will link to online resources to facilitate interprofessional discussion.

We hope pharmacists and other health care professionals will find the strategies in this series supportive of their own efforts to reduce polypharmacy. With recent regulatory and remuneration changes, pharmacists are even better placed to actively participate in optimizing therapy in the elderly.⁸ We hope those who develop clinical guidelines will take note and consider how they might include “deprescribing” guidelines to further support tapering and stopping of medications

when evidence is limited or when pharmacokinetic and pharmacodynamic parameters affecting medication distribution and effectiveness change with age.⁸

We’d like to thank the Bruyère Academic Medical Organization for its support, our colleagues in the Geriatric Day Hospital of Bruyère Continuing Care for their collaboration and our patients who willingly work with us to taper their medications, particularly the many patients who enthusiastically agreed to share their stories. We hope you enjoy the series and welcome your comments and feedback. ■

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LETTER TO THE EDITOR

Clinical services

I TOTALLY AGREE WITH THE EDITORIAL IN THE MAY/JUNE issue.¹ In the 1990s, we were wondering (in hospitals) why more pharmacies were not offering clinical services, and we wrote about it and studied it, hoping to stimulate the development of such services. Later, we and others clearly showed that community pharmacists *could* make great clinical improvements in patient care—in research study conditions. In real life, we wondered why it has not expanded more, and Frankel and Austin² have provided a significant insight into the issue. The solution of taking up responsibility may be

harder to inculcate, but it must start and start hard in our faculties. We can make huge differences, and doing anything else is a waste of our time. ■

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