

Faces in the crowd

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A football crowd at the Melbourne Cricket Ground is a good place to plan next month's editorial – particularly when your team is getting trounced. Gazing around the packed stadium, it struck me that I was in the company of over 50 000 people, all of whom were uniquely different.

We had all come to watch a game of football, but who were we and where had we come from? Different ages, genders, races, religions, occupations. Certainly different team allegiances. But all part of the same community and all mixed together to watch sport. The point struck me that – although we were all different people – we were more similar than we were different.

People with developmental disabilities are perceived as different, even to the extent of having an entire issue of *Australian Family Physician* devoted to their health care.

We have a dark history of segregating people with disabilities from the rest of society, ostensibly to allow each group to be happy in their ignorance of the other. We have condescended to people with disabilities through unwarranted allusions such as calling them 'eternal children', or 'God's special people'. An ancient South American culture (the Olmecs) is believed to have revered children with Down syndrome as the offspring of women who mated with jaguars¹ – much to the wry amusement of many modern day mothers of such children who reckon they would be up to that challenge. But were the Olmecs any more risible than John Langdon Down's 1866 original description of his eponymous syn-

drome that postulated a racial deterioration in hereditary traits leading to the repugnant term 'mongoloid'?²

This issue of *AFP* is dedicated to the care of people with disabilities not because they are different but because they struggle to be treated the same. In particular, people with disabilities receive health care that is less satisfactory than that enjoyed by the population at large. Several of this month's theme articles refer to landmark work by Helen Beange and Aidan McElduff on Sydney's North Shore that identified the huge burden of morbidity carried by people with intellectual disabilities: an average of 5.2 medical conditions per person, with over half being incompletely managed or completely undiagnosed.³

This is not to say that Australia's general practitioners are performing poorly. There are significant barriers confronting GPs working with this group of patients. A 1998 audit of 866 patients attending a Victorian clinic run by GPs with a special interest in this area – of whom I was one – found that 35% of patients expressed themselves by means other than easily understood speech.⁴ And that they had a high prevalence of challenging medical conditions such as epilepsy (31.8%) or undifferentiated illness (29%). Many consumed a complex cocktail of chemicals, with seven people seen at our clinic being on five antiepileptic drugs at the same time.

Communication stands as the greatest barrier to good health care. Each of the theme article's authors offers suggestions as to how GPs can find a common language

with which to communicate with their disabled patient; a flurry of self injurious head banging can mean anything from otitis media to unresolved grief. There are also some tips on how to translate that huge, mysterious neck-top medical encyclopaedia we all possess into information that a person with an intellectual disability can understand and use in making decisions about their own health.

A GP's waiting room holds a microcosm of the football crowd: lots of different people coming together for a common purpose. At the Melbourne Cricket Ground, it's to see highly trained athletes performing at their best. When our different patients come to see us, they expect the same.

References

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