Application of Virtue Theory to Public Policy:

A Compassion Example

Mary Elizabeth Collins, A.M., Ph.D.

Associate Professor, Department of Social Welfare Policy

Kate Cooney, MSW, Ph.D.

Assistant Professor, Department of Macro Practice

Sarah Garlington, MSSW, MPhil.

Doctoral Candidate

Social Policy Association Conference

July 2011

Authors are at Boston University School of Social Work, 264 Bay State Road, Boston, MA, USA. Dr. Collins can be reached at 617/353-4612; mcollins@bu.edu.
In this paper we utilize concepts of virtue and apply them to social policy. To do so we: 1) briefly review virtue from perspectives of philosophy and the social sciences; 2) describe its potential fit with social policy; 3) focus on the virtue of compassion, specifically, and its use in both liberal and conservative discourse; 4) provide an example of compassion in social policy by describing hospice care policy; and, 5) conclude with further reflection on the potential of virtue-based frameworks for social policy analysis.
“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.”

- William J. Bennett (1993), *The Book of Virtues*

At first glance the application of virtue to public policy might appear quizzical. Economic models of rational decision-making have long been the primary conceptual lens for addressing questions of policy. But this belies the reality that much of policy-making is values-based. This is particularly the case for major initiatives, such as the “Big Society” that aim to lay out vision for a multitude of more specific policies. These types of broad frameworks do not lend themselves to typical technically-oriented policy analyses. Questions and analyses related to values and virtues are more relevant to structure debate and discussion at this broader societal and political level.

In this paper we utilize concepts of virtue and apply them to social policy. To do so we: 1) briefly review virtue from the perspective of philosophy and the social sciences; 2) describe its potential fit with social policy; 3) focus on the virtue of compassion, specifically, and its use in both liberal and conservative discourse; 4) provide an example of compassion in social policy within hospice care policy; 5) conclude with further reflection on the potential of virtue-based frameworks for social policy analysis.

**Virtue in Philosophy and Social Science**

Most contemporary frameworks for understanding social policy and programs lack explicit attention to virtue. In liberal democracies public policy reflects and facilitates the attainment of shared societal goals. These goals are shaped by multiple factors (e.g., history, political economy, culture) at multiple levels (national, state, local, individual) explicated via cultural and policy analysis (Wuthnow, 1987). Implicit both in the goals and the social policy are virtues that Americans see as necessary to the social fabric. While scholars debate philosophical foundations of the social policy framework (from
residual and individualistic to progressive or communitarian arguments) (Bellah, et al., 1985; Etzioni, 2004; Walzer, 1990), there is little discussion of the forces supportive or detrimental to virtue that result from the social policies in place. The emphasis on civil society and civic engagement (Bellah, et al. 1985; Norton, 2005) begins to locate virtue at a societal level, but a more specific focus on virtue and public policy can be expected to identify different conceptualizations and processes.

Virtue has been largely the province of classical and contemporary philosophers. Aristotle and Nietzsche, among others (e.g., Spinoza, Schopenhauer, Kant, Rousseau), have engaged in philosophical inquiry regarding virtue, including specific attention to compassion. Theologians have also contributed to religious perspectives on virtuous life. Most of the scholarly discussion about virtue has focused on the individual level and it is understood to be a habitual, regularly practiced behavior reflective of character. However, there are multiple reasons why virtue may also be a useful framework for policy discussion. For example, MacIntyre (1981) importantly notes, that “no practice can survive for any length of time unsustained by institutions” (p.181). Individuals cannot engage in virtuous behavior without institutions supportive of these behaviors; social policy may create, support, or destroy institutions.

Attention to virtue has seen a resurgence in many scholarly fields. In addition to virtue’s typical home in philosophy and religion, the social sciences have also included discussion of virtues and debated their contribution to understanding of human nature, society, and politics. Several scholars in political philosophy and political theory have engaged with virtue theory. For example, Sabl (2005) has compared liberal democratic virtue theorists, drawing some useful conclusions regarding virtue and politics. Lists of virtues, especially in political discussion, may come in “conservative” and “liberal” versions; conservative versions highlight individual virtues (e.g., uprightness, self-discipline) whereas liberal versions highlight social virtues (e.g., empathy, fairness). Despite contrasts of emphasis and variations in lists of virtues, liberal democratic virtue theorists across the ideological spectrum have several things in common. At some point, virtue theorists move the discussion from virtues required for liberal democracy
to survive to virtues that make it *flourish*. The simultaneous search for an empirically plausible core and a sufficiently attractive ideal gives rise to tensions (Crick, 1962).

In addition to Sabl’s comparison of four theorists, he offers three hypotheses: 1) it is important to distinguish between the virtues needed to preserve liberal democracy (core) and those needed to perfect it (ideal); 2) virtues should be seen pluralistically; 3) political virtues are episodic -- specialized qualities may be needed in certain circumstances even if they are not necessary to the core of liberal democracies.

As noted above, political theorists have been active in discussion of the role of virtue theory in politics and society. Another body of literature relevant to the linkage of virtue and social policy is related to organizational theory. Organizations are key units in the policy implementation process. Moreover, organizations are a mechanism for potentially linking societal and individual virtue. Potentially they can (but may not) have the institutional mediating power of community between social policy and professional practice, for example.

Comparatively less scholarly attention has been given to virtue in organizations. Helpfully, Manz, Cameron, Manz, and Marx (2008) provide an edited volume examining virtuous organizations. Although their focus is primarily on virtue in for-profit businesses, the attention to virtue in organizational settings provides some helpful discourse on which to build. They note that although organizations, as well as individuals, aspire to be virtuous (e.g., honest, caring, courageous), such concepts have been replaced by more morally neutral terms such as corporate social responsibility, prosocial behavior, and morale. The attributes of organizations “that move individuals toward better citizenship, responsibility nurturance, altruism, civility, moderation, tolerance, and work ethic” (Seligman & Csikszentmihalyi, 2000, p.5) have been largely absent from organizational studies. A special issue of *Organization Studies* is largely devoted to responding to MacIntyre’s (1981) analysis regarding the role of organizations in promoting and constraining virtue. This series of papers (Beadle & Moore, 2006;
Virtue and Social Policy

At a level higher than organizations, virtue might also be examined within social policies. The quote at the beginning of this paper (by a conservative commentator) indicates a belief that the virtue of compassion may have once been undergirding America’s immigration policy. Other virtues commonly articulated in policy discussions 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).

Overall, policy discussions often refer to values but less frequently to virtues. 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.

More specific than values, virtues require behavior. This focus on behavior makes virtues more visible than values, and hence, more open to empirical study. The idea of moral character within a discussion of policy may partially capture what might be called national culture. Within these discussions there are often taken-for-granted assumptions regarding parameters and the policy options that would be legitimately under considerations versus those outside the mainstream. These assumptions make up the “national character” that might otherwise be called virtue.

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 values-oriented analyses are infrequent compared to technical,
particularly quantitative, approaches. Some scholars have identified the need for more attention to ideas, values and meaning within policies (Schneider & Sidney, 2009). Others (e.g., DeLeon & Steelman, 2001) have suggested the narrow, primarily technical, focus has led to deficiencies in the training provided by schools of public policy. Carrow, Churchill, and Cordes (1998) argue that “social values” should be at the center of both public debate and policy analysis.

Szostak (2005) also suggests that virtue-based approaches to analysis also represent “process ethics” which is concerned with process rather than results. Lejano (2006) states, “Virtue is actually a strong component in policy discourse, though it may be masked as other things (p.141).” Additionally he notes that virtuous qualities may exist within the individual, groups, organizations, or programs; “we can posit qualities that desirable institutions should have, and these can and do have a great sway on policy decisions” (p.141).

In thinking of the role of virtue in creating “desirable institutions” and “swaying” policy decisions, part of the question becomes: Which virtues? Some recent authors on virtue include Pope Benedict the XVI who focuses on the three theological virtues (faith, hope and charity) and four cardinal virtues (2009). William Bennett (1993) a conservative commentator in the U.S. discusses ten virtues, including compassion. Comte-Sponville (2001) a contemporary philosopher covers eighteen virtues, among them compassion, in his overview of philosophical treatment of the virtues.

MacIntyre (1981) provides a helpful, overarching perspective regarding various virtue lists. Classical and medieval thinkers differ from each other in many ways. They offer different lists, give a different rank order of importance, have incompatible theories of the virtues. For example, charity and forgiveness were not virtues in the world of Aristotle. Later Western and non-Western writers would add to the complexity. Additionally, the meaning of a virtue may change over time and there may be little shared understanding or common definition of the virtue. MacIntyre (1981) suggests, however, that a lack of coherence of virtue lists and fluid meanings are not new phenomena. Throughout history, virtues
have been identified as qualities that will ensure success, but, importantly, the definition of success is contextual to the society. MacIntyre (1981) offers, for instance, the examples of Ben Franklin (thrift) and Jane Austen (amiability) as contributors to newer conceptions of virtue based on the social contexts of their times. He notes that cultural history has deep conflicts over what promotes human flourishing and well-being; rival and incompatible beliefs on this lead to rival and incompatible tables of the virtues.

Compassion: Conservative and Liberal Perspectives

Compassion is a core virtue of all major religions, and, generally, a well-known but misunderstood virtue among the populace. Compassion may be confused with related, but distinct, virtues such as charity, altruism, or mercy. At the core of definition, and distinguishing compassion from similar, other-regarding virtues (e.g., charity, altruism, mercy) is: “to be with in suffering”.

One contemporary philosopher (Comte-Sponville, 2001, 106) addresses some of the nuance of compassion, explaining that compassion is a form of sympathy; it is sympathy in pain or sadness – in other words, participation in the suffering of others. Suffering “…is always morally regrettable” as it clearly suggests that society is not operating at its best level. Compassion, therefore, is a virtuous act as it demonstrates regret for the existence of suffering.” Compassion requires acting to relieve distress as well as having sympathetic feelings about it (Barad, 2007). According to the Dalai Lama, compassion is an attitude that not only wishes that others not be suffering but is associated with a sense of commitment and responsibility toward the others. Barad concludes, therefore, that “neither Aquinas nor the Dalai Lama thinks that good intentions alone amount to compassion” (Barad, 2007, 13). Barad (2007) also suggests that Catholic and Buddhist traditions are consistent in differentiating pity and compassion. Pity is solely an emotional response. It is not a virtue because virtue involves choice. Moreover, both Aquinas and the Dalai Lama are clear that compassion must be extended to outsiders and enemies, not just those in our close circles or those with whom we feel an affinity.
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 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” (p. 13).

Compassionate conservatism as stated by Olasky (2000) emphasizes a diminished role of “big government” in responding to needy Americans through programs, and proscribes 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 proscriptions 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. Similar ideas with the label of compassionate conservativism have also been articulated in the UK (Norman & Ganesh, 2006).

A liberal perspective 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 often takes 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 (Wilensky & Lebeaux, 1958; Pampel & Williamson, 1989; Huber & Stephens, 2001). 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.

A critically important point for discussion of compassion in social policy is that 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” (Porter, 2006, 100). Nussbaum (2001) makes a similar point identifying the losses to be of “basic goods” such as life, liberty, bodily integrity. Related to this definitional element, Nussbaum has cautioned that modern industrialized nations like the U.S. have tendencies to expand the meaning of suffering to include more trivial losses; these tendencies should be avoided as they are not to be deemed worthy of true compassion.

Example: Hospice Care

Elsewhere we have provided a more extensive review of the strengths and risk of compassion-focused virtue approaches to policy (Collins, Cooney, & Garlington, 2011) and we have conducted an analysis of three U.S. policy from the vantage of compassion frameworks (Collins, Garlington, & Cooney, 2011). To analyze the role of the virtue of compassion within social policy we chose examples of circumstances of fairly unambiguous suffering. Consistent with a definition of suffering regarding “the loss of truly basic goods” we focused on the loss of: life (terminal illness), safety (domestic violence), and home/community (community disaster). We then selected appropriate U.S. policies that addressed these
losses: the Medicare hospice benefit, the Violence Against Women Act, and the Stafford Disaster Relief and Emergency Assistance Act.

To conduct our analysis, we reviewed government documents, websites, and scholarly literature to form a description of these policies. In each of these policy domains we organized the data into the following framework: (1) form of aid; (2) eligibility criteria; (3) service delivery system; (4) staff: professional/para-professional groups involved; (5) language cues in the policy regarding suffering and compassion; and (6) implementation challenges. Moving beyond description, our analytic strategy then used an inductive approach to identify aspects of compassion – explicit and implicit – within the policy. Comparative analysis across the domains highlighted consistencies and differences in policy approaches.

Table 1 identifies key elements of each policy according to the identified criteria. Below we use one of these policy cases – hospice care – to discuss the detailed findings.

Insert Table 1

Hospice Care: Policy Description

The development of modern hospice care has been attributed to a British physician and the founding of St. Christopher’s Hospice outside London in 1967 (Dyeson, 2005). 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).

Legislation. In the U.S., policy regarding the use of hospice care is primarily in the form of the Medicare hospice benefit which provides payment for palliative care related to terminal illness. Medicare is the medical insurance program created in 1965 through amendment to the Social Security Act (Title XVIII).
Form of Aid. 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; any other item listed in a patient’s care plan as necessary for the palliation and management of the terminal illness (MedPAC, 2004).

Eligibility. The Medicare hospice benefit which 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).

The hospice benefit provides direct assistance to the individual suffering. The form of assistance involves services related to pain relief and emotional support. The potential benefit is held by the individual (as long as they are covered by Medicare) which the individual can utilize as long as the other conditions apply (terminal illness and decision to forego further treatment). Hospice care is broken into four levels of care with a price set for each level: routine home care, continuous home care, general inpatient care, general inpatient respite care. The hospice is paid at the fixed rate for one of the four levels each day that a beneficiary is in the program. Bereavement follow-up is required but not reimbursable.
Policy History. 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. As major impetus of the federal legislation it was noted 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). Yet, there is evidence that many individuals access hospice care only within the last stages of life (Centers for Disease Control and Prevention, 2003). Many experts in hospice policy suggest better planning and communication would benefit patients and their families: “Health care policy that incorporates end-of-life planning earlier during an illness trajectory has the potential to create smoother transitions and greater shared understanding, and decision making, at life’s end” (Waldrop & Rinfrette, 2009, p.577). President Obama’s health care proposal initially included plans for Medicare coverage of advance care planning. This was omitted from the final health care, however, because of claims that it would encourage euthanasia and involve government, through “death panels” to make these decisions.

Service Delivery. Beneficiaries can choose a Medicare-certified hospice provider. Several types of agencies provide hospice care to Medicare beneficiaries. Approximately half are freestanding, one-quarter are owned by a home health agency and another quarter by hospitals; most are not-for-profit but approximately one-third are for-profit agencies (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.

At the organizational level, there is little flexibility. All hospices that are Medicare-certified closely resemble each other in service delivery; they must each meet the federal guidelines. There is,
however, flexibility built into the provision of hospice care at the patient level. For example, there is built-in support to allow patients to stay at home until death. Most patients report they would prefer to die at home (Ratner, Norlander, & McSteen, 2001). If symptoms escalate and one-on-one care is needed, hospice programs must be able to provide continuous care at home. For care, that is not feasible to continue at home, general inpatient services need to be available (Shega & Tozer, 2009).

Language of Compassion. Explicit reference to easing suffering and reducing discomfort are provided in the legislation and the variety of professional and scholarly documents related to hospice. 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.

Implementation Challenges. The main implementation challenges associated with hospice care are societal and cultural factors that can make it difficult for people (the terminally ill, their families, and professionals) to address impending death. There are some reports that physicians express concerns that referral to hospice communicated “giving up” on a patient or concern with expensive costs of treatment (Mesler & Miller, 2000). Some types of death have specific associated stigmas and misunderstandings. In regard to dementia, for example, both families and health care providers can face difficulty understanding that people die from dementia, leading to efforts at futile care (e.g., feeding tubes, antibiotics, hospitalization, etc. (Shega & Tozer, 2009). Racial disparities have been identified; minorities are less likely to utilize hospice care potentially due to differences in culture related to views of death, differences in religion, and the overall lack of access to health care and health facilities (Crawley, Payne, Bolden, et al., 2000)
Summary. Hospice care seems to be a good fit with the classical definition of compassionate response, “to be with in suffering”. 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 of near death such as pain management.

We purposefully selected a largely unambiguous case of “suffering” for our analysis. It is a type of suffering that every person eventually endures (albeit some very quickly), consequently there is greater likelihood for political support to address this type of suffering. But hospice has unique characteristics of the timeline for suffering, which may affect perception. “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 in this regard. Thus while terminal illness has qualities of both pain and fear of death that deem it “worthy” of compassion, the benefit is expressly limited to cases in which death is determined to occur within six months (although this can be extended). This quality imposes a short-term need for compassionate response that makes it all the more popular. Other types of suffering may have far longer time horizons, and consequently, may lack the same level of political support.

Conclusion

In this paper we have reviewed some perspectives on virtue and discussed its potential for providing a framework for analysis of social policies. At least some attention to virtue can keep attention on critical questions related to the kind of society we want and how we might get there. Virtue focuses on qualities of moral excellence and links individual behavior with the “good society”. Its attention to inculcated habit also keeps attention on sustained patterns of behavior.
As we have noted there are multiple virtues and a prominence of specific virtues is not static but rather reflects the contemporary social and cultural milieu. Rather obviously, we have selected one virtue – compassion - as the object of focus. Why compassion? First, it appears to be an enduring, yet controversial, virtue. There must be something critically important about compassion throughout the ages that makes it worthy of both severe critics and enthusiastic supporters; “Compassion is controversial. For about twenty-five hundred years it has found both ardent defenders, who consider it to be the bedrock of ethical life, and equally determined opponents, who denounce it as ‘irrational’ and a bad guide to action” (Nussbaum, 2001, 354).

Second, it appears to be central to all major religions and has been articulated across the political spectrum. Thus, it has resonance across substantial key sectors of society. Third, it is our view that “compassion” has been missing as an element of public discourse. Like Sabl (2005), we recognize the importance of multiple virtues relevant to the political system. Compassion need not be the only or primary virtue. But it does have its place, particularly in social policy which is designed to address human need. We contrast this with the dominance of the virtue of “self-sufficiency” linked with recent welfare policies in the U.S. Self-sufficiency is an important virtue but our observation is that political argument has uplifted self-sufficiency to such an extent that other virtues have been crowded-out. Similarly, Hawkins (2005) also notes that self-sufficiency has become so “ingrained in American society that the media, policy makers, researchers, and the general public no longer question the legitimacy of the goal” (2005: 77). Thus, our attention to compassion is in the service of adding balance within the societal virtue debate.

Some political positions espouse the need for greater emphasis on societal level for 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. Thus, the appropriate means of delivering a compassionate response, particularly regarding
the role of government, is unresolved and remains a matter for political debate. To some extent, the hospice policy example bridges the liberal-conservative divide by providing national policy structure and funding but orienting services at the community level. This policy example involves the use of community-oriented agencies, multi-disciplinary teams, and volunteers in the delivery of compassionate response.

Our reading of a wide variety arguments regarding compassion suggest that it requires engagement not devolvement. “To be with in suffering” suggests an element of shared suffering and actions that help face the suffering. Therefore, to rely solely on community-based voluntary action, as articulated in compassion conservativism for example, would not be consistent with a compassionate response. When devolvement is primarily a mechanism for cutting spending it also has little to do with compassion.

Moreover, there is a critical role for professionals in providing compassionate care. Serious suffering is often extremely difficult to be around. Professionals typically (but not always) have training to withstand some of this very serious suffering (e.g., death, disaster, destruction, assault, debilitation, misery). Individuals who volunteer their time have a variety of motivations (Wuthnow, 1991). Many of them do care about others and want to help. 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. This is particularly true if they are expected to do serious compassion-oriented work. Volunteers do have a role, of course, as can be seen in the hospice example. But they are part of a much larger team that includes high levels of professional expertise. This interdisciplinary model is a strength of the hospice approach, which is mandated in the federal legislation, and can serve as a model in other areas of social policy that aim to address suffering through compassionate approach.
Virtue-based frameworks move to the forefront of political discourse questions about our ethical relationships towards others and the building of better societies. Use of virtue-based language may force 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.

Virtuous action at societal policy levels can be just as difficult as virtuous actions at the individual level. Numerous virtues should be discussed within the virtue mix. We have suggested compassion be central to this discussion. 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 considered a worthy endeavor. Indeed, suffering must be reduced to allow society to flourish.
References


<table>
<thead>
<tr>
<th>Policy domain</th>
<th>Legislation</th>
<th>Form of aid</th>
<th>Eligibility determination</th>
<th>Service delivery system</th>
<th>Staff</th>
<th>Explicit language of suffering and compassion</th>
<th>Implementation challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>Medicare hospice benefit (1982)</td>
<td>Palliative care to provide comfort</td>
<td>Terminally ill, certified by doctor, patient decision to seek hospice care and end treatment of disease.</td>
<td>Medicare reimbursement to private contractors providing hospice services</td>
<td>Hospice services include doctors, nurses, social workers, pastoral staff, and volunteers.</td>
<td>Explicit goal is to ease suffering and reduce pain, not to treat the disease.</td>
<td>Factors (societal difficulties dealing w/death, medical emphasis on “cure”) may prolong treatment and delay hospice.</td>
</tr>
<tr>
<td>Disaster relief</td>
<td>DREAA (1988)</td>
<td>Coordination of multiple federal, state, local systems: crisis care for individuals (food, shelter, counseling)</td>
<td>Presidential determination</td>
<td>Federal Emergency Management Agency coordinates with state and local agencies. Red Cross key component.</td>
<td>Federal, state, local government employees coordinate with police, fire, public health, etc., Red Cross and other private professionals (doctors, nurses, social workers) and community volunteers.</td>
<td>“Responsive and compassionate care for disaster victims is FEMA’s top priority.”</td>
<td>Extensive coordination of multiple complex systems; by definition response occurs on an “emergency” basis; potential politics involved in declaring federal emergencies.</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>VAWA (1994, 2000, 2005)</td>
<td>Coordination of multiple systems; crisis care, shelter, legal assistance, emotional support; emphasizes linguistic and culturally specific services.</td>
<td>Determined by individual service providers but must be victim, (usually women), emphasize non-discrimination based on other issues.</td>
<td>Federal grants to states and communities: formula grants and specialized grants.</td>
<td>Professional (social workers, counselors), paraprofessionals and volunteers. Advocates committed to the cause.</td>
<td>“Victim” and “empowerment” language rather than “suffering” and “compassion.”</td>
<td>Services provided in context that can be ambivalent about the problem; cultural differences regarding violence, gender, etc.; service recipients are a disempowered group.</td>
</tr>
</tbody>
</table>