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Decolonising Medical Education in South Africa: Reflections from a Medical Student on Curriculum, Context and Professional Standards

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Introduction

Decolonisation has become an important discussion within South African higher education, including health professions education. The debate extends beyond replacing one curriculum with another to questions of historical inequality, knowledge hierarchies, social context and community needs. South African health professions education has increasingly emphasised preparing graduates for national health priorities, including the needs of rural and underserved communities.[1]

A scoping review of decolonisation in health sciences curricula identified themes including coloniality, inequity, knowledge hierarchies, heritage and alternative forms of knowledge.[2] A subsequent scoping review examined how these ideas could be translated into practical curriculum transformation, highlighting a range of decolonial actions in health sciences education.[3] In medical education, this creates an important tension: curricula should be responsive to their context while maintaining scientific rigour, clinical competence, ethics and patient safety.

This article reflects on a clinical encounter observed during my clinical shadowing experiences, which prompted me to consider the relationship between patients' cultural and therapeutic beliefs, medical education and the realities of clinical practice. I do not evaluate my institution's curriculum, and I do not claim to represent the views of educators, patients or traditional health practitioners. My authority here is limited to what I observed and how I interpreted it.

I present three principles, epidemiological relevance, epistemic pluralism and community embeddedness, as a reflective framework for considering curriculum transformation in the South African context. The framework is conceptual: it is not an empirically validated model or a statement of stakeholder consensus.

The Experience

During clinical shadowing in a general medical ward, I encountered a patient whose clinical deterioration occurred shortly after the use of a traditional preparation. This is a temporal observation only: the contribution of the preparation to the patient's condition was not established, and I do not suggest that it caused the deterioration. The encounter made me consider how healthcare professionals could better understand the treatment choices patients make before reaching hospital, and it raised a question I had not previously considered: how should I, as a future doctor, ask about those treatments, and what should I do with the answer?

I began wondering whether communication and referral pathways between traditional healers and biomedical healthcare practitioners could, in appropriate circumstances, help patients reach medical care earlier when referral is necessary. Such collaboration would require clearly defined boundaries, patient-safety safeguards and evidence regarding its effectiveness. This was not something I could assess from the encounter, but it made me question whether medical education adequately prepares students to navigate the cultural and healthcare realities they may encounter in practice.

Before this encounter, my understanding of decolonisation had been shaped by discussions I was aware of: conversations about a curriculum review at my institution, student advocacy for greater integration of traditional medicine into medical education, and general awareness of the role traditional healing plays in healthcare-seeking for some communities in South Africa. As a third-year medical student, my role was that of an observer and reflective learner. I did not attend any curriculum meetings. I was not involved in curriculum design, and I did not formally evaluate the existing curriculum.

Critical Reflection: From Representation to Context

Initially, I viewed the inclusion of traditional medicine in medical education mainly as a question of representation: if patients use traditional healing, students should learn about it. This encounter made me realise that representation alone is insufficient.

The encounter made me more conscious of the importance of asking patients about treatments they may have used before presenting to hospital, including traditional remedies, in a manner that is open and non-judgemental. I recognised that patients may not volunteer this information if they anticipate criticism or feel that their beliefs will be dismissed. In future clinical encounters, I would therefore be more deliberate in creating space for patients to discuss previous treatments, exploring what they have used and their understanding of its purpose, while assessing potential safety concerns without compromising the therapeutic relationship.

Doctors may encounter patients whose explanations of illness or treatment choices differ from biomedical models. Simply dismissing these beliefs may damage trust or discourage patients from disclosing traditional remedies. At the same time, cultural respect cannot require clinicians to regard every treatment as safe or effective without appropriate evidence. I came to see that these positions can coexist: a doctor can respect a patient's beliefs while assessing potential harm and recommending evidence-based care when clinically indicated.

This also changed how I understood epistemic pluralism. It does not require biomedical and traditional knowledge to be treated as having identical evidentiary status. Rather, students can be taught to encounter, understand and critically engage with different systems of knowledge while evaluating individual practices according to evidence, safety, ethics and clinical relevance. I came to understand decolonisation as preparing students to practise safely and respectfully within the social and cultural realities of South African healthcare.

A Reflective Framework for Curriculum Decolonisation

These experiences led me to three questions: What should students learn? Whose knowledge should students encounter? Where and how should students learn? I organised my reflections around three interconnected principles: epidemiological relevance, epistemic pluralism and community embeddedness. I use these principles as a reflective framework for considering how undergraduate medical education can respond to South African contexts while retaining professional and scientific standards. Their relationship is illustrated in Figure 1, while Table 1 summarises the questions and safeguards associated with each principle.

Epidemiological Relevance – What Should Students Learn?

A curriculum should reflect the health problems and healthcare environments in which graduates will practise. South Africa's infectious and non-communicable disease burden, health inequalities and differences in access between urban, rural and underserved communities shape clinical practice. South African health professions education has therefore been encouraged to respond more closely to national health needs.[1]

This made me reconsider what constitutes a complete medical education. Students require a strong biomedical foundation and preparation for conditions encountered internationally, while the application of that knowledge should also reflect local realities. An illustrative teaching activity, which could be delivered within existing case-based tutorials, would be a diabetes case in which students address pathophysiology and pharmacological management alongside food affordability, transport to healthcare facilities, health literacy and continuity of care. Contextualising biomedical knowledge can help students apply it meaningfully without reducing its scientific content.

Epistemic Pluralism – Whose Knowledge Should Students Encounter?

In communities where traditional healing forms part of healthcare-seeking, students may encounter patients who have consulted traditional healers or used traditional preparations. Students need opportunities to understand these practices and discuss them respectfully with patients. South African literature has highlighted both the potential importance and uneven integration of African traditional medicine within undergraduate medical education.[4]

However, recognition should not automatically become endorsement. Students can learn about African traditional medicine, patients' explanatory models and the historical relationship between communities and biomedical institutions while also learning to identify potential treatment risks and communicate concerns respectfully. This may help students avoid dismissing patients' beliefs while also avoiding uncritical acceptance of health claims.

An illustrative teaching activity, which could be delivered within existing clinical skills teaching, would be a communication exercise in which students practise asking a patient what they have used without immediate dismissal, exploring the patient's reasons and expectations, and then assessing potential interactions, adverse effects or delays in care. The exercise would assess both the quality of the question and the quality of the clinical reasoning that follows it.

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Community Embeddedness – Where and How Should Students Learn?

Medical education can become detached from communities when students encounter patients mainly in tertiary hospitals. Community-oriented primary care and longitudinal community-based approaches provide opportunities to connect academic learning with community health needs.[5,6]

My reflection made me reconsider the meaning of clinical exposure. Seeing disease in hospital is important, but understanding why a patient presents late, follows a particular healthcare pathway or struggles with treatment requires attention to community circumstances. Community-based learning can therefore complement hospital training by helping students understand healthcare-seeking behaviour, access barriers and social determinants of health.

An illustrative teaching activity, which could be built into existing community-based or primary care placements, would be a learning task in which students explore the pathways through which patients access healthcare, including barriers to referral, transport and continuity of care, and the relationship between community-based practices and formal health services. The learning outcome would be defined in terms of clinical reasoning and communication, not simply exposure to a community setting.

Maintaining Professional and Global Standards

Contextualising medical education also raises concerns about maintaining scientific and professional standards. Medical education must produce graduates who practise safely, ethically and competently. Cultural sensitivity cannot replace clinical assessment, and contextual relevance cannot justify practices lacking adequate evidence of safety or effectiveness.

The World Federation for Medical Education provides global standards for basic medical education while allowing programmes to adapt to local social, economic, cultural and disease contexts.[7] This helped me distinguish between the standards graduates are expected to meet and the contexts through which those standards are taught.

A student should therefore meet fundamental expectations for clinical reasoning, patient safety, communication and ethical practice regardless of where they train. However, the cases used to develop these competencies, the communities in which students learn, and the cultural contexts discussed can reflect the population being served.

This distinction became central to my understanding of decolonisation. The goal is to examine whether rigorous professional standards can be pursued together with greater attention to the history, health needs, knowledge systems and communities of the society in which graduates will practise.

Implications for Curriculum Practice

These reflections suggest that curriculum transformation does not necessarily require entirely new courses. Existing teaching could be reviewed to determine whether cases and clinical examples adequately reflect South African health priorities and healthcare realities.

Teaching about traditional medicine could be incorporated into relevant clinical and public health contexts, including communication skills that enable students to ask about traditional remedies without judgement, recognise potential risks and provide appropriate evidence-based advice. Community-based experiences could likewise be strengthened where educationally appropriate.

Such changes should be evaluated according to whether they improve students' knowledge, communication, cultural responsiveness and ability to practise safely.

Avoiding tokenism is important. A single lecture on traditional medicine or a few African clinical examples do not necessarily constitute substantive transformation. Curriculum transformation should instead involve sustained attention to what is taught, whose perspectives are included, how students learn and the populations they will ultimately care for. The three teaching activities described above are illustrative; they are not a validated curriculum model, and their effectiveness has not been evaluated.

What I Learned

This process changed my understanding of decolonisation from a focus on representation to a broader question of how medical education prepares students for their context.

I learned that culturally responsive care requires more than recognising the existence of different health beliefs; it also requires the ability to engage with them during clinical practice. For me, this includes approaching treatment histories without assumptions, maintaining curiosity about patients' perspectives, and recognising that respectful communication and clinical judgement must operate together.

I also learned that cultural responsiveness and scientific rigour do not have to be competing objectives. Students can respect patients' beliefs while explaining potential risks, learn about traditional medicine without assuming that every practice is clinically effective, and study South African health priorities without abandoning the biomedical knowledge required for competent practice.

Most importantly, I learned that curriculum transformation requires continued questioning: what is taught, whose knowledge is represented, where learning occurs and whether students are prepared for the populations they will care for.

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Limitations

This reflection represents the perspective of a single medical student and is not based on empirical evaluation of medical curricula, traditional healing practices or patient outcomes. It draws on a clinical observation made during shadowing rather than a systematic series of encounters, and I did not formally evaluate my institution's curriculum or observe curriculum design processes. The framework therefore reflects my critical interpretation of educational and clinical experiences informed by the literature rather than a validated model or representation of all South African medical students, educators, clinicians, traditional health practitioners or communities. It has not been tested with educators, patients, traditional health practitioners or students, and it does not represent stakeholder consensus. Further perspectives across different South African contexts would be needed to explore its broader applicability.

Conclusion

Reflecting on curriculum transformation and clinical exposure changed how I understood decolonisation in medical education. I moved from viewing it primarily as the inclusion of African or traditional knowledge towards understanding it as a broader process of examining curriculum content, knowledge systems, learning environments and the contexts in which graduates will practise.

The three principles of epidemiological relevance, epistemic pluralism and community embeddedness provide a framework for this reflection. They suggest that a contextually responsive curriculum should reflect population health needs, enable critical and respectful engagement with different knowledge systems, and connect learning with the communities healthcare professionals serve. These principles must operate alongside scientific evidence, patient safety, ethics and professional competence.

I now think a curriculum can meet global standards while still being built around the patients and communities its graduates will serve. Scientific competence and local relevance can therefore be complementary requirements of medical education in South Africa.

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Conflicts of interest. The author declares no conflicts of interest.

Author contributions. Wanele Siyanda Khomo: Conceptualization, Investigation, Writing – Original Draft, Writing – Review & Editing.

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Figure 1. Reflective Framework for Decolonising Undergraduate Medical Education in South Africa. The framework considers epidemiological relevance, epistemic pluralism and community embeddedness within the overarching requirements of scientific evidence, patient safety, clinical competence and ethics.

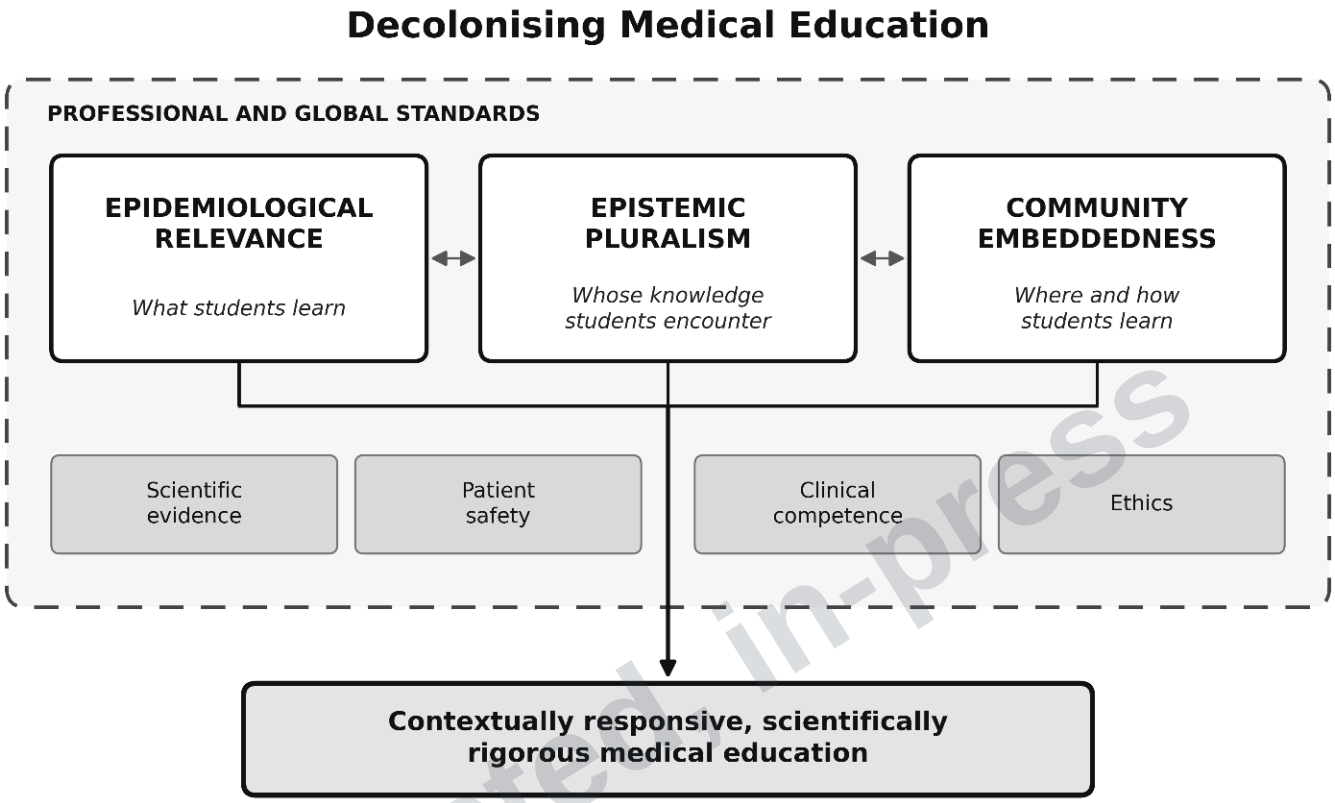

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Table 1. A Reflective Framework for Decolonising Undergraduate Medical Education in South Africa

Principle	Curriculum question	What it could mean in practice	Key safeguard
Epidemiological relevance	What should students learn?	Reflect South Africa's disease burden, health-system realities and major determinants of health in cases and learning priorities.	Maintain comprehensive biomedical knowledge and preparation for uncommon and global health threats.
Epistemic pluralism	Whose knowledge should students encounter?	Introduce relevant African, community and traditional health perspectives and teach students to engage with them critically.	Evaluate knowledge claims according to evidence, patient safety, ethics and clinical relevance.
Community embeddedness	Where and how should students learn?	Strengthen learning through primary healthcare, community, rural and underserved settings where appropriate.	Ensure community-based learning contributes to defined educational competencies and clinical standards.

Note: No abbreviations are used in this table. The table summarises a conceptual framework from the author's reflection; it is not an empirically validated model.