Accounting and Washing: Good Care in Long-Term Psychiatry

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Accounting and Washing

Good Care in Long-Term Psychiatry

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This article analyzes how the recent call for accounting in health care interferes with daily care practice and raises the question of how accounting practices relate to the aim of good care. The most influential accounting methods in the Netherlands suggest ways for professionals to legitimize their activities. The analysis of washing patients in long-term mental health care shows that different styles of accounting evaluate and legitimize care while structuring notions of what good care is. A specific style of accounting enforces certain values but does not tell about the tragic or unexpected effects that come with it, nor does it provide a repertoire to deal with these. Thus, care practices incorporating specific styles of accounting remain dependent on forms of care that are not accountable or ask for new forms of reflexivity.

Keywords: *accounting; justification; good care; ethnography; evidence-based medicine; ethics; long-term mental health care*

There are strong advocates and severe opponents of accounting in health care. On the advocacy side, for instance, evidence-based medicine promised transparency, solid scientific evidence for the workings of therapies, and equal access to good health care (Sackett et al. 1991; Sackett et al. 1996). Later, the idea was added that using evidence-based therapies also would reduce cost. Since the eighties of the twentieth century, evidence-based medicine has been booming, most prominently in practices of research,

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development, and use of clinical-practice guidelines (Timmermans and Berg 2003).

Another style of accounting in health care that developed around the same time derived its ideals from ethical and juridical reasoning (see, for instance, Beauchamp and Childress 1994). Ethicists and lawyers developed rules and protocols, and treatment contracts were implemented to regulate care practice. The ideal was to protect patients from unacceptable, unnecessary, or unasked-for interventions in their lives and bodies and to secure their autonomy.[1] Although both styles of accounting aim to enforce different ideals, they share the optimistic idea that accounting improves health care.

The opponents of accounting in health care, on the other hand, reject these ideals and analyze accounting practices as oppressive bureaucratic systems in disguise. These bureaucratic systems, it is argued, corrupt good care by bringing external elements such as costs into the clinic. In doing so, values such as altruism and love (Robins 2001) and good professional rationality (Kirschner and Lachicotte 2001; Hopper 2001) are threatened.

Yet other authors, working in a science and technology studies (STS) tradition, approach the matter in a different way. Instead of analyzing accounting as a singular phenomenon, good or bad, they study accounting systems at work in various practices (Berg 1997; Timmermans, Bowker, and Star 1998; Law and Mol 2002; Callon and Law 2005). These authors stress that systems and standards do indeed change health care practices. However, how protocols and accounting systems work out should be studied in specific sites before their acceptability can be discussed (Mol and Berg 1998; Timmermans and Berg 2003). Thus, we learned that what is to be taken as evidence may be a matter of debate (Latour and Woolgar 1986) and may differ greatly among professions and organizations (Green 2000). To complicate things further, the same protocol can be seen to interfere differently in different practices, depending on local enactments of the protocol within the local enactments of care.[2]

In this article, instead of advocating or condemning accounting as such, I will draw upon this latter approach to learn more about accounting practices and their goodness or badness. I will analyze how accounting is enacted (Mol 2002, 1998) in long-term mental health care practices in the Netherlands and study how this may or may not be good. How do nurses and other caregivers account in practice, and how does this relate to their aim of making daily care good?

The Case of Washing

To study accounting in practice, I will analyze an ordinary activity in long-term mental health care: washing patients. The analysis is based on

ethnographic research in four long-stay wards in two psychiatric hospitals and five residential homes for the elderly that house patients who grew old in psychiatric hospitals. In both settings, improving care is an important concern. Alternatives to lifelong hospitalization are sought by implementing preferably evidence-based[3] rehabilitation programs and by approaching patients in ways that support their autonomy and their reintegration in the community.

Washing, in both settings, is the topic of considerable debate. Different professionals argue about how the washing is to be done, to what end, and how this should be accounted for. In the residential homes, psychiatric nurses who formerly worked in psychiatric hospitals confront new colleagues, professionals in elderly care who are mainly geriatric assistants. Debates on washing and accounting are on the surface in this new community-based care setting. In the psychiatric hospitals, discussions emerge in the process of changing from institutional care to the rehabilitation of the patients. The question here involves what *rehabilitation* means in specific situations and which ways of washing would support it best.

Troubling these discussions is the reluctance of some patients in this study to wash. Explanations differ, and the reluctance is attributed either to negative symptoms of schizophrenia, physical disabilities, and hospitalization or to the wish to fight nurses. Although in all practices nurses finally will wash reluctant patients, when and how this should be done well is a controversial matter. I will present four different ways of good washing and bring out their controversies to analyze how accounting works in daily practice.

Tacit Accounting

This first practice of washing does have an elaborate notion of good washing, but accounting for this is not part of the practice. Let me first explain what good washing is here.

> "Good morning!" Julia, the geriatric assistant, says as we enter the room. When there is some movement in the bed, she pulls back the blankets. Julia wheels in a washbasin and asks Mrs. Norris to lie on her back. Julia takes off the incontinence pads. She takes a facecloth, puts soap on it, and washes Mrs. Norris' legs and genitals. She drenches a fresh facecloth and rinses off the soap. Then she dries the body with a soft towel. She covers Mrs. Norris with the sheet and goes to look for clothing. She also brings a bottle of perfume. "Her favorite!" Julia says to me with a wink. She brings new pads and underpants made of some elastic, net-like structure to keep the pads in place. Humming a cheerful tune, Julia turns Mrs. Norris to lie her on her side to wash the underside of the legs. "Good," says Julia. She explains to me, "She

> prefers lying on her side. She has a nasty bedsore on the heel of her foot." Julia puts cream on Mrs. Norris' buttocks. On the wardrobe is a list noting which ointment has to go where on Mrs. Norris' body. The new incontinence pads are put on, and the foot is bandaged. Then, "Sock one, sock two, slipper one, and slipper two," Julia counts. "One, two, three," Mrs. Norris says sleepily. Then, the nurse helps Mrs. Norris to put her trousers on. "No, not two legs in one trouser leg!" Julia says. "Two legs in one leg," Mrs. Norris says. "Good," says Julia, and the lower half of the body is ready.

The morning rituals of Mrs. Norris present a way of washing patients that has its basis in care for the elderly in residential homes. Here, cleanliness and washing patients are uncontested, routinized, even exemplary forms of good care. Caregivers, mainly geriatric assistants, perform the washing. A lot of machinery is present to facilitate the washing of patients. The residential homes sport seats in the showers, tools to lift people out of bed and into the bath, and transportable washbasins. Facecloths and towels are delivered in huge quantities. Wheelchairs are everywhere to wheel the person to the shower or the bath in the corridor. Incontinence material is supplied in many forms, shapes, and brands.

Cleanliness is institutionally enforced by the routinized nature of cleaning. The work is organized in rounds (see De Lange 1990) to guarantee the routine of cleaning. The first round is to wake everybody and the second is to wash and dress everybody, after which breakfast follows, and so on. Washing has its institutionally enforced space and returns every day, which makes it ordered and predictable. This routine is important because it is unacceptable that patients are left lying in bed, and possibly, in dirt. The geriatric assistants are the authorities on cleanliness and make sure that everybody gets a regular wash, even people who object. To stay dirty is not an option; to let patients wander around the ward dirty is thought of as very bad care because dirt would signify that a patient could not take care of himself or herself but was not assisted. It would be a form of professional failure and neglect if that would happen.

> Geriatric assistant: A person who can take care of himself or herself having a wash and getting dressed, you give them a good cleaning under the shower once a week for a checkup, for hygienic reasons. And in doing so, my opinion is I want to wash them from head to toe, even if this person could do it herself. Of course, you let them assist, but I want to inspect the skin to verify that nothing is wrong, because otherwise, if something is wrong, nobody sees it. That is our [the geriatric assistants'] responsibility, because very often,

people do not tell things. They are ashamed, they are in doubt, and when you take care of them, you are confronted with the problems.

The preservation of the body and prevention of physical pain is part of the expertise of the geriatric assistants. They take care of a person, and when something is wrong, they report it to the doctor. The doctor is in charge of possible treatment.

Prevention, hygiene, service, and control are important values in this type of caring.[4] But pivotal to all this cleaning is that a person's dignity depends on a clean and well-kept appearance. This is directly related to a person's place in the social order of the hospital or the residential home and its visitors. To be dirty would be to lose dignity in the eyes of the community one lives in. Mental disturbances or irrationality are less central to the person and often are not recognized as such by the geriatric assistants, who have no training in psychiatry. They constantly correct skirts creeping up, messed-up collars, and spots on dresses. Auditorial dirt, such as swearing and cursing, and sexual misbehavior are seen as very offensive and threatening to this social order. Other forms of deviant behavior often are perceived as typical characteristics that are easy to accept. To quietly hallucinate in a corner is seen as less disruptive than not being clean. The geriatric assistants relate symptoms that would be signs of psychiatric disorder elsewhere to individual characteristics and particularities.

Actions to Speak Louder

This nonverbal style of nursing does not ask for a justifying analysis or verbal account. There is no time for talking, discussing ways of approach in the nursing team, or building extensive care plans. This would distract from doing the real work.

Interviewer: Do you have something like care plans?

Head of geriatric-assistant team: No, no. We have care plans in the computer of all the people, how they are ADL [washing and dressing] and mentally, and so on. But they are not used. It's in the planning, but not yet started.

Interviewer: Would you think it is useful to work with care plans?

Head: No, no. You know, these days, so many things are done, quality improvements, care-plans, and . . . and then I think, "Just go to work and help these people and . . . " It is all so much paperwork, you see. So many meetings, and talking . . . If a new assistant comes to work on my ward, I just say, "This person has so and so, and that person this and that, and you

> have to help this way." And you do not say, "Well, why don't you read the dossier, see what the care plan is." There is simply no time. So I think there is a lot of time involved, but if you can actually do something with it.

Care plans are part of a practice of accounting that is self-evident to psychiatric nurses, but they are not seen as improving this type of caring because it is exactly the routinized nature of practice that would make it good practice. Nobody is neglected. No trouble can arise from disease spreading from overlooked filth. If everybody does her work, care will be good. Washing and cleaning function as goods in themselves. The clean and orderly ward signifies that everything is well looked after. This can be inspected, for instance by the head nurse, but it makes washing an act that is not regularly verbally justified. There is not much text to this type of care. This is explicitly contrasted with the talking that other professionals, such as the psychiatric nurses, do.

> Geriatric assistant: And then, to sit with people [patients], to talk to them, I would feel very miserable. I couldn't do that, when so much work has to be done and I would sit and talk to people while others work their fingers to the bone.

Sitting and talking are not good because they are opposed to work. The work that turns care into good care in this logic is not verbal. If you would sit and talk to patients, you would not be behaving like a good colleague because you would let others do the work. And to be a good colleague is important to make care function in a routine way. Indeed, not working would need a justification. As long as the work is done, this is in itself the justification of this practice.

> Psychiatric nurse: I had to deputize one day [on the other wards where geriatric assistants work], but I thought it was terrible. The day before, we were discussing Jake Elster with the doctor. And then you talk about questions: "Does he need more medication, or doesn't he?" So for a nurse, these are very interesting matters. And the other day I had to deputize and it was a Saturday or a Sunday. And all clients were out of their beds at nine. And after nine o'clock, we had to clean the night tables. And I could not detect a spec of dirt on them! I could have cried. I thought, "How can I explain to these people that I do not want to do that?" But this was so . . . they were so . . . they would not understand if I told them I do not want to do it. That was how I felt.
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> Interviewer: So you didn't tell them [no]. You washed the night tables.
>
> Nurse: I washed the night tables. Isn't that terrible? I think it's really bad. I didn't see the point.

This informant could cry about routines he thinks are pointless. Crying is the option, because words to argue against established routines and for values he finds so self-evident are lacking. The nonverbal nature of the practice and the negative value attached to talking make it hard to argue. Arguments can be given in interviews, but are not part of the daily practice in which the work simply has to be done. Accounting is not part of this practice of good washing. To put it differently, to be accountable to outsiders is signified by clean wards and clean patients—by doing, not by explaining.

This practice, where accounting is not part of everyday care, points out that accounting can indeed be seen as a practice on this level. Accounting is declined because it takes time, props, and words, and this time supposedly is better spent on actually washing patients. The geriatric assistants do not explain or justify why washing routinely has to be done to make it good care, but the result can be inspected. When pressed in interviews, the geriatric assistants account for their care in terms of hygiene. The importance of hygiene can be traced back to its historical origins (Boschma 1997), but as a repertoire of accounting, it has become tacit. Indeed, this practice does not seem to fit with recent calls for accounting. No scientist has considered a design to prove effectiveness of routine washing nor are there ethicists who argue for treatment contracts in this case. Quite the contrary, when routine washing ever reaches the public debate, it is to argue for more rigorous washing routines.[5]

Criticism of Routinized Washing

Routinized washing has gained severe of criticism from the new colleagues, the psychiatric nurses. The criticism not only concerns the way of washing but the way of not accounting for the practice of routinized washing.

> Project leader, psychologist: This is a form of cultural difference [between mental health care and care for the elderly]. In mental health care, people are used to calling one another to account for something, to discuss one another's behavior or attitude, to make agreements. While in the residential home, there is a team on each ward, but there is no such thing as structural team meetings or discussions of progress. You know how busy they are in the residential home, and to put four people together . . . just one has to be ill and there is no team meeting. And this is unthinkable in mental health care. There is always a team meeting. So these are essential cultural differences.

To just go ahead and do things is incomprehensible to methodical nurses. It is incompatible with their norms of professional nursing, and this is

referred to as a cultural difference, signifying differences that are hard to argue because they are firmly embedded in a strange and tacit worldview of related and indisputable values. Because these values are hardly articulate, the practice of routine washing is hard to defend and also hard to change, as there is no space or time for reflexivity.

Effectivity

The practice of effective washing can illustrate the different approach to good washing as washing that can and should be verbally accounted for. The main argument against routinized washing is that hospitalization of patients is a consequence of taking over tasks that patients are able to perform themselves. They become passive, helpless, and depressed. They are made dependent on caregivers and lose the skills to wash and take care of themselves. This is not the way professional nurses should work. Washing should be taken care of in a way that leads to results. Washing skills should be taught or relearned.

A fragment of Mrs. Townsends' morning ritual:

> "OK, now, first give your face a wash," Jolene [psychiatric nurse] says. "Like this?" Mrs. Townsend asks when she puts her hand in the facecloth. "Yeah, like that. Now wet it. Open the tap. That is the cold tap, see. Do you want hot or cold water?" "Hot water," says Mrs. Townsend. Jolene helps mix hot and cold. "This is better. Now start with your face." Mrs. Townsend rubs her face and her neck. "Now get the soap off. Just rinse the cloth." says Jolene. "What should I do?" asks Mrs. Townsend. Jolene repeats. Mrs. Townsend wipes the soap off.
>
> "Right, now just dry your face. Now wash your arms, and your armpits. Can you do that?" [Mrs. Townsend points to her armpits.] "Yes, that's your armpits. Put some soap on the facecloth." Jolene then asks, "Shall I wash your back?" "Yes, please. Ah, that is nice." Mrs. Townsend closes her eyes and enjoys the washing and the drying of her back.

The nurse tries to make Mrs. Townsend perform the washing act for herself, forming prosthesis for the bits she cannot do. She gives verbal cues to trigger Mrs. Townsend's remaining washing skills. Nurse and patient perform the washing together. It is pivotal that the patient is active; the nurse cannot simply take over. The idea is that Mrs. Townsend has to practice her skills or she will lose them. Even if the expansion of skills is not possible, it is important to train whatever skills are left to keep them fit and to take care that they do not deteriorate. Psychiatric symptoms are not seen as disruptive

to bodily skills. To hallucinate or be depressed does not affect the skills to wash oneself, although it might affect motivation to practice them.

> Interviewer: Do you actually notice patients progressing?
> Psychiatric nurse: Yes. Mrs. Vanderveen for instance, she has clearly improved since she came here. She walks again, every now and then she goes to bed by herself. She even cracks a joke at times. And also with personal hygiene. On the outset we took care of her completely, and now she does the upper part of her body herself very often.

Instead of the more physical work of washing a patient, with the professional good of the maintenance of skills, talking becomes an important act in nursing, as is functional diagnosis: what can a person do, what can't she do, what can he learn? Assisting and planning are essential. The skills approach can be seen as a professional and methodical way of organizing washing. It can and should be applied to all patients who do not suffer from physical disabilities.

Methods to Progress

The methodical approach to washing explains the need for the organization of nursing care and the materials needed. Care plans become important, and a smooth exchange of information in the nursing team is pivotal. Every nurse is supposed to be informed of what a patient can and cannot do, where assistance is needed, and what goal the training aims for. Every nurse should approach the person in the same way. Apart from the standard items (diagnosis, medication), care plans describe the training and are evaluated at regular intervals. The training of skills implies improvement; evaluations can and should be made. The nurses write reports on the progress made, troubles encountered, and so on.

Accounting takes the form of justifying care in terms of effects. Care plans and team meetings are necessary to account for the training between colleagues and for inspections from outside. Procedures are transparent and methodical. Because the training has to lead to results for individual patients, the ways of accounting these nurses use are oriented toward the epidemiological rationality of clinical trials. The training should be well documented and should be evaluated to see whether there is any progress toward independence or if the patient can handle more complex tasks. What can be argued by measuring effects is that the professional method of training works. As such, it can ultimately be compared to alternative methods that pretend to bring about patient independence and are more or less successful. In this way, nursing care can be based on knowledge of what works or does not work.

This practice of washing and accounting shows that accounting is not just functional on a formal level of gathering knowledge and legitimating care practice to outsiders, nor is the washing training a form of implemented therapy that has been proven effective. To be accountable on the level of daily practice here is intertwined with the logic of clinical trials and interferes with notions of what good care is. Daily practice is organized in ways that produce effective care. Accounting is not merely a way of legitimating care, but it also structures care on a practical level.

Criticism of Effectivity

The practice of skills training is transparent and accountable. Yet, geriatric assistants criticize the effective washing practice because they feel that nurses are too strict on the patients, notwithstanding the fact that they are living in a residential home or hospital, signifying their inability to act for themselves. Effective washers push them to do this anyway.

> Geriatric assistant: Some things are really obligatory, a certain structure. And not, "You don't feel like it today, OK, so don't go today." No. "You *must* go." That was really hard to swallow for a lot of people [geriatric assistants].

This informant would rather take over washing than force people to do it for themselves. The effective washers partly acknowledge this criticism.[6] They do experience problems with patients' resisting to be trained to wash. If the struggle cannot be brought to the desired conclusion of patients washing themselves, the nurses sometimes slip out of their professional mode and merely or routinely wash the patients. That patients should be clean is not debated.

> Geriatric nurse [moved from psychiatric hospital to residential home]: It's a fight, over and over again, every morning, to get her to do it herself. That she dresses and walks over to the living room. And it is difficult, because if you give in, you set back the training for a month. You should be persistent, consequent, constantly. And that usually works. But yes, sometimes you have a day that you cannot take that much and then you just quickly take over and wash the person. But in this case it is wise to just mention it: "Today I will help you a little, but tomorrow that's over." Indeed, there are patients who find it very comfortable if you just do it, because they cannot do it. So the fight remains.

In line with the criticism from the geriatric assistants but with a very different solution to the problem, other nurses question the goal of physical independence. These nurses propose a different goal instead: to respect the

right of patients to privacy and to decide on their own treatment. Professional training, these colleagues argue, does not respect individual differences and self-governance of patients. They compare it to the approach of the geriatric assistants, who routinely apply a good wash to patients. Washing patients or forcing them to learn washing skills both provoke hospitalization because it is still the caregiver who decides. Instead of routinely demanding that patients do things or forcing them to learn skills, what these nurses argue is that it is important to leave it to the patient to decide. Instead of guarding patients, the nurses should facilitate patients' making their own decisions.

Autonomy and Privacy

The objections to effective washing made by the nurses mentioned above are part of a practice of washing and accounting in which applying principles is an important way to make care good and account for it. What does this mean for good washing? To encourage patients to make their own decisions, these nurses try to individualize washing. They do this by relating to the washing norms of elderly patients (a shower once a week, the washbasin for the other days) or by helping them to find out what washing attributes patients prefer. Instead of the institutionally provided soaps and shampoos, the nurses go shopping with the patients to buy showering supplies the patients like.

The patient is perceived as an individual with personal preferences and norms. Yet, these preferences and norms often are not transparent but have to be developed because patients have gotten used to the institutional provisions and are unfamiliar with going to town to buy things for themselves. They do not know how to choose because there used to be no alternatives. Another way to develop their individuality is guaranteeing patients' privacy and responsibility. Preferably, they should be enabled to go for their shower alone. The surveillance of the nurses should be done away with.

> Rehabilitation coach: We discussed this in the team. "Yes, we are always there to see that he takes his shower. But do we have to be there? If he has got his towels and his things, he can manage without us." And thus, people [nurses] began to think about it.

To wash privately is a topic of concern and asks for creativity in the psychiatric hospitals, where sanitary facilities are shared by patients in the same corridor. In the residential homes, every person has his or her own bathroom. In the hospitals, privacy and individuality are created by abolishing general shower routines and surveillance by the nurses and by bringing in personal objects.

To encourage patients to make decisions about their own life, the preferred mode of nursing is to work from a consensus between nurse and patient. Patients are not forced to accept things. This is also apparent in the way these nurses use care plans that differ from that of the effective washers. Instead of goals decided by the nurses, the plans should list the goals formulated by the patients. Apart from the standard items, the plans contain information on the history of the patient, hobbies, preferences, contacts, and so on.[7]

The accent on consensus also can mean that patients can refuse a wash. When patients refuse a wash, the reason for this is not always clear. But for nurses who take patient autonomy seriously, what is a good reason not to wash can be stretched to hospitalization or delusions.

> Psychiatric nurse: These patients are here for a long time, and you might say they are much hospitalized. They lose their sense of dignity. And I think they don't really care what they look like; they just sit around in the hospital. That is what you hear some of them say, "What do we have except for our coffee and cigarettes? Why would I take care of myself? I am locked up in a madhouse." And with some people it has to do with their disorder. Like Mrs. Andersen, she says, "I have to be dirty or terrible things will happen to me. If I take a shower and wash, my skin will fall off." That's very extreme; some people have bizarre notions of their bodies. And her hair is not supposed to be washed either, it has to be just fatty, otherwise she thinks it will all fall out.

Indeed, there are some good reasons given for not wanting to wash. But even if the nurses would think the reasons are bad, they feel they have to respect the principle of patient autonomy. Washing or not washing is a personal matter to be decided on by the patient. Caregivers postpone interference to respect individual privacy as long as possible.

Principles of Respect

Good care here is to respect and sustain the individual in the choices he or she makes. It is about principles. Washing is good and legitimate if it is done with a person's consent and is as individualized as possible. Caregivers should not interfere lightheartedly in a person's private space. They can try to seduce patients to wash by using objects and routines the individuals prefer, or they can respect the patients' way of being not so clean as a way of authentically living their bodies and expressing their individuality. How one chooses to wash is a matter of historically contingent preferences, norms, interests, or even psychiatric disorder.

Again, accounting is an important part of this practice but in a different way than when it concerned the effectiveness of skills training. To account

for or to justify this practice would be to spell out the ethical standards of the practice to point out that principles are applied in a consistent way. Where washing has to be effective, caregivers orient their practice to quantities of progress, which is already more verbal than the tacit accounting of the geriatric assistants. But the form of accounting in this practice is even more articulate. The ethics of care are reasoned about with the use of principles that should guide and justify psychiatric nursing.

That the principles of choice are patient autonomy and privacy fits with recent legislation and values proposed in policy documents.[8] In daily practice, however, the procedural ways of accounting, by treatment contracts, for example, are not used for good washing. Instead, the principle of patient autonomy is taken out of its procedural context and is projected on other situations in daily care. Again, the type of accounting interferes substantially with what good care is.

Criticism of Autonomy and Privacy

This practice of applying the principles of autonomy and privacy to account for good care also has its limits. Geriatric assistants would label this practice as neglect because the nurses do not take disabilities, and therefore, the limits to autonomy, into account.

> Geriatric assistant: Personally, I think that the hominess is very nice for most of the residents. And I see this as the big difference, at least, from what I hear from the nurses that came from the psychiatric hospital. This is typical for geriatric assistants. We just do it all, and we make it nice and cozy. And the psychiatric nurses are different. Colleagues who have been there say, "Jeez, if you saw those rooms, they [the psychiatric nurses] don't do a single bit about them." They think that the residents should take care of that themselves. But these people are here because they are unable to do certain things. So we arrange a lot.

The effective washers also question the professionalism of neglecting patients; they do not consider that patients can be dirty. And these problems are also encountered within this practice. This happens when the principles and local ethics clash with situations that were not foreseen when patient autonomy was proclaimed. Such a situation occurs when the nurses feel a patient has become too dirty but cannot be persuaded to wash or be washed. No consensus can be obtained. At this time, the nurses will wash a patient, but there are no words to account for this transgression of the principles of patient autonomy and privacy. This subversive washing remains unaccounted for even if the nurses feel it is good.

> Nurse William says he could not stand it any longer the way Bill looked, all dirty and with the scabs on his face [he has a skin problem]. They had tried it long enough with own responsibility and with gentle insistence. Even with a prohibition to enter the common room in this dirty state. To no avail. William commanded Bill out of bed, dragged him under the shower and scrubbed off all the scabs. "Harder!" Bill had called. He has been in the shower for almost two hours.

Washing without consent is hard to think of as good if it has to be accounted for in terms of privacy and autonomy. The caregiver takes a passive attitude and waits until she really feels that a limit is reached. Sometimes this feeling is discussed in terms of the hindrance of others. A patient's smelling badly would disturb other patients living on the ward. However, in most cases, the unease can be brought back to the nurse herself. The other patients do not complain, but the nurse feels that this time, dirty has become too dirty. She then grabs the facecloth and gives the patient a wash. To do so can indeed be seen as a form of good care, as the example shows, however hard to justify in terms of patient autonomy or authenticity, or indeed, in any terms at all. The origin of the urge to wash a dirty patient is not known because it is not verbalized and cannot be accounted for in terms of patient autonomy. In these practices, dirt can be accounted for better than a forced wash.

Criticism of Accountable Washing: Contextual Accounts

Yet other nurses criticize both the effective and the principled washing-and-accounting practices. What both practices seem to overlook, it is argued, is the complexity of everyday care practice, of getting through the day with difficult patients. With all their accounting, these practices cannot deal with patients who experience little or no progress or are exceptions to rules and good principles. To make care practice good practice, these nurses argue that the practice has to come first, not as the secondary aim of accountability.

Washing, then, is not an activity that needs a clear method of approach nor do principles or rules surround it. In this style of washing, it is one of the elements of the daily muddle of things that have to be done. It is looked on as something that has to be negotiated in relations between nurse and patient. There is no hierarchy in the kind of activities to undertake. It is not even imperative that the person should wash himself or herself; the caregiver, patient, or both can do the washing, whatever is most convenient. The

nurse can give opinions or negotiate with a patient if she feels the patient needs a wash. The washing can be adapted by looking for a convenient time, by doing it together with the nurse, or by exploring preferred washing habits.

Variability to Juggle

Actions such as washing thus are thought of as dependent on different contingencies, such as moods or events that took place, and they change over time.

> Psychiatric nurse: I think these things are unplannable. On one day, you can say, "Hey, Ben, let's go for your shower!" And then I think, "That is nice, I can talk to him in an informal way." And the other day, I think, "Ben, today I am not going to ask you this." There is no standard that is always successful. Some other time, I would probably say, "Ben, you can do it on your own," or he says, "I don't do it." I think it is very hard to lay down rules how to do these things.

A person is not necessarily seen as autonomous or even coherent but changes over time and according to different relations and events. Nurses have to time their interventions to the right moment if they want the patient to do something (and the same is true for the patient wanting something from the nurse). To get through the day in an acceptable, or preferably, convenient way, they try to establish and maintain good relations with their patients. There is continuous negotiating and give and take.

> Psychiatric nurse: Oh, I know that every once in a while Frank [patient] puts his head under the shower and then it's done. But I don't think you should be too rigid in these things. I try to get him in the bath once a week, I fill the tub and then I know he has soaked at least once a week. And you have to accept that, you see? You shouldn't want it all. You should be a bit flexible. If you notice that he is doing well and his mood is good, then you shouldn't insist and say, "Take your shower now!" You have to give and take a bit with your relation, the trust you've built. Without being walked all over, of course. But you should show them the other side. And in this way you can do a lot with these people. Because you are not rigid, but show them the middle of the road, or the other side.

The flexibility in relating to patients and the process of contextual washing also can lead to patients' remaining dirty either because they strictly refuse to wash or because a relationship with them cannot yet be established to persuade them otherwise. There is no clear directive on how a good relationship is to be established. Some people get along better than others, and differences in personal style are used rather than standardized.

To establish a form of balanced relationship, continuity is provided, and the nurses take an emphatic attitude. But there is no endpoint to which the relationship should lead. It would be hard to establish the effect of contextual washing or of getting through the day, nor does getting through the day imply a set of principles or rules that have to be respected at all times. There is one minimal principle: coercion is to be avoided, as this would affect the building of a balanced relationship between nurse and patient. For care to be good here, it would have to adapt to the circumstances and juggle with different ways of entrance. There is no general method of approach.

Criticism for Contextual Washing

The everyday contingencies and flexibility make accounting difficult in this style of washing. This is the main criticism that comes from accountable practice. As a patient, you can just hope for a caregiver to whom you can relate. There is no protection offered by rules or methods from the much-feared abuse of power or bad treatment for which accounting procedures were designed in the first place. It is not easy to account for a good relationship and the specificity that goes with that.

This is indeed worrying the caregivers a little. The solution they propose is to be open to visitors from the outside world.

> Psychiatric nurse: Yes, you want to be dynamic about things in the process of caring, for your own development as well. We discuss things in our team. But best is when new workers come in with a critical perception, without the burden of the traditions that have established themselves. And they ask you things so that you start thinking again: "Why am I doing things like this, why do I talk like this?" You really need a fresh vision.

The way of accounting this nurse suggests is as flexible and contextual as the care with which it has to fit in. But what form of accounting is being suggested here? The nurse is not proposing to give a justifying analysis or explanation of practice to outsiders, nor does she point to good results. The nurse here suggests a different type of accounting, a kind of reflexivity that does not justify practice with reference to predefined standards such as effective treatment or respect for principles. This form of reflexivity needs fresh visions that are not burdened by traditions. Instead of justifying that what the nurses did was good, it opens up the possibility for others to say that a specific act in care was not so good after all, and wouldn't it be better to try it another way in a comparable situation? Here, accounting is oriented

toward improvement rather than justification. It does not deny the need for routines but tries to avoid automatism by creating moments for reflection.

Because there are no standards or goals compared to which this style of washing can be measured or weighed, washing would be good practice if it were done while taking into account the specificities of persons and situations. One could imagine nurses traveling around to visit other practices or the writing of case stories to be exchanged with colleagues. This could lead to inspiring stories and the exchange of ideas and fresh perspectives. However, because the practice is flexible and fluid, contextual, and connected with specific, changing individuals, it is hard to justify in a general way and so is hard to defend or transport to other situations.

Conclusions: Accounting in Daily Practice

What is asked from health care professionals when they are asked to be accountable? It seems that, both from the ideals of evidence-based medicine and health care legislation, caregivers must show that they have implemented therapies that have been proven effective or procedures that protect patient autonomy. In this way, care practice can legitimate itself by showing that effective therapies are used and procedures are attended to. Care is justified by showing that specific, predefined standards were met.

However, the analyses of the practice of washing show that accounting is entangled more substantially with defining and practicing good care. Effective washing, for instance, is not a practice in which an evidence-based treatment is implemented. Instead, the practice of washing is structured in a way that would make it possible to measure effects. Rather than positioning themselves as caregivers who administer some kind of effective therapy, the caregivers can be seen as taking the position of researchers preparing practice for a clinical trial. Other nurses translate the principle of patient autonomy from formal procedures such as treatment contracts to other situations in care. Rather than behaving like professionals using guidelines, they can be seen to be actively practicing ethicists who reflect on ethical principles and put them to use.

Notwithstanding these substantial changes, however, the style of accounting as a practice of legitimation can be recognized in both practices. These nurses explain that their practice is good because specific standards are applied. However, the activity of legitimating enforces certain predefined goals but does not tell about their actual workings. It does not make care good. This became clear because both care practices incorporate

tragic situations, unexpected exceptions, and maneuvering with methods and principles. Methods working toward effectivity run into problems when patients refuse their washing training. When this happens, the nurses apply a routine washing because they do not accept that patients can walk around in a dirty state. Principles of autonomy run into problems with washing unconsenting, polluted patients. The nurses do think it is good to wash these patients, but they cannot account for this in terms of autonomy and privacy. These forms of washing take the shape of wordless, subversive (because unaccounted for) improvisation.

The activity of legitimizing makes it difficult to discuss tragedy or unforeseen limits or find repertoires to deal with them. When one legitimizes one's work, one addresses successes rather than blanks or exceptions. This implies that to provide good care, practices using a legitimizing style of accounting depend on types of caring that ask for other forms of reflexivity, or indeed, are hard to account for at all. There are times when routinized washing or some flexibility with principles is inevitable because methods or principles do not provide an answer to a specific situation or a dirty patient. There are always patients who do not progress or who do not fit in with the principle of the autonomous self when this would imply neglect. To function well, legitimized care needs other forms of caring.

Discussion: Contextual Reflexivity as a Practice

If it is impossible for care practices that incorporate legitimizing styles of accounting to function without forms of caring that cannot be legitimated, it suggests that there is something to gain by giving these forms of care some reflexive backup. This would be hard for the routine practices, but contextual care has a space for reflexivity that can be developed. To establish practices of contextual reflexivity and open them up for fresh visions is a way a nurse suggested to think of such an aim. How can this be done?[9]

To create space for contextual reflexivity, what is needed is to think of a solid link between ways of knowing, reflecting on what is good, and practicing both while taking difficult situations into account. It would have to acknowledge that a certain amount of routine is necessary to practice care, without making these routines inflexible or turning them into single inflexible standards, however implicit or explicit.

Contextual reflexivity would need involved descriptions[10] that articulate goodness in care practice without defining what is good or knowing its object beforehand. Its analysis of good care holds back on judgments;

instead, it tries to show what facts and values circulate in care practice and what type of practice this brings about.[11] It does not ask if a certain therapy (method, value, artifact) is effective, but rather, what effects it brings about (Mol and Berg 1998). This enables analyses that make care practice understandable without erasing troublesome situations. The good as well as the more doubtful situations can be analyzed as a consequence of specific patterns of traditions, values, knowledge, and routines used. Routines can momentarily become unroutinized by reflecting on their values and effects. Instead of legtitimations, this could lead to improvements in care.

Contextual reflexivity can be practiced on different levels by nursing teams, between different professions, in an organization, between two organizations, by an involved ethnographer, and so on. It provides a form of knowledge that does not discipline participants in the field nor lose sight of moral sensitivities considering specific situations or persons. Instead of imposing predefined standards of knowing, the participants follow professionals and patients in their accounts of daily life and seek to spell out what concepts and values can describe their internal logic and what this logic enables or restrains.

Studying values and other types of practical orderings avoids the lighthearted taking of sides by specific parties in the field (for instance, the patients or the nurses).[12] But showing different practices of good care and tacit knowledge also challenges these same practices. To realize that there is not one form of good care but that there are different, conflicting ones that each have good and bad effects invites critical self-reflection. Instead of the suspicion built in in accounting procedures from the outside, involved descriptions are made from the analytical position that caregivers aim to give good care and know what they are doing, however much one might disagree with the specific aims or effects.

This is a way of putting contextual reflexivity into practice by telling stories to involved insiders as well as involving outsiders. Outsiders and insiders both are challenged to think for themselves and to become involved. Practice is not justified as good but is opened up to show tragic situations as well as best practices. Wins and losses can be compared and weighed; different ways of thinking can be mobilized to imagine alternatives. This might be an interesting way to help professionals and patients striving for something as complex as good care.

Notes

1. Good examples in the Dutch context are the implementation of the law on medical treatment contract (WGBO) and the sharpening of laws for involuntary admission to psychiatric hospitals.

2. See, for instance, Pols (2003, 2004). Latour (1987) describes the work of disciplining scientists to standardize their working methods as the transportation of immutable mobiles, technologies that are made to travel without changing. But talking about whether something works (and what that means) in one place as well as another may also demand a flexibility of the technology itself. De Laet and Mol (2000) relate the success of the Zimbabwe bush pump, a device to pump water to a well, to its capacity to be adapted to varying circumstances and aims. Depending on local specificities, the pump can be adjusted and remade with the use of all kinds of materials at hand. The pump is a success as a mutable mobile, a technology that is being shaped differently in different practices.

3. See, for instance, Torrey et al. 2001.

4. In the history of the Dutch residential homes, these homes started out as a service for the rich elderly and gradually changed to the form of nursing home, where disabled elderly are looked after. Because the residential home is financed according to the AWBZ (general law for special costs considering illness), a medical indication is necessary for admission in a residential home (see Bijsterveld 1996).

5. See, for instance, *NRC Handelsblad*, a Dutch newspaper, April 4, 2002. In Denmark, it recently has been debated whether coercion (fixation) should be legally allowed to force elderly people who resist hygienic routines to be washed. See for this debate, for instance, the Danish newspaper *Information*, February 26, 2003, p. 8 (Rasmussen 2003). Thanks to Estrid Sörensen and Brit Ross-Winthereik, who pointed this out to me and translated part of the debate for me.

6. A comparable complaint is heard from doctors troubled by translating results from clinical trials to individual patients. The patients in the trial often are selected for having a singular diagnosis, while real patients often suffer from complicating other diseases that interact with the treatment prescribed (see, for instance, Rothwell 1995). Likewise, the tension between patient autonomy and evidence-based medicine is a matter of debate (see, for instance, Chervenak and McCullough 1995).

7. These can also be present in the care plans of the effective washers but would not be relevant for effective washing, whereas they are relevant in ethical washing.

8. For the substantial interference of legal procedures in daily care, see Pols (2003).

9. For examples, see MacIntyre (1984); Benner (1984); Bulman and En Schuts (2004); Ghaye and Lillyman (2000); Kember et al. (2001).

10. *Involved* here is opposed to *neutral*, but does not mean *subjective*. Donna Haraway would talk here about situatedness in her attack on realist epistemology (1991). Harbers, Mol, and Stollmeyer (2002) use the term *involved description* and argue for an ethical position. Here, I explicitly add the link to an epistemological position (see also Pols 2004).

11. Boltanski and Thévenot (1991) set the inspiring example by classifying ways ordinary people (not in care situations) use to justify their actions into five different repertoires or worlds (mondes). They do not criticize legitimations but study their use.

12. For a thorough analysis of the politics of orderings as opposed to the politics of conflicts between groups, see Mol and Mesman (1996).

References

Beauchamp, T. L., and J. F. Childress. 1994. *Principles of biomedical ethics.* New York: Oxford University Press.

Berg, M. 1997. *Rationalizing medical work.* Cambridge, MA: MIT Press.
Benner, P. 1984. *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison Wesley Publishing Company.
Bijsterveld, K. 1996. *Geen kwestie van leeftijd: Verzorgingsstaat, wetenschap en discussies rond ouderen in Nederland, 1945–1982* (*Not a matter of age: The caring state, science, and discussions on the elderly in the Netherlands 1945–1982*). Amsterdam: Van Gennep.
Boltanski, L., and L. Thévenot. 1991. *De la justification : Les économies de la grandeur* (*On justification: The economies of grandeur*). Paris: Editions Gallimard.
Boschma, G. 1997. Creating nursing care for the mentally ill: Mental health nursing in Dutch asylums 1890–1920. PhD diss., Nursing University of Pennsylvania.
Bulman, C., and S. En Schuts, eds. 2004. *Reflective practice in nursing: The growth of the professional practitioner*. 3rd ed. Oxford: Blackwell Publishing.
Callon, M., and J. Law. 2005. On qualculation, agency and otherness. *Environment and Planning D: Society and Space* 23 (5): 717–33.
Chervenak, F. A., and L. B. McCullough. 1995. The threat of the new managed practice of medicine to patients' autonomy. *Journal of Clinical Ethics* 6 (4): 320–3.
de Laet, M., and A. Mol. 2000. The Zimbabwe bush pump: Mechanics of a fluid technology. *Social Studies of Science* 30 (2): 225–63.
de Lange, J. 1990. *Vergeten in het verpleeghuis* (*Forgotten in the nursing home*). Utrecht, Netherlands: Trimbos-instituut.
Ghaye, T., and S. Lillyman. 2000. *Reflection: Principles and practice for healthcare professionals*. Dinton, Wiltshire, UK: Quay Books, Mark Allen Pubs.
Green, J. 2000. Epistemology, evidence and experience: Evidence based health care in the work of accident alliances. *Sociology of Health & Illness* 22 (4): 453–76.
Haraway, D. 1991. Situated knowledges: The science question in feminism and the privilege of partial perspective. In *Simians, cyborgs and women: The reinvention of nature*. New York: Routledge.
Harbers, H., A. Mol, and A. Stollmeyer. 2002. Food matters: Arguments for an ethnography of daily care. *Theory, Culture & Society* 19 (5–6): 207–26.
Hopper, K. 2001. Commentary: On the transformation of the moral economy of care. *Culture, Medicine & Psychiatry* 25 (4): 473–84.
Kember, D., et al., eds. 2001. *Reflective teaching and learning in the health professions*. Oxford: Blackwell Science.
Kirschner, S. R., and W. S. Lachicotte. 2001. Managing managed care: Habitus, hysteresis and the end(s) of psychotherapy. *Culture, Medicine & Psychiatry* 25 (4): 441–56.
Latour, B., and S. Woolgar. 1986. *Laboratory life and the construction of scientific facts.* Princeton, NJ: Princeton University Press.
Latour, B. 1987. *Science in action: How to follow scientists and engineers through society.* Cambridge: Harvard University Press.
Law, J., and A. Mol. 2002. Local entanglements or Utopian moves: An inquiry into train accidents. In *Utopia and Organisation*, ed. M. Parker, 82–105. Oxford: Blackwell.
MacIntyre, A. 1984. *After virtue: A study in moral theory.* Notre Dame, IN: University of Notre Dame Press.
Mol, A. 1998. Missing links, making links: The performance of some atherosclerosis. In *Differences in medicine: Unraveling practices, techniques and bodies*, edited by M. Berg and A. Mol, 144–65. Durham, NC, and London: Duke University Press.
———. 2002. *The body multiple: An ontology of medical practice.* Durham, NC: Duke University Press.

Mol, A., and M. Berg. 1998. Differences in medicine: An introduction. In *Differences in Medicine: Unraveling practices, techniques and bodies*, ed. A. Mol and M. Berg, 1–12. Durham and London: Duke University Press.

Mol, A., and J. Mesman. 1996. Neonatal food and the politics of theory: Some questions of method. *Social Studies of Science* 6 (2): 419–44.

Pols, J. 2003. Enforcing patient rights or improving care? The interference of two modes of doing good in mental health care. *Sociology of Health & Illness* 25 (3): 320–47.

———. 2004. *Good care: Enacting a complex ideal in long-term psychiatry.* Utrecht, Netherlands: Trimbos-instituut.

Rasmussen, J. L. 2003. Ja, jeg begä overgreb (Yes, I use coercion). *Information* (Copenhagen, Denmark). February 26, 2003.

Robins, C. S. 2001. Generating revenues: Fiscal changes in public mental health care and the emergence of moral conflicts among care-givers. *Culture, Medicine & Psychiatry* 25 (4): 457–66.

Rothwell P. M. 1995. Can overall results of clinical trials be applied to all patients? *The Lancet* 346 (8496): 1616–9.

Sackett, D. L. 1996. *Evidence based medicine: How to practice and teach EBM*. New York: Churchill Livingstone.

Sackett, D. L., S. Strauss, S. Richardson, W. Rosenberg, and R. B. Haynes. 1991. *Clinical epidemiology: A basic science for clinical medicine*. Boston, MA: Little Brown.

Timmermans, S., and M. Berg. 2003. *The gold standard: The challenge of evidence-based medicine and standardization in health care.* Philadelphia, PA: Temple University Press.

Timmermans, S., G. C. Bowker, and S. L. Star. 1998. The architecture of difference: Visibility, control and comparability in building a nursing interventions classification. In *Differences in Medicine: Unraveling practices, techniques and bodies*, edited by A. Mol and M. Berg, 202–25. Durham and London: Duke University Press.

Torrey, W. C., R. E. Drake, L. Dixon, B. J. Burns, L. Flynn, A. J. Rush, R. E. Clark, and D. Klatzker. 2001. Implementing evidence-based practices for persons with severe mental illness. *Psychiatric Services* 52 (2): 45–50.

Zwartboek door verpleging: Verzorging in verpleeghuis neemt sterk af (Blackbook by nurses: care in nursing home declines severely). *NRC Handelsblad* (Rotterdam, The Netherlands), April 4, 2002.

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