University of Jaffna, Sri Lanka

Professor Chellathurai Sivagnanasundram Memorial Lecture 2026

Ethical Perspectives on the Influence of Religion and Culture on the Delivery and Reception of Medical Care within the Tamil Community

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Professor Chellathurai Sivagnanasundram
Memorial Lecture - 2026

Vice Chancellor's Message

It is with great pleasure that I offer this message on the occasion of the Professor C. Sivagnanasundram Memorial Lecture 2026, an occasion that commemorates the life and enduring legacy of **Professor C. Sivagnanasundram** affectionately remembered as **"Nanthi"** a visionary academic, a pioneer of community health, an inspiring teacher of public health, and a devoted servant of society.

A graduate of the University of Colombo in **1955**, Professor Sivagnanasundram commenced his academic career at the University of Peradeniya before being appointed, in **1978**, as the **founding Professor of Community Medicine at the University of Jaffna**. In this capacity, he played a pivotal role in establishing and nurturing the Department of Community Medicine, laying a robust foundation for community-oriented medical education and contributing substantially to the advancement of public health across the Northern Province.

Professor Sivagnanasundram was, above all, an exceptional teacher and communicator, possessed of a rare gift for rendering complex concepts in medicine and public health accessible and engaging to students and communities alike.

Through innovative storytelling and drama, he conveyed vital health messages in forms that resonated across diverse communities - anticipating, long before it became an established principle of health promotion and medical education, the central importance of community engagement, which he demonstrated through his own practice rather than merely advocating in theory.

His contribution extended far beyond the conventional boundaries of academic medicine. Through his writings, teaching, and public engagement, Professor Sivagnanasundram gave voice to universal human values: truth, right conduct, peace, love, and non-violence weaving them into the fabric of education and everyday life. He held firmly to the conviction that intellectual development must be accompanied by ethical and spiritual growth, particularly among the young and among healthcare professionals entrusted with the wellbeing of others.

His conception of Community Medicine was equally distinctive in its breadth. He understood health not as the mere absence of disease, but as the holistic wellbeing of individuals, families, and communities - recognising that genuine healthcare must extend beyond the treatment of physical illness to embrace the mental, social, cultural, and spiritual dimensions of human life. His abiding commitment to underserved and rural

communities found expression in his efforts to train paramedical workers and grassroots health personnel, thereby empowering communities to take an active role in safeguarding and advancing their own health.

It is therefore especially fitting that this year's memorial lecture will be delivered by **Rev. Professor Joseph Chandrakanthan**, a distinguished theologian, scholar, and Catholic priest ordained for the Diocese of Jaffna in 1979, whose scholarly work spans systematic theology, Eastern philosophy, Christian ethics, bioethics, literature, and the socio-cultural and religious traditions of South Asia.

Rev. Professor Chandrakanthan served as the first tenured Lecturer in Christian Studies at the University of Jaffna in **1981**, and later, upon completing his doctoral studies in Canada, became the **Founding Head of the Department of Christian and Islamic Studies**. His extensive research and publications have illuminated the intersections of religion, philosophy, bioethics, theology, and literature, with particular attention to the Buddhist, Hindu, Christian, and Saivite Tamil traditions in both their pre-modern and modern expressions. His scholarship draws together theology, ethics, culture, and the lived realities of society in ways of profound relevance to contemporary healthcare.

The theme of his lecture **“Ethical Perspectives on the Influence of Religion and Culture on the Delivery and**

Reception of Medical Care within the Tamil Community" is at once timely and deeply significant. Medicine, after all, is never practised in a vacuum; it unfolds within a social and cultural context in which perceptions of illness and healing, expectations of care, responses to suffering, and decisions surrounding treatment are shaped by deeply rooted cultural traditions, religious convictions, familial bonds, and ethical values. An understanding of these dimensions is indispensable to the delivery of healthcare that is not only scientifically sound, but also compassionate, culturally attuned, ethically grounded, and respectful of human dignity.

This theme resonates profoundly with the philosophy that guided Professor Sivagnanasundram throughout his life's work, a reminder that medicine is at once a science and a profoundly human endeavour. Advances in science and technology will continue to transform the practice of healthcare, yet compassion, ethical responsibility, cultural understanding, and respect for human dignity must remain its abiding heart.

The intellectual traditions represented by Professor Sivagnanasundram and Rev. Professor Chandrakanthan converge upon a shared and enduring principle: that knowledge attains its highest purpose only when placed in service of humanity. Their combined scholarship invites us to look beyond

disciplinary boundaries and to recognise the deep interconnections between health, culture, ethics, spirituality, education, and social justice.

In commemorating Professor C. Sivagnanasundram, we honour not merely an eminent academic and pioneer of Community Medicine, but a philosophy of education and service that remains profoundly relevant to our present moment. His life and work stand as an enduring reminder to our students, academics, healthcare professionals, and the wider community that a university's responsibility extends beyond the transmission of knowledge to the cultivation of wisdom, character, compassion, ethical leadership, and social responsibility.

I extend my sincere appreciation to Rev. Professor Joseph Chandrakanthan for graciously accepting the invitation to deliver this distinguished memorial lecture and for sharing his scholarship and reflections with our University community. I likewise commend the Faculty of Medicine and all those who have contributed to the organisation of this significant academic occasion, and to the preservation of Professor C. Sivagnanasundram's memory and legacy for the generations to come.

May the life and work of Professor C. Sivagnanasundram continue to inspire us to pursue knowledge with humility, to practise medicine with compassion, to uphold the

highest ethical values, and to employ education and scholarship in the service of healthier, more equitable, and more humane communities.

Snr. Prof. T. Velnampy
Senior Professor of Accounting
Vice Chancellor
University of Jaffna

Ethical Perspectives on the Influence of Religion and Culture on the Delivery and Reception of Medical Care within the Tamil Community

(Professor Chellathurai Sivagnanasundram Memorial Lecture - 2026)

- Professor A.J.V. Chandrakanthan

Preamble

I wish to express my sincere gratitude to the Organizing Committee of this Memorial Lecture, held in honour of the distinguished scholar, Professor Chellathurai Sivagnanasundram, whom we affectionately knew and addressed as Dr. Nanthi.

For nearly two decades, Dr. Nanthi was to me a thoughtful mentor, a valued friend, and an affectionate colleague. I therefore consider it a special privilege to be part of this occasion dedicated to honouring his memory and celebrating his scholarly legacy.

I am deeply grateful to Dr. P.A. Dinesh Coonghe, Head of the Department of Forensic Medicine, for his gracious invitation to deliver this presentation this afternoon.

I also wish to express my appreciation to Professor Rajendra Surenthirakumaran, Dean of the Faculty of Medicine, whom I had the pleasure and honour of meeting in Canada a few months ago. He was then visiting Toronto, together with several members of his faculty, to participate in an international conference.

It is indeed a privilege to join you this afternoon in remembering and paying tribute to a scholar, teacher, colleague, and friend whose life and work have left an enduring impression upon so many of us.

As Professor of Community Medicine and the third Dean of the Faculty of Medicine at the University of Jaffna, a consultant for Word Health Organization, a highly admired short story writer and Novelist with strong articulation of Social conscientization, a committed Social worker and dedicated patient advocate, with far-sighted vision, Dr. Nanthi introduced several advanced teaching programs in the curriculum of his subject as well as courses related to many innovative aspects of Medical studies.

It is heartening to see the growth of the faculty not merely in its external and physical infrastructure but much more in the expansion and diversification of departments embracing almost all aspects of contemporary medical advancements ranging from neonatology to nuclear medicine.

Perusing some of your research and publications, ranging from **A** - Autism Spectrum Disorder in the local context to **W** - war affected areas that require special attention in regard to primary care, I recognize that, in the first quarter of this century, you have made very significant advancements in your research potentials and publications, touching almost every facet of the medical arena.

Your research involvements some of which are both local and muti-centered spanning national terrains and extending to South and Southeast regions of the globe are a truly promising and reassuring, that the Medical Faculty at the

University of Jaffna is effectively and relevantly responding to the growing needs of the care- reservoir in keeping with the exigencies of innovation, knowledge building and dissemination.

As your former colleague who has been directly and personally associated with the University of Jaffna from the year 1980 to 1997, I take great delight in congratulating your former Deans and the present incumbent Prof. R. Surenthirakumaran, and my dear friend Dr. Dinesh Coonghe and all other distinguished members, Heads of Departments and teaching and support staff for your audacious and far-reaching vision.

The seeds you are planting by way of your commitment to research and knowledge-sharing will bear magnificent fruits in the years to come. Knowing the endless socio-religious thirst accelerated by a humanitarian desire to serve his people, my dear friend and mentor Dr. Nanthi Sivagnanasundaram's spirit that is inseparably linked to this soil I believe hovering some corner of this edifice he will hear with much delight all that I say about the prosperous and fruitful advancements made here in true gratitude to his of his hard work, until his demise in 2005.

In my presentation I wish to delineate the importance of integrating ethics, spirituality and culture as indispensable components of enriching the quality of patient care specially within the context of terminal illnesses or when caring for patients who are actively on an end-of-life situation.

Healing, Faith, and Culture: Ethical Perspectives on Medical Care

Ethno-cultural, racial and religious pluralism which could be viewed as mutually supportive societal aspects of enriching our understanding of illness and care, are sometimes seen as elements fraught with insurmountable challenges. This approach requires innovative responses from the care-provider at communitarian as well as larger institutional levels.

Historians and literary critics refer to our times as postmodern, postcolonial, postindustrial, post-technological, post-communist, post-socialist, and by many other descriptors. However, perhaps the most striking feature of our present era - one that is becoming increasingly ubiquitous - is the experience, as well as the challenges and possibilities, of pluralism, both cultural and religious. Our face-to-face encounters with the richness and resourcefulness of pluralism in the religious, cultural, ethnic, social, and ideological spheres beckon us to recognize, respect, and revere the magnificence of diversity in every facet of the created world. Pluralism and diversity have become facts of our daily lives and experiences, ranging from food and fashion to religious beliefs and gender identity. It may interest you to know that, on any given day, more than 200 distinct languages and dialects are spoken in the city of Toronto.

Religio-Cultural Sensitivity in the Provision of Care and Treatments

As medical practitioners delivering care in multicultural and multifaith contexts, we often encounter

difficult and intricate situations in which this pluriform reality manifests its influence in the design of care plans and in decisions concerning specific forms of treatment. These challenges range from neonatal contexts of delivery and birth to end-of-life settings involving palliation and death.

For instance, to a devout Buddhist woman from Southeast or East Asia, a stillborn fetus, regardless of the stage of pregnancy, may be understood as a potential Buddha who should be assuaged through offerings of money, rice, and even toys. A Hindu patient may interpret it as an insult if a caregiver uses the left hand to hand over medication. By contrast, among some Chinese people, the left side may be associated with blessing and respect. Indeed, some Chinese may wonder why, in Christian belief, Jesus is described as sitting at the right hand of God the Father when, in certain Chinese cultural contexts, the left may represent an even greater place of honour. A similar practice is said to exist in some Jewish contexts, where, at large banquets, the chief guest may be invited to sit on the left as a sign of honour.

A Vietnamese person may feel insulted if someone touches them on the head because of the belief that the soul or spirit resides there, making the head the most sacred part of the body. For a devout Jew, however, blessing may be conferred through the laying on of hands upon the head - a practice that reaches back to the time of the patriarchs and continues today in Christian liturgical and sacramental rituals.

In a pluralistic context, issues related to birth, just as much as those related to death, carry their own meanings and interpretations. This is especially evident in situations of

terminal illness and at the threshold of death, when there may be a profound longing for one's cultural and ethnic roots. In many cultures, death and dying encompass a social ritual. These are not merely individual experiences but familial and community events. Despite the intimacy and privacy associated with the dying process, many cultures and religions in Asia and Africa, for example, have developed complex familial, social, and religious rituals and have transmitted them across generations as matters of duty and responsibility.

There are many occasions when healthcare decisions must be made with due recognition of personal religious beliefs, cultural affinities, and social expectations. Sensitivity to these dimensions is not simply a matter of courtesy; it can be essential to providing care that respects the dignity, identity, and deepest values of the person who is receiving it.

Culture as a man-made social phenomenon, is commonly understood as encompassing a range of beliefs, practices, customs, values, and attitudes that are shared and perpetuated by members of a given social group. In this sense culture is not only a dynamic human invention but is also accepted as an open to change and growth, manifesting certain traits of flexibility and continuity.

It would also help us to look at the relationship between Culture and Nature. Culture is a product of human creativity and agency: it is created, nurtured, shaped, and transmitted by human beings, whereas nature is given to us and develops independently of human intention, consciousness, or action. A cave is nature, but this hall or room is culture, our body is nature but the shirt or shawl we wear is culture, our

hair is nature, but different hairstyles are culture.

In a world that is becoming polarized in many forms we tend to look at culture from different and rather divisive aspects. For instance, we try to present or understand culture in larger Geographical terms as Western/Eastern, then we narrow it down to regional perceptions as Local, National or even in linguistic, racial and Ethno-cultural segments. In societal or sociological aspects there's also a way of looking at culture as urban, rural, industrial, agrarian, technological etc.

Another enduring way of viewing culture is through the lens of religious identities. We speak of Saivite, Hindu, Buddhist, Christian, Islamic, Sikh, Jain, etc., with an emphasis on the manner in which culture is internalized. It is often affirmed that "Religion is the substance of Culture and Culture is a form of religion."

We could also speak of components of culture such as race, language, dialect, geographical origin, migratory patterns, employment levels, familial history, and such creative expressions as art, architecture, sculpture, music, dance, decoration etc. as significant components of culture.

Against this ever-expanding concept, when we come down to the specific understanding of the patient-physician or patient-care-provider context of the delivery and reception of care, we stumble against the fact that culture as having a strong influence on the patient's choice of whether to seek care at all or if he/she wishes to receive care where to seek that care. For instance, whether to place one's total trust in the contemporary Western world of biomedicine, or to explore alternatives such as *Ayurvedic* medicine in India, particularly in Kerala, as some

prominent politicians would choose, or Chinese medicine, acupuncture, or other alternatives that may offer promising forms of treatment and cure.

Culture also has a considerable impact on the role of the family of the patient, just as it has an influence on the patient's willingness to trust the diagnoses or prognoses, from the Physicians' side. It also has an influence on the how and what of the disclosure, subsequently such issues as consent, who is to be the decision-maker, patient or family member, the use and non-use of technology and many other factors that will have a direct impact on accepting or rejecting treatment options. Few decades ago the tidal wave of secularization or de-religionization that swept religious elements away from many of our institutional religious traditions is not there with the same ferocity. A renewed interest in religion, spirituality, and the realm of the spirit are going through a new resurgence. These vital dimensions have returned with a social vigour and vitality. Religion and spirituality are increasingly recognized as indispensable components of human wholeness and, consequently, as important dimensions of healing and health.

Concerted research has been done in the past few years to rediscover the link between faith and healing. In his ground breaking research Dr. Harold Koenig, an eminent professor, physician and scholar conducted multi-centered empirical research and published the results in his well respected book "*The Healing Power of Faith"*. Among the many findings that he published with elaborately supporting data, he affirmed that "Religious faith may protect people from cardio-vascular diseases, that religious people may have stronger immune

systems, and that religion offers protection from depression and helps those afflicted to recover quickly" (Koenig, 1999). He also writes about unforgettable patients who taught him so much as they triumph over life-threatening disease, heart breaking marital problems and dangerous addictions.

The Bases of Biomedical Ethics

At the outset, we must admit that some of the foundational principles commonly used in medical ethics consultations and their subsequent applications in patient care or treatment-related decision-making are largely drawn from Judeo-Christian values, blended with Western jurisprudence and ethical practices. Understandably, it is felt that these may not be wholly adequate to respond meaningfully to a multicultural and pluri-religious patient population (Wehbe-Alamah, Hammonds, & Stanley, 2021).

Normatively these ethical applications begin with the emphasis on the right to self-determination or the exercise of the principle of autonomy whence the patient as an individual, (whose rights and duties are guaranteed by the State) is made to decide her/.his choice of treatment and care.

Undoubtedly the aura of universalism enshrined in these principles is of global ethical importance, however its concrete application manifests a particular western worldview and several other socio-cultural limitations that demand attention.

Based on case examples (with PowerPoint slides as support), I seek to illustrate and analyze the challenges of cross-cultural and trans-cultural care in person-centered

decision-making especially when faced with terminal illnesses, for instance palliative sedation and withdrawing or withholding of treatment and other complexities of care that impinge on one's religious and cultural convictions.

The need to integrate multi-religious ethical insights and specific cultural values and beliefs in the larger context of the delivery of care will also be explored here as a way of promoting an involved and participatory approach to innovative and quality patient care within the context of larger familial process of decision-making which I advocate as segmented autonomy in decision-making.

The perception of illness as a familial experience and the process of illness and dying as a communitarian experience which I shall elucidate later will help to deepen the importance of understanding the ethical implications of cure and care in the context of religio-cultural pluralism where the intensity of intra-family relationships with their manifold ramifications become a mutually enhancing experience to both the recipient and the care-giver at large.

Addressing healthcare issues within a pluriform cultural mosaic is a major challenge in many western capitals. As pointed out by Robert Blank, "In some Western countries, considerable emphasis in recent decades has been directed toward empowerment of the patient or patient autonomy. A wide variety of legal mechanisms have been created toward this end. Prominent among these advance directives are living wills and the durable power of attorney" (Blank, 2005, p.3). Complementing this perspective, Beiser, Chandrakanthan, and colleagues (2007) highlight in their *Tamil Mental Health*

Community Survey that social stigma, religious predicaments, traditional beliefs, inter-family pressures for privacy and secrecy, and unresolved post-war trauma (including PTSD) significantly hinder Tamil-speaking new Canadians from seeking adequate mental health services. Their findings underscore the importance of fostering community awareness and affirming the role of family and community as effective caregivers (Beiser, Chandrakanthan, et al., 2007, pp. 7 - 34).

Blank further argues that these provisions are made so that the ailing/dying patient may have an autonomous control of his/her illness/dying process. In addition to this it may also be said that the principles and norms applied in clinical ethics consultations dealing with end of life issues are largely drawn from the Judeo-Christian and western ethical practices and these are again centered on the exercise of personal autonomy or the exercise of the principle of self-determination by the patient as a free and capable person. While the universalism enshrined in these principles are of global ethical importance, in their application and illustration they manifest a particular western worldview of socio-personal realities. At the same time, it would be too naive to assume that just because it is western it excludes the oriental mode of ethical practice or that it is inadequate and unacceptable to another culture or polity.

Medico-Ethical Decision Making Among the Tamil Community in Canada

It has been observed that "during the five-year period between 1996 - 2001, the Tamil community became one of Canada's fastest growing ethnic populations, increasing in size

by 38 percent. The vast majority of Canadian Tamils live in the Greater Toronto Area (GTA) and constitute the world's largest urban concentration of (Eelam) Tamils outside Sri Lanka" (Hyndman, 2003, as quoted in Beiser et al., 2007, p.6). This observation, when considered alongside broader discussions in bioethics and transcultural care (Fujiki et al., 1998) and empirical research on faith and health (Koenig, 2001), underscores the importance of culturally sensitive approaches in both medical ethics and community health. The Tamil community is not only growing in number but also in age and the mortality rate. Cancer, cardiac illness, stroke, diabetes, and Alzheimer's dementia are among the most common illnesses in addition to deaths resulting by motor vehicle accidents and industrial work-related hazards.

For the Tamil community from an ethnic and cultural perspective, as the disease process gets complicated particularly in relation to terminal illnesses, new challenges begin to surface. Words such as Palliative care, terminal illness, withholding of treatment, withdrawing of life sustaining measures, removal of gastro-intestinal feeding tubes, weaning of intravenous supply tubes, administering palliative sedation, end of life care comfort measures, CPR (= Cardio Pulmonary Resuscitation) or DNR (= Do Not Resuscitate) orders are among the most complex ones for patients and families to understand or grasp particularly when care decisions are to be made by a patient or by immediate members of the family of a patient for whom death is imminent or expected. Consenting to or refusing of aggressive and highly invasive treatments to a loved member

in the family for whom death is near and certain is not an easy task in the context of deep bonds of relationships that are nurtured by inter-family marriages and solidarity. This is further compounded by the real or potential conflicts of religious values, cultural beliefs and socio-ethnic customs that traditionally form part of the definition of illness and care as it does in a number of other ethno-cultural communities in Canada.

With the excessive use of technology, intravenous feeding materials and other invasive techno-medical interventions begin to replace the personal dimension of care. To the uninitiated layperson these machines hike up a false and astounding sense of medical and technological hope. The expectation that one cannot die with all the machineries with their colourful graphs and fluctuating numerical displays of heart beat, pulse and blood pressure, etc., induce an expectation that death can be managed, immobilized, prevented or even conquered.

The age of the dying person, the intensity of intra family or interfamily relationships inevitably contribute to the apprehensions, fear and painfulness of the decision making process. This is more so if the patient is clinically deemed incompetent to make her/his care-decisions for herself/ himself as result of being in a comatose condition, unconscious state or incapacitated due to her/his ailment, medication or other causes.

The burden of decision-making in such instances falls on the designated Substitute Decision Maker (SDM) or on those invested with the Power of Attorney (PoA) for personal

care or the next of kin is called as warranted by each case. Often an anxious feeling of inability, helplessness and even guilt enters those who have to make this decision. The intensity of relationships, the uncertainty of religious, ethical or moral rectitude causes a shadow of confusion and distress. In certain situations, the pressure of time and urgency plays a formidable role if decisions are to be made without much delay.

Herein lies the ethical dilemma of the Tamil patient: namely, whether to allow and accept the natural process of dying or delaying and even postponing that process by means of aggressive technological intervention; whether to place complete confidence in the rather unfamiliar western medical interventions or to seek care through their trusted native medical practices; whether to take control of one's medical decision-making even if it involves the dying process or to involve all family members and hand them in the right to make decisions; whether to have a family member to serve as an interpreter or to request a professional person to do the clinical interpretation; whether to withdraw or withhold treatments to allow the natural out comes or to treat aggressively despite the foreseen results of futility; whether to accept terminal sedation to alleviate pain in an end of life situation with the foreknowledge that such a sedation may eventually quicken the unintended dying process or to go through enormous suffering and pain to live an extra day to see and be with the dear ones; the list can be endless. For the sake of clarity and brevity I shall select a few of these and comment on them.

Interpretation, Over-interpretation and the Surplus of Meaning

When a person is diagnosed with a serious or a life-threatening terminal illness, she/he hears for the first time not only the bad news about one's illness but several technical words, acronyms and names of illnesses that one had never heard or used before. In the shock and confusion surrounding the bad news about ones unexpected diagnosis, the use of technical medical terminology further adds to the worry and anxiety or cause greater confusion and helplessness depending on the patient's ability and strength to deal with them. This is more complex if an uninitiated interpreter from among the family or outside is translating the information. It is common practice among majority of Tamil families to use their children as interpreters for parents or grand parents. The practice of depending on a young child for interpretation is considered "unethical, unprofessional, and totally unacceptable…, because reliance on family members tends to reduce the ability of the practitioner to act in his patient's best interest on issues where there is family conflict or misunderstanding" (Masi et al., 1993). In my view, although this research is dated, many of its findings remain unaddressed and therefore warrant efficient responses from care providers and national medical systems at large. Related perspectives on psychological and psychiatric disorders in cross-cultural health care further reinforce this concern (Rack, 1990). Interpretation in the context of healthcare is a very complex issue. The kind of mathematical

equation model that is used for word-to-word translation as often done in courts of law cannot be applied to the context of care. The *National Code of Ethics for Interpreters in Health Care* is rather ambivalent when it states, "The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural contexts…" (*National Code of Ethics for Interpreters in Health Care,* 2004, p. 3). Unlike the English language which freely coins medical terms from Greek and Latin, the Tamil language draws its medical terms from *Siddha* Medicine or *Ayurvedic*. For instance certain tropical illnesses associated with skin and muscular aches and pains have several names and sub divisions in Tamil. For example the word *vaatham* cannot be adequately rendered in English. The word is used to denote *parisa-vatham* (paralysis) to *mootuvatham* (arthritis) although paralysis (*parisa-vatham)* in the strictest medical sense does not fall within the category of *vatham*. Hemiplegic conditions or quadriplegia and such illnesses as multiple sclerosis, etc., have no adequate renderings in Tamil unless one is open to describe them fully in terms of their contents and symptoms. Alzheimer's illness and the various kinds of dementia, mental disorder beginning from schizophrenia to different forms of psychosis or paranoia are all translated wrongly as *paithiyam, mananoi, visar or piranthi.* All these words carry a layer of stigma and labeling.

There are several kinds of cancer some of which are terminal others incurable, treatable or even curable; but the Tamil word *putrunoi* is used as a common word for all kinds of cancer. A similar problem is also found in Chinese and some other African Languages. Healthcare interpreters

therefore face major challenges. In practice most of the interpreters follow the court model of interpretation which seeks to give almost a word by word literal translation. Explanation is both discouraged and even disallowed by the interpreter's code of ethics. The paucity of appropriate medical terms add to this complication. For example, Comatose, permanent vegetative state, unconscious, semi-conscious, sedated condition, terminal or palliative sedation are all translated as *mayakkam* and *mayankiponar, arivu-ninaivu illai.* Stroke and post-stroke, congestive heart failure, pericardial effusion and such similar conditions have hardly any equivalents in Tamil unless one is open to describe them.

In intensive care the use of medical technology becomes more frequent as more machines are added when death draws near, almost portending that death can be defeated and conquered. If in spite of all these heroic interventions death occurs, then death is seen as a defeat, a loss and waste. This reduces the deeper meaning of death as a natural process at the end of one's earthly life. Blood pressure monitors, ventilation - life support machines, pulse and heart monitors, gastric and intravenous tubes appear as signs of hope. On the other hand to the technology-dependent care team these machines serve as unchallengeable indicators of the patient's health condition. It is even possible that care-teams tend to pay more attention to the indicators that are available or perceptible in the machine than the oral or somatic expressions of the patient complaining of discomfort and pain. Pain which is a personal and subjective experience cannot be adequately measured by charts and machines even with the best of

machinery and technology.

The Rigorous Use of Medical Technology

In the intensive care units the use of medical technology becomes more frequent and increasingly more machines are added as death draws near almost portending that death can be defeated, immobilised and conquered. If in spite of al this death occurs then death is seen as a defeat, a loss and waste. This reduced the meaning of death as a natural process at the end of life. Blood pressure monitors, ventilation life support machines, pulse and heart monitors. GI and IV tubes with blood, saline, and other intravenous feeding materials begin to replace the personal dimension of care. To the uninitiated layperson these machines hike up a false sense of medical and technological hope. The expectation that one cannot die with all these machineries with their colourful graphs and fluctuating numerical displays of heart beat, pulse and blood pressure, etc.

On the other hand, to the technology-dependent care team these machines serve as unchallengeable indicators of the patient's health condition. It is even possible that care-teams tend to pay more attention to the indicators that are available or perceptible in the machine than the oral or somatic expressions of the patient complaining of discomfort and pain. We all realize that Pain which is a deeply personal and subjective experience cannot be adequately measured by charts and machines even with the best of machinery and technology. It is impossible to measure the intensity, quality and specificity of pain in a patient who is unconscious or semi-conscious or

even conscious. It is part of the person's inner struggle and experience often sharp and acute or intense and choric. Even in a patient who is reasonably conscious, pain transcends clarity and adequacy in verbalization. Knowledge about pain may be shared but not the experience of pain. People who suffer pain struggle for words in order to express their pain and to be understood.

Intrinsic Human Dignity

In his widely acclaimed work *The Rebirth of the Clinic* (Sulmasy, 2007), Daniel P. Sulmasy - a well-renowned physician, medical ethicist, and Director of the Kennedy Institute of Ethics at Georgetown University - justifiably argues that medicine should attend to the whole person: body, mind, and spirit. His work offers a counterpoint to the growing technocratic approach to medical care in many Western and North American nations.

Having dwelt at length on the core concept of human dignity from the perspective of medical sociology and philosophy, Sulmasy explains human dignity as the intrinsic and inviolable worth of every human being, grounded not in abilities, social status, health, or usefulness, but simply in being human.

In his exploration of the notion of human dignity, he explicates three interrelated dimensions. First among these is intrinsic dignity, which he describes as the unconditional worth all humans possess by virtue of their humanity, affirming that it can never be lost or diminished. Secondly, he defines attributed dignity as the value society assigns based on roles,

achievements, or relationships, which can vary and is morally secondary. Thirdly, he enumerates inflorescent dignity, which entails the dignity expressed when persons flourish morally through virtue, compassion, and ethical living.

Within the arena of medical ethics, Sulmasy emphasizes that intrinsic dignity must always guide care, especially for the sick, disabled, elderly, and dying, ensuring that patients are treated as persons, not problems to be managed (Sulmasy, 2007).

Any Illness affects the whole person and no person can be seen or referred to as vehicle that carries a disease or an illness. Such labels as amputees, schizophrenic, paralytic, quadriplegic etc. violate the very core of intrinsic human dignity that goes to affirm the universal essence of every human person.

Truth-telling and the withholding of information, together with privacy and confidentiality, form an essential part of recognizing the human dignity of the most vulnerable persons (*National Code of Ethics for Interpreters in Health Care*, 2004). Physicians have a primary ethical obligation to be truthful with patients about diagnoses, prognoses, and treatment options. Withholding information is rarely justified but may be acceptable if revealing it would cause direct, immediate, and severe harm, or in specific cases of cultural, familial, or patient-requested non-disclosure.

In some cultures, families may prefer to break bad news to patients, especially elderly individuals, to protect them from despair. Providers should explore the patient's preferences regarding information, rather than assuming

cultural generalizations.

In a socio-cultural context where care is defined and delivered as an institutional package, the Tamil traditional approach to care serves as a reminder to the communitarian responsibility of care as personal presence. In a technological society which is gradually turning the process of death as a technological event, the Tamil traditional understanding of death calls for a review of death as a personal and social ritual and an inseparable part of personal and familial life. In a society that reduces illness as a privation of the natural order and as a manageable or curable part of a fragmented human person, the Tamil ethics and ethos calls for a holistic approach to the person without focusing on this or that part of one's body that is ailing. Bodies do not suffer and go through pain, it is the person who suffers or endures pain.

Simone Weil, a French philosopher and mystic who died at a very young age after suffering from serious illness, wrote about attention as compassion in her book *Attente de Dieu* (Weil, 1951/1979). She observed, "We need to see things and people in their unique particularity, not as instances of general categories. The soul in such an instance empties itself of all its own contents in order to receive into itself the person it is looking at, just as he or she is, in all his or her truth. Only whosoever is capable of compassion and attention can do this" (Weil, 1951/1979).

References:

Baylis, F. (1995). *Healthcare ethics in Canada*. Harcourt Brace.

Beiser, M., Chandrakanthan, A. J. V., et al. (2007). *A community in distress: Results of a research study on Tamil mental health community survey*. Department of Psychiatry, University of Toronto.

Blank, R. H., & Merrick, J. C. (2005). *End-of-life decision making: A cross-national study*. MIT Press.

Chandrakanthan, A.J.V. (2002). Principles of biomedical ethics [Review of the book *Principles of biomedical ethics*]. *Annals of the Royal College of Physicians and Surgeons of Ontario, 35*(2), 117.

Chandrakanthan, A.J.V. (2007). When two cultures collide at the bedside: Religio-cultural value conflicts and medico-ethical decision making among the Tamil community in Canada. In C. Kanaganayakam et al. (Eds.), *History and imagination: Tamil culture in the global context* (pp. 138–149). TSAR Publications.

Fujiki, N., et al. (Eds.). (1998). *Bioethics in Asia*. Eubios Ethics Institute.

Hyndman, J. (2003). Aid, conflict and migration: The Canada Sri Lanka connection. *The Canadian Geographer, 47*(3), 251 - 268.

Koenig, H. G. (2001). *The healing power of faith: Science explores medicine's last great frontier*. Simon & Schuster.

Masi, R., et al. (Eds.). (1993). *Health and cultures: Exploring relationships* (Vols. 1–2). Mosaic Press.

National Council on Interpreting in Health Care. (2004, July). *National code of ethics for interpreters in health care*.

Rack, P. (1990). Psychological/psychiatric disorders. In B. McAvoy & L. J. Donaldson (Eds.), *Health care for Asians* (p. 299). Oxford Medical Publications.

Sulmasy, D. P. (1997). *The healer's calling*. Paulist Press.

Sulmasy, D. P. (2007). *The rebirth of the clinic: An introduction to spirituality in health care*. Georgetown University Press.

Webb, P. (Ed.). (2005). *Ethical issues in palliative care*. Radcliffe Publishing.

Wehbe-Alamah, H., Hammonds, L. S., & Stanley, D. (2021). Culturally congruent care from the perspectives of Judaism, Christianity, and Islam. *Journal of Transcultural Nursing, 32*(2), 119-128. https://doi.org/10.1177/1043659619900000

Weil, S. (1979). *Waiting for God* (E. Craufurd, Trans.). Harper & Row. (Original work published 1951 as *Attente de Dieu*).

Wolfe, R. W., et al. (Eds.). (1999). *Ethics and world religions: Cross-cultural case studies*. Orbis Books.

Wright, N. T. (2020). *God and the pandemic*. Zondervan Reflective.