Modern Medicine Is a Colonial Artifact: Introducing Decoloniality to Medical Education Research
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Abstract

Modern medicine is an artifact of colonialism because the science that underpins modern medicine emerged from Western knowledge structures based on a history of colonialism. The author suggests the colonial roots of Western-based modern medicine must be reexamined. While there are various critical theories that may be applied in this reexamination, most do not adequately account for intersectional, intergenerational, and sociohistorical inequities encountered in the multiplicity of global contexts in practice teaching and research within medicine. The author presents decoloniality as a theoretical perspective from which to interrogate sociohistorical, geopolitical, and economic perspectives on gender, race, and heteropaternalistic influences in medicine emanating from a basis in colonially developed systems of knowledge production. The author offers definitions of relevant theoretical terms and suggests that decolonial praxis begins with an initial realization or awareness of one’s position within the colonial matrix of power followed by the reflecting or deliberation, or a grappling with real-life struggles that are encountered in confronting the oppressive operations of the colonial matrix of power. Decolonial praxis involves action through challenging mainstream foundational theories—the questions they generate, the research methods they support, and the writing styles they employ. In medical education, this may involve changing powerful actors, such as medical journal editors and researchers, with historical privilege; shifting the balance of power in research spaces; and dismantling physical and intellectual structures and institutions established on colonial epistemologies.

Decoloniality, a less familiar approach in medical education, encompasses theory and debate around sociohistorical, geopolitical, and economic perspectives on gender, race, and heteropaternalism (heterosexual, male, paternalistic ways of thinking, viewing, acting, and controlling contexts, identities, and relationships) resisting the historical effects of colonialization. Decoloniality sees oppression as intersectional, multidimensional, multisystemic, institutional, historical, and self-perpetuating. It has been observed that

...any western medical institution more than a century old and which claims to stand for peace and justice has to confront a painful truth—that its success was built on the savage legacy of colonialism.4

Colonized people are forced to suppress parts of themselves such as language, ethnicity, ancestral knowledge, and pride in their bodies to attain the ideal of personhood defined by the coloniality of power as White and male. The impact of suppressing parts of the self to survive is a familiar sacrifice to marginalized people. The success of coloniality hinges on its effortless reproduction, by colonized peoples who are forced to deny their humanity and submit to and reproduce

Chasm
I can speak no words but my own,
I can speak with no voice but my own
My tongue is a stranger to your ears
Our minds reach towards each other
Over oceans of history
But you will never know the meaning of my heart
In forever you and I will die a thousand deaths
The atoms of our material will re-join endlessly
But not today, not now
Here we will never share the sway of life.

—T. Naidu

The contemporary shift toward social justice, equity, diversity, and antiracism in medical education and research has prompted a search for appropriate theoretical and philosophical lenses. Modern medicine is an artifact of coloniality, organized to preserve and regenerate powerful epistemological foundations through currently dominant structures and actors. The epistemic revolution in medicine must begin with scholarship and education where modern medicine’s basis in Western knowledge and knowledge production can be questioned and reimagined. Critical theories such as feminist theories1 and critical race theory2,3 have been used as a proxy to explain issues that pertain to language, religion, culture, gender, and sexuality in medical education. These theories do not account for intersectional, intergenerational, and sociohistorical inequities encountered in the multiplicity of global contexts in which medicine is practiced, taught, and researched. Moreover, these theories do not explain how oppressive contexts shape identities, self-image, and perspectives and coerce people to be complicit in their own oppression. One promising approach is the decoloniality. In Box 1, I provide definitions of some key concepts in decoloniality. I then provide some context of these key concepts and suggest actions toward decolonial practice for readers to consider. These concepts will be expanded upon in the Association of American Medical Colleges Learn Serve Lead 2021 RIME Address.
Box 1
Overview of Concepts

| Colonization: | the historical processes of suppressing Indigenous peoples’ bodies, and minds, appropriating land, labor, and resources, and enforcing colonizers’ languages and knowledge and educational systems. |
| Colonialism: | a political and economic relation where the sovereignty of a nation rests on the power of another making the powerful nation an empire. |
| Coloniality | is the long-standing patterns of power that emerged from colonialism, but that define culture, labor, relationships, and knowledge production beyond the limits and existence of colonial administrations. Coloniality outlines colonialism and is preserved in books, the criteria for academic performance, cultural patterns, “common sense,” self-image, aspirations of self, and other aspects of modern experience. |
| The colonial matrix of power | composed of sexism, patriarchy, the capitalist market, racism, authority, and subjectivity keeps modern global societies in a permanently conflictual and destabilized state. |
| Coloniality of power | shapes knowledge and determines what it means to be a person and is wielded by colonizers to assign some people and groups to the zone of subhumanity. |
| Decoloniality | involves delinking from the overall structure of knowledge to reconstitute ways of thinking, languages, ways of life, and being in the world. Decoloniality foregrounds reclaiming, reframing, and recentering of Indigenous knowledge systems, methods, and languages and correcting deficits created by colonialism and maintained by coloniality. |

Euro-American superiority, Modernity, the contemporary iteration of coloniality, defines what is considered human, space, time, structure, culture, subjectivity, objectivity, and methodology reinforcing the colonial foundations that perpetuate the superiority of some versions of being human over others. Recent reports of mass graves surfaced in Canada drawing attention again to the fact that since the 1800s, Indigenous children were forced to attend residential schools away from their families as part of an assimilation policy. The effect of this brutal action reverberates among survivors and their descendants. Such examples proliferate wherever in world colonization took hold and are beyond the scope of this Commentary. Here, the aim is to conscientize readers to the enduring effects of colonization in the modern world and introduce decoloniality as a restorative approach and practice in research.

Decolonial praxis is about rebellion, transgression, and resisting coloniality. It can feel devious and surreptitious because we are indoctrinated to self-censor in the interests of perpetuating coloniality. Decoloniality in practice involves 3 elements: awareness, deliberation, and action.

Awareness refers to positionality or realizing where you are placed in the colonial matrix of power with reference to your identity, history, and context. Marginalized persons are compelled to view the world from both the oppressors’ perspective and their own. Reflecting on this “double consciousness” in her medical education, Ayana Langston, who identifies as a Black woman, says, the more I learned about the physiology of the human body, the more I was forced to confront the degradation of the Black body. The better I became at learning the algorithms for diagnosis, treatment, and delivery of health care, the more apparent it was that these algorithms were never meant to cure, heal, save, or protect any patient who looked like me.

A personal history and identity of privilege may require recognizing how one has benefitted from the colonial matrix of power that has oppressed others. I am reminded daily that my medical knowledge is based on the discoveries made by people who looked like me without being reminded that some of the most painful discoveries were made through inhumane and non-consensual experimentation on people of color.

Deliberation involves reflecting on personal histories to theorize the dismantling of dominant structures. Decolonial feminist scholar Gloria Anzaldua calls this “entering into the serpent” and listening differently to the silenced and erased histories within us to engage in “border thinking.” Modern Western cultures draw a distinction between rationality and fiction while traditional and indigenous cultures value dreams and imagination. A decolonial perspective supports applying theories and epistemologies from outside the colonial matrix of power incorporating perspectives that coloniality excluded from modern knowledge production. Border thinking responds to real-life struggles against the oppressive operations of the colonial matrix of power.

Action in decolonizing approaches challenges mainstream foundational theories; the questions they generate, the research methods they support, and the writing styles they employ as significant acts to be critically examined before application. Decolonizing, is best understood as a verb that entails a political and normative ethic and practice of resistance and intentional undoing – unlearning and dismantling unjust practices, assumptions, and institutions – as well as persistent positive action to create and build alternative spaces and ways of knowing.

Decolonial action in research involves changing the actors, shifting power, and dismantling colonial structures and institutions. These actions are not sequential or independent, but intersectional and contemporaneous. Scholars and researchers in medical education research may begin decolonial action in the following ways.

Change the Actors

Changing the actors might begin by citing marginalized scholars’ work and inviting them to publish in mainstream journals. Citing the work of marginalized scholars foregrounds their scholarship and epistemologies. The recent impetus to create space on dominant scholarship platforms by inviting authors from marginalized groups to write in high-impact journals such as the call by *The Lancet Global Health* (Who tells the story?) and *Academic Medicine* (New Conversations) are such initiatives. However, delineating what may be said, when, how, and by whom negates potential benefits. Editors must be willing to embrace humility and surrender power. Existing structures of power are reinforced if the space of publication is constructed such that marginalized and underrepresented authors need a specific invitation. As long as the space is held by traditional power, it cannot truly be
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redefined. Allyship or speaking for and behalf of the oppressed is unnecessary when the spaces allow for their voices to be heard.20

Funders, editors, and researchers in powerful positions must question the privileges of their ancestry, location, and identity. Conscious or unconscious blindness to relative privileges may at best block emerging alternate viewpoints and at worst be exploitative and oppressive.11 Confronting privilege can be painful and threatening. The aim is not for the privileged to be shamed as this is unproductive and likely to provoke, defensiveness, denial, or overcompensating for oppression. Reactions can be to deny or explain one's privilege within epistemic frameworks, which is pointless, as it is these very frameworks that create and maintain the privileges associated with race, gender, sexuality, geolocation, and language.

A recent trend in medical education research has seen authors from privileged groups and positions invite authors from marginalized groups to co-author papers on social justice, equity, racism, and discrimination. While this is encouraging on one hand, the tendency for privileged authors to claim prime authorship positions (first and last) or to influence how and what should be written is counter to decolonial practice. Decolonial praxis promotes marginalized authors leading intellectual work. Similarly, replacing White male editors of medical education journals with White female editors from historically privileged groups may reconcile historical gender discrimination but not is not a decolonial practice.

Shift Power in Research

Intended audiences can influence what direction research takes and who benefits from the outcomes. Research findings presented at conferences of majority privileged researchers will focus on different issues than if the same research project were presented to marginalized people. Powerful funding sources influence research agendas. Significant funding goes to researchers demonstrating success in replicating Western-dominated research foci and paradigms. Funders must fund more risky projects with unconventional ideas, led by researchers who are not the White, male, or from a dominant country.

In research, decolonial praxis entails interrogating who one chooses to collaborate with and what your relative privileges and disadvantages are in the context of the colonial matrix of power. With these relative privileges in mind, one would need to ask who is leading the research? Who has invited whom to participate? And what the motivation is for each? Privileged researchers need to reflect on what their motivations are for doing research among disadvantaged groups. Whitehead et al have noted that "paying close attention to the language used to describe the nature of a relationship, medical educators may be able to move toward more collaborative, capacity-building international partnerships."21 How do these power disparities impact on where the theories and ways of viewing the world originate from? How often do dominant Western medical researchers consider spirituality, intuition, dreams, or imagination in their methodology? How are data and findings are used as an evidence base to reaffirm Western ways of understanding the world while ignoring or diminishing marginalized perspectives?

Coloniality perpetuates and reinforces dominant ways of knowing, thinking, understanding (epistemology), and conducting research (methodology), and we must come to the realization that how we make sense of the world extends beyond our body-bound senses and how we perceive and understand extends beyond dominant modern Western scientific conceptualizations of the body, space, and time. Applying methodological humility by considering different ways of conceptualizing seeing and understanding contexts and data in research requires different tools and perspectives as well as varied ways of processing data.22

Dismantle Structures and Institutions

Decolonial praxis may find resonance through alternative forms of writing and presenting research findings. Poetry, prose, and audiovisual and mixed media forms of communicating research or conceptual work that precedes fieldwork. A recent increase in concept papers, perspective papers, essays, commentaries, editorials, and letters on social justice, equity, diversity, and marginalization in a number of high-impact medical journals is a turn toward a decolonial praxis. These works introduce previously hidden and veiled epistemologies, perspectives, and voices. Satirical writing or poetry are "a way to resist domestication—methodological and otherwise."23,24 Insurgent poetry engages otherness, including the "other" inside ourselves, to extend writing beyond dominant colonial binaries.25

Autoethnography is recognized as decolonial praxis.25 Medical student LaShyra Nolen's writing in the New England Journal of Medicine (NEJM) is an example of revealing self while revealing another perspective.26 A decolonial reading of Nolen's reflection as a Black woman studying medicine reveals her realization that White skin as reference point in medicine is dangerous to the health of people of color. She becomes aware of this double consciousness, deliberates on her position, and acts through her writing in the neocolonial space of NEJM. The NEJM, an institution of coloniality, initiated a change of actors by creating the space for a Black woman's voice to be heard, and a small shift in power by reimagining itself as a space for the public realization that black skin presents differently; but not before LaShyra Nolen did the work of overcoming the barriers to entering medical school experienced by Black women in the United States.27,28 Nolen's disciplined outrage is not new. It represents the kind of view that has been never invited into that hallowed space before. Her voice could not previously find resonance within this structure.17 NEJM and Nolen's collaboration represents a nascent step toward changing the actors, shifting power, and dismantling structures.

The principles outlined in this article serve as a primer for readers endeavoring to explore decoloniality in practice. Through conscious awareness, deliberation, and action medical educators and health professionals can begin to dismantle colonial artifacts and practices that thrive in the modern world.

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