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Inpatient versus outpatient cervical priming for induction of labour: Therapeutic landscapes and women's preferences

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ABSTRACT

A qualitative study was conducted in Australia to explore women's preferences for inpatient or outpatient settings for cervical priming for induction of labour. The concept of therapeutic landscapes was used to explore the different aspects of the home and hospital that make them therapeutic to women. The therapeutic value of the home and hospital landscapes was defined by their ability to provide women with 'comfort' and 'safety', and women were found to draw on a range of contextual factors to negotiate between the comfort of home and the perceived safety of the hospital. The study provides important information for health professionals to enable them to enhance women's wellbeing should they be offered the choice of inpatient or outpatient priming.

1. Introduction

Induction of labour is a relatively common intervention in pregnancy in Western countries, with around a quarter of all births being induced in Australia, the United Kingdom, and the United States of America (Kelly et al., 2009; Kundodyiwa et al., 2009; Laws and Hilder, 2008). While there is some debate about expectant management versus induction of labour for post-term pregnancy (Sanchez-Ramos et al., 2003; Hermus et al., 2009), and concern about rates of elective induction for non-medical reasons (Simpson and Atterbury, 2003), there is strong evidence for compromised foetal outcomes after 41 weeks gestation (Neilson, 2007). An induction at this time is associated with fewer deaths without an increased risk of assisted vaginal delivery or caesarean section (Gulmezoglu et al., 2006; Nicholson et al., 2009). Within the health services in which this study took place, current policy is to schedule an induction so that women do not exceed 40 weeks+10 days gestation (Nicholson et al., 2009).

The literature on women's experiences of induction shows that women have both positive and negative attitudes towards induction (Heimstad et al., 2007; Waldenstrom et al., 2004; Baston et al., 2008). The experiences of women in Gatward et al.'s (2010) study, for example, ranged from welcoming to resisting the induction. What really matters within this range of experiences is having a "sense of involvement and inclusion" (Gatward et al., 2010, p. 8) in decision-making and the ability to exercise autonomy. One avenue for increasing women's autonomy is around place (home or hospital) in the pre-induction or priming process. In this paper we explore women's comparative experiences of outpatient (home) versus inpatient (hospital) cervical priming for induction of labour.

Cervical priming is a method of induction that involves using an agent to soften or 'ripen' the cervix in preparation for induction of labour (Vaknin et al., in press). The process of cervical priming usually involves an overnight hospital admission as part of the induction process. Women are given the priming agent in the evening and are asked to sleep overnight while the cervix softens. An alternative is outpatient priming, with several studies demonstrating the feasibility of using this approach (Awartani et al., 1999; Biem et al., 2003; Farmer et al., 1996; McKenna et al., 1999; O'Brien et al., 1995; Stitely et al., 2000). Outpatient priming for induction of labour involves the same processes as inpatient priming, the only difference being that women are allowed to go home after insertion of the priming agent. The potential benefits include reduced costs, reduced hospital stays, and women's improved experience of induction (Habib et al., 2008).

A randomised controlled trial is currently underway at two tertiary maternity care centres in a major urban area of Australia. The OPRA Trial (**O**utpatient **Pr**iming for Induction of L**a**bour) is a multi-centred, randomised controlled trial, which aims to compare inpatient and outpatient cervical priming for induction of labour in healthy pregnancies. Women in both groups receive their priming gels (in the form of vaginal prostaglandin) in the hospital and either stay in

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hospital overnight (control group—inpatient care), or are discharged home following a period of satisfactory foetal monitoring (intervention group—outpatient care). The trial includes a small-scale qualitative study exploring women's experiences of cervical priming for induction of labour in inpatient and outpatient settings.

To date only one other qualitative study has been published of women's experiences of outpatient priming. The study explored women's experiences of cervical ripening by self-medication with a nitric oxide donor (isosorbide mononitrate) at home (Reid et al., 2010), and found that the women were very positive about the experience of remaining in the home setting. In this paper we add to this emerging literature by drawing on the concept of therapeutic landscapes to explore women's preferences for undergoing cervical priming for induction of labour in the home or hospital settings.

1.1. Therapeutic landscapes

Previous research on outpatient cervical priming for induction of labour has focused on issues of safety, efficacy, and cost-effectiveness (Bollapragada et al., 2009; Eddama et al., 2009; Habib et al., 2008; Kelly et al., 2009), with one study exploring women's experiences in the outpatient setting (Reid et al., 2010). Ensuring that women are safe and have positive experiences is undoubtedly important. However, the home and the hospital are not just locations where cervical priming happens—what Moon (2009) calls "an unproblematized activity container" (p. 39). Instead, in this paper we draw on research and theorisation within Health Geography that view 'place' as "an experiential construct" (Moon, 2009, p. 39), formed by a dynamic interplay between physical, individual, social, and symbolic factors (Moon, 2009; Milligan and Bingley, 2007; Williams, 2002; Kearns and Moon, 2002). From this perspective, women undergoing cervical priming do not experience the home and the hospital as simply physical locations; instead these environments are viewed as meaningful and associated with particular beliefs, practices, and experiences. Exploring inpatient and outpatient cervical priming in this way provides a more "nuanced account" (Burges Watson et al., 2007, p. 874) of women's experiences and preferences.

While no one has yet explored cervical priming using this approach, researchers have explored the role of place in women's experiences of pregnancy and childbirth. For example, Kornelsen et al. (2010) investigated the importance of giving birth locally to Aboriginal women from remote communities in British Columbia, Canada, highlighting the centrality of the women's ties to their family, community, and place to their birthing experience. The impact of the hospital obstetric setting on women and midwives has also been explored, where the interrelations between the corporeal, social, and spatial have been found to marginalise midwives' practise and constrain women's bodies (Davis and Walker, 2010). Place has furthermore been found to have a negative impact on women's ability to follow health advice in the workplace during their pregnancy (Gatrell, 2010).

A central concept within Health Geography is the therapeutic landscape (Moon, 2009). Therapeutic landscapes are "those places that have been identified as producing health effects (positive and negative), or places dedicated to health care provision" (Dunkley, 2009, p. 88). This concept "provides a framework for analysis of natural and built, social, and symbolic environments as they contribute to healing and well-being in places—broadly termed landscapes" (Williams, 2007, p. 2). The concept was introduced by Gesler in the early 1990s (Gesler, 1992), whose early work focused on exploring the ways in which 'extraordinary' places, such as shrines, spas, and baths, have developed and sustained a reputation for healing (Moon, 2009; Williams, 2007).

Later critiques of Gesler's early work on therapeutic landscapes led to an expansion of the literature both in terms of the places of interest and the theoretical understanding of the concept (Gesler, 2005; Williams, 2007). For example, researchers have highlighted the importance of exploring everyday places, such as the home (Dyck et al., 2005; English et al., 2008; Martin et al., 2005) and the community (Cattell et al., 2008; Milligan et al., 2004; Wilton and DeVerteuil, 2006; Glover and Parry, 2009; Laws, 2009), in addition to more specific sites of health and healing. The therapeutic landscape concept has furthermore been expanded to incorporate the notion that these landscapes are not intrinsically therapeutic (Conradson, 2005; Wilton and DeVerteuil, 2006), but are perceived and experienced differently by different people (Milligan and Bingley, 2007). Finally, therapeutic landscapes are understood to be context dependent, in that they are affected by social and economic conditions (Kearns and Collins, 2000), such as the increasing shift in the provision of health care from the hospital to the home for economic reasons (Dyck et al., 2005; Martin et al., 2005) and, in the case of childbirth, the apparent dichotomy in cultural discourse between the medicalisation and the normalisation of birth (Davis and Walker, 2010).

While Gesler's early work focused on the use of therapeutic landscapes to facilitate healing and recovery from illness, the concept also applies to the maintenance of health and wellbeing (Williams, 2002). Conradson (2005), for example, describes the therapeutic landscape experience as "a positive physiological and psychological outcome deriving from a person's imbrication within a particular socio-natural-material setting" (p. 339). According to Williams (2002), this positive outcome (i.e. wellbeing) occurs when "a healthy, definitive place-identity fit exists" (p. 142). In other words, wellbeing is experienced when a person's thoughts, ideas, and feelings associated with a particular location interact positively with the physical, social, and symbolic factors associated with that location. This relational formulation of landscapes as therapeutic is an ongoing process rather than being static or predetermined (Conradson, 2005).

While the concept of therapeutic landscapes has been applied across a diverse range of settings and in relation to many aspects of health and wellbeing, such as therapeutic camping (Dunkley, 2009), 'alternative' self-help groups (Laws, 2009) and recently arrived youth with refugee backgrounds (Sampson and Gifford, 2010), to name but a few, little attention has been paid to pregnancy and childbirth, with two exceptions. Burges Watson et al. (2007) explored pain relief in labour, focusing on the construction of spaces (the home and hospital) as therapeutic and flexible. They found that the flexibility of the home and hospital in offering pain relief in labour is constrained by the availability of pain relief technologies, and the discursive constitution of the hospital as medicalised and the home as 'natural'. In another study Chakrabarti (2010) explored the relationship between place and Bengali immigrant women's use of social networks in relation to living a healthy pregnancy. In this paper we draw on this evolving body of literature to explore the therapeutic landscape experience of women undergoing inpatient and outpatient cervical priming.

2. Methods

2.1. Sample

Eligibility criteria for the OPRA trial included: a healthy singleton pregnancy at term, the ability to read and write in English, reliable transport, live within a 45 min drive to the hospital and to be at least 18 years of age. At the time of sampling (February 2009) approximately 45 women in each of the inpatient and outpatient groups (total $N=90$) had completed the treatment

protocols and given birth. Maximum variation purposive sampling from these two groups was performed to select participants for the interviews (Grbich, 1999). Participants were chosen based on a selection matrix of: age, parity, language other than English spoken at home, education, and type of delivery.

Ten participants were selected from each of the two participating hospitals, with the view to interviewing approximately 12–18 participants, or until information saturation was achieved (Pope et al., 2000). A personalised letter was sent to each of the 20 women inviting them to participate in an audio taped interview at a location and time of their choice. Sixteen (16) women, 8 from each hospital aged between 20 and 35 years, agreed to be interviewed in their homes. Data saturation was achieved after 12 interviews; however a decision was made to continue with the remaining scheduled interviews to obtain the full range of socio-demographic backgrounds in the sample.

The final sample of 16 women was generally representative of the overall cohort with 2/3 of women in the study being primiparous (i.e. pregnant for the first time) and highly educated. Half (8) of the participants gave birth spontaneously, 3 had assisted vaginal deliveries and 5 had emergency caesareans. Four (4) women spoke a language other than English at home. Thirteen (13) women had the labour ward (a traditional hospital ward) as their intended place of birth, with 3 intending to give birth in a birthing centre, which aims to provide a more home-like birthing environment. Actual place of birth was the labour ward for all but one of the participants (who gave birth in a birthing centre). Nine (9) women received inpatient care and 7 received outpatient care. The sample included one woman who was randomised to outpatient care but changed her mind before delivery and asked to be put into the inpatient care group. Her decision will be discussed later in the paper.

2.2. Data collection

All participating women had given birth between 7 weeks and 4 months prior to the interview. The interviews were semi-structured based on a schedule that was developed and piloted in a study of 5 women who had an induced labour, focusing on what women identified as important in the induction experience. This included: knowledge of, experience with and information about induction of labour, continuity of care, location of care, time waiting at home/hospital, access to pain relief, and support (Wilson, 2005). The interviews occurred over a 4-week period from March to April 2009, with the average length of the interviews being half an hour. Women were given the opportunity to talk as long as they wanted, however the interviews were relatively short as they were often distracted with the care of their new baby. The interviews were recorded and transcribed verbatim.

2.3. Ethical considerations

Ethical approval for the randomised controlled trial, including the qualitative element reported here, was sought and granted by the relevant university and hospital ethics committees. The ethics protocol emphasised the importance of informed consent, confidentiality and anonymity, and an independent committee was established to monitor any adverse events of the trial.

Women were assured that their decision to participate in the study would not affect their care, and that the information provided would not be seen by hospital personnel. A digital recorder was used during each interview. Participants were identified in recordings only by study ID and no potentially identifying information was included in the interview.

2.4. Analysis

The interviews were transcribed verbatim and a thematic analysis of the transcriptions was undertaken following the procedures outlined by Braun and Clarke (2006). This involved generating initial codes, which were then collated into themes. A theme "captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set" (2006, p. 82, italics in original). In this case the themes relate to the original research question in providing information about the therapeutic landscape experience of women undergoing cervical priming for induction of labour in inpatient and outpatient settings. In what follows we explore the ways in which the home and hospital landscapes contribute (or fail to contribute) to women's wellbeing during cervical priming, followed by a discussion of how women negotiate between the (competing) therapeutic elements of the home and hospital landscapes.

3. Findings

All of the participants, irrespective of the group to which they were randomised, were asked whether they would prefer inpatient or outpatient priming in the future. The participants demonstrated an overall preference for the outpatient (home) option for cervical priming, with only one participant expressing that she would prefer inpatient (hospital) care if she were induced again. However, both the home and the hospital were identified as having therapeutic value to women experiencing priming for induction of labour.

The relative therapeutic value of the home and hospital landscapes was defined by their ability to enhance women's wellbeing by providing 'comfort' and 'safety'. As the concept of therapeutic landscapes suggests, women's experiences of comfort or safety was made possible by more than simply the physical aspects of the hospital or the home; rather it was the interconnection between the physical, individual, social, and symbolic aspects of these landscapes that provided, or failed to provide, women with a sense of comfort or safety.

In order to ensure anonymity, the participants are referred to by the hospital they attended, their participant number and the option of care they received (i.e. inpatient or outpatient) (e.g. Hospital 1, P1, Outpatient).

3.1. Comfort

When asked about why they would prefer outpatient priming, women explained that they feel "comfortable in my own home" (Hospital 1, P3, Outpatient). Home is not merely a physical, fixed space in which we live; it is also a place of symbolic meaning, social relationships, and developed rhythms (Wiles, 2008). This is reflected in the women's discussion of their preferences for cervical priming in the home landscape.

Being comfortable at home was related to the physical aspects of the environment, such as the comfort of sleeping in a comfortable bed, having comfortable pillows, and a quiet environment. This was contrasted to the hospital, which was described as having uncomfortable beds and being noisy and rushed with too many lights and machines:

> Aspects I didn't like [about staying in hospital], it was very uncomfortable in bed. Just all the lights and the machines, they just kind of kept waking me up. (Hospital 2, P1, Inpatient.)

This demonstrates how the materiality of the hospital and home impact on women's therapeutic experience in these environments.

Women also described the comfort associated with being able to follow their developed rhythms in their home environment – "Being comfortable in your own home and being able to just do what you normally do" (Hospital 1, P1, Outpatient) – such as eating the food they like, showering, and watching television or a movie.

The importance of the comfort of home was expressed even when the time spent at home was relatively short. Approximately 20% of women go into spontaneous labour after receiving their first priming gel, requiring some outpatient women to return to the hospital after a relatively short time spent at home. One woman, who had to return to the hospital for early labour approximately 5 h after receiving the gels, described how she was happy that she was able to go home, have an evening meal with her family and relax at home for a short time before returning to the hospital (Hospital 2, P3, Outpatient).

The women referenced the importance of the symbolic meaning of home. For example, they talked about the home as a "familiar" place where you have "your own bed … your own smells, your own, like, touch" (Hospital 2, P6, Outpatient). This was contrasted to their views of the hospital as a sterile, institutional environment associated with being sick:

> … had I been at home I probably would have had a lot more [sleep]. … It was just from a new bed, a new environment, a hospital sterile kind of environment. (Hospital 2, P7, Inpatient.)

They also talked about the freedom associated with being at home, such as going where they want to go and doing what they want to do while waiting for labour. One woman explained her decision to go home after her second set of gels (received the morning after the previous evening's gels) as follows:

> I knew again that I'd have the freedom to do whatever I wanted. If I wanted to go for a walk I could, you know, around my familiar neighbourhood … Or if I wanted to have a lie down or watch TV, you know, I just felt like it would be a lot more comfortable if I was in my own environment. (Hospital 2, P8, Outpatient.)

Of particular importance to the participants was the comfort associated with the social relationships of the home, chiefly those with their husbands/partners and family. This was an important difference between inpatient and outpatient care, as in most cases husbands/partners are not able to stay overnight at the hospital due to a lack of facilities:

> I would like to try the outpatient, just to see what it's like to be home with the family and have their support a bit more. Yeah, I think I'd prefer the outpatient option if it came again. (Hospital 2, P1, Inpatient.)

Being with family members in the home environment was also beneficial as women did not need to arrange care for their children during the priming process.

Women identified that being comfortable at home contributed to their wellbeing through a greater feeling of relaxation, a better night's sleep, being less focused on contractions and not waiting for or anticipating labour. This allowed the women to be more rested in preparation for labour and birthing:

> Because like I got slight contractions coming during the night and at home I can feel more comfortable, like more relaxed like just trying to sleep well with my family you know so they can help me and I won't be that scared. But I think if I stay in hospital just maybe too (sic) concentrate on the contractions coming, like oh, when's that next one coming and you know can't take much sleep, yeah. So I think going home is the best way. (Hospital 1, P8, Outpatient.)

Although the majority of women associated the home with greater comfort, there was one woman who identified the hospital as a more comfortable and more relaxed environment, where she could have a good night's sleep and not have to think about anybody else while her son was being taken care of by her family. This supports the idea that therapeutic landscapes are experienced differently by different people.

3.2. Safety

While the home was associated with feelings of comfort, the hospital was associated with greater feelings of safety. Although the participants viewed outpatient priming positively, for some women there was a degree of fear and apprehension associated with not being in the hospital during this time. This was generally related to not knowing how their bodies would react to the gels, or whether they could recognise if something was wrong, and for primiparous women, not knowing if they could recognise contractions:

> I was happy to go home but apprehensive as well because I had never had [contractions]. (Hospital 2, P1, Outpatient.)

Concerns about safety were an overriding factor for one woman who was initially randomised to outpatient care, but two days before her induction asked to receive inpatient care (Hospital 2, P7, Inpatient). Her main concerns were the possibility of any risk to the baby associated with the priming process and this being her first experience of labour. The hospital was viewed as a place of safety where these fears and concerns could be alleviated. However, she did state that for her next birth she would opt to go home for priming.

While the physical environment of the hospital was viewed as uncomfortable, as described in the previous section, women perceived that this environment provided them with access to foetal monitoring (if needed), medical expertise should an emergency arise, and pain relief during the process of cervical priming. This was seen as valuable in easing their fears about labour and the baby's safety:

> Staying in the hospital you had a doctor, you had a midwife to check on you, you know you are safe and you know if something happens they have somebody there for you to help, that's the benefits. (Hospital 1, P5, Inpatient.)

The hospital also provided women with professional support in the form of readily accessible expert advice and answers to their questions, which was identified as a positive benefit of inpatient priming:

> There was somebody there that you could just, like, ring the bell and ask them to come straight away rather than, you know, if you were at home you'd, kind of, have to wait around … (Hospital 2, P5, Inpatient.)

For some women, having access to professional support over the phone was enough to allay their concerns about being at home during this period:

> As long as I, like, had somebody to contact when, you know, if I did feel something or had any questions … just as long as I … would have had the support [outpatient care] would have been fine as well … (Hospital 2, P5, Inpatient.)

These elements of the hospital landscape are therapeutic to women through allaying their fears and concerns, and were described as "comforting" (Hospital 2, P7, Inpatient) and providing women with "peace of mind" (Hospital 2, P5, Inpatient).

3.3. Negotiating between the home and hospital for cervical priming

It is increasingly recognised in the literature that the therapeutic value of particular environments is often context-dependent, rather than being inherent in the places themselves (Martin et al., 2005), and this was supported in our findings. The participants considered that it was good for women to be given the option of outpatient priming, and that her decision would depend on her personal context. Four contextual factors were identified as being central to the way in which the women negotiate between the comfort of home and the perceived safety of the hospital for cervical priming: previous experiences of labour; the availability of personal support; the distance to the hospital; and weighing up perceived risks.

Previous experience of labour was one factor the women thought would make outpatient priming more acceptable. When asked how she would have felt if she had been randomised to the outpatient group, one woman answered: "I think already having one [child], I think you're a bit wiser. So I think, yeah, the decision of going back would have been ok. I don't think I would have had a problem with that" (Hospital 2, P2, Inpatient). Another participant stated: "if it's the second baby you would probably be pretty relaxed about [travelling to the hospital]" (Hospital 1, P6, Inpatient).

Women identified the availability of personal support as another factor influencing their decision. When this support was not available at home, such as in those situations when the husband/partner was away or was not involved in the pregnancy and labour, women stated that they would prefer to stay in the hospital:

> If it was just me [with no support available at home] I would have stayed at the hospital for sure because I wouldn't have necessarily known what was happening at various points in time. (Hospital 1, P7, Inpatient.)

Conversely, women stated that if they could not have their husbands/partners stay with them in the hospital while they waited for the gels to take effect (which is often the case due to lack of facilities), they would prefer to go home where this support is available.

The third contextual factor influencing women's decision-making is the distance from their homes to the hospital. Outpatient priming was considered preferable when living close to the hospital (15–30 min), while inpatient was preferable when living far from the hospital (45 min away or more):

> So I guess if you were to live quite a distance it may, and you have quick labours it might be a concern. (Hospital 1, P4, Inpatient.)

Finally, women identified concerns about risk as influencing their decisions regarding inpatient or outpatient priming. While nearly all of the women stated that they would prefer outpatient priming, the one condition in which they would opt for inpatient priming is if they had a high-risk pregnancy, if complications arose or there were concerns about the baby's safety. The women were informed that in these situations they would not be eligible for outpatient priming in any event. Another perceived safety concern impacting on women's decisions related to the event of needing a second set of gels, where in most cases the participants identified that they considered it 'safer' to stay in the hospital at this point.

These contextual factors furthermore impact on each other in women's decision-making regarding the therapeutic value of the home and hospital. For example, some women identified that distance is only a factor when no support is available at home or if you don't know what labour feels like. When asked if distance to the hospital would impact on her preferences, one woman answered: "No, no, because my partner was here, so he would have been able to help me" (Hospital 2, P1, Inpatient). Lack of support was seen as less of a concern if you live close to the hospital or have experienced labour before. Perceived risk, too, is less of an issue if you live close to the hospital: "I guess probably because I knew we're not that far away from the hospital so if anything, you know, would have happened, we would have been really close anyway" (Hospital 2, P8, Outpatient).

4. Discussion

Women in this study indicated a preference for outpatient priming for induction of labour. Their positive experiences in the outpatient setting support the findings of Reid et al. (2010), although that study only included women who underwent outpatient priming and examined the anticipated benefits of home versus hospital, while our study focused on women's actual experiences in both settings. Furthermore, our study offers insight into the therapeutic landscape experience – the "positive physiological and psychological outcome deriving from a person's imbrication within a particular socio-natural-material setting" (Conradson, 2005, p. 339) – of women undergoing cervical priming in the home and hospital settings.

The home and hospital landscapes affect a sense of wellbeing through a network of factors (Burges Watson et al., 2007), including the physical, personal, social and symbolic. Through this network both the home and the hospital offered therapeutic benefit to women by providing them with a sense of wellbeing, but they did so in different ways. According to Williams (2002) places are therapeutic when people experience a healthy place-identity fit. For women in this study, this 'fit' relates to the experience of feelings of comfort and safety associated with the home and hospital.

The ability of the home environment to provide the women with a sense of comfort was brought about by their understanding of the home as physically comfortable and familiar, compared to the harsh, sterile and unfamiliar environment of the hospital. The hospital was generally viewed as a place of safety through the perceived availability of technologies such as foetal monitoring and pain relief. Furthermore, the findings highlight the different ways in which place facilitates supportive relationships (Wiersma, 2008; Williams, 2007), where the home was seen to facilitate better access to personal support from husbands/partners and family, while the hospital facilitated supportive relationships with health professionals.

The cultural context in which cervical priming for induction of labour occurs can also be seen to impact on women's experiences. Currently in many Western countries such as Australia our understanding and experience of childbirth is influenced by the ideologies of medicalisation and normalisation (Burges Watson et al., 2007). For example, previous research has found women's experiences of fear to be associated with the medicalisation of childbirth in high-income societies (Fisher et al., 2006). This was apparent for women in our study in relation to the perceived safety of the hospital environment for undergoing cervical priming. In most cases women's discussions of safety were unrelated to concerns about the procedure itself, but indicated a more generalised fear about labour and childbirth, such as a fear of not recognising labour, a fear of not getting to the hospital in time, and the need for reassurance regarding the baby's safety.

Researchers have also pointed to the ways in which pregnant women negotiate between the prevailing ideologies of 'natural childbirth' and the medicalisation of childbirth in their decision-making about various aspects of their care (Fenwick et al., 2005;

Westfall and Benoit, 2004; Pitchforth et al., 2007, 2009; Viisainen, 2001). This is reflected in the way in which women negotiate between the importance of being comfortable at home, which has more association with childbirth as a natural process, and the perceived safety of the medicalised hospital environment for cervical priming for induction of labour. In particular, when women know what labour feels like, have access to support, don't live too far from the hospital and believe the baby is not at any risk, the ideology of 'natural childbirth' takes the fore. However, under different contextual circumstances concerns about safety and risk engendered by the cultural ideology of medicalisation take precedent.

Following much of the developing literature on therapeutic landscapes, this study demonstrates that places such as the home or hospital are not intrinsically therapeutic; instead they are experienced differently by different people (Conradson, 2005; Williams, 2007). Thus while the majority of women in this study showed a preference for outpatient priming for induction of labour, and emphasised the value of the comfort of home during this experience, for other women their feelings of safety in the hospital environment might be more important. This suggests women's preferences for inpatient or outpatient cervical priming for induction of labour are complex, and that health professionals cannot assume that either the hospital or home environments are intrinsically therapeutic for individual women. As such, this study provides important information for health professionals to enable them to enhance women's wellbeing during the priming process should they be offered the choice of inpatient or outpatient priming.

In particular, the findings provide information about transposing the therapeutic elements of the home to the hospital and vice versa. One way in which this could be done is by making the hospital a more comfortable environment for women undergoing cervical priming, such as through the provision of facilities for husbands/partners to stay overnight in hospital during this process, and giving women the opportunity to be induced in more home-like environments such as that afforded by birthing centres. Health professionals can also enhance women's sense of wellbeing in the outpatient (home) setting by supporting them to feel safe at home through the provision of clear information as well as easy access to professional support. For example, women in this study who were randomised to outpatient care were given written instructions about what to expect after going home following priming, given a 24 h phone number to call and talk with a midwife for any reason, and assured that they could come back to the hospital at any time. This information was seen by the women to enhance their feelings of safety within the home environment. It is also important that health professionals are clear in their provision of information to women about the amount of monitoring they will receive while in hospital, as many women had unrealistic expectations of being 'monitored' throughout the night, whereas in reality women may only be briefly checked on once during the night.

5. Limitations

Overall the women in this study expressed a preference for outpatient cervical priming for induction of labour. However, given that this is a qualitative study and not aimed at generalisation, we recognise that these findings are not necessarily reflective of the views of all pregnant women. Furthermore, it is possible that women who did not feel comfortable with the possibility of being randomised to outpatient care did not participate in the trial (although the refusal rate for the OPRA trial was only around 15%). Finally, the study was limited geographically in being located in a major urban area of Australia, and may not be reflective of women's experiences or options in other countries or in rural areas.

6. Conclusion

At a time when maternity policies in many countries are promoting less medicalised care (Burges Watson et al., 2007; Devane et al., 2007), outpatient priming for induction of labour is becoming increasingly available to women. This paper provides much needed information on how women perceive their options from a therapeutic landscapes perspective. It offers an insight into women's views of the therapeutic experience of the home and hospital landscapes for cervical priming for induction of labour, and the way in which women negotiate between the competing elements of comfort and safety in their decision-making processes.

This study provides a useful starting point for developing our understanding of women's preferences for inpatient and outpatient care for cervical priming. Further research is needed to explore the extent to which these findings are representative of women's preferences and decision-making more generally.

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