specialist services — has been modified, differential fees now having been removed.

In all, initiatives representing $25 million in new funding have been been established to support rural medicine in Australia.

How have such profound changes in health policy and funding occurred over the last 3 years in Australia, a country that matches Canada in problems of recruiting and retaining rural physicians and in budgetary problems? Two factors were involved: first, Australian rural physicians organized themselves into an independent and politically effective lobby, representing both themselves and their rural communities; and, second, Australian national and state governments listened to rural physicians and rural communities and directed policy appropriately. As a result, there is renewed optimism about the future of rural practice and rural communities in Australia.

Mark Craig, MB, BS, FRACGP
Training coordinator
Queensland Medical Education Centre
University of Queensland
Brisbane, NSW
Australia

We must challenge the statement in Ms. Brooks' article that in Australia "anesthetists, for example, refuse to allow GPs [general practitioners] to be trained to perform epidural anesthesia." Two recent surveys of epidural practice in rural obstetric units, in South Australia[1] and Western Australia,[2] have shown that "general practitioner anaesthetists provide the majority of epidural services in regional and country hospitals."[3]

Australia and Canada are similar in that anesthetic services are provided by specialist and GP anesthetists. One reason for this is the "tyranny of geography":[4] doctors who practise in small, often isolated towns have to be both GPs and anesthetists. The Australian and New Zealand College of Anaesthetists and the Canadian Anaesthetists' Society recognize this situation. The former believes that "anaesthetics should be administered by fully trained and certified specialists except in areas where specialists are unavailable or in insufficient numbers to provide a complete service,"[5] and the latter believes that "ideally, physicians practicing anaesthesia should have certification in this branch of medicine, but recognition is given to the fact that Canadians will continue to be dependent on non-certified anaesthetists to provide anaesthetic services in many parts of the country."[6]

Furthermore, there are programs in both countries directed at training GP anesthetists. The Faculty of Rural Medicine of the Royal Australian College of General Practitioners established training curricula in surgery, anesthesia and obstetrics for rural general practice. Although Canada lacks a comprehensive, national program, rural GPs can be trained in anesthesia at, for example, the Department of Anaesthesia of the University of Calgary.

Thus, there does not appear to be a "refusal" to allow GPs to be trained in anesthesia.

Jan M. Davies, MSc, MD, FRCPC
Professor of anesthesia
Richard E. Priddy, MB, BS, FANZCA, FRCPC
Director
Rural Education Programme in Anaesthesia
University of Calgary
Calgary, Alta.

References

1. Watts RW: Obstetric epidural services in rural South Australia. *Anaesth Intensive Care* 1992; 20: 345–347
2. Paech MJ, Godkin R: A survey of epidural analgesia practice in Western Australia Obstetric Units. *Anaesth Intensive Care* 1991; 19: 388–399
3. Watts RW: A five-year prospective analysis of the efficacy, safety and morbidity of epidural anaesthesia performed by a general practitioner anaesthetist in an isolated rural hospital. *Anaesth Intensive Care* 1992; 20: 348–353
4. Davies JM, Priddy RE: The best of both worlds. In Kerr D, Thirlwell J (eds): *Australasian Anaesthesia*, Australian and New Zealand College of Anaesthetists, Melbourne, 1992: 223–226
5. *Privileges in Anaesthesia Faculty Policy* (policy doc P2 [1991]), Australian and New Zealand College of Anaesthetists, Melbourne, 1991: 1
6. *Guidelines to the Practice of Anaesthesia*, Canadian Anaesthetists' Society, Toronto, 1993: 3

[The author responds:]

Drs. Davies and Priddy seem to have missed the statements in my article that "specialist bodies [in Australia] are reluctant to allow GPs to be trained in certain procedures, even though they must often perform them anyway since specialists are rarely available in rural areas . . . . If specialist guidelines were strictly applied, huge numbers of expensive evacuations and referrals to urban areas would be required" (paragraph one, column two, page 578). Just because GPs perform specialist procedures doesn't mean specialists like the idea. As I also stated, the authors of the 1992 background paper "Improving Australia's rural health and aged care services," to which I referred, concluded that the rift between Australian specialists and rural GPs ran so deep that resolving it might require third-party negotiations. Perhaps between the time I researched the story and when it appeared in print, some of these differences were ironed out, but it is misleading for Davies and Priddy to imply that differences never existed.

As well, their point that "the Faculty of Rural Medicine . . . established training curricula in surgery, anesthesia and obstetrics for rural general practice" is redundant, because I wrote that "the faculty wants to offer trainees the option of studying the special skills of obstetrics, anesthesia or surgery that are required in rural practice."

Janet Brooks
Hong Kong

Prescribing practices

The response letter (*Can Med Assoc J* 1994; 151: 142, 144) from Dr. Warren Davidson and his colleagues concerning their research into drug prescribing by