College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

The College Connector

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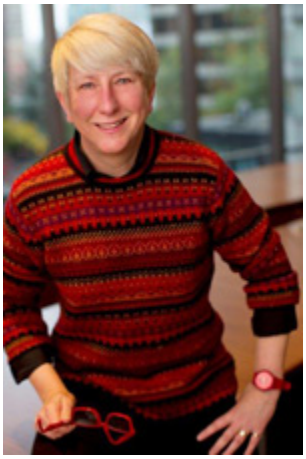
In this issue:

The *College Connector* is sent to every current registrant of the College. Decisions of the College on matters of standards and guidelines are contained in this publication. Questions or comments about this publication should be directed to communications@cpsbc.ca.

Registrar's message



Since the very start in 1868, the College has maintained a register of all physicians in the province. At that time, the register comprised of handwritten pages bound together as a softcover booklet. Now the register exists as an electronic database, and much of the information about College registrants is pushed in real time from the database to the website, making it available to the public in accordance with the *Health Professions Act*.

The online register (or directory) is the most popular feature of the College website. On any given day, more than 20,000 searches are conducted. This includes patients searching for a family physician, MOAs looking for specialists for referrals, or transcriptionists seeking contact information. Up until now, the College has displayed business contact addresses and phone numbers only, and those registrants who only provided the College with a home address have not appeared in the online register.

Starting in January 2014, in order to be compliant with current legislation, the College will be displaying home addresses in the online register—if that is the only address that has been provided. College registrants affected by this change have been communicated with directly advising them to update their profile by adding a business address and telephone number. A post office box is considered acceptable.

Additionally, to enable more efficient referrals, registrants should also be aware that starting in January 2014, the College will be displaying business fax numbers and MSP billing numbers on the public view of the online register. Previously, this information was only viewable by registrants who were logged in to the website. After contacting many other regulatory organizations, and conducting random searches of BC physician websites, it became clear that fax numbers are readily available in most circumstances, and hiding them behind a login process appeared unnecessary and cumbersome for those users, i.e. MOAs and other health professionals, who require them to do their business.

Note: Please ensure that the fax number you have provided to the College is a business fax number and not a home fax number. You can update your contact information at any time by logging in to the College website and clicking into your profile.

H.M. Oetter, MD
Registrar

We hope registrants and other readers enjoy this new method of receiving College news. We welcome your feedback.

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Special feature – 2014 annual licence renewal is almost here

Annual licence renewal begins January 1, 2014. Here's what you need to know.

BEFORE YOU START

Use the right technology and systems

- The Annual Licence Renewal Form is best experienced using a PC or a Mac. Mobile devices or smart phones are not yet supported.
- It is best practice to have the most recent version of a web browser installed on your computer.
    - Optimum browsers include Internet Explorer 7, Safari 5, Firefox 14 or better.
    - Optimum operating systems include Windows XP or OSX 9 or better.
    - Lower versions, other operating systems or browsers may cause viewing problems.

Gather your documents

A few things to have on hand before starting the online renewal process include:

1. Your BC driver's licence
2. Your method of payment (debit or credit card or online banking details)
3. Your CPD cycle date

HOW TO RENEW YOUR LICENCE

1. **Login**
   The College launched its new website in August and with it comes a new, simpler login for registrants. To log in to the website and begin your licence renewal you will need your CPSID and password. (A web security code is no longer required.)

   TIP: Learn more about logging in to the College website at https://www.cpsbc.ca/login-qa

2. **Click 2014 Annual Licence Renewal**
   Once logged in, you will land on the My Tasks page. Simply click the 2014 Annual Licence Renewal link.

3. **Confirm / Update Contact Information**
   You can add, delete or change contact information in this section of the form.

   TIP: Log in to the College website to update your mailing and email address before January—this will save you some time during the renewal process.

   IMPORTANT—At least one contact address must be published on the College website and made accessible to the public. As of January 1, 2014, if that one address on file is a home address, it

will be published. Please ensure you have made the necessary updates by adding a business address—this could be a PO Box address.

4. **Questions**
   There are approximately 25 questions to complete. The majority of registrants complete the entire process in 15 minutes.

   Most questions remain the same on the 2014 renewal form and some have been updated or slightly altered in their appearance to ensure a positive user experience. However, a few new questions have been added.

5. **NEW Questions**

   Driver's licence number
   You will be asked if you have a BC driver's licence and if so, will be required to provide your driver's licence number in order to fulfill the requirements of a criminal record check in accordance with sections 13–15 of the *Criminal Records Review Act.*

   Privileges at a public hospital
   Like years past, you will be asked to indicate all the hospitals at which you hold privileges. However, this year you will be asked to identify the type of privileges (active, provisional, locum, associate or temporary) you hold at the given hospital. It is a simple chart to fill in by using the drop down menu.

   Previous names
   One question asks you to identify other names you have used in the past. For example, this could include a maiden name, birth name or a previous married name.

6. **Certification / Declaration**
   At the end of the questions and prior to submitting the online form, registrants will be asked to certify that the information provided is truthful, accurate and complete.

7. **Submit Form and Payment**
   Your renewal fee can be paid in one of three ways online:
   1. By credit card
   2. By *Interac*® Online - Use your BMO, RBC, Scotiabank, or TD Canada Trust debit card.
   3. By online banking - Go to your online bank, log in and set up the College of Physicians and Surgeons of BC as a payee. Submit a payment exactly like you would do with a hydro or cable bill.

8. **Confirmation Email and Receipts**
   Once your form has been submitted you will receive a confirmation email from the College. You will also be emailed a receipt.

More details on licence renewal (including fees) will be sent to registrants via email in December.

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Savings result from purchase of new office space

On October 17, 2011, the College made an historic move to newly purchased premises at 669 Howe Street—seven floors at the Offices at Hotel Georgia in downtown Vancouver. Before making the decision to purchase, the Board conducted a comprehensive assessment on the benefits of purchasing versus renting in Vancouver. In total, 24 buildings and land properties were evaluated before the final selection was made. The Class AAA building complies with energy efficiency standards of BC Hydro's PowerSmart program, and is easily accessible to all modes of public transport and other amenities.

This was a very significant move both in terms of providing the College room for growth as well as securing the College's long-term financial health. The Board's direction at the time was to purchase a building that cost no more than an additional $500,000 per year to operate. In fact, in the first year alone, the College's new office space cost $790,000 less to operate than the previously leased premises. These savings will be realized for at least the next three years, and are likely understated due to significant increases in leasing costs. This investment has been prudent. The money saved is being thoughtfully reinvested into important quality assurance programs, information management systems and qualified people who deliver on the College's mandate of patient safety.

Registrants are encouraged to review the College's audited financial reports, which are published in June of each year on the College website.

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2014 Award of Excellence—call for nominations

Nominations are being accepted for the 2014 Award of Excellence in Medical Practice, which recognizes registrants or former registrants who have made an exceptional contribution to the practice of medicine whether in teaching, research, clinical practice, administration or health advocacy.

Eligibility
Candidates must be current or former registrants of the College in good standing, and with no history of disciplinary action. Current board members are not eligible to receive the award. A maximum of five candidates will be selected to receive the award each year.

Criteria

- Exceptional contribution to the practice of medicine whether in teaching, research, clinical practice, administration or health advocacy
- Contribution to the practice of medicine in her/his community
- Character, integrity and ethics beyond reproach
- Demonstrated leadership
- Collegiality and professionalism in all interactions within the profession and with patients

Written nominations of candidates, from a minimum of two current registrants, must include the name and biography of the nominee, and should describe in detail his/her fulfillment of the above criteria. A current curriculum vitae of the nominee, along with letters of support are also recommended. Nominations must be provided to the registrar by Friday, February 28, 2014.

Award Recipients
Selected award recipients will be recognized at the College's Annual Dinner in May 2014.

Please note that previous nominations are not carried over from year to year.

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Take responsibility for minimizing influenza

The College reviewed information from the BC Centre for Disease Control (BCCDC) regarding a strategy to minimize influenza exposure to hospital/nursing home patients. Influenza on average:

- annually results in 20,000 hospitalizations and 4,000 deaths nationally
- annually affects 10–20% of the population and 20–30% of children
- affects populations disproportionately, particularly the elderly, very young, and immune-compromised

The BCCDC notes that immunization paradoxically protects the healthy more than those most at risk.

Given that hospitalized patients carry a higher mortality/morbidity from influenza, it is incumbent on all physicians and health-care workers to lessen influenza exposure risk to patients. While wearing protective equipment during the influenza season may accomplish this, a more pragmatic approach is for physicians and health-care workers to be immunized.

The College supports the BC Enhanced Influenza Control Policy and reminds physicians that they have an ethical responsibility to minimize the risk of influenza exposure to patients.

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Updates from the Prescription Review Program

Ask about addiction before prescribing—a standard of care

The Prescription Review Program recently received a letter from a family physician relating the tragic story of a man who had been in long-term, abstinence-based recovery suffering a life-threatening relapse triggered by an inappropriate prescription:

"I was asked to help a young man, an addict in recovery, who was given hydromorphone for pain despite both him and his wife explaining he could not receive narcotics. He had a good job, had achieved a university education and was living with his wife and baby in their new home. He is now on the street, his life is in shambles and he may well die."

Patients who suffer from the lifelong disease of opioid addiction may require opioids to treat severe acute pain associated with objectively demonstrable pathology like fractures and major surgery, but the medicating must be actively managed and closely monitored. Addiction is a disease characterized by loss of control. People with addiction cannot be relied upon to take their meds safely on a PRN basis, and they must never be sent home with a bottle of pills without supervision. The inevitable struggle to withdraw the opioid when the tissues heal requires explicit advance planning, including a pre-determined end date, consideration of daily dispensing and mobilization of recovery resources such as attendance at a 12-step program, and recruiting a sponsor and other supports. The patient, family or friends, and the physician must all be actively engaged. It is never acceptable to simply issue a prescription in such circumstances and hope for the best.

Similarly, alcoholic patients are too-often provided with opioids, benzodiazepines, and/or sedative hypnotics, and not even asked about that very strong relative contraindication.

History-taking in advance of prescribing a potentially addictive drug must always include consideration of risk. Physicians would never start a beta-blocker without inquiring about asthma! It is equally unacceptable to prescribe an opioid or sedative without asking the high-yield question: have drugs or alcohol ever caused problems in your life? An affirmative response requires very careful consideration of whether the modest potential benefit justifies the significant risk and must often conclude with an empathic, evidence-based, patient-centred "no."
All physicians struggle with this issue as they inevitably become healers to relieve suffering. In the context of addiction, a physician's inclination to medicate symptoms has the potential to cause harm.

Protect duplicate prescription abuse

Registrants should be aware that using a sticky-label patient identification on a duplicate prescription can enable misuse and diversion as the labels are easy to remove, and therefore are not appropriate for a prescription—especially for controlled medication.

Take note of the *Pharmaceutical Services Act*

Registrants are reminded that the *Pharmaceutical Services Act* states that only "prescribed information management technology" can be used for issuing electronic prescriptions. In British Columbia, the prescribed interface is PharmaNet. The Ministry of Health is currently conducting a pilot test for e-prescribing through PharmaNet. However, until such time as e-prescribing is implemented, pharmacists are obligated to insist on an original or unique signature each time a prescription is authorized. The College is encouraged by the work being done by the ministry to enable e-prescribing in future, and will continue to update registrants as more information becomes available.

The Prescription Review Program (PRP) is a practice quality assurance activity established to assist physicians in the challenging task of utilizing opioids, benzodiazepines, and other potentially addictive medications with appropriate caution for the benefit of their patients. The work of the PRP is informed by the PharmaNet database.

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Updates from the Methadone Maintenance Program


BC METHADONE MAINTENANCE TREATMENT CONTROLLED PRESCRIPTION PROGRAM FORM
Take to pharmacy of choice.
PLEASE PRINT
PATIENT NAME
ADDRESS
METHADONE 10 mg/ml
QUANTITY
DIRECTIONS FOR USE
METHADONE mg/day
CPSID
FOLIO
PHARMACY USE ONLY
VOID
PHARMACY COPY - COPYING OR DUPLICATING THIS FORM IN ANY WAY CONSTITUTES AN OFFENSE
PRESS HARD
YOU ARE MAKING 2 COPIES

A new commercially available methadone 10 mg/ml solution (Methadose®) has been available for purchase by pharmacies in Canada since 2012. Starting on February 1, 2014, Pharmacare will approve coverage of Methadose® for the treatment of opioid dependence. At that time, Methadose® will replace the current anhydrous methadone solution for the treatment of opioid dependence in patients registered in the BC Methadone Maintenance Program.

New prescription pads for Methadose®

Prescriptions for Methadose® for opioid dependence must only be written on a newly developed Methadone Maintenance Program prescription pad, which the College will make available to all methadone maintenance prescribers in January. At that time, prescribers will be required to return any of the former unused prescription pads to the College for secure shredding. (Physicians should keep any used carbon copy prescriptions, which form part of the patient record.)

Physicians who are exempted to prescribe methadone for opioid dependence but currently do not have a methadone prescription pad, and are using their duplicate prescription pad to write methadone prescriptions, should contact the College to ensure that they receive the new pads in 2014. These physicians may include hospital-based physicians such as hospitalists, and specialists in internal medicine, psychiatry and anesthesia.

The month of February will be considered a transition period where existing prescriptions written on the old forms will be honoured until they run out. All new prescriptions for opioid dependence must be written on the new pads.

Note: As of February 1, 2014, pharmacists will not accept new prescriptions for methadone for opioid dependence unless the prescription is written on the new pads.

The new prescription reflects medication dosage in milligrams not millilitres. The new prescription pads do not include the words “Void if Altered” since specific space has now been provided to document any special instructions. This does not mean that alterations are permitted and pharmacists will not accept altered prescriptions.

It is likely that Methadose® will also be covered by Pharmacare for the treatment of palliative and chronic non-cancer pain. Prescriptions which are for pain and not opioid dependence should be written on the duplicate prescription pad.

Although the current anhydrous methadone powder may still be available in the future, it will become less available over time and some pharmacies may not stock it.

Patient safety concerns

Methadose® is different to anhydrous methadone solution in appearance, strength and handling. The new strength of 10 mg/ml is 10 times the concentration of usual compounded methadone 1 mg/ml solution and may present a public safety risk during the transition period.

Methadose® is a red, cherry-flavoured solution and, unless diluted, does not require refrigeration. It therefore resembles many other commonly used over-the-counter medications. Patients will need to be reminded that Methadose® must be stored safely and out of reach of children. This is of particular concern given the new concentration.

Patients with a true allergy to certain ingredients of Methadose® will require approval from Pharmacare for coverage of an alternate product.

The Methadone Maintenance Program makes recommendations to Health Canada regarding physicians obtaining authorizations to prescribe methadone as exemptions under section 56 of the Controlled Drugs and Substances Act*.*

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Updates from the Physician Practice Enhancement Program

A good foundational program has evolved to become even better

Quality assurance activities, such as ensuring the competence of registrants, are not new to the College. In fact, the original Committee on Medical Practice Assessment (COMPA) began conducting peer reviews in 1987. The COMPA program was well accepted by community based physicians because it was collegial, remedial and educational, and it often led to a practice improvement diffusion effect among colleagues.

With all of its strengths, the original program was relatively expensive and inefficient (only 100 assessments were conducted in a given year), and was unable to comment on the standards of practice of all physicians. Nevertheless, it provided a solid foundation for a new, expanded and more comprehensive peer assessment program for all physicians.
When considering what an ideal physician assessment program should look like, the College concluded that it must:

- be educational, remedial, collegial (like the previous COMPA program) and not punitive
- be created and administered by physicians, for physicians
- be peer-based
- be able to capture the CanMEDS competencies
- be applicable to all BC practising clinical physicians on a cyclical basis
- guarantee confidentiality under section 26(2) of the College Bylaws which state that the information cannot be shared under FOI legislation, legal requests or by any other College department other than the Medical Practice Assessment Committee (MPAC), a committee comprised of family physicians and specialists
- be able to capture systemic clinic environments which may impact physician performance
- be efficient and cost-effective
- not be duplicative

In 2011, building on these principles, the College renamed the COMPA program to the Physician Practice Enhancement Program (PPEP). The PPEP is comprised of three distinct assessment modules:

- peer assessment of recorded care
- assessment of office premises and processes
- multi-source feedback (MSF)

The peer assessment of recorded care is no different than that previously conducted under COMPA except that assessors now conduct 500 peer assessments annually, which necessitated the expansion of the assessor pool to 60 physicians—all of whom have undergone peer assessments themselves and attended the College's assessor training workshop.

Currently, the assessment of office premises and processes is being conducted by the physician peer assessors; however, in future, this process will be modified to become a much more valuable evidence-based teaching opportunity for clinic staff. Using a tracer methodology adopted by the College's facility accreditation programs, office assessments will focus on reprocessing of instruments, storage of drugs, and patient safety issues.

The multi-source feedback component of the PPEP was initiated in February 2013 and is administered by an external company called Pivotal Research Inc., an Alberta-based firm that processes the feedback reports from 25 patients, eight physician colleagues and eight co-workers (nurses, MOAs, pharmacists) of the physician's choosing. The data used to develop the final report is completely anonymized. Due to the amount of data collected, response rates, and the coordination of the MSF component with the office visit, it is not unusual for the entire process to take six months or more from start to finish.

The Medical Practice Assessment Committee reviews the peer assessment and MSF reports and, based on assessment outcomes, may recommend remedial or educational activities to the physician.

While the PPEP is still very much in the beginning stages of implementation, ideas for enhancements are already being considered, such as:

- Expanding the program to include specialists who choose to practise outside of the hospital environment (e.g., dermatology, ENT, orthopedics). Specialists interested in becoming assessors should contact the PPEP staff.
- Piloting an e-assessment program that will make the assessments more objective, efficient and allow for instant access to evidence-based standards for teaching purposes.
- Engaging in academic research to help answer the question: How is feedback best given to physicians to improve their clinical care? Physicians who have already been assessed will be asked to participate in a survey to evaluate the program.

The Physician Practice Enhancement Program is a collegial program that proactively assesses and educates physicians to ensure they meet high standards of practice throughout their professional lives. The goal of the program is to promote quality improvement in community-based physicians' medical practice by highlighting areas of excellence and identifying opportunities for professional development.

Are you about to be assessed? Click here to find answers to frequently asked questions about the assessment process.

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Updates from the Non-Hospital Medical and Surgical Facilities Program

Skin preparation—a collaborative effort

Special care and attention must be taken to prevent injury such as chemical burns to a patient during surgical skin preparation, especially when prepping areas such as the face, eyes and ears or mucous membranes.
Selecting an appropriate skin preparation is a collaborative effort, which requires both surgeons and perioperative nurses alike to be knowledgeable in the selection process, including awareness of any contraindications and/or special precautions. The surgical site prep solution used should also be reviewed during the briefing period of the surgical safety checklist with all members of the surgical team present.

The surgical skin preparation is documented on the perioperative record, and must include the condition of the skin if other than healthy and intact, name and concentration of prep solution used, any skin reaction that occurred, and the name of the person performing the skin prep.

Note: Incidents that result in a harmful or undesired effect to the patient, whether or not the risk or hazard was averted, must be reported to the College in accordance with the Bylaws.

For more information, registrants should refer to the Operating Room Nurses Association of Canada (ORNAC) *Standards for Perioperative Registered Nursing Practice* and the Association of periOperative Registered Nurses (AORN) *Perioperative Standards and Recommended Practices* for further information on surgical skin preparation.

CPR for health-care providers

Physicians and dentists who perform surgery or procedures in a non-hospital facility and all clinical staff at the facility, e.g. nurses, refractive assistants, must hold current Basic Life Support for Healthcare Providers (BLS HCP) training.

Education providers of BLS HCP training are issuing training certificates with expiry dates ranging from one to three years from the date of completion of the training course; however, an expiry date of one year is becoming more common. The NHMSFP Committee has decided the following:

- that current BLS HCP will be based upon the date of completion of the training course and not the expiry date on the certificate; and
- that BLS HCP must be completed every two years from the date of the training course.

Anesthesia Laerdal Trachlights™ must be removed

In September 2009, Laerdal announced that they had discontinued their Trachlights™, Stylets and Tracheal Lightwands. Laerdal further advised that Trachlights™ (handles, wands and starter kits) not be kept for more than three years due to the material properties and lifetime expectancy. With three years now past, registrants should take action to remove Trachlights™ from non-hospital facilities.

In addition to basic intubation equipment, all Class 1 facilities must have at minimum two alternative methods for difficult airway intubation and management. Alternative intubation methods are left to the clinical judgment and preference of the anesthesiologist(s) working at the facility. Suggestions include but are not limited to: LMA Fastrack, glidescope, Light Wand™ (not to be confused with the Trachlight™), McCoy curved laryngoscope.

Providing a latex-safe environment

Non-hospital facilities are required to provide a latex-safe environment for patients with a known or suspected latex allergy. Registrants are reminded of the importance of identifying patients with food allergies and/or sensitivities that may suggest a latex allergy as outlined in the NHMSFP accreditation standard: *Latex Allergy*. Latex cross-reactivity foods include but are not limited to: bananas, avocados, chestnuts, apricots, kiwis, papayas, passion fruit, pineapples, peaches, plums, cherries, melons, figs, grapes, potatoes, tomatoes, celery, apples, pears, carrots, hazelnuts, wheat, rye, molds and pollen. Further information on cross-reactive foods can be found at American Latex Allergy Association.

Allergies and reactions need to be up to date and the information shared with all health-care professionals. As a final check, allergies and reactions must be discussed by the surgical team during the briefing period of the surgical safety checklist before proceeding with the surgery.

Flooding may pose risk to patient safety

Flooding in a health care facility poses a potential threat of infection to current and future patients, therefore, flooding of a non-hospital facility must be immediately reported to the College and scheduled surgeries may potentially be cancelled. The non-hospital facility must retain a certified infection, prevention and control (ICP) consultant to immediately assess the situation, direct the facility and restoration team on the remedial measures, and provide written confirmation when the potential threat of infection has been effectively mitigated. The ICP reports must be submitted to the College for review and the non-hospital facility may not recommence surgery until final approval has been granted by the College.

The Non-Hospital Medical and Surgical Facilities Program requires private facilities to maintain high standards of practice equal to or exceeding public hospitals. The program establishes accreditation and performance standards, procedures and guidelines to ensure the delivery of high quality health services. The 700 physicians who work in private facilities across the province must be granted privileges by the College.

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CME events: mark your calendars

Medical record keeping workshop
Wednesday, February 19, 2014
Wednesday, May 14, 2014
Wednesday, August 27, 2014
Wednesday, November 5, 2014

This course is primarily directed at family/general practitioners and other physicians providing primary care. The course is delivered in an interactive format using real case examples and simulated patient encounters to demonstrate the practice of effective clinical record keeping.

- More information on the program
- Register now

Pain and Suffering Symposium
Friday, March 7–Saturday, March 8, 2014

The 27th annual Pain and Suffering Symposium is presented by the Foundation for Medical Excellence in cooperation with the College of Physicians and Surgeons of British Columbia. This course is designed to assist clinicians in managing the most challenging of pain patient; patients with complex chronic pain.

- More information on the program
- Register now online or on page 4 of the brochure

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Discover evidence quickly at the library

Valid and relevant evidence from the College library

Systematic reviews and meta-analyses are the highest level of evidence to support clinical decisions. Registrants can quickly locate these publications by searching any of several online resources through the library section of the College website.

The Cochrane Database of Systematic Reviews from the Cochrane Collaboration provides access to the full text of highly regarded, comprehensive and independent reviews. The content of the reviews focuses on summaries and analyses of randomized controlled trials on clearly defined questions, primarily on clinical effectiveness of diagnostic procedures and therapies. Cochrane reviews can be lengthy but the structured abstract and plain language summary in each review provide quick overviews of the issues and final recommendations. Another location for searching out Cochrane reviews is MEDLINE. While the full text of the reviews is not available through this source, registrants may request a copy from the library staff or locate the Cochrane Database of Systematic Reviews title in the library's list of e-journals and download the review.

Clinical Evidence from BMJ Group, like the Cochrane Database of Systematic Reviews, is a database of systematic reviews but also contextualizes the reviews in a larger body of useful clinical information. Browse to a clinical condition, e.g., Raynaud's phenomenon, and view a one page summary of the review, summaries of interventions ranked by their effectiveness, background information about Raynaud's phenomenon, and a tabular view of the evaluation of all therapeutic interventions considered for this condition. Clinical Evidence content arises from systematic and rigorous searching of the international literature on common clinical situations and therefore is a valuable and practical tool.

PubMed Health is a new free database designed for the public and practitioners. It aggregates high levels of evidence published by select institutions such as DARE (Database of Reviews of Effects) and NICE (National Institute for Health and Care Excellence) from the UK, the US Agency for Healthcare Research and Quality, and the Cochrane Collaboration. Search results can be filtered by consumer information, clinical information from guidelines, and systematic reviews. This database appears to be small as yet; however, with the resources of the US National Library of Medicine behind it, PubMed Health may become an influential health information resource in the future.

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Disciplinary Actions

- Mahjoob, Mojtaba – November 8, 2013
- Costin, Avrum – November 8, 2013
- Nesbitt, Patrick Michael – November 7, 2013
- Rohani, Farrokh – October 28, 2013

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