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Bedtime negotiations: Unravelling normative complexity in hospital-based prevention

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Abstract

This study explores how actors deal with normative complexity in the design and implementation of practices of preventative care. Previous studies have identified conflicting (e)valuations of prevention within health care at large, but little empirical research describes how these conflicts are resolved in day-to-day interactions. Zooming in on the work of a single actor, our ethnographic study describes a Dutch psychiatrist developing a novel type of hospital bed that provides preventative psychiatric care for women in the post-partum period. Drawing on pragmatic sociology of justification, we construe 'beds'—and the time, people and resources they represent—as points of convergence between conflicting valuations of care. The results show that embedded modes of valuation in a curative hospital setting generate significant normative complexity during implementation. We identify three main strategies through which normative complexity is managed: (a) *translating* between different modes of valuing prevention, (b) *compromising* in (material) design of care beds and (c) *transcending* embedded valuations through moral appeals. By showing the normative complexity of

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prevention in practice, our study highlights the need for a diverse and situated accounting for preventative care.

KEYWORDS
maternity services, mental health services, prevention, values

INTRODUCTION

In many health-care systems today, prevention is seen as a valuable strategy for reducing the demand for care in ageing populations, decreasing health inequalities due to lifestyle, improving well-being and creating better value for money for the health-care system. At its most basic, prevention denotes any present-day action meant to avert or promote some future course of events. Within health care alone, this simple definition covers an astonishing variety of activities, such as population screening, vaccination programmes, food regulation, public education or lifestyle interventions or family assistance.

Prevention practices are complex and involve a range of different actors, including practitioners, researchers, citizens, funding agents and policymakers (Greenhalgh & Papoutsi, 2018; Lich et al., 2013). Relations between these actors are complex for multiple reasons. First, long-term outcomes of preventative activities are always to some extent *uncertain*, which means researchers, practitioners, clients and funding agents must negotiate what level of uncertainty is acceptable in making short-term investments (Hillman et al., 2013; Zinn, 2008). Second, prevention may be motivated by *heterogeneous values* like public health, social equality, civic participation or economic efficiency. In designing interventions, ensuring funding or determining responsibilities of different values and interests associated with prevention may appear at odds with one another (Hurlimann et al., 2017; Matar et al., 2019). Third, the value of prevention and public health practices is assessed through multiple *incommensurable measures* (Hawkins and Parkhurst, 2016), for example, in weighing increased quality of life vis-á-vis financial expenditures. Innovations like social cost-benefit analysis, value-based healthcare or social impact bonds are meant to reduce this complexity, but reconciling incommensurable measures of value remains an issue in practice (Chiapello & Knoll, 2020; Rowe & Stephenson, 2016).

Despite sustained interest in complexity within implementation science, the implementation of prevention and public health interventions is still frequently construed as a largely technical matter, where evidence-based interventions are implemented by overcoming real-world barriers and facilitators. In everyday care practice, however, implementation requires actors to weigh complex normative decisions like the ones above. Little research on prevention has given attention to this 'normative complexity', which occurs when multiple valuations of prevention practices are at conflict with one another (Cribb et al., 2021). Studies that have touched upon normative complexity have largely described value-conflicts in health-care systems at large (Gough, 2015; Mykhalovskiy & French, 2020; Schoemaker et al., 2020).

This study draws on pragmatic sociology (Boltanski, 2011; Boltanski & Thévenot, 2006) to explore how professionals manage normative complexity in designing new prevention practices. Pragmatic sociology foregrounds the 'justification work' people do to manage everyday normative disputes (Jagd, 2011; Oldenhof et al., 2014). These disputes not only appear in abstract deliberation or debate but also in the way time is treated, work is organised, outcomes are measured and material settings are arranged (Boltanski & Thévenot, 2006; Thévenot, 2002). Following earlier

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work by Nettleton et al. (2018), our ethnographic study investigates justifications for prevention by focussing on an especially salient element of the health-care system: The hospital bed. Nettleton et al.'s work show that bedsand the 'people, knowledge, space and technology' associated to them (Allen, 2014)—inscribe ideas and ideologies of care, materialising wider debates about the organisation of health care. Seemingly, mundane objects like beds therefore provide an entry point for studying the normative complexity of preventative care.

Our article presents the results of a 2-year ethnographic study of a Dutch pregnancy psychiatrist by implementing a new type of preventative psychiatric bed at her hospital department. Through intensive care in the post-natal period, this treatment aims to prevent parents' psychiatric problems from worsening at a later stage. At the same time, it intends to prevent newborns from developing problems much later in life, reflecting a wider interest in the preventative potential of the perinatal period (Lowe et al., 2015). In a hospital setting, the beds needed for this prevention strategy required intensive justification towards relevant audiences like peers, hospital management or health insurers. Beds are seen as a paragon symbol of curative care (Geest & Mommersteeg, 2006), whereas prevention is valued for reducing the time patients spend inside hospital beds (McKee, 2004). In the Netherlands, specifically, hospitals are incentivised to decrease the time patients spend in bed and transfer non-acute care to outpatient ambulatory services. This policy of the 'right care in the right place' has contributed to one of the lowest average lengths of stay in Europe (OECD, 2019). Going against this logic of reducing 'bedtime', the psychiatrist imagined a bed that would significantly increase parents' length of stay. By unpacking how preventative beds are justified in this demanding context, our article illuminates the normative complexity of preventative care. The following research question guides our analysis: How do health-care actors conduct justification work to manage normative complexity in designing a new practice of preventative care?

In the theoretical section of this article, we first introduce pragmatic sociology to conceptualise normative complexity. In the method section, we outline our case and research methodology, focussed on shadowing a single protagonist. In the empirical part, we describe recurring normative tensions around the preventative hospital bed, many of which originate in conflicting 'temporalities of care' (Buse et al., 2018) enveloping the bed. Our analysis distinguishes three types of justification work through which actors manage this normative complexity: *translating,* where a situation is reframed in accordance with different registers of value; *compromising,* creating situations or objects that conform to multiple orders of worth; and *transcending,* invoking values that override conventional justifications of people to legitimate situations. In the discussion and conclusion, we outline the theoretical and practical implications of our study.

EXPLORING NORMATIVE COMPLEXITY WITH PRAGMATIC SOCIOLOGY

Drawing on the pragmatic sociology of valuation originally developed by Boltanski and Thévenot (1999, 2006), this article investigates how actors deal with normative complexity in implementing preventative care. In *On Justification*, Boltanski and Thévenot (2006) develop a structured approach for studying how people, time and objects participate in normative disputes. Synthesising empirical research with an analysis of classical political philosophy, Boltanski and Thévenot find that people use a limited number of justifications, logics, repertoires or orders when they justify and criticise situations they are involved in. In *On Justification,* they distinguish six: (1) market, (2) industrial, (3) civic, (4) domestic, (5) inspired and (6) fame. Each of

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these orders is coherently organised around a *central value* that determines what is considered valuable, how value is *measured* and how *people*, *time* and *objects* are treated. A market order, for instance, centres on short-term profit *(value)* that is made by selling commodities *(objects)* to consumers *(people)* against a certain price *(measure)*. An industrial order foregrounds efficiency and reliability *(value)*, measured in operational criteria *(measure)*, from instruments *(objects)* developed by professionals *(people)*. A civic order, in contrast, values collective welfare *(value)* for citizens *(people)* through policies *(objects)* that demonstrably contributes to a public cause *(measure)*.

In everyday life, actors mobilise different orders as they submit situations to so-called 'tests of worth': situations in which the value of people, time or objects is 'put to the test' of critique. As Boltanski & Thevenot note, material objects can be used to construct situations that are better able to withstand criticism (Boltanski & Thévenot, 2006, p. 143). In a professionalised hospital setting, for instance, professionals *(industrial subjects)* may wear uniforms *(industrial objects)* to ensure critics will not question their reliability *(industrial value)* by saying they are distracted by appearances *(fame value)* or self-expression *(inspired value)* (Edwards et al., 2012). In this sense, people and objects can materialise and strengthen particular justifications.

In the above example, there is agreement about the order of worth used to construct a situation: Professionals inside a hospital should be reliable and task-oriented. Often, however, people precisely disagree about what 'test of worth' is appropriate. Oldenhof et al. (2014) for instance describe how managers of assisted living homes struggle to reconcile safety rules and regulations *(civic)* with creating a homely environment *(domestic)*. In these cases, actors need to construct pragmatic solutions to pass the test of worth. This may consist in finding a right rhetorical formulation but also in constructing 'complex moral objects' (Thévenot, 2002) that materialise a compromise between different orders of worth.

Because they bring together incommensurable orders of worth, the 'murky situations in which beings of several different orders are involved are particularly apt to invite denunciations' (Boltanski & Thévenot, 2006, p. 57). Compromises are vulnerable to critique. In these situations, people need to do considerable 'justification work' to hold together compromises in the face of critique (Thévenot, 2002, p. 411). Earlier, research using a pragmatic lens has found that organisations operating in normatively complex environments are a key site for producing such compromises (Oldenhof et al., 2014, 2022; Patriotta et al., 2010). Health care is a case in point. For instance, hybrid organisations like hospitals need to balance diverse values like clinical professionalism, patient-autonomy, managerial efficiency, private-sector interests and the needs of health-care systems at large (Brandsen et al., 2005).

As prevention and public health often take place beyond the traditional boundaries of health-care systems—in streets, homes, supermarkets and offices—prevention likely causes normative complexity to proliferate, as preventative aims may conflict with values like profit, autonomy or efficiency. The next section zooms in on these value conflicts by investigating justifications for prevention in the curative setting of hospitals, zooming in on a central object within the hospital organisation: The hospital bed.

Beds and normative complexity

Hospital beds are normatively complex objects that bring together a range of conflicting valuations and can therefore serve as a 'prism, revealing the ways in which political, economic and moral issues constrain designs' (Nettleton et al., 2018). Metrics like bed occupancy, discharge

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rate, beds per capita and nurse-to-bed ratio are widely used to evaluate the operational efficiency of wards, hospitals or even health-care systems as a whole (OECD, 2021b). At the same time, beds are places of healing that set the stage for professional interactions with patients and their loved ones. In the Netherlands, imminent shortages of intensive care beds during the SARS-CoV-19 pandemic—that is, shortages of staff—dramatically illustrated the physical and emotional toll incurred when beds are lacking (Wallenburg et al., 2021). Commentators noted that these shortages were themselves incurred by a steady stream of policy measures designed to reduce the number of hospital beds and the time patients spend in them (Wallenburg et al., 2021). Here, two notions of what constitutes a 'good bed' are at conflict: On the one hand, beds should provide the space for quality care for those who need it, and on the other, beds should be used efficiently to provide care to the largest possible population against the lowest possible costs.

Well, before the SARS-Cov19 pandemic, various ethnographic studies observed this same normative tension in everyday care practice. Echoing earlier work by Green and Armstrong (1993), Allen (2014) finds that nurse's daily bed management practices are marked by a conflict between a 'logic of efficiency' and a 'logic of individualised care'. Nurses must constantly 'balance their professional responsibilities for individual patients' quality of care with the needs of whole populations'. Through frequent transfers meant that beds were opened up to new patients; yet, this sometimes meant patients felt 'pushed around and uncared for'. A recent study by Nettleton et al. (2018) finds that, before beds are put to use, architects struggle with conflicts between commercial imperatives, risk reduction and allowing patients to personalise rooms to feel at home. They show that beds and bedrooms are 'contested artefacts which carry differing notions of care, risk and value nested within their material forms' (p. 1157).

Drawing on this work, we look at hospital beds to examine normative complexities surrounding preventative care. Many actors in health care today see prevention as a fruitful—if difficult to realise—strategy to stimulate good health, contain costs and reduce health inequalities. Here prevention is generally seen as an efficient *(industrial)* long-term strategy for reducing the number of beds in hospitals, as well as improving collective welfare *(civic)* (Faden et al., 2019). These abstract values of prevention may hardly seem questionable but may generate significant normative complexity on the ground. In the section below, we describe how we investigated and in what ways actors deal with this normative complexity.

SETTING AND METHOD

Setting

To analyse normative complexity in the implementation of preventative care, we conducted a qualitative case study at a Dutch hospital situated in a major Dutch urban area. It has a formal bed capacity of around 500 beds, making it a large hospital by Dutch standards. The hospital setting interested us because Dutch hospitals are generally expected to concentrate on providing curative services, making it hard to justify a preventative use of hospital beds. This focus on curative care was intensified by recent sectoral agreements. In 2018, concerns about the system-wide growth of health-care expenditures had resulted in a covenant between the ministry of Health, representatives of the hospital sector, nurse and patient federations and the union of health insurers. The covenant expressed a shared commitment to bring the rising expenditures on the hospital sector to a halt. While it emphasised the need for preventing care by intervening at an early stage, the main strategy for achieving this aim was to 're-place' non-acute hospital care

to ambulatory service providers, epitomised in a widely known policy maxim known as 'the right care at the right place'.

In this challenging context, our research centres on the justification work of a single protagonist (Iedema et al., 2004). Our analysis foregrounds how one individual mobilises different justifications to change local practice in different settings. The first author 'shadowed' a Dutch psychiatrist (from here on referred to as 'the Psychiatrist') situated in a department at the interface of pregnancy, obstetrics and paediatrics. To change care practice, the Psychiatrist needed to justify her plans towards a variety of audiences. These include the *board of directors*, who need to ratify and finance the project, *health insurers*, who in the semi-privatised Dutch health-care system must sign contracts to reimburse the new bed, *financial directors,* who demand a firm financial justification of the service, *ambulatory service providers,* to whom patients in the bed should seamlessly transfer after discharge and the *daily medical board*, who should ratify plans to allocate limited budgetary space to the new bed.

Like many of her scientific peers, the Psychiatrist argues that good mother-infant relations in the post-partum period prevents the child from developing various problems later in life—ranging from cardiovascular diseases and obesity, to depression and anti-social behavioural disorders. These issues may affect how a child develops in other areas of life (e.g. education and career) making the perinatal period a critical period for prevention. In the Netherlands, this approach recently materialised in a large-scale policy programme titled *Promising Start,* which intends to prevent developmental problems by improving parenting support during 'the first 1000 days'—the period between −9 months and +2 years.

Building on this wider concern with prevention in maternity care, the Psychiatrist imagines a new form of preventative psychiatric care for mothers suffering from relatively 'mild' psychological issues like depression or anxiety disorders. Before the project started, this patient group was discharged within a few days after giving birth. Seeing the preventative potential, the Psychiatrist attempts to implement a service of psychiatric support and parenting training, significantly extending the average length of stay for this patient population from 3 to 14 days. Additionally, this period would be used to invite ambulatory caregivers to start up treatment inside the hospital, creating care continuity between the hospital and home.

Data collection

As we entered the field, our main question was how preventative care is justified in a curative hospital setting. Between April 2020 and November 2021, we followed the design phase of the implementation which, at the time of writing, is still ongoing. Theoretically, this phase of implementation interested us because the value of the bed is still open to interpretation. This meant we could study how actors translated values into concrete design choices.

In this context, we triangulated between three modes of data collection. First, the first author conducted ethnographic observations in a wide variety of settings attended by the Psychiatrist, including meetings with various colleagues, sales pitches, training sessions, board meetings and conferences. During these meetings, we conducted 'fly on the wall'style observations, as well as having numerous informal conversations with the actors involved. Both were recorded through field jottings, elaborated in ethnographic field notes later that day. Second, we conducted 32 semi-structured interviews of which 20 were conducted with the Psychiatrist and the other 12 with practitioners involved in the project (psychiatrists, nurses, managers and policy advisors). In these interviews, we discussed the ongoing project and reflected on themes picked up during

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our observations. Since over half of these interviews were held with the Psychiatrist, this allowed us to continuously member-check our findings. Third, we included various written documents in our documents. We analysed manuscripts of the business case for the new bed across 18 different versions to see how justifications for the new bed dynamically evolved over time. With consent, our team also had access to much project-related e-mail correspondence between the Psychiatrist and relevant audiences, allowing us to see some of the justification work that usually remains hidden. Through these three data sources—interviews, observations, documents—we were able to closely observe how justifications and critiques of the bed affected design choices over time.

Data analysis

Our data analysis was conducted in two phases, combining inductive and deductive analysis. Interested in value conflicts over prevention and public health, the first phase inductively searched for moments of friction between actors. It quickly became clear that professionals continuously referred to non-human actors (e.g. discharge protocols, policy programmes, research findings and imbursement mechanisms) to strengthen their arguments during these moments of friction. Financial consultants, for instance, not only criticised the bed's profitability by itself but rather referred to a lack of contracts with health insurers, arguing they would likely be unwilling to close these contracts.

Triggered by recurring correlations between values, objects, people and time, the second phase of our analysis deductively coded our dataset by using the theory of justification developed by Boltanski and Thevenot. We were drawn to their work because it explores 'justifications and critiques and the ways in which these make links among cognitive, moral, and material issues' (Thévenot, 2002). Using this framework, we coded the main value conflicts in our data. These mainly appeared in industrial, domestic, market and civic orders of worth. Other justifications were also coded (e.g. a *fame* justification of the bed as an *innovative* service that would increase the hospital's *public profile*), but these were not nearly as prevalent as the four justifications referred to above. After classifying our data in this way, we searched for recurring combinations of justifications, in order to understand how actors managed the normative complexity of conflicting orders of worth. Using this methodological strategy, our analysis induced three recurring ways of dealing with value conflicts, which are further described in the results section below.

RESULTS

In the curative setting of the hospital, there was a strong imperative to justify the need for preventative care. This imperative of justification first arises in the context of securing funds for innovation projects, which is marked by fierce competition. In this interview excerpt, the Psychiatrist conveys the normative complexity involved in this process:

> So many others are also trying to land that money from the hospital innovation fund. (...) And besides all that I also have to get the health insurer to the table. No, I'm definitely not getting my hopes up. But if I don't get the money I'll just continue as described in the business case: try to break even, maybe even make a tiny bit profit and possibly convert a standard psychiatry bed, if the health insurer tells me I've reached the limit. If my department allows me to, that is. Then there's also the other psychiatrists at paediatrics ... (...) Everything's just so complex! I have to tell you I'm a bit frustrated with the time it's taking. It's like... Aaarggh... It's such a trip.
>
> (Psychiatrist, interview)

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TABLE 1 A schematic overview of the ways in which the beds in our case are treated within different orders of worth. Based on Boltanski and Thévenot (2006).

	Industrial bed	Domestic bed	Market bed	Civic bed
Value	Efficiency, reliability	Trust, proximity, human relations	Profitability	Collective welfare, public good
Test	Clinical effectiveness, operational efficiency,	Good mother-family-child attachments	Sales, contracts, profitability	Contribution to public cause, reducing health inequalities
Form of proof	Quantitative output measures	Exemplary anecdotes	Financial outcomes, profits	Official support
Qualified objects	Number sheets, financial models	Homely environment	Contracts, product characteristics	Policy programmes
Qualified subjects	Patient categories, experts, professionals, operational managers	Mother, child, father, family, local contacts	Salespersons, procurement officers, purchasers	Society as a whole, Dutch newborns, public bodies
Temporality	Time as production variable; long-term effects; length-of-stay; throughput; bed occupancy	Time to build up relations	Time as a price variable	Societal futures; long-term benefits for society, future generations

In the results section, we analyse how the Psychiatrist attempts to justify a preventative bed to this complex field of actors which, as we can see here, proved to be a frustrating endeavour at times. Table 1 provides an overview of the different orders through which beds are justified in our case, what tests of value are used, what people and artefacts are relevant within different orders and how time is conceived. Throughout the text, these different dimensions of bed design are italicised, so as to bring out how different justifications of prevention materialise in distinct ways of handling time, people and objects.

As we entered the field, the Psychiatrist had no more than a general outline for a new service of preventative psychiatric care that she called the Family Baby Unit. The idea gradually became more defined as design choices had to be justified towards various critical audiences. Our analysis first describes several long-term civic and industrial justifications of a preventative bed. Second, it investigates how domestic design choices are informed by this long-term value. Third, we see how actors in the hospital criticise these domestic beings by invoking industrial and market orders of worth. Finally, our analysis describes three types of justification work the Psychiatrist uses to counter these critiques, thereby crafting a normatively complex object that materialises a variety of justifications.

A smart investment for society: Civic-industrial justifications for prevention

Our analysis starts with a number of general justifications for a more preventative use of beds. Within an industrial order, prevention is valued because *clinical evidence* proves it is an *efficient investment* on the long term. For example, nearly all public presentations of the Psychiatrist refer

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to the Heckman-curve, an influential figure that visualises the economic efficiency of early childhood welfare policy. This work describes early childhood development programmes as a *smart investment* with a good *rate of return*, situating the bed within the *longue durée* temporality of *investing in the future*. In line with this, the Psychiatrist frequently notes that untreated perinatal mental health issues exceed the costs of improving services by five times. Long-term efficiency is a key justification for implementing prevention.

The Psychiatrist usually aligns this industrial justification with a civic one. Here, prevention is justified through its long-term *macro-economic benefits* for *society as a whole,* for *future generations* or for *healthy and resilient populations.* This composite industrial-civic justification for the new bed appears in this excerpt from the business case for the Family Baby Unit:

> [M]aternal psychiatric illness in pregnancy and the post-partum period constitute a risk-factor of psychiatric illness for the child. Various *studies* for instance show that maternal depression negatively affects the child's development, incurring *huge costs on society*. With the right help mothers can recover from their depression, positively affecting the child's development. Preventing psychiatric illness in *the next generation* therefore begins with a good start for mother and baby during pregnancy and the peripartum period. Currently this is also recognized by the *Ministry of Public Health, Welfare and Sports* who, following an *advice by the Health Council*, have recently enacted the *action program* Promising Start to improve the first 1000 days of *Dutch children*.
>
> (Business Case, final version)

Here, civic justifications for prevention are strengthened by alluding to civic *representatives of collective welfare*, like the *Ministry of Health* or the *Health Council*, while industrial justifications are given by through the available *scientific evidence* that associates material depression to *societal costs*. *Society at large* and the entire *population of Dutch children*, rather than *parents* or *professionals*, are the subjects of justification. By invoking the *huge societal costs of unhealthy generations,* prevention is justified by aligning civic and industrial value, a justification characteristic of the field of public health at large (Faden et al., 2019).

Occasionally, long-term civic-industrial justifications of prevention are specified: Less psychopathology means *fewer healthcare costs*, *less crime*, more *labour productivity*, less *need of social support*. However, few actors ever felt the need to criticise the long-term promises of prevention. Sociologists of public health have noted this uncontroversial status of prevention (Mykhalovskiy et al., 2019). Yet, the above citation illustrates that future promises of prevention require good domestic relations on the short-term: A *good start for mother and baby*. Longue durée temporalities are folded into the period parents spend inside a hospital. This was a key point of normative complexity, as domestic time was at odds with industrial orders of bed use. The next section describes how the Psychiatrist justifies the new bed through a critique of this industrial order.

A place for mother-family-child attachment: Domestic bed justifications

Leveraging the long-term preventative potential in the previous section requires investments in good mother-child relations. Such added investments are hard to justify in a hospital setting that routinely draws on short-term industrial tests to value beds, generating significant normative complexity. Here, we describe how the Psychiatrist invokes domestic justifications to critique these short-term industrial orders of bed use.

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Within a domestic order, the length of stay is valued in relation to the time it takes to *build relations* of *trust and proximity*. Time is valuable because it helps parents *grow into the parenting role* and *develop good mother-family-child attachment.* Time is also valued because it allows caregivers in the hospital to develop a relationship of *trust* with local ambulatory care providers. They can seamlessly continue treating the mother after being discharged *home,* a so-called *warm transfer.*

This 'warm' valuation of time contrasts with 'cold' industrial temporality. Here, the value of time is not tested through the quality of human relations but rather through quantities of standardised clock time like *average length of stay* or *bed occupancy rates.* Within a domestic order, this industrial ordering of bedtime appears *cold*, *anonymous* and *impersonal.* Standardised industrial objects like discharge protocols pay little heed to parents' needs, let alone their relation to their child. In a presentation to a team of health insurers, the Psychiatrist criticises industrial temporality by invoking domestic justifications:

> It's important to create a family baby unit that aims at the large population of women with depression and anxiety problems. If we see these women in the clinic, they do get a referral, but they often fall *in between the cracks*. You might have heard the stories about *maternal psychoses* and *suicides*... That's why during treatment we need to *take our time* and see what's available in the care network.
>
> (Psychiatrist, presentation for health insurance team)

The bed's temporality—how the bed is situated in time, what this time means—constitutes a key topic of normative complexity. In the bed, the *longue durée* temporality of future population health is folded into the 'time it takes' to develop good relations. As we describe later, however, this complex temporality conflicts with the short-term efficiency demanded in everyday care routines.

Another domestically justified design choice appears in the above citation. In line with *efficiency-minded* attempts to *reduce the number of patients treated in hospitals*, current beds only target a small population with severe, acute psychiatric issues (e.g. post-partum psychosis). Mobilising a domestic justification, the Psychiatrist proposes to admit a new population of women with mild problems (e.g. depression and anxiety disorder) because these mild issues affect *parent-child attachment* and *child's development*. For the same reason, these children should be treated in the *maternity ward*, rather than a psychiatric clinic, since this environment is more conducive to *the mother role*. The business case for the bed defends this choice like this:

> Our Family Baby Unit targets a broad target group of women with psychiatric problems (e.g. depression, anxiety) in the first period after birth with the aim of organizing a care framework and developing a personalised treatment plan. Ideally the Family Baby Unit is located near the maternity ward rather than a psychiatric department, like most FBU's in the country. This helps to *destigmatise psychiatric orders* in the post-partum period and prevents, aside from other problems, another loss, that of her *mother role.*
>
> (Business case, final version)

These citations illustrate how timing protocols, bed placement and target populations are subject to normative complexity. They are ordered through normative frameworks entailing different visions of 'good bed use'. In the next section, we see how different actors inside the hospital criticise the domestic justifications of bed use suggested by the psychiatrist.

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Enhancing throughput of babies: Industrial and market beds

Unsurprisingly, many critiques of the bed were voiced in an industrial mode. Though 'taking the time' for prevention promises *efficiency on the long-term*, short-term industrial justifications require beds to *efficiently* produce *treatment outcomes* at a *measurable rate of time and resources.* Alongside this industrial critique, several actors criticised plans for the new bed by invoking market justifications. These actors treat hospital beds as *goods or services* that can be sold to *health insurance purchasers* to *turn a profit* for the hospital.

Industrial critiques denounce domestic design choices because they contravene on-going efforts to *decrease the length of stay, alleviate staff shortage* and *shift non-acute care* to ambulatory care providers. After receiving the business case for the new bed, a medical manager at an involved paediatrics department sends the following e-mail to the Psychiatrist:

> Like you know all too well, the vision of the health insurer/hospital and the Woman-Mother-Child Center (WMC) is to *organise care close to home*. Looking at *staff shortages* and *sharp reductions in clinical beds* at paediatrics, we are critical of "what care should really take place within hospital walls" and what we can transfer to the ambulatory care network. So I have some questions about a length of stay of 17 days? Is it possible to do this differently, shorter, with more use of ambulatory care? Considering the current circumstances of WMC and also to enhance *throughput of babies*, I would really like to discuss this further.
>
> (Medical manager, e-mail correspondence)

This e-mail illustrates a prevalent industrial criticism of domestic temporalities of care. Under pressure to make *efficient use of beds,* the value of time spent with a baby is not measured through *bonding* and *attachment* but rather through its implications on the department's *production process*, it's *throughput of babies.* This illustrates a tension within industrial temporality: What is efficient on a longer time-scale (slowing down hospitalisation) conflicts with what is efficient in the short-term (speeding up throughput). Also note that the e-mail advances an alternative valuation of ambulatory care. It is not valuable, not because it creates a domestic *warm transfer*, which would indeed require more time than current protocols allow, but rather as a means of *reducing hospitalisation time*.

Within a market order, a bed is valued as a *product* that is sold to a *purchaser* (i.e. the health insurer) against a certain *price* to make *profit*. In an informal conversation after a meeting, one nurse expresses her worries about the profitability of the new bed:

> You're kind of hospitalizing a healthy baby, who therefore won't be reimbursed by the health insurer. So yeah, I'm kind of curious about the *financial dimensions*. Can we *make some money*? I mean it would be great to have this *in our city*, but is it also *profitable*?
>
> (Nurse, interview)

The following excerpt from our observations illustrates how such short-term market critiques contrast with long-term civic justifications for prevention. Promising long-term civic profits that are as huge but intangible, these justifications have an almost comic quality in a curative hospital context, where industrial justifications set the tone:

> During a meeting a financial consultant makes a rough financial estimate of the bed's financial viability. "How many patients? With what *length of stay*? What is

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> the expected *bed occupancy*?" He makes a rapid *calculation* and comes up with a large sum of *money*. "Health insurers will not be willing to *pay that kind of money* out of nowhere! Especially at a time when the insurers are only talking about *reducing* the amount of care given in hospitals. In that respect this is a bad moment for doing this kind of thing. A bed that *generates losses* … that's simply out of the question in the current situation." A while later he concludes that the profits are *marginal at the very best*. "Yes," the Psychiatrist concedes tongue-in-cheek, "but the *profits for society* are huge! Keep in mind that this is prevention!" Everyone laughs at her joke. The operational manager chimes in, raising her arms above her head in a gesture of limitlessness: "Why, of course! We are doing this for *all of us*, for *society*!"
>
> (Meeting observation)

Apart from the short-term industrial and market critique of costly, inefficient domestic relations, the citation above illustrates a third critical tension. Some actors not only questioned whether building domestic relations was *profitable* and *efficient* on the short-term but also whether doing so would indeed leverage the preventative potential promised by the scientific literature and whether the *huge profits for society* would indeed materialise. Here, normative complexity derives from the tension between an intangible long-term justification needed to implement preventative care and short-term justifications used to organise care practices on a day-to-day basis. In the next section, we see how the psychiatrist responds to this normative complexity.

Negotiating justifications of bed use

To implement the new bed, the Psychiatrist and her audiences not only had to develop strong justifications and critiques but also negotiate pragmatic solutions to the disputes that emerged. In the previous sections, we saw how actors in the hospital invoked conflicting orders of worth to justify the new bed. In the next section, we describe the three types of justification work through which the Psychiatrist dealt with these conflicting valuations of preventative beds.

Translating: Efficient care through the social support system

Where the value of beds is determined through industrial tests, one approach to mitigate the critique was to show that domestic entities could in fact be valuable in an industrial order. We describe this as *translating*: Reframing a situation to make it conform to another order of worth.

Examples of translating appear throughout the business case for the new bed. For instance, even though *active family involvement* is domestically justified for its *contribution to mother-family-child attachmen*t, it is industrially translated into an *instrument of efficiency*: The *family* appears as a *social support system* that is *scientifically proven* to *speed up treatment* and *relieve work pressure* at the maternity ward. Analogously, integration with ambulatory care is presented as an *efficient use of the existing infrastructure*:

> [B]y involving the system from the start of admission, care for a (healthy) baby by obstetric nurses is *reduced*. In short, good extant care and infrastructure is used,

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> increasing the value of care and *reducing length of stay* through a *faster transition* to the ambulatory care network in the city.
>
> (Business case, final version)

The value of a newborn baby can also be translated through market justifications. This statement, for instance, appears in a one-page presentation slide that is used to obtain funding from health insurance through a *sales pitch*:

> Reducing Length of Stay: "Research shows that a combined hospitalization of mother and baby leads to a faster recovery and therefore reduces length of stay."
>
> (Excerpt from presentation slide)

In this citation, we see that shorter hospitalisation appears as a *product characteristic* that is used to *attract the health insurer* into *signing contracts* for the new bed. These two citations show how industrial and market critiques on domestic design choices are mitigated by translating domestic entities (e.g. infants, family and time spent with ambulatory caregivers). While some actors took these translations at face value, others critically pointed out that the fact remained that the bed admitted a non-acute population of women, increased their length of stay and spent resources on healthy family members. This shows that translations are easily criticised, as observant critics can easily 'unmask' a translation as 'pure rhetoric', when they are not backed up by material arrangements (Oldenhof et al., 2014).

Compromising: As short as possible, as long as necessary

Rather than translating entities from one order of worth to another, a second response to the critique consisted in constructing a (material) *compromise* between multiple orders of worth (Boltanski & Thévenot, 2006). Here, we see that the designs of the bed are in various ways altered to craft a 'complex moral object' (Thévenot, 2002) that conforms to different justifications of bed use at the same time.

Compromising can be readily observed in successive versions of the business case. Early versions, for instance, describe *dedicated rooms for rooming-in the partner* as a hard requirement for successful implementation, spatially inscribing a domestic justification of bed use. Later versions try to negotiate industrial and market critiques of *rooming-in* by sketching out different scenarios that drop this requirement altogether. This compromised version of the bed is the one ultimately ratified by the board of directors.

Another instance of compromising occurs when the bed is subjected to a *cost-benefit analysis*, an industrial test that leads to a rather critical assessment of the bed's *efficiency*. Where the first plans for the bed demand treatment by a continuous supervision by skilled nurses and psychiatrists, later versions significantly diminish the number of hours spent at the bedside after meeting a critique from financial advisors. This generates an awkwardly justified compromise:

> The beds were *extremely expensive*, but that meant we would have to give an extreme amount of care. (...) In all honesty, I think that would have been a bit out of proportion. Establishing an entire team just for three beds, that doesn't seem realistic in these times (...). So I decided to take the minimal... Or well, the minimal... It's just a good intake. A talk with the partner every day, one multidisciplinary meeting each

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> week, daily visitations. That's kind of what it boils down to. And treatment consultation. We're doing neither of these things now! (…) You know, it's not necessary to have a highly educated nurse at the bedside all day. Because, well, how much can you do on a day? Observe some interaction, give some advice, offer psycho-education… But at some point diapers will have to be cleaned.
>
> (Psychiatrist, interview)

In this citation, we see how short-term market and industrial measures of value—couplings between *reimbursement* and *time spent on the bedside*, an *efficient use* of *available personnel*—constrain structure choices about which professionals spend time on the bedside. Early designs of the bed describe intensive treatment within hospital walls as a prerequisite for successful prevention. Later designs increasingly emphasise that hospitalisation is only focussed on a good, *efficient transfer to ambulatory care*. Thus, when a member of the board of directors asks the Psychiatrist for further arguments to justify the bed, this is her response:

> The admissions are *not about diagnosis*, but rather about drafting a *shared care plan* with ambulatory caregivers, to create a *good transfer of care*. Costs are therefore as low as possible (admissions as short as possible), but long enough for safe and better care (as long as necessary).
>
> (Psychiatrist, e-mail correspondence)

The phrase *'as short as possible and as long as necessary'*, which gradually grew into a mantra of sorts, neatly captures the strategy of compromising. It creates a compromise between short-term industrial justifications of bedtime and the necessity of building strong domestic relations. Compromises like these were made throughout the project, relating to where the bed would be situated, how it would be staffed and how long patients could spend in it. When critiques ran the risk of delegitimising the bed's value altogether, however, actors resorted to a final mode of justification work we describe as 'overriding'.

Transcending: If we don't want this, there's something wrong

Rather than conforming to short-term industrial justifications of bed use, either through translation or compromise, a third response to critique was to convince relevant actors that the long-term value of prevention trumped short-term criticism. We call this *transcending:* Demonstrating that the weight of certain justifications overrides the ones routinely used to justify situations. During a staff meeting, a clinical manager in support of the project provides a good example:

> For a while now the meeting consists in a long-winded and technical discussion about *financing*, *formation*, *patient categories* and the *number of beds*. "We really need to get down to what is necessary in terms of *minute-based time registration*. The *expected formation is not realistic* at all!" a financial advisor asserts. A medical manager interrupts: 'Guys, what we really need now is a tick in the box by the board of directors, so we can start talking to health insurance. Right now it's not necessary to focus on the *financial nitty-gritty*. Focus on the *bigger picture*! On the *macro-level*, everyone is happy! If *we* don't want this, then there's really something wrong. (…) Then comically: "And if you look at it like this, isn't it just great that it's *almost*

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> *profitable*? Of course the hospital is not going to get *rich*! (...) The central idea is, because we are so awesome, later in life you will need *less social support, less police, and so forth*. You name it!"
>
> (Meeting observation)

In this meeting, the manager clarifies the importance of focussing on long-term justifications *(the bigger picture)* over short-term justifications *(the financial nitty-gritty)*. Justifications in terms of short-term *profits* or *adequate forecasts* shrivel in the face of the overriding import of prevention. The citation below shows another example of overriding:

> The psychiatrist gives me a quick call from her car. There are new developments. In today's meeting several unit-leaders expressed their concern about hospitalizing care for a new population of apparently non-acute patients and the *implications for "production."* She tells me the paediatric department was concerned about this especially. I ask her how she solved this. She replies she pointed out "that it was in fact very worrying that they did *not* do this earlier, especially in regards to earlier incidents, maternal suicides and so forth." This, she notes, worked quite well.
>
> (Psychiatrist, interview)

Here, we see how the overriding value of a terrible event like a parent committing suicide is used to override short-term industrial concerns of some people in the hospital. In one meeting, the psychiatrist describes this as 'parrying with maternal suicides'.

Our analysis shows that an apparently mundane object like a hospital bed harbours significant normative complexity. Beds are places where recovery takes place and family bonds solidify, but they are also units of planning, products on a market and a basic infrastructure for society. Justification work is part and parcel of everyday work involving beds: Beds are easily critiqued and nurses, managers, patients and doctors must therefore continually justify how beds are used in daily practice (Allen, 2014; Green & Armstrong, 1993). In case an actor calls for a new way of using beds altogether, actors need to redraw the equilibrium between different valuations of bed use.

DISCUSSION AND CONCLUSION

Even though prevention is prioritised in many sectors of health care today, attempts to implement new practices of preventative care are fraught with complexities (Braithwaite et al., 2018; Greenhalgh & Papoutsi, 2018). This was very much the case with the bed we studied where different valuations of bed use conflicted in practice. The results indicate that implementing a preventative innovation requires intensive justification work. Actors need to engage in the ongoing creative work of tying together different justifications and dealing with normative complexity (Heerings et al., 2022b). Pragmatic sociology, we argue, provides a valuable toolkit for understanding the normative complexities of health-care innovation. Rather than seeing values as 'static entities outside of action' (Dussauge et al., 2015)—as underlying principles of institutional fields or as cognitive dispositions of actors—it places value *in action:* in the objects, temporalities, rules and persons that together make up everyday life in health-care organisations (Boltanski & Thévenot, 2006; Oldenhof et al., 2022; Thévenot, 2001). It thereby uncovers the work of negotiation and justification that often remains invisible in studies of health-care innovation. Our

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micro-level ethnography identified three types of such justification work: *translating* the value of an object into the register of another order; *compromising* by bringing objects from different orders together; or *transcending* the routine use of justifications by referring to the overriding value of another.

The bed we studied makes for a somewhat odd place for studying justifications of preventative care. A 'preventative hospital bed' may sound like an oxymoron, since beds are often seen as the penultimate symbol of curative care. However, Ivanova (2020) argues that such 'odd, out of the box, weird places' make visible the taken-for-granted logics through which care is organised. Odd places break with conventionalised justifications in a field and encourage those involved to make their choices and dilemmas explicit. This makes them a productive site for studying justification work. They make justification work especially challenging and thereby make the effort of working with normative complexity visible (Oldenhof et al., 2014).

Another methodological oddity relates to a strong focus on a single actor of health-care innovation. This focus inevitably raises questions of generalisability, though the complexities facing the Psychiatrist resonate with wider debates about preventative care. Positively, our close shadowing gave us access to data that generally remains outside the scope of research, including moments of doubt and frustration, e-mail exchanges between actors and progressive iterations of documents, as they underwent feedback over time. This not only made it possible to go back and forth between the frontstage and backstage of negotiation processes but also allowed us to closely trace how justification work changed over time.

While the value of prevention is clear-cut for many, normative complexity abounds in practice, where prevention tends to face a hefty burden of proof. Here, two interrelated reasons play a role. First, generating hard evidence for the long-term (cost) effectiveness of interventions is challenging. It is time-consuming, investment-heavy and has to account for 'real-world' causal complexity, issues that play a smaller role in generating clinical evidence (Mykhalovskiy & French, 2020; Rychetnik et al., 2012). Second, a narrow focus on efficiency and (financial) cost-containment dominates justifications of prevention. Policymakers expect prevention to reduce costs, not increase them. This may partially explain why health-care expenditures are still strongly skewed towards curative care. OECD reports note that on average, about 80% of health-care expenditures within the European Union are spent on curative or rehabilitative goods and services, while only 6% is spent on prevention and public health (OECD, 2021a).

By taking into account the different 'temporalities of care' (Buse et al., 2018) within which care practices are situated, our article reveals a neglected dimension of complexity in health-care systems. Under the policy maxim of 'the right care at the right place', the Dutch health-care system has seen various initiatives to relocate hospital care to 'the right' place, yet, our study highlights that good care is also very much a matter of the 'the right care at the right time'—especially when it comes to preventative care.[1] This may require stimulating rapid throughput of patients, but, at other times, it may require slowing down and taking the time to see what is needed in terms of care. Though prevention situates care on a longer timescale, there is still little research that shows what care for the future implies in everyday care practices.

Care practices are normatively complex since they must bring together heterogeneous values—as manifested in people, places and time. Making this work requires ongoing justification work. However, the tools used to account for care practices (e.g. benchmarks, checklists and critical performance indicators) often are highly decontextualised, measuring a general notion of good care that fails to describe what good care means in specific situations (Jerak-Zuiderent, 2015; Pols, 2015). Pragmatic sociology helps us to rethink such accountability tools since it makes visible the trade-offs, compromises and alignments that are made to operationalise abstract 'goods'.

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It can thereby inspire policy instruments better attuned to the normative complexity of care, including more narrative approaches to accountability (Heerings et al., 2022a).

Whereas much earlier, research in the pragmatic sociology of valuation has centred on the use of justifications within fields or sectors at large. Our research describes some of the dynamics of justification and critique on the micro-level. More comparative research is needed to reveal its similarities and differences with prevention practices embedded in less challenging or 'odd' contexts of justification.

AUTHOR CONTRIBUTIONS

Hugo Peeters: Conceptualization (Equal); Formal analysis (Lead); Investigation (Lead); Methodology (Lead); Writing – original draft (Lead); Writing – review & editing (Equal). **Lieke E. Oldenhof**: Funding acquisition (Equal); Methodology (Supporting); Supervision (Equal); Writing – original draft (Supporting); Writing – review & editing (Equal). **Wilma van der Scheer**: Conceptualization (Equal); Formal analysis (Supporting); Funding acquisition (Equal); Supervision (Equal); Writing – review & editing (Equal). **Kim Putters**: Conceptualization (Equal); Supervision (Equal); Writing – review & editing (Equal).

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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ENDNOTE

[1] We would like to thank one of the reviewers of this article for suggesting this argument.

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