EDITORIAL

How Do People Interpret Their Family Histories of Diabetes, Coronary Disease, or Cancer?

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In this issue, Fiona Walter at University of Cambridge and her colleagues Emery, Braithwaite, and Marteau share a systematic review of the personal meaning of family medical history.[1] This meta-synthesis of qualitative research is particularly important because rather than emphasizing rare genetic disorders, it focuses on common diseases. These diseases have genetic, environmental, and behavioral causes that are well known to "run in families." The result is a conceptual model likely to be useful for clinicians and researchers for understanding how to target chronic disease prevention according to familial risk.[2] The personalizing processes that this synthesis illuminates largely have been ignored in early efforts to systematize the use of family history in public health and primary care.

The meta-synthesis by Walter et al moves beyond summarizing what is known by producing a new and helpful theoretical framework. This theoretical model explains the "overall process by which people make sense of their family history." The model depicts how family history interacts with the salience of that history through a personalizing process to create a personal sense of vulnerability. By identifying both the important domains and their relationships, the model can focus risk communication and management. The authors' analysis discerns that the personal interpretation of the family history is likely to be a stronger determinant of people's lifestyle choices and actions than the information viewed in the family history diagrams we currently produce.

The information and perspective in this work are urgently needed. The US Surgeon General's November 2004 campaign—"Know your family medical history"—will urge people to collect their relatives' medical histories and to discuss their health implications with a personal physician. As an aid to this process, members of the public will be able to freely download a computerized family history questionnaire that generates a family tree. It will systematically display the family history of 6 common diseases (soon to be available at http://www.hhs.gov/familyhistory). The model developed by Walter et al challenges us to assess systematically the personal significance of the family medical history. Clinicians and public health practitioners can use this model to enhance peoples' personal capacity to act on and live with familial risk.

This study also serves as an exciting exemplar of rarely used methods for the systematic meta-analysis of qualitative research. Little has been done to synthesize insights from the tremendous growth during the past decade in the number and quality of peer-reviewed articles using qualitative research designs. The nursing and primary care medicine literature often have sufficient numbers of qualitative articles on a given topic for a meta-synthesis (the qualitative equivalent to a meta-analysis) to identify larger themes and patterns. Importantly, many of these articles focus on exploratory research questions or capture individual stories

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that are largely inaccessible through clinical trials and other common epidemiological designs. The collective voice of these manuscripts needs to be heard. A qualitative meta-synthesis like the one conducted by Walter and colleagues offers a wonderful learning opportunity for both researchers and clinicians.

While quantitative meta-analyses are widely conducted, the same is not true for a qualitative equivalent. In preparing for this editorial, we did a quick PubMed search on "meta-analysis" and came up with more than 17,000 citations. Similar searches on a range of topics, such as "meta-ethnography," "metasynthesis," and "meta-synthesis," yielded a scant 33 citations. Virtually all of these qualitative meta-syntheses were in the nursing literature, and a number of them were how-to methods articles. The technology and methods for doing a qualitative meta-synthesis have existed for many years,[3] but clear examples are exceedingly rare.

Fortunately, the manuscript by Walter et al is a model of how to conduct and report a qualitative meta-synthesis. The methods are well explained and transparent. In fact, the manuscript is as good as most methods articles in providing a step-by-step process for conducting a qualitative meta-synthesis. We encourage others to perform similar meta-syntheses for other topical areas on which there have been a large number of qualitative articles—important questions in diabetes and depression immediately come to mind. This study would also serve as a nice model for Cochran Collaboration reviewers who have not taken advantage of the emerging qualitative research repertoire.

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