section on the investigation of infective endocarditis and one quotes a report referred to above[5] as evidence of a negligible risk[9]. The third[10] states 'the passage of a catheter through a valve covered by friable vegetation is likely to be disastrous' but provides no supportive evidence for this comment.

It is routine practice to document and treat by means of coronary artery bypass grafting coexisting coronary artery disease in patients undergoing valve replacement surgery: not to do so reduces late survival[11]. As the average age of patients with infective endocarditis has risen so has the prevalence of coronary artery disease in the affected population. It is likely that at least 50% of patients merit pre-operative coronary angiography in order to avoid missing significant coronary disease[12]. There is no objective evidence to suggest that this poses a significant risk, ie there is no justification for withholding coronary angiography on the basis of unsubstantiated claims that it is dangerous.

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Slowing the rate of acute medical admissions

Editor – Dr Wanklyn and colleagues (March/April 1997, pages 173–6) recommend that medical receiving rooms in hospitals should be staffed by experienced doctors. As the senior registrar grade will probably disappear, will there be a role for physicians in general (internal) medicine with a special interest in acute medical admissions?

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Calman's not for me

Editor—It is difficult to write a letter on a subject about which I know so little. But then, when I look around me and question my senior SHO friends, I find out that they too know very little about Calmanisation even though it is now directly affecting their lives. So it was with interest if not reassurance, that I read the article by Professor Shaw on the Calman proposals [1]. I aspire to carry out clinical research in infectious diseases in the tropics and cannot envisage going through the Calman system.

As acknowledged by Professor Shaw, academic medics have always taken risks. I left for America straight after my preclinical course at Cambridge and turned a year's laboratory work into a four-year PhD on viral encephalitis at the Scripps Research Institute. Now back at clinical school in Oxford, I have taken another year off to write a book. I will finally qualify in 1998, 11 years after I started medicine, a little late but with the experience gathered in 12 papers and two academic books.

The Calman proposals seem incompatible with this past freedom and future plans. I am offered stability and a 'guaranteed' consultant job in return for five years in a single UK teaching district (with few exceptions). This offer of stability is causing even my friends who want to become standard NHS consultants, to put off applying for their Calman posts. They feel unsure about tying themselves for so long to one town.

Ignoring the reticence of my friends, the Calman proposals do appear to be a good idea for service doctors. They are likely to improve the medical care of this country's patients and offer stability to trainees where there was little before. However, I wonder if these proposals are not going to push medical trainees into two groups—those who undertake the standard training with limited freedom to move and perform research and those of us who want our freedom and will therefore stay outside this training system.

Professor Shaw does not mention this latter group of academic doctors. If I go away to do clinical work in Asia for ten years, will I ever be able to return to the British medical system? The *Guide to Specialist Registrar Training* does address this point: research doctors may have access to the Specialist Register by application through their College...to be assessed for equivalence to the CCST standard and, if successful, subsequently apply to the GMC for entry to the Specialist Register' [2].

This appears to offer academic

doctors a way back into British medicine. How difficult will this be? Will we be encouraged to do unusual things by the Royal Colleges and supported on our return, or looked at askance and turned away from the door? To say that a door is present is a beginning; we now need to know how big it will be and how difficult it will be to pass through it. One of my consultants suggested that it would only be suitable for the immortals amongst us.

The prospect of five regulated years of infectious disease training in an English town does not excite me at all. I would prefer to go to the tropics, to perform research in an infectious disease hospital there and receive, in the process, a good training. If I am not allowed to do this, I will probably simply leave the profession. Calmanisation is incompatible with the academic medical career that I would like to follow.

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In response

Dr Eddleston expresses legitimate concerns and it is difficult to give him the reassurance he seeks. The NHS Executive left appointment of specialist registrars and conversion to new-style programmes in the medical specialties to the last and there has been insufficient time to see the effects of change. Most discussions about the Calman recommendations relate to clinical training but strenuous efforts have been made to safeguard the training opportunities for those with academic and research inclinations. Specialist Registrars are free to take time out for research for long enough to complete a PhD and have guaranteed right of re-entry. Overseas experience, research or clinical, can count towards training for a CCST provided it is adequately supervised and approved in advance. The Specialist Order makes provision for those whose training has involved specialisation in a narrow clinical field, usually on the basis of particular research interest, to gain direct entry to the Specialist Register without the need for a CCST.

These are a few examples of the flexibility that does exist and it is hoped that full advantage will be taken of the opportunities that the regulations permit. An academic and research medicine supplement to the NHSE *Guide to Specialist Registrar Training* has recently been published, and it clarifies many of the issues about which concern has been expressed. Dr Eddleston's letter is important in revealing that even among medical students there are anxieties about future training opportunities – a stage when we cannot allow academic aspirations to be discouraged. It is to be hoped that it may prompt deans of medical schools to ensure that well-informed advice about future training prospects is readily available to undergraduates.

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The acute uraemic emergency

Editor – Due to the age-related nature of both non-steroidal anti-inflammatory drug (NSAID) usage and congestive cardiac failure (CCF), the latter, although not cited by Dr Tomson (January/February 1997, pages 10–5), also deserves mention as a risk factor for NSAID-related nephrotoxicity[1]. The irony is that, when CCF co-exists with acute gout, itself an acknowledged complication of diuretic treatment of CCF, the symptomatic relief of arthropathy, through the use of NSAIDs, may occur at the penalty of NSAID-related deterioration of renal function, due to the adverse effects of these drugs on the compromised renal haemodynamics of heart failure patients[2].

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'Brain attack'

Editor – Neil-Dwyer and Lang (January/February 1997, pages 49–52) can be reassured that their recommendations for investigating aneurysmal subarachnoid haemorrhage (SAH) are not the 'narrow and perverted' view of the specialist. In our Accident and Emergency (A&E) Department, we too found that a high proportion of patients (25/43) attending with non-traumatic recent onset headaches were discharged from A&E without further investigation. Two of these patients were re-admitted with SAH within a week. Of 18 patients admitted from A&E, and a further 7 directly from GPs, for investigation of severe headache, 18 (72%) were appropriately investigated: 13 (52%) SAH were identified (9/13 by CT scan and 4/13 by lumbar puncture).

Locally developd regional guidelines for the management of SAH were applied retrospectively to the study group. Eleven (48%) of the 25 patients discharged without investigation fulfilled the criteria for admission, ie sudden onset of severe headache with one other