as in previous studies,[7,8] we compared peak expiratory flow rates over seven day periods during respiratory episodes and control periods. By doing this we may have failed to recognise brief asthma exacerbations with modest decreases in peak expiratory flow rate, but we were less likely to include as exacerbations variability in airflow related to poorly controlled asthma.

None of the previous studies in adults tested for coronaviruses, and Huhti *et al* did not culture for rhinoviruses.[6] In our study, identifications of rhinoviruses by seminested reverse transcriptase polymerase chain reaction and coronaviruses by ELISA improved the diagnosis of both viruses and enabled us to show that they are important causes of respiratory disease leading to exacerbations of asthma in adults as well as in children.[2-4,24,25] Given the far better performance of polymerase chain reaction than conventional diagnostic techniques, the newer molecular methods should greatly facilitate research in this important area.

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Use of chaperones by general practitioners

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Little has been written about the use of chaperones in general practice. Jones found 10 years ago that 13% of male general practitioners always used a chaperone, while 25% never did.[1] The defence organisations still advise that every doctor, male and female, should have a chaperone present when performing an intimate examination on a patient of the opposite sex. We investigated the views of female general practitioners and whether the attitudes and practice of male general practitioners had changed in light of the sharp increase in litigation and the defence organisations' advice.

Methods and results

A questionnaire was sent to 200 randomly selected male and to all 60 female general practitioners listed by Norfolk Family Health Services Authority. It asked about doctors' characteristics and their use of chaperones when examining patients of the opposite sex—for example, to take a cervical smear or assess testicular swelling. The results were analysed by computer with the Epi Infor version 5 statistical program separately according to the doctor's sex and are shown in the table.

Fifty one questionnaires were returned by the female doctors. Forty seven felt comfortable examining without a chaperone. Their comments generally suggested that they had never thought it necessary to have a chaperone present; some said that it had never crossed their minds.

In all, 181 questionnaires were returned by the male doctors, the mean age of whom was 42·8 years. Ninety eight worked in rural practices. Only two doctors did not have a practice nurse available. Many used a chaperone with young patients. Other reasons for use included fear of litigation (41), the doctor's knowledge of the patient (13), and intuition (22). The main reasons given for not using a chaperone were too time consuming, impractical, unnecessary, and not beneficial to the doctor-patient relationship. Sixty six thought that the use of a chaperone could damage the doctor-patient relationship, while 80 thought the opposite. Thirty one male doctors felt uncomfortable and 129 felt comfortable without a chaperone. We found no correlation between the frequency of use of chaperones and the practice size or doctor's age.

Male doctors mostly used practice nurses (135) as chaperones, but some also used receptionists (40), dispensers (one), and practice managers (two).

Use of chaperones by general practitioners according to sex of doctor. Values are numbers (percentages) of doctors

	Never	Rarely	Sometimes	Always
Female (n=51):				
Intend to use chaperone	38 (75)	10 (20)	3 (6)	0
Intend to offer chaperone	40 (78)	8 (16)	3 (6)	0
Male (n=181):				
Intend to use chaperone	38 (21)	79 (44)	35 (19)	29 (16)
Intend to offer chaperone	62 (34)	57 (32)	34 (19)	24 (13)

Comment

Our results show that female general practitioners never or rarely used a chaperone and felt comfortable examining a male patient without one. However, the defence organisations strongly advise both female and male doctors always to use a chaperone. Few female general practitioners pointed out the logistic difficulties in obtaining a suitable chaperone for a male patient; others prefer to refer the patient for examination to a male partner when necessary.

About 65% of male general practitioners never or rarely used a chaperone, or even intended to offer a chaperone. However, 16% always used a chaperone. These results are similar to those of Jones in 1983.[1] It seems inappropriate that up to 25% of male general practitioners use medically unqualified staff such as receptionists as chaperones.

In conclusion, a chaperone seems justified in selected cases, for young patients, and for medicolegal reasons; however, the availability of a full time chaperone would have financial implications and may damage the doctor-patient relationship. There seems to be a disparity between doctors' views and medical defence organisations' advice. General practitioners should be able to offer their patients a suitably qualified chaperone, and the decision to use one should be a two way interaction between the doctor and the patient.

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Condoms: a wider range needed

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Previous research has assumed that condom failures, other than those due to manufacturing faults, have been the result of user behaviour or condoms being too loose. We report the findings of a survey of men attending a busy genitourinary medicine clinic in an area of south London with one of the highest incidences in Britain of pregnant women positive for HIV. The results of our study indicate that tightness of condoms is an important factor in their failure and suggest that a larger condom may be needed by some individuals and that this would reduce the risk of condoms coming off as well as splitting.

Methods and results

Three hundred men attending the clinic were asked to answer a questionnaire; 281 were returned. In their responses 188 men considered themselves white, 76 black, and 14 Asian.

Seventy men (25% of the sample) reported difficulties putting on condoms, of whom 52 (19% of the sample) said that condoms were too tight. Seventy three per cent (38) of these men had experienced condoms coming off, compared with 52% respondents (96) who reported that they were not too tight. Of respondents who said condoms were too tight, 68% (34) reported splitting, compared with 52% (95) of those who reported that they were not too tight. Condoms coming off occasionally had been experienced by 22% (17) black, 27% (51) white, and 36% (5) Asian men, and 8% (6) black, 2% (3) white, and 21% (3) Asian men had had condoms come off frequently. In all, 20% (15) black, 19% (35) white, and 28% (4) Asian men had occasionally had a condom split, and 18% (14) black, 7% (14) white, and no Asian men had experienced condoms splitting frequently.

Sex with two or more partners during the preceding 12 months was reported by 56% (157) of respondents (53% (99) white, 70% (53) black, and 36% (5) Asian). Although 22% of the sample (63 men) claimed to always use a condom, only 9% (7) of black men, compared with 27% (51) of white and 36% (5) of Asian men, made this claim.

Comment

Most condoms in Britain conform to the specifications of the British Standards Institute, which specify a flat width of 52 (SD 2) mm.[1] Our results suggest that a proportion of men have penises sufficiently large to cause difficulty in putting on condoms, and for these men condoms are likely to come off or split more often, which may influence the acceptability of condoms. It is often assumed that a condom is elastic and that, size is therefore unimportant, but little stretch is actually possible when the condom is in a tightly rolled state.

Relation between condom tightness, condom failure, and racial origin. Values are numbers (percentages); not all subjects answered all questions

	Condom tight (n=52)	Condom not tight (n=186)	p Value*
Condom came off (n=250):			0·0003
Frequently	6 (12)	4 (2)	
Occasionally	32 (64)	92 (49)	
Never	12 (24)	90 (48)	
Condom split (n=249):			0·0001
Frequently	13 (26)	14 (11)	
Occasionally	21 (42)	18 (15)	
Never	16 (32)	92 (74)	
Racial origin (n=281):			0·0007
Black	25 (48)	40 (22)	
White	25 (48)	136 (73)	
Asian	2 (4)	10 (5)	

*χ^2 Test with two degrees of freedom.

An important cause of a condom coming off, paradoxically, is that it may be too tight. Difficulty rolling the condom fully down the shaft allows the ring to enter the partner and be rolled off the penis. If a condom is tight breakage may be due to placing fingers inside the ring to drag on the condom; this accounts for breakage occurring most often at the closed end (S L Solanti, personal communication).

Failure related to tightness would contribute to negative images of condoms. The World Health Organisation's guidelines indicate that over a third of penises exceed the British Standard Institute's standard dimensions for condoms.[2] This standard therefore inhibits the manufacture of a suitable range of size of condoms. This aspect of condom design needs further research.

The survey also highlighted a higher reported rate of condom failures, lower uptake of condoms, and reporting of a greater number of partners by black respondents. These findings indicate that this group, who may be at particular risk of exposure to HIV infection through second generation spread, could benefit from specific promotion and products.

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1 British Standards Institute. *British Standard specification for natural rubber latex condoms: BS 3704.*
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