The Center for Migration and Development
Working Paper Series • Princeton University

Toward an Economic Sociology of Compassionate Charity and Care

by

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February 2007

CMD Working Paper #07-02

ASA-econ-Charity 7-06.doc Revised Jan 07

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TOWARD AN ECONOMIC SOCIOLOGY OF COMPASSIONATE CHARITY AND CARE

Revised from Paper for the ASA Economic Sociology Section
August 11, 2006 Montreal

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OUTLINE:

- Why compassionate charity and care is theoretically and empirically important 8-10
- Beyond reciprocity and rational self-interest - Challenges to economic and sociological theory 10-22
- Sources of Compassionate Care (see Figure 1) 23-28
- "Social Capital" – Building social capacity through compassion and caring 29-
- Dynamics and dilemmas of institutionalizing and legitimating compassionate care 35-
    - Institutionalizing Liminality 43-
- Compassionate care and the nature of a moral economy 46-

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[1] This paper is based on extensive conversations with and contributions by Alejandro Portes, as a sponsor and partner in field studies and as a prominent contributor to the economic sociology of migration, markets, opportunity structures, and societal responses to immigration. As this paper has evolved, his other commitments precluded him from co-authoring, though he remains an active collaborator. This project has been sponsored by the Center for Migration and Development at Princeton University, which he directs, as a 'leading edge' exploration of economics highlighted by the moral challenges of undocumented immigrants when they become ill.

Economics and economic sociology are based on an action model of self-interest and exchange, even though tempered by structural and cultural kinds of embeddedness. People are said to always expend their valued scarce resources – time, skill, energy, money, and other resources – to gain income, wealth, or other rewards such as pleasure or prestige which they regard as worth as much as or more than what they expend. Yet there is clear evidence that people employ or give away their scarce resources for other reasons. Motives like moral convictions; compassion; love; a sense of duty such as a duty towards a sick, disabled, or needy relative or other with whom one feels founded solidarity; and principles or beliefs that transcend self-interest and even call for self-sacrifice prompt or contribute to substantial portions of economic and political action that are missing from theories of economic action and from economic sociology. Yet they are morally and culturally important, and they may underlie large societal shifts that shape economic behavior, like the rise of the movements to Make Poverty History and eliminate absolute poverty. REF At a personal level, millions of people give away scarce time and valued resources they worked to earn rather than keep them for themselves and their pleasures.

Even if these more altruistic motives affected a small part of the economy, they would pose a conceptual anomaly to theories of economic action based on rational self-interest. Let us consider just acts of charity. In 2002, millions of Americans over 21 reported giving $247 billion in charitable contributions, most of them small, while corporations and all others gave $82 billion (Independent Sector 2002). Religiously active donors gave on average $2247 of their income, more than three and one half times the average of those who gave only to secular organizations. In return, most individuals get little or nothing back in tangible goods

or services. The tax deduction is modest for most donors, and they still lose most of what they give away. Of particular interest here is compassionate charity or that portion of giving to help relieve the suffering of others, because this emotional source of economic action has implications for the foundational role that emotions play in social life (Massey 2002) and also implications for how people regard mainstream economic institutions and the moral character of the economy.

A clearer, pervasive measure of compassion and altruism is volunteering one's time for the needs of others. Wuthnow (1991) reported that 45 percent of American adults claim to set aside time from all the demands on them and from pleasurable activities to do some formal kind of volunteering for an average of five hours a week. Though such self-reports are overstated, that would amount to 22.5 billion hours of donated time. If valued at $10-20 an hour, $225-450 billion more is added to the economy of charity and compassion. Many people might regard their time as worth more, especially what limited, personal time left over after work is done and duties completed. This total does not include informal acts of charity which people report doing as well. In his national survey at the end of the 1980s, Wuthnow (1991:200) found that among people who did no volunteer work in an organized setting, 67 percent reported they gave to a beggar, 64 percent visited a patient in a hospital, 58 percent cared for someone who was very sick, and 58 percent helped someone through a personal crisis. These are not necessarily the same people as those who volunteer in an organized setting are more likely to be. Putnam (2000) also reports that different kinds of charitable actions correlate with other kinds. Those who volunteer, for example, are more likely to make charitable contributions.

Besides the 22.5 billion hours of volunteering in formal settings, there are a number of less well documented forms of compassionate care. For example, millions of family members spend billions of hours over weeks, months, or years caring for a chronically ill or disabled relative. A recent survey (Ho, Collins et al. 2005) found that one in every ten adults age 50-64, and one in every five women are caring for such a relative, despite their own hardships and the toll it takes on them. Sixty percent report either being disabled themselves or having one or more chronic conditions, and significantly more report not being able to afford medical care than comparable others. They are also significantly poorer. Clearly, this widespread pattern of caring is based on altruism and sacrifice. The value of their care might be measured by the gross charges for professional caretakers.

The institutional context for this paper is a study of responses by health care organizations and providers to the medical needs of uninsured immigrants, particularly those who are poor and undocumented. In the United States, the mainstream system delivers services to those who can pay for them, usually by having health insurance issued by for-profit companies that compete to cover healthier lives at lower premiums and that profit from minimizing or delaying payments against revenues. Competitive forces lead companies to employ forms of risk selection, deny coverage to persons or for conditions deemed too risky or costly to bear, and delay payments through a cluster of techniques known as "claims harassment" (Light 1992). Repeated regulatory efforts to constrain these practices, which actually follow from maximizing rational self-interest, have resulted in enormous frustration and limited success (Light 2001). Private, revenue-driven and competitive American health care provides medical services only if someone pays for them. Health care is not a human right or a civil right in the United States. A large and growing minority of employers offer no health

insurance at all, or offer it at premiums their employees cannot afford. Employer-based health insurance varies by size of firm, economic sector, and job level, with low-wage service jobs in smaller firms being triply disadvantaged. Among immigrants, over half who have lived here for 6 years or less have no health insurance (Kaiser Commission on Medicaid and the Uninsured 2004 (Nov)). They are part of over 46 million uninsured, whose ranks have been increasing for years at the rate of about 3,000 a day, even though Medicaid and related public programs have generally expanded their eligibility and enrollments. Around this average, insurance coverage varies five fold by income.

Overall, uninsured patients receive about one third as much care as insured patients, and uninsured immigrants receive services worth less than half the care received by uninsured US-born patients (Mohanty, Woolhandler et al. 2005). When controlled for poor health status, age, income, or education, the costs of medical services for immigrants are also lower than for native-born citizens. The uninsured are also 3 to 4 times more likely than the insured to postpone medical attention or not fill a prescription because of the cost, and 3 times more likely to be contacted by a collection agency about bills for hospital care they could not avoid (Kaiser Commission on Medicaid and the Uninsured 2004 (Nov)). These differences reflect barriers of income, language, and prejudice (Smith 2005).

And yet the cup is half full as well as half empty. While the Institute of Medicine and most other policy leaders rightly emphasize how much less health care the uninsured poor receive, they nevertheless receive substantial services, given their inability to pay. In the most comprehensive study yet on the quality of care received by residents who have had at least one medical visit in the previous two years, a team at RAND has found that, using 439

measures of clinical quality across 30 medical conditions, once they are seen the uninsured received care of comparable quality to insured patients (Asch, Kerr et al. 2006). This contradicts many studies showing they receive inferior care but based on more limited sampling and scope (Institute of Medicine 2003). Although the investigators did not measure country of birth, clearly, a great deal of effort is made by thousands of nurses, physicians, and administrators to provide good care to those unable to pay.[2] The sociological implications of such widespread economic behavior driven by the informal culture and organization as distinct from the formal, revenue-driven rules of the mainstream organization have yet to be researched.

This perspective struck us at the Center for Migration and Development at Princeton University when we found in our field visits to urban centers of immigration that many physicians clinical administrators went out of their way to treat these patients and to figure out ways for them to receive the tests and procedures they needed. What strategies they use, what networks they form, how they work the revenue-obsessed systems to get services worth billions to help poor patients is a major area for research, especially at a time when hospitals cry that the dead weight of about $40 billion in uncompensated care is pushing them under the waterline.

These observations and interviews led us to think about compassionate or charity care. Looking up these words clarified our work. *Charity* refers to “generous actions or donations to aid the poor, ill, or helpless”. It stems from *charite,* meaning Christian love (Random House 2001:348). *Compassion* means a ‘deep sympathy and sorrow for another who is

[2] Quality for everyone is significantly below standard, only 54.9 percent of recommended care.

stricken by misfortune, accompanied by a strong desire to alleviate the suffering" (p. 416). When physicians, nurses, or clinical administrators provide medical care to treat the afflictions of uninsured patients, especially in hospitals, they may do so because they feel such patients should receive such care, that access to needed medical care should be available to anyone who is suffering from an affliction, that access to health care should be a right, as it is in all other industrialized countries, and most others as well.

The more researchers at the Center for Migration and Development looked, the more compassionate charity they found, not just at the level of personal efforts by clinicians and administrators but also at the institutional level of programs, networks and complex organizations funded by city, county, and state governments. These observations are borne out nationally in the billions that hospitals report in uncompensated care (PriceWaterhouseCoopers 2005). In addition, the 514,000 active office-based physicians in 2001 reported that they donated on average 8.5 hours a week of their time to care for patients who lack insurance and cannot pay (American Medical Association 2004; Herring 2005).[3] The amount of time donated varies considerably by a) whether or not physicians own their practices; b) how much physicians feel they have control over their practice; c) how much the they report being subjected to managed care (Cunningham and Kemper 1998). If the total costs of office visits to a practice average $200-$400 an hour (net of patients' contributions), these 201 million donated hours represent $40.2 - $80.4 billion of charity, given in a very personal way, one patient at a time.[4] Although not nearly enough or dependable enough to substitute for universal access that is guaranteed in every other country, a significant amount of compassionate care and loss of income is represented by these actions. These acts of

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[3] AMA staff affiliated with the survey are not sure what physicians are reporting as donated time and feel the quality of the data needs to be improved.
[4] 514,016 office-based in 2001 x 8.5 x 46wks = 201mm x $200 = $40.2 bn.

compassion seem to embody something like Pogge's (2005) concept of relational injustice in a society or community, where the strongest moral obligation is to fellow human beings whose condition would worsen if not helped, whether immigrant or citizen.

Foundational Challenges

Based on field observations and interviews, secondary sources, and a critical reading of literature in sociology, psychology, economics, and moral philosophy, it would appear that the sociological analysis of compassionate charity and altruistic care pose foundational challenges to economics and economic sociology. First, compassionate charity and care (CC&C) are significant economic phenomena and not confined to a given sector like the household economy (Swedberg 2003:9). Second, they represent a theoretical frontier, because they challenge the allegedly universal laws of rational self-interest and reciprocity. They force us to consider the role of emotions and non-economic motives in significant realms of economic life. For example, CC&C employ scarce resources but not to make a profit. They have use value but often little or no exchange value (Swedberg 2003:7, 14).

Acts of compassion depend on private property (starting with one's own time) but open a new theoretical front. To the proposition, "Once private property exists, exchange becomes possible," is added, "Once private property exists, giving becomes possible." Third, acts of compassion and charity aim to redistribute scarce resources but in ways contrary to most existing models and theory. Fourth, the economy of compassionate care is profoundly different from and in part a response to the commodification of social life that Polanyi (1944 (1957):75) described. They aim to personalize, to leave something of one's self in another or object or relationship. Compassion, charity, and caring for the poor, the oppressed, or the

suffering, whether strangers or intimates are not recognized by markets and treated as "externalities." But they de-commodify and sometimes do so to counter the harmful effects of commodification, the unjust consequences of market activity or institutions. Further, they may result in transforming one's private property or resources into shared, communal goods and services.

Fifth, the institutionalization of CC&C appears to involve seven levels of increasing scope and three modes of legitimation. Of particular interest is the liminal mode that is rife with ambiguity and economic as well as emotional conflict. A new term, *institutional liminality* is used to characterize formal and relatively stable arrangements that keep treating uninsured patients in a no-man's land of uncertainty about whether a given visit or procedures will or will not get paid, and if so by whom for how much? The tensions and interactions between informal practices and culture and formal rules are central to CC&C but often overlooked in the organizational literature.

Sixth, CC&C is an unrecognized but important form of social capital, and an important resource for building social capacity. It seems uniquely able to initiate, generate, and foster social relations and trust where they are most needed. Finally, CC&C, except when episodically practiced, reflects the ways in which actors feel that prevailing institutions are inadequate or dysfunctional or unjust. As the authors of *Habits of the Heart* and *The Good Society* observe, the plight of the homeless or the untreated sick immigrant "…comes from failures of the larger institutions on which our common life depends" (Bellah, Madsen et al. 1991:4). Thus, sociological studies of how CC&C gets institutionalized and practiced will provide new and challenging perspectives on mainstream economic institutions and

government programs. Implicit is a desire for what Fred Block (2003; 2006 (March 20))has outlined as a care economy and a moral economy. What might such an economy look like? Should this not be a question that economic sociologists address in their work on the economy's relations to and impact on personal, family, and community life?

Beyond Reciprocity and Self-Interest

Giving, gift-giving, and philanthropy have received more attention than caring in the sociological and economic literature, but largely to explain them as expressions of self-interest, including reciprocity as an alleged universal law of society (Gouldner 1960). It may be universal in the sense of being pervasive, but not in the sense of explaining the motivational foundations of all social life.

Beyond the Reciprocity of Gifts

One important focus of anthropological and socio-economic theory and research has been on gifts, and the classic in this field is *The Gift* by Marcel Mauss (1950). He contended that the freely given gift "is only a polite fiction, formalism, and social deceit, when really there is obligation and economic self-interest" (pg 3). Benevolence is ruled out from the start. Mauss emphasized the socio-cultural context of individual behavior, principally the moral order of reciprocity that the collectivity creates through an iron triangle of norms: to give, to receive and to reciprocate. If someone refuses to do one of these, he threatens the enforceable trust that binds all three and thus faces severe sanctions. Around this triad of social interaction is "the notion of credit, or the time limit placed on it, and also the notion of honour…" (p 35). Together they form a "*system of total services*" that constitute a gift economy.

The continued attention to *The Gift* is puzzling, given its rigid insistence on an archaic, pre-market view of economic exchange centering on gifts and given its derivative nature. Mauss drew heavily on earlier studies by Levi-Strauss, Firth and Malinowski of gift economies, where gift-giving was the dominant form of economic exchange. Based on details of the Polynesian potlatch, Mauss's gift cycle is the pre-market equivalent of market exchange and Adam Smith's invisible hand. "The gift economy," Mary Douglas explained in her Forward to *The Gift*, "comprises all the associations – symbolic interpersonal, and economic – that we need for comparison with the market economy" (p xiv). Although reciprocal giving plays a role in modern life, Mauss overreached by trying to make his theory account for all of social life, and by elevating gift exchange into a utopia of sharing and happiness for modern society. Gift exchanges are not nearly as central to modern society as are other institutionalized forms of economic exchange (Gouldner 1960; Cook and Hardin 2001; Cook 2005). Acts of compassion, such as tending the sick or helping victims of disasters, challenge Mauss's core norm of reciprocity because what is given transcends pricing and because often so little reciprocity is possible. This is what makes the economic sociology of of compassion and caring important.

Far more relevant to modern gift-giving is the work of David Cheal and his intriquing concept of a gift economy within a moral economy that operates alongside the mainstream political and commercial economy. Over the course of 20 years' research, Cheal has studied in greater detail than anyone the symbolic, economic, and other sociological dynamics of giving but again focused primarily on gifts. This work is synthesized in *The Gift Economy*, "a system of action which is characterized by the principle of redundancy" (Cheal 1988:12). For a gift to be a gift it must be experienced as something extra that could be obtained by the

recipient, Cheal maintains. In gift exchanges, there is usually no net benefit to either party. Rather, gifts "are symbolic media for managing emotional aspects of relationships" (p. 5) in what Cheal calls a moral economy made up of "a system of transactions which are defined as socially desirable (i.e. moral), because through them social ties are recognized, and balanced social relationships are maintained." The absence of trust or the difficulty in trusting others in modern, mass society is overcome in the moral economy by individuals being committed to fulfill customary obligations to each other norms of beneficence that simplify the complexities of modern life and make one's world safely predictable. "A moral economy consists, in the first place, of a set of normative obligations to provide assistance to others so that they can carry out their projects" (p. 16), and when they are broken, reactions are vehement and the sense of betrayal acute. Gift exchanges are "a system of redundant transactions within a moral economy, which makes possible the extended reproduction of social relationships" (p.19).

Although this model is appealing, it is not clear what is meant by the word "economy." If gift-giving has little economic significance and mainly occurs to manage relationships, then a term like "gift interaction rituals" seems more apt than calling it an economy. The moral economy Cheal describes is grounded in interpersonal relationships, like oases of moral exchange in a world of commercialism and large-scale capitalism. Altruism and caring contribute to those personal microcosms of exchange, but they also extend beyond normative obligations and by definition may not or cannot be reciprocated. It is this claim to acts beyond reciprocity and rational self-interest that we now turn.

Although reciprocity may play little or no role in certain kinds of compassionate or altruistic behavior, Gouldner, Parsons and other theoreticians assume that reciprocity *must* exist for a given social behavior to persist. Yet Gouldner (1960) realized that the persistence of exploitation challenged his concept of reciprocity, though it did not work out a response. One could go further and make the same argument for torture. So would certain forms of compassionate care, the obverse of exploitation and torture. Another challenge is posed by power relations, and Gouldner discussed the problem of unequal reciprocations. But he considered them only from the perspective of those with power and not those without. Nor did he consider the willingness of those who feel compassion to reach out to the powerless, even when little or no reciprocation is likely. In sum, gift-giving and reciprocity are inadequate for explaining much of compassionate charity and care.

Beyond Rational Self-Interest

A basic challenge to any study of giving and caring is that they are self-interest in disguise. A long list of distinguished social scientists agree with Mauss that a true gift or benevolent act is a polite fiction, a social deceit. Claude Levi-Strauss, Peter Blau, Alvin Gouldner, Pierre Bourdieu, Robert Emerson, and nearly all economists believe that the rational self-interest of reciprocity is a universal law of social life. People only give or help in expectation of being reciprocated, even if deferred to a later time or returned in other ways, and that these acts are largely or entirely based on rational calculations. In other words, self-interest and the rational brain rule. Already one's theoretical suspicions are aroused: is this universal law of reciprocity based on self-interest disprovable, or is it true by conviction? If so, does the conviction serve the interests of its believers? Gouldner (1960) was smart enough to recognize that exploitation contradicted his universal theory of reciprocity because the

exploited cannot reciprocate, but he did not resolve the problem. The same challenge is posed by the obverse, altruism or caring that is not or cannot be reciprocated in any reasonable sense of social or economic exchange.

Rational theories of self-interest dominate academic and popular thinking, even though they have been shown to be limited and flawed (Mansbridge 1990; Monroe 1991). To explain seemingly altruistic behaviors, economists have argued that the presumed altruist assumes the preferences of the other and thereby tries to maximize them. This theoretical move preserves the theory that all action is based on self-interest, but it makes caring or benevolent individuals, associations or organizations seem unnatural, and it leaves unanswered why anyone would give up their own interests and take on someone else's interests in the first place? If there are reasons why one person would put the interests or needs of others before her own, why not others as well?

The Nobel-laureate in economics, Gary Becker (1976) proposed another variant of altruism as self-interest in disguise. He argued that altruism involves "interdependent utility functions" such that the altruist reduces his own gains for another. The beneficiaries, who are egoistic actors too, could take advantage of the altruist, but they would not want to inflict costs on the altruist that exceeded the benefits the altruist derives from giving, or the benefits would end. Thus altruism can be explained within the general framework of self-interest and egoism. Such a fine-grained, cynical calculus by egoistic beneficiaries, of just how much they can squeeze the altruistic goose without reducing its production of golden eggs, does not explain most benevolent acts (Monroe 1996:163-4). Becker's model allows no place for self-sacrifice; the altruist always gains along with the others.

More fundamentally, the distinguished economist, Amartya Sen, (1978) showed that the theory is circuitous and non-falsifiable. Agents' preferences are inferred *ex-post facto* from their actions. "It is possible to define a person's interest in such a way that no matter what he does he can be seen to be furthering his own interests in every isolated act of choice." Behavior is explained by preferences, which are explained by behavior. Econometric models assume that actors have a set order of self-interested preferences, and Sen pointed out that rational choice based on them would be inflexible and simplistic, making the ideal economic actor a "rational fool."

Philanthropy: The Warm Glow Theory

One answer to problem of economic man[5] as a rational fool is the economic theory of "warm glow" theory. Economists do not seem to have considered altruistic behaviors except philanthropy, perhaps on the tacit assumption that economics is about money and not valued goods and services more broadly. The puzzle is why do two-thirds of Americans donate to charities, especially given that they "only receive tokens (a coffee mug?), if anything, for their donations" (Andreoni 2001). The theoreized answer is that donors receive a feeling of warm glow or personal pleasure, a self-reward commensurate with the size of the altruistic gesture. Andreoni cites a decade of economic articles to support this idea, though no measures of relative pleasure or warm glow are used and no persuasive data presented. He concludes that giving away one's money is "just like any other consumer good" that makes one feel good; so that the warm glow from writing a check is like the warm glow from going to a good concert and having a latte. Some people have a preference for more warm glow,

[5] A woman is less likely to get herself in such a box. Much of the theorizing about giving and caring smacks of men trying to explain anomalous behaviors in simplistic, masculine terms.

Andreoni argues, just as they might have a preference for more lattes. People with more money give more because they "consume" more warm glow, just as they consume more of other goods. It is heartening to learn that wealthy people have a much greater capacity for feeling good about themselves, just as they have a greater capacity to consume lattes and vintage wines.

The warm-glow economic theory is, of course, an *ex post facto* construct that stands in for the premise that all acts that involve sacrificing (an inadmissible word in this literature, it seems) one's worldly possessions or time or even well-being. are based on self-interest. How much warm glow would one be able to measure when giving involves pain, or risk, or other forms of sacrifice? And if the warm glow from altruistic acts is no different than from other acts, why would people bother when they can get more direct and tangible warm-glows from a good conversation, a dinner, a good movie or even a good book than from writing a check for $100 or $1000 and putting it in an envelope? Finally, the warm glow theory is indifferent as to how one gets it. Some soldiers get personal pleasure from torturing military prisoners (Human Rights Watch 2005 (Nov 3)), while others feel good about taking care of a buddy suffering from loneliness away from home. It's just a matter of preferences. In his Nobel lecture, Gary Becker (1996) described his approach to racial discrimination in terms of "tastes for discrimination." Whether wage differentials by race are efficient depends in part on the "distribution of tastes for discrimination."

One could just as logically hold that some people have a preference for sacrifice or a preference for helping others as for warm-glow. But the warm-glow can quickly wear off. Working-age adults caring for a sick or disabled family member illustrate this point (Ho,

Collins et al. 2005). In a recent survey, one in every ten adults, and one in every five women age 50-64 is a caregiver, and over one-third reported missing more than one week of work during the past year because a family member was sick. On average these caregivers cannot afford to miss work; they are economically worse off. Nearly all these adults who were devoting hours every week to a sick family member were struggling with their own medical problems. They were nearly twice as likely to report poor health as other adults, and significantly more of them report not getting medical attention because of the cost. They are significantly less likely to have health insurance coverage, and sixty percent said they had problems paying their medical bills. How much of this huge voluntary effort is explainable by warm glow? Love, compassion and duty come to mind as other motives.

A Genuine Concern for Others

Does altruism, or “an unselfish concern for the welfare of others” exist? August Comte (Comte 1875 (1851)) recognized both self-serving motives and the unselfish desire to live for others. He seems to be the first to introduce the terms “egoism” for the first motive and “altruism” for the second. Anecdotes and intuitions aside, scientific empirical evidence that compassionate altruism exists as an independent and prevalent motive was not established for another century. The most rigorous body of research that examines the distinction between egoistic and selfless altruism has been carried out by C. Daniel Batson and Laura Shaw. The key distinction is that an egoist helps another in order to increase his own welfare, while an altruist helps others in order to increase *their* welfare (Batson and Shaw 1991:108-9).

One egocentric explanation for why people help others who are suffering that has been emphasized since Hobbes (but without good evidence) is that they want to reduce their own discomfort; while the altruistic hypothesis holds that altruists primarily want to reduce the suffering of the other for its own sake. Batson and Shaw's (1991) experiments found that subjects predominantly exhibited selfless rather than egoistic behavior. A second egoistic argument is that people help others to win praise or to avoid criticism for failing to help. Testing for the prevalence of these alternate hypotheses, Batson and Shaw found that subjects predominantly chose to help the victim, even when they knew their efforts would go unrecognized. Another claim made by skeptics of selfless behavior is that people help those suffering to avoid self-criticism. This too was not supported by the Batson and Shaw experiments. Aside from the widespread use of suppositional examples and anecdotes, these experiments carried over 20 years have not been challenged. Batson and Shaw's years of rigorous testing have established the prevalence of unselfish altruism over egoistic altruism. The fact that altruistic behavior can vary from occasional, minor actions to frequent, dedicated commitment suggests differences in temperament, socialization, culture, social supports, and institutionalization that warrant investigation. It also implies that society can design programs and organizations to facilitate expressions of altruism and caring (Wuthnow 1995; Healy 2000; Block 2003).

In her pursuit of *The Heart of Altruism*, Kristen Monroe (1996) provides a depth of qualitative detail that complement Batson and Shaw's rigorous experimental data concerning the nature of compassionate altruism. As a moral philosopher, Monroe sought out exemplars of altruism in order to learn more fully its nature. For Monroe, the archetypal altruists are those who rescued Jews in Nazi Europe. They risked their lives. Some used their food

rations to feed the Jews they were hiding before feeding themselves or in some cases their children. They risked being separated from their children and having either them or themselves killed. Why would they make such sacrifices and take such dangerous actions against their self interests?

Monroe tracked down surviving rescuers and interviewed them in depth. She also interviewed others who have exhibited sustained altruism in various other ways. She interviewed them using questions grounded in the philosophical and empirical literature on altruism. One might characterize Monroe as an empirical philosopher. From these materials, she concluded that committed altruists have a worldview or set of convictions about helping those in need, even at one's own risk or sacrifice. They did not help people indiscriminately, however, but acted only on specific occasions in response to specific needs of certain others. Monroe found no evidence that these altruists helped others in order to win approval for themselves, or to alleviate guilt, or to get something in return. Background factors included having suitable role models and growing up in a small town.

Sacrifice for Beliefs, Principles or Duties

One powerful kind of altruism raised by Sen (1978) that seems not to be addressed directly by these studies is dedicating oneself, even at great sacrifice, for a principle or belief. Sen argued that principled behavior poses the deepest challenge to economic theory of rational self-interest. People will give and sacrifice time and resources worth billions without any expectation of economic reward. Sen emphasized the economic importance of principles in affecting decisions about what goods or services should be made publicly available and how they should be allocated.

Agape

Closely related selfless altruism is the wider concept of *agape*. Stephen Post (2002:56) explains, "*Altruism* is other-regarding, either with regard to actions or motivations; *altruistic love* adds the feature of deep affirmative affect to altruism; *agape* is altruistic love universalized to all humanity as informed by theistic commitments." Altruism, Post explains, is the discovery of "the other as other" beyond one's self and self-interests, "…an affective, affirming participation in the being of the other." As Karl Barth, one of the most significant Christian theologian of the 20th century, put it, agape calls for a person to identify with another's interests, "…in utter independence of the question of his attractiveness, of what he has to offer, of the reciprocity of the relationship, or repayment…with no expectation of a return, even at the risk of ingratitude…"(in Outka 1972:208).

Because of the moral and cognitive strength that realizing agape requires, it is a commitment that can endure anger, hardship, and abuse (Outka 1972). Rooted in evidence from neurobiology (Post, Underwood et al. 2002: Part IV), *agape* implies a theory of social justice, not unlike Adam Smith's goal of benevolence for all (Smith 1759(1997)), and thus the development of social institutions that facilitate people's ability to care for others (Block 2003). Massey (2002:22) points out that ours has "become a fearful society," and fear releases chemicals that persist for some time. Endemic fear leads to impairments of learning, memory and bodily functions resulting in disease. Might a caring environment or commitment to agape elicit comparable nurturant responses that persist? In assessing what kind of difference faith-based social services can make to American society, Wuthnow (2004:256) writes, "The one thing that religious organizations claim to be doing that truly

makes a difference in the world is communicating love – unconditional love, the kind that comes from God and has been exemplified by great people of faith throughout the centuries. By serving the needy, religious organizations put into practice their traditions' teachings about love." For example, the policy board for the Methodist Church, like other Christian sects, exhibits a tireless commitment to compassionate care and bringing everyone together in fellowship (United Methodist Church General Board of Church and Society 2006):

> We commit ourselves as a Church to the achievement of a world community that is a fellowship of persons who honestly love one another. We pledge ourselves to seek the meaning of the gospel in all issues that divide people and threaten the growth of world community.
>
> We believe private and public economic enterprises are responsible for the social costs of doing business, such as employment and environmental pollution, and that they should be held accountable for these costs. We support measures that would reduce the concentration of wealth in the hands of a few. We further support efforts to revise tax structures and to eliminate government support programs that now benefit the wealthy at the expense of other persons.

The Board has developed specific positions regarding hunger, poverty, social security, debt relief, globalization, and economic justice. For example,

> While we recognize that the current state of immigration is complex, we believe that our calling as a people of God is to welcome the stranger and offer

> hospitality to the poor. This is a *command* that all who claim to be the people of God *must* follow (emphasis added).

There is no wavering here about immigrants taking away jobs from citizens or swamping social services. As a practical matter, Wuthnow has found in his detailed studies that unconditional love is not unconditional. It is limited by time, resources, emotional energy, standards of professionalism, and a set of expectations that recipients will be truthful, trustworthy, and take responsibility to get themselves back on their own feet. In major empirical work, Wuthnow (1991; 1995) has also documented that the degree to which people care for others, express concern, and sacrifice for others depends on how they were raised, what they learned as responses to the plight or suffering of others, and what organizational and institutional contexts exist that both legitimate and facilitate acts of compassion and charity. Those contexts may also legitimate universal rights, or they may sharply oppose rights and universal programs, as distinct from voluntary acts of compassion.(Hicks 2006).

Altruism and compassion challenge major economic and sociological theories of action and need to be recognized as motives in their own right for action by individuals, groups, organizations, and even states. Behaviors and relations in which reciprocity is minimal are extensive, and research into them would be rewarding. Batson and Shaw's studies indicate that selfless altruism and caring are prevalent. Their research foreshadowed the joining of economics with experimental social psychology in order to establish behavioral economics, and like other behavioral research, it opens the door to major revisions of welfare economics. Principled altruism and *agape* seem especially prevalent today, both for better

and for worse. Sorokin's (1950; 1954) extensive investigations at Harvard into altruism after the horrors of world wars and the holocaust concluded that while universalistic forms of altruism are a vital societal force, forms of what he called tribal altruism or sacrifice for one's tribe, such as religious wars and ethnic cleansing, have wrought more destruction than all hurricanes, tidal waves, and earthquakes combined.

Sources of Compassionate Care

The argument so far has established evidence that quite a few people express concern and compassion for others for altruistic reasons (and for egoistic reasons as well). What are the sources of these feelings and actions? It seems to me that the biopsychosocial predisposing factors can be organized into four categories: inborn biophysiological factors; early socialization and operant conditioning; the group and cultural context that leads to bounded solidarity, incorporation of beliefs or principles, and selective or segmented compassion; and the institutional settings in which people work or live that legitimate compassionate care and organize responses to it. Particularly relevant are churches and the degree of involvement among parishioners, and there is a broader, cultural halo effect as well (Wuthnow 1991; Ruiter and De Graaf 2006).

The other, complementary source consists of individuals or especially groups perceived to be vulnerable or in need as the objects of compassion. Feelings may be intensified by a sense of injustice. Organized expressions of compassion or injustice, and organized ways of responding (Wuthnow 1995; McFarland and Thomas 2006), plus the relative time and resources to do so are key variables that explain and predict the probability of actions on behalf of those suffering. These are summarized in Figure 1 and explored in their complexity

by Robert Wuthnow (1991; 1995) in his studies of volunteers that combine national survey data with detailed interviews and observations. Early socialization and early examples of bounded solidarity and selective compassion are principal reasons that volunteers give for their commitment to helping others. Volunteering for personal rewards is one, clear egoistic motive. In Wuthnow's national survey, 64 percent of volunteers reported that "It makes me feel good about myself when I care for others." Some of Wuthnow's subjects maintained the opposite, that one must first feel good about oneself and take care of oneself before you can effectively help others. Still others volunteered to get something back such as meeting interesting people or getting a feel-good pat on the back; so egoistic reciprocity is also part of the picture.. Thirty-two percent of the volunteers in the survey checked as a major motive, "If I am kind, others will be kind to me."

Figure 1

Experienced volunteers said that helping others to feel good or have their efforts reciprocated soon exhaust themselves or backfire. When things go wrong and inexperienced volunteers feel terrible, or the work stops being "fun" or "useful," or gets unpleasant, they quit. Caring was one of the weakest predictors of respondents' self-esteem or sense of worth, and 42 percent of all volunteers listed "I want to give of myself for the benefit of others" as a major reason their devoting their time to volunteering. This supports Batson's conclusions from his more precise social experiments and reflects a combination of the second and fourth motives in Figure 1. Just the fact that one has to stop doing everything else, for example, and perhaps travel to an immigration center to work with those in need is an act of both small-scale sacrifice and fulfillment of a kind that is not matched by pleasures like going to a concert or a ball game. But Wuthnow's studies do not consider ways in which people like

the clinicians who helped immigrant clients did so as extensions of their everyday work. Religious commitment was checked by 57 percent of those who volunteered as a major reason. Religious beliefs are intertwined with being active in church as a significant, independent predictor of voluntary activity – an example of group solidarity with principled agape.

Wuthnow also found evidence of something like an "altruism gene" or a personality trait. Since at least Adam Smith, compassion or what the Scottish philosophers called sympathy have been considered as part of human nature. For example, Wuthnow describes how Jack Hadley was always ready to help just about anybody: "Somebody'll call me up at midnight and ask me to drive them to the airport, so I will; or somebody'll call me at three in the morning and ask me to pick up their friend at the train station. So I'll say, sure I'll pick them up." (Wuthnow 1991:15). In this self-centered society, he wondered if he was neurotic.

Learned behavior, habit, and custom play a significant role in the lives of many volunteers. Wuthnow found that the children of parents who volunteered were much more likely to volunteer as adults, and Batson's group thinks this is an important source (Batson, Lishner et al. 2005). Many others had early formative experiences, like Tanika Lane (Wuthnow 1995:51). She grew up in a low-income neighborhood, and her parents did not volunteer; but her experiences at age 9 with a homeless family and reaching out to their daughter was the beginning of her caring for others. Beyond learning to care on a personal basis are communities and cultures where service to others is customary and constantly reinforced by routines and rules – our third and fourth source of compassionate charity. Behavior based on self-interest can be the exception or deviant, as in Amish communities. The medical

profession's current campaign to restore some of the trust and respect lost through the increasingly commercialized practice of medicine over the past 40 years emphasizes a dedication to service. Efforts to institutionalize a service ethos is one of several ways in which altruism gets institutionalized and helps people express their compassionate sentiments in a post-modern capitalist society. The success of such efforts in a health care system structured to reward profits and to avoid risks has been limited so far (Light 2000).

Biogenetic roots of compassion and caring?

Perhaps the least familiar and most intriguing source of compassionate charity and care is the possible role of deep-seated emotions. Among the sociologists who have explored the often ironic role of emotions on economic life (Zelizer, Hochschild, Smelser, Collins, DiMaggio, Berezin), Douglas Massey (2002) has assembled the most foundational case for their importance. Massey's synthesis of literature about the central and precognitive influence of emotions on what is usually considered rational action calls for sociological researchers to recognize the far greater number of signals from the seats of emotions in the "emotional brain" to seats of cognition in the "rational brain" than the number being sent back the other way. "Emotionality remains a strong and independent force in human affairs, influencing perceptions, coloring memories, binding people together through attraction, keeping them apart through hatred, and regulating their behavior through guilt, shame and pride" (Massey 2002:20). Is nurturance and caring for others part of the emotional brain? Given that a self-selected minority devote time to the well-being of others, is empathy and the desire to help others a genetic or temperamental expression?

Caring for others appears to have neurobiological foundations (Post, Underwood et al. 2002: Part IV). Experimental social psychologists have found three types of evolutionary empathy in chimpanzees as well as humans: *emotional empathy* (understanding another's emotion and aligning with it), *cognitive empathy* (understanding another's non-emotional state and aligning with it), and *extended empathy* (extending oneself to help meet the needs of strangers) (Preston and deWaal 2002). Ruse (2002:157) believes that humans "…have built in innately, or instinctively if you like, a capacity for working together socially." Humans use this capacity to construct social norms and mores and institutionalize them. This is not an option but the way humans are, and it takes one beyond survival of the fittest or expansion of the species to more universal forms of altruistic caring.

Is a sense of injustice, or what the moral philosopher, Thomas Pogge (2005), calls "relational injustice," part of the emotional brain? When seeing or hearing that others are being abused or allowed to suffer badly, are emotional responses of shock, empathy, or shame largely products of socialization and learning, or is there an emotional seat of injustice as well? When people adopt someone else's child, or help the weak and needy, reach out to victims, or invest in caring for the dying and the dead, they seem to be expressing deep parts of the emotional brain. Even so, Massey emphasizes the key role of operant conditioning, early learning, and environment in activating, shaping, and in a sense exercising basic emotional components of *homo sapiens*. The implication is that, beside temperamental variations, basic parts of the emotional brain are activated and shaped by early childhood experiences and subsequent role models, by cultural practices, and institutional capacities. This biopsychosocial model of emotional expression implies that early childhood experiences, role models, cultural practices and institutional supports contribute to compassionate care in

complementary ways, and that missing factors may leave such feelings dormant, or present but without knowing how to express themselves. This may be why it seems so hard to move closer to “the good society” (Bellah, Madsen et al. 1991).

Outcomes: Building Social Capacity Through Compassion and Caring

One of the strengths of compassion and caring is their self-generated capacity to build what Putnam (2000) called “bridging social capital.” This metaphor, however, does not do justice to the broader roles that compassion and care can play in not only bridging what is already there but building social capacity by establishing trust, forming social bonds, and enabling people to find common solutions to challenges they face. Compassionate care puts a different slant on these relationships. It bestows social or economic capital, or both, on individuals or groups by giving some of oneself or one’s money, based on a spiritual or emotional source. Caring tends to strengthen bonds, generate greater trust, and enhance solidarity, usually in a bounded manner.

Caring may be grounded in one’s identity with the object of caring, such as members of an ethnic group helping others in need. But a substantial proportion of caring reaches out beyond one’s group and may create new manifestations of social capital. People with little income may feel compassion and care for others, though having some economic capital and social capital helps. Such caring usually is not based on reciprocation, except perhaps in long, indirect ways. Intertwined with caring as a new source of social and perhaps economic capital is what might be called religious capital. Religiously active people form friendships and networks with kindred spirits, and while this might be called social capital, it differs profoundly in its source and character. REF It is grounded in faith before anything else and

thus warrants recognition as "religious capital." People of faith believe it is their responsibility to act like the Good Samaritan, the one story in the Bible that Wuthnow found was remembered by more people than any other. Caring and giving, especially to those too poor, or lost or wounded to reciprocate, are a duty grounded in belief.

It would be interesting to investigate the relationships between social and economic capital and the different kinds of response to a national tragedy such as Hurricane Katrina. In a substantial though proportionately small cases, distant strangers perform acts of compassion that create new relations, obligations and build up social and economic capital that has been shredded by disaster. Churches nationwide urged parishioners to take a displaced family into their homes or adopt a family, and many responded. The family featured in *Life* had very little income and modest social capital, it would seem, but took an entire extended family into their home (Stricklin 2005 (Oct 14)). Less unusual but notable were the thousands who used personal and vacation days from work to travel to New Orleans or Houston and helped displaced victims personally in ways that created powerful, lasting bonds (Gaona 2005 (Oct 10)).

These examples suggest more work needs to be done on interactive dynamics between compassionate charity, agape, and social capital. We already know that social capital and networks are so powerful that they can affect one's health as much as regular smoking (House, Landis et al. 1988; Patrick and Wickizer 1995). Hendrix and his colleagues (2002) carried out a sophisticated study that developed measures of social capital by state, such as the number of services a state's health department provides and funds, the number of collaborations by health departments with others, and the level of perceived trust and self-

esteem. He found they correlated with poor people's access to health care. Putnam's concept of bridging social capital may provide a useful start, but how does it actually work?

In addressing this question and the special capacities of caring, one needs to rethink the nature of "social capital" itself. The term has become such an intellectual bandwagon that it now refers to a heterogeneous mixture of definitions and attributes as well. Bourdieu defines it as "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutional relationships of mutual acquaintance or recognition" (Portes 1998:3). With "actual or potential" and "more or less", plus "linked" "acquaintance or recognition" as further qualifiers, this definition is embarrassingly vague. Coleman's definition is even more vague and circuitous because he defined social capital by its function: a "variety of entities" involving "some aspect of social structures" that "facilitate certain action of actors…" Other definitions are equally vague, circuitous or contradictory, such as competing theories that social capital benefits from loose ties, strong ties, or no ties. The relationships between what are inputs, what is social capital, and what are outputs shifts from study to study. Is social capital a source of parental and kin support, or is parental and kin support a source of social capital? Is enforceable trust and the social control it provides an input or an outcome of shared values, solidarity, and interaction? Are the benefits an input – the resourced linked to the network or group – or an outcome? Is trust a source of social capital, or part of it, or an output?

The elements of "social capital" do not always go together either, and more widely it is unclear in which direction the causal relationship goes. Do more networks and associations generate more generalized trust, or does a greater level of trust generate more networks and

associations? As Portes points out, this wider concept is vulnerable to circularity, whereby its existence is measured by its outcomes; but the same problem holds for more sociological definitions as well. The larger question is why call this cluster "social capital"? What is the value added, or value lost? As Stephen Smith and Jessica Kulynych (2002:150) write, "to characterize civic engagement and the preconditions of democracy as social capital is to foster the view that community involvement and political participation are forms of economic activity…" They make a persuasive case for characterizing the benefits of community projects, associations, and generalized trust as *social capacity*. While social capacity can have economic benefits, it is much broader.

Economic sociologists use the term in an economically narrower way than do other social scientists to mean "the ability of actors to secure benefits by virtue of membership in social networks or other social structures"(Portes 1998). According to Bourdieu, "the profits which accrue from membership in a group are the basis of the solidarity which makes them possible," so people deliberately construct sociability for the purpose of creating this resource. Portes (1998:3), in his review of Bourdieu, continues, "Social networks are not a natural given and must be constructed through investment strategies oriented to the institutionalization of group relations, usable as a reliable source of other benefits." Is this why people make friends, join others who share their interests, organize a soccer league for their kids, or go to church? Much of social life, it seems, and decades of solid sociological research is being reduced to a form of capitalism.

Besides conceptual vagueness, circularity, and the danger of characterizing social life as seeing what people can get out of their friends, neighbors, and colleagues, the concept of

social capital is challenged by negative cases. How, for example, can social capital theory and research explain the downward, even drop-out, mobility of children (particularly males) who grow up in university-trained, professional homes, surrounded by an unusual degree of trust, reciprocity, resource-rich networks, and supporting social structures, not to mention a large amount of human capital and money? Or what are the implications of delinquent gangs for the prevailing upbeat concept of social capital. Rich in networks and interaction; replete with value introjection, bounded solidarity, reciprocal exchanges, and enforceable trust; these gangs use all that "social capital" to trash getting an education, taking jobs, saving money, starting a legitimate business, or supporting community life. Portes (1998) is one of the few to identify the negative as well as the positive consequences, such as bounded solidarity also restricting individual freedoms and excluding outsiders; but cases like delinquent gangs (and there are more) indicate that the concept needs to go beyond negative effects and take into account backfire examples of negative cases.

Stephen Smith and Jessica Kulynych (2002) provide a detailed and compelling account of how this unfortunate metaphor arose and why it is both damaging and misleading. One implication is that economic sociology is relegating itself to become a branch of economics, whose task it is to analyze how actors can profit from social forms of indirect capital. The same dangers hold for "human capital" and "cultural capital." Is the only or principal point of education to increase one's earning power? If so, most professors are wasting their time as they read, puzzle out an intriguing problem, or just want to learn something new. If the goal of getting a PhD is to make more money, think again. Compared to a high school classmate who took up a trade, like plumbing, a PhD graduate in a solid but not prestigious program might catch up with his classmate's life earnings by the time he is 55. Is the point of

acquiring cultural knowledge and skills to cash in on them, even indirectly? Granted that "resources" are occasionally linked to soccer leagues, or having a PhD, or knowing modern art, but what does the term "social capital" mean for the rest of us? If no benefits are secured, does this mean there is no social capital?

Outside economic sociology, "social capital" is defined more broadly as "features of social organizations, such as networks, norms, and trust, that facilitate action and cooperation for mutual benefit. Working together is easier in a community blessed with a substantial stock of social capital"(Paxton 202; Putnam 1993:35-36). The community stock comes from having many social organizations and associations, and the networks between them and beyond. Mutual benefit is intentionally broad, and a large international focus has been on generalized trust and trust in political institutions as critical to enabling cities, regions, or states to solve a range of problems or launch new programs successfully. Thus a decade later, social capital still refers primarily to generalized trust, civic engagement, and trust in political institutions (Hooghe and Stolle 2003:1, 136). Participation in voluntary associations and informal networks are said to generate this wider engagement and trust, which also reinforce each other. These involve a structural component (organizations, associations, networks), and attitudinal component (norms, trust, reciprocity), and possible action (participation levels, civic engagement).

Since greater social capacity is said to enable a neighborhood, community, region or nation to address problems more successfully and to facilitate entrepreneurship and economic growth, a fundamental question is how to restore lost social capital or generate more of it. Heads of state and national programs have launched myriad programs to generate more

social capital as a key to enhancing social trust, civic capacity to manage problems, and entrepreneurial growth (Hooghe and Stolle 2003). But little empirical evidence supports these programs. Efforts to establish which attributes generate the others and therefore “social capital” as the collective noun have found the search complex and frustrating (Hooghe and Stolle 2003). Probably the clearest contributors are the least subject to change. Putnam (1993), Fukuyama (1995) and others (Foley and Edwards 1998) have emphasized the role of history and culture in explaining why some countries, regions, or subcultures have more civic engagement and generalized trust. Level of education and income, degree of inequality and poverty, race, and gender correlate strongly and suggest self-reinforcing differences among social groups. None of these six variables is a promising candidate for policy reform, and most of them are interconnected in path dependent ways. This leads one to ask, is social capacity really social class in conceptually fancy dress? If the dynamic relationships between the elements that make up social capacity are largely self-reinforcing, or bonding, how can bridging or building networks, associations, and community efforts be made from the well-resourced to the least?

One possible answer worth exploring is the hypothesis that acts of compassion and charity help build bridges between groups separated by class, culture, stigma, or institutional barriers. A corollary hypothesis is that caring individuals, groups and organizations can play an important role in building social trust and capacity to work together in a Putman kind of way. Studies like *Acts of Compassion* are about the actors, not their effects on recipients. If one were to assess community-based efforts to help or shelter a particular group of vulnerable people, would one find evidence that social bonds and trust had been built that were not there before? Organized efforts by churches and other groups to aid, befriend, and

advocate for immigrant groups would be a good research site. At a broader and therefore more diluted level, social welfare organizations advocate for the social, economic and political welfare of others, as distinct from interest-group organizations that advance their own interests (Van Deth and Kreuter 1998). From the perspective of economic sociology, such movements can change the institutional and legal environment for economic action substantially by providing organized voice for those who feel there is no exit (Light, Castelblanch et al. 2003).

Figure 2 summarizes the sources and outcomes of compassionate charity and care. The list of positive outcomes specifies the ways in which social capacity can be increased and the plight of others can be helped. The most substantial economic consequences result from redefining and mobilizing values or principles, such as civil or disability rights, and getting them institutionalized in laws, customs, and programs. But short of institutionalizing voluntary acts, compassionate charity and care can have serious limitations that center around their paternalistic nature. Actually, there are two perspectives on this matter, summarized in Figure 3 as two ends of a continuum. Interesting research could be done on the institutional circumstances and organizational features that distinguish more altruistic from more egoistic initiatives.

INSTITUTIONALIZING COMPASSIONATE CHARITY AND CARE

In a market economy and a commercialized society, acts of compassion from an economic perspective are informal behaviors outside or at the edges of mainstream economic institutions. They involve a different, or several related logics of action that challenge the completeness or legitimation of the mainstream logic. Mainstream institutions may attempt

to outlaw, or limit or control or embrace or even co-opt CC&C activities and players. Institutionalization appears to take place at 7 levels of increasing institutionalization and scope: personal and episodic, personal and routine, local unit routinization, trans-unit but intra-organizational routinization, development of networks and collaborations, interorganizational routinization, and systemic institutionalization. FIGURE 4 provides a matrix of levels of institutionalization and degrees of legitimation in health care.

Figure 4 about here

While the levels of institutionalization imply a progression of development over time, researchers may find that different patterns of CC&C are practiced at different levels so that one finds some individuals who carry out acts of compassion episodically, , others who are committed on a regular basis, some localized institutional arrangements, and perhaps some patterns of collaborative care. These are intertwined and affect each other over time. For example, in one metropolitan market area we found some primary-care physicians who see charity care as part of their role but also some primary-care practices, where charity care is part of their institutional identity and financial planning. Getting subspecialists to donate their time and testing is the most difficult in this market and most others. One solution has been to find over time those subspecialists who are willing to donate a certain amount of time and expenses to poor patients in special need; but this informal network works largely on an episodic, personal basis. Most specialists have formed for-profit, corporate practices and run them like businesses. Patients' doctors call on the compassion of willing specialists, but sparingly. These interactions are a nice example of informal economic behaviors found in many economic domains yet not usually captured in studies of economic transactions (Light 2004).

Cross cutting these seven levels are types and degrees of legitimation, which can be regarded as modes of incorporation into the organizational context of donating goods, money or one's time. For example, an independent plumber or physician can make a home visit to address a crisis and decide not to bill a client in financial distress, but not as an employee of a company or medical practice. The legal and regulatory issues surrounding donations of goods often differ from giving one's time or even the time of another. For example, just before leaving for the airport, a worker stepped on a rusty industrial staple. When he arrived at his destination, friends rushed him to a large primary care practice that treats patients on a cash, insurance, and *pro bono* basis (an example of institutionalized compassionate care in a local practice). One of the doctors saw him between patients, that is, off-record; but giving him a tetanus shot posed other issues, because it is a controlled substance, and each vial must be accounted for. Mentioning his dilemma, he recorded that it was a defective vial and discarded, thus administering the tetanus shot off-record as well. The patient was deeply grateful for being rescued from spasms, rigidity and possible death, a priceless service which he could never repay. For the record, this act of compassion and charity never happened.

At the other end of the continuum, organizations celebrate employees who go out of their way to help the needy. They give out Community Service Awards and set up programs of voluntary services. This can edge over to co-optation, as described in a review that contrasted community health care of the 1960s based on advocacy for the poor with a second wave in the 1990s based largely on image-making by increasingly commercialized organizations (Light 1997). As Ron Anderson, one of the most dedicated institution builders of community services for the poor observed at the time, the distance that hospital CEOs

traveled to attend workshops on how to do community service was inversely related to how serious they were about it. Travelling to an executive workshop in Beaver Creek or Bermuda with one's partner and best golf clubs was a sign that one did not know one's own community and the unmet needs of its residents.

Most interesting is the liminal character of many donated services and goods, hovering between the boundaries of legitimate or illegitimate, routine or exceptional, personal or institutional. Antithetical to structure and hierarchy, liminality obliterates established categories and is characterized by ambiguity and paradox (Turner 1969; Lindsay 2006). Implicit in the cells is the tension and dialectic between informal cultures and practices among staff clinicians and the organizational rules and regulations. Also implicit and not captured by this static matrix are the ways in which personal, illegitimate practices in the upper left corner can lead to systemic changes in the lower right. A sociological study of rules requiring thorough documentation of patients to qualify for Medicaid or for other programs offering free care, for example, would find initial efforts to break the rules or fake the records by clinicians who wanted to treat sick immigrants. But the rules defining illegitimate care and the mission to treat the sick and reduce "health disparities" threw compassionate care for undocumented patients in a state of liminality. This led to increasingly intense discussions: is our primary goal to be sure no one lacking full documentation gets the care they need in order to protect the program from malingers? Or is our primary goal to treat sick patients and encourage them to come in? Patients who don't want to be traced give us false names and addresses anyway; so what is the point? Increasingly, more local units (principally family medicine departments and primary care practices) in high-impact areas developed ways to satisfy bureaucratic regulations and/or

persuaded legislators to relax documentation requirements. Documenting undocumented poor patients had move down and over in Figure 4 to the middle cells. Customs and rituals were developed among leaders of immigrant health care to assure undocumented patients that coming in for treatment was completely confidential and safe from INS officers trying to nab them at a point of vulnerability, visibility and record. By 2005, federal rulings and practices had completely reversed the nativist, strict rules of documentation.

Discourse analysis is the most coherent framework for analyzing the processes of institutionalization, especially in the case of charity and compassionate care, where they get constituted through discourse and rituals of legitimation (Phillips, Lawrence et al. 2004). That acts of compassion produce texts and documents lends them to research and to identifying different kinds of compassionate care and charity in terms of their relationships to the boundaries and practices of the prevailing organizations. Acts of compassion produce both sense-making accounts and documentation that deign to fit their liminal character into the accountability rituals of the prevailing organizations (Weick 1995). The liminal nature of compassionate care means that it can be regarded as a compensatory act that actually reinforces the inadequacies of prevailing institutions and practices, or as a symbolic challenge to their legitimacy, or as simply personal exceptionalism that has no larger implications. This a-political, individual framing comes across in the studies by Wuthnow (1991; 1995), which is probably why the relationships between the acts and the institution-rooted problems they are addressing are not explored. But a testable hypothesis is that physicians and service units offering *pro bono* care to poor patients come to realize how futile and frustrating it is to treat one uninsured patient after another within a system that “manufactures” uninsured patients by design.

A sense of compassion and charity leads some actors to a sense of injustice towards dysfunctional institutions that need to be reformed (Bellah, Madsen et al. 1991:Ch 2). This is what Bellah and his colleagues call "the great problem…of embodying ethical ideals in the individual actions of people working with others when one cannot alter the larger institutional context that produces the suffering one is trying to alleviate" (pg 32). As one volunteer, Murphy Davis, put it, "our little crumbs are not enough. What the poor and the downtrodden need is not our piecemeal charity but justice." The discourse of her institutionalizing her compassionate care is anchored in Biblical text and God's commandments, but its liminal character challenges the legitimacy of long-established economic institutions that manufacture hungry and homeless people, as corporate health care in a system where access is an option manufacture patients who cannot afford the medical services they need.

Medical impoverishment is official United States policy. One cannot become eligible for Medicaid coverage until one has used up one's life savings ("spend-down") and lost all but a minimal income. On the other side of medical impoverishment are hospitals and clinics that legitimate charity care as part of their mission and evidence of how much they care about the victims of the system in which they operate and accept. The most notable examples are community, non-profit hospitals, where offering charity care is required to retain their tax-exempt status but is also a source of story-telling about compassion and generosity that become established as part of the institution's identity. For-profit hospitals also offer free charity care to indigent patients, though to a lesser degree, and they too construct coherent discourse about their dedication to healing the sick. Less commonly understood is the

“hidden abode” (Portes 2000) or covert goal to keep health care voluntary and fragmented, because such a structure maximizes opportunities for profit while shifting less profitable services to other institutions and minimizes an equitable, level playing field for all providers as well as patients (Starr 1982; Light 2004).

Another interesting way to frame compassionate care and charity is as entrepreneurial action (McMullen and Shepherd 2006). That is, acts of compassion are acts of initiative in response to perceived opportunities, in this case opportunities to help those in need and to sacrifice one’s time or resources. Some, like Murphy Davis, are true entrepreneurs, what Spector and Kitusi characterized long ago as moral entrepreneurs. REF What started out as an effort to shelter the homeless led to Ms. Davis selling her home in order to finance a community shelter and a full-time avocation. Like the Austrian model of entrepreneurial action promoted by McMullen and Shepherd, her willingness to bear uncertainty was a key attribute, as it is of people who give away time and resources in their job as physicians and administrators. Will they be called on the carpet and disciplined, or will their extra efforts be used as a symbol of their institution’s high moral character? Given the liminal character of such charitable acts, why not both? In my own case, an exhausting initiative to stop Blue Cross and Blue Shield from discriminating by income and ethnicity led first to a formal warning that such actions had nothing to do with my job or the university’s institutional functions, and later to being given a university award for community service (Light 2005).

In our field studies, we found a number of physicians and administrators seeking and taking entrepreneurial action to make free care available to the poorest and most vulnerable, often undocumented workers. They were agents of organizational change like Durand and Calori’s

(2006) unusually philosophical contribution to organization change theory and the role of "practically wise powerful agents" to epitomize moral leadership in addressing the challenges of "otherness," such as patients with significant medical needs but no way to pay for treating them.

A paradox of institutionalization for compassionate care and charity is that as it becomes more fully institutionalized, it loses its perception of being either compassionate or altruistic. More and more people have a stake in the revenues and budgets, in the economic levers, and in control over the resources or agencies dedicated to charity care. As one moves down the column in Figure 4 of legitimated charity care, the formality and scope of institutionalization increases. In the bottom right corner is systemwide arrangements for charity care. A companion paper (Light and Lee 2006) traces the history of how voluntary charity care by hospitals in New Jersey (that is, intraorganizational routinization) led to a series of unanticipated consequences and systemic pathologies that threatened its continuation. Hospital leaders and legislators worked together as "practically wise powerful agents" to create a mandatory system to spread the burden of inner-city hospitals across all hospitals. This created new kinds of problems and resulted in a revised set of institutional practices that spread the burden even more widely. Practically speaking, free care to indigent patients, especially to those sick enough to be hospitalized, has become increasingly universal or "socialized," but is it then no longer compassionate care? Is the universalizing of compassionate care bureaucratic care? The hundreds of millions of dollars involved are being allocated with increasing fairness and efficiency. Voluntary charity care no longer has to depend on the good will or moral commitment of individuals. Yet there is no vocabulary for celebration, like "the caring society." New Jersey has done much more. It offers the full

Medicaid range of options to the greatest number of residents. It has maximized insurance coverage for employees, and it has exploited federal programs for community health centers. This multi-pronged effort has produced one of the most universal and just health care systems in the nation, especially for immigrants. Thus an ironic consequence of compassionate care leading to more just institutions seems to be its absorption into a language of public health care.

Institutionalizing Liminality (Move to 39?)

The moral dilemmas and economic burdens that uninsured patients pose to hospitals and other providers have undergone only modest changes since 1964, when Medicaid and Medicare were finally passed so that the costs of services for the elderly and about half the poor would be paid. In every subsequent decade, senior administrators have felt tormented by the liminal state of uncompensated care and charity care. Which parts of this huge economic activity will be paid for and by whom, if anyone? The number of uninsured has been rising steadily for years, and the costs of treating them have been rising faster. Because almost all the research is based on secondary analyses of large data sets, or on interviews, we know relatively little about how different hospitals actually decide which uninsured patients to treat, or what scripts or practices they employ. But the continual, tormented dilemmas about treating sick patients without means or insurance indicate that that the liminal nature of efforts to help them is deeply institutionalized.

One aspect of this institutionalization is how American hospitals are paid for uncompensated care, or not paid as is so widely claimed. For example, the New York Times reported that in 2005, California hospitals “spent at least $1.02 billion on health care for illegal immigrants

that was not reimbursed by federal or state programs" (Preston 2006 (July 18)). One wonders, who in those hospitals decided to provide so much care that was not going to be reimbursed? What rules and rhetorics shaped those decisions? If we assume that clinicians and administrators decided *not* to provide at least an equal amount of medical treatment for sick immigrants, how were those decisions made? At the same time, one needs always to "follow the money," and this turns out to be more difficult than either the New York Times reporter or the government report he cites can accomplish. First, one needs to know that "spent $1 billion" usually refers to the total value of *charges*, billed at the maximum retail or rake-rate to patients or any party with whom a hospital does not have a discount contract. Thus the word "costs" almost always refers to charges, as in "That operation cost $12,000." The cost of hospital services are usually 1/3rd to 1/4th the retail charges or the rake rate. Thus, even if federal and state programs for charity and uncompensated care were to reimburse all the actual costs, two-third to three-quarters of what hospitals "spent" would not reimbursed.

Second, one usually does not know what the denominator is to a claim that a billion dollars was spent on health care for illegal immigrants. Was it 1 out of 4 or 8 or 16 billion? What is the proportionate loss? Further, if government programs reimbursed a quarter or a third of that total, they probably reimbursed all the costs, and the hospitals were made whole, even as their powerful CEOs became increasingly enraged at how immigrants and "the system" was abusing them.

If we turn from theoretical speculation to the tangled and occult ways in which hospitals get paid, we find that all this charity care is not given away. In one of the most comprehensive and authoritative efforts to find out how much hospital treatments for uninsured patients cost

and how much hospitals receive for them, a veteran research team concluded that nationally in 2001 the uninsured received hospital-based services worth $38.6 billion in charges and patients paid $14 billion out of pocket, a huge personal burden and a major cause of medical impoverishment (Hadley and Holahan 2003). These services actually cost the hospitals about $10 billion; so uninsured patients were made to pay 40% more out of low incomes and meager savings than needed to fully pay for the *costs* of the services they received!

Hospitals, meantime, claim that they bear a burden of the $24.6 billion difference between $38.6 and $14 billion. To recover these "losses" in charges (but not costs), they have lobbied hard and won at least five forms of payments. Hospitals where many uninsured patients are treated receive Medicare DSH payments from the federal government for treating a Disproportionate Share of inpatients lacking coverage. There are Medicaid DSH payments as well. Additional funds come wrapped inside payments for graduate medical education. State tax appropriations are another source, as are local indigent care programs. Finally, tax exemptions and other tax concessions constitute an indirect form of compensation for treating all who need help. Thus, "charity care" is compensated in at least five ways besides direct cash collected from uninsured patients. When Hadley and Holahan totaled all these sources of compensation, they concluded that hospitals received $26-28 billion for their $24.6 billion in uncompensated care, almost all of it from legislative programs "with the intent of providing care to the uninsured." Thus the $10 billion in costs for treating the uninsured yielded $14 billion in cash from uninsured patients plus $26-28 billion in government payments, a summary one will rarely find in the press or literature. The liminality of "charity care" – who is to treat the poor and how is it going to be paid for within a deeply commercialized and revenue-driven system, is embedded in the legal

ambiguities and institutionalized practices. Meantime, patients with serious symptoms stay away from hospitals for fear of getting large bills and being chased by collection agents; doctors and clinical administrators wring their hands over whether to treat a given uninsured patient and to what degree; and the overall system spends far more than it needs to in highly inefficient and unaccountable ways, just to avoid what is called "socialized medicine," which in many other wealth, capitalist countries consists of private care paid for by everyone in proportion to their ability to contribute to shared funding systems. The other facets of liminality in Figure 4, the tacit and limited forms of charity care, the informal networks and arrangements to handle certain kinds of cases, and the ways that care is decided to be given or not, await further research. Of equal interest are accounts over time describing how liminal practices become legitimate or illegitimate.

COMPASSIONATE CARE AND THE NATURE OF A JUST ECONOMY

This paper has made the case that compassionate charity and care constitute significant economic activities that challenge basic tenets of economics and economic sociology. Acts of compassion, if done with a consciousness of the institutional practices and injustices that often contribute to the plight of those being helped, can lead one to thinking about what a just economy would look like. This search could be one way of characterizing the most systematic effort in our time to think through a moral philosophy of social and economic justice in the 188-page, single-spaced "letter"(National Conference of Catholic Bishops (USA) 1986). The principles and the working out of their implications are grounded in Old Testament as well as New Testament scripture so that Jews as well as Christians are likely to agree. It seems to me that agnostics and atheists are likely to agree with most of the argument on humanitarian grounds. If sociologists took several years to think through what a

just economy would look like and consulted widely as the Catholic Bishops did with business, government and other leaders, they might conclude in different language that their research into the sociological nature of racism, the injuries of class, the meaning and alienations of work and unemployment, the factors that make communities viable, and the dynamics of family life support a rather similar design as in the 188-page, single-spaced "letter" that the U.S. Catholic Bishops wrote (National Conference of Catholic Bishops (USA) 1986).

This treatise on a just society and economy begins with the dignity of each person and the command to love one's neighbor as one's self. It quickly comes to the conclusion that compassion for the poor and powerless is the clearest manifestation of a respect for and love of other individuals. Writ large, this means that *all social and economic activity should be evaluated from the viewpoint of the poor and powerless*, a point so seminal that the authors put it in italics. Increasing active participation in economic life by those who are presently excluded or vulnerable is a high social priority. Human dignity can only be realized and protected through full participation in community life.

The human dignity of all is realized when people are given the power and resources to work together to improve their lives, strengthen their families, and contribute to society. Basic justice calls for more than providing help to the poor and other vulnerable members of society. They must be empowered as well. Respect for personhood and the Golden Rule lead to the concept of basic rights to life, food, clothing, shelter, rest, medical care, basic education and employment. In order to ensure these necessities, all persons also have a right to earn a living. Thus maximizing full employment, at fair wages and under humane

conditions, are a more primary goal of a just economy than maximizing profits. People who cannot get a job are deprived of participation that is vital to human development. The right of workers to organize and advocate for their rights and interests must be recognized.

A just society and economy are based on three kinds of justice: commutative justice, distributive justice, and social justice. Commutative justice calls for fairness in all agreements and exchanges between individuals or private social groups. Distributive justice requires that the allocation of income, wealth, and power in society be evaluated in light of its effects on persons whose basic material needs are unmet. Social or contributive justice requires that all who are able contribute to the community as a whole. Governments are to protect human rights, secure conditions of justice, generate employment and fair labor practices, and assist the poor, the disadvantaged, the handicapped, and the unemployed in participating fully in economic and social life.

Could a similar coherent vision of a just society and economy be developed from other starting points than God's commandments in the Old Testament or Jesus's unconditional love in the New Testament? I think it could. For example, one could start with Aristotle's view that the goal of life is to flourish, for each individual to flourish to the greatest extent possible. Or one could start with Carol Gilligan's view that caring is the foundation for morality. Both would lead to requiring the conditions needed to flourish or to care for one another, or both – to flourish and to care. Both would condemn sharply racism, sexism, other forms of discrimination, and all forms of exploitation. Both would also call for a participative kind of governance. And both would call for profound improvements over an economy and society based on self-interest.

Figure 1: Sources and Mediating Stimuli of Compassionate Charity and Care

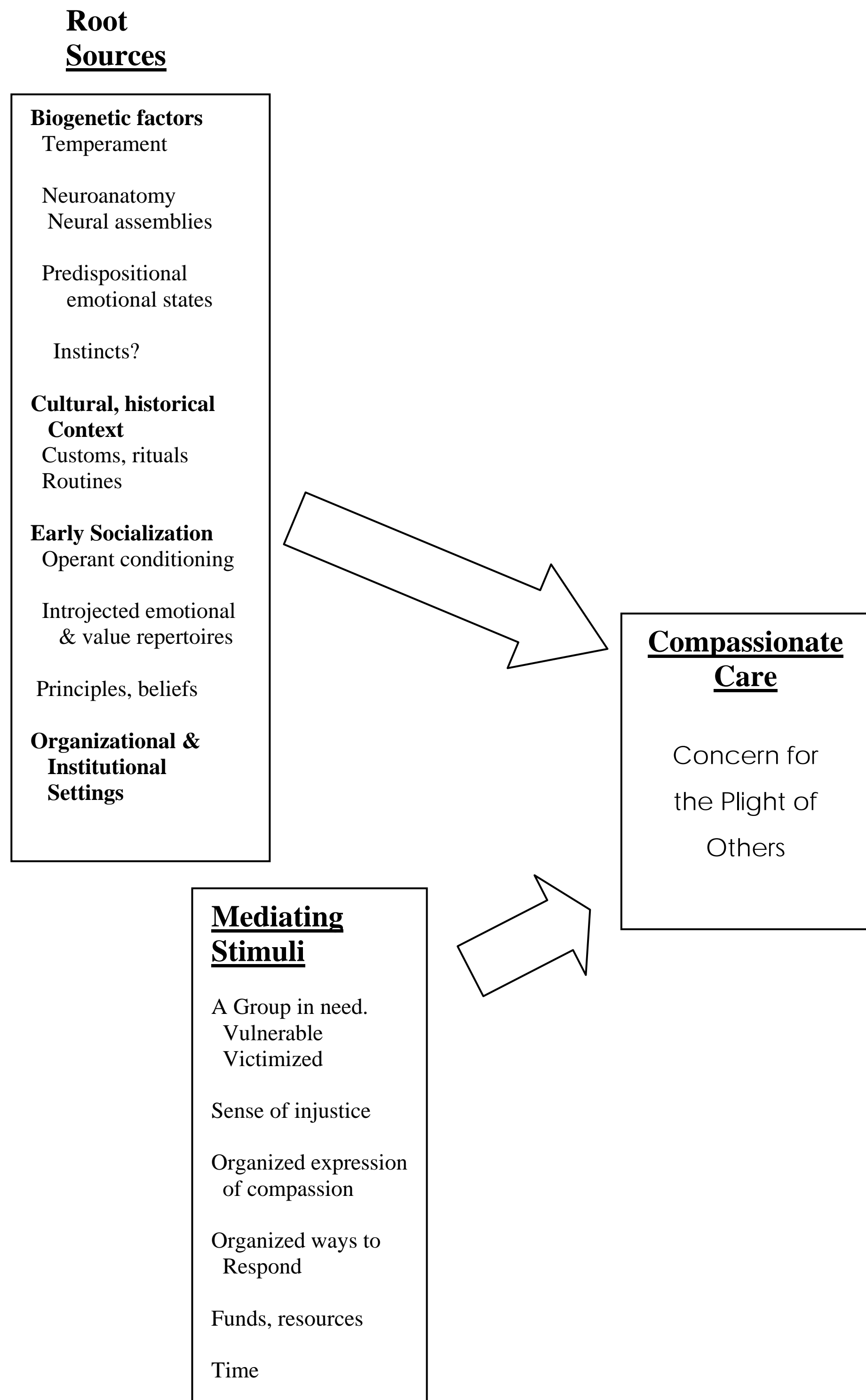

Figure 2: Sources, Mediating Resources and Outcomes of Compassionate Charity & Care

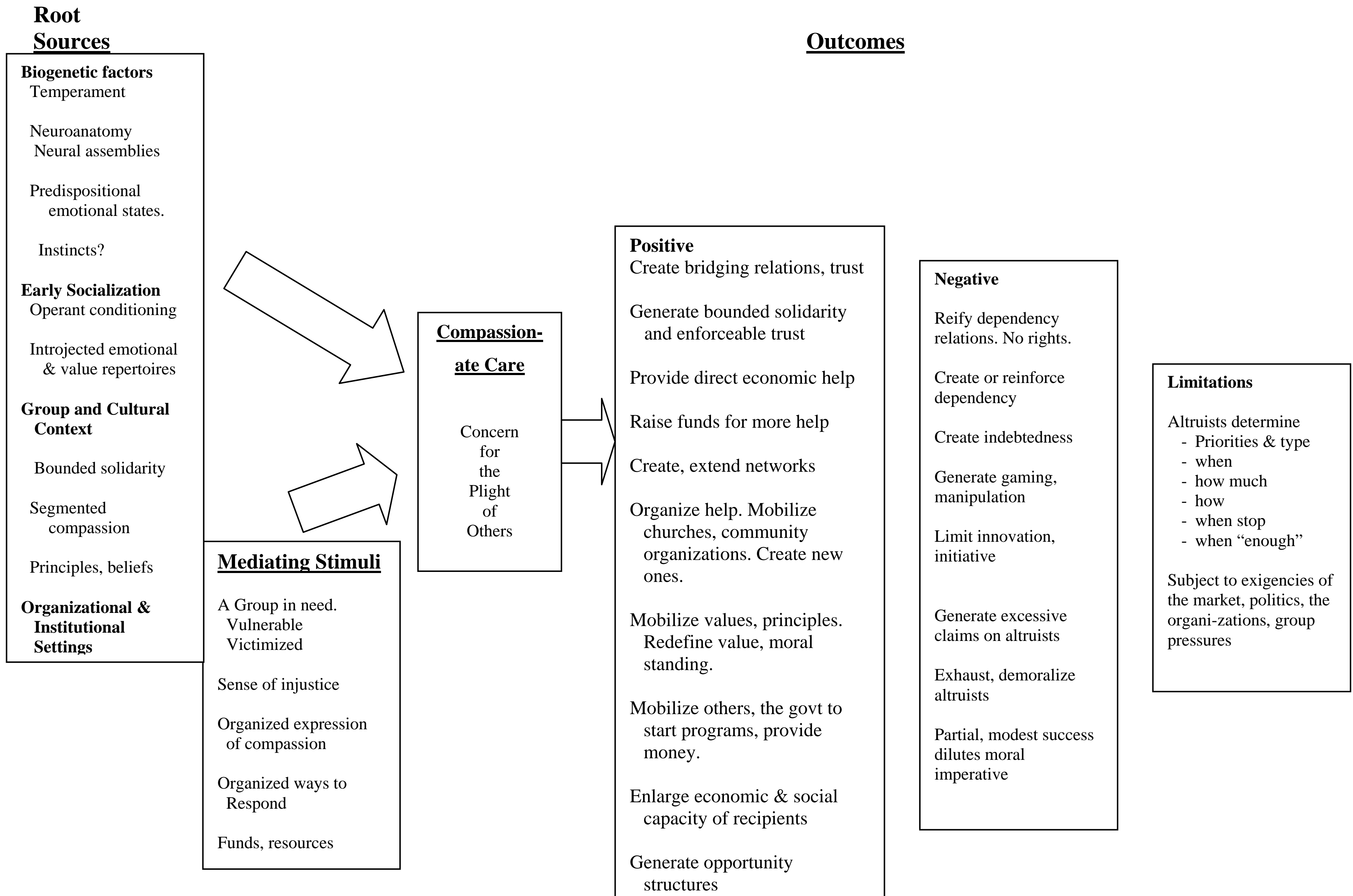

Figure 3: Two Perspectives on Compassionate Care

The Egoistic Perspective	The Altruistic, especially religious, Perspective
Charity care (CC) is paternalistic	Charity care is helping a fellow being who is suffering (The Good Samaritan).
CC reifies the hierarchical distance between the giver and the receiver -almost caste-like, unbridgeable.	
CC controls how many services or resources the recipients get.	The needs of the recipient define what kind of care is given and how much.
CC is done until the giver thinks it's enough. I.e. the efforts have diminishing personal returns, or become tedious, or exhausting, or too abusive.	CC aims to help the other, not oneself, even at sacrifice. Dedicated, experienced carers are not deterred by tedium, fatigue or abuse.
CC is done on the giver's terms: - when it starts and when it ends - on what terms and in what coinage	Care is freely given, not doled out on other terms.
The giver can leave at will and return home or go on vacation.	The carer feels s/he cannot leave (even when he must) until the needs of those who suffer are met.
CC helps to placate the victims of capitalism on a voluntary basis. They have no rights to help or resources (i.e.no institutionalized welfare rights).	(could be same)
Welfare programs are institutionalized charity care.	(could be same)

COMPASSIONATE CARE AND CHARITY IN AMERICAN HEALTH CARE:

TYPES AND DEGREES OF INSTITUTIONALIZATION

Levels of Institutionalization — **Degrees of Legitimating Compassionate Care**

	Illegitimate	**Liminal** (a no-man's-land)	**Legitimate**
Personal, episodic:	**Stolen time, resources (undocumented)**	**Personally donated time, resources (documented)**	**Sanctioned, the celebrated member or employee**
Personal, routine or dedicated:	**Same**	**Same**	**Same**
Local unit, interpersonal routinization:	**Covert. Threatens financial viability and institutional rules. Informal, internal culture & norms vs Formal ones.**	**Organizationally atypical. Ambiguous status. Unresolved value clashes.**	**Same**
Trans-unit, intra-organizational routinization:	**Empty cell?**	**Tacit or limited commitment to CC&C. Ambiguities remain.**	**Organizational commitment to CC&C**
Informal networks:	**Off-book relations and arrangements.**	**Possibly known but ignored. Challenges mainstream arrangements.**	**-within network relations and norms**
Interorganizational institutionalization:	**Empty cell?**	**Informal relations and arrangements in tension with primary goals and practices.**	**Eg public hospital tradition – refer all cases to "Charity Hospital"**
Systemic institutionalization:	**Manipulating or exploiting charity care system**	**Underfunded or indirect compensations that reproduce ambiguities & uncertainty**	**Charity Care Fund Universal incorporation into laws or funding**

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