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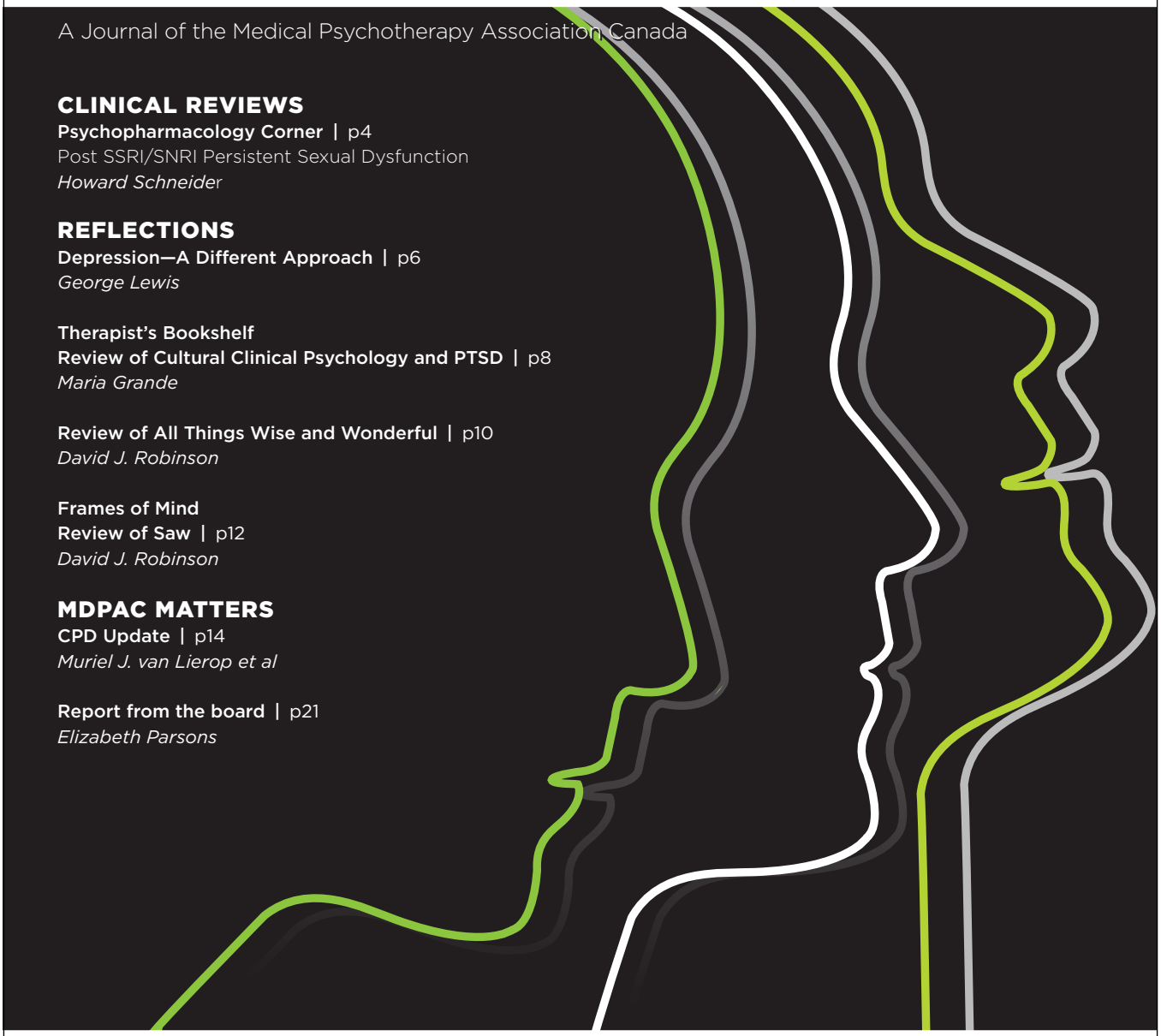

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MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

"ALL ART IS AT ONCE SURFACE AND SYMBOL. THOSE WHO GO BENEATH THE SURFACE DO SO AT THEIR PERIL. THOSE WHO READ THE SYMBOL DO SO AT THEIR PERIL. IT IS THE SPECTATOR, AND NOT LIFE, THAT ART REALLY MIRRORS. DIVERSITY OF OPINION ABOUT A WORK OF ART SHOWS THAT THE WORK IS NEW, COMPLEX AND VITAL. "

Oscar Wilde

Many themes are apparent in Wilde's quote; some of which are relevant to psychotherapy. Our work involves looking beneath the surface and reading symbols could indeed be described as perilous, perhaps more so during pandemic times. I admit that sometimes I don't want to ask the questions I know I should. Counter transference, perhaps less common with virtual visits, highlights the close relationship between therapist and client, between spectator and art. We continually mirror each other. Another theme of Wilde's is the complexity of art and life in general, and our diverse approaches and opinions on it. During the pandemic, we have had more time for introspection and observation. Although most of us would rather be spending more time living life than reflecting on it!

Not surprisingly, these themes are mirrored in this issue of the *Medical Psychotherapy Review:* moods, emotions, context, evil, and the complexities of medical treatment and understanding how and why things happen. Psychological issues are so important and foundational that they appear in almost all aspects of our lives; well beyond the confines of the therapist's office (or "virtual space" whatever form that takes). Our journal offers both clinical information for medical practitioners and opportunities for us to reflect on the artistic and broader aspects of psychotherapy.

In his regular column, Howard Schneider provides the latest updates on persistent sexual dysfunction related to SSRIs; medication use is one example of complexities of treatment. In our reflection section, we have two book reviews, a movie review, and a personal reflection. In her review of *Cultural Clinical Psychology for PTSD*, Maria Grande comments on the complexities of cross-cultural psychotherapy. This topic may broaden our conceptions of how we practice therapy and is important because Canada is becoming increasingly multicultural. Regular columnist Dave Robinson reviews a book as well as a movie for this issue. Somewhat awkwardly,

The MDPAC Mission is to support and encourage quality Medical Psychotherapy by Physicians in Canada and to promote Professional Development through ongoing Education and Collegial Interaction.

the book, *All Things Wise and Wonderful*, is written by me and, although not focused on psychotherapy, Dave points out its relevance to ourselves and our patients for understanding how and why things, such as COVID-19 occur (hint: it's complex). He reviews a somewhat creepy series of movies, the original being *Saw.* Dave points out much that is relevant to psychotherapeutic issues; indeed such issues are often more evident in those who choose hate, sadism, and evil (I told you the movie was creepy).

From creepy and complex, our reflections turn to sad and complex. I have written before about how much I appreciate the diversity of approaches in our organization.

Finally, on more practical matters, we have updates from MDPAC officials. Muriel van Lierop and the CPD Committee provide important information about changes to the Continuing Professional Development program; you may have heard hints about this already. Elizabeth Parsons delivers her final report as chair of the MDPAC board of directors. She emphasizes the importance of relational support during these challenging times. But despite the times and the perils of our profession, there is encouraging news about educational opportunities.

Thanks to all who contributed to this issue, with special appreciation for Vivian Chow who delayed her retirement from the committee to help with one more issue. We hope this journal is interesting and informative for our readers—feedback and contributions always welcome!

Grace and peace,
Janet Warren

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Post-SSRI/SNRI Sexual Dysfunction

Howard Schneider, MD, MDPAC(C), CCFP, FCFP

Abstract

A recent Health Canada Summary Safety Review warns about potential persistent, worsening, or even new sexual dysfunctional problems after an SSRI or SNRI is stopped. It found only rare cases of long lasting persisting sexual dysfunctional problems, and the authors do not make any claims about a causal effect between stopping an SSRI or SNRI and the development of persistent sexual dysfunction. Informing and developing a cautious collaborative plan with our patients may be the best approach until more definitive evidence and guidelines emerge with regard to post-SSRI/SNRI sexual dysfunction.

Introduction

On January 6, 2021, Health Canada released a Summary Safety Review: "Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)—Assessing the Potential Risk of Sexual Dysfunction Despite Treatment Discontinuation." After receiving a report from the European Medicines Agency's Pharmacovigilance Risk Assessment Committee, Health Canada reports that this triggered their review of the potential risk of persistent or worsening sexual dysfunction after stopping SSRIs or SNRIs (Health Canada, 2021).

Health Canada reports that they "could not confirm, nor rule out, a causal link between stopping SSRI or SNRI treatment and persistent sexual dysfunction." They found only rare cases of sexual symptoms persisting chronically after treatment was stopped. As such, their recommendation was that healthcare practitioners should explain to their patients that there is a potential risk of sexual dysfunction after the medication is stopped, which could possibly last weeks to years.

Health Canada considers the following as SSRIs approved for use in Canada: citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, vilazodone and vortioxetine. As discussed in the last issue of the Medical Psychotherapy Review (Schneider 2020), vilazodone and vortioxetine may be better considered as multimodal antidepressants. Health Canada lists the following as SNRIs approved for use in Canada: desvenlafaxine, duloxetine, levomilnacipran and venlafaxine. They note that in 2019 there were 37 million prescriptions in Canada for SSRIs or SNRIs filled, although it is not specified how many patients that actually represents.

Approach to Post-SSRI/SNRI Sexual Dysfunction

Any irreversible adverse effect of a psychiatric medication is a challenge for the practitioner. The potential metabolic and neurological irreversible adverse effects of antipsychotics, for example, are recognized and practitioners take care in choosing to use an antipsychotic and monitoring the patient, including weight, sugar levels and abnormal movements. What approaches should be taken with regard to SSRI and SNRI antidepressants, given the recent Health Canada Review?

If we examine Stahl's Sixth Edition of the Prescriber's Guide (Stahl, 2017), for a typical SSRI such as sertraline, in the Notable Side Effects section the following are listed: "Sexual dysfunction (dose-dependent); men: delayed ejaculation, erectile dysfunction; men and women: decreased sexual desire, anorgasmia." In the Life-Threatening or Dangerous Side Effects there is no mention of persistent post-SSRI sexual dysfunction.

Coskuner and colleagues (2018) reviewed the literature and published an article titled "Post-SSRI Sexual Dysfunction: Preclinical to Clinical. Is it Fact or Fiction?" They note that in rats exposed to SSRIs at a young age there may be permanent sexual dysfunction, even after these are stopped. However, this does not occur in adult rats. They note that there are no controlled trials in humans, and thus human evidence for post-SSRI sexual dysfunction is largely from case reports and online internet communities discussing experiences. Another literature review of post-SSRI sexual dysfunction by Bala and colleagues (2018) describe its symptoms: genital anesthesia, pleasure-less or weak orgasm, decreased sex drive, erectile dysfunction, premature ejaculation. They note that further research is needed to determine prevalence. As well, they note that there is no definitive treatment at the time of writing.

Healy and colleagues (2019) obtained permission from the European Medicines Agency to obtain details from 62 patients reporting post-SSRI sexual dysfunction on an adverse event reporting webpage. They note that many patients felt that their health care providers were unsympathetic to their symptoms.

Health Canada states that they will be working with manufacturers this year to modify safety information for SSRIs and SNRIs to recommend that health care providers tell patients about the potential risk of post-SSRI/SNRI sexual dysfunction. Inform-

ing our patients about this risk is certainly possible and necessary, although it is not without potential harms. For example, in a patient who would not develop post-SSRI/SNRI sexual dysfunction, poorly informing them so that they stop their medication and develop a worsening of depression or other condition is a real risk.

Developing a collaborative plan with our patients may be the best approach until more definitive evidence emerges with regard to post-SSRI/SNRI sexual dysfunction. This would include discussing with the patient the measures to be taken to minimize this risk. As in any field of medicine, the indications for starting an SSRI or SNRI should be reviewed again. As well, the length of time the patient has been taking the SSRI or SNRI should be reviewed again. Stahl (2017) notes that in second and subsequent episodes of depression "treatment may need to be indefinite." Stahl notes this also for use in anxiety disorders. Kennedy and colleagues (2016) discuss the evidence for longer term maintenance therapy where there are risk factors for recurrence of depression. For maintenance treatment for more than two years, the evidence for doing so is generally Level 3 or Level 4; i.e., controlled studies are lacking. Obtaining another opinion in such cases can always be part of a collaborative plan. Similar to the way certain parameters are monitored in patients on atypical antipsychotics, there can be better monitoring, i.e., history, of sexual function.

Conclusion

The Health Canada Summary Safety Review of January 6, 2021 warns about potential persistent, or worsening, or even new sexual dysfunctional problems after an SSRI or SNRI is stopped. They note the review found only rare cases of long-lasting sexual dysfunctional problems, and they do not make any claims about a causal effect between stopping an SSRI or SNRI and the development of persistent sexual dysfunction. In sum, informing and developing a cautious collaborative plan with our patients may be the best approach until more definitive evidence and guidelines emerge with regard to post-SSRI/SNRI sexual dysfunction

Conflict of Interest: None

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Howard Schneider started his career performing psychiatric consultations and short-term follow-up care in the emergency department in Laval, Québec. For the past 20 years he has provided care for psychiatry and psychotherapy patients in the community in the Toronto area

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Depression – A Different Approach

George Lewis, MD

I first came across "John" in 1990 or so. He had just arrived in Canada, having left a secure job at a bank in his homeland. He had two lively teenage boys and a wife who soon got established on the Faculty at the University of Toronto. They had left their jobs, family, and friends, to forge a whole new life in Canada, as they were becoming increasingly concerned about their personal safety in their home country.

This was the context in which I first met John professionally. He was not overtly depressed but clearly was having problems adjusting, hence my tentative diagnosis of adjustment disorder. The fact that I had survived my move from Ireland *en famille* in 1974 seemed to help our process. Over time it became clear to me that he was carrying a lot of unresolved childhood trauma left over from a somewhat harsh and critical father, and extensive bullying at school. To cope with all of this, he had developed a somewhat prickly personality with a harsh, critical sense of humor which he seemed to enjoy, especially when he was firing it towards others.

I continued to see him on a regular basis. The thrust of our therapy was for him to be more accepting of himself and his emotions, and also more accepting of others, as well as to face and express his unresolved emotions via mindfulness and deep diaphragmatic breathing.

Another strategy we used was one I had learned in 1992, when I underwent a powerful personal growth through The Hoffman Process. I went to a retreat centre with 15 others for seven days. On the first day we "had it out" with our mothers, on the second day we "had it out" with our fathers (or to be more precise, with their negative personality traits), and on the third day we buried the suckers! On the fourth day we gave birth to ourselves emotionally and on the fifth, sixth and seventh days we celebrated the newly arrived child - US! It was a powerful emotional workout for me and really helped me on my healing journey, so I encouraged John to do the Hoffman Process. He completed this in 1997 and it helped him to be more at peace with himself and more accepting of others. His basic personality still remained with its harsh, critical sense of humor.

I continued to see John on a monthly basis or so, providing mainly supportive therapy. By this time, he was well established in his new bank job and his two adult sons had left home. He was concerned about one son in particular, who seemed to have a drug and alcohol problem.

In one visit in 2001, he walked into my office, or rather, he shuffled in with the help of his wife who was holding his hand and leading him. He was in a semi-catatonic state. His eyes were gone. He just was not "there" anymore. He shuffled towards a chair with the help of his wife and collapsed into it. Wow. What had happened?!

Apparently, a policeman had arrived at John's house informing him that they had to arrest his son for being drunk and disorderly. That was the moment when John turned all his criticality against himself, and down he went into a deep dark depression where he just could not function.

He spent several weeks in hospital and was on a lot of medications by the time I caught up with him months later in my office. At least this time he came on his own steam and was able to verbalize. The whole process had really frightened him and now his anxiety was part of the clinical picture. I continued to see him on a regular basis and monitor his mood and medications, but he was starting to despair about ever getting better.

At that time, I was involved in my own personal growth journey and had found my way to a Men's Therapy and Personal Growth Group which I found most helpful. Apart from our weekly two-hour sessions, we also went to a retreat centre in Owen Sound called The Mill. We went there once a month from Friday evening to Sunday evening to do intensive inner work. I thought John might benefit from this process and I invited him to come with me for the next weekend retreat. (Boundary Keepers would not like this approach, I think!) He accepted my offer.

So off we went. We drove up together and arrived late Friday evening, in time for the evening circle and gathering of the men. We all had to check in and share with the group our intention for the weekend. That was when John started with "I am so depressed. I am…." and this sort of narrative continued. Finally, the group leader said, "When are you going to give up your dirge?" Everything stopped. No one spoke. John was in a state of shock. We all were. Now what?

Then Dr. Laing, the facilitator, explained that we all had to enfold John with love and loving awareness. Anytime we saw John alone or brooding over the weekend, we were to give him hugs and engage with him. John

was instructed to do his deep diaphragmatic breathing any time his mind wandered back into the thought "I'm so depressed." He was invited to stroke his heart area, and to say something loving to himself either inwardly or out loud. Each man was instructed to approach John in a loving way and to not leave him alone over the weekend.

Our weekend finished late Sunday evening, we said our goodbyes and we left together in my car to head back to Toronto. He was in the front passenger seat and I was driving. We were both in a reflective mood, but after about 30 minutes John became a little agitated and energized. He started to look all around himself as if something was happening for him. Then he said out loud, "IT IS LIFTING. MY DEPRESSION IS LIFTING!" He was looking around in wonderment at what he was now experiencing and seeing. Could it be that all the loving energy he had received into his heart over the weekend had finally overcome his own self criticism and perceived unlovingness?

I continued to see John after that and he was able to maintain this state of loving self acceptance. He ended up joining the Men's Therapy Group for a while, but eventually he developed his own meditation and mindfulness routine.

I see John now on a monthly basis. He continues to have some emotional ups and downs (bipolar tendencies?), but mostly he is stable and enjoys his life. The only medication he takes now is Tryptophan 500 TM QID and Vitamin D, and maybe melatonin, plus a sunshine trip or two to Trinidad (COVID permitting).

Touching base regularly helps to keep him stable. He is grateful for my care, and I am grateful for sharing his journey with him. He is also delighted that his journey might be a part of our MDPAC Journal.

Conflict of Interest: None

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George Lewis completed his medical degree in Ireland in 1971 and is celebrating 50 years of practicing medicine this year. He emigrated to Canada in 1974 and started a practice as a Family Doctor in Woodbridge, ON. A personal crisis led him to his own Healing Journey and to take up the practice of Psychotherapy as a Physician in 1990. Although he does prescribe medication from time-to-time, he tends to work with his patients in a mindful way as they learn to regulate their own emotionality and wellness.

A Fresh Approach

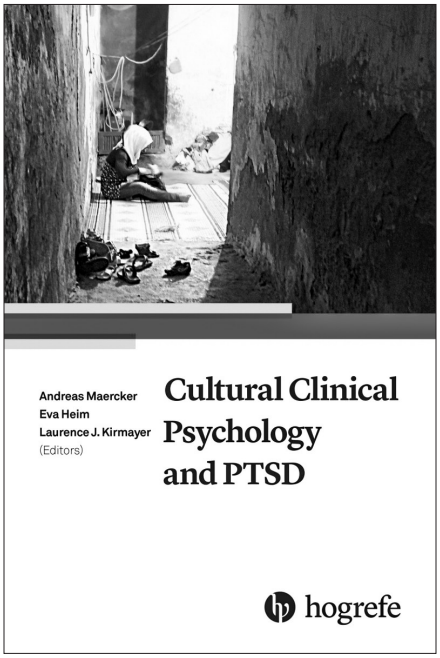
Review of Cultural Clinical Psychology and PTSD Editors: A. Maercker, E. Heim and L. J. Kirmayer Hogrefe Publishing Corporation, 2019; 236 pp $62.50, soft cover

Maria Grande, MD

I suffered from the consequences of a malfunctioning vehicle in 2015, which made it a not-so-easily forgotten year. Unable to participate in any meaningful activities without significant assistance and definitely not able to return to work, I was grateful when my friend and peer at MDPAC, Vivian Chow, suggested that I do a book review for the *Medical Psychotherapy Review*. The book that attracted my attention was about Post Traumatic Stress Disorder, PTSD, of which I had some knowledge, written from a clinical cultural psychology perspective, which I had never heard of. Thus began my journey into a 230-page volume of research, new concepts, new language, and a deeper understanding of how an individual's cultural background significantly impacts the psychotherapeutic relationship.

I discovered that contributors to this reference book were from all over the world and were a mix of social anthropologists, sociologists, linguists, and epidemiologists, in addition to psychologists and psychiatrists. The qualitative and quantitative research findings contained herein derived from interviews with persons originally from Brazil, Bosnia, Cambodia, India, Kenya, Lebanon, Pakistan, Syria, Turkey, Uganda, Vietnam, and Zimbabwe, displaced by wars or natural disasters and resettling in neighbouring and distant countries. Refugee populations were as much a new dimension to me as they have been to a large part of the world's governmental and non-governmental organizations.

One of the strengths of this book is the careful organization of material that builds upon each of the parts. Since we, as medical professionals, have our own training and language, mostly rooted in North American and European institutions, the leap into a Social Science-based presentation of mental health in non-westernized settings required the acquisition of a new set of cognitive perspectives.



Another strength of this collaborative collection is the inclusion of regular and supportive information from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the World Health Organization (WHO), and the American Psychological Association (APA), in addition to other internationally recognized institutions, which can buttress the transition from a medicalized view of mental health to the more inclusive and expansive, culturally aware and humble road into and out of human suffering.

To begin, rather than using the diagnostic label of PTSD, the authors have chosen to focus on the individual and collective experiences of trauma, distress and adversity of different populations worldwide in order to be able to elaborate upon the strategies and interventions that would be of assistance in allowing the affected persons to return to what the individual and their support systems see as acceptable function.

The members of MDPAC are quite familiar with the importance of narrative medicine as a means to build trust and gain an understanding of the world of their patient in order to instill hope and guide change. This book expands on this tenet to delineate how to determine what components of evidence-based psychotherapeutic interventions can be adapted, what internationally accepted tools exist to facilitate communication and how to gather the results of these proceedings to further the delivery of personalized mental health care in settings far removed from the controlled spaces of a professional office.

In order to be able to understand the breadth of material covered, it is important to introduce and define some pivotal terms. What is *culture*? Culture refers to all social aspects of life that an individual is exposed

to and may integrate consciously and unconsciously to build their specific identity and guide their behaviours. This includes the norms, values, ideologies, and practices that can be found in the nuclear and extended family, and in the beliefs, hierarchies and knowledge contained in the religious, educational and political systems in place in the area inhabited, both locally and nationally.

What is a *cultural clinical perspective?* It is the acknowledgment, and the elaboration, of the influence of the many components of an individual's culture on the present manifestation of their personal adversity experience. For example, ghosts, spirits, internal energies, and religious doctrines have their place in the lives and realities of many of the world's diverse populations. By becoming aware of these influences, the helper is able to interpret the metaphors and idioms that are used by the presenting individual in communicating their distress and thus assist rather than hinder in the journey of recovery.

To minimize the effect that conscious and unconscious biases may have on the relationship between provider and recipient, the suggestion is put forth that cultural training, sensitivity and curiosity be included in the professional schooling of those providing mental health and foreign services. There is an excellent chapter that dedicates itself to this topic and includes information on how to develop material that is specific and general enough to be used in subpopulations of an identified culture.

In the assessment of a number of commonly adapted interventions, I wasn't surprised to find that cognitive behavioural therapy (CBT) has been the most successful. Given that CBT is goal-oriented, structured and time limited, it is ideal for translation into online or onsite materials. It is also amenable to delivery in group formats, whereby people who have similar issues can assist and model their struggles, thereby assisting each other on the road to acknowledgement, acceptance and functioning. The embedded practice of daily relaxation and activities between sessions, combined with input from local healers and leaders, allows the intervention team to truly target external and internal identified problems. Additionally, by reframing problem solving into problem management, there is the explicit acknowledgement that problems may not be solved but can be addressed, thus bringing expectations to a more realistic level.

What was less intuitive was that the type of response to an intervention is influenced strongly by whether or not the person comes from a culture that is either predominantly individualistic or collectivistic. The majority of the world has collectivistic cultures, unlike most of North America. In an individualistic approach, the past event is a personal memory, in a collectivistic culture, the event is part of a shared history, with the former encouraging the discussion and examination of the experience, while the latter discourages discussion because of the need to preserve existing social structures. Another key difference is that applying a diagnostic label is encouraged in individualistic cultures and discouraged in collectivistic cultures to prevent stigmatization.

Hence, in order to maximally assist those in a collectivistic culture, it was suggested that the helper address the signs and symptoms that are present by using techniques and language that are familiar and known; for example, mediative practices and goal oriented, concrete behavioural activation approaches. An important component of this is to identify to the person what is considered a normal response to their experience, to highlight the individual's and society's prior strengths that would be accessible to them now; i.e., their self-efficacy.

One of the perspectives on trauma that I found quite interesting and applicable in any setting was that about post traumatic growth (PTG). This refers to the positive qualities that can be exhibited following severe adversity. This is clear and separate from resilience which is considered a premorbid characteristic. PTG can include a change in priorities; for example, rather than devoting as much time to working, there may be a heightened desire to increase the depth of personal or spiritual relationships. Concomitantly, there may be an acknowledgement of previously overlooked inner strengths.

In conclusion, a diversely skilled, highly integrated team is needed to effectively deliver culturally sensitive mental health care, especially when dealing with PTSD. The principles and concepts developed in this book can be easily adapted to the care of immigrant, multicultural populations found in Canadian hospitals, clinics and offices.

Conflict of Interest: None

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Maria Grande lives in St. Catharines, where she had practised for 23 years in the fields of Mental Health, Physical, Sport and Occupational Rehab before retiring. She was the Editor of the GP Psychotherapist (now the Medical Psychotherapy Review) from 2013 to 2015.

A review of: *All Things Wise and Wonderful: A Christian Understanding of How and Why Things Happen, in Light of COVID-19*

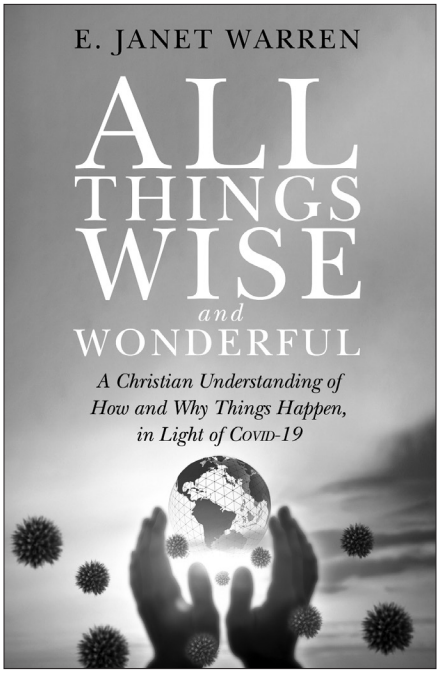
E. Janet Warren, MD, PhD, Eugene, Oregon: Wipf & Stock
212 pp. $34.70

Reviewed by David J. Robinson MD, FRCPC

All Things Wise and Wonderful, in addition to being the subject of this book review, is the title of a novel by the English veterinarian James Alfred Wight, whose *nom be plume* was James Herriot. It is also the penultimate line in the first verse of a poem by Cecil Frances Alexander, the last line being "The Lord God made them all." This publication, written by the editor of *Medical Psychotherapy Review,* has far more to do with the latter attribution.

My interest in reviewing this book stemmed from a friend and colleague's health scare in 2020. An incidentaloma, found on a routine imaging study, was determined to be a small mass near the neck of his pancreas. He feared the worst, and since he has a loving partner, two happy daughters and a thriving career, this had the makings of a tragedy—as the saying goes—of biblical proportions. My friend would describe himself as a "cultural" Jew and someone who had eschewed most of the religious elements. However, when faced with the potential dire prognosis of his new abdominal mass, he started doing something he had not done in decades…he began to pray.

In tandem with the unfolding COVID-19 pandemic, my friend's ordeal highlighted an existential question that people ask during catastrophes; if there is a benevolent God, then why did she/he/they/it allow this tumour/pandemic/genocide (etc.) to occur? I have heard this question being asked with increasing frequency by my patients over the last year, making this book an especially timely offering. Dr. Warren describes herself as a post-conservative evangelical Christian and interdisciplinary scholar whose vocations include theology, medicine and psychotherapy. But what does this book offer readers who might describe themselves as atheists, agnostic or non-Christian? As it turns out, quite a lot.



The intertwining of religion/spirituality and medicine/psychiatry/scientific inquiry extends back for millennia. However since the Scientific Revolution, it may be fair to say that prominent figures from one of these areas of endeavour, for the most part, are not generally known for significant achievements or being high-profile representatives of the other. I have found people who have a foot solidly placed in both camps to be rather intriguing. How can someone reconcile such disparate views of the world? One notable figure who has done so is Dr. Francis Collins. He is the director of the National Institutes of Health, ran the Human Genome Project, and has won numerous accolades for his outstanding scientific work. He also wrote the *New York Times* bestseller *The Language of God: A Scientist Presents Evidence for Belief.* It was a revelation to me that the Vatican has had an official observatory. Its astronomical institution extends back at least 130 years that continues to make contributions to the scientific world.

Dr. Warren has divided her book into three main sections, along with a detailed introduction and conclusion. *All Things Wonderful and Wise* is very well researched and referenced, and demonstrates an impressive depth of knowledge across many areas. For example, a pithy review of Aristotle's "levels of causality" is followed by an excellent explanation of increasingly complex models of causation. Just pages later, she demonstrates an encyclopedic understanding of Scripture, finding passages that are pertinent to the current pandemic to answer central questions about the role of faith, particularly Christian, when it appears that random destructive forces are shaping the future of the world.

The nature of causality is the dominant theme in this book. Dr. Warren does an extraordinary job of looking at the essential human mental function of seeking meaning from a variety of viewpoints. The concept of causality helps us make sense of the

world, learn from experience, and plan for the future. Whether your theoretical lens is Darwinian, Christian, Buddhist, or neurophysiological, her treatment of this topic is fascinating and enlightening.

What I enjoyed most about this book was Dr. Warren's openness, her sense of humour, and her confidence. Her writing answered fundamental questions for me about how people who have made accomplishments in religious and scientific disciplines reconcile these seemingly divergent fields. I have a better sense now about how to engage people in a more enlightened discussion when they believe that God has pre-determined the path for their lives (though they still look both ways when crossing the street), as well as those who see only the random collision of molecules as the guiding force in the universe.

Irrespective of how you view the world, there are some excellent takeaways from this books. Here are some of my favourites:

- There is often redundancy or over-determination in causation.
- Correlation is not causation.
- No one likes being wrong, so we either insist on our original view or make up extra explanations to justify our beliefs and help things make sense.
- The Bible does not explain COVID-19
- Humans are charged with caring for creation and for one another
- People will seek explanations for causation that may involve natural, divine, human or demonic forces (or any combination of them)
- Emotions are more persuasive than logic

I think this book is an excellent repository of wisdom and guidance provided in parallel streams of scientific discussion and Christian perspectives on the human condition, which we are all trying to comprehend, both for ourselves and in order to help our patients on their journey. Religion and spirituality come up frequently in psychotherapy, and this book provides an exhaustively researched resource. When the topic of divine causation comes up, readers will be in a much better position to further a reasoned perspective regardless of the patient's religious or spiritual beliefs.

Conflict of Interest: None

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Dave Robinson is a psychiatrist practicing in London, Ontario. His friend made a full recovery after the mass, which was benign, was removed. We are grateful to anyone and anything that contributed to the joyous outcome.

Saw

Wan, J. (director) (2004) Saw (motion picture). United States, Twisted Pictures..

Reviewed by David J. Robinson MD, FRCPC

Saw is the initial offering in a series of films that started in 2004 and ended with the eighth installment, called *Jigsaw* (aka S*aw VIII*) released in 2017. With the exception of the original, the *Saw* movies were filmed in Toronto, and the first seven were released annually, just in time for Hallowe'en. *Saw IX* is due for release later in 2021, ostensibly under the name *Spiral: From the Book of Saw*, and with a completely revamped cast.

Saw opens with a disorienting scene, a faint blue light attached to a short chain illuminates the face of a man underwater in a bathtub. The man panics, causing the light and chain to make a hasty exit down the drain. Flailing, bewildered and distraught, he cries out for assistance and finds that he is not alone. The man's name, as we eventually learn, is Adam (Leigh Whannell, who co-wrote the script along with director James Wan). Adam has no idea where he is, how he got there, why he's there, what he is supposed to do, or who put him there. He quickly discovers that one of his legs has been chained to a solid pipe. Adam shares his predicament with Dr. Lawrence Gordon (Cary Elwes) who roused earlier from a sedative and has been trying to take stock of their situation. Lawrence gropes around and finds the light switch, and the true extent of their circumstances is revealed.

Each of them is tethered to a thick plumbing pipe with a heavy steel chain. They are at opposite ends of a dilapidated industrial bathroom sealed off from the rest of the building. In between them is the body of a man lying in a pool of blood with a gaping hole in his head, a revolver in one hand and a small tape player in the other. Adam and Lawrence soon discover mini-cassettes in their pockets, and with a little "MacGyvering" are able to reach the tape player. There is a special message for each of them, and they are summarily apprised of their situation. The recording was done by Jigsaw (Tobin Bell), aka Saw aka John Kramer, though it isn't until *Saw III* that his full name is revealed to viewers.

Adam and Lawrence are effectively in an "escape" room, but one with rather dire consequences and no panic button for quick egress. The message on the tape outlines the rules and what the expectations are for them, which at least answers some of their questions; but the main ones that remain are why they are there and who exactly masterminded the grungy torture chamber. In order to obtain release, Lawrence's task is to kill Adam. Lawrence is given a single bullet, but he cannot reach the revolver. In order to motivate Lawrence to do the deed, he is informed that his wife and daughter will be killed if he doesn't complete his assignment by 6:00 pm…and Jigsaw has kindly provided a clock for them. Lawrence doesn't know Adam, but is told later that Adam knows more about him than he initially reveals. The two men learn that they increase their chances of sorting out why they are there, and possibly their survival if they cooperate with each other…but Adam isn't forgetting what would get Lawrence released and remains surly and tempestuous most of the time.

Jigsaw is the embodiment of a Joseph Campbell quote about computers being like Old Testament gods — lots of rules and no mercy (Joseph Campbell Foundation). Jigsaw survived a medical ordeal that he feels made him stronger, gave him clarity and purpose, and he sets out on crusade to give others this gift. He selects as his victims people who, objectively, harm others or themselves, or who have become in some significant way incompetent or indifferent about an important role. The puzzles and traps he puts people in will take their lives unless they make extraordinary efforts or sacrifices to survive. One such character is Amanda (Shawnee Smith), who survived a "reverse bear trap" device that would have pulled her jaws apart (with fatal consequences). Amanda was addicted to recreational substances, but in a TV interview with police, credits Jigsaw with giving her a new perspective on life. Amanda goes on to become Jigsaw's accomplice and figures more prominently in *Saw II, III* and *VI*. Jigsaw effectively becomes omnipotent to the people he ensnares. He sees everything that they do (particularly learning their secrets and weaknesses), issues a pronouncement on their transgressions, and facilitates swift judgment for those who see life as devoid of value.

Director James Wan and Leigh Whannell met at the Royal Melbourne Institute of Technology's prestigious Media Arts course. With an estimated budget of $1.2 million for *Saw*, they created a franchise juggernaut that grossed $1 billion over the eight films. *Saw* has recognizable names (Danny Glover, Cary Elwes, Monica Potter, Tobin Bell, etc.) but their talents are not what carry the film, and the rest of the franchise does not depend on star power in the cast. Instead, we get to see the brilliant (though brutishly sadistic) mind

of Jigsaw at work, and over the series of films we gradually learn his story and the source of his rage. His victims, for the most part, are one-dimensional figures that we don't get much of an understanding of, and for whom we generate little sympathy. The audience learns mainly about their failings, and they are generally people who may well be deserving of the crucible of Jigsaw's deadly puzzles to realign their priorities…if they live.

If we could migrate the *Saw* series into the psychotherapeutic realm, it would be re-titled *(Counter) Transference Hate, Illustrated.* Hate, as D.W. Winnicott detailed in his classic 1949 paper (1949), was a normal and expectable reaction to someone's personality and behaviours, particularly if that person had marked symptoms. Winnicott broadened the understanding of countertransference to include validating the strong, negative, conscious feelings that patients stirred up, in addition to the narrow and more unconscious perceptions initially described by Sigmund Freud. Winnicott proposed that hate was an essential developmental step, present in the mother-child relationship and re-ignited in the patient-therapist dyad. He even went on to enumerate 18 reasons why a mother would hate her baby, some present even before birth! In another classic publication, Maltsberger and Buie (1974) reported on countertransference hate in treating suicidal patients. This hate, he proposed, contains two components: aversion and malice. Countertransference hatred is purported to be the strongest with people who have borderline personality disorder, psychosis or who are suicidal. The latter group often evoke sadistic responses in others to, at a minimum, maintain some semblance of a relationship. The urge to abandon patients—the aversive element—is considered to be the more dangerous of the two. Rensko (2017), writing as a psychiatry resident, describes a situation where she engaged in an act of avoidance based on her countertransference hatred of a suicidal patient, adding a personal verification to Maltsberger's concerns.

How is this psychoanalytic theory applicable to *Saw*? Two of Jigsaw's early victims were men; one attempted suicide (by cutting himself) and the other was a malingerer collecting disability payments, both being easily understood targets for loathsome feelings. The man who attempted suicide had to traverse a length of razor wire to survive. The malingerer had to work very hard to enter thousands of potential combinations into a safe that contained the antidote to a poison Jigsaw had given him.

As it turns out, Jigsaw was a patient of Dr. Gordon. Jigsaw had colon cancer that metastasized to his brain. While he lay on his hospital bed (feigning sleep), Dr. Gordon conducted rounds with his entourage. Dr. Gordon didn't even know Jigsaw's name or anything about him as a person, he just spouted the basic biological elements of "the case." Dr. Gordon was also showboating to impress trainee Carla (Alexandra Bokyun Chun), who caught his eye. When Zep (Michael Emerson), an orderly, interrupted Dr. Gordon's presentation to mention that the patient's name was John and that he was quite an interesting person, Zep was ridiculed for forming inappropriate bonds. Rather than conveying a sense of empathy or getting to know the patient as a person, Dr. Gordon mentioned the poor prognosis rather indifferently, thus fulfilling the aversion part of his countertransference hatred, thereby invoking Jigsaw's malice. Sharp-eyed viewers will see the sketch of Amanda's puzzle on Jigsaw's hospital table at exactly 20:34 of the movie.

The *Saw* series is often described as a guilty pleasure where irresponsible parties get their comeuppance and the perpetrator is by far the more compelling and complex character study, similar to the villains in *Se7en and Silence of the Lambs* and the TV series *Dexter*. It is a fascinating look into the perverse logic of target selection for (fictional) serial killers and how they believe they are making the world a better place by removing certain types of people from society. The ending of *Saw* was very cleverly written and worked brilliantly as the hook to keep fans coming back annually…to see the latest installment of who violated Jigsaw's rules!

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Conflict of Interest: None

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Dave Robinson is a psychiatrist practicing in London, Ontario. He has been noticeably kinder to strangers and murderers since watching the Saw movies.

MDPAC Update on CPD Expansion

Muriel J. van Lierop, MBBS, MDPAC(M), Stephen Sutherland, MD, Barbara Kawa, MD, Dip.PH, BSc, Barbara Whelan, MD, BSc, MDPAC(C), Linda Macdonald, MD, BSc

The first part of this article is to give Medical Psychotherapy Association of Canada (MDPAC) members information on the context and reasons for the new Continuing Professional Development (CPD) Program that will be implemented October 1, 2021. The second part of the article will describe the specifics of the changes.

Background

MDPAC has had its own CPD Program since the 1st Annual Educational Conference in 1987. Membership in the Association has required some total of annual CPD credits (varied by Membership Categories) since 1995.

MDPAC was granted Third Pathway status in 2013 by The College of Physicians and Surgeons of Ontario (CPSO). This allows our members from Ontario to choose to have their CPD activities "tracked" by MDPAC rather than by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC). The "tracking" of all Ontario physicians' CPD activities has been made mandatory by the CPSO since 2013.

The name "Third Pathway" comes from the fact MDPAC is the third professional association in Ontario formally allowed to "track" physicians' CPD, the other two obviously being the RCPSC and the CFPC. To maintain the Third Pathway status, the CPSO expects MDPAC to have a CPD Program that is essentially equivalent to the programs of both the RCPSC and the CFPC, while remaining distinctly MDPAC-based.

For many years now, both the RCPSC and the CFPC have had CPD activities (given "approval") under a relatively new framework known as the CanMEDS Guideline Roles. Additionally, there has been the introduction of accrediting (and therefore approving) certain educational activities under a new category called "Assessment." The CPSO considers these aspects of their respective CPD Programs essential, and thus MDPAC must integrate both the CanMEDS Roles' educational activities and the category of CPD called "Assessment" into its own CPD Program.

The CanMEDS Guidelines constitute a framework that identifies and describes the abilities/competencies physicians require to effectively meet the health-care needs of the people they serve. It is organized under roles and competencies any physician performs within their day-to-day professional life, irrespective of the subspecialty they practise. CanMEDS Guidelines were first introduced in the mid-1990s by the RCPSC and have been updated several times over the years. They are now used in all undergraduate medical education, all post-graduate residency training, and are in the complex and difficult process of being integrated into the Continuous Professional Development of practising physicians across Canada, regardless of specialty.

For those MDPAC members unfamiliar with the CanMEDS Roles/Framework/Guidelines, they are:[1]

- Medical Expert: for MDPAC members, all matters related to psychotherapy, psychiatry or mental health
- Communicator: all matters related to effective communication, whether with patients or colleagues
- Collaborator: all matters related to constructively working with any other healthcare provider
- Leader: all matters a physician could participate in for the functioning of the healthcare system (at whatever level) or its constructive developments
- Advocate: all matters related to a physician's efforts to promote positive health outcomes for patient populations or the healthcare system as a whole
- Professional: all matters related to a physician's ethical behaviour
- Scholar: all matters related to ongoing learning and teaching of any physician (including oneself) in matters of research methodologies, research, research results evaluation, patient safety, etc.

"Assessment" is a type of learning activity that is intentionally structured to evoke insight and reflection by the learner about their theoretical knowledge and practice skills on the topic the course is addressing. This is achieved by a series of self-evaluations (pre-course, intra-course, and post-course) plus third-party observation and evaluation, and then a post-course debriefing.

Please remember that the new MDPAC CPD Program was constructed in order to fulfill the CPSO's expectation of MDPAC to have equivalence in these aspects of its CPD Program and thereby continues to be granted its Third Pathway status.

The Board tasked the Professional Development Committee (PDC) back in 2014 with the duty to construct the new CPD Pro-

[1] For more detail, see http://canmeds.royalcollege.ca/en/about

gram integrating the CPSO's expectations of MDPAC. Given that the Board wanted an MDPAC-based integration of the CanMEDS Guidelines and "Assessment," the PDC undertook a consultative process with MDPAC members. This involved a survey of our members (47 submissions) and a face-to-face "Brainstorming" session with 35+ participants. The final document, approved by the Board in March 2018, includes an integration of that substantive membership input.

Specific changes to MDPAC's CPD Program.

First, there are a number of specific ideas/practical principles all members need to understand.

Members DO NOT need to change what they have always done with respect to their Continuing Education (CE) and Continuing Collegial Interaction (CCI) CPD activity, except for a change in the apportionment of credits required between CE and CCI activities and a change in the "minimums" and "maximums" of some of the CPD activities.

The CE/CCI apportionment changes for Clinical CPSO/CPD, Certificant and Mentor members go from 25 hours of CE and 25 hours of CCI to 30 hours of CE and 20 hours of CCI. The CE/CCI apportionment changes for Clinical members go from 12 hours of CE and 12 hours of CCI to 15 hours of CE and 10 hours of CCI. The changes to the minimums and maximums (in the various CPD activities to which they apply) are a function of the overall context and rationale for the changes to MDPAC's CPD Program; i.e., the integration of both the CanMEDs Roles and the new CE category "Assessment." The maximum of Self-directed CE for Clinical CPSO/CPD, Certificant and Mentor members has increased to 12 hours from 11 hours 40 minutes. The maximum of Self-directed CE for Clinical members has decreased from 5 hours 20 minutes per year (16 hours per cycle) to 4 hours per year (12 hours per cycle). Other specific changes to the minimums and maximums within the new CPD Program will be elucidated in tabular documents.

The CPSO demands that the RCPSC, the CFPC and, therefore, MDPAC give their respective members, regardless of their specialty, the appropriate CPD credits for CPD activities that justifiably fall under one of the CanMEDS Guidelines Roles beyond those activities in the Medical Expert Role, i.e., the Communicator Role, the Collaborator Role, the Leader Role, the Advocate Role, the Professional Role or the Scholar Role.

CPD Expansion: Summary of Key Changes

A. CE

(1) More educational content will be eligible for CPD credits (both CE-Group and CE-Self-directed)

- currently only content related to the "Medical Expert" role can be claimed (psychotherapy/ psychiatry/mental health)
- in the expanded CPD program, educational content related to any of the seven CanMEDS roles will be eligible for credit as CE-Group or CE- Self-directed
- there will be limits to the number of hours that can be claimed for CE-Group or CE- Self-directed outside the Medical Expert role
- if desired, all CE content can still be claimed within the Medical Expert role (for those who do not want to change)

(2) Preparatory Work for MDPAC Committees

- currently preparatory work done outside the committee that does not involve personal/phone communication with others is not eligible for CPD credits
- in the expanded CPD program, preparatory work done outside the committee (without personal/ phone communication with others) will be eligible for CE-Self-directed credits (under the appropriate CanMEDS role), up to a maximum of 4 hours

(3) New Category: CE-Assessment

- in the expanded CPD program, there will be a new category under CE called CE-Assessment
- supervision (as the supervisee), developing a Personal Learning Plan (PLP), a practice audit, or reviewing audio- or video-taped sessions with a supervisor can be reported either under CE-Assessment or under CCI (but not under both, for the same session) in the expanded CPD program

B. CCI

(1) One hour of CCI will now also be granted for attendance at an eligible 6-hour Group CE course related to all seven CanMEDS roles (not just the Medical Expert role—psychotherapy, psychiatry, or mental health)

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(2) Committee meetings which are not related to the Medical Expert role

- currently, attendance at these meetings; e.g., OMA Council, other hospital meetings, cannot be claimed for CCI credits (if part of the meeting was related to the Medical Expert role, that part could be claimed)
- in the expanded CPD program, attendance at these meetings can be claimed as CCI under the relevant CanMEDS role (up to a maximum)

(3) Supervision

- supervision (as the supervisee) can be claimed as either CCI or as the new category of CE-Assessment in the new expanded program

C. Changes in the Number and Allotment of CE and CCI Hours

- Change in Number—Clinical Members (*from* a total of 24 hours per year *to* 25 hours per year)
- Allotment—overall, an increase in CE and a decrease in CCI to accommodate the new category of CE-Assessment and the CanMEDS roles

Summary

The above changes are summarized in the tables below. The PDC has worked hard on behalf of MDPAC members. We hope that the information in this article, and the following tables, will be helpful to members as we transition to the new CPD system.

Table 1: MDPAC CPD Expansion
Summary of Components that Remain the Same or Change after October 1, 2021

CPD Activities (CE and CCI)	The CPD activity categories of CE (Continuing Education) and CCI (Continuing Collegial Interaction) will remain after October 2021	A new CPD activity "CE- Assessment" will be added under the CE category
CE Activities: under CE-Group	Conference Course Seminar Workshop Teaching Online CE- Group – PteR (McMaster)	These will all remain
CE Activities: Under CE-Self-Directed Note: there is a maximum to the number of CE hours that can be claimed for CE-Self-directed	Audio/Video tape Book/Journal CD-ROM Internet Teaching preparation Writing an article Peer assessment - preparation as assessee Peer assessment - review as assessor	These will all remain (including a maximum to the number of CE hours that can be claimed for CE-Self-directed)
CE Activities: Under CE-Assessment	Currently no such category	Supervision (as a supervisee) in psychotherapy or other Development of a Personal Learning Plan (PLP) Practice audit Reviewing audio or videotaped sessions with a supervisor
CCI Activities Note: there is a maximum to the number of CCI hours that can be claimed for Listserv	Case supervision (as supervisor) Case supervision (as supervisee) Meeting (Committee, Board, AGM - GPPA or other) Discussion with colleague - e.g., case Peer Assessment Discussion (as assessor) Peer Assessment Discussion (as assessee) GPPA Listserv	These will all remain, including a maximum to the number of CCI hours that can be claimed for Listserv **In addition:** Supervision and Peer Assessment Discussion (as assessee) can be entered for CPD credits under either (not both) CCI or CE-Assessment after Oct 1, 2021
Total number of hours of CE and CCI required per 3 year cycle: **For Clinical members:** (currently 72 hours total required per 3 year cycle of combined CE and CCI)	See changes	Clinical members: Increased to 75 hours total per 3 year cycle of combined CE and CCI

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Number (proportion) of CE and CCI hours per 3 year cycle **For CPSO/CPD, Certificant and Mentor members:** Currently **75 hours of CE** and **75 hours of CCI** are required per 3 year cycle (i.e., the same number of CE and CCI hours)	See changes	**After Oct 1, 2021, 90 hours of CE and 60 hours of CCI** will be required per 3 year cycle for CPSO/CPD, Certificant and Mentor members Note: The number of CE hours has been increased and the number of CCI hours has been decreased to accommodate the new category of CE-Assessment, which will be under CE
Number (proportion) of CE and CCI hours per cycle **For Clinical members**: (Currently **36 hours of CE** and **36 hours of CCI** are required per 3 year cycle (i.e., the same number of CE and CCI hours)	See changes	**After Oct 1, 2021, 45 hours of CE and 30 hours of CCI** will be required per 3 year cycle for Clinical Members Note: The number of CE hours has been increased and the number of CCI hours has been decreased to accommodate the new category of CE-Assessment, which will be under CE
Content of Learning Activity that is eligible for CPD credits (CE or CCI credits) **Currently the content of the learning activity that is eligible for CPD credits is limited to psychotherapy, psychiatry and mental health**	Under the Medical Expert role, content of the learning activity includes psychotherapy, psychiatry and mental health Note: MDPAC members who want to do all of their CPD activity in this content area (under the CanMEDS Medical Expert role) can continue to do so There will be no requirement to do any CPD activities in any of the other CanMEDS roles if the MDPAC member does not wish to do so	After October 1, 2021, CPD credits may be claimed (up to a maximum) for learning activities in the six other CanMEDS roles: - Communicator - Collaborator - Leader - Health Advocate - Scholar - Professional Note: the details of the content areas included under each of the CanMEDS roles can be found in the document "Criteria for defining a CPD activity under one of the seven CanMEDS Roles" Note: The maximum number of credits allowed for learning activities done in CanMEDS roles outside the Medical Expert role can be found in the table below

Table 2: MDPAC CPD Expansion
Credit Requirements for Clinical CPSO/CPD, Certificant, and Mentor Members

	CURRENT	As of October 1, 2021
CE		
Total Hours per 3 Year Cycle	**75 hours per 3-year cycle** (50% of total number of CPD hours required)	**90 hours per 3-year cycle** (60% of total number of CPD hours required)
Medical Expert role (psychotherapy, psychiatry, mental health)	**75 hours** Note: there is a **maximum of 35 hours** of CE- Self-directed allowed (out of the minimum 75 hours required in the Medical Expert role)	**60 hours per 3-year cycle.** This includes CE-Group, CE- Assessment, and CE- Self-directed Note: there is a **maximum of 36 hours** per 3-year cycle (12 hours per year) of CE-Self-directed allowed (out of the minimum 60 hours required in the Medical Expert role per 3-year cycle)
Other CanMEDS roles (other than Medical Expert)	**0 hours**	**Maximum of 30 hours** per 3-year cycle. Note: there is a **maximum of 12 hours** per 3-year cycle (**4 hours** per year) of CE- Self-directed allowed in CanMEDS roles other than Medical Expert.
Note: maximum for total number of CE- Self-directed credits	**35 hours per 3-year cycle** (maximum of 11 hours and 40 minutes per year)	**Maximum of 36 hours** per 3- year cycle (**maximum 6 hours** per year). This includes CE- Self-directed in Medical Expert or any of the other CanMEDS roles
CCI		
Total number of hours required per year	**75 hours** per 3-year cycle (50% of total number of CPD hours required)	**60 hours** per 3-year cycle (40% of total number of CPD hours required)
Medical Expert role (psychotherapy, psychiatry, mental health)	**75 hours** per 3-year cycle	**Minimum of 36 hours** per 3 year cycle (12 hours per year) of "real time" contact
Other CanMEDS roles	**0 hours**	**Maximum of 24 hours** per 3-year cycle (**8 hours** per year) of CCI from a combination of MDPAC Listserv and CCI "real time" in other CanMEDS roles (other than Medical Expert)

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Table 3: MDPAC CPD Expansion
Credit Requirements for Clinical Members

	CURRENT	**As of October 1, 2021**
Total Hours per 3 Year Cycle	**72 hours** per 3-year cycle	**75 hours** per 3-year cycle
CE		
Total number of hours required per 3-year cycle	**36 hours** (50% of total number of CPD hours required)	**45 hours** (60% of total number of CPD hours required)
Medical Expert role (psychotherapy, psychiatry, mental health)	**36 hours** per 3-year cycle Note: there is a maximum of 16 hours of CE- Self-directed allowed (out of the minimum 36 hours required in the Medical Expert role) per 3-year cycle	**30 hours** per 3-year cycle. This includes CE-Group, CE-Assessment and CE- Self-directed Note: there is a **maximum of 12 hours** per 3-year cycle (4 hours per year) of CE- Self-directed allowed (out of the minimum 30 hours required in the Medical Expert role per 3 year cycle)
Other CanMEDS roles (other than Medical Expert)	**0 hours**	**Maximum of 15 hours** per 3-year cycle **(maximum of 5 hours** per year) Note: there is a **maximum of 6 hours** per 3 year cycle (**2 hours** per year) of CE- Self-directed allowed in CanMEDS roles other than Medical Expert
Note: maximum for total number of CE- Self-directed credits	**16 hours per 3-year cycle** (maximum of 5 hours and 40 minutes per year)	**Maximum of 18 hours** per 3-year cycle (**maximum 6 hours per year**). This includes CE- Self-directed in Medical Expert or any of the other CanMEDS roles
CCI		
Total number of hours required per 3-year cycle	**36 hours** per 3-year cycle (50% of total number of CPD hours required)	**30 hours** per 3-year cycle (40% of total number of CPD hours required per 3 year cycle)
Medical Expert role (psychotherapy, psychiatry, mental health)	**36 hours** per 3-year cycle	**Minimum of 18 hours** per 3 year cycle (**6 hours** per year) of "real time" contact
Other CanMEDS roles	**0 hours**	**Maximum of 12 hours per 3-year cycle (4 hours per year)** of CCI from a combination of MDPAC Listserv and CCI "real time" in other CanMEDS roles (other than Medical Expert)
Maximum for Listserv	**16 hours**	See above

Report from the MDPAC Board of Directors

Elizabeth Parsons, MD, CCFP, FCFP

My time on the Board of Directors of MDPAC is soon coming to an end; I will be stepping down at the end of the AGM on May 12. My four years on the Board (the last three as Chair) have been an incredible learning experience and an opportunity to deepen my connections within the association. My only regret is that we won't be able to meet in person this May. I have such fond memories of past conferences, meeting new colleagues and seeing those I hadn't seen in a year or more. I know we will meet in person again, but it's bittersweet to be saying goodbye to my fellow board members over Zoom.

The last six months have been a very busy time for MDPAC. Despite the pandemic we continued to offer educational programming, a virtual conference, and opportunities for collaboration. Since October, you will have noticed that we are sending out monthly newsletters with a summary of the association's work. We'd love to hear if you find these helpful or not.

Committee News

The Listserv has undergone some significant changes since October. Many of you will remember that the Board executive made the difficult decision to pause the Listserv on October 25, 2020. This was in the wake of concerns brought forward by several members about some of the posts. The executive (Caroline King, Alison Arnot, and I) felt that the situation was escalating and needed to be addressed. I believe it's important to acknowledge that members of our association were harmed by what happened on the Listserv and that changes were needed.

Once the Listserv was shut down, we worked as quickly as we were able to address the situation with revised policies and a new moderation procedure and were able to reopen the Listserv five days later. At the next board meeting on November 26, the Board revised the Listserv policies further, trying to simplify and clarify the wording.

Listserv moderator Carlos Yu has been joined by two committee members, Risa Adams and Conrad Sichler. They have developed and sent out a survey to try to address members' needs more fully. I have heard that many other associations have had similar challenges arising over the past year, specifically related to anti-racism and anti-colonialism discourse. Other groups have sometimes split as a result. I believe that our association will be persistent in engaging in the ongoing hard work of introspection, improving communication, and repair and I look forward to seeing how this unfolds.

Another change in our committees was the amalgamation of the Education and Conference Committees into the **Conference and Webinar Committee.** This committee will plan the annual conference and will develop webinars on diverse topics to meet the needs of the membership for accessible and useful learning. A reminder that recordings of these webinars are available for purchase under "MDPAC Events—Webinar Recordings" on the website. Another change is that non-members are now able to attend and/or purchase the webinars as well (at a higher rate than members).

The Psychotherapy Training Program is well underway again with two cohorts participating online over five weekend modules. Again, the online format has allowed many to participate who otherwise might not have been able to and it's exciting to see where this will take the association in the future. I'm looking forward to teaching Module 4 with Robin Beardsley in April and again in June.

The Fall Retreat had to be cancelled in 2020 but the committee has been hard at work planning for an in-person retreat in the fall of 2021. Look for more news about this soon.

We recognize that our online events are not always at convenient times for our members who are not in the eastern time zone. Our association's membership is still mainly Ontario-based (90%) but we are always looking for ideas on how to bring in more members from across the country. If you are based outside of Ontario and would like to put your efforts to work in this area, please consider joining the Outreach committee or putting yourself forward for a Board position.

MDPAC 33rdAnnual Conference

We held our first ever virtual conference on November 6 and 7. The conference was really well received and we had 164 attendees, much higher than our usual numbers for the conference. A bonus was having access to all the recordings for a period after the conference. There was a lot of work involved in setting up and running the virtual conference, especially as this was our first time. A big thank you again to Liz Alvarez and the Conference Committee, and especially to Carol Ford for all their hard work. Our next conference will also be virtual and will be held this fall.

AGM

Our Annual General Meeting will once again be held online, this year on Wednesday, May 12 from 7-8:30 pm EDT. I hope you will be able to attend and hear from your committee

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Report from the MDPAC Board of Directors | continued

chairs as well as being present for the annual presentation of the *Theratree Award*.

Looking back over the four years that I have served on the Board, I am proud and honoured to have been part of so many changes. The past year has been challenging but also so rewarding. I am very grateful for the relationships that have grown and deepened as a result of the difficulties that we have faced together. I want to extend a special thank you to Caroline King, without whom I would not have undertaken this journey and who was always there when I needed her. And I am always so grateful to Carol Ford, who knows this association like no one else, and works so hard for us all. As in most of life, it really comes down to relationship. If you haven't yet considered it, I encourage you to volunteer for a committee; it's such rewarding work, and a wonderful way to get to know your colleagues. Be part of the change that you would like to see at MDPAC.

Conflict of Interest: none

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Elizabeth Parsons, the current chair of the board, has been a member of the MDPAC since 2007, and involved in committee work since 2010. Her medical practice began in Ottawa where she worked at Carleton University in student health from 2002–2016. She focused her practice on psychotherapy in 2007 and currently engages in full-time medical psychotherapy, for groups and individuals, in private practice in Ottawa.

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