The RDA's demands were related to improvements in security. There were no incidents of violence. ESMA was invoked twice in October 2008, and in February 2011.

There was a significant decrease in the number of patients attended to in the outpatient department (OPD) during strike periods, compared to the number of patients seen preceding each strike. The number seen in OPDs each day, averaged over a month, preceding the five strike periods, were 4,866, 4,719, 4,920, 4,878 and 4,550 respectively, and the average number seen in OPDs during the corresponding strike periods were 1,680, 2,377, 3,668, 1,389 and 3,093 respectively. The cumulative average of the number of patients seen during the strike period is 2,441.4 which is only 51% of the cumulative average of 4,786.6 patients seen during the month preceding the strike period.

Information on remedial measures by the management revealed that during the August 2007 strike, the management promised that "the present security will be scrapped and a better agency will be employed" and "regular surveillance will be done in the security services and patient care facilities". A written assurance was given in reply to our RTI application, for time-bound implementation of these measures and also that no action would be taken against striking doctors. During the April 2008 strike, the management issued directions for regular rounds by security officers. A file was moved for 95 extra security guards. During the September 2008 strike, the management deployed additional security, installed close circuit televisions at intensive care units. Also a "one patient-one attendant" norm and the display of a gate pass by one attendant at a time were made mandatory.

No record was available of whether any RDA member's services were terminated or suspended, or whether there was a cut in the salary of any RDA member due to the strike.

Our analysis of the strikes revealed that there is a significant decrease in the average number of patients seen in OPDs during strikes. Though striking residents often start parallel OPDs during strikes, it is clear that the health services are seriously compromised during strikes (5). Some studies have shown that strikes have led to decreased mortality though the reasons suggested for this were scarcity of emergency services and lack of emergency surgeries (4).

Repeated strikes for the same demands suggest that despite announcing appropriate measures every time, the management has failed to address the grievances of the residents adequately.

Tight regulation of security personnel and a serious assessment of the quality of security services are needed. Inclusion of RDA members in the decision making team may help formulate effective policies for ensuring the safety of residents at the workplace.

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Human embryonic stem cells: cells without end?

Recently, human embryonic stem cells (HESC) have been in the public discourse for a number of reasons. Prominent critiques have been about the ethical issues related to killing human embryos, adverse reactions, immune-rejections, malignancy, phenotypic/genetic anomalies in transplanted cells and futuristic notions of eternal life. Key stake holders in our social and health system need to provide sustainable solutions for an under-mentioned issue that concerns not only medicine and science; but also humanity as a whole.

HESC policy models vary between countries, from being restrictive to permissive and flexible. Countries like India, China and the United Kingdom have a flexible policy. In India, HESC treatment is allowed for incurable conditions. All countries except the USA have legally banned reproductive cloning. In the present scenario of varied legal frameworks, resource-limited nations like India still need an open platform for evidence-based HESC application and a responsible discussion on the HESC concept.

Should stem cell research be encouraged in India just because it is easier to produce embryonic cell lines owing to greater legal flexibility and lower costs? A significant chunk of the Indian population still exists below the poverty line and donors are willing to 'sell' eggs for meagre incentives without ever questioning their own rights or the medico-legal aspect. This certainly raises concerns about inducement or coercion of vulnerable groups. The issue is not just 'whether to pay' but also 'when and how much to pay'. Who must set these boundaries, and how does society conduct an informed debate on this subject? The promise of stem cells is too alluring to be undermined just because these concerns are not posed and addressed adequately.

The common Indian is perplexed by extreme claims and confusing terminology. There is a clash between religion and science in this spiritual nation. But we don't need a biology or philosophy degree to understand what the real issue is. The fundamental ethics is easy enough to understand when it involves large scale production and instrumental killing of viable embryos. Destruction of human life cannot be justified, even in the name of saving another life.

It must be remembered that benefits may still be a long way off as cures for complex diseases are never simple. We require many more years of intensified research to know what we are trading in. Till then, India and the rest of the world will remain in precarious speculation. No serious researcher is engaged in producing a 'whole human being' from stem cells; rather, the efforts revolve around standardising HESC usage and production methods. Still, it cannot be ruled out that human cloning is possible. As of now, there is a general consensus that human cloning is a boundary that should not be crossed (2).

India needs a stem cell debate that is coloured neither by religious and utilitarian fanatics nor by the 'big science with big funding' profit driven agenda of biotech corporate giants.

Uncontroversial progenitors like adult cells, marrow, placenta, cord blood and induced pleuripotent cell lines should be increasingly explored as a standard therapy medium that will be both useful and ethical. Using surplus embryos from IVF clinics with dignity and 'multiple re-use' of source embryo could further alleviate our moral burden. The medical benefits of HESC in the treatment of dilapidating diseases are quite promising and it certainly is a worthwhile direction to explore in India. However, ethical discussions must be advanced judiciously to avoid untimely political truncation of the true potential of stem-cell research in India.

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Ethics of bedside clinics

Teaching at the bedside is a time-tested and traditional method of instilling the basics of medical practice in students. In fact every medical student looks forward to "clinics at the bedside." The students see clinical signs, hear murmurs and palpate organs with excitement and enthusiasm. The teachers in turn demonstrate disease manifestations with zing and zeal. It is here that basic clinical skills as well as "bedside manners" are acquired by the students. Each patient is a chapter of a medical text book to be written in the grey matter of the student.

Let us imagine ourselves in a typical case discussion at a teaching hospital. The day before the class there is a frantic search for "good cases". Once the "case" is identified, the presenter moves to the "case" and starts asking for details of his or her illness. Then he or she is examined, exposing parts of the chest or abdomen. The patient is asked to twist, turn and obey various commands to make the physical examination complete. More often than not, the willingness of the patient to be part of the class the next day is not requested. Once history taking and examination are accomplished, the batch mates come in twos and threes and repeat this procedure, despite protests and signs of non-cooperation from the afflicted individual. This kind of prior preparation for the class happens in the general ward, with no screen or curtain to maintain some privacy. The class follows the next day, where the entire process is repeated. Full length discussions on the different diagnoses, treatment options and prognosis are heard by the patient who is obviously anxious to gather any detail of his illness. Ardent discussions and conversations about complications and causes of death go on. Everyone, including the presenter and the teacher enjoys the class, ignoring the fact that some patients may be well versed in the English language.

While respecting the basic rights of all human beings, "autonomy" affirms the right of every individual to determine what shall be done to his/her body. The word autonomy originates from the Greek word for self rule. Autonomy is one of the four basic principles of medical ethics, affirming that the choice of a patient with regard to his/her therapy should be respected by the treating physician. Confidentiality in a doctor patient relationship also stems from the patient's right to autonomy. This has been emphasised equally in the ancient medical codes of Hippocrates and Charaka as well as in the modern day ethical codes of the World and Indian Medical Councils.

Textbooks of medicine and clinical methods in medicine acknowledge and honour the above rights of patients as human beings. History taking and physical examination together is considered the beginning of a doctor-patient relationship. *Hutchison's clinical methods* states that clinical skills are grasped during a lifetime of practice (1). The authors demand that students treat patients with sensitivity and gentleness, causing only minimal disturbance. Self introduction and statement of purpose should be done at the beginning of examination (2). It is also recommended that permission be sought to conduct physical examination (1). Adequate privacy should be maintained by means of a screen and conversation should be in low tones to prevent others from hearing the interview. When a male doctor examines a female patient, and vice versa, a chaperone is recommended. It is stated that presentations may be embarrassing for the patient and so the students are asked to be "kind, thoughtful and brief". Subsequent discussions which cause unwanted anxiety to the patient should be avoided in his/her presence (3). Widely accepted textbooks of medicine like those of Harrison and Davidson also reiterate the importance of good communication and respect for the patient's dignity all through a doctor's interaction with a patient (4, 5). The Latin word *patiens,* from which "patient" has originated means "sufferance" or "forbearance". It is the duty of the physician not to cause any further distress or discomfort to the patient.

Let us extend the principles of autonomy and confidentiality to these classes so that ethics begins at the patient's bedside.

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