2000 presidential campaign of George W. Bush, compassion meant "suffering with the poor and acting on the consciousness of your suffering" with the role of government to "shift power

away from the bureaucracy to the people in the compassionate community, who actually deal with these problems" (Olasky, 2000, p. 13).

Compassionate conservatism as stated by Olasky (2000) emphasizes a diminished role of "big government" in responding to needy Americans through programs, and prescribes a government role that supports civil society and religious actors to perform this front line work. Olasky also stresses the transformational power of responding compassionately for the giver of compassion, as well as for the recipient. As the term compassionate conservatism suggests, the attention to "compassion" is combined with prescriptions for behavioral modifications in the needy or the poor (described as "challenges to change") associated with the goals of social conservatives and with attention to costs, effectiveness and outcomes associated with concerns of fiscal conservatives. Thus, most of the recent attention to compassion in social policy has been situated within the discourse on compassionate conservatism as initially articulated by Olasky and adopted by the G.W. Bush administration. Much of the scholarly literature has examined the resulting faith-based initiatives, their promise, politics, and impact (e.g., Biebricher, 2011; Persons, 2011).

While compassionate conservatism has been the most recent dominant discussion of compassion in public life, more liberal perspectives also utilize compassion as central concept. A liberal standpoint would suggest that, like other manifestations of social assistance, compassionate action historically occurred within the family and community. As societies become more complex, however, government has taken on responsibilities previously held by smaller units, such as the family and community. Social welfare policy literature, for example, describes the way industrialization necessitated creating government structures to assist individuals as family and community structures changed (Huber & Stephens, 2001; Pampel & Williamson, 1989; Wilensky, 1975; Wilensky & Lebeaux, 1958). Economic and social changes wrought through the industrialization process included geographic mobility, smaller families, dislocation from traditional communities, and new structures of work. The increasing wealth of the state from tax revenues provided resources with which the state could address the needs of individuals who could no longer rely on extended

family and community networks for assistance.

Addressing compassion specifically, Nussbaum (2001), in contrast to conservative perspectives, suggests that compassion should be approached at both the level of individual psychology and institutional design. According to Nussbaum (2001) prescriptions for institutional design include such things as the basic structure of society, choice of its distributional principles, and legislation at a more concrete level (e.g., tax code, welfare system, duties of rich nations toward poorer nations). Institutions also teach citizens "conceptions of basic goods, responsibility, and appropriate concern, which will inform any compassion that they learn. Finally, institutions can either promote or discourage, and can shape in various ways, the emotions that impede appropriate compassion: shame, envy, and disgust" (2001, p. 405).

Application to Policy Analysis: Values and Virtues

Public policy analysis has historically tended to focus on narrow rather than "big" questions. It is client-oriented and therefore the ends and goals are provided, and it has tended to emphasize method over theory (Radin, 2000). Consequently technical, quantitative approaches are dominant. Yet, Carrow, Churchill, and Cordes (1998) argue that "social values" should be at the center of both public debate and policy analysis. Social values are one of the many factors that influence policy choices, design, and implementation. Lipset's (1996) major work on the specific values that inform welfare policy, contrasting individualism in the United States to more communitarian values in European welfare states, exemplifies the traditional way that values-based policy analyses have been conducted.

Because virtue approaches emphasize character, behavior and action rather than mere value perspectives, they may be better suited for analyzing policy. Situated within ethical evaluation, virtue ethics emphasizes moral character, in contrast to ethical analysis, which focuses on either duties or rules (deontology) or the consequences of actions (utilitarianism) (Hursthouse, 1999). Szostak (2005) suggests that virtue-based approaches to policy analysis represent a form of "process ethics." Lejano (2006) states, "Virtue is actually a strong component in policy discourse, though it may be masked as other

things" (p. 141).

Elsewhere we have identified examples of the virtues of mercy, self-sufficiency and compassion within contemporary policy (Collins, Cooney, & Garlington, 2012). Justice is a virtue that receives extensive attention in both academic (philosophy) and applied (legal) discourse (e.g., Rawls, 1971; Reilly, 2006). Our purpose in this paper is to present a policy analysis with the virtue of compassion at the core. To do so, we examine three policy domains in which suffering is likely to occur and provide a descriptive analysis of relevant policies targeted toward those affected. We then compare across the domains to identify areas of variation. Although we have selected one virtue for analysis, we recognize that compassion is not the only relevant virtue to guide public policy. It is, however, central to improving the human condition and is consistent with social work's commitment to vulnerable populations. In our conclusion, we address how compassion might interact with other relevant virtues.

Methods

The recognition of suffering and compassionate response should be aimed at circumstances in which there has been a loss of "truly basic goods" (Nussbaum, 2001, p. 374) such as life, loved ones, freedom, nourishment, mobility, bodily integrity, citizenship, shelter. Similarly, Porter states the losses leading to suffering must be non-trivial: "serious pain, anguish, torture, misery, grief, distress, despair, hardship, destitution, adversity, agony, affliction, hardship, and suffering" (2006, p. 100). Following this scholarly guidance, we selected fairly unambiguous instances of suffering for examination: terminal illness, violent victimization, and community disaster. We then identified specific, relevant federal domestic policies that address these types of suffering: the Medicare Hospice Benefit, the Violence Against Women Act, and the Stafford Disaster Relief and Emergency Assistance Act.

In this section we provide a description of these policies organized according to the following criteria: (1) form of aid; (2) eligibility criteria; (3) service delivery system; (4) role of religion; (5) language cues in the policy regarding suffering and compassion; and (6) implementation challenges. Table 1 identifies key elements of the policy according to the identified

Table 1: Characteristics of Policies

Policy domain/ Legislation	Form of aid/Eligibility determination	Service delivery system	Role of religion/religious organizations	Explicit language of suffering and compassion	Implementation challenges
Hospice: Medicare hospice benefit (1982)	Palliative care to provide comfort; eligibility: terminally ill, certified by doctor, patient decision to seek hospice care and end treatment of disease.	Medicare reimbursement to private contractors providing hospice services/Hospice services include doctors, nurses, social workers, pastoral staff, and volunteers.	Death is central concept in religious beliefs; dignity of human life; pastoral care has key role	Explicit goal is to ease suffering and reduce pain, not to treat the disease.	Factors (societal difficulties dealing w/death, medical emphasis on cure) may prolong treatment and delay hospice.
Domestic violence: VAWA (1994, 2000, 2005)	Coordination of multiple systems; crisis care, shelter, legal assistance, emotional support; emphasizes linguistic and culturally specific services. Eligibility: determined by individual service providers but must be victim, (usually women), emphasize non-discrimination based on other issues.	Federal grants to states and communities: formula grants and specialized grants./ Professional (social workers, counselors), paraprofessionals and volunteers. Advocates committed to the cause.	Culturally-bound perspectives on problem can be a barrier to service; religion as key element of culture could be central to intervention	"Victim" and "empowerment" language rather than "suffering" and "compassion."	Services provided in context that can be ambivalent about the problem; cultural differences regarding violence, gender, etc.; service recipients are a disempowered group.
Stafford Disaster relief: DREAA (1988)	Coordination of multiple federal, state, local systems: crisis care for individuals (food, shelter, counseling); eligibility: Presidential determination.	FEMA coordinates with state and local agencies. Red Cross key component. Coordination w/ police, fire, public health, etc., Other private professionals (doctors, nurses, social workers) and community volunteers.	Primarily through the role of community volunteers who may be related to congregations; focus on provision of concrete assistance (food, shelter); some instances of resource coordination	"Responsive and compassionate care for disaster victims is FEMA's top priority."	Extensive coordination of multiple complex systems; by definition response occurs on an "emergency" basis; potential politics in declaring federal emergencies.

criteria.

Comparative analysis across the domains highlighted consistencies and differences in policy approaches. These observations led, in turn, to operating assumptions regarding the role of compassion in public policy. Our discussion is based on this comparative analysis.

Findings

Terminal Illness: Medicare Hospice Benefit

U.S. policy regarding the use of hospice care is primarily in the form of the Medicare hospice benefit which provides payment for care related to terminal illness. The hospice philosophy is the provision of comfort and support to terminally ill people and their families when a life-limiting illness no longer responds to cure-oriented treatments (Myers, 2002). This comfort includes multiple domains (physical, psychic, social, and spiritual comfort) and aims neither to hasten nor postpone death (Mesler & Miller, 2000). When the conditions are met (see below), a plan of care is devised by an interdisciplinary team. The benefit covers reimbursement for the following services: skilled nursing care; medical social services; physician services; patient counseling (dietary, spiritual, other); short-term inpatient care; medical appliances and supplies; drugs for pain control and symptom management; home health aide services; homemaker services; therapy (physical, occupational, and speech); inpatient respite care (providing a limited period of relief for informal caregivers by placing the patient in an inpatient setting like a nursing home); family bereavement counseling; and any other item listed in a patient's care plan as necessary for the palliation and management of the terminal illness (Medicare Payment Advisory Commission [MedPAC], 2004).

The hospice benefit falls under Part A of Medicare, which the beneficiary receives automatically with Medicare coverage. Three conditions must be met: (1) the patient's physician and the hospice medical director certify that a patient is terminally ill, with a life expectancy of 6 months or less; (2) the patient chooses to receive care from hospice rather than treatment for the terminal illness; and (3) care is provided by a hospice program certified by Medicare. A recognized source of

ambiguity is that no common language exists for determining if and when end-of-life care (hospice admission) is appropriate (Brickner, Scannell, Marquet, & Ackerson, 2004).

Hospice care under Medicare became law as part of the Tax Equity and Fiscal Responsibility Act passed in August 1982. Miller and Mike (1995) provide an historical summary of the Medicare hospice benefit. A major impetus of the federal legislation was the recognition that death is expensive; hospice care could offer humanitarian help and also save Medicare funds. Although in early years there was concern about the low use of the benefit, in more recent years it has grown rapidly (MedPAC, 2004).

Hospice services require coordination, but this occurs at the individual case level in terms of a team approach to service delivery. The policy is explicit regarding the interdisciplinary nature of the team (registered nurse, medical social worker, physician, and pastoral or other counselor). A hospice nurse and doctor are on-call 24 hours a day. The use of volunteers is also required; volunteer service must constitute five percent of paid staff hours.

Explicit reference to easing suffering and reducing discomfort are provided in the legislation. Easing suffering is the primary goal of the policy with attention to multiple aspects of suffering. The legislation also recognizes the suffering of family members with provisions for respite and for bereavement counseling after the patient's death. In addition to language, there are visual images in policy documents that also convey compassion. The official government booklet describing the Medicare hospice benefit has a picture of hands-holding-hands on the cover (Centers for Medicare and Medicaid Services, n.d.). Such imagery reflects the "suffering with" concept of compassion.

The main implementation challenges associated with hospice care are societal and cultural factors that can make it difficult for people to address impending death. Physicians have expressed concerns that referral to hospice communicated "giving up" on a patient (Mesler & Miller, 2000). Some types of death have specific associated stigmas and misunderstandings (Shega & Tozer, 2009). Minorities are less likely to utilize hospice care, potentially due to differences in culture related to views of death, differences in religion, and lack of

access to health care and health facilities (Crawley et al., 2000)

In summary, hospice care seems to be a good fit with the classical definition of compassionate response, "to be with in suffering." Moreover, issues related to death (and afterlife) have obvious relevance to religious beliefs. The hospice team is consistently available through the time period of care until the time of death, including some follow-up with surviving family members. All team members are presumably committed to the hospice philosophy. Explicit inclusion of counseling-oriented staff (e.g., social workers, pastoral care) ensures attention to emotional needs in addition to technical aspects such as pain management.

Domestic Violence: Violence Against Women Act

In the 1970s, domestic violence shifted from a private family matter to a public social issue through the work of feminist grassroots organizations. Over the next twenty years, civil protection orders became more available to victims of domestic violence and non-arrest policies of local police departments began to change (Sack, 2004). The Violence Against Women Act of 1994 (P.L. 103-322) (VAWA) was passed by Congress and signed into law by President Clinton. It has been reauthorized by Congress in 2000 and 2005. VAWA created national legal structures for enforcing domestic violence as a crime and provides funds to states for services. While VAWA discusses extensive systems-level change (e.g., arrest policy, prosecution protocol), the community programming-oriented policy is most relevant to the discussion of compassion.

Under VAWA, the federal government provides grants to states for the funding of community organizations (Rosewater & Goodmark, 2007). The Office on Violence Against Women, located within the U.S. Justice Department, administers grants under VAWA and develops federal policy around domestic violence and related issues. Domestic violence was the primary initial focus of VAWA; however, the focus has expanded to other forms of violence disproportionately affecting women, such as stalking, workplace violence, and victimization of specific groups, such as elderly or disabled individuals.

Victim services specific to domestic violence are provided by community organizations. These services include: crisis hotlines; medical and legal advocacy; temporary housing; mental

health counseling; and coordination with other services. The core operation of these domestic violence organizations is to provide support, whether material or emotional, in the form of shelters and other aid. Women disproportionately experience domestic violence (Tjaden & Thoennes, 2000), hence the majority of programs offer services only to women. Other eligibility requirements may apply, such as income, geographic residency, drug and alcohol history (Sack, 2004), but VAWA emphasizes the need for assisting all victims in crisis, regardless of other characteristics.

Delivery of domestic violence victim services occurs through a combination of government and private grants to community organizations, as well as the coordination of community services with other service systems (police, social services, court, etc.). Providers include social workers and other social service personnel, paraprofessionals (for example, shelter workers), and trained volunteers. Service providers have a range of roles, from counseling to legal and medical advocacy to coordinating broader services (such as long term housing, etc.).

Because of the potential for severe physical harm, domestic violence services focus initially on the safety of the victim. As part of this, VAWA language emphasizes the suffering of the victim and the need to address this suffering. However, VAWA also focuses on empowering the individual beyond her victim status. Implementation challenges range from cultural differences in the understanding of domestic violence to drug and alcohol use to persistent violent relationships (Burman, Smailes, & Chantler, 2004).

Services to domestic violence victims require some coordination, but this typically occurs at the community level, as opposed to the individual case-level, through the establishment and maintenance of coalitions. Religion is closely connected with culture, and religious leaders (e.g., ministers, etc.) are often on the front-line in addressing problems that face women and children. Consequently, issues related to faith can have an important role in addressing the needs of victims, and religious organizations, therefore, are important in coalition efforts (National Resource Center on Domestic Violence [NRCDV], 2007a). The coalition approach has been central to this policy domain, reflecting both an effort to coordinate

services and also to be a stronger political force in the fight for justice. Domestic violence services, particularly through shelters, emphasize interpersonal contact between sufferer and service providers. Within a shelter, the milieu approach facilitates a physical nearness with the suffering and potentially can be fairly long-term. The interaction of service providers and clients, and between clients, provides the emotional element of compassionate response.

Explicit language of suffering and compassion was not found in the VAWA legislation. Instead, use of empowerment language was common. This is consistent with more of a rights-based strategy of achieving justice. This legislation and its service system have been highly intertwined with advocacy for victims, seeking not only potentially compassionate care but also justice in both courts and relationships.

The main implementation challenges associated with compassionate response in domestic violence are related to continued societal ambivalence regarding this type of violence as a social problem versus a private problem. Moreover, although in reality there is little religious justification for marital violence (NRCDV, 2007b), an abusive mentality may aim to use religious traditions to justify abusive actions. Victims, themselves, may struggle to regard their own circumstances as worthy of compassionate response. Furthermore, as our analysis pointed out, compassion does not appear to be the primary response desired. Empowerment and consequently, justice, appear to be the overriding considerations of intervention.

Community Disaster: Stafford Act

The key federal policy in this domain is the Robert T. Stafford Disaster Relief and Emergency Assistance Act. (P.L. 93-288, as amended, 42 U.S.C. 5121-5207). This legislation provides statutory authority for most federal disaster response activities, especially as they pertain to the Federal Emergency Management Agency (FEMA). More recent legislation in response to the September 11th terrorist attacks and the aftermath of Hurricane Katrina (i.e., Homeland Security Act and Post Katrina Emergency Management Reform Act) also has implications for disaster management.

Title 1, Sec. 101(a) of the Stafford Act states:

> Congress hereby finds and declares that—(1) because
> disasters often cause loss of life, human suffering, loss
> of income, and property loss and damage; and (2)
> because disasters often disrupt the normal functioning
> of governments and communities, and adversely affect
> individuals and families with great severity; special
> measures designed to assist the efforts of the affected
> States in expediting the rendering of aid, assistance,
> and emergency services, and the reconstruction and
> rehabilitation of devastated areas, are necessary.

Both "emergency" and "major disaster" are defined in the leg-
islation. In both cases the determination of the President is re-
quired to assess that the scale is beyond the capabilities of state
and local efforts to address alone.

FEMA works in partnership with other organizations to
form the nation's emergency management system. Partners
include state and local emergency management agencies, 27
federal agencies and the American Red Cross. FEMA's core
operations include: service to disaster victims; integrated pre-
paredness; operational planning and preparedness; incident
management; disaster logistics; hazard mitigation; emergency
communications; public disaster communications, continuity
programs. As identified, services to disaster victims is listed
first and is described as follows: "Responsive and compas-
sionate care for disaster victims is FEMA's top priority." The
website of the American Red Cross identifies the organization
aim of "preventing and relieving suffering." Moreover, in ad-
dition to their role in domestic disaster relief, they offer "com-
passionate services" in other areas (such as educational pro-
grams that promote health and safety).

The overall service delivery system is highly complex and
involves a variety of entities and professional groups (e.g.,
civil engineers, public health, police and fire). Coordination is
an obvious central element. Moreover, each of the individual
core operations would call upon different types of skills and
expertise. The focus on services to disaster victims (as opposed
to hazard mitigation) would be the "operation" where com-
passion might be expected. This operation alone, however, still

suggests extensive collaborative efforts would be required.

Roberts (2010) provides a discussion of the evolution of national disaster policies and the relevant implementing organizations in the U.S. Partially in response to the uncoordinated nature of many agencies, in 1979, President Carter established FEMA by executive order, which merged many of the separate disaster-related responsibilities into a single agency. More recent developments have been in response to the terrorist attacks of 2001 and the highly public and widely criticized failures of FEMA during and after Hurricane Katrina. FEMA became part of the Department of Homeland Security in 2003.

The coordination of disaster management is extensive and involves all levels of government and the private sector. Moreover, because disaster management must anticipate a wide range of disasters and emergencies, planning involves a number of units that may or may not be actually called upon in a disaster.

Within the disaster relief domain, the nearness to the sufferer and the potential for long term involvement would appear more variable than in the case of hospice and domestic violence. Partially this is due to the characteristics of emergencies—they are sudden and of varying types. Moreover, in the immediate emergency, priority may be given to concrete assistance, particularly if danger is still imminent. Long term assistance, both concrete and emotional, would generally not be provided, but one role of the service delivery system would be to link persons with other potential sources of help. Research into the activities of churches during and after the events of Hurricane Katrina, for example, show that faith-based organizations played an equally significant role, compared to FEMA and other secular organizations, in providing assistance to victims both in short and long term capacities (Cain & Barthelemy, 2008; Hurst & George, 2009).

The main implementation challenges associated with compassionate response in disaster management are the extensive coordination of multiple systems, preparation for events which often occur suddenly, and the potential politics involved in declaring federal emergencies.

Discussion

Each of these policy domains included some elements of interpersonal connection, but utilized differing means of providing this connection. Furthermore, coordination was central in each domain, but the mechanisms of coordination and the relevant parties involved in coordination were sources of variation. The compassionate delivery of aid is found within each of these three policy areas, but in each case it is a small part of a much larger policy. This is particularly the case for hospice (which exists in the large Medicare program) and disaster management (in which service to victims is one of several core operations). Other areas in which we found variation that has relevance to providing authentic compassion include policy origins, mechanisms of interpersonal connections, social constructions, time horizon, and the primacy of government role in addressing suffering. These are discussed further below.

Policy Origins

Each of the three cases reflects quite different policy origins. The hospice benefit was a development within Medicare, a widely enrolled and supported program within the Social Security Act. Although hospice care is well-connected to known conceptions of compassion, interest in providing it as a benefit through public policy was also largely related to cost considerations. VAWA had different origins. This legislation was the culmination of long-standing grassroots efforts to acknowledge the social problem of domestic violence, and consequently provide assistance to its victims. Stafford legislation evolved from numerous, earlier, largely uncoordinated efforts to prepare for and respond to both natural disasters and other large-scale emergencies.

Each of these policy areas has continued to develop, especially VAWA and the Stafford Act. These developments have come about in response to new knowledge development as well as political considerations. For instance, VAWA reauthorizations have included attention to specialized groups (e.g., immigrant communities, elders), which may provide unique considerations, and Stafford reauthorizations have recognized the changing nature of threats (e.g., terrorism), updated technologies, and post-Hurricane Katrina outrage at the ineffectiveness

of FEMA. In comparison, the Medicare Hospice benefit has remained relatively unchanged, although policy discussions surrounding health care reform included some focus on end-of-life decision-making.

Interpersonal Connection

The definitional element of compassion, "to be with in suffering" requires nearness to the sufferer and the essential element of human contact. This distinguishes a compassionate response from other types of helping, such as charitable aid to ease financial distress. Furthermore, some length of time might also be implied. In circumstances where suffering is of a long-term nature, a caring response that is too brief may not fit with an understanding of "being with" in suffering.

Each of the policy domains examined provides for interpersonal contact with sufferers, both through professional intervention and the use of volunteers. This is particularly important because the common use of the term "compassion" often does not recognize the necessity of the interpersonal relationship required. In each of the three policy domains, those on the front lines doing the bulk of the compassionate work would need to handle the emotional demands of being with people as they are suffering. It is not easy to sit with people who are dying, have been battered, or are in emotional distress because of a community emergency. A human instinct is often to recoil from such pain. Individuals have varying capacities to approach people in physical or emotional distress. Professional training (social work, nursing, ministry) typically provides targeted attention to helping individuals become emotionally capable of handling grave distress. Moreover, professionals generally choose the kind of work they are comfortable doing, and thus can avoid these types of activities if they perceive themselves unable to handle certain types of situations (e.g., imminent death).

Volunteers are central to service delivery (e.g., spend time with the sufferers) in each of the domains. Religion is a central motivation for many volunteers, and churches are often the conduit for connecting individuals with volunteer opportunities. It is this nexus where compassion, based on religious tradition, has the potential to be most conspicuous. But volunteers may only be capable of certain types of helping. The

type of training volunteers receive is likely to fall far short of the emotional and technical capacities needed to assist in circumstances of real suffering. Additionally, as Evans (2011) has noted in her discussion of the UK's Big Society, volunteers are not free. The infrastructure needed to recruit, train, manage, and support volunteers can be costly.

Social Construction of Problems/Populations

Classic writing of Ryan (1976) gave prominence to the phrase "blaming the victim" and outlined some of the psychological and social processes that result in attributing blame for an individual's misfortune to actions or characteristics of that individual rather than to social conditions. Ryan emphasized the sociological aspects of victim-blaming process, i.e., maintenance of current class structures and their inequalities as a primary motivation for defining social problems as residing within individuals rather than larger systems.

Even within the three relatively unambiguous cases examined—terminal illness, violent victimization, community disaster—there can be efforts to blame the victim for his/her misfortune and, therefore, to negatively affect the delivery of compassionate response. The aftermath of Hurricane Katrina provides the most drastic example of this (Napier, Mandisodza, Andersen, & Jost, 2006). In the case of domestic violence, VAWA was enacted due to long-term efforts to change victim-blaming in domestic violence cases. Through the advocacy work of VAWA-funded coalitions, this work continues. The case of terminal illness is less likely to result in victim-blaming, although there can still be psychological and societal pressures to avoid illness and death.

Victim-blaming inclinations are entwined with beliefs about deservedness, i.e., whether one is responsible for the difficult circumstances they are in and, consequently, whether they should receive assistance. Discussions of this have a long history and cross many disciplinary and professional boundaries. Our review of the literature suggests division as to whether deservedness is needed in order to obtain a compassionate response. Nussbaum (2001), for example, suggests the reason for the suffering is relevant in determining whether compassion is appropriate, whereas others (e.g., Comte-Sponville, 2001; Whitebrook, 2002) suggest that a lack of attribution of blame is

characteristic of a compassionate response and contributes to its moral weight.

In policy discussions, "deservedness" and "power" are key concepts to the social construction of target populations; those considered more deserving and more powerful are likely to get more favorable treatment in social policy (Schneider & Ingram, 1993). Those affected by community disaster, those who have been victims of violence, and those who are near death are all likely candidates for a compassionate response. Yet, the circumstances leading to this suffering may be considerations as to whether compassion is the predominant virtue observed and supported by the political environment.

Time Horizon

"To be with in suffering" provides no indication regarding the appropriate time period for engaging in compassionate action. Some suffering occurs over a long period of time. The hospice care benefit is unique regarding the time horizon; while terminal illness has qualities of both pain and fear of death that deem it worthy of compassion, the benefit is explicitly limited to cases in which death is determined to occur within six months. This quality imposes a short-term need for compassionate response that likely contributes to its political popularity.

Other types of suffering may have far longer time horizons. Domestic violence victims are often engaged in abusive relationships for extensive periods of time. Victims often make several efforts to end abusive relationships before they are able to fully gain their independence; some never do (Arias & Pape, 1999; Humphreys & Thiara, 2003). These realities are known to experienced workers in the domestic violence field. Responses to community disasters also have a complicated time horizon. The distinction between emergency response and later efforts at rebuilding are relevant. Scenes of devastation are generally effective at eliciting a response that is a combination of concrete aid and emotional support. There is typically widespread consensus of public support for intervention. But public attention, and consequent support, often wanes as the effort for rebuilding becomes more complicated.

Government Role

Some political positions espouse the need for greater emphasis on societal-level actions that take care of people and encourage people to take care of each other. Other positions emphasize the primacy of the individual and his/her freedom to decide when and how to engage with others. These perspectives are common in contemporary political dialogue, but have long-standing, even ancient, predecessors and shape policy responses to suffering even in these three cases where some level of compassion is undeniably appropriate.

In respect to the role of government, these three policy examples partially bridge the liberal–conservative divide by providing national policy structure and funding but orienting services at the community level and facilitating community leadership. Each of these three policy areas involves the use of community-based agencies and volunteers in the delivery of compassionate response.

Conclusion

Despite the extraordinary resources and privileges accorded to the American people, suffering abounds. Actions to relieve suffering may take many forms. In addition to the interpersonal connection highlighted in each of these policy domains, concrete assistance (food, safe shelter, pain medication) is also typically needed to be effective in easing suffering. But a requirement of compassionate response is an element of "shared suffering." Explicitly, compassionate response does not allow those enduring pain and loss to deal with it alone. Networks of family and community appropriately provide the bulk of compassionate response. But in many instances, the level of suffering is beyond the response capacities of these units. Therefore, compassion appears to be a relevant virtue for government policy.

Compassion-oriented policy requires federal and state funding infrastructure to support community-based networks of professionals (social workers, physicians, emergency management personnel), para-professionals (nursing assistants, group home staff), and volunteers (advocates, mentors). Professionals are central for several reasons. Serious suffering

is often extremely difficult to be around and professional training typically (but not always) can help individuals develop the capacity to withstand some of this very serious suffering. Also, professionals are trained to engage with the large, complex systems (e.g., hospitals, government bureaucracies, courts); understanding of these systems is needed in order to effectively secure resources and conduct case and systems advocacy.

There are additional policy elements that are necessary to achieve a sense of "shared suffering." There needs to be formal policy recognition that suffering does occur and that those suffering have a right to the alleviation of suffering. Moreover, there needs to be sustained funding to allow continuity of assistance throughout the period of suffering. As noted, suffering can occur over a very long period of time.

In modern complex societies, no one virtue should undergird all of public policy. Such an approach would be simplistic. Reconciling the variety of virtues and determining associated policies is the role of sophisticated political leadership and an engaged citizenry. Our analysis has focused on one virtue. We do so for analytic purposes; we do not argue it is the only necessary virtue relevant to public policy. Many virtues are relevant to society. Sabl (2005) has argued that some virtues are necessary for basic functioning of a liberal democracy (e.g., justice) and that others are more specialized, needed in certain circumstances. An ongoing challenge to the role of virtue in civic life is that virtue lists can be fluid, with the most critical virtues being dependent on the specific social context (MacIntyre, 1981). Yet some remain fairly core to the human condition. Our choice of compassion for analysis is due to the recognition of suffering among vulnerable populations and our social work commitment to these populations.

How does compassion interact with other virtues? In one of the examples that we provided we observed an interaction of compassion and justice in the case of domestic violence. It does not seem necessary to choose one over the other. Compassion might be the dominant early response in domestic violence but may take a secondary or more episodic role as the machinery of justice is engaged. Greater attention regarding how virtues interact in various policy domains would be a fruitful area of inquiry.

As a second example, self-sufficiency is a valid virtue, and has been central to social welfare policy in the last two decades. Some have asserted that it has become so dominant in policy discourse that it is no longer even questioned (Hawkins, 2005). Elsewhere (Collins et al., 2012) we have provided some thoughts as to how the self-sufficiency aspect of welfare policy might be enhanced if there were more attention to compassion in our various poverty policies. More generally, resolution of a variety of problems might occur earlier and with a more sustained focus if compassion were delivered initially and with more visibility. This might be the case with victims of violence, national disaster, or the surviving loved ones of those who have died. It might be the case with other populations—foster children, refugees, homeless individuals—as well.

We have not argued that any of these policies are or are not effective in their delivery of compassionate response. A virtue-based approach, however, is focused more on "being" than "doing" and consequently more on "process" than "outcome." Efforts to ease suffering are considered part of a compassionate response; but even when unable to effect a change in the conditions that cause the suffering, compassionate action is still a worthy endeavor. Some circumstances, wounds, and burdens may not improve (e.g., terminal illnesses, imprisonment). In these cases, the sharing of suffering is the outcome. Sometimes the compassionate act exists largely in the ability to be present with those suffering pain or loss. An inordinate preoccupation with measuring objective outcomes (e.g., employment) ignores the potential benefit of intervention aimed at the subjective reduction of suffering.

Virtue-based frameworks move to the forefront societal questions about our ethical relationships towards others and the building of better societies. Use of virtue-based language forces us to confront these bigger questions motivated by values and vision. Equally, they can force difficult decisions about sustained character that may withstand reactive policy-making to meet an immediate need or to respond to political tension. Thus discussions of compassion within a virtue-framework emphasize morality and ethics. Because of the sense of "character" reflected in virtues, this manner of examining policy speaks more to the sustained, dispositional sense of our nation. The more typically used policy metaphors such

as "sticks and carrots," or investment and prevention, are relegated to secondary status.

Our analysis considered cases of largely unambiguous suffering and, therefore, there is likely to be greater consensus that action should be taken to alleviate suffering. Consideration of additional cases would add further detail to our emerging framework. Other relevant policy areas might include homelessness, immigration, bullying, and nursing home care. Those who suffer in these areas might also be in need of compassionate response. Yet, issues related to social construction of the populations, time horizon of suffering, ideologies regarding role of government, and other factors may result in a more opaque compassionate response.

Additionally, analysis of different virtues reflected in key policies may further clarify the utility of a virtue-based approach to policy development and analysis. We have already noted the virtues of justice and self-sufficiency. Other notable virtues that may lead to intriguing observations include generosity, courage, and humility, for example. We also believe our analysis has application to the development and implementation of policies in many other countries besides the U.S. Indeed, the focus on alleviating human suffering is likely shared across the globe, although specific policies may differ depending on the social, political and cultural context. Comparative analysis across countries regarding the delivery of compassionate response may be useful to identify some of the specific cultural elements related to the practice of compassion in the public arena.

References

Adams, P. (2009). Ethics with character: Virtues and the ethical social worker. *Journal of Sociology & Social Welfare, 36*(3), 83-105.

Arias, I., & Pape, K. (1999). Psychological abuse: Implications for adjustment and commitment to leave violent partners. *Violence and Victims, 14*(1), 55-67.

Banks, S., & Gallagher, A. (2009). *Ethics in professional life: Virtues for health and social care*. London: Palgrave Macmillan.

Bartlett, R. C. (2002). Socratic political philosophy and the problem of virtue. *American Political Science Review, 96*(3), 525-533.

Bennett, W. J. (1993). *The book of virtues: A treasury of great moral stories*. New York: Simon and Shuster.

Biebricher, T. (2011). Faith-based initiatives and the challenges of governance. *Public Administration, 89*(3), 1001-1014.

Brickner, L., Scannell, K., Marquet, S., & Ackerson, L. (2004). Barriers to hospice care and referrals: Survey of physicians' knowledge, attitudes, and perceptions in a health maintenance organization. *Journal of Palliative Medicine, 7*(3), 411-418.

Burman, E., Smailes, S. L., & Chantler, K. (2004). Culture as a barrier to service provision and delivery: Domestic violence services for minoritized women. *Critical Social Policy, 24*(3), 332-357.

Cain, D. S., & Barthelemy, J. (2008). Tangible and spiritual relief after the storm: The religious community responds to Katrina. *Journal of Social Service Research, 34*(3), 29-42.

Carrow, M., Churchill, R. P., & Cordes, J. N. (1998). *Democracy, social values, and public policy*. Westport, CT: Praeger.

Centers for Medicare & Medicaid Services. (n.d.). *Medicare hospice benefits.* Retrieved from http://www.medicare.gov/Pubs/pdf/02154.pdf

Chamiec-Case, R. (2013). The contribution of virtue ethics to a richer understanding of social work competencies. *Social Work & Christianity, 40*(3), 251-270.

Collins, M. E., Cooney, K., & Garlington, S. (2012). Compassion in contemporary social policy: Applications of virtue theory. *Journal of Social Policy, 41*(2), 251-269.

Comte-Sponville, A. (2001). *A small treatise on the great virtues*. New York, NY: Holt and Co.

Crawley, L., Payne, R., Bolden, J., Payne, T., Washington, P., & Williams, S. (2000). Palliative and end-of-life care in the African American community. *Journal of the American Medical Association, 284*(19), 2518-2521.

Dutton, J. E., Worline, M. C., Frost, P. J., & Lilius, J. (2006). Explaining compassion organizing. *Administrative Science Quarterly, 51*, 59-96.

Evans, K. (2011). "Big Society" in the UK: A policy review. *Children and Society, 25*, 164-171.

Hawkins, R. L. (2005). From self-sufficiency to personal and family sustainability: A new paradigm for social policy. *Journal of Sociology and Social Welfare, 4*(need issue #), 77-92.

Huber, E., & Stephens, J. (2001). *Development and crisis of the welfare state: Parties and policies in global markets*. Chicago, IL: The University of Chicago Press.

Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: 'I call it symptoms of abuse'. *British Journal of Social Work, 33*(2), 209-226.

Hurst, J., & George, J. P. (2009). Preparing communities: The critical integration of faith-based organizations into emergency planning and response. *Journal of Emergency Management, 7*(3), 11-20.

Hursthouse, R. (1999). *On virtue ethics*. Oxford, UK: Oxford University Press.

Lejano, R. P. (2006). *Frameworks for policy analysis: Merging text and context*. New York, NY: Routledge.

Lipset, S. (1996). *American exceptionalism: A double-edged sword*. New York: W.W. Norton.

MacIntyre, A. (1981). *After virtue*. Notre Dame, IN: University of Notre Dame Press.

Manz, C. C., Cameron, K. S., Manz, K. P., & Marx, R. D. (2008). *The virtuous organization: Insights from some of the world's leading management thinkers*. Singapore: World Scientific Publishing.

Medicare Payment Advisory Commission (MedPAC). (2004). *Hospice care in Medicare: Recent trends and a review of the issues*. Washington, DC: MedPAC.

Mesler, M. A., & Miller, P. J. (2000). Hospice and assisted suicide: The structure and process of an inherent dilemma. *Death Studies, 24*, 135-155.

Miller, P., & Mike, P. (1995). The Medicare hospice benefit: Ten years of federal policy for the terminally ill. *Death Studies, 19*, 531-542.

Myers, G. (2002). Can illness narratives contribute to the delay of hospice admission? *American Journal of Hospice & Palliative Care, 19*(5), 325-330.

Napier, J., Mandisodza, A., Andersen, S., & Jost, J. (2006). System justification in responding to the poor and displaced in the aftermath of Hurricane Katrina. *Analyses of Social Issues and Public Policy, 6*(1), 57-73.

National Resource Center on Domestic Violence (NRCDV). (2007a). *Religion and domestic violence: Information and resources—Developing comprehensive responses to domestic violence*. Retrieved from http://www.vawnet.org

National Resource Center on Domestic Violence (NRCDV). (2007b). *Religion and domestic violence: Information and Resources—Interpretations of religious doctrine*. Retrieved from http://www.vawnet.org

Nussbaum, M. C. (2001). *Upheavals of thought: The intelligence of emotions*. Cambridge, MA: Cambridge University Press.

Olasky, M. (2000). *Compassionate conservatism: What it is, what it does, and how it can transform America*. New York: Free Press.

Pampel, F., & Williamson, J. (1989). *Age, class, politics, and the welfare state*. Cambridge, MA: Cambridge University Press.

Persons, G. A. (2011). Administrative policy initiatives and the limits of change: Lessons from the implementation of the Bush Faith-Based and Community Initiative. *Politics & Policy, 39*(6), 949-978.

Pilbeam, B. (2003). Natural allies? Mapping the relationship between conservatism and environmentalism. *Political Studies, 51*(3), 490-508.

Porter, E. (2006). Can politics practice compassion? *Hypatia, 21*(4), 97-123.

Radin, B. A. (2000). *Beyond Machiavelli: Policy analysis comes of age*. Washington, DC: Georgetown University Press.

Rawls, J. (1971). *A theory of justice*. Cambridge, MA: Belknap Press of Harvard University.

Reilly, R. (2006). Compassion as justice. *Buddhist-Christian Studies, 26*, 13-31.

Roberts, P. S. (2010). Private choices, public harms: The evolution of national disaster organizations in the United States. In A. Lakoff (Ed.), *Disaster and the politics of intervention* (pp. 42-69). New York: Columbia University Press.

Rosewater, A., & Goodmark, L. (2007). *Steps toward safety: Improving systemic and community responses for families experiencing domestic violence*. San Francisco, CA: Family Violence Prevention Fund.

Ryan, W. (1976.) *Blaming the victim*. New York, NY: Random House.

Sabl, A. (2005). Virtue of pluralists. *Journal of Moral Philosophy, 2*(2), 207-235.

Sack, E. J. (2004). Battered women and the state: The struggle for the future of domestic violence policy. *Wisconsin Law Review*, (need issue/volume info), 1657-1740.

Schneider, A., & Ingram, H. (1993). The social construction of target populations: Implications for politics and policy. *The American Political Science Review, 87*(2), 334-347.

Shega, J., & Tozer, C. (2009). Improving the care of people with dementia at the end of life: The role of hospice and the U.S. experience. *Dementia, 8*(3), 377-389.

Szostak, R. (2002). Politics and the five types of ethical analysis. *International Journal of Politics and Ethics, 2*(4), 275-290.

Szostak, R. (2005) *Unifying ethics*. Lanham, MD: University Press of America.

Tjaden, P., & Thoennes, N. (2000). Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. *Violence Against Women, 6*(2), 142-161.

U.S. Conference of Mayors. (2013). *U.S. Conference of Mayors endorse compassion as effective public policy.* Retrieved from http://charterforcompassion.org/us-mayors-endorsement

Weaver, G. R. (2006). Virtue in organizations: Moral identity as a foundation for moral agency. *Organization Studies, 27*(3), 341-368.

Whitebrook, M. (2002). Compassion as a political virtue. *Political Studies, 50*(3), 529-544.

Wilensky, H. (1975). *The welfare state and equality*. Berkeley, CA: University of California Press.

Wilensky, H., & Lebeaux, C. (1958). *Industrial society and social welfare: The impact of industrialization on the supply and organization of social welfare services in the United States*. New York: Russell Sage Foundation.