RCGP SCOTLAND

Whole person medical care:

The value of the General Practitioner

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Executive Summary

As the landscape of general practice changes, it is more important than ever to celebrate the unique value of the general practitioner. RCGP must use its voice to defend the power of generalism, and the GP's ability to use multiple forms of knowledge, collaborative working, pragmatism and flexibility, allowing for patient-centred, caring medicine. The RCGP definition of a GP, approved in October 2023, sets out the framework by which we can begin to explain the vast contribution of general practice to policy makers. This is not just about the value of general practice and the sense in investing in it, but also to demystify the elements that aren't as simply measured or understood. There are some things that only GPs are trained and able to do – and those are the very things at risk when workload becomes unmanageable, medicine becomes more industrialised, or patients become further removed from their GP.

The paper explores the distinct expertise and experience that GPs have in providing whole person medical care whilst managing complexity, uncertainty and risk. It looks at how GPs provide evidence informed, personalised care, characterised by mutual trust, and how these relationships benefit from continuity of care. GPs work at the heart of their communities and have an important role in improving population health and reducing or mitigating health inequalities. They lead and connect with multidisciplinary teams, and they also make contributions to healthcare in many other ways, beyond the GP surgery and in different settings.

This paper seeks to influence policy decision makers in Scotland and make clear that general practice is the solution; delivering immense value to patients, to the wider NHS, and to the taxpayer. The College also wants our GP workforce – current and future – to know that their immense contributions and potential are recognised. As patient need grows, population demographics change, and the burden of ill health intensifies, policy makers worldwide are looking for answers to issues of patient access and rising costs.

We must be welcoming of progress that builds on the best aspects of GP care and set out general practice as the solution to the NHS crisis.

Foreword

I have been a GP for many years and want others to have the same fulfilling career. Working with patients and knowing we can have a positive impact on their lives has been a hugely rewarding experience.

I know firsthand that GPs become the connection for patients between the lives they know and the medical world. As Chair of RCGP Scotland, I am frustrated that while policy documents and international reports keep emphasising the importance of an increased focus on primary care, the funding we receive still suggests that general practice is undervalued, poorly understood, and neglected.

General practice is a very productive area of the health service, providing a 24/7 service and carrying out 90% of the care with a fraction of the budget. But, at times we can feel invisible, having soaked up so much extra demand while seeing a fall in GP numbers. Across my career I have witnessed the intensity of the job becoming greater and greater, with need and demand having grown enormously. This workload is not sustainable – not now, nor in the future.

GPs are the shield for the rest of the NHS, holding a vast amount of risk in the community. GPs draw upon incredible professional knowledge and experience. Our daily work is dealing with complexity. The consultations we are involved in are so often well beyond what might be covered by any protocol.

Like many GPs, I have taught undergraduate medical students and doctors at various levels of training. We are also team players. I have been involved in training pharmacists, physiotherapists, practice nurses and link workers – imparting what it means to work in general practice. I'm mindful too of how much GPs contribute through research, leadership and service planning, and the huge contribution made by the GPs who work in Out of Hours services.

We must resist becoming an over industrialised and transactional medicine system because it is bad for patients and bad for clinicians. Instead, we must collaborate and build a system that uses resources efficiently while acknowledging and caring for fellow humans, not creating further barriers to human connection. I want to be clear: this is not some nostalgic view looking back but a modern evaluation of what is effective and best for the people of Scotland.

I hope this paper galvanises policy makers, resonates with GPs, and inspires our future workforce.

Dr Chris Provan
Chair of RCGP Scotland

Introduction

As the landscape of general practice changes, it is more important than ever to celebrate the unique value of the general practitioner.

As patient need and demand grows, population demographics change, and the burden of ill health intensifies, policy makers worldwide are looking for answers to issues of patient access and rising costs. RCGP must use its voice to defend the power of generalism and the most precious contributions of general practice. GPs are trained and experienced in the art of generalism. This brings the ability to use multiple forms of knowledge, collaborative working, pragmatism and flexibiliient-centred, caring medicine. In many ways, whole person generalist care is incompatible with overindustrialised medicine that facilitates transactional consultations between patient and clinician, dehumanising patients and creating its own inefficiencies.

General Practice Nurses (GPN) are key members of the general practice team and have their own form of generalism which contributes to helping patients manage their chronic conditions within the context of their daily lives. Prevention of conditions such as diabetes and managing these conditions is crucial and we need to support the huge potential of the GPN workforce.

We must be welcoming of progress that builds on the best aspects of GP care. The Scottish policy context at time of writing is one of multiple, interconnected challenges – but there are also glimmers of progress in rhetoric from the Scottish Government. The Cabinet Secretary for Health and Social Care Neil Gray set four priorities for his programme for healthcare reform, including improving population health, a focus on prevention, providing quality services, and maximising access.[1] In November 2024, the Scottish Government published the General Practitioner Recruitment and Retention Action Plan 2024 – 2026, which contains commitments to stabilise and grow the GP workforce.[2] More recently on 27 January 2025, the First Minister stated he was persuaded by the call from GPs for more resources to fulfil their role in the shift to community-focused care.[3]

This paper has been written with three audiences in mind. Firstly, it seeks to influence policy decision makers in Scotland. General practice delivers immense value to patients, to the wider NHS, and to the taxpayer. We hope that this paper inspires bold policy and resourcing decisions with a long-term lens – a change to the status quo of health spend and emphasis on acute care, shifting instead to community based, preventative, and sustainable healthcare. Secondly, we want our GP workforce to know that their immense contributions and potential are recognised. The sense of being undervalued as a profession, worsened with negative stories in the media that emerged in the COVID-19 pandemic, has left many GPs reporting a loss of hope and love for the job. There is no NHS without general practice, and we should celebrate the stature of the discipline. Finally, we want to encourage and welcome the future GPs of Scotland. This paper articulates the breadth of opportunity a career in general practice holds, and the autonomy and complexity of general practice as a distinct clinical discipline, rooted in the community.

This paper seeks to set out an evidenced narrative around the work of a GP in primary care and the value that it brings. This paper is not intended to be a comprehensive literature review of the evidence in general practice, rather, it is a living document that underpins the policy, campaign and media activity of RCGP Scotland.

In October 2023 RCGP Council approved a new definition of a GP. It reflects the expertise and experience of GPs as specialised generalists in medicine, dedicated trainers of the new entrants to the profession, with many other responsibilities. Furthermore, it aims to give primary care specialists parity of esteem with colleagues in secondary care, reflecting the complexity of the work they undertake every day.

This paper is aligned with that definition, using it as a framework by which to recognise and celebrate the diverse contributions and value of the GP.

Definition of a GP

A GP is a doctor who is a consultant in general practice. GPs have distinct expertise and experience in providing whole person medical care whilst managing the complexity, uncertainty and risk associated with the continuous care they provide. GPs work at the heart of their communities, striving to provide comprehensive and equitable care for everyone, taking into account their health care needs, stage of life and background. GPs work in, connect with and lead multidisciplinary teams that care for people and their families, respecting the context in which they live, aiming to ensure all of their physical and mental health needs are met.

GPs and their patients

Through confidential trusted partnerships with their patients (characterised by empathy and mutual trust, without bias or judgement), GPs provide evidence informed personalised care in the community in an accessible way. Whether remotely or in person, they lead, support, and embrace innovation in medicine and technology, whilst working as an advocate for their patients and the population, to optimise the care they provide.

Outside the practice

As consultants in general practice, GPs can contribute to healthcare in many other ways beyond the GP surgery. They may work in local, regional, and national medical leadership and commissioning roles, undertake research and provide education, work in extended clinical roles or provide 24-hour, 365-day care within organisations who cover patient care outside standard GP opening hours.

October 2023

This paper seeks to explore the value of general practice. Historically, we have a very limited empirical base for generalist practice. A King's Fund report states, "There is a 'cycle of invisibility' for primary and community health and care services; they are hard to quantify and easy to overlook."[4]

It is easier to conceptualise and measure the value of specialism than of generalism, and that lack of data and hierarchy of evidence has been embedded in the traditional ignorance over the value of general practice. We urgently need better and more consistent data in general practice, where GPs know huge value is being delivered, but the data available on productivity and workforce is suboptimal. This is a major barrier to campaign and collaborative success – as policy decision makers demand clear evidence to back up spending decisions.

Furthermore, studies on general practice are often entangled with broader primary and community care sectors. This is in part due to multi disciplinary working and difficulty extracting input of different roles, and also due to different system arrangements across international examples. Primary care in Scotland is now mainly comprised of four independent contractor groups (general practice, community pharmacy, dentistry and optometry) and Community Urgent Care (NHS 24, Scottish Ambulance Service and Out of Hours).

Value to the system

Healthcare systems based on strong primary care are associated with enhanced patient satisfaction with, and access to healthcare services, better health outcomes, and a decrease in hospitalisation and use of emergency departments.[5 6 7]

Multiple studies have found that primary care is associated with better health outcomes and can help counteract the negative impact of poor economic conditions on health.[8 9] A 2018 study in England linked better primary care supply with improved quality of care, particularly in indicators related to cardiovascular disease, arthritis, diabetes, incontinence, and hearing problems. It also noted that distance to GP practice had a significant and negative association.[10]

There is also clear association with primary care and Gross Value Added (GVA), and a markedly reduced cost for the wider NHS.

From every £1 spent, there is a return on investment for primary care spending of £14 in extra growth for the economy.

The NHS Confederation analysis of England estimates that an investment of £1 billion in primary care in the areas that spent the least would have raised an additional £1.68 billion for the NHS's national budget – paying for itself.[11] The increased return on investment for primary and community care reflects the connection with local economies: improving population health, supporting people to remain in work, improving local infrastructure and providing good jobs.

Further research from the NHS Confederation identifies an explicit relationship between an increase in the GP workforce and a decrease in use of acute services. Investing in more GPs per head results in reductions in both A&E attendances and long-stay, non-elective inpatient spells. In monetary terms, adding one GP for 10,000 people equates to an estimated reduction in cost to be £82,071, relative to need. This will be an underestimation, with economic benefits likely to be far wider beyond direct saving from hospital care, due to an increase in the employment rate and economic activity growth.[12]

Assuming a causal relationship, the NHS Confederation finds that the reduction in acute demand associated with this higher primary and community spend combined could fund itself through savings on acute activity. It suggests an average 31% return on investment and recommends that primary and community spend is prioritised as a mechanism to reducing acute sector pressure, improving system productivity, and providing patients with the best possible care.

In Scotland today, general practice delivers around 90% of patient contact on any given day with less than 7% of the NHS budget. It is one of the most fiscally responsible parts of our health system and represents one of the greatest returns on investment.

Systematically neglected

While there have been recent signs of a positive shift to properly valuing general practice in Scottish Government policy, data over the last decade paints a picture of systematic and cultural neglect. In March 2025, Audit Scotland published its assessment of the implementation of the 2018 GMS Contract. This stark report states that the Scottish Government vision for general practice is not clear, and there has been insufficient transparency about investment over the medium term.

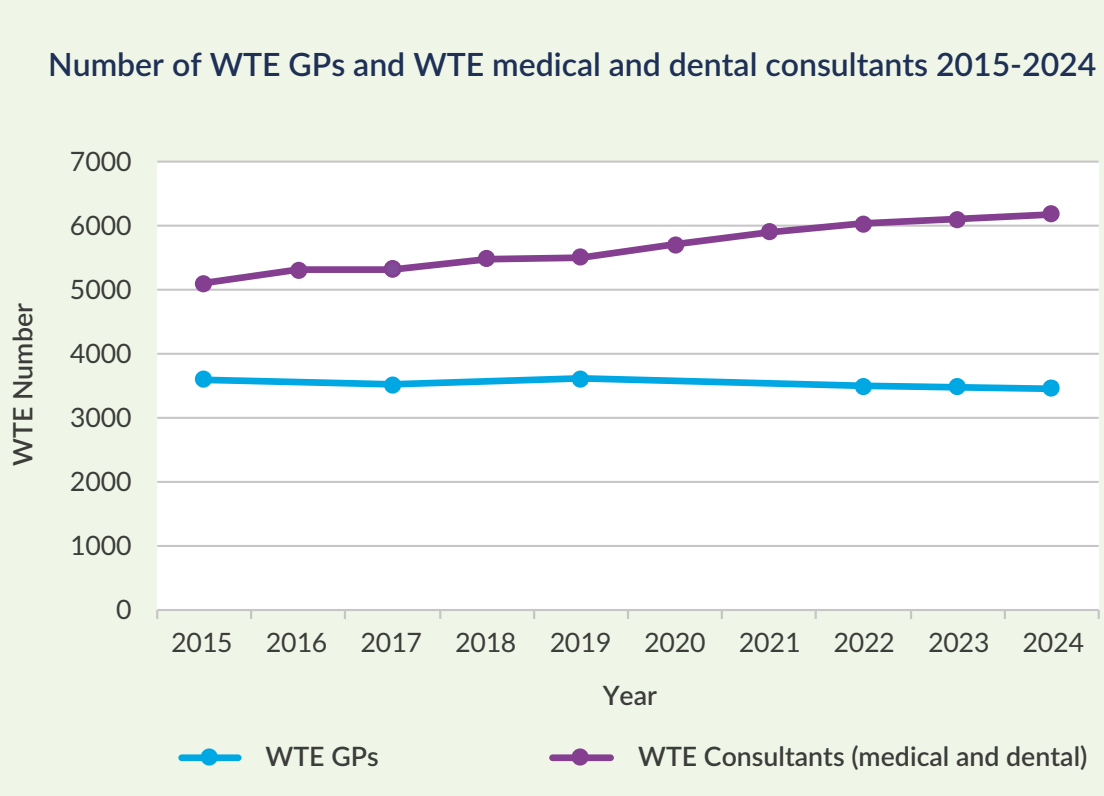
Direct spending on general practice has decreased in recent years both as a proportion of overall NHS spending, and in real terms. From 2017/18 to 2023/24, the general practice share of the NHS budget decreased from 7% to 6.5%. Between 2021/22 and 2023/24 direct spending fell by 6%.[13]

This has come at a time when the number of patients registered with a GP has continued to rise as has the complexity and health needs of the population.

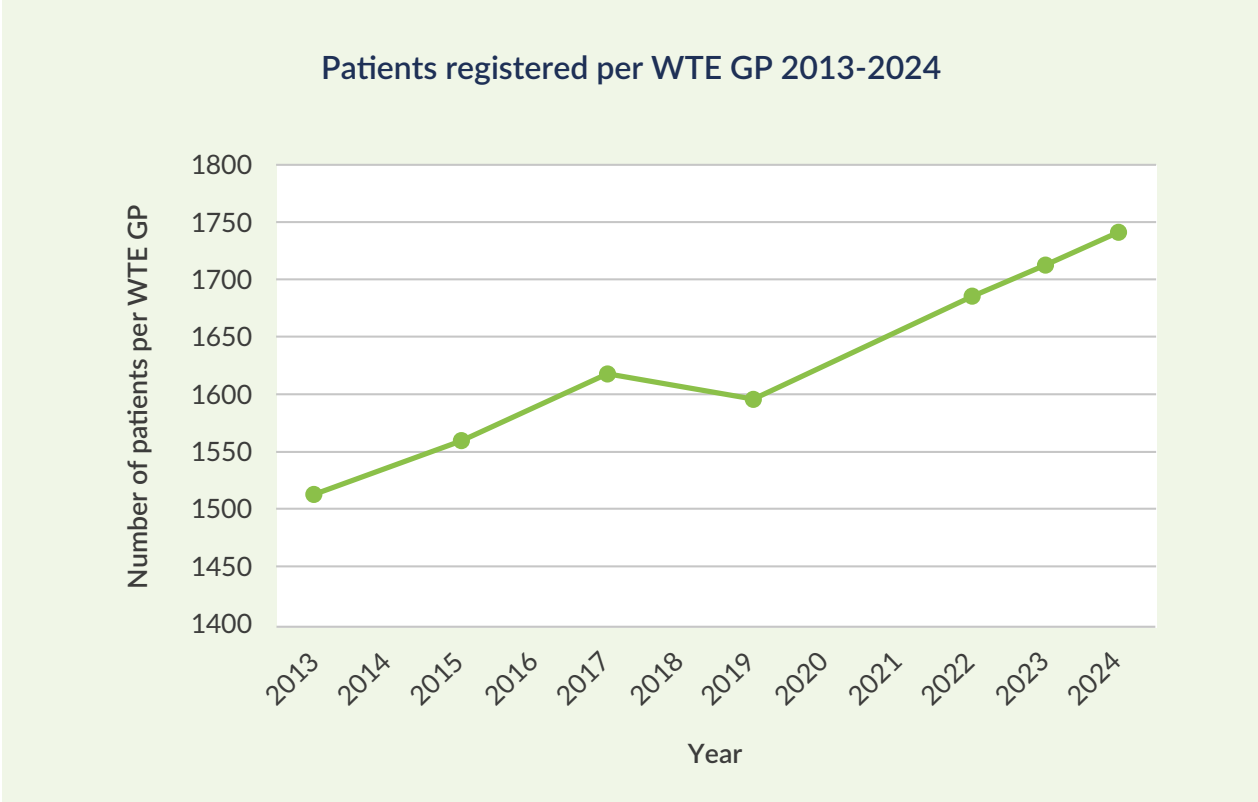
The Scottish Government's current target is to increase the number of headcount GPs in Scotland by 800 by 2027. It is the view of Audit Scotland and RCGP Scotland that this target will not be met. The Scottish Government did not provide practices with specific additional funding to achieve this commitment, and the emerging challenges with GP underemployment in parts of Scotland show the impact of the dire financial constraints practices face.[14] Furthermore, Audit Scotland states it is not clear that an additional 800 GPs is even sufficient to meet population health needs.

RCGP Scotland has previously called for future GP workforce planning to be predicated on whole time equivalent (WTE) numbers of GPs as this measurement better reflects the true state of the GP workforce.

Since 2015 the number of WTE GPs in Scotland has decreased by 4.2%, from 3,603 WTE GPs in 2015 to 3,453 in 2024. In contrast, the number of WTE medical and dental consultants has risen by 21.2% over the same period, from 5,101 to 6,181.[15]



According to RCGP Scotland analysis, the number of patients registered per GP has risen from 1,515 in 2013 to 1,742 in 2024, representing a 15% increase in the patient:GP ratio. It is estimated that the average GP consultation in the UK is 9.2 minutes, one of the lowest among economically advanced nations.[16]



These statistics lay bare the uphill battle to return general practice to a stable footing. However, this paper hopes to present the indispensable work that GPs across Scotland are still doing in the face of these challenges, and the rationale for why they urgently need better support to provide highest quality care for their patients.

Complexity and whole person care

GPs have distinct expertise and experience in providing whole person medical care whilst managing complexity.

GPs are unique in that they are able to integrate knowledge from different dynamic areas to help the individual patient in front of them. These areas of knowledge include bio-medical science, guidelines, the psychology of illness, and socio-economic factors. These factors combine to understand a way forward that best meets the needs of the individual patient at the time. Professor Joanne Reeve describes generalist practice as "constantly operating at the interface between different sets of knowledge, and boundaries between what is and is not known."[17]

The rapidly changing elements of primary health care include the availability of new medicines, emerging evidence and updated guidance that incorporates these. The Scottish Intercollegiate Guidelines Network notes that its guidelines are intended as "neither cookbook nor textbook" but assist in providing evidence of effective practice to assist healthcare professionals in making decisions about appropriate and effective care for their patients.[18] In general practice, the professional judgement of the GP is a necessary, complementary yet undervalued addition to deliver care in context.

Many guidelines are however built around a narrow scope. Scotland's population now has many people who have multiple morbidities – where more than one chronic disease is affecting them – while 1 in 4 people in Scotland live with two or more health conditions.[19] Generalism holds the skills, experience and broad-based knowledge to translate different care options and help patients to decide what fits their needs and walk the journey with them. While helping these patients make health-related decisions, GPs are constantly making allowances for other contributing factors.

The use of this generalist expertise avoids those patients encountering a burden of unnecessary medications, unwanted side effects, contradictory advice, and other harms. Some guidelines can contradict each other, and some guidelines rest on health research that focused on homogenous populations, that may be problematic for a patient from a diverse population historically excluded from clinical research.[20]

Evidence based medicine (EBM) helps us to make the most from a wide range of research, but to make best use of this will often take a GP explaining choices to match individual need and circumstance. The extensive training of GPs ensures a familiarity with a very broad range of clinical presentations and equips them to join the dots holistically for the patient in front of them.

Uncertainty and risk

GPs have distinct expertise and experience in managing uncertainty and risk associated with the continuous care they provide.

GPs need to be comfortable at times with not being equipped with all the answers. Much of GP work is adaptive problem solving using different types of knowledge through a medical lens, and curiosity linked to clinical skills to find what is causing the patient's problem. This may be medical, psychological or social – and usually is all of these together. Professor Joanne Reeve describes this as remaining in a zone of uncertainty, balancing when to act with when to wait and see.[21]

Some patient presentations never coalesce into a traditional medical diagnosis. The organ-based specialist service can mean patients being passed around the system with multiple investigations.

While specialists discharge patients who do not appear to fit under their banner, GPs have an enduring role, managing the consequences of illness – diagnosed or not – in their patients' long-term interests.

One of the key roles of a GP is to use these multiple skills and medical knowledge to simultaneously manage many types of risk. For example, patients frequently present with symptoms that may be undifferentiated, perhaps early in an illness and not necessarily specific to any one condition. GPs are trained to establish if a symptom represents illness that is mild, self-limiting, or even a sign of a life-threatening condition. Experienced GPs are highly effective at picking out who needs to be further assessed or admitted. Where a GP is satisfied that a patient is not unwell or deteriorating, they may monitor progress, rather than make unnecessary use of investigation and treatment.

GPs have a professional "gut feeling" of something "not being right". This has been described as both a sense of alarm and a sense of reassurance: the uneasy feeling about a possible adverse outcome even without specific indications, and also the secure feeling about the further management of a patient's problem, even without a certain diagnosis.[22]

GPs serve patients, the wider NHS, and the taxpayer by holding the risk in the community.

The importance of these professional attributes has disappointingly not been reflected in the workforce changes in recent years. The way GPs are trained through an experiential apprenticeship helps learn the skills and build confidence to take on managing risk. No other professional group can adapt, flex and problem-solve in the way that GPs do. GPs endeavour to avoid overdiagnosis, over investigation and excessive use of resources when the chance of serious pathology is low. Understandably, not all other clinicians are prepared to handle this type of "risk taking" as it can leave them feeling exposed. Skilful triage and unhurried consultations can mitigate risk as much as possible by using time, safety netting and building on continuity and trust with patients. Every day GPs are responsible for a large number of decisions, helping their patients navigate all sorts of risks. Within such an environment, it is remarkable how few negative outcomes occur.

NHS GPs also hold a large amount of financial risk on behalf of the service. Besides providing services and patient care, GP partners hold the responsibility and liability associated with the running of a practice; managing practice staff, the finances, and the administrative work.

Building relationships and continuity of care

Through confidential trusted partnerships with their patients (characterised by empathy and mutual trust, without bias or judgement), GPs provide evidence informed personalised care in the community in an accessible way.

One unique selling point of the GP is relationship-based care, defined as 'care in which the process and outcomes of care are enhanced by a high-quality relationship between doctor and patient'.[23]

Former Chair of RCGP Professor Martin Marshall stated, "Given this evidence, if relationships were a drug, guideline developers would likely mandate their use."[24]

GPs are trained and experienced in developing consulting skills that build therapeutic relationships, taking time to understand the whole person, their community, and what might be important to them. Workload pressures put a strain on building this rapport. Over half (51%) of respondents to the 2024 RCGP Scotland GP Voice tracking survey reported that they did not have enough time during appointments to build the patient relationships they need to deliver quality care.

It should be noted that highly trained generalists can also build trust rapidly, making useful connections even in single consultations, meaning that relationship-based care is still a facet of GPs working on a sessional basis or in Out of Hours services.[25]

General practice is one of only a few parts of the healthcare system where we may be invited deep into people's lives – sometimes for the whole of their lives. Patients want to know that their clinicians will engage emotionally, that they regard their problems as valid, and are committed to finding a solution.[26] Research has found that patients search for clues to reassure themselves of their clinician's competence and caring.[27]

Patient-centred care is another valued element of GP care. Putting patients at the centre of their own healthcare has been shown to have positive effects on patient satisfaction and may reduce risk of litigation.[28]

Building rapport in practice

"Something that I really value is my GP is not afraid to say I don't know. There is a lot of psychological safety in that. He's quite happy to go away and look up something he doesn't know – he doesn't pretend he has all the answers and he is not afraid to admit that to me. I think that is really important because it shows he is willing to investigate. While that may leave you with a sense of uncertainty it also leaves me with a sense of confidence that I matter enough for the doctor to go away and do their homework."

Member of the RCGP Scottish Patient Forum

RCGP supports the Chief Medical Officer in his endorsement of Realistic Medicine and enabling careful and kind care. GPs are ideally placed to implement the pillars of Realistic Medicine, which include listening to patients to understand their problems, ensuring they have the information required to make an informed choice, and sharing in decision making for a personalised approach to healthcare. If people are fully informed about the risks and benefits of their treatment options they choose less treatment, or more conservative treatment.[29]

One of the most important aspects of GP care is the contribution of relational continuity of care to the quality and cost effectiveness of care. Relational continuity of care prioritises a long-term relationship between patient and doctor and is particularly impactful for chronic disease management and complex health needs, mental health care, and for tackling health inequalities.[30]

RCGP Scotland's 2023 GP Voice tracking survey of members found that delivering continuity of care was the third most selected motivating factor for working in general practice, following working as part of a team and spending time with patients. Good relationships and mutual trust give GPs the confidence to do what they do best.

Trust forms the bedrock of the patient-doctor relationship, and GPs describe the importance of that sense of responsibility and accountability to their patients, which helps to retain and recruit to the GP workforce.

Continuity of care can hold universal benefits. While recognising that not every patient will value clinical continuity, for many patients these meaningful connections are key to building trust and to better health outcomes. The evidence base for the positive impact of continuity of GP care is significant:

- Lower death rates[31 32]
- Better quality of care, for example, in earlier identification of patients at risk of cardiovascular events who would benefit from statins,[33] suspected meningitis in children,[34] better condition control with patients with diabetes,[35] and fewer hospital admissions and episodes of delirium for patients with dementia[36]
- Reduced admissions to hospital, particularly for older patients with ambulatory care sensitive conditions (conditions for which effective management and treatment should limit emergency admission)[37 38]
- Reducing health inequalities[39 40 41]
- Reduced attendances at emergency departments[42 43 44 45]
- Better uptake of advice about lifestyle and preventative medical advice, such as screening and vaccination[46 47]
- Better patient satisfaction[48 49 50]
- Higher level of trust between patient and clinician, reducing anxiety and enabling earlier symptom disclosure[51 52]
- Less complaints and litigation[53]
- Reduction in workload. A major study in England found that when patients were able to see their regular doctor for a consultation, they waited on average 18% longer between visits[54]
- Lower costs across the whole health system[55 56 57]
- Less overuse of medical procedures[58]
- Better following of medical advice and prescribed medication, and therefore less waste[59 60]
- Reduced risk of patients becoming 'lost' between clinicians[61]
- Better GP job satisfaction

Continuity of care is especially impactful for vulnerable groups such as trauma survivors, the elderly, marginalised communities, and those impacted by socio-economic deprivation. The Scottish Deep End Group describes how continuity of care allows for incremental relationship building, and for those patients who struggle to trust, this becomes intrinsic to the care given.[62] Despite this wealth of benefits, embedding continuity of care into everyday GP practice in Scotland has been underprioritised. RCGP Scotland's 2024 GP Voice tracking survey found that under half of GPs (48%) felt they were able to deliver continuity of care which meets their patients' needs.

The growing workload pressures in general practice have meant patients face longer waiting times, to which decision makers often respond with actions that favour speed of access.

While the growing mix of multi-professional staff holds many benefits, general practice teams have not had sufficient, protected time to come together to develop team relationships or devise approaches to improve their services.[63] This can increase the risk of care fragmentation, and patients slipping through the gaps when no individual clinician has oversight.

A vision of the future where patients have the ability to consult with their trusted GP has many benefits to patients, GPs and the system. Transactional, industrialised medicine is not good for patients or the efficiency of healthcare. Patient care and their real lives are too complex to be reduced to a checklist that anybody can follow. In fact, a poorly risk managed protocol is likely to draw more inappropriate referrals into the system.

If we are going to achieve the goals of caring, patient-centred, and realistic medicine, there is no substitute for an unhurried consultation with your GP.

Striving for equity

GPs work at the heart of their communities, striving to provide comprehensive and equitable care for everyone, taking into account their health care needs, stage of life and background.

Community cohesion in practice

"When I got married and started having children, general practice was a real source of comfort and knowledge, and a sense of community. Then, the health visitor was based in the practice, and they held meetings for women about to deliver at the same time. The GP knew me and my family… It was very much a family doctor; she knew everyone and what they were doing. If we lost GPs, we would lose so much of that community cohesion. It's about a sense of belonging."

Member of the RCGP Scottish Patient Forum

GPs have the privilege of being a trusted member of their community. High-quality general practice has an important role in improving population health and reducing or mitigating health inequalities, but it can only fulfil this role if adequately resourced, with a sufficient workforce distributed according to need. Inequalities utterly dominate Scotland's health landscape, with stark and unfair outcomes in health and wellbeing across the population, and life expectancy now falling for the most socio-economically deprived.[64]

A literature review of Scottish Government policy on reducing health policies since devolution in 1999 found twenty policies that recognised general practice's importance in this space.[65] The report found an implementation gap between policy ambition and reality on the ground, with only four of the twenty interventions ongoing, and with uncertain long-term futures.

Avoidable mortality is rising, with the leading causes of deaths that were either preventable or treatable are consistently cancers (29%), diseases of the circulatory system (25%) as well as alcohol and drug related conditions.[66] These are the everyday work of Scottish general practice, especially in deprived areas.

In 1971 GP Julian Tudor Hart first defined the inverse care law as how the people who most need healthcare are least likely to receive it. The inverse care law has been shown to manifest in general practice in Scotland both in the distribution of resources and within consultations. Despite higher levels of need in the most deprived areas, the core general practice-employed workforce is smaller than in the most affluent areas. GPs and their teams in the most deprived areas experience higher stress, lower patient enablement and worse outcomes in practices in disadvantaged areas.[67] RCGP Scotland and the Scottish Deep End Group have campaigned for fairer general practice provision in the most disadvantaged communities in Scotland in order to recognise the exceptional potential general practice has to address health inequity.[68]

Many public health interventions from governments rely on, or benefit from, substantial engagement with general practice. GPs serve as primary guardians of preventive healthcare.

With the GP's position set in the heart of communities, providing care over the long term, they are ideally placed with the data, skills, relationships and insight to understand the local factors that drive missingness, exclusion, and reduced life expectancy.

Leading teams

GPs work in, connect with and lead multidisciplinary teams that care for people and their families, respecting the context in which they live, aiming to ensure all of their physical and mental health needs are met.

The development of the multi disciplinary team (MDT) in general practice has been a major primary care reform implemented by the 2018 GMS Contract. It aimed to promote long-term sustainability of the service and easing pressure on GP workload. Almost 5,000 new WTE staff within the extended MDTs have been recruited since the rollout of the new contract.[69]

The intention has been for clinical workload to be appropriately shared out, which can help GPs have the headspace to deliver holistic, relationship-based care to patients with the most complex needs. The GP role remains the lynchpin of expanded teams, holding the ultimate clinical responsibility for patients. Many GPs take on leadership roles in their teams, providing supervision, and training opportunities. GPs are relied on for support and advice in risk management and clinical decision making. A national evaluation of over 200 new models of care pilot projects supported by the Primary Care Transformation Fund from 2016 to 2018 found a perceived increase in GP workload because of the need for training and clinical supervision of new members of the multidisciplinary team.[70] It should also be recognised that a GP can only be working at their best with the right staff around them, working in the right ways and focusing on the right things.

It is a strength of generalists that they can position themselves with colleagues and patients: sharing knowledge, sharing decisions, asking for and integrating the perspectives of others.

However, analysis of progress of the 2018 GMS Contract has found many challenges to effective implementation remain that must be addressed if transformation of primary care in Scotland is to become a reality.[71]

GPs also played a pivotal role in leading their teams through the COVID-19 pandemic response. In this time of national emergency, practices remained open, continuing to provide care to patients, alongside maintaining Out of Hours working. They adapted to a rapidly changing and extraordinary landscape in healthcare, using their skillset as generalists to continue to provide person-centred care, to lead the practice teams in anxious and complex times, and to bear new levels of risk and responsibility. GPs were instrumental in staffing COVID-19 pathways, efficiently rolling out the vaccination programme, and providing non-COVID-19 services to keep patients out of hospitals where appropriate.

Wider contributions

As consultants in general practice, GPs can contribute to healthcare in many other ways beyond the GP surgery. They may work in local, regional, and national medical leadership and commissioning roles, undertake research and provide education, work in extended clinical roles or provide 24-hour, 365-day care within organisations who cover patient care outside standard GP opening hours.

General practice provides a 24/7 service for its patients. Patients rely on good care during the Out of Hours period of 1800 – 0800, weekends, and public holidays. **Out of Hours services** benefit from the leadership of GPs for the highest quality of clinical care in this often pressurised and undifferentiated environment. Here, the GP skills of risk management and effective communication help to protect patients and the system from unnecessary admissions.

Within practices and as part of **GP Quality Clusters,** GPs can carry out important quality improvement projects to improve service delivery and patient outcomes. The enabling support for this work is currently inadequate in many cases and does not meet the expectations set out in the National Cluster Guidance.[72] This conclusion was confirmed in the March 2025 Audit Scotland report on progress since the 2018 GMS Contract and we need to allow GP Quality Clusters to reach their potential to continue to improve the quality of patient care.

A consistent approach to the delivery of required support and a review of the funding available is necessary if GP led quality improvement work is to flourish.

GPs are also involved in many levels of **education in general practice.** The system relies on GPs as the source of teaching at undergraduate level and in training as an experiential apprenticeship, learning within the practice about managing undifferentiated presentations, being comfortable with uncertainty, building relationships and holding risks – the skills we have set out in this paper.

It is common for GPs to have **extended roles in a specialty,** such as orthopaedics or dermatology. These roles bring additional expertise to a practice and have the potential to be used more to help with waiting list management. Bringing the generalist view to specialist services, and vice versa, can only help patients.

With the prospect of further services to be placed within primary care there is a need for more **research within primary care** on which changes improve effectiveness of services. Scottish academia produces the highest quality research, and the Scottish School of Primary Care has contributed to Scotland's position as a world leader in primary care research. Unfortunately, funding in recent years has been project specific and we ask for multi-year awards, taking a capacity-building approach. It is important we support academic fellowships to develop the next generation of researchers and maintain Scotland's reputation.

One of the advantages of general practice is its flexibility to meet the needs of different patient communities.

In remote, rural and island areas of Scotland GPs are highly valued by their communities due to their unique ability to deliver generalist skills and understand their local area needs. The challenges of general practice are often exacerbated in these areas, with additional barriers to recruitment and infrastructure issues. Implementation of the 2018 GMS Contract has been particularly difficult in rural areas. All policies should undergo a process of 'rural proofing' to protect these areas from unintended consequences.

These are some of the roles that GPs are carrying out to support patients and the system in Scotland, but this list is not exhaustive. NHS Scotland would benefit from increased numbers of GPs and having their voice acknowledged and supported properly.

Conclusion

To be a GP is to be part of a rewarding profession. GPs accumulate extensive training, knowledge, and communication skills to help our patients navigate the medical world, building trust through the therapeutic relationships that develop. It is a privilege to work with our patients over time and bridge the space between medical care and the human condition.

General practice has been the cornerstone of our NHS since its inception. Today it is integral to the vision of a healthier, more equitable Scotland. Its continuous evolution to date speaks to the flexibility of the profession.

The RCGP definition of a GP sets out the framework by which we can begin to explain the vast contribution of general practice to policy makers. This is not just about the value of general practice and the sense in investing in it, but also to demystify the elements that aren't as simply measured or understood. There are some things that only GPs are trained and able to do – and those are the very things at risk when workload becomes unmanageable, medicine becomes more industrialised, or patients become further removed from their GP.

The Scottish Government has stated its intention to deliver more care in the community, and this is welcome. Realising this ambition will take a shift in the focus towards primary and community health and care across domains of leadership, culture and implementation. The King's Fund warns that partial or short-term implementation of policies or initiatives will not be sufficient.[73]

There will always be a need for general practice, but if we don't change course, the form it takes is open to question. If patterns of workforce decline and underinvestment continue, market forces could direct the growing patient need away from the family doctor and towards a less efficient and holistic skill mix, over industrialised mega-practices or private providers.

General practice is the bedrock, the cornerstone, the heart of the NHS. Whatever the metaphor – general practice needs proper support, recognition and investment if we are to preserve the NHS for future generations.

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RCGP Scotland represents a network of around 5,000 doctors in Scotland aiming to improve care for patients. We work to encourage and maintain the highest standard of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

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