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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Are doctors soft targets for government?

Every medical graduate is aware of the fact that getting a post-graduate seat in a good medical college in India is not child's play. The numbers of post-graduate seats, especially in medical colleges run by state governments, are dwindling every year. One has to spend a good 10 years up to post-graduation in intense study and get out of medical college as aged, unmarried, balding doctors. To add to our woes, a few states in the country have made compulsory a bond service period of three years after post-graduation.

Recently, the state of Maharashtra, in an unprecedented move, had decided to execute the said bond services for medical graduates from colleges run by the state government or by municipal corporations. The Director of Medical Education and Major Hospitals, Municipal Corporation of Greater Mumbai, issued a notification regarding the execution of the said bond services for candidates passing out from three corporation medical colleges viz. Seth GS Medical College, Lokmanya Tilak Medical College and Topiwala National Medical College located in the region of urban Mumbai. To our utter surprise, candidates with a super speciality degree i.e. Doctorate of Medicine (DM) and Master of Chirurgical (MCh) qualifications were, after 13 years of toil, allotted posts of assistant medical officers which could have been allotted to an MBBS graduate, rather than posts of Assistant Professors in the respective specialty, with unrealistic duty schedules and work hours. These 66 candidates decided not to accept their postings and filed a writ petition in the Honourable High Court of Bombay demanding posts at par with their qualification.

On the directives of the Honorable High Court of Bombay, in a writ petition 1440 of 2011 (Dr Maqsood Khan & others vs. State of Maharashtra), the Directorate of Medical Education and Research was given the responsibility of allotting such bond services (1). In a shocking and incomprehensible move, the Director of Medical Education and Research undertook a massive drive to allot the so-called bond services to around 900 candidates (PG Diploma – 235, MS – 189, MD – 420, DM – 30, MCh – 33) who passed out from government and corporation-run medical colleges in an overnight procedure from the morning of September 6, 2011, to the next morning. The allotment procedure was chaotic, with the authorities being oblivious to the candidates' queries regarding the nature of duty, work profile, and duty hours.

Many of the DM and MCh candidates were allotted the post of medical officer in a speciality (a post created on paper), but in reality these doctors were assigned the duties of an MBBS doctor. Thus, the expertise and talent of well-qualified doctors was under utilised by the state authorities (2). The government machinery grossly misinterpreted the health needs of society by pushing over-qualified doctors into the rural sector which lacks basic infrastructure. Even more shocking was the government action of removing ad-hoc medical officers (already serving for a period of five to seven years) to accommodate the bonded candidates. When the Honorable High Court was apprised of the tactics employed by government machinery, the state received a sharp rap on the knuckles for making super-speciality and broad speciality doctors serve as general duty medical officers. Some of the MD/MS doctors were allotted posts that had either been discontinued or were already occupied. One of my dermatology colleagues got an allotment as a medical officer in a leprosy unit of Pune district. To her utter surprise, the said post had been discontinued much earlier, and she was asked to serve under the tuberculosis control programme, taking instructions from the medical superintendent, attending polio vaccination camps and doing work which was in no way related to her speciality. If such misapplication of mind continues, our medical colleges will be lacking in full-time teachers and none would get timely promotion.

Since 2006, the Maharashtra Public Service Commission has not filled the regular posts of Assistant Professor, and Associate Professor and government is trying to fill those vacancies with such bonded candidates who cannot be permanently commissioned. Thus there is an acute shortage of medical teachers, to the extent that some medical colleges are on the verge of losing the mandatory Medical Council of India recognition of their post-graduate courses.

It is high time that the government applied its mind to tackling this issue with common sense and sincerity. If the government does not have enough vacancies to accommodate bonded doctors, shouldn't one question the validity of such bonds?

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