An Interview with Joseph Parks, MD

Dr. Joseph Parks serves as the Chief Clinical Officer for the Department of Mental Health as well as the Director for the Division of Comprehensive Psychiatric Services for the State of Missouri Department of Mental Health in Jefferson City. He also serves as a Clinical Assistant Professor of Psychiatry at the Missouri Institute of Mental Health and University of Missouri in Columbia, and as the President of the Medical Director's Council of the National Association of State Mental Health Program Directors. Dr. Parks practices psychiatry on an outpatient basis at Family Health Center, a federally funded community health center established to expand services to uninsured and underinsured patients in the Columbia area.

Dr. Parks has authored or coauthored a number of original articles, monographs, technical papers, and reviews on implementation of evidence-based medicine and pharmacy utilization management in behavioral treatment programs, and, in 2006, he was awarded the American Psychiatric Association Bronze Achievement Award for a program controlling pharmacy costs by improving prescribing practices.

CS: **What decisions did you make regarding your career that led you to become the medical director of Missouri?**

JP: I have had two key educational experiences that led me to my current position. Halfway through the second month of my first year in residency training, our training director called a meeting to inform the other residents and myself that he would not be able to pay our salaries for that month and did not anticipate being able to pay salaries for the next two-to-three months. The program personnel had made mistakes regarding authorization of inpatient stay, billing, contracting, and labor practices, which had resulted in the program becoming insolvent. This taught me that I would have to learn more than diagnosis, psychotherapy and psychopharmacology. If I wished to provide mental health services to patients, I would have to learn about administrative and fiscal matters and what it takes to maintain the systems that support the provision of care.

When I completed my residency in emergency psychiatry, I requested work on the University clinical research unit, but my faculty adviser recommended instead that I apply to become medical director of a local 400-bed state psychiatric hospital. I said that I didn't think I would be considered qualified as I've never had operational responsibility for even a single hospital unit. My advisor pointed out that he thought I would be hired because the hospital was a disaster. If that were true, I said, then why should I seek the job? My advisor pointed out that I had not learned the lesson of regression to the mean: the hospital was in such bad shape that it was unlikely to get any worse, and since I was so junior in my career, if I could not show improvement I would not be blamed. He went on to point out that if the hospital became even somewhat better, I would be viewed as a success. I took the job, he turned out to be correct, and I learned that the best opportunities are most often found where the problems are the greatest. I've been working in the public mental health system ever since.

CS: **What does your typical workday look like?**

JP: What I do on a workday varies widely. Some days are a series of fifteen-to-sixty minute meetings and conference calls with directors of community mental health centers, the department chief financial officer, heads of other state agencies, middle management personnel responsible for program development and certification, speaking to reporters, responding to legislators who have received complaints and requests for services from constituents, meeting with local community groups regarding mental health services they are getting or would like to get, reviewing cases of individual patients that are particularly complicated or have gone poorly, as well as a wide variety of other topics and issues. On other days, the entire day is taken up by one or two long meetings involving strategic planning or sitting through legislative testimony. I travel out of town at least once a week to hospitals, community mental health centers and healthcare provider meetings. I typically work a ten-to-eleven hour day and will have meetings during meal times two or three times a week.

CS: **Do you still see patients?**

JP: Ever since completing my fellowship I have continued to do direct patient care. For the last eighteen years I have seen

patients for at least half a day a week. For the first ten years I did medication services at local community mental health centers or university clinics. Doing direct patient care has been very helpful in terms of keeping my skills current, providing me with a change of pace, and keeping the focus on what the real point of the whole enterprise is—good clinical care. It also has been invaluable in informing my administrative work. Any policy decisions or mandates that I make I have to live with, too, so I'm able to see to what extent the expected results of programs and policies actually occur in the community. The latter has been sobering.

For the last eight years I've been providing psychiatric diagnostic and medication services in a primary care clinic. I find that I'm able to provide much better psychiatric care in a primary care setting than in a community mental health center or university clinic. Laboratory studies can be drawn immediately, and EKGs done and read without delay. Getting injections for patients is no problem. All my patients have immediate access to primary care. The care is better coordinated since both the psychiatric and the primary care information are recorded on the same medical record. I am much more attentive to medical causes of behavioral and psychiatric symptoms. The primary care physicians I practice with are also much more sophisticated in diagnosing and treating mental illness prior to making their referrals to me, and they are more comfortable and accepting in working with patients who have severe mental illness. I believe that co-locating primary care and psychiatric services is probably the greatest opportunity to improve patient care that we currently have available.

***CS:* Why did you choose a career in psychiatry?**

JP: I didn't feel that medical school had left me adequately prepared to treat psychiatric illness and that more training had to be obtained. I'd gotten better scores and reviews in surgery, but was not interested in a specialty that would require me to do a few things extremely well or to stand in one location for a long period of time. I was attracted to the great variety of career options available in psychiatry, and basically, I just found it more interesting.

***CS:* What did you learn early on in your career that has turned out to be important or helpful to you?**

JP: In my second year after medical school a patient I had treated died of a ruptured ectopic pregnancy, and I was named in the lawsuit. This forced me to decide if I were going to let anxiety and fear about legal liability determine how I practiced medicine or approached anything else in my life for that matter. I decided that being sued is part of the American experience, and that if I did not wish to be sued I should move to Canada or Europe. If I were to continue to do important work in America, I should focus on doing the right thing as opposed to doing that which would minimize my legal liability. Basically, I thought that no matter what I did, I would be sued, and I would rather be in court, on the stand, explaining why I gave what I thought was good and proper medical care for a particular person at a particular time, compared to explaining why I gave care that wasn't necessarily the best, but that I thought at the time would keep me from being sued.

Also, somewhere around the third or fourth year of my career it became very clear to me that while I was pretty good at helping people, I was lousy at prognosis. I have remained increasingly unimpressed by my ability to predict who will do well and who will not. While this is humbling, it is helpful in that no matter how sick someone is, I do not lose hope in their ability to recover. I have seen too many people I was certain would crash and burn do extremely well.

Finally, approximately in the fifth or sixth year of my career I became impressed by the power of spending at least as much time focusing on what the patient has been able to do well or enjoy as much as discussing their symptoms and deficits. When we only review the symptoms and deficits we and our patients get a skewed, pessimistic view that is not the whole story.

***CS:* What advice would you give to residents who are considering a career in public psychiatry?**

JP: I would urge them to go for it. Public psychiatry is where the largest number of the most complicated and sickest patients is to be found. The pathology is more interesting and the opportunity to help people is greater. If there are behaviors that people carry out that no one else can understand or tolerate, public psychiatry is asked to step up to the plate, figure it out, and make it better. And usually we do. Given a decade or two to struggle with a difficult new syndrome or group of patients, we almost always find solutions to make progress.

I would also refer residents to the two lessons that I learned at the beginning of my career: 1) don't just learn about diagnosis and treatment, educate yourself about the administrative and funding systems that deliver and support healthcare services; and, 2) look for the biggest problem you can find because it is almost always the biggest opportunity to make a difference, as well as a means for rapid career advancement. Do something well that nobody else wants to do, and you will surely be rewarded.

***CS:* What has been the greatest disappointment in your career?**

JP: The greatest disappointment of my career is having to choose, on a regular basis, whether I will see two patients for

too short a period of time for them to really feel listened to, understood and cared for, or if I will see only one of them for a more adequate amount of time, and the other not at all. This is a painful and lousy choice, but it is the alternative I have to struggle with since I decided to continue working in the part of healthcare that has the largest number of patients with the greatest need. Limiting the number of referrals I accept so I can see the few for fully adequate amounts of time has not provided me with any relief; I still know all those other patients are out there who have never been seen but still need help. I make an effort to adjust the frequency and duration of my time with each patient so I can still make a difference in relieving their suffering and improving their functioning. I struggle to get the maximum benefit across the largest group of patients as opposed to the greatest benefit for a smaller group of patients. For instance, I believe that it's better to spend half as much time with two people who each improve by 60%, as opposed to spending twice as much time with one person who improves by 90%. It's an ongoing disappointment for which I have not yet found an answer. Even if I never met the other patient who never gets care, I still know that he is out there with untreated illness and that I could have seen him but chose otherwise.

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***CS:* What has been the greatest joy in your career?**

JP: The greatest joy in my career has always been when a patient I have treated, or another professional that I've worked with and mentored, tells me years later that what I had done made a difference for them. They usually mention a specific instance of something said or done that I had no idea had any benefit or impact at the time. We can never know with any certainty what, of the many things we do, will make a difference to someone else.

***CS:* What do you think are the major issues currently in public psychiatry?**

JP: The biggest issue is the general and increasing shortage of psychiatrists. Stigma has been greatly reduced in recent years mostly due to the newer antidepressants and antipsychotics being perceived as effective treatments for mental illness. I believe the stigmatization of an illness is driven more by a perception of the illness being untreatable than by a misunderstanding of illness etiology. The flip side of the reduction in stigma is the released pent-up demand for treatment of mental illness at a time when the actual supply of psychiatrists is shrinking relative to population growth. We are increasingly unable to staff hospitals and clinics. Eventually this will force either a marked expansion in residency training or a complete restructuring of how care is conveyed, so that it can be delivered without regular psychiatric involvement with most mentally ill patients. The first option would be extremely difficult in tough budget times, and the second option would require a dramatic change in the role of psychiatrists and reorganization of the usual systems of care.

The second major issue for public psychiatry is the premature death of our patients due to chronic medical conditions related to increased risk factors, the medications we prescribe, and inadequate access to good medical care. No one who dies prematurely of a chronic medical illness ever recovers from his serious mental illness, and the people we serve are dying twenty-five years younger than the general population. While 60% of psychiatrists report that they are screening for metabolic issues, review of insurance claims shows that only about 5% of patients on antipsychotics actually receive the recommended screening, let alone adequate treatment for their illnesses. In the CATIE study of patients with schizophrenia going to psychiatric clinics that were organized well enough to participate in a major research study, over 60% of the patients with hypertension were not being treated and over 30% of patients with diabetes were not being treated. How can we claim to be physicians when we fail on such basic measures?

***CS:* What do you think are the major opportunities for psychiatry over, say, the next ten years?**

JP: The opportunities are boundless. Demand for psychiatrists is up, and the supply is down. Society is increasingly looking to public mental healthcare to address new populations of peoples and conditions not previously viewed as mentally ill or psychiatric in nature. Major opportunities include: autism and maladaptive behaviors related to mental retardation, traumatic brain injury and posttraumatic stress disorder. Primary care physicians, along with those in other medical specialties, are increasingly aware of the high prevalence of mental illness among persons with chronic medical conditions and the degree to which it drives overall healthcare costs and outcomes. These three areas provide major opportunities for us as a profession and for individual young psychiatrists about to choose a particular area in which to develop their expertise.

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