able to seek help for themselves with confidence rather than resort to concealment for fear of jeopardising their career. Medical students have the same rights of confidentiality as any other patient, and there must be a clear separation between those managing the students' health and those managing the medical school.[6] All the medical school needs to know is whether the student is fit to continue the course. But failure to follow professional advice about the student's health in a way that could affect patient safety introduces a conflict between the doctor's duty of confidentiality to the student and their wider responsibility to protect patients. So far as the United Kingdom is concerned, the General Medical Council would expect that doctor to put patient safety above their duty of confidentiality by notifying the medical school. This would preferably be with the student's consent, but without it if necessary.

Reliable figures on the numbers of students involved in serious misconduct are difficult to obtain, but they are likely to be very small. For example, one medical school in the United Kingdom with about 1000 medical students has dismissed two students for serious misconduct in the past three years. Nevertheless, the issues are very big—the rights of the individual student to pursue his or her chosen education and career can collide with the safety of the public. At the end of the day, public safety must take priority.

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Competing interests: PR is chairman of the GMC Education Committee.

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Acute compartment syndrome of the leg

Fasciotomies must be performed early, but good surgical technique is important

Acute limb compartment syndrome is a surgical emergency characterised by raised pressure in an unyielding osteofascial compartment. Sustained elevation of tissue pressure reduces capillary perfusion below a level necessary for tissue viability, and irreversible muscle and nerve damage may occur within hours. Causes include trauma, revascularisation procedures, burns, and exercise. Regardless of the cause, the increased intracompartmental pressure must be promptly decompressed by surgical fasciotomy. Missed diagnosis and late decompression are associated with significant morbidity due to irreversible ischaemic necrosis of the muscles and nerves in the compartment. Increased awareness of the syndrome and the advent of measurements of intracompartmental pressure have raised the possibility of early diagnosis and treatment. Recent publications have, however, highlighted some of the problems associated with measurements of intracompartmental pressure.[1 2] Furthermore, late or poorly performed fasciotomies may contribute to morbidity.

The essential clinical feature of compartment syndrome in conscious patients is severe pain out of proportion to the injury, aggravated by passive muscle stretch. Sensory loss in the distribution of the nerves traversing the affected compartments may be a useful early sign. The diagnosis may be difficult in the presence of impaired consciousness, in children, and in patients with regional nerve blocks. Although intracompartmental pressure can be measured easily by using readily available devices, wide variation in the intracompartmental pressure value is accepted as diagnostic.[1] The difference between the diastolic pressure and the intracompartmental pressure has been suggested as a more sensitive indicator of tissue perfusion pressure, and a value of 30 mm Hg or less has been recommended as the threshold for fasciotomies.[3 4] But treatment based on this measurement alone may lead to unnecessary surgery.[1] Increased specificity can be achieved by combining the reduced perfusion pressure with the presence of clinical symptoms, but at the expense of a much reduced sensitivity.[1] Measurements of intracompartmental pressure are not necessary if the diagnosis of a compartment syndrome is clinically apparent and are probably best reserved for uncooperative patients or equivocal cases, where serial measurements may be required. It is of concern that, in the United Kingdom, less than 50% of hospitals had dedicated measuring devices for intracompartmental pressure.[5]

Despite the problems associated with long skin incisions,[6] open fasciotomy by incision of the skin and fascia is the most reliable method for adequate compartment decompression.[7] But performing fasciotomies on a tense, swollen limb can be a daunting and difficult undertaking. We recommend a technique using two incisions,[8] which is endorsed by the joint working committee of the British Association of Plastic Surgeons and the British Orthopaedic Association.[9] The superficial and deep posterior compartments are decompressed through a medial longitudinal incision placed 1-2 cm posterior to the medial border of the tibia. A second longitudinal incision 2 cm lateral to the anterior tibial border decompresses the anterior and peroneal compartments. Accurate placement of the incisions is essential. The medial incision must be anterior to the posterior tibial artery to avoid injury to the perforating vessels that supply the skin used for local fasciocutaneous flaps.[9] Placement too anteriorly leads to exposure of the tibia and any underlying fracture.

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Palpation of the subcutaneous borders of the tibia can be difficult in the swollen leg and we recommend marking anatomical landmarks before making the incisions. Care must be taken when decompressing the deep posterior compartment, as the posterior tibial neurovascular bundle lies just deep to the investing fascia (see figure). A lateral incision inadvertently placed over the fibula will expose periosteum, and extending the incision too far distally may expose the peroneal tendons. Exposure of bone or tendons increases the risks of delayed healing, infection, and ultimately amputation. After decompression, the viability of muscle is carefully assessed and all non-viable tissue radically excised.

Management of the fasciotomy wounds remains controversial. Wound complications were recorded in 51% of patients who had primary or delayed primary closure compared with 5% who had split skin grafts.[10] If all devitalised tissue has been confidently excised we favour immediate coverage with meshed, split skin grafts secured with a foam vacuum suction dressing. Cosmetic appearance may be improved by subsequent scar revision.

Fasciotomies are not benign procedures, and some evidence implies that they may lead to chronic venous insufficiency due to impairment of the calf muscle pump.[11] The role of fasciotomy in cases of compartment syndrome that have been diagnosed at a late stage (after 8 hours) is questionable. Established myoneural deficits seldom recover after fasciotomy. Furthermore, fasciotomies performed after 35 hours from injury were invariably associated with severe infection and even death.[12] Compartment syndrome remains a challenging condition, but significant morbidity can be avoided by prompt diagnosis and decompression using a careful two incision fasciotomy technique.

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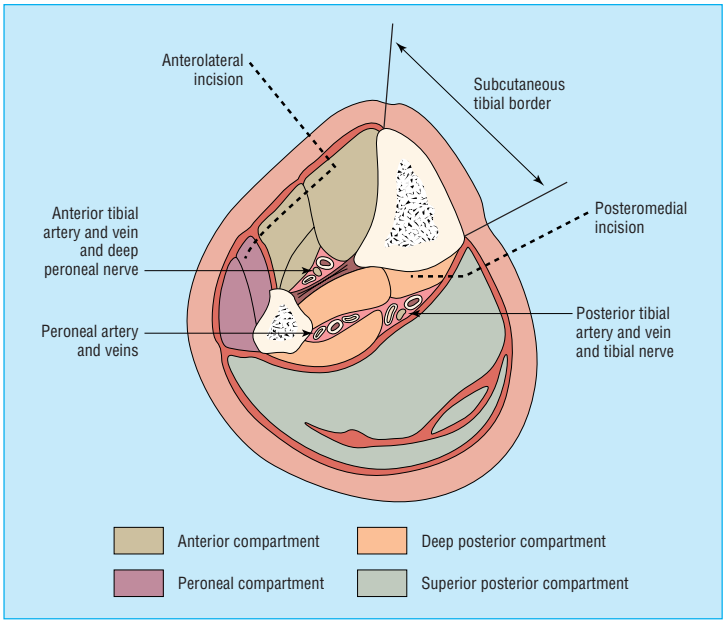
Competing interests: None declared.



Cross section through leg showing site of fasciotomy incisions to decompress all four compartments

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Patient education programmes for adults with rheumatoid arthritis

Benefits are small and short lived

As with other chronic diseases, no cure is available for most types of arthritis including rheumatoid arthritis. Furthermore, the course of the disease is often unpredictable, and the symptoms can vary from day to day or even from hour to hour. Because of the nature of pain and disability, the partial and inconsistent effects of treatment, and the unpredictability that people with arthritis face on a daily basis, education programmes for patients have become a complement to traditional medical treatment.[1] These programmes have given people with arthritis the strategies and tools necessary to make daily decisions to cope with the disease.[2 3]

From the available literature, the effectiveness of educational interventions for people with rheumatoid arthritis and the clinical relevance of the benefits are still unclear. It is also unclear what specific types of educational interventions are most effective in improv-

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