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Modern medicine as a site of colonial continuity

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Abstract: This paper critically analyses modern medicine as a social institution, tracing its foundations to European colonialism. Drawing on historical examples, it demonstrates how ethnocentric and authoritarian approaches in colonial medicine continue to produce and shape contemporary medical knowledge and practice. The article then assesses the modern medical paradigm where all aspects of human behaviour are medicalised reflecting a subtle continuation of colonial authority. Modern medicine thus remains fundamentally an authoritative and normative institution grounded in colonial discourses, albeit in different forms. Reconstituted and intensified under neoliberal capitalism, this framework, which often reduces patients to consumers and commodifies well-being, entrenches health disparities, reproduces and reinforces existing power imbalances within healthcare systems.

By engaging with this topic, the paper aims to contribute to decolonial discourses in medicine and global public health. It advocates for reimagining health systems that move beyond colonial logics of domination, control, and extraction, towards models rooted in justice, plurality, and collective well-being.

Keywords: colonialism, colonial medicine, health commodification

1 Introduction

Despite remarkable technological advancements and growing global calls for social justice and equity, healthcare inequality remains a pressing challenge, with approximately 3.8 billion people at present facing structural and social barriers that directly affect their short-term and long-term health (World Health Organization, 2025). Simultaneously, the reach of medical authority is expanding, increasingly pathologising human emotions, behaviours, and social conditions – a process known as medicalisation (Conrad, 1992).

This essay argues that these two seemingly distinct phenomena - healthcare inequality and the expanding scope of medicalisation - are not only interconnected but fundamentally shaped by authoritarian and paternalistic logic that structured colonialism. This logic continues to inform who holds power, whose knowledge is valued, and how care is distributed within contemporary health systems. Central to this dynamic is the commodification of healthcare under neoliberal capitalism which transforms health from a collective right into a market commodity (Ratna, 2020). These processes have shaped a health system that is embedded with exploitation and exclusion, which continues to fuel disparity and consolidate medical power (Alang, Carter and Blackstock, 2023).

Access to care remains stratified along lines of race, class, gender, and geopolitics (see Marmot et el., 2008; Manuel, 2018). Meanwhile, the ideological authority of modern medicine continues to produce the definitions of health, illness, and normalcy, influencing our very ways of being and thinking (Foucault, 1973; Zola, 1976). These systems not only decide who is considered sick, but also who receives care (Manuel, 2018). Yet, while colonial logics of domination and control have contributed to persistent disparities, individuals and communities continue to challenge and resist exclusionary practices and reclaim traditional knowledge and practices, demonstrating that healthcare systems as sites are continually negotiated and contested (McKenzie et al., 2022).

This paper seeks to contribute to decolonial discourses in medicine by tracing the historical and political roots of healthcare inequality, commodification, and

medicalisation. Through an extensive literature review, the paper will interrogate the colonial foundations of Western medicine, and unpack how, based on these very foundations, medicalisation in the backdrop of neoliberalism has intensified healthcare inequality. Ultimately, this essay advocates for a decolonised approach to healthcare, one rooted in justice, plurality, and collective well-being. In doing so, it asks: how can we imagine healthcare systems that move beyond the structures of domination and control, and instead foster equity, participation, and diverse ways of knowing and healing?

2 The colonial foundations of Western biomedicine

The western biomedical system is the most influential and dominant approach to understanding the human body and treating illnesses in the world today. This system of medicine that has saved millions of lives, increased life expectancy, and significantly improved our standards of living did not develop in a political vacuum, nor is its global dominance a neutral scientific triumph (Lock and Nguyen, 2010). Instead, its current form is deeply rooted in the legacy of colonial expansion and continues to perpetuate certain forms of knowledge, ways of knowing, practising medicine, and power structures that originated in the colonial era (Lock and Nguyen, 2010; Naidu, 2021).

After the fall of the Roman Empire, Christian institutions in Europe became the primary custodians of medical knowledge and care (Hajar, 2012; Porter, 1997). Over time, this religious authority gave way to “secular” and scientifically oriented institutions, but religious dominance remained influential and thus, by extension, the monopoly endured – medical knowledge and authority became the assets of a small group of elites who were trained in church sanctioned institutions (Porter, 1997). Doctors thus trained became not only the gatekeepers of medical knowledge but also asserted authority over ways of knowing the human body (Foucault, 1973; Porter 1997). This authority depended upon assertions of “scientific objectivity” of biomedicine, which often led to the dismissal of experiential and cultural knowledge, particularly that of those outside the profession (Good, 1994; Lock and Nguyen, 2010). This asymmetrical gap in knowledge, or rather what was an acceptable form of knowledge, further entrenched the power dynamics between those who had knowledge and

authority and who lacked them: health care providers and patients (Good, 1994). This institutionalisation of medical authority was sustained by a monopoly on medical knowledge (Porter, 1997). Habinek and Haveman (2019, p.81) show how modern medicine maintains its professional monopoly by "defending its cultural authority against rival claims and preserving its institutional support from the state".

During the European colonial expansion – alongside violence, slavery, genocide, exclusion, exploitation, control, and fragmentation – medicine and medical advances were frequently deployed as tools of colonialism (Torres Rivera, 2023; Viniegra-Velazquez, 2020). This deployment includes both overt biological warfare like the British attempt to spread smallpox to Native Americans (Dollar, 1977), and the medicalisation of resistance with diagnosis like "drapetomania" – a disorder invented solely to pathologise the desire for freedom among enslaved workers (Bynum, 2000). While the effectiveness of General Jeffery Amherst's method to cause an outbreak has remained under discussion (Hibbard, 2023) and "drapetomania" was met with varying reception even in its own time, the linguistic narratives used by General Amherst and physician Samuel A. Cartwright reveal the dominant ideologies of those periods.

While significant scientific progress took place during the period of colonialism, this advancement was primarily instrumental – designed to serve interests of the colonisers rather than to promote scientific development or genuinely benefit the colonised population. Crucially, the colonial empires suppressed and illegitimized the pre-existing knowledge and science of colonised communities (Naidu, 2021; Smith, 2012). Medicine in this context supported the broader goals of empire; the assertion of racial superiority, authoritarianism, paternalism, and resource extraction (Starrs, Croke and Muellenbroich, 2021). As such, the history of Western biomedicine is inseparable from the political ideologies that underpin colonial and postcolonial domination (Naidu, 2021).

A central claim of Western biomedicine – both historically and in the present – is its foundation in scientific rationality. However, this is not an objective or universal science, but a particular form of European rationality (Qin et al., 2024; Valles, 2020). By presenting Western science as culturally and politically neutral, European powers framed their medical practices as inherently superior to local and indigenous knowledge

and systems. This ethnocentric worldview led to the systematic marginalisation of traditional and local healing practices, dismissing them as primitive, irrational, and superstitious (Davis, 2016; Qin et al., 2024; Smith, 2012). For example, during apartheid, the Witchcraft Suppression Act of 1957 criminalised Sangomas – traditional South African healers – and portrayed them as witches. This official vilification led many Africans to believe they were victims of sorcery, consequently leading to a rise in mob and witchcraft-related violence (Hund, 2004).

This paternalistic stance also justified the imposition of Western medicine on the colonial population, with little or no regard for local knowledge, cultural contexts, and lived realities. Under this logic, colonial medical institutions criminalised indigenous healing, erased alternative epistemologies, and legitimised cultural assimilation policies (Smith, 2012). The result is epistemic racism where the imposition of Western biomedicine silences and delegitimises other ways of understanding the human body, health, and illnesses. As a result, indigenous and local healing practices and traditions are systematically marginalised (see Matthews, 2016). For example, in colonial India, following the reports of Dr John Grant and Thomas Macaulay (Macaulay1835), the 'Native Medical Institution' in Calcutta, which offered medical training in both western and traditional (Ayurvedic and Unani) systems in native languages, was abolished and replaced with institutions that delivered only western medical knowledge in the English language (Anshu and Supe, 2016).

In colonised territories, Western medicine often functioned as a "civilizing" force (Amster, 2022; Greene et al., 2013). This included the development of "tropical" medicine, a medical speciality that focuses on "unique" diseases of the tropics and sub-tropics (Greene et al., 2013). Medical schools and hospitals were established, but primarily to benefit the empires and European settlers (Bhattacharya, 2014). Additionally, Christian medical missionaries offered both physical healing and spiritual salvation of the "diseased natives" through conversion to Christianity (Vaughan, 1991 cited in Greene et al., 2013). This imposition presented as objective science dismissed local epistemologies and pathologised non-conforming practices or individuals (see Fanon, 1965).

These dynamics were sustained by a paternalistic and authoritarian ethos that reproduced and reinforced the ideology of racial superiority. This perspective frames intervention in the lives of an "inferior" population as a moral obligation, all under the guise of care and progress (Arnold, 1993). This approach was central to colonial medicine that sought not only to cure illness but to produce a specific kind of subject – one that was obedient, submissive, and manageable (Arnold, 1993; Fanon, 1965).

This ideology of racial superiority and the drive to control "inferior" populations manifested beyond colonised territories to domestic contexts as well. A particular example of this is the Tuskegee Syphilis Study (1932-1972) conducted in rural Alabama, in which African American men were deliberately denied treatment of Syphilis to observe the natural progression of disease (Fairchild and Bayer, 1999). This appalling abuse of authority is representative of a broader pattern in which racialised populations were treated as expendable in scientific progress. It illustrates the same ideology of racial superiority that justified colonial medical enterprise across the globe (Reverby, 2009).

To reiterate, the authority of Western medicine has long been intertwined with mechanisms of social control, cultural domination, and epistemic violence. It has operated not only as a means of healing but as a disciplinary apparatus that decides who is normal, who is sick, and who is fully human (Foucault, 1977). Understanding this history is essential for decolonising healthcare as these colonial logics persist within medical institutions, global health policies, and clinical practices today (Amster, 2022). The biomedical model continues to prioritise biological explanations, and western institutions often dominate the research agenda, funding, and decision-making (Engel, 1989; Farmer, et al., 2013). These asymmetries reproduce the very colonial hierarchies they claim to dismantle, which is evident in the healthcare system today.

However, it is crucial to acknowledge that these colonial impositions did not go unchallenged. Instances like advocacy of the reformists in colonial India for the preservation of Unani medicine against the backdrop of growing dominance of Western biomedicine (Quaiser, 2020); the repealing of the Tohunga suppression act of 1907 brought to illegalise Tohunga healing practices, which was only able to prosecute very few Tohunga practitioners (BPAC NZ, 2008) – reveal that even in the oppressive colonial context, communities and individuals resist, and contest with the oppressive structures,

making power as conceptualised by Foucault (1977) a dynamic and often negotiated site.

3 Medicalisation and neoliberal capitalism

Medicalisation refers to the process by which medical knowledge, practices, and institutions extend their authority beyond the clinic, transforming ordinary human experiences into matters requiring diagnosis and intervention (Conrad 1992). Emotions like grief, shyness, and life processes like menstruation or ageing become sites of medical scrutiny. Medicalisation in this context is the analysis that for a condition to be legitimised as an illness requiring or not requiring medical attention is in itself a socio-political process (Conrad, 2007). This process is sustained by the same ideologies behind historical colonialism – authoritarianism and paternalism.

The normative authority of medicine is sustained by its epistemic power. Biomedical norms define normal and abnormal; the normal way for a person to think, behave, feel, and exist. Through this "biopower", human lives and bodies are transformed into sites of surveillance, discipline, and control. However, biomedical norms are not created in a societal vacuum (Foucault, 1973; Foucault, 1977; Johnson; 2008; Zola, 1976). Medical definitions of health and what is considered a disease are fundamentally shaped by broader social values (Kleinman, 1980). As briefly discussed earlier with "drapetomania", these biases are evident in various historical contexts. Another significant historical example of this is the classification of homosexuality as a mental disorder for much of the 20th century. This categorisation, which both reflected and reinforced heteronormative ideologies and prevailing societal prejudices, was actively legitimised through medical discourse. Such instances reveal how the definitions of normality and abnormality are products of socio-cultural influence (Drescher, 2015; Katz, 2007).

While medical authorities turn emotional states into medical problems requiring intervention, capitalism ensures that these are profitable. Private healthcare clinics and hospitals aggressively market different levels of health check packages: whole body package, diabetes package, cardiology package, etc, reframing health as a consumer choice, and compelling individuals to constantly monitor, manage, and invest in their

bodies. Further, advertisements that focus on mental and emotional wellbeing are now commonplace, urging you to take charge of your mental and emotional state, to be organised, self-governing and responsible individuals (Esposito and Perez, 2014; Defossez, 2016).

This contemporary commodification of medicalised problems mirrors the underlying logic of colonial medicine: while in colonial context, colonised people and their ways of life were often blamed for their "condition", medicalisation driven by neoliberal ideologies, attempts to fix individuals by transforming them into self-regulating, productive subjects whose health and behaviour can serve the demands of the economic system (Farmer, 2003; Packard, 2016; Defossez, 2016).

While the authoritative power of biomedicine can legitimise suffering and access to care, how does one get help for the suffering when that access is withheld and health care is increasingly treated as a purchasable commodity? Consequently, medicalisation primarily serves as an authoritative force that individualises social problems and diverts attention from structural violence and reinforces neoliberal ideologies that prioritise personal responsibility by recasting systemic issues as apolitical technical problems (Farmer, 2003; Johnson, 2008).

This market-driven healthcare culture further entrenches global health disparities. Holistic and personalised care is reserved for those who can afford it, while others are relegated to the strained and underfunded and often coercive public health systems (Farmer, 2003). Additionally, the neoliberal medical regime reinforces the narrative where health becomes an individual burden, absolving the system of responsibility and encumbering the individual. Consequently, a stark divide in health outcomes persists worldwide; while the high-income nations grapple with internal health inequalities, the low-income nations face dire resource constraints and access problems (Farmer, 2003). In response, international health agencies frequently promote "one size fits all" responses that sideline local expertise and existing infrastructure, consequently risking the reproduction of colonial dynamics (Buyum et al., 2020; Packard, 2016).

In summary, the current medicalisation of everyday life driven by neoliberal capitalism, much akin to historical colonialism, is an ideological hegemonic project (Esposito and Perez, 2014). The neoliberal medical regime, by continuously defining,

controlling, and "improving" individuals under the guise of empowerment and self-care, exacerbates global health disparities and fundamentally diverts attention from the structural violence that underpins collective suffering.

4 Conclusion: Towards decolonising healthcare

Although formal colonial rule has ended, the authoritarian, and paternalistic logics that underpinned it continue to structure contemporary healthcare systems. These logics manifest today through the intertwined process of medicalisation, and commodification. While medicalisation through the epistemic authority of modern medicine defines the ways for individuals and populations to exist, and what counts as illness, neoliberal capitalism turns them into profitable enterprises. Together they create a system in which human experiences are continuously pathologised and monetised.

Thus, decolonising healthcare is not a symbolic gesture or academic abstraction (Tuck and Yang, 2012). It is an ongoing process of continuously challenging the ingrained power structures embedded within global health systems. It means reclaiming health as a collective human right – disentangled from capitalist forces and colonial biases – and empowering communities to define and pursue well-being on their own terms. Based in Alaska, the "Nuka system of care" is an example of such an approach. This system, owned and operated by the native people of Alaska, prioritises overall holistic well-being through shared responsibility. As a result, it has achieved remarkable improvements in health outcomes, patient satisfaction, and reduced healthcare costs (Gottlieb, 2013).

A decolonised healthcare system fundamentally rejects the commodification of wellbeing. It treats health not as a product to be bought and sold, but as a shared, relational process rooted in solidarity, justice, and care. This entails resisting the corporatisation of medicine, challenging the patient-as-consumer model, and reimagining care as participatory, reciprocal, and liberatory rather than coercive and hierarchical (Abimbola, 2019; Buyum, et al., 2020; Pai, 2021).

Crucially, decolonising healthcare involves community-centered partnerships that shift both funding and decision-making power to local institutions. It means ensuring that research agendas and health interventions are shaped by those most affected, not

by external experts, NGOs, or funding bodies, where communities are not subjects of interventions but are equal participants in identifying problems and creating solutions (Khan et al., 2021; Pai, 2021). The WHEELER study in Kenya exemplifies a community-centered partnership model by using participatory methodologies that fostered reciprocal learning and shared decision making in addressing gender, health and economic equity during crisis (Adam et al., 2025).

It also requires humility from those trained in dominant institutions – an active process of unlearning of relinquishing epistemic control, and of recognising that no single framework holds a monopoly on healing. Ultimately, decolonising healthcare demands radical thinking of what counts as valid knowledge, who defines health, and how care is practised (Pai, 2021; Smith 2012; Wong et al., 2021). As Abimbola and Pai (2020, p.1628) put it, "the goal of global health should not be to survive its decolonization, but to rise up and live up to the pressing demands of its mission."

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