From Research to Application: The Development of an Antenatal Psychosocial Health Assessment Tool

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ABSTRACT

Objective: To describe the development of an assessment tool for antenatal psychosocial risk factors associated with poor postpartum outcomes.

Methods: A survey of Ontario family physicians established a need for an antenatal psychosocial health assessment (ALPHA) form. A critical literature review identified important antenatal factors for inclusion on the form. Focus groups of obstetrical care providers indicated acceptance of the provider-completed ALPHA; their feedback led to the development of a self-report ALPHA. Satisfaction, yield and reliability of the self-report and provider-completed ALPHA forms were studied and found to be comparable.

Results: Physicians and patients reported good satisfaction and usefulness of the ALPHA form in identifying antenatal psychosocial risk factors. The provider ALPHA was further tested in clinical practice. ALPHA endorsement was obtained from physicians, nurses and midwives.

Conclusion: A program planning process, which included multidisciplinary involvement, evaluation and endorsement by professional organizations, aided the development, refinement and application of the ALPHA forms as primary care tools. ALPHA topic headings are incorporated into the official 2000 Ontario Antenatal Record and the ALPHA adopted for use on Prince Edward Island.

La traduction du résumé se trouve à la fin de l'article.

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Assessment of psychosocial issues in pregnancy is now a standard of care.¹ Adverse postpartum outcomes affecting women and their children direct attention to the psychosocial needs of pregnant women. Since 1989, a multidisciplinary group of Ontario researchers, representing family medicine, nursing, psychiatry, women's health, midwifery and obstetrics, has worked to develop an Antenatal Psychosocial Health Assessment (ALPHA) Form for the systematic assessment of psychosocial risk factors during pregnancy.

Psychosocial interventions can positively affect postpartum functioning. Social support can lessen psychosocial stressors² and improve the health of mothers and children.³ Couples communication classes in pregnancy can reduce the anxiety and postpartum adjustment difficulties experienced by new parents and attenuate negative shifts in their marital relationship.⁴ Awareness of a previous depression has led to anticipatory counselling and care by health visitors⁵ and home visits by nurses, which have been found to decrease the incidence of child abuse and neglect-related injuries.⁶

Overview of the process

We followed a program planning cycle of needs assessment, objective setting, implementation and evaluation. First, Ontario family physicians were surveyed to determine if they perceived a need for an antenatal assessment form.⁷ Next, objectives were formulated to review the literature and develop an evidence-based tool. A critical literature review identified antenatal factors associated with adverse postpartum outcomes.⁸ The form was implemented in a field study and groups of obstetrical care providers found the provider ALPHA acceptable and indicated the need for a self-report ALPHA.⁹ Evaluation studies were undertaken. Provider and patient satisfaction, psychosocial yield and inter-rater reliability of the two ALPHAs were found to be comparable in one study.¹⁰ Data from another trial are currently being analyzed.

Do physicians already assess for psychosocial issues? Would a form be useful?

To answer these questions, in 1990 we surveyed a network of Ontario family

physicians to determine how important they considered psychosocial issues such as woman abuse, child abuse, alcohol and drug use during pregnancy, and how often they asked about them.⁷ Over 80% of the physicians responded that psychosocial issues were very important, but less than 25% asked pregnant women about them. When asked, 77% replied that a form would be somewhat or very helpful.

Delineation of essential components of an assessment tool

After a preliminary literature review, child abuse, woman abuse, postpartum depression, couple dysfunction and increased physical illness were identified as the most important antenatal factors associated with adverse postpartum outcomes. A comprehensive, critical literature review was conducted by searching MEDLINE, Cinahl, Famli, Psych Abstracts and the Oxford Database of Perinatal Trials for relevant articles published from 1980 to 1993 (the study year) that studied associations between antenatal psychosocial factors and the selected adverse postpartum outcomes.⁸ A variety of MeSH headings were used including, but not limited to: "child abuse", "child neglect", "domestic violence", "family", "marital adjustment", "social support", "psychosocial risk", "family health" and "risk factors".

Articles were included for review if they explored any association between antenatal risk factors and poor postpartum outcomes. In total, we identified 370 articles: 88 on child abuse, 97 on woman abuse by her partner, 73 on postpartum depression, 70 on couple dysfunction and 42 on physical illness. We evaluated the articles using a modified version of the analytic framework developed by the Canadian Task Force on the Periodic Health Examination,¹¹ which looks at the strength of study evidence. Using a standardized review form, some articles in each section were evaluated by all members and discussed to reach consensus and to maximize inter-rater reliability.

Class I was evidence from a randomized, controlled trial or well-designed natural-history study; *Class II-1* was evidence from prospective cohort studies; *Class II-2* was evidence from case-control studies or systematic literature reviews; *Class II-3* was evidence from studies comparing different

TABLE I

Associations Between Antenatal Risk Factors and Poor Postpartum Outcomes

Antenatal Risk Factors	Child Abuse	Woman Abuse	Postpartum Depression	Couple Dysfunction
Family Factors				
Lack of social support	good	good	fair	
Recent stressful life events	good	good	good	
Poor couple adjustment/satisfaction	fair	fair	good	good
Traditional, rigid role expectations		fair		good
Maternal Factors				
Prenatal care started in 3rd trimester		good	unclear	
Prenatal classes - quit or refused	good			
Unwanted pregnancy after 20 weeks	good	good	unclear	
Poor relationship of woman with parents	good		unclear	
Low self-esteem	good	fair		
Psychiatric disorder - past or present	good	good	fair	
Antepartum depression			good	
Substance Abuse				
By woman or partner	fair	good		
Family Violence				
Woman experience/witness as child	good	fair		
Current or past woman abuse	fair	good	fair	
Previous child abuse, harsh discipline	good			

* At the time of the literature review (1993), physical illness did not show any good association with the postpartum outcomes because of a lack of available studies. There was a fair association with recent stressful life events and no clear association with lack of social support.

sites and populations or from descriptive studies; and *Class III* was evidence from traditional reviews/overviews or from expert opinions.¹¹

The association between each antenatal factor and any increased risk of a poor outcome was evaluated according to the level and quality of evidence available. Strong evidence received a *Class A* or good association; moderate evidence, a *Class B* or fair association; and unclear evidence, a *Class C* association. Of the 129 antenatal risk factors identified, we found only 15 with a *Class A* association with at least one postpartum outcome (Table I).

Constructing a provider-completed ALPHA form

This review provided information to develop an *antenatal psychosocial health assessment* (ALPHA) form, containing the 15 *Class A* factors. This form was modified through feedback from focus groups of obstetricians, family physicians, midwives, nurses, social workers and childbirth educators. The final form (available upon request from the corresponding author) contains 32 questions on the 15 risk factors, with space for documentation by a provider during an interview with women at approximately 20 weeks. The questions are examples of what a provider could ask, and modification of the questions to suit the characteristics of different women is encouraged.⁹ A list of interventions at the end of the form helps providers identify appropriate resources.

With grants from the Ministry of Health (Ontario) and the Ontario Medical Association, this first iteration of the ALPHA form was piloted in 1995 in eight Ontario clinical settings with obstetricians (n=5), family physicians (n=10), midwives (n=7) and antenatal clinic nurses (n=4).⁹ Sixteen pregnant women participated in a semi-structured telephone interview after the assessment and discussed their comfort level with the ALPHA form. A *Provider's Guide*¹² and a short video were developed for provider training.

Developing a self-report ALPHA

Feedback from both providers and women in the pilot study indicated that a woman-completed version might be helpful for women with better reading than speaking skills in English or for providers who prefer a self-report format. The provider version was converted to a self-report, with 45 questions that have either a 5-point rating scale or are open-ended (Figure 1).

In 1998, these two versions of the form were evaluated for reliability, yield and satisfaction in a randomized trial on Prince Edward Island (PEI).¹⁰ Following training, four family physicians and three public health nurses from three health regions received versions of the ALPHA form in opaque envelopes and administered a randomly chosen ALPHA version to a consecutive sample of 76 pregnant women. Study findings indicated that both versions were equally reliable and yielded comparable numbers of psychosocial issues.¹⁰ In total,

Figure 1. The ALPHA Self-Report Questionnaire for Women

Name _____ Date _____ Months Pregnant _____

Having a baby usually means changes in your family life. You may wish to discuss some of these topics with your healthcare provider. She/he may help you with these changes. Please answer the questions the best way you can. Your answers are confidential and will be kept private.

Please answer the questions by circling a number on the scale, writing an answer in the space, or marking "yes" or "no". If some of the questions do not apply to you, please circle N/A (not applicable).

Your Family Life. Please answer the following questions about your family life.

Family Factors

1. About this pregnancy, my partner feels	very happy	1	2	3	4	5	very unhappy
2. About this pregnancy, my family feels	very happy	1	2	3	4	5	very unhappy
3. I feel supported in this pregnancy	very much	1	2	3	4	5	not at all
4. My partner will be involved with the baby	a great deal	1	2	3	4	5	not at all
5. When I am home with the baby I will have help from (state relationship) _____							

Comments: _____

Recent Life Stresses (moving, job change or loss, family illness or death, money troubles, and so on)

6. Over the past year, my life has been	very relaxed	1	2	3	4	5	very stressful
7. I am making life changes during this pregnancy	No _____ Yes _____						

If yes, describe _____

Comments: _____

Relationship With Partner (if this applies)

8. My relationship with my partner is usually	very happy	1	2	3	4	5	very unhappy
9. After the baby, I expect my partner and I will get along	very well	1	2	3	4	5	not at all

Comments: _____

Your Own Life. Please answer the following questions about your own life and feelings.

10. In this pregnancy, I first came for care when I was _____ months pregnant. This is my ____1st ____2nd ____3rd (indicate number) child.

11. I am planning to take prenatal classes
 Reasons, if no, _____

Comments: _____

Feelings About Being Pregnant

12. My feelings about this pregnancy at first	very happy	1	2	3	4	5	very unhappy
13. My feelings about this pregnancy now	very happy	1	2	3	4	5	very unhappy

Comments: _____

Relationship With Parents

14. When I was a child, I got along with my parent(s)	very much	1	2	3	4	5	not at all	
15. As a young child I felt loved by my mother	very much	1	2	3	4	5	not at all	N/A
16. As a young child I felt loved by my father	very much	1	2	3	4	5	not at all	N/A

Comments: _____

Feelings About Becoming/Being a Mother

17. I have concerns about becoming/being a mother	none at all	1	2	3	4	5	very many
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Comments: _____

Emotional Health

18. I have had some emotional problems	No _____ Yes _____						
19. I have seen a psychiatrist/therapist	No _____ Yes _____						
20. In this pregnancy, my mood has been usually	happy/up	1	2	3	4	5	sad/down

Comments: _____

(continues next page)

238 issues were disclosed: 115 with the provider ALPHA and 123 with the self-report. Issues ranged from negative partner and family feelings about the pregnancy (8%), being abused as a child (17%), to physical, emotional and/or sexual abuse by partner (20%).

The providers rated the provider-completed version significantly higher than the self-report with respect to degree of new information learned and usefulness of the assessment. On a 5-point scale with 1 being "very much" and 5 being "not at

all", the mean rating for the provider-completed form was 2.21 for new information learned and 1.82 for usefulness, in comparison to means of 2.89 and 2.28 respectively for the self-report. Women on the other hand preferred the self-report, though the differences were not significant. For example, with respect to women's comfort level with the assessment, the overall mean rating was 1.57, with 1.63 for the provider form and 1.51 for the self-report. Both providers and pregnant women were satisfied with the assessment process and found

it enhanced the provider-client relationship. The majority of women believed that psychosocial assessment should be part of routine prenatal care on PEI.

Consequently, the P.E.I. Reproductive Care Program integrated modified versions of both forms into routine prenatal care, recommended that comprehensive psychosocial assessment be undertaken for all pregnant women, and trained family physicians and public health nurses in ALPHA assessment. The study also recommended that the health impact, costs and

Figure 1. The ALPHA Self-Report Questionnaire for Women (continued)**Stress in Your Life.** Please answer the following questions about stress in your life.**Alcohol and Drug Use During Pregnancy**

21. Each week I drink ___ drinks. (1 drink = 1 1/2 oz liquor, 12 oz beer, 5 oz wine) No___ Yes___ If yes, describe _____
22. There are times when I drink more during the week No___ Yes___
23. Sometimes I've felt: A need to cut-down my drinking No___ Yes___
 Annoyed by people criticizing my drinking No___ Yes___
 Guilty about my drinking No___ Yes___
 A need for a drink first thing in the morning No___ Yes___
24. I use recreational drugs, e.g., marihuana never 1 2 3 4 5 very often
25. I have some drug problems No___ Yes___ If yes, describe _____
26. My partner uses recreational drugs, e.g., marihuana never 1 2 3 4 5 very often
27. My partner has some drug problems No___ Yes___ If yes, describe _____
- Comments: _____

Parent's Relationship (when you were a young child)

28. My parents usually got along very well 1 2 3 4 5 not at all N/A
29. My father sometimes scared or hurt my mother never 1 2 3 4 5 very often N/A
30. My parents sometimes scared or hurt me never 1 2 3 4 5 very often N/A
31. As a child I was sexually abused No___ Yes___
- Comments: _____

Relationship With Partner (if this applies)

32. My relationship with my partner usually has no tension 1 2 3 4 5 a lot of tension N/A
33. We work out arguments with no difficulty 1 2 3 4 5 great difficulty N/A
34. I've sometimes felt scared by what my partner says or does never 1 2 3 4 5 very often N/A
35. I've been hit/pushed/slapped by a partner never 1 2 3 4 5 very often N/A
36. I've sometimes been put down or humiliated by my partner never 1 2 3 4 5 very often N/A
37. I have been forced to have sex against my will No___ Yes___
- Comments: _____

Raising Children

38. I have children not living with me No___ Yes___
39. My partner has children not living with him No___ Yes___
40. I've been involved with Children's Protective Services (e.g., Children's Aid) No___ Yes___
- Comments: _____

41. As a child, I was harshly disciplined by parents/family never 1 2 3 4 5 very often
42. I think spanking is necessary never 1 2 3 4 5 very often
- Comments: _____

43. Overall, how concerned are you about your emotional and family life? not at all concerned 1 2 3 4 5 6 7 extremely concerned

44. What issues in your life are most concerning to you? _____

45. What help, if any, would you like? _____

savings of the assessments and interventions be tracked and calculated.

Gaining acceptability for the ALPHA forms

Throughout this development process, it was critical to gain acceptance from obstetrical providers. With a grant from the Lawson Foundation, an expert panel of providers was convened in 1998 to discuss psychosocial assessment and the ALPHA form. Over 40 obstetrical providers from across Ontario attended, representing obstetrics (the largest group), family medicine, midwifery and nursing. The Chairs of Family Medicine and Obstetrics at the five medical schools in Ontario, the Committee of Heads of Nursing Schools and the College of Midwifery were

approached for names of providers interested in psychosocial issues. Community providers, including providers from Northern Ontario, were also invited to provide diverse perspectives.

The participants completed exercises to determine the facilitators and barriers to psychosocial assessment from the perspective of their discipline.¹³ Time was identified as a significant barrier for obstetricians and family physicians, since completing the provider-completed ALPHA in one sitting would take about 20 minutes. Other barriers, mentioned by all groups, were the lack of knowledge of many providers about how to ask about issues such as woman abuse and the paucity of referral resources. However, the participants concurred that psychosocial assessment was a crucial com-

ponent of prenatal care and should be completed regardless of these barriers. The panel also offered valuable suggestions about modifying the guide and training video.

The politics of dissemination

We felt it was critical to obtain endorsement from relevant stakeholders and were pleased to obtain ALPHA endorsement from the Canadian Pediatric Society, the Canadian Psychiatric Association, the College of Family Physicians of Canada, the Ontario Association of Midwives, the Ontario Medical Association, the Royal College of Physicians and Surgeons of Canada and the Society of Obstetricians and Gynecologists of Canada. The Healthy Babies, Healthy Children Project in

Ontario, Office of Integrated Services for Children, has recommended the use of the ALPHA form by public health nurses for assessment of all primiparous women and high-risk multiparous women. The ALPHA was included in *Healthy Beginnings*,¹⁴ a 1998 publication on prenatal care by the Society of Obstetricians and Gynecologists of Canada and was identified as an assessment tool in the *Family-centred Maternity Care Guidelines* published by Health Canada in 2000.¹⁵ Internationally, the ALPHA forms have been included in the WHO manual for prenatal care.¹⁶

During the ALPHA development process, we realized that the Ontario Antenatal Record (OAR), used by obstetrical providers across the province, was undergoing revision by the Ontario Medical Association. Having a tested and effective assessment tool would make the inclusion of psychosocial data on the OAR logical, easier, and more compelling. One of the ALPHA team was fortuitously on the OAR revision task force and was able to represent our work. The new 2000 OAR includes a summary box for psychosocial data with headings that correspond to the information obtained through ALPHA assessment. This inclusion reminds all providers of prenatal care of the importance of psychosocial assessment during pregnancy.

Validity research underway

In 1997, the ALPHA Group received a grant from the Ontario Ministry of Health and Long Term Care (MOHLTC) for a randomized, controlled trial with the provider-completed ALPHA. In this study to determine the number of antenatal psychosocial concerns identified, family physicians, obstetricians and midwives were randomized into either a standard practice group or an ALPHA assessment group. Standardized questionnaires on woman abuse, child abuse potential, couple functioning and postpartum depression were administered during pregnancy and postpartum to both groups of women. Comparison with these inventories will provide further construct validity for the ALPHA form.

The intervention group physicians received a short ALPHA training session (30-45 minutes). A "round-robin" role-

play of a pregnant woman with self-esteem and self-identity problems allowed each provider practice with the ALPHA form. With further MOHLTC funding, printed information on woman abuse, outlining interventions if abuse was disclosed and locations of community resources, was distributed at these sessions. The analysis of this trial is now underway.

ALPHA dissemination and future research

Reliability studies are being conducted in several family practices. One study, wherein women complete a self-report ALPHA before and immediately after an in-depth interview (the gold standard) with a specially trained nurse, will further evaluate ALPHA reliability.

The ALPHA is regularly presented at local and international meetings. One team member is part of the Peer Presenter Program, Ontario College of Family Physicians, which presents the ALPHA process across Ontario; another promotes the ALPHA form throughout the European region as part of the WHO approach to perinatal care.¹⁶

DISCUSSION

The development of a structured antenatal assessment form has been successful insofar as it is used on PEI and recommended by Health Canada in its Family-centred Maternity Care Guidelines. Ontario has included the headings of ALPHA in its 2000 OAR, thereby giving official recognition to these important topics. However, despite official endorsement of ALPHA by relevant professional bodies, there remain pockets of resistance to psychosocial enquiry among some practitioners.

The adherence to a program-planning model developed by a multidisciplinary research group has been both its boon and its bane. The collaborative process has not been without problems, and scheduling meetings with far-flung participants has been difficult and has protracted the process. The analytic framework for the literature review required that each researcher read all the studies and necessitated numerous meetings to reach consensus on the relative importance of various antenatal factors. All the physicians had demanding practices without adequate research fund-

ing, thereby increasing time-lines for publication and grant development. Literature reviews will always require updating and may in time require further modification of the ALPHA form.

CONCLUSION

Antenatal psychosocial health assessment is a vital component of prenatal care. A long process has led to the development of a unique assessment form, which we hope will lead to better assessment of antenatal psychosocial health and ultimately better health for Canadian women and their families.

REFERENCES

1. Culpepper L, Jack B. Psychosocial issues in pregnancy. *Prim Care* 1993;20:599-619.
2. Nuckolls KB, Cassel J, Kaplan BH. Psychosocial assets, life crises and the prognosis of pregnancy. *Am J Epidemiol* 1972;95(5):431-41.
3. Oakley A. Measuring the effectiveness of psychosocial interventions in pregnancy. *Int J Technol Assess Health Care* 1992;8(1):129-38.
4. Midmer D, Wilson L, Cummings S. A randomized controlled trial of the influence of prenatal parenting education on postpartum anxiety and marital adjustment. *Fam Med* 1995;27:200-5.
5. Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: Controlled study of health visitor intervention in treatment of postpartum depression. *BMJ* 1989;298:223-26.
6. Olds DL, Eckenrode J, Henderson CR, Kitzman H, Powers J, Cole R, et al. Long-term effects of home visitation on maternal life course and child abuse and neglect. *JAMA* 1997;278(8):637-43.
7. Carroll JC, Reid AJ, Biringer A, Wilson LM, Midmer DK. Psychosocial risk factors during pregnancy. What do family physicians ask about? *Can Fam Phys* 1994;40:1280-89.
8. Wilson LM, Reid AJ, Midmer DK, Biringer A, Carroll JC, Stewart DE. Antenatal psychosocial risk factors associated with adverse postpartum family outcomes. *CMAJ* 1996;154(6):785-99.
9. Reid A, Biringer A, Carroll J, Midmer D, Wilson L, Chalmers B, Stewart D. Using the ALPHA Form in practice to assess antenatal psychosocial health. *CMAJ* 1998;159(6):677-84.
10. Bryanton J. The ALPHA (Antenatal Psychosocial Health Assessment) Pilot Study Report. Charlottetown, PEI: P.E.I. Reproductive Care Program, 1999.
11. Canadian Task Force on the Periodic Health Examination: The periodic health examination. *CMAJ* 1979;121:1193-254.
12. Midmer D, Biringer A, Carroll JC, Reid AJ, Wilson L, Stewart D, et al. *A Reference Guide for Providers: The ALPHA Form - Antenatal Psychosocial Health Assessment Form*, 2nd Edition. Toronto: Department of Family and Community Medicine, University of Toronto, 1996.
13. Midmer D. ALPHACARE: Expert Panel Report. Toronto: Department of Family and Community Medicine, University of Toronto, 1998.
14. Society of Obstetricians and Gynecologists of Canada. *Healthy Beginnings: A Guide to Prenatal Care*. 1998.
15. Health Canada. Family-Centred Maternity and Newborn Care - National Guidelines. Ottawa: Minister of Public Works and Government Services, 2000.

16. Chalmers B, Mangiaterra V, Porter R. WHO Principles of Perinatal Care: The Essential Antenatal, Perinatal and Postpartum Care Course. *Birth* 2001;28:202-7.

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RÉSUMÉ

Objectif : Décrire l'élaboration et l'implantation d'un outil exhaustif d'évaluation des risques psychosociaux de la grossesse associés à de mauvais résultats en post-partum.

Méthode : Le besoin d'un questionnaire d'évaluation anténatale des risques psychosociaux a déjà été établi par les médecins de famille ontariens. Une analyse documentaire critique a confirmé la pertinence des composantes de l'outil d'évaluation (ALPHA). L'Outil a été modifié à la suite de groupes de discussion avec des obstétriciens, médecins de famille, sage-femmes, infirmières, travailleurs sociaux et éducateurs anténataux. Un vidéo d'enseignement et un guide de l'utilisateur furent élaborés. Un groupe de consommatrices a aussi exprimé ses opinions lors d'entrevues.

Résultats : Patientes et médecins semblent satisfaits de l'outil ALPHA pour l'identification des risques psychosociaux durant la période anténatale. Des fonds de recherche ont été obtenus pour l'évaluation de l'outil en pratique clinique. L'Outil a été approuvé par divers groupes de médecins, infirmières et sage-femmes. Les en-têtes d'ALPHA ont été adoptés pour la nouvelle formule de dossier anténatale de l'Ontario, et l'outil ALPHA a été incorporé au dossier de l'Île-du-Prince-Édouard.

Conclusion : Le feedback multidisciplinaire ainsi que la base scientifique de l'outil ALPHA ont aidé à son élaboration, son perfectionnement et son application en première ligne.

Recension Book Review

Benoît Gaumer, Georges Desrosiers et Othmar Keel. *Histoire du Service de santé de la ville de Montréal, 1865-1975*. Les Presses de l'Université Laval, 2002. ISBN 2-89224-332-7.

Voici que paraît enfin une histoire complète du développement organisationnel des services de santé publique dans ce qui fut longtemps la plus grande agglomération urbaine du Canada. Comme la nécessité des services de santé publique apparaît toujours et d'abord, en milieu urbain, il importe de bien connaître les conditions d'installation puis de consolidation de ces services pour comprendre la configuration qu'on leur découvre, plus particulièrement quand on a choisi de faire carrière dans cette discipline. Et c'est le défi auquel se sont attaqués ces auteurs, défi qu'ils relèvent de manière admirable. D'emblée, leur perspective est celle de l'étude de l'organisation et de son évolution à travers les différentes administrations municipales et les crises de santé auxquelles chacune s'est trouvée confrontée un jour ou l'autre. Ce qui fait donc de ce volume une lecture particulièrement intéressante pour les initiés, ce qui ne signifie pas qu'elle ne soit pas tout aussi passionnante pour qui s'intéresse à l'histoire de notre société. Ce type d'ouvrage ne peut pas ne pas parler des maladies qui perturbaient périodiquement la vie de la cité mais les auteurs évitent le jargon qui eût rendu des parties du livre inintelligibles pour beaucoup de lecteurs.

Cette histoire comporte six chapitres dont quatre sont construits autour de l'œuvre des directeurs qui ont construit les services de santé publique de Montréal : Alphonse-Barnabé Larocque, Louis Laberge, Séraphin Boucher et Adélard Groulx. Il faut dire que la longévité de ces quatre directeurs dans des postes aussi politiquement périlleux serait rigoureusement impensable de nos jours. Cette stratégie des auteurs permet de bien baliser le parcours suivi par l'institution de santé publique au travers des crises locales, nationales et mondiales dont le siècle sous étude n'a pas été

dépourvu. Les deux autres chapitres sont consacrés à la mise en contexte en introduction puis au démantèlement du service de santé de la ville de Montréal au milieu des années 70 et à une comparaison de cette évolution avec la situation qui prévaut à Toronto, autre métropole qui a choisi, elle, de protéger jalousement son service de santé.

L'écriture est alerte, les appels de notes multiples, les illustrations instructives et fort attrayantes et la facture de l'ouvrage fort élégante, à l'image des normes usuelles de *l'Institut québécois de recherche sur la culture*, l'éditeur de ce volume. Les auteurs ont eu accès à des fonds d'archives extrêmement fournis et on devine le travail de bénédictin qu'a dû requérir le tour de force qu'ils ont réussi de contenir le tout en 262 pages fort compréhensibles.

On ne saurait trop recommander la lecture de cet ouvrage à tous ceux qu'exaspère le caractère incontournable du travail politique qu'impose la pratique efficace de la santé publique : institution vouée au service de citoyens libres et souverains, souvent ignorants des aspects qui rendent évitables bien des catastrophes et qui sont volontiers réfractaires aux consignes émanant de l'autorité publique, même quand ces consignes sont porteuses de bénéfices. Chaque développement de la connaissance qui permet de réduire le fardeau de la morbidité évitable doit confronter puis remplacer des préjugés sur lesquels sont bien souvent construites des politiques et ceci ne survient jamais sans combat. L'histoire des services de santé de Montréal qui vient de paraître est riche d'illustrations de ces combats et présente plusieurs modèles de rôle porteurs d'enseignements très actuels pour les défis contemporains de santé publique. C'est donc un grand service que les auteurs viennent de rendre aux artisans de ce domaine spécialisé des services de santé. Il faut souhaiter à cet ouvrage de connaître le rayonnement qu'il mérite.

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