The establishment of modern medicine is inextricably intertwined with colonization, exploitation, and slavery. A frightfully clear example of the intersection between medicine and racial exploitation is the story behind modern gynecology by questionably acclaimed physician J. Marion Sims. Sims is known to have performed numerous exploratory procedures on unanesthetized enslaved Black women in Alabama during the 19th century. The practices of the "Father of Modern Gynecology" set an alarming precedent for the treatment and devaluation of Black women by the medical system, rooted in questions of how race constructs biology. Racism and white supremacy are woven into the intrinsic fibres of the medical system by nature, clearly seen when analyzing contemporary race-based health data.

Two types of answers can address this question: one is rooted in philosophy, and the other in reality. As such, it is imperative to fully understand the historical context and social paradigms that continue to perpetuate the current health disparities. Disparities exist not as an accidental collateral damage of the system, but as an intentional means to maintain a power differential that benefits the oppressor. The historical and contemporary context of medicine portrays an inherently oppressive institution that was not designed to care for Black women, among other systemically marginalized individuals. Moreover, the ongoing perpetuation of racial injustice in obstetrics continues as the system operates as designed. The philosophical solution to this question is simple in theory: reimagine what medicine could be and reinvent what medicine is. If a system is broken, create a new system.

Unfortunately, challenges arise when attempting to disentangle hundreds of years of white supremacy from the contemporary practice of medicine. As such, we are forced to consider solutions that fit within the confines of the broken system. However, to bridge the gap between philosophy and reality, one must engage in praxis, where critiques of the historical present are used to inform transformative action.

For example, transformative action may begin with the standardized collection of race-based data as an essential step in addressing maternal mortality. The comprehensive collection of race-based epidemiological data is critical to establish a baseline understanding of structural racism and inequity. Many practitioners deny the presence of racial injustice in care outcomes, which inadvertently allows socially learned implicit bias to obscure one's clinical judgement, paradoxically worsening racial disparities. Without this data, informing health policy and care guidelines is impossible. Canada needs to emulate the practices in other countries that collect race-based obstetric data to inform health policy and practice. Through race-based data on maternal morbidity and mortality, standardized care guidelines can provide incredible nuance when considering the potential shortcomings in obstetric care. Evidence-based protocols could also incorporate thresholds for earlier intervention based on race-stratified data to avoid the subjective perpetuation of racial biases.

Additionally, race-based data should be stratified by socioeconomic status (SES) to highlight communities that may warrant increased resource allocation. SES intersects with race/ethnicity incredibly to influence healthcare access, health literacy, and care outcomes. Likewise, SES directly relates to one's ability to access prenatal and postpartum care due to healthcare coverage, transportation, finances, and inability to take time off work. A crucial step in supplementing primary care access involves reducing barriers and providing individualized care to those

potentially disconnected from healthcare. Stratifying data by SES and race allows for tailored interventions while addressing financial and racial barriers to healthcare outcomes. These solutions arise primarily out of policy advancement, which is impossible without adequate intersectional data and research. The right to health is a human right that renders useless if the means of population health data analysis are socially unjust. This is but a stepping stone in a larger social paradigm shift to radicalize healthcare with tenets of social justice and anti-oppression. Knowledge rooted in community is the necessary power needed to fuel the movement to imagine what healthcare can be.

Dreaming of radicalized healthcare is not foreign to me. The career I have always imagined for myself intertwines concerns from the social world with biomedicine to highlight the intersectionality of identity and health. I want to push the boundaries on how physicians view healthcare by emphasizing an individual's lived experience rather than illness alone. As a queer, non-binary, and racialized individual, my lived experience drives my commitment to transformative healthcare. My journey has consisted of a deliberate pursuit of equity and anti-oppressive practices in medicine and research alike. From engaging with leaders at the University of Toronto's Faculty of Medicine to incorporate Black patient experiences into our OBGYN curriculum, to coordinating a grassroots organization focused on diverse queer and trans identities, I am unyielding in dismantling systemic barriers. While navigating medical school, I feared being unable to reconcile my biomedical curiosity and social justice values. However, the SMFM's mission demonstrates that this does not have to be the case.

My diverse clinical and academic interests extend to the racial disparities in obstetrical care and address the unique needs of those with substance-use disorders and transmasculine individuals during pregnancy. My goal is to become a Maternal-Fetal Medicine Obstetrician who can unify their unique clinical interests in social justice with obstetric care to provide individualized care to those often missed by the medical system. The Medical Student Scholars Program provides an incomparable experience of academic mentorship with physicians who personify my values. The SMFM's commitment to antiracist approaches in obstetric health equity emulates precisely what I hope to do in my career.

Much of the work I am involved with is deeply personal, as it is intrinsically linked to identity: myself and the communities that raised me. Some may argue that to have a personal connection to the work introduces bias; however, it has allowed me to develop a nuanced sense of integrity, ethics and resilience. My driving force is the need for anti-oppressive approaches within healthcare. With an upstream approach to medicine in mind, emphasizing the social determinants of health, I wish to contribute to redefining the roles and responsibilities of a physician

Thank you for taking the time to consider my application for the Medical Student Scholars Program offered by the SMFM.

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