HAROLD WISE MEMORIAL LECTURE

From Reproductive Rights to Reproductive Justice

Marji Gold, MD

This month the *Social Medicine Journal* offers readers the text of the Annual Harold Wise Memorial Lecture held on June 13, 2017 at the Department of Family and Social Medicine at Montefiore Medical Center.

Harold Wise was the founder of the Residency Program in Social Medicine and the award recognizes a faculty member who best represents the values of the Residency Program

Introduction by Peter Selwyn, MD, Chairman of the Department of Family and Social Medicine

It is my pleasure to welcome everyone to the tenth Annual Harold Wise Memorial Lecture. I want to thank June Wise, Harold's wife, for being here today. Marji Gold is not only today's speaker, but she has enough longevity to have actually worked with Harold, so it's really an honor for me to introduce her to give this talk. Marji is the longest continuous faculty member in the department. She's been here since 1976, which was before a lot of you were born, as my grandmother used to say. Marji went to Sarah Lawrence, followed by NYU Medical School, and did her training here from 1973 to 1976. She was in the first class of family medicine residents and was chief resident during her final year. She underwent additional special training in abortion care and reproductive health care in the early 80s.

Marji felt it was important for caregivers to acquire skills and expertise in women's health and reproductive health care, especially given what might be coming in the way of political forces opposed to women's health and reproductive choice. Over the years she's been a leader not only locally, but also regionally and nationally in reproductive health services, and specifically the integration of reproductive health care and abortion care in family medicine and primary care training.

Since 2003 she has been the director of the Center for Reproductive Health Education which provides training and education both locally and nationally. She is a tireless educator and has given hundreds of presentations and done hands-on teaching in many different settings. She has over 70 peer-reviewed publications, many with junior faculty, and has been a treasured teacher and mentor for many generations of family physicians and primary care providers. Marji has an unwavering commitment to excellent care and advocacy for women, but also more broadly to social justice and health equity.

Speech given by Marji Gold, honoree of the 2017 Harold Wise lecture:

It's an honor to be speaking to everybody today. I want to give special thanks to all of my patients and to my colleagues and clinic staff for sharing their stories with me over the years so I could learn about reproductive justice. I want to give special thanks to the team here at Montefiore who challenge me and support this work every day. My presentation is really a team effort. I would never have been able to put it together by myself. I might not even have come today if they hadn't escorted me.

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I will be using an old lady's prerogative to talk about reproductive rights and reproductive justice by telling lots of stories of my own journey as well as some history and stories of patients. I hope to inspire all of you to incorporate the lens of reproductive justice into all the work that you do every day with patients, with any political activist you work you do, and with life in general. I will start with a brief story of my experience with Harold Wise.

Meeting Harold Wise

I knew Harold from the beginning. He was a visionary who applied the concept of the barefoot doctors in China who provided basic medical skills training to rural villagers in order to bring healthcare to areas where doctors wouldn't go. Harold helped create urban community health centers by offering on the job training to people who lived in the housing projects near the Martin Luther King Health Center in the 60s and early 70s. He didn't believe the health care system was serving communities of color and of course neither did the community. There were many large demonstrations demanding change both in communities of color and in other venues. As Peter said, I was in the first family medicine class at RPSM and when I was an intern at Morissania Hospital in the Bronx, Harold came to visit me one evening to talk about developing a curriculum for family medicine. I of course was a terrified intern, afraid of killing patients because of my lack of knowledge. When he asked me what I thought I needed to know I said "everything." I said I needed to know about heart disease, about asthma, about heroin overdose, which was a big deal then as well as now. He looked at me and said I shouldn't just be like everybody else practicing medicine, that I should have a different focus. Well at that time I just thought he had different ideas than I did about what it meant to be a good doctor, although as often happens, as I moved from being a terrified intern into being a slightly less terrified faculty member, I realized that I needed to incorporate some of his perspective into the patient care and teaching that I offered others.

Eliana Korin, the director of the behavioral science department, and who many of you know, often refers to the brilliant Brazilian educator activist Paulo Freire, who is well-known for his book Pedagogy of the Oppressed. I think Harold Wise would have agreed with this statement from Freire "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 and the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world.

Lessons from Brazil

Eliana invokes Freire often to remind us that teachers should be problem posers, not problem solvers. And in that vein I want to stress that although I have been asked to stand up here and talk to you like an expert for an hour, like Harold Wise, I reject this model of teaching and learning. I'd actually hoped we would be in a setting with tables so that we could all easily share our own ideas and experiences. But that venue was not available, so I am here somewhat reluctantly I must say on a podium in an auditorium with fixed seats. Fixed seats would not have stopped Harold Wise or Paulo Freire from working with others to generate thoughts and conversation. So I will do the same.

During this talk I will present some scenarios that we can talk about in groups. In addition, I encourage everyone to interrupt me as needed and also encourage everyone in the room to answer any questions rather than expecting me to know it all. There are two people from my team who have microphones that they will carry around if people want to speak. I hope that by the end we will all come up with ideas and actions to join the reproductive justice work with the other activism we are doing, and to integrate a reproductive justice lens into our work as clinicians, teachers, and activists.

Two disclaimers to clarify things: I joined the reproductive justice movement as an ally and activist knowing that I come from a position of privilege. I hope that in this discussion today I will encourage more of us to consider using our privileged voices to support and advance the work, remembering that we are not in charge, nor are we the ones to fix it. But, as the old saying goes, staying out of the movement makes us part of the problem.

Secondly, there is increased conversation today about inclusive language and avoiding the binary gendered conversations that are more commonly

used. We should not ignore the history of oppression of women, and reproductive coercion in particular, while keeping in mind that the oppression can also affect transgendered and other people who can get pregnant. I will try to use the word "patients" as much as possible, in this case as a shortcut for people who can get pregnant. But I will also use the words "woman" and "women" frequently. I know many in this room are more fluent in this new language than I am and I am open to feedback on how this conversation works in this setting. By the way, as you probably already realize, this talk will not be linear since the issues are nuanced and overlap. Although it is data driven I am not sharing lots of data. In fact if I were not prone to motion sickness I might have organized this talk with Prezzie instead of PowerPoint.

Who in this room has heard about reproductive justice? How many of you were part of the grand rounds that we actually did two weeks ago?

For those of you who raised your hands, the definitions and explanations that I'm going to use are a review, and then we will go a little bit further. But for others some of these ideas may be new. So first, we're going to look at what reproductive rights are.

Movement for Reproductive Rights

The movement for reproductive rights is based on securing legal rights and access to abortion care. It is often considered the pro-choice movement. However in this context, choice involves individuals and often ignores the social problems like poverty and race that prohibit women from exercising their rights.

Reproductive Justice was developed by women of color in many communities who felt that the concept of choice was too narrow and didn't work for them. They all faced a complex set of reproductive oppressions and felt that people's ability to determine their own reproductive destiny is directly linked to the conditions in their community, and these conditions are not just a matter of individual choice and access.

Intersectionality

A little bit about intersectionality: It's a concept and term first used by a legal scholar named Kimberly Crenshaw in 1989. She wrote that, taken separately, anti-discrimination law, feminist theory, and anti-racist politics all failed to address the experiences of black women because they each focused on only a single factor. Reproductive Justice is based on the understanding that oppressions based on race, class, gender, and sexual identity, as well as other factors, working simultaneously, produced the paradigm of intersectionality. This concept can be understood by thinking about a traffic intersection. Imagine you are standing in the middle of a busy intersection. Depending on your specific attributes you will be impacted by what's coming your way at the same time.

You may be privileged, oppressed, or a combination. An intersectional approach can help us to ensure that as we work with patients, and are part of larger social movements, we aren't overlooking the challenges facing people with multiple oppressions. Intersectionality can also be helpful in working with communities that face overlapping oppressions

Let's look at what is often called Reproductive Justice, and that's probably how I'll refer to it. Reproductive Justice weaves together social justice, racial justice, and human rights perspectives and focuses on intersectionality. It encompasses all movements and stresses the lived experience of marginalized and vulnerable individuals and communities. Reproductive rights focus on a single issue, and ignores the fact that for people of color, and people without resources, there may be the no possibility for a real choice about whether to get pregnant or to have a child.

Choice primarily resonates with those who feel they can make decisions in other areas of their lives. However it is important to remember that Reproductive Justice is not about dismissing the need to have access to a safe and affordable abortion as part of routine health care. The Reproductive Justice community opposes restrictions on abortion care and supports increased access to the full spectrum of contraception and abortion without judgment or coercion. And I want to stress that all of this is in the context of the U.S. history of racism, which in some groups of people, often white, Christian, educated, having money, and so forth. Some things are more valuable than others, and thus some women more fit to be mothers than others.

Reproductive Justice is a response to the long history of reproductive coercion and abuse of women, especially women of color, in this country

and internationally. I invite us all to think during and after this talk about how the system of placing a value on motherhood, for different people, impacts the way we provide care to our patients, teach our learners, and work within the existing health care system.

What are the parameters of reproductive justice?

The concept of reproductive justice has been evolving and expanding. Some of the preliminary work was done by Loretta Ross and her colleagues at Sistersong. Other Reproductive Justice groups include Forward Together, the Native Youth Sexual Health Network, National Advocates for Pregnant Women, and Color. All are involved in movement activity, continually applying and refining the original context, extending beyond rights and choice to address historical, social, and economic factors contributing to reproductive coercion, and discrimination. This encompasses the right not to have a child, the right to have a child, the right to parent children in safe and healthy environments, and the right to maintain personal bodily autonomy.

Do all women have choices in the same way?

Reproductive Justice recognizes the multiple forms of social oppression and discrimination which keep individuals from being able to have and raise healthy families. Reproductive freedom therefore requires addressing all forms of inequality. Reproductive Justice is a response to the fact that many women of color, low income women, and younger women come from communities and situations with few real choices.

A movement that is grounded in the concept of choice leaves out those who are most affected by government regulations and other systemic issues. A woman with adequate resources can have a choice to get pregnant and stay pregnant, or have an abortion based on timing and in the stability of her life. Limited or no access to contraception make some women's decision not a real choice at all. A decision to stay pregnant or terminate a pregnancy may also not be a choice, dictated by her life circumstances and local government politics.

So now to go back to my story. Many of you probably think of me as the person in the department who talks and teaches about abortion. So I want to share my entry point into this work and how it evolved. I know this is different for everyone but I hope that my story can resonate with many of you and help clarify the need to incorporate an Reproductive Justice lens into all the work we do.

How did I get involved with social justice, reproductive rights and then with Reproductive Justice?

My grandparents fled Russia during the pogroms seeking a place that was safe to raise their families. My father's parents first moved to Hungary, and then they had to flee - with their kids - again in the face of rising anti-Semitism. This time they came to the Bronx. My mother's family came to Connecticut. My mother's father was an organizer for the tailor's union there andshe lost her leg in a confrontation with scabs crossing a picket line. Despite a comfortable life as a child, I was always aware of the impact of oppression and the importance of organized resistance.

As a teen I worked as a tutor in a local housing project. In those days the kids I worked with were mostly African-Americans and their parents and grandparents had moved to Connecticut from the south. I saw that their lives were different from mine, but didn't understand how systemic racism and oppression created these differences.

In 1963, while I was working in the projects, some tenants told me about a march being planned in Washington for civil rights. Buses were coming to the project to take people down and back. And somehow I convinced my parents to let me go. There is no way to explain the feelings I had as part of that community on the bus or at the mall in D.C. I had never seen so many people in my life or heard so much singing. And as a naive teen I thought for sure we would just win what was right at that time. Live and learn, right.

I actually had very little understanding or experience with abortion until I was a medical student. I was on an obstetrics rotation at Bellevue Hospital in the city before abortion was legal. And every night we admitted many patients, mostly poor young women of color, with terrible complications from self-induced or unsafely performed abortions. Once abortion was legalized, while I was still a medical student, the patients simply stopped coming. This experience made me see abortion as a public health issue, emphasizing the fact that

women have abortions when they are pregnant and don't want to have that child, and unsafe and/or illegal abortions put women's bodies and lives at risk.

In that context I saw abortion as a medically necessary intervention. Of course that was before abortion became as polarized an issue as it is now. And it was before the Hyde Amendment which prohibited using federal Medicaid funds to pay for abortion care. But seeing the many attacks on Roe v. Wade, I - a privileged white woman - became increasingly committed to protecting reproductive rights. And so I listened to the stories of my patients and my coworkers

I often saw that the context in which my friends and professional colleagues could make decisions did not apply to large groups of people both in this country and internationally. I didn't know the term Reproductive Justice then, but I was learning that in order to provide the care that my patients needed I had to look at issues of economic justice, the environment, immigrants' rights, disability rights,' discrimination based on race and sexual orientation, and a host of other community-centered concerns which directly affected each woman's decision making process. This shift to focus on fighting against reproductive oppression challenged me to examine my own attitudes and behavior and to reflect on how my language and actions might be perceived by patients. We all need to be sure that we are not perpetuating the old order even with good intentions. Before going back to look at what each of the different, although overlapping, rights in the Reproductive Justice list mean, let's look at a few examples of the history of reproductive coercion and oppression in the U.S.

Reproductive coercion

Women in the U.S. and especially women of color, have been the subjects of reproductive coercion and abuse since the 1600's. Although women in slavery had no rights at all, by the 20th century doctors and other professionals, using the lens of eugenics and racism, contributed to the belief that people of color were not entitled to full rights. Reproductive injustices continued up into the present time in the form of coercive contraception and sterilization, as in the 1968 campaign to sterilize Puerto Rican women without their consent. This perpetuated the sense of mistrust of medical professionals by patients of color.

Reproductive coercion still continues even as recently as this decade, and this year. The current government is proposing limiting food stamps to families who have no more than four children, demonstrating that we need to keep vigilant against suppression and coercion. Many legislators, social scientists, and medical professionals have strong beliefs about who they think will be a good mother, and who shouldn't parent. These beliefs can impact the way we see and talk to our patients, and the policies we support or fight against in all of these situations. The dominant perspective has been that some women are more fit to be mothers than others, and some children deserve better lives than others. As I've said already, in many of these situations the medical community was complicit in reproductive oppression and coercion.

So let's go back now to look at the specific rights that are included in the Reproductive Justice framework.

First, the right not to have a child.

This is the one we're most familiar with since it's linked to the hotly discussed issue of pregnancy prevention and abortion, and often considered the benchmark of the pro-choice movement. But the question raised by the Reproductive Justice framework is: do all women have choices in the same way? Or is choice only a right of privileged women with an education and financial resources? What about women who are living in someone else's house, or who don't have a job, or have two jobs, or are afraid of deportation if they interface the health care system to get prenatal care and deliver? In the medical realm, choice is also a systemic issue of access. It is not just a legal protection for an individual decision to contracept or to have an abortion, but also being able to get to the place where the services are, and have the financial resources to pay for them, which may include the ability to miss work, get child care, and so forth.

Second, the right to have a child.

This is where the concept of who is fit to be a mother and parent really shows up. During slavery, female slaves were coerced into having sexual relations with male slave owners and their children were not theirs to raise; they were slaves to be worked and sold as property. They had no rights to

not bear the child of the slave owner, or his sons, or staff. But in the end they did not have a right to parent their child. When slavery was abolished, and women and their children were no longer considered property, the perspective on who should have children changed. The idea that certain women were not fit to parent had not changed. But now that women were not legally owned, the system had a slightly different perspective on procreation. Looking at the long history of forced contraception and sterilization of women of color in this country, it's hard to ignore the way the medical profession was brought in to be complicit with these social ideas and governmental plans. And as we know overcoming historical ideas and practice is hard.

When I first started working in the Bronx I had incorporated the concept that teens should not be parents for all the reasons I had heard, and also that people who are poor shouldn't have children or at least not so many children. So I spent a lot of time talking about contraception, although of course in the 70s the conversation was pretty short, because there weren't really too many contraceptive options. But I learned to do abortions and offered my patients an abortion with me, their primary care doc. Of course, despite the conversations, many patients became pregnant for all the reasons that people get pregnant, and many chose to stay pregnant. I had the opportunity to see the strength and resilience of individuals in their communities as they supported each other and demonstrated how their village could raise a child. I saw teens mature through parenthood. Some who had dropped out of school after their children's birth chose to go back to school later, realizing that they didn't have enough education to help their kids with their homework. Some of these women have now completed graduate degrees and their kids are now in college, demonstrating to me that getting pregnant and staying pregnant doesn't automatically keep women and families in poverty. This realization transformed my patient care and teaching and really pushed me into the Reproductive Justice camp.

Third, the right to parent children in safe and healthy environments.

The intersectionality of life for people facing multiple oppressions and the integration of Reproductive Justice into other movements is most ap parent in the right to parent children in a safe environment. In today's political climate, many of us are involved with various organized resistance activities.

The Reproductive Justice perspective recognizes that unless we address the many causes of oppression and equity we cannot have true reproductive justice. The right to parent children in safe and healthy environments means that we need to address all of the following issues: the environment and climate change, the criminal justice system, minimum wage and fair working conditions, immigration, violence, single payer health reform, and many more.

The final right in the Reproductive Justice framework is the right to maintain personal bodily autonomy.

This is a really important issue for us to consider as clinicians and others who intersect with patients and have multiple opportunities to support or undermine their personal bodily autonomy. As people with power, we have to be really conscious that we're not unwittingly acting out these dynamics, letting our biases on how and when people should parent impact the quality or the content of our patient care.

I'd like to us to take a few minutes now for everyone to talk with the people sitting next to you. Think about a movement or an organization you've been involved with, or supportive of, and in your experience, were issues around reproductive justice considered explicitly or not? Can you think of ways that groups you're a part of could have taken on these issues in their work?

(break for small group discussion)

There are two issues that I just wanted to be sure to highlight since for me they're really important and I didn't get to talk to anybody in the groups.

There is a tension between access and coercion. As we work to practice in a way that embodies the principles of Reproductive Justice, we need to be conscious of the tension between increasing access and coercion. In our enthusiasm to offer what we consider the best options to our patients, (which include all the medical issues we address, but today we're just talking about reproductive options), we often fall back into deciding what we think is best for the patient, and then pushing that option.

One example is the relatively recent change in the promotion of long acting reversible contraception (LARC), like IUD's and implants.

Until recently IUDs were considered a last resort option only if other methods had failed. With new data from medical professionals looking at efficacy, LARC methods are considered the most effective. The updated studies demonstrate that the previous restrictions on eligibility for IUDs, such as already having a healthy child, and being an adult in a monogamous relationship, are no longer valid. This new data pushes us to offer LARC as a first line option. Reproductive Justice addresses both access to care and avoiding coercion, especially unintentional. In our excitement about having this new option, you must recognize that efficacy might not be the most important issue for patients deciding about contraception. Remembering this, you must avoid the idea that LARC is the best method for all patients. Be careful not to push those methods on your patients. Some studies done here at RPSM show that physicians felt they had failed in their work if the patient did not leave the office with a LARC device, and were reluctant to remove a device if the patient requested it. On the other hand, we must address systemic barriers that make LARC and other methods inaccessible to patients because of cost, insurance issues, outdated eligibility requirements, lack of training conditions, and the policies of the current government.

We must maximize access to care while maintaining patient autonomy. We need to know as much as we can about all contraceptive methods, and present them in a patient-centered way. Contraceptive options discussions with our patients should be without judgment or assumption about which method we think is best for them.

The other issue that I think is important to talk about is teen pregnancy, which is a very hot item in this country.

We focus on the notion that teens live in poverty because they get pregnant, and believe that we as professionals know their options better than the teens themselves. I just want to state clearly that social inequality, especially poverty, is the context for adolescent birth, but not the result of it. Of course, in my experience as a family physician in the Bronx, I see a lot of teenage boys and even though they don't get pregnant, poverty remains an issue for them. Getting a good job remains an issue. Getting into college is often not possible even with a high school diploma because the schools in poor communities may not have prepared students for college level work. In fact, a recent studies show that the program for choice in public high schools in New York City is actually impacted by all the same social and economic factors. Thus the kids with more resources get into the better schools. As members of the progressive health care community, and as members of society in general, we want the best opportunities for everyone, but our job is to promote and respect personal bodily autonomy and offer non-judgmental information. As I said earlier, I have seen many teens who have the social and emotional resources and support to parent well. So I think we need to rethink our biases about what pregnancy means for a teen, and to give her information if she wants it and to support the decision she thinks is best for her.

What reproductive issues do you see playing out in your patients' lives? How do you avoid pushing your own opinions or values into these conversations and make your care truly patient centered? *(break for small group discussion. After the break, an audience member reported on a teenage patient who rejected her doctor's advice to get an implant. The patient wanted the birth control pill and reported that she could use her cell phone every morning to wake her up and remind her to take the pill, something that hadn't occurred to her physician.)*

We need to be able to be respectful of patient's histories and fears. I only learned a lot of this stuff by working with my patients, listening to my patients, and having them tell me their stories. I could then realize that I was not necessarily in the place that was right for them. And I had to change what I did.

To summarize a little bit, why is Reproductive Justice important to us?

Reproductive Justice gives context and perspective to the underlying social issues faced by many of our patients when they are seeking reproductive health care including contraception care, during pregnancy, abortion care, and routine preventive services. Patients may carry stories about reproductive coercion and abuse from their families and friends and this may impact how and what they hear when we are talking to them. Doctors and other professionals in the health care world

have been complicit with coercive and abusive actions and policies.

We need to reject this idea and surrender the power that it is we who should decide who can be a parent and when they should parent. As people with power we have to be really conscious that we're not unwittingly acting out these old dynamics and letting our biases on how and when people should parent, impact the quality of our care. Reproductive Justice issues intersect with other social and political activism. But the other movements often don't address or ignore the importance of including an Reproductive Justice framework in their work.

To inspire us to go forward with integrating Reproductive Justice into all of our work, I'd like to briefly share some of the work that has been done by Reproductive Justice groups on the ground. There are lots of these groups and I am not picking any one because I think they're better than the others, but just mostly because they had really nice pictures on the Internet.

In May, Black Lives Matter and other groups organized phone calls and other activities to raise bail and demanded the release over 100 incarcerated mothers the week before Mother's Day. They are planning to continue this work.

National Advocates for Pregnant Women based in New York City works on many issues around the rights of incarcerated and drug using pregnant women. They recently organized and won a campaign to defeat a bill in Wisconsin that had authorized the incarceration of pregnant women who are using alcohol or controlled substances. They also do a lot of work around shackling of pregnant incarcerated women.

Color is the Colorado Organization for Latina Opportunity and Reproductive rights. It's a Latina youth organization working on comprehensive sex education and fighting the stigma of both abortion and teen parenthood.

Academic and political activists in Oklahoma collaborated to organize a forum on Reproductive Justice integrating the Reproductive Justice perspective into the academic work.

Sister Song and the National Women's Health Network published this statement as a call to action. They wrote "Our ultimate reproductive justice end game is to enhance the health, social well-being, and bodily integrity of all our patients. In that spirit, let us continue our efforts to make LARC affordable and easy to access. But let us also respect women's decisions not to use LARC, their ability to have LARC removed when they wish, and their ability to have the children they want to have. Let us remember that women themselves know best where contraception fits into their lives relationships and long term goals at any particular moment. "

So now that you've seen the many different ways that people in groups contain tribute to Reproductive Justice work from political arenas to academic forums to writing white papers, I invite us now to talk about our ongoing work or ideas for new ways to be involved. *(break for small group discussion)*

As the invited speaker I guess I can have the final word and I will be the final problem poser. I know that in this charged political climate where common conversations now embody the antithesis of the values that most of us share, the very right wing is trying to use their religious beliefs to claim the moral high ground. However, I strongly disagree and feel that reproductive justice is the moral high ground, and that we need to claim it, and act on it. I have a moral commitment to equity, and when I see particular individuals and communities not able to have full participation in the wealth of our country it makes me furious and self-righteous. When I see the possibility of women dying because once again they don't have information or access to full spectrum reproductive health care services, I am morally outraged. I recognize all the important work that all of us are doing and are committed to doing more and better. So here are the final thoughts and questions I leave you with. In our political activist lives, we need to keep going to meetings and demonstrations and all the other stuff we've been doing.

The question is, what do we need to do to infuse an Reproductive Justice perspective into all our work?

Can those of us with privilege speak up in tense situations and be the ones to take risks? In the clinical venue, I wonder if the clinicians and other people involved with health care here are involved with providing full spectrum contraceptive care to patients in a way that is consistent with your job and training. Specifically, medical abortion offers us the opportunity to never go back to unsafe abortion. And so I ask everybody in this room if you are providing medical abortions to patients in your

clinical setting, and if not, are you willing to learn and start? I and my team are willing to train anyone who is interested. You can just let us know.

Thanks everybody for coming and listening and hopefully this is the beginning of thinking and talking about these issues, or the continuation of grappling with them, depending on where you are in the process. Hopefully we will make really good progress together.