Documentation of the long term benefits of pancreas transplantation may soon lead to its wider acceptance and availability. Better control of rejection, with earlier diagnosis or better prevention, may soon permit transplantation of the pancreas alone to be an accepted treatment for diabetic patients without advanced complications. Other strategies being investigated include transplantation of islet cells and fetal pancreas, gene therapy, implantable insulin pumps, and biohybrid artificial pancreas units. Although some or all of these methods may have a place in the treatment of insulin dependent diabetes in the future, it will be difficult for these alternatives to improve on the

metabolic efficiency currently being achieved with vascularised pancreas transplants. With the improvement in quality of life and the potential for arresting diabetic complications, pancreas transplantation may no longer be regarded as the extreme but rather as the ultimate form of insulin delivery in the immediate future.

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Defining core general practitioner services

A threat to the future of general practice

General practitioners feel trapped between the twin forces of increasing patient expectations and a growing transfer of work from secondary to primary care. Far from welcoming the secretary of state's recent proposals to increase the health service's focus on primary care,¹ general practitioners have reacted by insisting that boundaries should be drawn around their responsibilities. The profession's negotiators are mandated to define a core of services which general practitioners would be contracted to provide. Services outside this core would be subject to separate contracts, probably negotiated locally with district purchasers. In this way, resources could be made to follow the patient, and limits could be placed on the inexorable flow of unrewarded work from the secondary sector.

This approach has clear attractions. If satisfactory negotiations were concluded general practitioners would feel in control of their workload and resources would become available in primary care to support further development of its role within the NHS. General practitioners would start to feel valued again for the work that they do, and the recent decline in morale would be reversed. So say the optimists. But there are dangers in this approach.

If general practitioners have to contract separately for services outside a defined core they will find that they face competition. This was very apparent at a recent conference on the future of 24 hour care hosted by the National Primary Care Research and Development Centre,² when there was no shortage of providers who expressed willingness to provide out of hours care—acute trusts, community trusts, and even ambulance trusts—all of whom would presumably employ general practitioners to do much of the work. Competition would come in other areas too, from providers who have had five years to develop their skills in bidding for contracts. Physicians would bid for a greater role in chronic disease management, surgeons would bid to provide postoperative care, community psychiatrists would bid for the care of schizophrenics, and community geriatricians would bid to care for the elderly at home. General practitioners, who, as

fundholders, have grown used to using the internal market, would find the full force of the market turned on them. They would either have to put time and effort into mounting successful bids for these contracts or see them pass to other providers.

What would this do for general practice? A key feature of general practice is the provision of first contact, coordinated, and comprehensive care.^{3 4} In seeking—for understandable reasons—to limit the comprehensive nature of the commitment, the profession will allow a variety of specialist and quasi-specialist services to become the patient's first point of contact. General practitioners, who are already overburdened with management, will become increasingly involved in defending their own territory. Primary care will become fragmented, with some practices able to provide only a rump of core contracted services, and the discipline of general practice will become unrecognisable. That is the doomsday scenario.

The profession's negotiators have a tightrope to walk. If no mechanisms are developed to fund the continuing transfer of care from hospitals to general practice then morale and recruitment will decline further. If core services are defined too narrowly, however, the very existence of general practice as we know it becomes threatened. It would be ironic indeed if, in trying to protect itself from external threats, the profession inadvertently destroyed itself from within.

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