one small wrong be justified because it is helping us prevent a bigger wrong arising out of a problem which is not the doing of the doctors? Do these actions subvert established codes of ethical conduct? Are the residents not guilty of deceiving one set of patients and relatives? Do they merit a reprieve because their actions were guided by the sole intention of serving the poor?

Resident doctors would argue that such Robin Hood antics were needed to ensure that the system did not collapse. Surely, this was the least pleasant way of addressing the issue of lack of basic amenities in hospitals.

Let us not forget that such undignified methods were resorted to only after more acceptable measures of addressing the problems failed to elicit a response from the authorities. What happens if a poor patient with a potentially curable head injury is left to be managed without a scan because he is unable to afford the fees charged by the CT firm?

One also has to ponder over the fall-out of this practice. Some critics would argue that the silent approval of one's actions paves the way for deceit of larger magnitude later in their careers. In an era of falling ethical standards in public services could such practices lead to more serious problems? Does the end always justify the means in such circumstances?

Commentary: living by deceit

Thank heavens we did not have similar moral dilemmas when we were residents.

Much has changed since the time of my internship nearly three decades ago. The private sector in health care has grown disproportionately and has better health care facilities than in public hospitals, specifically in terms of access to newer technologies. However, this advantage is denied to most of our people because they have insufficient means to meet the escalated treatment costs.

A caring, concerned and compassionate physician today habitually confronts the setting in the case study presented here. In finding a solution he is often in conflict with the dictates of his conscience. The necessity of speedy action forces one to follow one's nose. At times of relative leisure he ruminates over the ethics of his deeds and often takes refuge in the maxim: "The end justifies the means."

The problems narrated in the case study are not rare; they are unlikely to be resolved in the near future. The callous response of administrators and the mute endorsement of deception and wrong-doing by seniors in the profession reflect their inability to grapple with such disturbing issues and find appropriate solutions. However, their lack of concern cannot legitimise such unseemly acts by subordinates. Impropriety does not merit a reprieve. Robin Hood antics may occasionally be condoned in exigent circumstances, but they cannot be approved as a rule.

The essence of the vexatious instances cited in the case study is scarcity of money in public-funded hospitals. How often, and how seriously, have medical professionals deliberated to find means to prevail over administrative apathy, and to discover novel ways of mobilising resources for such institutions? There is no dearth of funds when meetings are to be arranged, when financial support has to be found to attend conferences far and wide, and for other private activities of doctors. Why do the beneficiaries not contribute a small proportion of their extras to a permanent patient care fund in their own hospitals? Suppliers to hospitals can also be approached to donate a small share of their profit to the same fund every time they procure an order from the institution. These voluntary grants are ethically more acceptable than robbing rich patients through deceit or bartering in violation of the law. Honesty and trustworthiness are vital in health care.

Lest one forget, "*There is none so cruel as the lying ascetic who lives by deceit. A weakling's philanthropy is a sword in a eunuch's hand.*" (Tiruvalluvar: *The Kural*).

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