

# **Generosity and the moral imagination in the practice of teamwork**

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## **Abstract**

In this article we discuss generosity, a virtue that has received little attention in relation to nursing practice. We make a distinction between material generosity and generosity of spirit. The moral imagination is central to our analysis of generosity of spirit. We discuss data taken from a team meeting and identify the components of generosity, for example the role of the moral imagination to interrupting value judgements, protecting the identity of the chronically ill patient through use of the psychosocial format, and displaying empathetic maturity. The talk of the team enables us to understand and make visible the link between generosity, moral imagination and identity construction. The topic of generosity, although contextualised in a UK setting has relevance to other cultural contexts.

## Introduction

In this article we examine the virtue of generosity. This is a virtue that has received little attention in relation to nursing practice. We make a distinction between material generosity and generosity of spirit. It is the latter which is of most relevance to healthcare practice. The moral imagination is central to our analysis of generosity of spirit. This imagination helps us recognise, acknowledge, reflect and react to the difficulties experienced by those with chronic illness who are receiving care. It also contributes to generous-mindedness and generous-heartedness. Generosity is but one of a range of virtues required for professional practice and will be considered in relation to care, charity, courage, compassion and justice. An analysis of generosity facilitates reflection on some different and, we suggest, little explored issues providing valuable insights into the nature of healthcare relationships.

The focus of this article is on a practice example from a larger research project. We discuss how, in a team meeting, a hospital palliative care team report on a troubled patient who has severe unrelieved neuropathic pain. The team meeting is attended by a nurse, chaplain and a medical consultant. We make links between their discourse, the moral imagination and generosity. We also consider how value judgements about patients can be challenged in the setting of team work. Finally we examine the implications for teamwork practice and the importance of the participation of nurses and other members of the team in terms of psychosocial knowing. Our discussion of the moral imagination draws on the work of Arthur Frank and Iris Murdoch. Frank writes of the significance of imagination in constructing identities.<sup>1</sup> He discusses his

own realisation (as a sick person with a chronic illness) that he was dependent on the imagination of others: 'I knew myself through others' p.32. He goes on to say that our moral imagination determines the kind of story we find ourselves in and is part of the caring relationship but crucial to identity construction of the ill person. Murdoch emphasises the role of imagination in moral perception. <sup>2</sup> Our analysis of generosity draws, primarily, on the work of Frank and virtue theorists.

### ***Generosity***

In *The Renewal of Generosity*, Frank <sup>1</sup> explores the meaning and significance of generosity in the stories of patients and practitioners. Generosity, according to Frank, goes beyond the transfer of material things or gifts, it involves the imagination and is related to consolation. Frank <sup>1</sup> (p.2) writes:

When the giving of consolation is taken to be the paradigm of generosity, our imagination of what might be a generous relationship moves beyond material gifts and the economy of exchange that material gifts instigate (p.2).

Consolation is central to generosity and, according to Frank, provides comfort when loss is inevitable. The giving of consolation enables a new imagination of what the relationship could be or become. Thus consolation, in the context of caring, may be a gift freely given to another. However, it may not measure up to expectations and may even fail but this should not stop one giving consolation.

Compte-Sponville <sup>3</sup> describes generosity as 'the virtue of giving' and describes it as being 'at the crossroads of two Greek virtues, magnanimity and liberality. He states that:

The magnanimous person is neither vain nor low, the liberal person is neither miserly nor prodigal, and a person combining both qualities is always generous (p.93).

Virtues can be described as dispositions to feel, think and act in particular ways and are commonly considered to represent a 'mean' between excess and deficiency (pp.108-109) <sup>4</sup>. This also applies to generosity. The Greek philosopher, Aristotle, discusses the 'magnanimous man' who is eager to help others, who takes great risks for good causes, and who cannot bear to be dependent on others or to harbour resentment (p.153). Aristotle <sup>5</sup> states that:

He does not care for personal conversation; he will talk neither about himself or about anyone else, because he does not care to be complimented himself or to hear others criticised; nor again is he inclined to pay compliments.

A deficiency of magnanimity is said to be 'pusillanimity' or mean-spiritedness and an excess is vanity or conceit. In a healthcare context, Aristotle's view of the 'magnanimous man' is out of step with contemporary practice. Leaving aside the issue of the gender bias, it suggests a rather detached view of someone who does not engage in relationships as expected in healthcare contexts. It is, surely, necessary to sometimes discuss one's own achievements and to give compliments to others if the objective is the

improvement of practice rather than self-aggrandizement. Magnanimity also suggests an important dimension of generosity, that is, generosity of spirit. Kupper<sup>6</sup> distinguishes between two aspects of generosity of spirit: generous-mindedness and generous-heartedness. Generous-mindedness is concerned with judgements that show giving, an ability to appreciate positive aspects of people or situations where others might see only negative aspects. Kupper suggests that this kind of generosity of spirit requires effort and involves valuing, having faith in and giving others the opportunity to excel. The opposite of generous-mindedness is, according to Kupper, being mean spirited and hypocritical, disposing people 'to overlook merits, ferret out flaws and delight in nit-picking' (p.358).

Examples of generous-mindedness from nursing might include the registered nurse who praises a student for her sensitivity rather than focusing on what s/he has not done well. Other examples might include practitioners (be they in clinical practice, research, management or education) who provide opportunities for colleagues to take the credit for joint activities and who point colleagues in the direction of helpful resources that will enhance their practice and development.

Generous-heartedness relates to emotional giving and manifests when people forgive the transgressions, failings and lapses of others. It involves not bearing grudges and holding resentment providing, as Kupper puts it, the releasing people 'from a claim against them and a chance to begin anew'.(p.360). Nurses who forgive people who have been disrespectful, difficult, or aggressive towards them are demonstrating generous-

heartedness. Most situations call for generous-mindedness, to imagine and understand situations from other people's perspective. They require generous-heartedness to let things go and feel sympathy or empathy for the other person and, arguably, to be able to maintain positive relationships.

As Compton-Sponville <sup>3</sup> suggests, generosity is at the crossroads of magnanimity and liberality as it comprises a positive sense of oneself and an ability to give appropriately both of material things such as money (liberality) or to give of oneself (magnanimity). An excess of liberality is described as prodigality and a deficiency as meanness <sup>5</sup>. Although liberality seems less applicable to nursing - the nurse, for example, is generally not in a position to give away material goods to patients – we may take the view that to be truly generous nurses should give a proportion of their income to good causes. If, however, she gives away her entire salary she may be described as prodigal and if she does not share material goods with others she may be described as mean.

In being generous one is aware of the good of the person or persons on the receiving end of the action and this is generally more than is expected in the circumstances. <sup>7</sup> A person who fails to act generously in some situations may not violate a moral obligation, but never acting generously may be a moral failing.<sup>8</sup> Generosity embodies an openness to others <sup>9</sup> and is about the dispossession of the self and happens at a prereflective level, at the level of corporeality. According to Diprose, in generosity the self is both given to others and affected by others and in this movement between the self and 'other', social relations are constituted. She describes generosity as a key

virtue and the 'primordial' condition of interpersonal, personal and social life and operates at the level of sensibility rather than conscious intention.

In his discussion of generosity Frank<sup>1</sup> observes that:

We humans seem to be most generous when we feel grateful and desire to pass on some measure of what we have been given. Medical care can play a privileged role in this cycle of generosity, gratitude and more generosity. Medical generosity sets a standard for the rest of society, because illness is a universal form of suffering (p.1).

In addition to offering diagnosis and treatments medicine should offer consolation according to Frank.<sup>1</sup> This consolation is a gift providing comfort when loss and suffering occurs and reassurance that people will not be abandoned. Such consolation, according to Frank (p.2) is 'an act of generosity' and the process is described:

Generosity begins in *welcome*: a hospitality that offers whatever the host has that would meet the need of the guest. The welcome of opening the doors of one's home signifies the opening of the self to others, including guests who may disrupt and demand. To guests who suffer, the host's welcome is an initial promise of consolation.

In the above discussion the guest is not always a 'nice' guest, as the guest may make demands. With such a guest, the hope that what is offered by the open door remains generous. Generosity, according to Frank, can cope with demanding and disruptive people. Quite simply, generosity is not about the

needs and interests of the host (in this discussion, the professional) but rather it is about responding to the needs of the guest (or the patient) even when the guest or patient may make demands and also disrupt. Therefore, according to Frank, those who are generous can cope with the demanding and the disruptive.

Nurses in particular have been found to have a non-judgemental approach to patients and staff in the context of multidisciplinary work and a reflexive understanding of patients' suffering can be accomplished in team meetings and team reflections.<sup>10-12</sup> Caring requires both physical and psychosocial skills and the confidence to assess and represent patient's physical and psychosocial needs accurately in ward rounds and settings such as team meetings. Caring relationships which are generous is the means by which the person in their totality is cared about and the disintegrative effect of life-threatening illness is reduced. In the next section we discuss how a troubled patient is discussed in a hospital palliative care team meeting. The patient is unhappy and complaining about his treatment. This data extract is chosen because it demonstrates a challenging situation for the team and enables close and detailed attention to their response to a troubled and unhappy patient.

### ***Background to the study***

The data reported here are taken from an audio recording of a team meeting in a hospital palliative care setting. Ethical approval for the study was granted by the local ethics committee. Consent was not taken as a once and for all

issue but negotiated on each occasion when the team met to discuss the patients under their care. A fuller discussion of methodology can be found elsewhere.<sup>13</sup> The data were transcribed verbatim and analysed using a grounded theory approach. The principle of constant comparison together with the tools of discourse analysis were used to analyse the data. The data extract was chosen because it demonstrates:

- i) How a troubled patient is discussed within the team meeting and how an identity for the patient is developed.
- ii) How the nurse and chaplain enable a generous account of the patient's experience and interrupt value judgements.

The data extract that follows is taken from a hospital palliative care team meeting in the South of England. The hospital palliative care team consists of a medical consultant who is a specialist in palliative care, a hospital chaplain and a specialist palliative care nurse. This data extract enables us to see how a patient's identity is presented in a team meeting, how the team work within their roles as doctor, nurse and chaplain to construct a story about a patient's psychosocial and physical suffering. The team meet with the consultant once a week to discuss all the patients who are referred to the hospital palliative care team.

1	Nurse	P, there is not a lot to say really. He is
2		the chap who has had the amputation.
3	Chaplain	I had a lot to do with him.
4	Nurse	Oh good. I'm pleased. He actually has a bit of
5		sepsis. Yes. I don't know how much, whether it is just a
6		bit wet or whether it is worse than that. I'll have to
7		check because I haven't seen anything.
8	Chaplain	It seemed okay at the weekend.
9	Nurse	Yes. That's good.
10	Chaplain	He's much brighter and positive. He's doing all right
11		I think.
12	Nurse	Yes, better than he was.
13	Consultant	He was being rather aggressive when he was in pain.
14	Nurse	I think he is better but it was a bit wet one side of
15		his knee.
16	Chaplain	Yes. He was anxious about that.
17	Consultant	He was writing complaining letters to the Chief
18		Executive because
19	Chaplain	Was he?
20	Consultant	Well talking about it wasn't he?
21	Nurse	I think he was just fed up.
22	Consultant	Demanding to see this that and the other surgeon,
23		and so on.
24	Nurse	The trouble is they are just nibbling away as they do
25		with diabetic peripheral vascular disease. You know they
26		can't just chop a big bit off, they have to keep nibbling
27		at it.

In this data extract the team discuss a patient, P, who has diabetic peripheral neuropathy disease and he has had an amputation from which he is recovering. He also has a problem with his wound for which he is receiving

treatment and he is still having pain (lines 5 and 13). This patient is a challenge for the palliative care team as he is presented as frustrated with his situation by the consultant (Line 13). Potentially, this is not a good story as this patient is reported to be aggressive and his symptom of pain is noted to be poorly controlled. In this situation, symptoms that are difficult to manage may contribute to feelings of personal failure in health care professionals.<sup>13 14</sup>

The chaplain makes a very positive statement she reports how P is much brighter, positive and 'He's doing all right I think' (line 10/11). This marks P's character as someone who is coping and has the right approach, namely positive and bright. The nurse agrees with this and it seems that P is now better than he has been (line 12). Thus the character of P is being developed by the nurse and the chaplain as someone who is remaining cheerful and bright despite his difficult circumstances. The chaplain and nurse are, it seems, demonstrating generous-mindedness in describing a patient who is appropriate in the context described. They are using their moral imagination to present the patient as having a positive identity despite his very difficult problems and behaviour. However, in a topic change the consultant reports that P is, 'rather aggressive when he was in pain' (line 13). This unmarked statement is an unfavourable assessment of P's behaviour when P is in pain. It does not produce an immediate response (line 14). Pomerantz<sup>15</sup> says that there are many ways in which speakers can pursue responses to their assertions. If a speaker expects a recipient's support or agreement and does not get it the speaker will try to work out what went wrong and to remedy it. One type of remedy pursuit is to check out the facts. The consultant uses a

remedy pursuit he presents the facts: how P is 'writing complaining letters to the Chief Executive' (line 17) and 'Demanding to see this that and the other surgeon and so on' (line 22).

Health and illness often contain value judgements and these value judgements sometimes lead to attributions of blame. For example: blaming patients for their illness associated with lifestyle choices that lead to disease; poor adherence to treatment; and complaints and dissatisfaction with their care. Such responses suggest a lack of generous-mindedness and generous-heartedness. Generosity of spirit interrupts negative value judgements and comparisons, to see the suffering patient and to be able to respond in a manner that creates a connection and goes beyond attributions of blame. In this team meeting the nurse and chaplain 'interrupt' and challenge the criticisms of P. The nurse interprets the difficulty around the complaints as P being 'fed-up' (line 21). She is aware of the limits of surgery for this type of condition and identifies the limits of conventional surgical treatment (lines 24/25). The nurse and chaplain are representing P as someone who is anxious, and fed up with the limitations of treatment for his type of disease. They are concerned to present P as doing well and coping with his surgery and other problems. Together they portray P as anxious and worried rather than aggressive. They avoid talk of blame even though the patient is writing letters of complaint. They are re-presenting P's behaviour and identity as to be expected or 'normal' within the sequence of experiences he has undergone in the surgical trajectory, where disease can only be 'nibbled' away and they counteract the consultant's talk of 'aggressive' behaviour.

It is reported that hospital staff can develop a 'patient reputation' when individual patients are reported to be 'unco-operative' or 'manipulative'.<sup>16</sup> The account of the patient's aggressiveness could begin to develop P's reputation as a difficult and complaining patient. It could be argued that the consultant is lacking in generosity and moral imagination. Fortunately, in the context of palliative care, the ethos of team work enables the nurse and chaplain to provide a different perspective. They give an account that takes a generous interpretation of the patient's behaviour and an understanding of his emotional expression. It has been observed that staff use different role formats to cope with distressing and emotionally charged situations through talk and one of the role formats identified is the bio-medical-psychological format.<sup>17</sup> Hunt found that nurses talked about psychosocial aspects when confronting situations involving uncertainty and emotions, such as when patients experienced unrelieved pain. According to Hunt, nurses, by shifting from the biomedical role format to the psychological format, were able to cope with patients who were not responding to medical treatment. In the above data extract there is a shift between the biomedical and the psychological format. The shift to the psychosocial format is made by the nurse and the chaplain. Together they convey a broader understanding of the patient's behaviour. The nurse and chaplain are offering a reason and mitigation for P's aggressive behaviour by using the psychological format. This mitigation enables the patients' behaviour to be re-interpreted as understandable and acceptable in the circumstances presented. In this team the nurse together with the chaplain enable a positive construction of the patient's identity. They do not join in the criticism instigated by the consultant. The nurse and the chaplain

keep their footing as compassionate practitioners, who have a moral imagination to turn the situation around; to place the suffering patient in a context where his behaviour is understandable and expected. This is the basis for their continuing relationship with this patient. They are highly skilled practitioners with a deep knowledge of the emotional needs of patients. Furthermore, they are comfortable in voicing these needs in a team setting, where the holistic needs of patients are considered important.

Patients who are emotional and aggressive when they experience unrelieved pain are potentially a threat to the reputation of the palliative care team. One of the strategies used by the nurse and the chaplain is moving between psychosocial and biomedical discourses that explains the patient's behaviour as emotional as well as 'normal' within a complex chronic illness trajectory. The nurse and chaplain characterise P's behaviour as, 'positive and bright' and 'anxious' rather than 'aggressive' and 'complaining'. They construct a suffering patient who is 'fed up' with the limitations of treatment. This is a team setting where the emotional and social factors involved in the experience of symptoms are allowed voice and the nurse and the chaplain together achieve a psychosocial interpretation of the patient's experience. The nurse and the chaplain enlarge the context of talk to take account of the subjective experience of the patient. The data extract illustrates the confidence of the chaplain and the nurse in contributing to the team meeting. They clearly know the patient well and have psychosocial skills and understanding, which bring a fresh look at the patient. We suggest that they achieve a generous interpretation of the patient's behaviour by avoidance of criticism by shifting to

the psychosocial frame and, it might be argued, displaying a high level of empathetic maturity.<sup>18</sup> Empathetic maturity is how the self understands the personhood of another, and it is the basis on which mutuality develops within human relations and enables one person to care for another.<sup>19</sup> The use of these strategies and the human relations skills discussed above protect the patient's identity as a suffering patient. The nurse and the chaplain use their moral imagination to convey an empathetic understanding of the patient's situation and to keep their footing as compassionate carers.

According to Frank <sup>1</sup> a generous performance is one that interrupts value judgements and comparisons to see the suffering as an occasion to respond. We therefore argue that a high level of empathic maturity is exhibited by the nurse and chaplain together. They convey their knowledge of this patient as a person together with an understanding of the effect of his disease process on his person. Therefore they move easily between medical and psychosocial frames.

### ***Discussion***

Murdoch <sup>2</sup> illustrates the moral imagination by discussing the situation of M & D. M is a woman who feels hostility to her daughter-in-law D:

M finds D quite a good-hearted girl but while not exactly common yet certainly unpolished and lacking in dignity and refinement. D is inclined to be pert and familiar, insufficiently ceremonious, brusque, sometimes positively rude, always tiresomely juvenile. M does not like D's accent

or the way D dresses. M feels that her son has married beneath him (p.16).

Despite holding these views M behaves well towards D. As time goes by M revises her view and demonstrates that she is capable of 'careful and just attention' to what confronts her. She reconsiders:

I am old-fashioned and conventional. I may be prejudiced and narrow-minded. I may be snobbish. I am certainly jealous. Let me look again (p.17).

Following her reflection M concludes that D is not vulgar or undignified but that she is 'refreshingly simple' and spontaneous and that she is 'delightfully youthful.' The point is made that although M's behaviour does not change she has changed her value judgement of D. She has been, as Murdoch puts it, 'morally active'. She has been attentive to and seen D 'justly and lovingly'. In 'seeing more' M has, arguably, made moral progress. We suggest that the moral imagination is a necessary component of generosity of spirit. Shifts in imagination lead to shifts in the way we think and re-evaluate people's behaviour and values as well as our own and requires openness to new possibilities and ideas. It requires, as Murdoch suggests, a just and loving gaze. It requires, on occasion, a retelling of a story to accommodate the vulnerability and fallibility of those involved. All of this requires generosity on the part of professionals, effectively, generous-mindedness and generous-heartedness.

The team discussion conveys an openness to the patient and his difficult circumstances. The team avoids finalising P as aggressive and complaining by challenging and changing the interpretation of P's behaviour. According to Hunter <sup>20</sup> it is important to reconcile the clinical view of the situation with the patient's experience of illness and the sense of a life. This appears to be one of the strengths of teamwork that the illness and the patient experience can be brought together as practitioners such as the chaplain and the nurse have time to spend with P, getting to know and understand his difficult circumstances, and have a relationship with him and an empathetic understanding of his suffering.

The importance of the team in challenging negative presentations of patients with explanations that demonstrate a compassionate understanding of a patient is discussed by Crepeau <sup>12</sup> in relation to a patient called Gloria:

In this story, the last told about Gloria before her discharge, a new image emerges. Emily reconstructs Gloria from the person who "won't start" and "wouldn't accept" to someone who is "overwhelmed" and in need of physical contact (p.782).

Crepeau <sup>12</sup> writes that we should think carefully about the discourses within which we work and how needs are assessed and represented in team meetings as these have material effects on the building of trust, interpersonal relations and ultimately the meeting of patient and staff needs. Opie <sup>21</sup> discusses how team discourse has material effects in the social world. She gives an example of team discourse that lacks generosity where a patient is characterised as 'greedy' and 'demanding'. She says that we should strive to

work reflexively and start to ask different questions that will enable different representations of clients. This process she calls 'thinking jointly' and this joint thinking contributes to the development of reflexive practice in team work and is a marker of effectiveness. According to Opie, an effective team is one that is alert to the range of discourses used.

Teamwork enables palliative care staff to contribute to a joint understanding of the patient that goes beyond the biomedical and psychosocial to a just and loving attentiveness and a generous approach as illustrated in the data extract discussed. A number of authors argue for representations of patients, which include emotionality, relationships of self and those with others, irrationality as well as bodily and physical degeneration. It is the chaplain and the nurse who interpret the emotionality represented in the patient's behaviour as part of the lived experience of his illness. Thus the patients' emotionality is located in a psychosocial and moral context that avoids developing a reputation for this patient as difficult, complaining and aggressive.

A good effective team is a reflecting team, as this expands people's sense of who they are and who they could be, and does not offer judgements but reflections.<sup>1</sup> Thus the reflecting team keeps dialogue open and it is this openness to 'others' that is the mark of generosity as we have identified earlier. Generosity relates to the dispossession of the self in a way that the self is affective and affected by others and constitutes social relations. Thus generosity is about individual dispositions and about the social context in which health care staff and patients work together to achieve a helping relationship in very difficult circumstances. Thus we suggest that the

generosity displayed and enacted by the chaplain and nurse towards P sustains an interpersonal relationship in difficult circumstances where medical interventions are limited and pain management is challenging. Therefore the nurse and chaplain in this meeting have an important part to play in maintaining an individual and a team relationship with this patient that is positive and helpful. Perhaps without the team approach this patient may be labelled as a 'difficult'.

### ***Generosity and other virtues***

In this article we have focused on the virtue of generosity primarily because it has, thus far, been too little examined in the context of healthcare practice and because the data extract suggested its significance. Generosity is, however, not the only virtue to consider. Healthcare practitioners working in palliative care and in other areas require a range of intellectual and moral virtues to respond ethically to the complexity and subtleties of everyday practice.<sup>22</sup> To demonstrate generosity appropriately, neither too much nor too little and in the right way, requires professional wisdom. The moral imagination can be considered as part of professional wisdom. Practitioners also require care, charity, courage, compassion and justice. The differences, similarities and relationships between each of these virtues and generosity requires more analysis than we can provide here. Each virtue points to dispositions to think feel and act in particular ways in relation to others. Generosity is concerned with a giving disposition, as exercising the imagination and emotions, with forgiveness and with opportunities to start anew. Care, for example, is a complex virtue that encompasses attentiveness, responsiveness and

competence, and, it can also be argued, generosity. Charity is also closely related to generosity as this can be taken to refer to material charity (the giving of alms, for example) and a charitable disposition, to think the best of people and to forgive. Charity does, however, have religious and possibly derogatory associations that generosity does not. It is suggested that being on the receiving end of a charitable act has a different interpretation to being on the receiving end of a generous action. The virtue of courage may be necessary to enable practitioners to present an alternative and perhaps unpopular view, which is, nonetheless, generous and ethical. Compassion and the expression of sympathy are also closely related to generosity in a healthcare context. Arguably, one cannot be compassionate without being generous. Justice is a particularly interesting virtue because it relates to generosity. If a gesture is more than is owed, for example in giving more positive feedback than a piece of work deserves, then this may not be a just state of affairs. Generosity needs, therefore, to be accompanied by other virtues. This is particularly important because it is possible for practitioners to possess some elements or modules of generosity but not others. Some people may be generous in giving material things, for example financial donations, but lack generosity of spirit. Others may demonstrate some aspects of generosity of spirit but not others. They may, for example, be generous-minded and generous-hearted as they relate to patients but lack this in their relationships with colleagues. That is, they may demonstrate modules of generosity but not composite generosity. <sup>23</sup>

## ***Conclusion***

An analysis of generosity facilitates reflection on some little explored issues, thus providing valuable insights into the nature of healthcare relationships. In the data extract, the team members' talk and interpretation of the patient's experience is important in relation to the patient's identity and how this is constructed. Identity constructions in chronic illness contexts can affect the type of relationships that health care staff have with patients and the development and outcomes of supportive and comfortable relationships with patients. This is particularly important when managing complex symptoms and psychosocial distress. We have suggested that generosity of spirit is significant in the work of nurses and other team members in maintaining and enhancing the reputations and character of those in their care. Close attention to the virtue of generosity and to the possibility of a just and loving gaze enables a deeper understanding of team talk about patients' pain and suffering and the social and moral context in which these discussions occur. It suggests that psychosocial knowing and professional wisdom enables a generous construction of the patient's identity as someone troubled in both body and mind. The talk of the team enable us to understand and make visible the link between generosity, moral imagination identity construction and suffering.

As discussed above, Frank relates generosity to a hospitality that 'offers whatever the host has that would meet the need of the guest'. He refers to guests who may be disruptive and demanding and to the importance of being able to offer a welcome and to provide consolation. The data extract and the experience of healthcare practitioners more generally provide examples of

patients that practitioners may consider challenging. Practitioners may struggle to understand and respond ethically in such situations to, effectively be welcoming and hospitable. Generosity is, therefore, a necessary virtue for everyday nursing practice.

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