

# 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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# 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.

#### POINTS DE REPÈRE DU RÉDACTEUR

- Le projet de récits oraux sur la maternité à Marathon utilise des narrations personnelles sur l'accouchement pour explorer comment les services d'accouchement et les soins de maternité sont compris et valorisés dans la collectivité rurale de Marathon, en Ontario, où la population est d'environ 3 500.
- La méthodologie de recherche à partir de récits oraux permet aux voix et aux expériences des personnes de jouer un rôle dans la prise de décisions cliniques et la conception des systèmes médicaux. Ce projet offre une approche novatrice à la collecte et à la dissémination de narrations en médecine familiale, et invite les lecteurs dans des espaces et des contenus largement absents dans la formation médicale, y compris les points de vue individuels de patientes identifiées, leurs expériences et les relations patientes-professionnels. Cet article présente une façon de comprendre l'importance de l'accouchement en milieu rural, la méthodologie des récits oraux en médecine familiale, et la place des narrations et des récits dans les soins de santé et la planification.
- Ce projet dévoile de nouvelles perspectives à propos des expériences des patientes et des professionnels en matière de soins de maternité à Marathon. De multiples conclusions spécifiques à propos des participantes et de leurs récits peuvent être tirées à partir de ce projet. Elles varieront d'un lecteur à l'autre; nous mettons les lecteurs au défi de s'investir dans les narrations qui fondent les constatations de ce projet.

Cet article a fait l'objet d'une révision par des pairs.  
*Can Fam Physician* 2014;60:58-64

**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 préserver 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 oraux offrent 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.

*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<sup>1</sup>  
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.<sup>2,3</sup> 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.<sup>4,5</sup> Although access to local maternity services is an

established and independent predictor of positive birthing outcomes,<sup>6,7</sup> 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.<sup>8-10</sup> 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.<sup>5</sup>

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.<sup>11,12</sup> Marathon's health care system is an exception to the rule: while rural communities across Canada are facing eroding health services, "Marathon works."<sup>13</sup> 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



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**Table 1. Priority and desirable characteristics for interviewing**

PRIORITY CHARACTERISTICS	DESIRABLE CHARACTERISTICS
<ul style="list-style-type: none"> <li>• Women who have delivered in Marathon in the past 10 years</li> </ul>	<ul style="list-style-type: none"> <li>• Women who delivered either in Marathon or elsewhere before the establishment of Marathon's cooperative family practice team</li> </ul>
<ul style="list-style-type: none"> <li>• Women who have left Marathon to deliver in the past 10 years</li> </ul>	<ul style="list-style-type: none"> <li>• Physicians and nurses who have attended deliveries in Marathon</li> </ul>
<ul style="list-style-type: none"> <li>• Women who have undergone intrapartum or postpartum medical evacuation from Marathon in the past 10 years</li> </ul>	<ul style="list-style-type: none"> <li>• Physicians, nurses, or patients who have been a part of any delivery with an adverse outcome in Marathon</li> <li>• Hospital administrators and community leaders</li> </ul>

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.<sup>14</sup> 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 transcriptions 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.<sup>14</sup>

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

**Table 2. Marathon Maternity Oral History Project list of narratives**

PARTICIPANT NAME	INTERVIEW DATE	LINK
Penny Armitage <sup>23</sup>	August 14, 2008	<a href="http://www.cfp.ca/content/60/1/e49.full">www.cfp.ca/content/60/1/e49.full</a>
Jennifer Coleman <sup>24</sup>	August 11, 2008	<a href="http://www.cfp.ca/content/60/1/e53.full">www.cfp.ca/content/60/1/e53.full</a>
Nancy Fitch <sup>25</sup>	August 12, 2008	<a href="http://www.cfp.ca/content/60/1/e57.full">www.cfp.ca/content/60/1/e57.full</a>
Jillian McPeake <sup>26</sup>	August 21, 2008	<a href="http://www.cfp.ca/content/60/1/e61.full">www.cfp.ca/content/60/1/e61.full</a>
Cheryl McWatch <sup>27</sup>	August 21, 2008	<a href="http://www.cfp.ca/content/60/1/e65.full">www.cfp.ca/content/60/1/e65.full</a>
Constance (Connie) McWatch <sup>28</sup>	August 12, 2008	<a href="http://www.cfp.ca/content/60/1/e69.full">www.cfp.ca/content/60/1/e69.full</a>
Marie Michano <sup>29</sup>	August 21, 2008	<a href="http://www.cfp.ca/content/60/1/e73.full">www.cfp.ca/content/60/1/e73.full</a>
Tracy Michano-Stewart <sup>30</sup>	August 18, 2008	<a href="http://www.cfp.ca/content/60/1/e77.full">www.cfp.ca/content/60/1/e77.full</a>
Ada Parsons <sup>31</sup>	August 22, 2008	<a href="http://www.cfp.ca/content/60/1/e81.full">www.cfp.ca/content/60/1/e81.full</a>
Rupa Patel <sup>32</sup>	November 22, 2008	<a href="http://www.cfp.ca/content/60/1/e84.full">www.cfp.ca/content/60/1/e84.full</a>
Patti Pella <sup>33</sup>	August 22, 2008	<a href="http://www.cfp.ca/content/60/1/e88.full">www.cfp.ca/content/60/1/e88.full</a>

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.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17-20</sup> Oral history and narrative medicine research methodologies have also been affirmed as effective modes of family medicine inquiry.<sup>21,22</sup>

## 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**,<sup>23-33</sup> 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

formative personal and community processes. No matter where they gave birth, interviewees articulated the central importance of safety, family and familiarity, comfort, relationships with birthing providers, and kindness in their birthing experiences. This is not to suggest that place was unimportant to participants. Traveling outside Marathon to give birth involved recurrent themes of uprooting, isolation, disconnection, uncertainty, and financial strain, but local birthing in Marathon was consistently coupled with some awareness and concern about access to surgical or anesthetic services. How do expressions 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 cultural, industrial, and economic development. These historical and political trends play a dominant role in some narratives (eg, Penny Armitage,<sup>23</sup> Connie McWatch<sup>28</sup>).

How are community members and their birthing providers aligned, and how do they diverge? Many women articulated 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 personal beliefs and choices. Women articulated an appreciation for birthing opportunities that permitted an expression of their own choices and values. Health care providers not only echoed these concerns, but also identified 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 community where maternity services are working well. These narratives offer a chance for renewed reflection, inspiration, perspectives, and ideas, and offer readers the chance to gain new insights about their own birthing experiences, communities, and relationships. The experiences and conclusions of those who read these narratives can also be expected to be as varied and diverse as the narratives themselves.

Does oral history research have a place within the evidence-based medical paradigm? Greenhalgh and Donald critically defined evidence-based medicine as “the use of mathematical estimates of the chance of benefit and the risk of harm, derived from high-quality research on population samples, to inform clinical decision-making.”<sup>34</sup> This definition exposes 3 underlying assumptions of evidence-based medicine. First, that clinical practice equates more or less with clinical decisions; second, that clinical decisions are best made using mathematical predictions; and third, that evidence from population samples maps more or less directly to decisions for individual patients.<sup>35</sup> Such a definition underscores the limitations of an exclusively population-based approach to medicine, and also reveals that statistical ways of knowing cannot provide comprehensive understandings of clinical care or health systems planning. This form of evidence is, somewhat by definition 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.<sup>36</sup>

Conducting medical research with oral history methodology 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, personality, and experience are meaningful subjects of research inquiry. Oral history is therefore naturally compatible 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, economic, and sociologic factors influence public health and clinical and personal decisions regarding the availability, 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 primarily 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.

### Box 1. Questions for guided reflection

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 family, 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 sustainability be linked with local birthing services?
- How are community members and their birthing providers aligned, and how do they diverge?

## Limitations

These methods do face limitations. Because participants were invited through a purposive and selective process, many potentially important voices and perspectives might not be included. Less articulate or exuberant personalities and individuals with more private or introverted demeanours might be less likely to find this methodology an effective way to share their stories or voices, and might be excluded from oral history research. Women who experienced adverse or unfavourable outcomes through their birthing experiences in Marathon might also have been less willing to participate in this project, so these voices might be underrepresented in this collection. However, these limitations might misrepresent the goals of the oral history endeavour, which is committed primarily to the authentic articulation of the individual story, not the collection of a representative sample of narratives. The potential exclusion of some voices does not affect the authenticity, truths, or impressions garnered from the interviews conducted. Each narrative conducted achieved the primary goal of successfully sharing the voice, worldview, and expression of the named participant within the context of the interview and editorial process.

## Conclusion

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. 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 reveals new insights about patient and caregiver experiences in maternity care in Marathon. 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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