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REFLECTIONS

Southern exposure: levelling the Northern tilt in global medical and medical humanities education

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Abstract
Global medical education is dominated by a Northern tilt. Global universities' faculty and students dominate research, scholarship and teaching about what is termed global education. This tilt has been fixed in global biomedical education with some acknowledgement from the Global South of the comparative benefits of global exchange. Student exchange is predominantly North to South. Students from the Global South are less likely to visit the North on global medical education visits. Global indigenous and traditional ways of knowing rooted may be suppressed, hidden or misappropriated and repackaged for consumption in the Global South with Global North ways of knowing as a reference point. A global history of colonization has shaped this trend influencing postcolonial theorists and decolonial activists to question the legitimacy and depose the influence of dominant Global North ideas. This is evident in how communication skills, reflective practice and narratives are presented and taught. Global North students must be introduced to Global South ways of knowing before visiting the Global South from a position of critical consciousness. Emancipatory education is best led by transformative Global North–South dialogue.

Keywords Medical humanities · Global South · Decolonization · Health humanities · Ways of knowing · Transformative dialogue · Global medical education

Ideas of what constitutes global medical education differ greatly between the Global North and Global South and reflect the Global North and Global South perspectives of health and illness. Global health or global medicine has undergone several iterations, from a discipline developed to protect white settlers (tropical medicine) to its latest version, where low and middle income country (LMIC) researchers lead health programmes in LMICs based on research agendas and funding heavily influenced by high income countries (HICs) (Abimbola 2018). In this paper I focus on global medical education in terms of how the historical and geopolitical phenomenon of colonialization has shaped the teaching of medicine throughout the world. Fuelled by my experience as a Global South health practitioner, having had to adapt my Global North influenced training to my Global South self and context,

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I propose that current exchange in global medical education is based on colonial artefacts and that the discussion on authentically globalising medical education must itself be decolonized (Richards 2014; Pillay et al. 2018; Diab et al. 2013).

While there have been initiatives to address the issue through attention to social justice, social responsibility and equity in medical education, I argue that these responses do not acknowledge the effect of colonization in reproducing disparity in the first place. I pose that a decolonization framework provides a foundational response to social injustices and inequity such as racism and gender discrimination prevalent in global medical education. Why is contemporary attention to social justice, equity and social responsibility in global medical education propelled by the Global North inadequate to level the global disparity in medical education? I explore four ideas in answering this question. Firstly, I explore how the tension between Global North–South medical education is due to an over-reliance on colonial ways of knowing and how the oppression of epistemologies (ways of knowing) of the South has resulted in a "northern tilt' in modern medical education and its influence on the direction of global medical student migration. Secondly, how resistance to the northern tilt from postcolonial and decolonial movements in other disciplines may provide a stimulus for resistance in medical education. Thirdly, how including epistemologies of the Global South can contribute to the levelling of epistemic frameworks in the medical humanities and medical education (De Sousa Santos 2018). Finally, I present some ideas for how emancipatory medical education may be attained through Global North–South transformative dialogue.

Definitions and disparities in Global North–South medical education and medical humanities

Definitions and descriptions of "Global North–South" are ardently debated and often vague. A geographical reading of the terms 'Global North' designates industrialised geopolitical contexts and usually includes countries which were colonial powers. 'Global South' refers to under-resourced or recently industrialised nations, which were not colonial powers and are conceptualised as poverty stricken and underdeveloped (Schneider 2017). A second reading sees the Global South as the collective of people around the world disadvantaged by neoliberal policies who are socially, politically, and intellectually disempowered. They are "global" because they may no longer be confined to a single region (Schneider 2017). The third is a metaphorical definition seeing the global South as a flexible metaphor that defies any geographical or social fixation but is relational. This relational definition marks a division between an assumed powerful Global North and a deprived and dependent Global South. For example, it could be related to the border line between the relatively affluent Northern states and the relatively less affluent Southern states in the United States or the borderline between the first world economy of Norway and the developing economy of Malawi. Moreover, economically influenced global migration results in disadvantaged immigrant communities in affluent Global North cities. At the same time communities with Global North-equivalent economic resources, identities, social resources and aspirations exist in the Global South. I use a combination of the first and second readings to discuss on the Global North–South medicine and medical education.

Typically the Global South is characterised by inadequate population-wide availability and access to medical education, low health resource contexts and poverty. People are more likely to consult traditional medicine practitioners and there is widespread faith and

investment at all levels in traditional practices to a greater degree than in the Global North (Gureje et al. 2015). Modern medicine, rooted as it is in the Global North epistemology of Cartesian, positivist science has a largely undisputed, illustrious reputation. The legitimacy of modern medicine is aligned with the scientific, technological and economic momentum of the Global North (Goldenberg 2006; Kriel 2000). The Global South is associated with belief and practice in traditional health, epidemics and failing health systems, thus subjugating Global South ways of knowing and teaching about human health. Decolonial theorists and activists term attempts to denigrate epistemologies of Global South through Global North lenses as 'epistemicide', a process through which Global South epistemologies are at best undermined and at worst eradicated (De Sousa Santos 2014, 2018).

Global North–South medical student migration

Most global medical education writers and researchers are based in the Global North with an interest in educating Global North medical students (Bozinoff et al. 2014; Crane 2011; Huish 2012; Sznajder et al. 2018). Literature on global medical education, emanating primarily from the Global North, refers predominantly to the education and training of Global North medical students in Global South contexts as "global medicine" or "global medical education" (Crane 2011). In practice this entails sending medical students, or students taking global health courses, on brief periods of work experience to foreign countries, usually in the Global South (Huish 2012; Kraeker and Chandler 2013; Sznajder et al. 2018). Many global medicine programs can be coveted opportunities for Global North medical students to experience tourist-like trips to developing countries; and to polish their curricula vitae for admission into postgraduate clinical training programs in elite institutions in their home countries (Huish 2012; Attwood 2016; Adams et al. 2016) or to prepare for the spread of disease that global mobility brings (Attwood 2016). The current climate of global medical education offers Global North students opportunities to gawk at and comment from a largely uninformed and decontextualized perspective on health care in the Global South (Huish 2012).

Students in the Global South have often been excluded from the opportunity to travel and gain a global perspective on health systems (Crane 2011). Opportunities for "mutual respect and recognition [that] ….finds fruition in dialogue on equal terms". How equal can this be; given the very significiant Global North–South disparity in financial resources and political support and where guidelines for engagement are recommended by the Global North? (Crump et al. 2010). This question has long been raised but not comprehensively answered (Crump et al. 2010; Peluso et al. 2012; Costello and Zumla 2000; Olapade-Olaopa et al. 2014). In the Global South, global medical education, if it is called that, usually involves migrant education. Due to a lack of resources to train the required number of doctors within the home country, students travel and live away from their home countries for extended periods for medical training. For example, many South African, Pakistani and Ghanaian students routinely travel to China to study medicine, where universities offer specialized curricula for foreign students who are expected to gain clinical experience in their home countries (Rizwan et al. 2018). Countries, such as Mauritius, recruit medical students from other African countries, and the South African government has an agreement with Cuba to train doctors to address the shortage of primary healthcare physicians in South Africa (Sui et al. 2019).

Internationalisation programmes in the Global South can inform how graduate profiles are revised for a globalising world. However, educational standardisation is risky and

securing equity in global health education is challenging, as is preparing students to be adaptable to the requirements of a rapidly changing future local healthcare context. The risk inherent in balancing contextual and global demands of training can overburden and ultimately abrogate curricula (Brouwer et al. 2019). Collectively this has resulted in a decidedly Northern tilt in medical education.

Northern tilt in modern global medical education and its precursors

Global North dominance in medical education creates cultural hegemony and results in 'othering' of Global South patients, students and practitioners (Nemutandani et al. 2018; Raju 2018; De Sousa Santos 2014). Perhaps equally, if not more, concerning is that the Global South has followed the North where 'medical humanities is culturally limited by a pedagogical and scholarly emphasis on Global North cultural artefacts, as well as a tendency to enact an uncritical reliance upon foundational concepts' (Hooker and Noonan 2011). Global pre-Cartesian and pre-colonial local health and medical practices emanating from both the Global North and Global South would typically have been suppressed or maligned (Goldenberg 2006). There is currently minimal research and teaching on these practices in mainstream medical education globally—outside of an academic or anthropological interest in exotic epistemologies. Research into traditional approaches lags well behind modern Global North-dominated biomedical research and attracts far less attention and funding. Consequently, there is ever increasing import of scientific ways of knowing from the Global North to the Global South than the reverse. That Global North biomedical ways of thinking, research and practices have contributed extensively to the progress in global human health, has been widely publicised, and extolled, even in the Global South. Certainly, Global South medical schools' biomedical curricula are based predominantly on Global North biomedical philosophies, methodologies and practices (Olapade-Olaopa et al. 2014).

Global health and global medical education are often promoted in the interest of global health progress. *Progress according to whom and on whose terms?* Currently, training offered in most global health programmes does not consider medicine and the medical humanities through the lens of historical, social, structural and contextual issues that are fundamental to the understanding of health and health system disparities between the Global North and Global South (Huish 2012). Many Global South nations' social and economic structures are weighed down by a history of exploitation by the Global North through colonization and more recently, through exploitation under the guise of international economic development (Escobar 2011; Orelus and Chomsky 2014). The result is the fragmentation of cultural, social and interpersonal structures that provided a margin of protection for vulnerable groups in the past now impacts contemporary Global South societies and nations in the form of racism, sexism, and genocide. There is a sense among those in the Global North that disparities in wealth, resources, education, and health care between the Global North and South are somehow "natural" and "immutable" or self-inflicted. Biomedical theories of disease and treatment, concepts such as competencies, evidence-based medicine, and acceptable professional activities, as well as culturally mediated notions, such as professionalism, communication skills, doctor–patient relationships, and even reflection are often imposed on learners in or from the Global South (Naidu and Kumagai 2016). A decolonial strategy in the health would reveal the cultural differences in the health care of "peoples with knowledge and ways of life that do not fit into the Western standard".

Imposing a Global North perspective on health professionals and trainees from the Global South can foster "othering" among medical students and trainees towards their patients. Othering is a process which serves to mark and negatively label those thought to be different from oneself" and one through which people construct their own identities in reference to others (Weis 1995; Spivak 1988). Othering can lead to blaming and judging patients as primitive, superstitious and ignorant when illness behaviour does not align with modern Global North conceptualisations of illness and health (Kleinman 1988). The colonial legacy manifests in a lingering sense of cultural inferiority held in African societies in relation to Global North culture and ideas (Ndlovu-Gatsheni 2018). Fears of inferiority lead to deference, veneration and an uncritical acceptance of foreign ideas, so that a sense of false consciousness arises leading to questioning of fundamental indigenous cultural values and beliefs (Naidu and Kumagai 2016). This "epistemic violence" or "epistemicide" causes the devaluation of ancestral, traditional and Indigenous ways of knowing, and favours the values and perspectives from industrialized Global North countries (De Sousa Santos 2014; Spivak 1988; Tuhiwai-Smith 1999). These patterns reflect global historical practices of reinforcing who the gatekeepers of legitimate knowledge are and who are not.

Colonized identities are propagated through generations of colonial domination following the descendants of colonized people as they migrate to new lives and territories (Maldonado-Torres 2007). The minds of people born and raised in colonized contexts become colonized. Descendants of colonized peoples aspire to the ideals and ideas of colonizers rather than those of their own ancestors. This phenomenon known as "mimicry" or "sly civility" is a means of survival in a postcolonial world which still aspires to the ideals of colonialism (Bhabha 1984).

Frantz Fanon described this acquiescence as colonization of the heart, mind and spirit and noted that it is here that meaning and identity is produced and nurtured in the image of the oppressive, dominant (usually white) colonizer (Fanon 1952; Maldonado-Torres 2017). More than a half-century after Fanon's observations, I have witnessed the same in my own practice as a clinical psychologist in South Africa. For example, an intern psychologist colleague who had been previously trained as a Zulu traditional healer described the intense internal conflict she experienced in these two healer roles. In many instances she was able to discern that Indigenous Zulu patients' psychological or mental health problems were of a spiritual or ancestral nature. She struggled with using Global North psychotherapeutic methods whilst intuitively sensing the 'true nature' of the problem. She helped the patients' problems by praying and communicating with their ancestors after work and dealing with the 'mental health' issues in the clinic (Nondize 2019. 'My experience as a Sangoma and a psychologist' T. Naidu. Durban (personal communication)).

Given these yet unconsidered differences in power, privilege, legitimacy and resources between the conceptualisations of global medical education in the Global North and Global South, how do we move towards equity, social responsibility, and social justice in global medical education? There is an essential obligation to look at global, historical, structural and contextual patterns that have resulted in this situation. These patterns have their origins in some historically big ideas, most notably colonization.

Colonization and coloniality in modern medicine and medical education

Coloniality refers to interrelating the practices and legacies of European colonialism in social orders and forms of knowledge, advanced in postcolonial studies. Decolonial theorist Walter Mignolo notes that "colonialism is not over, it's all over". Coloniality is

ubiquitous and enduring calling for "epistemic disobedience" or rebellion against colonial ways of knowing in all modern fields (Mignolo 2009). Coloniality is unquestioned in the modern world (Weis 1995). However, interpretations of its impact often depend on sociocultural location of the interpreter—Global North versus Global South. Theorists have posed that the Global South has been viewed by the Global North as having no history or culture independent of their colonializers (Said 1978; Fanon 1961). According to the Global North, the influence of colonialization has generally been modernizing or civilizing (Richard 2018; Matunhu 2011; Grosfoguel 2011). Approaches imported and imposed through colonization have been accepted as preferred modern practices in the global South (Mignolo 2011). Modern medicine and medical education have been established on the Global North premise that there is an all-knowing subject that objectively categorises the world. This lays the foundation for the conceptualisation of modern medicine not simply as a utilitarian movement focused at seeing what was already there, and therefore a value-neutral science without a philosophy and a culture, but rather a decisive shift in the structure of knowledge (Goldenberg 2006; Mehta 2011).

The imposition of the Global North view of the body and human life into Global South contexts of health has been seriously questioned. (Tilley 2016; Nemutandani et al. 2018; Sharma and Kuper 2017; De Sousa Santos 2018). The Global North Cartesian tradition in which Being is divided into body and mind and spirit is ignored, disregards most non-Global South traditions, including those of Indigenous peoples of North America, in which mind, body and soul/spirit are inextricably linked not only to each other within one person but to other people, nature, the environment and collective notions of Spirit. The space of configuration of disease encompasses all of these entities collectively and interchangeably. Methods of communication, conceptualisation and understanding are not restricted to positivist Global North scientific methods based on engagement with the world through objective observation but take into account and use multiple ways of knowing that would be deemed, according to Global North views, irrational, subjective, unreasonable, esoteric, superstitious or unreliable and therefore not valid in modern medicine. (Tuhiwai-Smith 1999). These different ways of knowing may include intuition, dreaming, visions, alternate levels of consciousness, spirit communication, emotion, imagination, sensations and others.

Southern sedition: postcoloniality and decoloniality

Resistance to colonialization is as old as colonization itself. However, how does one resist the colonialization of the mind? Two movements have arisen in an attempt to address and overcome intellectual and cultural colonialization. *Postcolonialism*, characterized by views and practices that are in contrast and opposition to colonial ideas prevalent in Asia and parts of Africa, tends be more prominent in areas of arts and culture. Prominent postcolonial theorists are Franz Fanon (race and identity); Edward Said (Western cultural stereotyping of the East); Gayatri Spivak (the concept of "othering") and Homi Bhabha ("hybridisation"—the intrusion of colonial histories on contemporary cultural representations). In contrast, *decoloniality* represents a fundamental rejection of colonialism and its intellectual and cultural legacy. While postcolonial theorists may advocate adopting some outcomes of colonization, such as language and educational systems, decolonial theorists would argue that this acceptance perpetuates and even reinforces colonial dominance in the modern

world (Mignolo 2009; Grosfoguel 2011; De Sousa Santos 2014) and a colonization of the mind (Fanon 1952). Decoloniality consists of analytic and practical "options confronting and delinking from […] the colonial matrix of power".

"Decoloniality" or "decolonializm" focuses on understanding modernity as an emergent epoch of colonializm. A colonial matrix of power exists in the modern world, where ideas of knowledge, subjectivity, gender and sexuality are based on racism and patriarchy and founded in the economy and authority that emerged from colonializm (Mignolo 2011; Quijano 2000). This matrix of power ensures that the underlying structures, practices and conventions established through colonializm have survived and flourished in the forms of current global, structural racism, paternalism, and North–South global economic disparities. The question of how to move from superficial to structurally responsive equity, social responsibility, and social justice in global medical education lies in recognising that the canon of knowledge, produced by the colonial matrix of power dominated by white men, is entrenched in 'Westernised' universities, thus rooting and perpetuating the perspectives of white men and negating women and people of colour (Grosfoguel 2013). Emerging discussion and awareness of the impact of racism, gender discrimination and most significantly white privilege has entered the discussion in medical education in the Global North (Sharma and Kuper 2017; Romano 2018; Hobbs 2018; Sharma 2019). Colonialism and colonial projects were varied and certainly not homogenous but often employed the social capital of white supremacy which is equally evident in medical education (Romano 2018; Hobbs 2018; Sharma and Kuper 2017). However, this question is not yet satisfactorily addressed through global North–South discussion in medical education.

A decolonial perspective posits that Eurocentric theories of knowledge conceal their socio-historical and geo-political basis in colonialism by creating the idea of universal knowledge as if the knowing subjects were also universal (Weis 1995; De Sousa Santos 2014). 'Universal' is the idea that knowledge or perceptions of the natural world exist independently of the knower (the person observing the world) and disregarding that the knower's understanding is shaped by their own history, culture, and social, psychological, and geopolitical influences (Tuhiwai-Smith 1999). This illusion is pervasive today in the social sciences, the humanities, the natural sciences, and the professional schools. It is pervasive in medicine and by consequence, in medical education, most especially in the Global North. This divide between the global North and South is particularly stark in the importation of several humanistic concepts currently in vogue in Northern medical education e.g. narrative medicine, reflective practice, communication skills, and reflection.

Different ways of knowing

Global North medical education programs and Global-North-influenced medical education programs in the Global South are increasingly shaped by a competency-based framework. The impetus for this shaping ranges from the need to include vast curriculum content effectively in a limited time frame; to the idea that a structured, standardized, compartmentalised approach to medical education is the most efficient method for both teaching and assessment. Recently, questions have been raised about whether the Competency Based Medical Education (CBME) approach is appropriate for all aspects of medical education. Kumagai has argued that medical education should also "aspire toward the development of practical wisdom (*phronesis*) which, when embodied in the physician, links the knowledge and skills of the biomedical and clinical sciences with a moral orientation and call

to action that addresses human interests in the practice of medicine" (Kumagai 2014, p 978). This calls for a reorientation from predominantly competence-based medical education towards exploring and utilising alternative 'ways of knowing'. A re-focus is especially called for in the health humanities to unearth ways of knowing referenced in global traditional healing practices that were suppressed during colonialization and dominance of Global North scientific methods and epistemologies. While less so than reported in the past people in the Global South have continued to actively use traditional methods such as storytelling, dreams, visions, intuition, spirit possession and divination to diagnose disease and recommend treatment (Oyebode et al. 2016) Similarly these practices were abandoned and eschewed as 'witchcraft' in what has become the geographical Global North in the sixteenth century (Grosfoguel 2013).

Looking back to the future

Approaches, such as narrative medicine, reflective practice and communication skills, have attracted great attention in medical education in the Global North (Bleakley 2015; Crawford et al. 2015; Jones et al. 2014). In some cases these methods have been imported into the Global South. However, narrative-based practices and dialogical methods have been a core cultural activity for centuries in the Global South and have represented ways of knowing passed down through custom and tradition. In a view from the Global South, the importation of such "novel" practices from the Global North can be seen as naïve at best, arrogant and subjugating at worst. Although meant with altruistic intent, the humanistic claims in this context become a form of epistemicide in which indigenous knowledges are devalued and disowned in favour of Global North discourses. As such, introducing Global North concepts and methods filtered through Global North ways of knowing creates the danger that ancient and valuable traditions will be lost to people globally (De Sousa Santos 2018).

Despite their differences, both postcolonial and decolonial approaches share a goal of unmasking hidden sources of power and oppression in the imposition of dominant epistemologies in Global South contexts. Both also share an appreciation of traditional and indigenous ways of knowing in health and illness. In the following section I refer to a few of the countless ways in which traditional ways of knowing find expression through methods and practice amongst traditional healers in South Africa in the colonial and apartheid eras when Global North traditions of the British and Dutch colonizers were dominant. As in the Global North, ways of knowing that were in opposition, refuted or did not support the theories and finding of modern science were lost. Many of these practices and ways of knowing were suppressed and labelled as 'witchcraft' with traditional practitioners being called 'witchdoctors". This echoed the oppression of traditional medicine in the Global North fuelled by ethnic and gender discrimination beginning in the sixteenth century. Currently these ways of know are regaining recognition in communities through process that may offer insights into how they may be resurrected in current global exchange in medical education and practice (De Sousa Santos 2018).

Narratives

In the Global North, narrative medicine is used predominantly to understand the social and personal constructions of health and illness. These narratives are highly individual and

express personal frameworks of meaning (Kleinman 1988; Charon 2006; Frank 2013). Storytelling has been used for millennia as an enduring part of shamanic practices in African traditional healing. In contrast to the approaches in the modern Global North, these practices in the Global South are intended to enhance collective understanding of illness and convey messages from spirits and ancestors to patients usually through metaphor and imagery. Often interpreted by Global North observers as vague and subjective, storytelling as part of healing practice creates space for personal interpretation and connecting present and past; earthly and spiritual; literal and figurative; body and soul; mind and brain. In a typical diagnostic consultation an *isangoma* will not expect the patient to tell her the illness narrative but will often tell the patient the story of how the affliction came to be after divining using bones and shells. She may allow herself to be possessed by the spirits of the patients' ancestors who will tell the story of how a particular spiritual or genealogical transgression has caused the condition. Remedies are prescribed in the same way. Patients typically listen as their lives are storied through communication with the ancestors as the isangoma is in a trance (Edwards et al. 2009). These practices use narrative ways that have not yet been considered or explored in Global North medicine.

Reflective practice

Modern medical education has lauded the introduction of reflective methods to facilitate practitioners' understanding of and engagement with patients and their lives, the illness experience, as well as practitioners' own emotional reactions to suffering, tragedy, and loss. However, these methods appear limited when compared to how traditional medicine practitioners use reflective methods (Naidu and Kumagai 2016). The very process of becoming a traditional healer is prompted through using dreams as reflective practice when the potential initiate experiences dreams which alert them to the calling of the profession (*ukuthwasa*). Epistemological perspectives underpinning traditional healing validate dreams, intuition, and visions as essential and indispensable tools for practitioners to support and enhance their healing skills. Through using these methods of reflective practice practitioners are able to access information in ancestral, spiritual, human and natural planes. In the area of reflective practice modern Global North practice lags in comparison to reflective methods in traditional healing practices. It has been previously suggested that reflective practice is a particular aspect of medical education where "educators should aspire to turn exportation of educational theory into a truly bidirectional, collaborative exchange in which culturally conscious views of reflective practice contribute to humanistic, equitable patient care" (Naidu and Kumagai 2016).

Communication

Observing and becoming familiar with traditional practices could enhance students' understanding of the variety of means of communication used when Global South ways of knowing form the framework of interaction. In South Africa, traditional medicine communication occurs on multiple levels and is not restricted to verbal and non-verbal means. Methods of communication can include divining, embodied communication and continuous communication with ancestors (Edwards et al. 2009). Continuous communication refers to exchanges with deceased relatives that continue after death. When a person dies, relatives must return to the site of the death, where an assigned elder conducts a series of acts which returns the deceased to the familial burial ground. Even in modern urban

hospitals family members may to arrive to 'collect the spirit' of a deceased patient. This practice will usually include talking to the deceased. Traditional African healing systems employ dreams as a channel to communicate information in rural and urban contexts for important issues such as warnings, providing guidance and appointing someone for divinity (Mfusi and Edwards 1985; Thwala et al. 2000). Methods for understanding and interpreting dreams are taught in the training of *izangoma.*

Emancipatory education and dialogue

From colonization to emancipatory education

> Education either functions as an instrument which is used to facilitate integration of the younger generation into the logic of the present system and bring about conformity or it becomes the practice of freedom… Emancipating the mind – from the known and familiar, from blind conformity (Freire 1985).

Why spend time studying traditional ways of knowing as part of global medical education? Is it as a form of "cultural safari" in which Global North medical students learn about exotic practices of exotic peoples? Is it to understand the depth of delusion that peoples of the Global South possess in order to gauge the distance they must travel to learn and incorporate the "objective," evidence-based knowledge of the Global North? I would argue that an understanding of traditional ways of knowing of communities in which medical care is practiced opens perspectives to different ways of seeing self and other, health and illness and spark reflection and dialogue leading to creative and generative approaches to care.

Following Paulo Freire's call for education to free the mind to different ways of knowing, Global North students visiting the Global South must be prepared to free their minds to recognise different ways of knowing and the methods of healing practice that emerge from these ways of knowing. This is possible through engagement based on mutual respect and recognition and finds fruition in dialogue on equal terms (Freire 1985). Global student migration seems inevitable, so critical consciousness and decolonization based teaching perspectives must precede Global North student visits to the Global South.

Global North–South transformative dialogue for education

Every formerly colonized country harbours its own demons. Fanon makes the case for emancipation from such colonial possession by proposing that just as the colonizers have constructed ideas of what the Global South is and should be, freedom from colonization implies a freedom for colonized peoples to 'allow me to build the world of You', that is to build Global South versions and understandings of the Global North (Fanon 1952). This could create a context where Global North and Global South theories of knowledge have equal influence and impact in global medical education and form the basis for generative dialogue and learning. The decolonial turn has been pushed to dramatic ends in South Africa and parts of Africa, especially in universities, where students have protested against colonial structures, ideologies, epistemologies and practices within academia (Maldonado-Torres 2017). In South Africa, institutions of higher education have been compelled to revise their pedagogy and practice and adopt more decolonial positions in response to student demands (Maldonado-Torres 2017).

So what does this dialogue between Global North and Global South look like? A previous publication compared goal-driven discussions to exploratory dialogues (Kumagai and Naidu 2015). Unlike discussions which seek answers and solutions, dialogues engage individuals—as human beings with identities, histories, unique perspectives and lived experiences. Discussions summarize and conclude while dialogues open new horizons by posing new questions and possibilities. In this vein a challenge for the Global North is to soften its voice and listen with humility, to redistribute privilege, and to relinquish the possibility of absolute epistemological power over an Other perceived as inferior. Programmes aiming to achieve these goals must be founded on dialogic principles where programme planning and curricula development evolve through truly collaborative, iterative processes between Global North and Global South stakeholders (Singh et al. 2012; Wondimagegn et al. 2018). Precise benefits for Global South teachers, institutions, communities and countries must be clarified and cannot be negotiated away under the guise of Global "educational need." Global North students must be provided with historical backgrounds and locally relevant mentoring that facilitate their learning about the needs, concerns, values, worldviews and contexts in which communities in the Global South live and thrive.

The benefits of global dialogue have been mentioned with reference to transatlantic medical education (Hodges and Segouin 2008) but comparatively less has been said about the medical educational divide between North and South. Open dialogue between the Global North and Global South, freed from subtle coercion or intellectual domination, can allow for critical review of a country's public health history, tracing how events in the past, including the colonial past of most nations of the Global South, have shaped the present state of health (Bhandal 2018; Kraeker and Chandler 2013; Whitehead et al. 2018). Vistas for exploration should include different burdens of disease in Global North and Global South; health and globalization; and determinants of health, including economic exploitation and violence; capacity building; promoting collaboration and partnering; the ethics of international business practices; professional practice; and health equity and social justice. Creative explorations of Global South methods of healing practice and communication such as dreams, intuition, visions, and ancestral communication may open perspectives in areas such as reflection, mindfulness, human connections and identities, and may give rise to new hybridities between the Global North and Global South, modern and ancient, individual, communal, and historical. Informed by a critical awareness of one's assumptions and perspectives, as well as the histories of the colonizing and colonized, such dialogues may introduce new avenues for inclusivity and mutual recognition in a polyphonous, richly human world.

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