Clinical Pharmacy Practice: looking back and ahead

As the new vice-president of ESCP I like to share some personal thoughts with you. When you are beginning with such new duties, you should – for a moment – feel like Janus, the god of the ancient Romans with the two faces, one looking back, one looking ahead. You must recognise where you come from in order know where you want to go.

Looking back in my case means to have an overview of almost twenty years of hospital pharmacy practice. Over this period I have experienced an enormous change in my personal work field but also in how pharmacy developed. When I started my career in hospital the pharmacist – at least in Switzerland – normally stayed in their pharmacy, now and then up to the ward to check the drug stocks there and to tell the nurses how to keep them in good order. The term “clinical pharmacy” was unknown to me; in my undergraduate education it was never mentioned. In our country there were just a few enthusiastic pioneers in this field. Sometime later I had the opportunity to participate in an ESCP conference where I live in Basel. Impressed and fascinated by all the possibilities how the pharmacist could be involved and integrated in patient care, I started with some small projects in clinical pharmacy in our hospital.

I do not want to tell you our whole story now. However perhaps by reading these lines you started to remember yourself how it was some years ago, how all started. When you compare this with the present, you recognize what has been achieved over time. Looking around me, I can see clinical pharmacy activities everywhere: at our university there are currently two chairs in this field (pharmaceutical care and clinical pharmacy/pharmacoeconomics), undergraduate students get a broad training in addressing the needs of patients and assessing their pharmacotherapy, there are postgraduate education programs in our hospital and many other sites in clinical pharmacy. In my daily practice I spend much more time on the ward than in my office, community pharmacists in Switzerland can provide a medication review to patients (polypharmacy check) for which there is reimbursement by the health insurance without a physician's prescription. Many other examples could be added. A bright future ahead – this was once the title of an ESCP symposium. This bright future has begun. This success story will continue when pharmacists all over Europe, in community pharmacies, in hospitals, in health authorities and in academia maintain the same enthusiasm as the pioneers I met about twenty years ago. Clinical pharmacists are no longer pioneers, they are in most health care systems established partners in the patient's care team. However in our minds we should keep the spirit of the pioneers. We must remain open for changes in the field and continue our effort to implement new developments.

Our society is supporting you in these efforts. This is also why the conference 2013 in Prague will be dedicated to the implementation of clinical pharmacy in practice, management and education. Supporting our members by providing interesting, up-to-date and evidence-based continuous education is the main goal of ESCP.

This is essential for promoting clinical pharmacy but not enough in isolation. Each member is strongly encouraged to participate in this process not only in his personal field but also in the ESCP. Discussing new developments, redefining definitions or setting standards is not only up to the official committees of ESCP but up to each of us. The definition of clinical pharmacy, the differences in provision of pharmaceutical care and the consequences thereof is one of those topics which should not only discussed by expert panels but considered in different approaches and levels of practice in the various European countries and worldwide. This year ESCP will start a process addressing these issues in which our members will be involved. I hope that as many as possible will be part of the discussion. You and me and all our colleagues can stimulate the thinking and contribute to the further development of clinical pharmacy.

Happy New Year!

A Few Words

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Marcus Lampert
ESCP Vice-President
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The overall aim of the Society is to develop and promote the rational and appropriate use of medicines by the individual and by society.
Who's who: Tobias Dreischulte
Member of scientific committee for ESCP Copenhagen (2014)

Personal details: Tobias Dreischulte, born on 10th January 1976 in Haselune, Germany.

Education: PhD (2012) from the University of Strathclyde, Glasgow (supervised by Prof Steve Hudson), MSc in Clinical Pharmacy (2005) from the University of Strathclyde, Glasgow. Approval as pharmacist (3. Staatsexamen)2001. Pharmacy degree (2. Staatsexamen), University of Bonn, Germany.

Work activity: Being the child of two community pharmacists, I started my professional career in community pharmacy in Hamburg, Germany (2001 to 2003), where I became interested in providing ‘pharmaceutical care’ to HIV positive patients. I soon realized the limitations of the German undergraduate pharmacy curriculum (which did not include clinical pharmacy at the time) and decided to go abroad to learn clinical pharmacy the “Scottish way”.

On my return, I took on a post as a hospital pharmacist (2005), where I contributed to developing clinical pharmacy services in parallel to the implementation of unit dose dispensing systems (2005 to 2009). Towards the end of my PhD (2009), I took the opportunity to return to Scotland to take on a research post at the University of Dundee/NHS Tayside.

Research: My PhD built on methods developed at the University of Strathclyde, Glasgow, to assess adherence of prescribing to evidence based guidelines for chronic disease management. Medication assessment tools - MATs. I have conducted research in Germany, Scotland and the Netherlands in order to pilot-test the use of these MAT instruments as part of a multi-disciplinary strategy for continuous quality improvement of drug therapy use in inpatient, outpatient and primary care settings.

My current post as a lead investigator on the Data-driven quality improvement in primary care (DQIP) program, has allowed me to further develop this strategy in primary care and to test it in a randomised controlled trial. For the purposes of the DQIP trial, we have operationalised a selection of prescribing safety indicators in general practices’ electronic medical records (EMRs) to identify patients at risk who may benefit from a targeted medication review. GPs can access the list of patients affected by targeted prescribing via a web-based IT tool, with access being controlled by practices. Financial incentives are provided to practices for reviewing patients (but not for changing prescribing). Although DQIP currently has a rather narrow therapeutic focus, I believe that the approach of using EMRs to systematically identify patients at risk of harm or other suboptimal drug therapy outcomes may potentially be extended to other therapeutic fields. This would open up opportunities for practice and/or community based pharmacists to become involved (and potentially be re-imbursed for) reviewing patients with actual opportunities for better care.

Other current research activities of mine include epidemiological research into the link between high-risk prescribing and patient clinical outcomes and into the conceptual basis of pharmaceutical care and clinical pharmacy.

Scientific Committees and Elected Positions: ESCP general committee (since 2012); ESCP research committee (since 2012); Member of scientific committee for ESCP Copenhagen (2014).

Tobias Dreischulte
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41st ESCP Symposium on Clinical Pharmacy
Barcelona, Spain, 29-31 October 2012
Personalised and Safe Therapy

Based on the nominations received until the deadline 31 March 2012, the General Committee (GC) of the ESCP decided on five additional members to be recognized as ESCP Fellows. The awardees received both a certificate and a plaque (see photo).

ESCP Fellowship is awarded in recognition of continued excellence in clinical pharmacy practice and/or research, contribution to the advancement of clinical pharmacy, preferably in Europe, and services for ESCP (www.escpweb.org/cms/node/75).

In detail, all awardees have been a full member of ESCP for at least 5 years, have been in pharmacy practice and/or research for at least 5 years since receipt of their highest professional pharmacy degree, and have made a sustained contribution to ESCP through activities i.e., numerous presentations at ESCP conferences and symposia as well as taking leadership for workshops. In addition, they provided voluntary service to ESCP committees such as the International Office or served the Society as elected officers to the General Committee and/or SIGs. Moreover, longstanding contributions to publication and communication activities for our communication tool ESCP News and/or our official scientific journal International Journal of Clinical Pharmacy (IJCP) and/or for our website, among others, contributed to their outstanding record.

The following outstanding colleagues have, therefore, been recognised on 29 October 2012 during the opening ceremony at the ESCP Symposium in Barcelona, Spain.

The 2012 Fellows (see picture in the last issue of ESCP News 157) are:
PD Dr. Johnny Benney (Switzerland)
Prof. Dr. Margarida Caramona (Portugal)
Dr. Marie-Caroline Hussin (France)
Dr. Foppe van Mil (The Netherlands)
Heidi Sørensen (Denmark/The Netherlands)

Congratulations New ESCP Fellows!

The next Fellows will be awarded during the ESCP symposium in Prague this year.

Please, email your nomination in the required format (www.escpweb.org/cms/node/75) before 31 March 2013 to: The President of ESCP at president@escpweb.org

Martin Schulz
M.Schulz@abda.aponet.de

FESCP description & criteria, few precisions
This workshop was organised in collaboration with Stephanie Steurbaut (PharmD, MSc, PhD), assistant professor in Pharmaceutical Care at the Free University and University Hospital, Brussels, Belgium.

The SI-G workshop was in line with the overall theme of this year’s conference. Its main aim was to provide the participants with practical tools in the prompt identification of adverse drug reactions (ADRs) in the patient setting. It was also designed for participants to practice causality scales on clinical patient cases.

More than 40 colleagues registered, but only 30 could be accommodated in the assigned room. The participants were welcomed with a mini-survey to provide an insight into pharmacovigilance in their institution and country. The results of this survey will be published in the next ESCP newsletter.

The objectives of the workshop were for the participants to:
- Appreciate the importance of early recognition of possible ADRs and differentiate them from disease-related events.
- Practice the causality scales to assist in a prompt identification of ADRs.
- Become familiar with information sources providing relevant details about ADRs.

We started off with a brief introduction providing definitions and terminology used to describe ADRs. This was followed by a practical guidance about causality scales such as the Naranjo scale and the WHO-UHC system.

The main part of the workshop involved case studies in small groups and the feedback from each of the groups. This allowed highlighting the advantages and limitations of the causality scales currently available.

The workshop was completed with a demonstration of the initiatives taking place at the European level (http://eudravigilance.ema.europa.eu and http://www.adreports.eu) and stressing the overall importance of early recognition and reporting of ADRs.

The motivation and enthusiasm of the participants made it a very enjoyable event. Stephane and I thank all the participants for joining us and sharing their experience.

The slides are posted on the ESCP website.

Yolande Hanssens
SIG Leader - Medicine Information
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The prescription of a medicine is one of the most common interventions in healthcare. However, the full benefit of pharmacological interventions can only be achieved if patients follow drug regimens closely. Adherence is, however, low in chronic medical conditions: approximately 50% of all people with chronic medical conditions do not adhere to their prescribed medication regimens.

The implications of non-adherence are far reaching as non-adherence might severely compromise the effectiveness of treatment and increase health care costs. The cost of non-adherence in the USA, for example, has been estimated to reach $100 billion annually. The reduction of non-adherence is therefore thought likely to have a greater effect in health than further improvements in traditional biomedical treatment.

### Three phases of non-adherence

Adherence is defined as the degree or extent to which patients follow agreed upon recommendations from health care providers. Looking more closely, adherence can be divided in three quantifiable phases: “initiation”, “implementation” and “discontinuation” (figure 1). Initiation of pharmacotherapy occurs when the first dose of a prescribed medication is taken, whereas discontinuation occurs when the medication is stopped. Implementation means finally the extent to which patient’s dosing corresponds to the prescribed regimen.

### Causes

Non-adherence has various causes, including lack of motivation and insufficient knowledge, concerns about the medication, practical barriers and forgetfulness. According to DiMatteo, interventions to improve adherence should focus on 3 aspects: information (understanding of medication therapy), motivation (patient’s beliefs in the medication) and strategy (practical barriers like being unable to open the blisters or forgetfulness) (DiMatteo, et al, 2012). Because the causes underlying nonadherence vary from patient to patient, a multifaceted, individually tailored intervention tailored to the specific needs of the patient and reasons for nonadherence seems to be the most effective approach to boost adherence (van Dulmen, et al, 2008).

### Role of the pharmacist

Clinical pharmacist can have an important role in the improvement of medication adherence. They have knowledge of the (dis)advantages of pharmacological treatment, have an overview of the patient’s actual medication use and might help patients to discuss their thoughts about the pharmacological treatment and practical barriers during treatment. Several clinical pharmacists already give adherence interventions. For example, in a prospective study of 200 community-based patients aged 65 years or older taking at least four chronic medications for coronary disease, pharmacist intervention - through standardised medication education, regular personalised follow-up, and medications dispensed in blister packs - led to increases in not only medication adherence and persistence but also clinically meaningful reductions in blood pressure [Murray 2004].

### ESCP Special Interest Group Medication adherence

Thus pharmacists have, in close collaboration with other health care providers, a variety of behavioral, educational, and technical tools at their disposal to identify, encourage, and improve adherence. Realizing this, an ESCP special interest group Medication adherence is constituted which will be a platform on which both clinical pharmacist interventions to improve adherence and medication adherence research by clinical pharmacists can be shared and discussed. The ESCP SIG medication adherence will organize during the ESCP congresses sessions to discuss, share and educate issues (practical/methodological) on this topic.

Are you interested in this Special Interest Group, don’t hesitate to contact the SIG (b.vandenbemt@maartens-kliniek.nl). This SIG is an open SIG, for which we will invite all pharmacists with clinical and/or scientific interest in medication adherence. Together we can determine the first themes to cooperate internationally. I look forward to working together with you on medication adherence!

**Bart van den Bemt,**
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**In Memoriam**

Marija Marić

The news that Marija Marić, passed away at the tender age of 28 years was received as a shock and with great sorrow.

When Marija, from Serbia, was still a pharmacy student she had a vision of leadership and internationalisation of pharmacy. She was active in activities organized by the European Pharmaceutical Students Association (EPSA) and was the EPSA treasurer for the period 2008-2009. Through these activities she collaborated with the Department of Pharmacy of the University of Malta and with Maltese pharmacists including Marisabelle Bonnici who at the time was EPSA President and Marjesca Attard Pizzuto who was a Pharmacy Awareness Working Committee Director.

Marija believed in the impact and value of getting pharmacy students together and that students should take an active role in shaping the developments in their profession. She was undoubtedly a role model for European students and then later took up her professional career with great enthusiasm. The pharmacy profession has lost a great pharmacist at a young age. Marija will be sorely missed, not only for her knowledge, abilities and professionalism, but also for the kind of person she was and the way in which she encouraged her friends and colleagues.

The Department of Pharmacy of the University of Malta would like to offer condolences to her family and to EPSA. Marija’s legacy will continue through the work of EPSA which strives to instill in pharmacy students international collaboration for the developments in the pharmacy profession.
From Clinical Pharmacy Practice to Clinical Pharmacy Research: defining your research question

Where studies are generated in a lot of cases by researchers themselves, the process usually involves an initial idea or topic generating from daily practice, from personal theories or hunches, or from other research papers. No matter the origin of the study, these original ideas need to be translated in more specific questions. The researcher has to become very clear about what exactly it is they want to describe and explain, and also about the more detailed questions they will need to address the issue. Such detailed questions are the solid base for the research study design which will be written up in a study protocol.

A good research study design is one which has a clearly defined purpose, in which there is coherence between the research questions and the methods or approaches proposed, and which generates data which is valid and reliable. It is also one which is realistic, conceived with due regard both for practical constraints of time and money and for the reality of the research context and setting.

The research question is the most critical part of a research protocol: it defines the proposal, it guides the arguments and inquiry, and it provokes the interests of the reader. It demands time to write a strong research question. Step away from your computer; consider what drew you to your topic. Next, extensively research your topic: What have people said about it? How have they framed their research? What gaps, contradictions, or concerns arise for you as you read, talk to people, and visit places? Reviewing the literature and talking to experts in the field will help you in this process. After you have done this, you can start defining the question itself. Specific frameworks have been developed to help researchers formulate research questions step by step and factor by factor. Examples of such frameworks are PICOT, PESICO, and SPICE. They provide a structured method for brainstorming and finalising your research questions:

- **PICOT**: Population, Intervention, Control, Outcome, Time frame
- **PESICO**: Person/problem, Environments, Stakeholders, Intervention, Comparison, Outcomes
- **SPICE**: Setting, Population, Intervention, Comparison, Evaluation

After finalising your draft research question, check if it follows the characteristics of a good and strong research question. The research question should be:

- clear, intelligible and unambiguous;
- focused, but not too narrow;
- capable of being researched through data collection;
- relevant and useful, whether to policy or practice;
- informed by and connected to existing research or theory, but with the potential to make an original contribution or to fill a gap;
- feasible, given the resources available.

Alternatively, characteristics of a strong research question can be summarised by the mnemonic FINER: Feasible, Interesting, Novel, Ethical, Relevant. Subsequently, the research question must be further refined and determined whether it is worth pursuing until it matches the above criteria. It is important, at the outset, to spend the energy and resources necessary to establish a clearly defined research question prior to study design. The research question should subsequently guide the research design, methods, and analytic strategies. A strong research question will help you in getting your results disseminated.

I hope this brief introduction in the first step of setting up your own research study will stimulate you in identifying new areas of research in clinical pharmacy and in defining solid research questions. I’m looking forward to receiving the results of your various studies as abstracts submitted (check out our revised ESCP scientific guidelines on our website: [http://www.escpweb.org/cms/Guidelines](http://www.escpweb.org/cms/Guidelines)) to one of our upcoming meetings.

Siska Desplenter
ESCP President
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References


ESCP SIG Geriatric

Answer of the clinical case (page 3).

To be able to detect a prescribing cascade, it is important to obtain the prescribing sequence. The last medication prescribed for this patient was Primidone 125 mg twice daily for tremors according to the daughter. This patient saw her family doctor for her tremors according to her daughter.

When treating essential tremors, it is important to review medications and diseases that can worsen symptoms. TSH level was 0.01 µIU/mL upon admission to the hospital which is suggestive of hyperthyroidism.

The patient was receiving Levothyroxine 0.075 mg daily which was too high considering a suppressed TSH level. Pregabalin has also been associated with tremors as part of its side effect profile.

Primidone has been used for the management of essential tremors. It is metabolised to phenobarbital. Side effects from primidone include sedation, vertigo. It is not a drug of choice in elderly patient. In this case, her hyperthyroidism was probably the cause of her tremors along with pregabalin.

Second potential prescription cascade:

- Primidone was discontinued. No tapering was necessary since it had been started 2 weeks prior to admission.
- Dose of Levothyroxine was decreased to 0.025 mg daily. TSH to be repeated in 6 weeks.
- Atorvastatin was discontinued (at 104 year of age who needs atorvastatin).
- Pregabalin was slowly tapered and discontinued.

The patient was not able to return home.

ESCP SIG Geriatric
The Medical Humanities are concerned with "the science of the human", and bring the perspectives of disciplines such as history, philosophy, literature, art and music to the understanding of health, illness and medicine. They explore how the humanities, traditionally concerned with recording and exploring human experience, engage with specific experiences of patients, doctors, health, illness, and suffering (1). An integrated conception of the Medical Humanities carries this engagement through to the perennially important question: What is medicine for? It affirms medicine's unique character as a form of human self exploration, recognising that in medicine our material and our experiential natures are irreducibly fused; our bodily tissues and our personal values unite in constituting those experiences of illness and suffering which send people to their doctors. Medicine's objects, its patients, are also self reflecting subjects who, together with the prescriber, actively form and transform the clinical encounter, the central arena of medicine.

The Medical Humanities are designed to overcome the separation of clinical care from the "human sciences" and to foster interdisciplinary teaching and research to optimise patient care. The separation between biomedical and human translates too easily into stereotypes: science as cold, unfeeling, and sometimes dangerous, and the humanities as warm-hearted and well-intentioned, but possibly less "scientific". Both sides can be united if a shared approach is used to deepen our understanding of human health and wellbeing by calling on multiple perspectives, biomedical, philosophical, historical, artistic, literary, anthropological and sociological. The result of this approach should be a more insightful view of the patient, the doctor and the healthcare system, and an enhanced capacity to cure, relieve and comfort (2). This important integration is echoed in the World Health Organization's 1946 preamble, wherein health is defined as "a state of complete physical, mental, and social well-being rather than merely the absence of disease or infirmity". Engagement with the humanities might offer several benefits, including fostering clinicians' abilities to communicate with patients, to penetrate more deeply into the patient's wider narrative, and to seek more diverse ways of promoting well being and reducing the impact of illness or disability (3). For chronic illness in particular, where biomedical offers only a partial response, clinical medicine seems likely to serve its patients best by incorporating into their treatment an appreciation of individual patients' experience into their treatment. This might help to avoid overprescribing, or occasionally under prescribing, and overdependence. There is a wealth of scientific journals devoted to Medical Humanities providing evidence of a great interest in the topic.

Do art and literature belong in a medical journal?
"Every contact with patients has an ethical and artistic dimension, as well as a technical one" (4). These words from a BMJ editorial (1999) announced a new journal, "Medical Humanities", belonging to the BMJ group. This journal reflects the whole field of medical humanities and aims to encourage a high academic standard for this evolving and developing subject and to enhance professional and public discussion.

Early, the Annals of Internal Medicine inaugurated (1990) a new section, "On Being a Doctor" that examined the human experiences of being a doctor and thus reflected the literary and philosophical sides of medicine (5). "On Being a Doctor" attracted enthusiastic interest and attention; authors sent their experiences of doctoring and increasingly, they often told the story from the other side of the desk, the other end of the bed: the experience of being a patient. In 1995 the editorial board decided, therefore, that the patient's universe deserved its own place in the Annals of Internal Medicine pages and set up a new series, "On Being a Patient," a natural extension of and counterbalance to the doctor's perspective (6).

• The Canadian Medical Association Journal (CMAJ) also launched its space for medical humanities: the left atrium, a gracious and accommodating space, designed to reach out to poets, writers,ographers and artists with an interest in illness and healing (7).

• The Journal of the American Medical Association, JAMA, has a section "A piece of my mind" devoted to Medical Humanities (8).

• In the "Perspective" section, the New England Journal of Medicine (NEJM) publishes pieces on the intersection of medicine and society (9).

Daniela Scala
Chair of ESCP Communication Committee
Sdaniela2000@yahoo.com

Bibliography:

Improving Patient care through Collaborative Practice is the title of the international workshop to be held in Edinburgh 30-31 May 2013. Participants will have the opportunity to hear 4 plenary lecturers and attend 2 (of 4) linked workshops which will be repeated on both days.

Day 1 starts at 9.30am and includes a lecture from Professor Barr, president of the UK Centre for the Advancement of Interprofessional Education (CAIPE). He serves on the Board of the International Association of Interprofessional Education and Collaborative Practice and also the WHO study group reviewing interprofessional developments worldwide. Following participation in a workshop, Day 1 will conclude with a lecture from a practicing clinical pharmacist, Gordon Thomson Lead Pharmacist, Urgent Care and Medicine NHS Tayside. He is a faculty member of the Scottish Patient Safety Programme and has several years experience in implementation of multidisciplinary patient safety initiatives in the acute care setting.

Day 1 finishes with a welcome reception at the conference centre http://www.edinburgh-first.co.uk/venues/johnmceintyre-conference-centre

Day 2 starts at 8.30am and includes a lecture from Professor Han de Gier, University of Groningen, on the development of information technology to support information sharing between professionals with particular emphasis on community pharmacy. The final lecture will be given by Dr Margaret Whoriskey who leads the joint improvement team at the Scottish Government and will explain the need for health and social care integration in the management of chronic diseases including opportunities for pharmacist engagement.

Four parallel workshops will allow participants to further explore collaborative practice. The same workshops will be repeated on days 1 and 2 allowing participants to attend 2 of the workshops. Abstracts on the theme of collaborative practice are invited, an oral communication session will be held in the afternoon of day 2 and the workshop will close at 17.00hrs. Edinburgh has several excellent restaurants - participants will be provided with a list of recommendations. We look forward to welcoming you in Edinburgh 30-31 May 2013.

To learn more about the programme and register, visit: www.escpweb.org or mail info@escpweb.org

15 December 2012 Registration open
15 December 2012 Abstracts submission open
5 March 2013 Abstracts submission deadline
5 March 2013 Early registration deadline
20 April 2013 Early bird registration deadline for Abstract submitters

The number of participants will be limited to 135.

On behalf of Section of Clinical Pharmacy of Czech Pharmaceutical Society of Czech Medical Association of J.E. Purkyne and Czech Society of Clinical Pharmacy of Czech Medical Association J.E. Purkyne and the European Society of Clinical Pharmacy (ESCP), we are pleased to invite you to the 42nd European Symposium on Clinical Pharmacy in Prague (October 16th -18th, 2013).

The implementation of clinical pharmacy practice is essential for patients, and for clinical pharmacists. Clinical pharmacy knowledge is valuable only if it is used for the benefit of patients. To implement clinical pharmacy there is a need for management support, appropriate education and research to build the practice upon. The rate at which clinical pharmacy is implemented varies throughout Europe. In some countries, clinics, hospitals and community pharmacies are more developed than others in this sense although some are strong in implementation of clinical pharmacy in particular areas. This symposium will give us all a chance to learn from each other.

The key question is – How do we achieve a good and patient oriented implementation of clinical pharmacy practice in our respective countries, clinics, hospitals and community pharmacies? What are the experiences of others and what are the problems that we should try to avoid or learn overcome? The answers depend on the individual country, the individual pharmacist, and the care setting.

Come and join us in Prague to discuss and learn how to implement clinical pharmacy with the aim of achieving high quality clinical pharmacy practice with the patient’s best health as the ultimate goal. During three days you will meet international experts reporting on recent developments, exchange and share knowledge during workshops, oral communications and poster sessions. And naturally since the symposium is in Prague, you will have ample opportunities for networking and friendly socialising.

15 March 2013 Deadline for Workshop abstracts
30 March 2013 Onlione-Registration open
1st May 2013 Abstracts submission open
1st July 2013 Abstracts submission deadline
31 July 2013 Early registration deadline
30 August 2013 Notification to abstract submitters
15 September 2013 Early Registration Deadline for Abstract presenters
2013

**30-31 May**
Edinburgh (UK)  ESCP Workshop
« Improving patient care through collaborative practice »

**16-18 October**
Prague (CZ)  42nd ESCP Symposium on Clinical Pharmacy
« Implementation of Clinical Pharmacy Practices: Research, Education and Management »

2014

**22-24 October**
Copenhagen (Denmark)  43rd ESCP Symposium on Clinical Pharmacy
« Patient Safety - Bridging the Gaps »

### New Members

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### Membership 2013

**2013 Membership fees**

- 1 year Full Membership .................. € 75
- 3 years Full Membership .................. € 185
- 5 years Full Membership .................. € 289
- Student Membership ...................... € 20

Address: [http://www.escpweb.org](http://www.escpweb.org)

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