
## Dirk Devroey

Dean of the Department of Family Medicine and Chronic Care, Faculty of Medicine, Vrije Universiteit Brussels (VUB), Belgium; Member of the Scientific Committee for the 28th World Organization of Family Doctors (WONCA) European Conference



**Citation:** EMJ. 2023; DOI/10.33590/emj/10304915. https://doi.org/10.33590/emj/10304915.


**Q1 With your vast experience in the disciplines of primary care and family medicine, could you tell our readers what initially attracted you to specialise and practice in this area?**

I undertook my university courses at University Hospitals, and at several other hospitals in Belgium, but I also had some training in general practice. From the start, I felt much better in these small practices that were outside of the city, and very close to the patients. It was a very diverse experience, as the general practice experience is not about one specialism. The combination of diseases also very much attracted me, as well as the very close long-term contact that the general practitioner (GP) has with patients. This attracted me so much that I started a practice in the very small town where I was born and lived as a child, so I still have patients who knew my mother and father, and were there when I was born, and who even knew me when I was born! So, all these aspects of being very close to the patient attracted me so much that I never doubted my choice of primary care as a GP.

**Q2 Do you feel that there are any key misconceptions about the specialism of primary care? What impact do you feel these misconceptions can have?**

Before I started my university studies, the misconception was that GPs were those who could not specialise. They were the ones who had to choose to be a GP because they thought that they were not clever enough, or they could not arrange a place for specialisation, and so on. I think that is a very important misconception. During my studies, I was not the best student in my year, but other very good students, who were much cleverer than I was, chose to be GPs when they had the opportunity to specialise, but did not want to. They made a positive choice to be a GP.

Another important misconception is that we as GPs are there to deal with very common diseases, the easy diseases, even the self-curing diseases; or that we are there to write sick notes, to do the admin, or to do blood tests. I think that is a very important misconception, because we are here to manage complex patients with multiple comorbidities, and the complex patients who are very old, and cannot go to the hospital anymore. Currently, we deal with patients with complex diseases who cannot get appointments with specialists because there are not enough specialists, or the waiting lists are too long. I think this makes our profession as a primary care doctor very, very attractive now, although very challenging.

**Q3 In 2022, you co-authored a paper, entitled 'Diabetes and Cardiovascular Diseases Risk Assessment in Community Pharmacies: An Implementation Study'. Can you enlighten our readers about some of the key findings from the study of this pilot project?**

This was a part of a bigger study where we tried to find out how we could better organise care for outpatients with pharmacies. First, we tried to study self-testing, such as which kind of self-tests were interesting for patients, and what role the pharmacists could play. We

had to do research with pharmacists, GPs, and psychologists. However, this was not that successful, so we had to try to find another way of studying diabetes and cardiovascular risk assessment in community pharmacies, and to find out how it could be implemented in pharmacies.

The study started several years ago but was published in 2022. With the COVID-19 pandemic, COVID-19 vaccinations, and COVID-19 testing, pharmacists have massively progressed in their role in primary healthcare in Belgium, and in other European countries as well. I think that this has also contributed to the place that the pharmacist could take in primary healthcare, especially in delegating certain tasks from GPs to pharmacists. The results of this study opened the door for collaboration between both.

**"We especially looked at their mental health, and traumatic stress experienced during the hunger strike."**

I must admit that COVID-19 has opened a lot of doors, and that without the study, the same doors would still have been opened. We started this study several years before COVID-19, but we are happy with where we are now with regard to the tasks that pharmacists can now do in Belgium. In other countries, such as France and the UK, pharmacists already did many more of these tasks than the pharmacists did in Belgium, where doctors were very protective of primary care: no other people, no nurses or pharmacists, could interfere with their primary care. However, these doors were opened with the study.

**"My focus will be to try to give family medicine a predominant place in healthcare in Belgium."**

**Q4 You also recently contributed to a fascinating article entitled 'Between Sympathy, Fascination, and Powerlessness. The Experiences of Health Professionals During the Medical Monitoring of a Hunger Strike Among Undocumented Migrants'. Can you explain to our audience the importance of a study like this, and how it relates to larger issues faced by primary care physicians, such as patient non-conformance and physician mental health?**

This is very complex question, and it was also a very complex study that was part of a PhD study on undocumented migrants on hunger strikers. There is a very unique and challenging situation in Belgium, where undocumented people embark upon hunger strikes to attain documents, or at least to get authorisation to stay in the country. One of the ways to stay in the country is to get so sick that you need medical treatment, and so undocumented migrants will try hunger strikes to get sick, and to get these documents. There are many personal and political views on this phenomenon, but with this study we tried to have a medical view. These people risk their lives and their health to get these documents and there were many problems that we encountered when trying to monitor them. We never tried to influence the people, the politics, or the hospitals. We were simply just trying to help the people. They could irreversibly damage their health, and we did not want that.

The first time I encountered undocumented migrants was in 2009, when we had about 150 hunger strikers in one of the car parks of our university. We had to organise the medical care for these hunger strikers. But we also learned more about these people. We understood what the problem was, and how they were driven into this situation.

When trying to help them, we found that there were no guidelines. When should someone stop the hunger strike? What kind of hunger strikes were there? Were they not eating or drinking, or were they only drinking sugar water and so on? It was very interesting to find out there were no guidelines, and that there were only guidelines for prisoners, where they were obliged to take some food and drink. We never forced the hunger strikers to eat or drink, but we tried talking with them to help them. From there, we tried to start developing guidelines surrounding how to manage the people who were on hunger strike.

Secondly, we did follow-up studies to see what had happened to the individuals 5 years after the hunger strike, in a social context, but also in a medical and mental health context. In this study, we especially looked at their mental health, and also the traumatic stress that they experienced during the hunger strike, and in the period after it. It was so fascinating, but we are very happy that this is no longer a technique that is being used by undocumented refugees. We are still trying to take care of them as much as possible.

## Q5 As a researcher and practitioner in the primary care field, where can we expect to see your focus lie in the coming years?

I will turn 60 in November, and I am now Dean of the Faculty of Medicine at Vrije Universiteit Brussels (VUB), which I am very honoured by. I am now in charge of all the personnel in the medical faculty. At the University Hospital, we have a Chief Executive Officer, but I also take part in the governing of the hospital. It is a recognition that GPs can also have an important position in the faculty, and in a university.

My focus will be to try to give family medicine a predominant place in healthcare in Belgium, and maybe in the world, as there are still so many problems to solve. But, at my age, I think it is important to stimulate young researchers, and GPs in particular, to try to conduct high quality research in primary care, and also in collaboration with other specialties. I think it is important that we do research on integrated care with all kinds of specialists, where primary care also has its place. It is important that I can stimulate this in young researchers, and also encourage young, high-potential students to get a PhD. This is important in primary care, because we still do not have enough young people with PhDs.

I would also like to encourage these young researchers to get funding for their work. I was funded by the University, so I did not have external funds; however, I think that things have changed, and we need now to get the external

funding, which is important for your place at university, and in the faculty.

The healthcare system is important, and we should keep the patient-centric approach in all the work that we do. The patient is still the most important thing in medicine, but for me, what is also important is the sustainability of medicine: the planet's health, global health, and our carbon footprint in medical industry, especially the pharmaceutical industry. I think the importance of this can sometimes be underappreciated. At the World Organization of Family Doctors (WONCA) conference, I had the opportunity to discuss this with a lot of young colleagues, and I am happy, and hopeful, to hear that sustainability is important to them. Perhaps in the future we will drive more of our research to look at sustainability.

**Q6 You played a role in the organisation of the 28th WONCA European Conference. Can you talk about the ways in which WONCA aims to empower patients and create a dialogue aimed at optimal healthcare benefits?**

For one, I think that patient-centeredness is one of the most important things. Patient-centeredness has always been important as an approach to healthcare. I have participated in WONCA for 30 years, and 30 years ago decision-making was mostly done by the GP alongside the specialists. However, the patient can now take part in that decision-making. I think that is one of the most important things that WONCA tries to stimulate. I also think that health education and promotion are important. Patient education to improve health outcomes is one of the focuses, especially as chronic conditions are becoming more common. Lifestyle choices are important for patients, and these are decisions that the patients can make themselves. I think that WONCA is very open in discussing these topics and this goes fluidly with the shared decision-making.

I am very happy that we have already discussed hunger strikes, as WONCA is also advocating patient rights, and plays an important role. Health literacy is another one of the important things that WONCA tries to promote, and recognises as an important part of patient empowerment.

**Q7 Over the years that you have been practising as a primary care physician and researcher, how have you seen the field evolve in terms of changing practices, and advancements to the technology used?**

I remember my first personal computer: it was a huge machine. It had two hard drives, and each hard drive had a 20-megabyte capacity. But I still learned a lot on that machine. During my first 10 years as a GP, I also worked for our National Institute for Public Health, which is now Sciensano in Belgium, and I also had experience in public health. The introduction of laptops, which we could take with us to patients' homes, and to the homes for the elderly, was important. But I remember the first day that I worked as a GP. There were no mobile phones. Can you imagine that? When we had an emergency, people had to try to call from the practice to the patient where we were. Otherwise, they had to call the next patient to tell us that there was an emergency call. Communication is the first thing that changed with mobile phones and the introduction of laptops.

Then, the Internet was very important for patient empowerment, health literacy, and so on. But the Internet also changed our way of working. Now we are prescribing medication via the Internet, we are getting money from health insurance via the Internet, we are working paperlessly, and payments are paperless. Normally, I do not print out anything during my consultations. The Internet has played an important role.

Very recently, in my timeline anyway, we have seen the growth of mobile health, and now I see artificial intelligence (AI) here, in my University Hospital. It is used in almost every service, especially in radiology and diagnostic processes. AI is also used by students writing their papers. I think this is one of the new challenges.

AI is really a challenge for the medical world, because people can find things on the Internet. What will the limits of AI be? Things are just getting faster, and it is a pity that I am already 60 years old. I cannot imagine where we will be in the next 60 years. Sixty years ago, we would not have believed that we would communicate by a small screen, no matter where we are in the world. But this is very common now. Children who are 6 years old can do this.