Marathon Maternity Oral History Project
Exploring rural birthing through narrative methods

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Abstract
Objective To explore how birthing and maternity care are understood and valued in a rural community.

Design Oral history research.

Setting The rural community of Marathon, Ont, with a population of approximately 3500.

Participants A purposive selection of mothers, grandmothers, nurses, physicians, and community leaders in the Marathon medical catchment area.

Methods Interviews were conducted with a purposive sample, employing an oral history research methodology. Interviews were conducted non-anonymously in order to preserve the identity and personhood of participants. Interview transcripts were edited into short narratives. Oral histories offer perspectives and information not revealed in other quantitative or qualitative research methodologies. Narratives re-personalize and humanize medical research by offering researchers and practitioners the opportunity to bear witness to the personal stories affected through medical decision making.

Main findings Eleven stand-alone narratives, published in this issue of Canadian Family Physician, form the project’s findings. Similar to a literary text or short story, they are intended for personal reflection and interpretation by the reader. Presenting the results of these interviews as narratives requires the reader to participate in the research exercise and take part in listening to these women’s voices. The project’s narratives will be accessible to readers from academic and non-academic backgrounds and will interest readers in medicine and allied health professions, medical humanities, community development, gender studies, social anthropology and history, and literature.

Conclusion Sharing personal birthing experiences might inspire others to reevaluate and reconsider birthing practices and services in other communities. Where local maternity services are under threat, Marathon’s stories might contribute to understanding the meaning and challenges of local birthing, and the implications of losing maternity services in rural Canada.

EDITOR’S KEY POINTS
- The Marathon Maternity Oral History Project uses personal birthing narratives to explore how birthing and maternity care are understood and valued in the rural community of Marathon, Ont, with a population of approximately 3500.
- Oral history research methodology allows the voices and experiences of individuals to play a role in clinical decision making and medical systems design. This project delivers a novel approach to gathering and disseminating narratives in family medicine, and invites readers into spaces and content largely absent in medical scholarship—including individual and named patient perspectives, experiences, and patient-provider relationships. This paper offers an understanding of the importance of birthing in rural settings, oral history methodology in family medicine, and the place of narratives and stories in health care and planning.
- This project reveals new insights about patient and caregiver experiences of maternity care in Marathon. Countless specific conclusions about participants and their stories can be drawn from the individual narratives produced through this project. These will vary from reader to reader, and we challenge readers to engage with the narratives that form this project’s findings.

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Recherche

Projet de récits oraux sur la maternité à Marathon
Exploration par méthodes narratives de l’accouchement en milieu rural

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Résumé
Objectif Explorer comment l’accouchement et les soins de maternité sont compris et valorisés dans une communauté rurale.

Conception Recherche fondée sur des récits oraux.

Contexte La collectivité rurale de Marathon, en Ontario, qui compte environ 3 500 personnes.

Participants Une sélection délibérée de mères, grand-mères, infirmières, médecins et leaders communautaires dans la circonscription médicale de Marathon.

Méthodologie Des entrevues ont été réalisées auprès d’un échantillonnage délibérément choisi, au moyen d’une méthodologie de recherche par récits oraux. Ces entrevues ont été menées sans prêter à l’anonymat pour qu’on puisse reconnaître l’identité et la personnalité des participantes. La transcription des entrevues a été résumée sous forme de courtes narrations. Les récits ouvrent des points de vue et des renseignements qui ne sont pas révélés par d’autres méthodes de recherche qualitative ou quantitative. Les narrations individualisent et humanisent la recherche médicale en permettant aux chercheurs et aux praticiens d’être témoins de la façon dont les décisions médicales influencent les expériences personnelles.

Principales constatations Publiés dans le présent numéro du Médecin de famille canadien, 11 récits distincts représentent les constatations de ce projet. Tels des textes littéraires ou des nouvelles, ils ont pour but de stimuler la réflexion personnelle et une interprétation par le lecteur. La présentation des résultats de ces entrevues sous forme narrative exige du lecteur qu’il participe à l’exercice de recherche et prenne part à l’écoute de la voix de ces personnes. Les narrations recueillies dans le projet seront accessibles aux lecteurs des milieux universitaires ou non et intéresseront ceux qui œuvrent en médecine ou dans d’autres professions de la santé, en humanités médicales, en développement communautaire, en études sur la problématique homme-femme, en anthropologie sociale, en histoire et en littérature.

Conclusion Le récit d’expériences personnelles de l’accouchement pourrait en inspirer d’autres à réévaluer et à réexaminer les pratiques et les services d’accouchement dans leurs collectivités. Les récits des personnes de Marathon pourraient contribuer à mieux faire comprendre la signification et les défis des accouchements en région, là où les services de maternité sont menacés, ainsi que les répercussions de la perte des services de maternité dans les milieux ruraux canadiens.

Cet article a fait l’objet d’une révision par des pairs. Can Fam Physician 2014;60:58-64
To ensure that maternity care is patient-centred, we must listen to the voices of the patients. This is essential—to incorporate women’s input into their maternity care at all levels. By listening and sharing information we will enable informed decision-making about the mother’s maternity care.

National Birthing Initiative for Canada, Priority 1
Signatories: Association of Women’s Health, Obstetric and Neonatal Nurses of Canada, Canadian Association of Midwives, College of Family Physicians of Canada, Society of Obstetricians and Gynaecologists of Canada, Society of Rural Physicians of Canada

In 2008, the National Birthing Initiative for Canada identified 7 top priorities for Canadian maternity care, and listed “Listening to Women’s Voices” as the top priority in planning and developing Canada’s birthing system. This recommendation serves as the guiding principle for the Marathon Maternity Oral History Project. This project aims to develop and share a selection of birthing stories from Marathon, Ont, and to place these stories within the context of rural maternity services in Canada. How is birthing understood and valued by a selection of women in Marathon?

Oral history methodology might be the most appropriate and rigorous way to address this kind of research question. This paper describes the research protocol and methods of the Marathon Maternity Oral History Project, and addresses the scholarly and practical contribution of this form of inquiry to medical and evidence-based medical research paradigms.

Rural birthing and Marathon, Ont
A lack of local birthing services is a central feature of rural health disparities in Canada and might be a direct contributor to health inequities between rural and urban populations. Although access to local maternity services is an established and independent predictor of positive birthing outcomes, obstetric services in rural hospitals in Canada are becoming increasingly rare, with closures of rural birthing systems following a general trend of health service amalgamation and regionalization. Identifying ways to enhance rural birthing services could simultaneously enhance the health of rural populations and help to secure the sustainability and resilience of rural communities and their access to other health care services.

Marathon is a rural Ontario community on the north shore of Lake Superior. With a population of approximately 3500, Marathon is geographically, economically, and demographically representative of many communities in northern Ontario and rural Canada; but Marathon’s medical services are unusual among many other rural Canadian settings. This population has witnessed a sustained expansion of health care services and consistent access to comprehensive family practice services. For more than 10 years, Marathon has maintained a relatively stable foundation of family physicians working together under a cooperative consensus-based, team-practice model. The Marathon Family Health Team offers comprehensive outpatient and inpatient family medicine, including non-surgical birthing services. The model has contributed to physician satisfaction and retention, and has been documented and celebrated in the Canadian medical literature. Marathon’s health care system is an exception to the rule: while rural communities across Canada are facing eroding health services, “Marathon works.” This system provides health care services for a population of about 6500 people, including 2 First Nations reserves.

METHODS

Project oral history methods and procedures
This was a community-based project in Marathon. Access
to interviewees relied on well-developed and existing relationships among Marathon’s health care community, patients, community leaders, and other citizens. Participants in this oral history project were recruited following discussion with a small advisory panel of Marathon’s family physicians. Potential interviewees were approached with a standardized letter from a nonclinician member of the Marathon Family Health Team, inviting them to share stories, thoughts, and experiences about having a baby in Marathon. In keeping with best practices in oral history research, interviewees were not selected to generate a representative sample of women in Marathon. The purposive selection was designed to deliver informative and insightful sources and engaging narrative. Recruitment strategies targeted priority and desirable demographic or historic characteristics for interviewing, as listed in Table 1. Gathering narratives from First Nations people who might fit into any of the desirable interview groups was treated as an additional priority. Interview questions focused on medical experiences; personal, psychological, social, professional, familial, economic, and spiritual aspects of the pregnancy, birthing, or caregiver experience; overall satisfaction with experiences; and other related issues. Participants who were health care providers were invited to share their birthing experiences both as patients and as providers. Interviews were designed to allow participants to tell their own stories and share aspects of their birthing experiences or contributions to birthing in Marathon in their own ways. Interviews were audiorecorded and professionally transcribed.

Project investigators edited the interview transcripts into narratives. All of the text used to develop these narratives was taken directly from the interview transcripts. Each narrative was developed to create a readable and stand-alone literary piece, reflecting features of the participant’s character and dominant themes in her birthing story. Recognizing that the interview is itself a relational and situated event, the narratives were developed to bring to the fore the specific moment of interaction between the investigator and narrator, and to develop a narrative that expressed how the narrator’s story was understood and interpreted by the investigator. Among other themes, the narratives were developed to emphasize participants’ expressions of decision making and risk in the birthing process; the roles of family, home, and place in birthing; rural life and geographic isolation from regional hospital facilities; and evolving birthing services and practices in Marathon’s local history. The narratives were also edited to consider the coherence and overall effect of the collection of narratives as an anthology. Where changes or clarifications were necessary, these were made in direct consultation with the participant.

Once a narrative had been developed, member checking was conducted by reviewing the edited narratives with interviewees. The transcribed interview data were therefore interpreted and analyzed through a process of distillation and editing into readable narratives, rather than conducting conventional coding, theme extraction, or other qualitative data analysis procedures. This encourages the user or reader to contend with and listen to voices and stories, rather than reading or integrating themes or summary points.

The study received ethical approval from the Lakehead University Research Ethics Board. Informed consent followed a 2-step written process. Participants first consented to be interviewed, and renewed consent was provided before publication. Interviewees had the opportunity to withdraw consent and participation at any time. Participants were provided the opportunity to be interviewed anonymously if this was their preference. All project participants were older than 18 years of age and were able to provide direct informed consent.

Oral history and narrative research
In accordance with best practices developed for oral history and narrative research, names and identifying features were not removed from oral histories for publication without request or specific consent. As oral historian William Moss has argued,

> When sources choose anonymity whether out of privacy, humility, or fear, the record produced not only suffers the loss of user confidence that accompanies any anonymous testimony, but the primary assertion of oral history that the individual indeed matters is also lost.  

By attributing names to individual stories, the authenticity and individuality of those stories are preserved. Participants maintain a degree of ownership of their stories.

Oral history and narrative research should be differentiated from other dominant forms of qualitative health research methodology. Conventional qualitative research
identifies a given population as its subject of inquiry and treats individual participants or focus groups as a point of entry to study that population. Sampling and analysis techniques involve efforts to identify a set of themes and ensure that enough data are gathered to capture all relevant themes within the target population—a concept known as theme saturation. In contrast, oral history research methodology is based on the primary assertion that the individual person is, by definition, a unique and complete identity or subject of inquiry. Like an n-of-1 randomized controlled trial, an oral history studies the individual in order to understand her, and not primarily to draw generalizable conclusions about a given population. The participant’s voice is treated as “her voice” and not a representative or randomly selected voice from within a population. Her voice is situated, singular, communicated through narrative, and requires the reader or user to participate as both a listener and an interpreter. This approach reinforces the importance of offering participants the opportunity to speak non-anonymously.

Qualitative, interview-based research methodologies have been effectively employed to explore the experiences of rural women and rural communities around birthing. Unstructured interview techniques are a particularly effective means of exploring the interconnected physiologic, social, political, cultural, psychological, and spiritual complexities and dynamics of maternity care. Similar methodologies have been successfully employed in other medical and maternity research. Oral history and narrative medicine research methodologies have also been affirmed as effective modes of family medicine inquiry.

**FINDINGS**

Fifteen individuals were invited to participate in project interviews. One individual declined to participate and 2 were unavailable for interviewing during the scheduled interview period. Twelve interviews were conducted and all participants consented to be interviewed non-anonymously. One participant later withdrew from the study after being interviewed. All priority characteristics were represented in the interviews conducted, but no participants who described adverse birthing outcomes participated in the project. Many participants represented multiple priority or desirable characteristics.

The 11 stand-alone narratives, published in this issue of *Canadian Family Physician* and listed in Table 2, form the project’s findings. Similar to a literary text or short story, they are intended for personal reflection and interpretation by the reader.

**DISCUSSION**

This project’s primary objective was to listen to women’s voices. This goal was achieved by preserving the authenticity and individuality of women’s narratives throughout the editing and dissemination process. Many participants expressed enthusiasm for participating in the project and sharing their stories non-anonymously. By maintaining the name and identity of interviewees through this methodology, the subtleties, nuances, and even contradictions and paradoxes of the participants are preserved and respected. This opportunity is not available through conventional approaches to medical research.

Presenting the results of these interviews as narratives requires the reader to participate in the research exercise and take part in listening to these women’s voices. The narratives are subject to a limitless range of reader interpretations, but some insights and questions might enhance the reader’s engagement with these texts. Questions for guided reflection on the narratives appear in Box 1.

How do women in Marathon balance their perceptions about obstetric risk and uncertainty with a need for family, community, and a sense of home in the birthing process? Irrespective of place, all participants consistently communicated birthing stories as deeply valuable and
were aware of changing local services over time—about fnancial strain, but local birthing in Marathon was con-
in Marathon was valuable, and emphasized that birthing
ulated a sense of personal empowerment in the birthing
narratives (eg, Penny Armitage,23 Connie McWatch28).

How are community members and their birthing provid-
erors aligned, and how do they diverge? Many women artic-
lated a sense of personal empowerment in the birthing
process, argued that maintaining the option of giving birth
in Marathon was valuable, and emphasized that birthing
choices were ultimately an expression of a woman’s per-
sonal beliefs and choices. Women articulated an apprecia-
tion for birthing opportunities that permitted an expression
of their own choices and values. Health care providers not
only echoed these concerns, but also identifed the choice
to give birth in Marathon as an overtly political expression
about women’s rights, local values, and their commitment
to rural comprehensive family medicine.

The project demonstrates the value of listening and
bearing witness to birthing stories, and contending with
the uncertainties and questions that emerge from those
narratives. Through original narratives by women and
health care practitioners in Marathon, this project offers
readers a chance to explore how birthing and maternity
care is understood and valued by members of a small com-

Community Maternity Oral History Project  | Research

formative personal and community processes. No mat-
ter where they gave birth, interviewees articulated the
central importance of safety, family and familiarity, com-
fort, relationships with birthing providers, and kindness
in their birthing experiences. This is not to suggest that
place was unimportant to participants. Traveling out-
side Marathon to give birth involved recurrent themes
of uprooting, isolation, disconnection, uncertainty, and
financial strain, but local birthing in Marathon was con-
sistently coupled with some awareness and concern
about access to surgical or anesthetic services. How do ex-
pressions of “safe” birthing vary among narratives?

How might Marathon’s stability and sustainability be
linked with local birthing services? Some participants
were aware of changing local services over time—about
the disappearance and inconsistency of local surgical and
obstetric services, or even vanishing traditional midwifery
skills in local First Nations communities—and the link
between these services and other features of local cul-
tural, industrial, and economic development. These his-
torical and political trends play a dominant role in some
narratives (eg, Penny Armitage,23 Connie McWatch28).

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narratives. Through original narratives by women and

Box 1. Questions for guided refl ection

The following questions might enhance reader engagement
with the Marathon Maternity Oral History Project birthing
narratives:

How do women in Marathon balance their perceptions
about obstetric risk and uncertainty with a need for fam-
ily, community, and a sense of home in the birthing
process?

How do expressions of “safe” birthing vary among
narratives?

How might Marathon’s community stability and sustain-
ability be linked with local birthing services?

How are community members and their birthing providers
aligned, and how do they diverge?

Does oral history research have a place within the
evidence-based medical paradigm? Greenhalgh and Donald
critically defned evidence-based medicine as “the use of
mathematical estimates of the chance of benef and the
risk of harm, derived from high-quality research on popu-
lation samples, to inform clinical decision-making.”34 This
defnition exposes 3 underlying assumptions of evidence-
based medicine. First, that clinical practice equates more
or less with clinical decisions; second, that clinical deci-
sions are best made using mathematical predictions; and
third, that evidence from population samples maps more
or less directly to decisions for individual patients.35 Such
a defnition underscores the limitations of an exclusively
population-based approach to medicine, and also reveals
that statistical ways of knowing cannot provide compre-
hsive understandings of clinical care or health systems
planning. This form of evidence is, somewhat by defnition
and intent, devoid of the individual personality, identity, and
context of those patients and relationships. This reinforces
what Nicholas Jewson termed the “disappearance of the
sick [wo]man” from medical cosmology, where diseases,
medical choices, and health care systems come to exist in
isolation from the individuals who inhabit them.36

Conducting medical research with oral history method-
ology reasserts that the individual still matters. Through
these methods, understanding the patient remains the
essential feature of clinical practice and research. The
unique characteristics or nuances of identity, personal-
ity, and experience are meaningful subjects of research
inquiry. Oral history is therefore naturally compati-
ble and closely aligned with patient- and relationship-
centred approaches to health care, placing patients and
their voices at the centre of health care planning and
systems. Innumerable pathophysiological, political, eco-
nomic, and sociologic factors infuence public health and
clinical and personal decisions regarding the availabil-
ity, provision, sustainability, and use of birthing services
in rural settings. If policy and planning decisions around
the future of maternity care are to remain driven primar-
ily by the needs of women and their communities, rural
women’s birthing stories must be articulated and shared
clearly and publicly. Such narrative evidence ought to
be considered alongside dominant forms of statistical
evidence in health care policy and decision making.
These insights might not be accessible through traditional quantitative or qualitative research methods. Conclusions drawn through conventional clinical or economic research might not be the only relevant factors in designing and allocating local birthing services or making intrapartum clinical decisions. Understanding and sharing the birthing experiences and perspectives of mothers and caregivers in rural communities might play an important role in these decisions as well.

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Contributors Both authors contributed to the concept and design of the study, data gathering and editing, and preparing the manuscript for submission.

Competing interests None declared

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