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LETTER TO THE EDITOR

Population Health Across Contexts: Reflections From UK GP Training

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TO THE EDITOR:

Carek et al's insightful study captures the extent of variation in how US family medicine residency programs get their residents involved with population health information and panel management.[1] This article provides a welcome spur to global reconsideration of how training programs instill a sense of responsibility for a patient group—especially how continuity of patient care influences that learning.

General practice (GP) training programs in the United Kingdom—our version of family medicine residency programs—are infused with population health through various mechanisms.[2] Trainees normally are attached to one GP surgery for 6 to 18 months and are urged to build a continuing relationship with their list of patients. Although the United Kingdom relies less on individual dashboards, the continuity experienced in placements offers a complementary path to cultivating a sense of ownership and accountability for patient care.

It is built not just through consultation but through involvement in reviews each year, via visiting people's homes, through safeguarding and multidisplinary meetings, and through quality and outcomes framework checks.[3] These practices may support habits of attentiveness that, in many contexts, work in parallel with tools like dashboards to build a fuller understanding of patient populations.

Crucially, patients themselves become de facto educators under this model. When a GP trainee encounters an individual with diabetes that is inadequately controlled for the third or fourth time, and behind it often lies a pattern of nonattendance or other underlying complexities, a different kind of learning takes place—a kind that ties together management of disease and social determinants of health. For instance, repeated consultations might gradually reveal deeper structural factors, such as financial hardship affecting dietary choices, transportation difficulties limiting regular clinic visits, or language barriers impacting medication adherence. Over time, these insights educate the trainee about how social and structural influences intricately shape patient outcomes. This situated, longitudinal interaction fosters a type of understanding that complements but does not substitute for quantitative panel measures. Patients are not merely data points but tellers of context, obstacles, and resilience.

Alongside patients, UK national services also offer population health learning experiences.[4,5] GP trainees rotate through local child safeguarding boards, community mental health services, and social prescribing initiatives. Such interagency interactions introduce them to the wider system that affects health outcomes. While often considered supplementary to clinical training, these experiences impart knowledge that sustainable health improvement hinges on multisectors working together—something reflected in US initiatives to bring together coordinated care teams and address upstream drivers.

Additionally, population health education can occur organically out of quality improvement (QI) activity.[2,4] In the United Kingdom, trainees regularly complete QI projects based on local-level data—for example, increasing take-up of cervical

screening among hard-to-reach communities or improving flu vaccination in residential homes. The projects provide a microcosm for population health learning: detecting variation, making change, and assessing impact. They are teaching systems thinking, encouraging stakeholder engagement, and sustaining improvement challenges focused on equity—all key skills for contemporary primary care.

An added depth is in how these experiences contribute to professional identity. When trainees interact repeatedly with the same group across a period of time, whether through QI, continuity clinics, or home visiting, they start perceiving themselves not only as caregivers, but as guardians of community health. This evolving self-concept—from solo clinician to population champion—appears to be one lasting effect of continuity-based learning environments.

Crucially, much of this learning takes place not in consultation rooms, but between them. Discussion of a patient who has defaulted or meetings with voluntary organizations over issues of food access are moments of reflective application that deepen insight. These relational, boundary-crossing encounters make the data human and add depth of humanity to what would otherwise be abstract scores of risk. There, trainees start to observe health as a social process—a process influenced not just by biomedicine, but by belonging, access, and context. This awareness has a powerful emotional resonance, and it is there that seeds of long-term advocacy are often sown.

There is much potential along these lines for transatlantic dialogue among educators, trainees, and curricular programs. While the United States is developing panel data and predictive analytics, the United Kingdom is intensifying its priorities to address health inequalities, prevention, and community integration. Concrete opportunities for collaboration might include joint virtual workshops between UK and US trainees, where continuity-based patient scenarios from the United Kingdom are explored alongside population data dashboards used by US residency programs. Another initiative could involve creating transatlantic QI projects, enabling trainees from both contexts to compare approaches to common health issues such as vaccination coverage, chronic disease management, or health inequalities. Additionally, both nations could collaborate on a shared digital platform that combines anonymized longitudinal patient narratives from UK training with US-generated panel health data, facilitating joint trainee analysis and discussion of complex cases from multiple perspectives.

A further innovative option would be establishing transatlantic trainee exchange placements, with short-term virtual or physical rotations allowing UK trainees to directly experience data-driven population health analytics in US settings, while US trainees participate in UK-style community-focused continuity experiences. Such structured initiatives would enable both systems to exchange practical methods and deepen understanding of each other's educational strengths. Common discussion would help speed up innovations, minimize blind spots, and create technically competent, human-focused, and contextually astute population health skills.

It is likely that if medical educators across the Atlantic are striving to equip trainees to think about populations, the most important question is not necessarily what information they are given, but rather what kind of mindset they acquire. Whether fostered through data dashboards or long-term continuity, ownership is ultimately about seeing patterns, building trust, and driving meaningful improvement in patient and community health. This shared purpose offers a powerful opportunity to align our systems.

REFERENCES

1. Carek SM, Brown C, Neutze D. Understanding population health management practices among family medicine residency programs. *Fam Med.* 2025;57(6):417-423.
2. Promoting Continuity of Care in General Practice. *Royal College of General Practitioners.* 2011. https://www.rcgp.org.uk/getmedia/aeff056b-da14-40ad-8e6e-66ac9388a461/RCGP-Continuity-of-Care.pdf.
3. Sell J, Riley TD, Miller EL. Integrating quality improvement and community engagement education: curricular evaluation of resident population health training. *Fam Med.* 2022;54(8):634-639.
4. How to develop and maintain a role in population health and health inequalities. *Royal College of General Practitioners.* 2024. https://www.rcgp.org.uk/your-career/gp-extended-roles/maintain-develop-role-population-health.
5. General practice (GP) and public health dual (PH) certificate of completion of training (CTT) programme. *National Health Service England.* 2025. https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/gp-and-public-health-dual-certificate-of-completion-of-training-programme.