by 1980, and budgeting constraints in France are both threatened and inevitable. 

Experience in British general practice since the reforms of 1965 suggests that fiscal means can be used with success by a government to encourage change. It would be possible for the French authorities to use a similar device. They could, for example, manipulate the proportion of fees reimbursed in such a way as to discourage direct access to specialists and to encourage true group practice, the employment of ancillary staff, and prudent prescribing. But the use of fiscal means to encourage modernisation of French general practice would create an acute dilemma. The underemployment of French doctors, at the present moment, may be asked by their performing tasks that could well be delegated, and if reorganisation is encouraged the situation will be shown in all its seriousness, and medical unemployment will be exacerbated.

For the British authorities the problems are different and fourfold. Firstly, the study suggests that British GPs cannot be entrusted to continue their own postgraduate education; fiscal encouragements, which existed up to two years ago, should therefore be re-established. Secondly, the most urgent reform needed in British general practice is a modest increase in competition among doctors. It must be made much easier for patients to change doctors and to seek second opinions from other GPs. Thirdly, in both countries there is a need to encourage economy by establishing a restricted list of subsidised drugs using generic names only. Fourthly, the dual system in British specialist practice is of dubious ethics and of ill repute abroad. British specialists should choose either to practise privately or within the NHS but not both; the ethical dilemmas are too serious, but they are not inevitable and they are not found in France.

Fiscal factors are vital in determining what doctors do and how they do it. Both Roemer and Glaser have written on the consequences and effects of the three different ways of paying doctors. The observations made in this study permit relevant postulates to be defined. The effects of the capitation method of payment are as follows: firstly, it protects the doctor from competition; secondly, it shifts the balance of power from the patient to the doctor; thirdly, it permits the doctor to absolve himself from his practice without financial penalty; fourthly, it encourages continuity of care; fifthly, there is a slow evolution to the fee-per-item-of-service category in response to the need for incentives; and sixthly, it requires a central bureaucratic body. The effects of the fee-per-item-of-service method of payment are as follows: firstly, it creates a reluctance to share profits with partners and thus encourages professional isolation; secondly, it shifts the balance of power from the doctor to the patient; thirdly, it discourages the discharge of the patients from medical care; fourthly, it restricts the doctor's freedom to withhold treatment and leads to over-prescribing; fifthly, when combined with open access to specialists it deprives the general practitioner of experience; and sixthly, when extended to ancillary services it leads to the dispersal of resources. It is not possible to derive from this study postulates relating to the effects of the salary method of payment as the only doctors paid entirely by salary were four British and three French specialists. The General Medical Services Committee of the British Medical Association has recently dismissed payment by salary as an acceptable alternative to the three French specialists who were paid by a generous salary were both impressive and contented. In view of the serious disadvantages of the capitation and fee-per-item-of-service methods a salary service should be seriously considered in any new system of health care for both GPs and specialists.

We thank the British and French doctors for their co-operation and the following for help and advice: Professor A E Bennett and the department of social medicine, St George's Hospital; Professor W W Holland, Mr A K Maynard, York University, Dr G Benedetti, and Dr J Mercadie. We are particularly grateful for the hospitality we received from so many French doctors and their families. The study was supported by a grant from the Research Foundation, Royal College of General Practitioners.

It is regretted that reprints will not be available. Further tables relating to the origins of GPs and specialists, their work load, prescribing, and attitudes are available from AMWP.

References
1 Jones RVH. A week with a French country doctor. J R Coll Gen Pract 1974;24:899-93.

What might be the cause of spontaneous penile erection and rapid ejaculation in a man in his 50s with a normal sexual history?

Apart from erections during REM sleep, intercourse, and masturbation, the major causes of erection are psychic. Spontaneous erection due to these last tends to wane with age. But there is not enough information in the question to know under what psychic and physical conditions the spontaneous erections occur. Possibly he is now seeking out new sexual situations to try to sustain a belief in his continuing prowess. This is not too uncommon as men get older and find libido and performance weaker. This man suffers from a form of premature ejaculation, and understanding its causes requires a detailed psychosexual history. Physical disorders causing spontaneous erections have so far not been explored very deeply, but the enlarged prostate is one and should be looked for. This is a reminder to look into urinary and lower alimentary tract symptoms, and there must be consideration of possible diseases of the nervous system, perhaps any that may affect the lower segments of the spinal cord and the cauda equina. A recent book that may help is by Trimmer.

Corrections

Asthma mortality in Birmingham in 1975-7: 53 deaths

We regret that an error occurred in this article by Drs L P Ormerod and D E Sackett in J R Coll Gen Pract 1980;26:629. In the fourth line of the discussion the phrase "in 25-5% (4/51) of deaths" should have read "in 25-5% (13/51) of deaths."

Procedures in Practice: Laryngoscopy

We regret that in the above article by Mr Philip H Beales and Dr M J Al-Khaled (1 March, p 629) the photograph of carcinoma of the vocal cord on p 629 was inadvertently reproduced without acknowledgment from Mr T R Bull's A Colour Atlas of ENT Diagnosis.