

Peripatetic Column

The Doctor's Chauffeur

P Madhok

Chauffeurs are a rare commodity and all doctors don't have them. In a busy city like Mumbai with traffic snarls and jay driving having a driver is a MUST for a doctor. But job opportunities for them are so many that they tend to keep job hopping. Doctor as employer is good for him and he knows it. Hours are regular, cars are in good condition and medical treatment is free. Although doctors are in the preferred category, not all doctors have drivers. A lucky few have long standing chauffeurs (syn. Drivers) and they are a class by themselves. Seeing them sit with other drivers in the waiting area is a lesson by itself. They boast about the VIP patients that the doctor has and even hold themselves out as part time doctors – often prescribing common medicines to other drivers. The ones that wear a uniform are egoistic and look disdainfully at their peers. Although having driver for a long time is a blessing, sometimes it can only be a mixed blessing. As they get senior they get highly self opinionated. You may not be able to control his smoking or tobacco chewing. The fat ones tend to belch and occasionally let off a fart – much to our annoyance. I remember the one I had for 15 years made it a point to use our Nursing Home toilet, first and foremost after reporting on duty. He then followed it by doing a "round" in the wards exchanging pleasantries with all the patients.

Ex. Hon. Paediatric Surgeon, Bai Jerabi Wadia Hospital for Children, Parel. Hon. Surgeon, Arogyanidhi Hospital, Juhu and BARC Hospital, Deonar, Mumbai.

I had to wait my turn till he had finished. He then proceeded to have breakfast and even polished off the left over breakfast of patients. Yet he always wanted medicine for poor appetite. He expanded in the middle over the years and I had to struggle getting him an insurance policy as he was overweight.

Some of them are in the habit of asking for "advance" payment on lame excuses. This is not easy to adjust later, and you may have to write off some of it. Going to village/native place is another bone of contention. One month pay or leave is given by most employers. Some of them want more of it, out of turn. The excuse of losing his father or mother is so common that it has become a cliché. One of my drivers lost his mother three times before I discovered she had died in his childhood.

On the upside, a good old driver can be a useful companion. You can trust him with ladies and children of the house and they are often good propaganda machines for you. It is difficult to find a driver who does not drive fast. You will not appreciate it unless you suffer from cervical spondylosis or have loose teeth; and the road has potholes. Admonition for misdemeanours can only be limited. After all our life is in their hands when they drive.

Their attitude to the vehicle is variable. Some like to keep the car spick and span. Others feel it is the job of the cleaner and will often find faults with it. It is a rare driver who regularly checks the engine/brake oil and tyre pressure.

Gossip about home members and other

drivers is inbuilt in their job. The senior one might even become a player in the family politics. One has to be on the look out that your driver does not develop an amorous relationship with maids of the house or in

the neighbourhood. This can cause some tricky problem especially if the doctor himself indulges in peccadillos with his own secretary or female patients. And the driver knows it!!

MANAGING PATIENTS WITH DIFFICULT ASTHMA

A diagnosis of asthma may commit patients to lifelong therapy, so it is important to carry out objective tests to confirm diagnosis.

Patients with airflow obstruction should have a reversibility test with 400µg inhaled salbutamol, a 6-8 week trial of 200 µg inhaled beclomethasone (or equivalent) twice daily or a two-week trial of oral prednisolone 30 mg daily.

It seems likely that in the near future the measurement of FE_{No} will become much more widely available, both in hospital and primary care, to help confirm diagnosis.

Time will tell how this new measurement fits into the routine management of asthma in primary care.

Bronchial challenge testing was formerly a complicated procedure carried out only in respiratory research units. However, newer techniques using the indirect challenge of mannitol will soon become more widely available.

Patients with COPD tend to have persistent and gradually worsening symptoms of breathlessness and wheeze, much are typically worse in the early morning but does not cause night-time waking.

Patients with a confirmed diagnosis of asthma should be given a short-acting beta-agonist (SABA) and counselled on inhaler technique. Those using a SABA more than three times a week, or waking from sleep with respiratory symptoms one night a week or more, should start inhaled steroid therapy.

Those with an FEV₁ < 30% have very severe COPD and are usually very disabled. They should be considered for long-term oxygen therapy (LTOT), particularly if resting oxygen saturation while breathing air is < 92%.

Allergy testing should probably be performed in all patients who have poorly controlled asthma.

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