

"gray areas" as well. Examples include the balancing of service versus education in particular tasks (i.e. phlebotomy or other "scut") as well as a lack of communication or neglect in the clinical setting.

Another difficult subject related to instances in which two parties have different versions of the same story and the best mechanisms to resolve such a conflict. It was agreed that it is very important to establish clearly at the beginning of rotations the expectations of teachers and students in a manner such that they are understood by everyone involved.

When these issues were presented to the ORR membership the day after the lunch discussion, several other ideas were raised, including the possibility of developing a joint ORR/OSR program at the 1995 Annual Meeting, perhaps also with the Women in Medicine group. This issue also was felt to tie into that of the role of residents as teachers, another major focus of discussion at this conference. It was felt that residents should model behavior to medical

students, including in the treatment of hospital ancillary staff as well as one another. The idea of defining professionalism and incorporating this into program certification was also discussed at some length. ▼

Goals for 1995

Denise Dupras, M.D., Ph.D.

During our brief Ad Board meeting on Sunday, October 30, the Board set forth three goals for the coming year. First - improved **communication** among ORR members and with other resident groups. YOUR input regarding your training area is vital to making this happen. I will develop a database of resident groups and plan to send our newsletter to them on a regular basis. We will also establish communication with Melissa Thomas, M.D., Ph.D., who is the resident representative to the ACGME.

The second goal is the development of an **orientation manual** to be disseminated to incoming members of the ORR. Nick

Gideonse has volunteered to coordinate this project. Please send comments and thoughts to him.

The third goal is the development of a **position paper on "Quality in Residency Training."** David Jones will coordinate this effort. This is the most challenging of the tasks we have set out to complete in the coming year. The first activities will involve the identification of studies or articles on quality. Please send any references or citations that you are aware of along with your comments to David. We anticipate that many of the recent efforts of other resident groups, e.g. the American College of Physicians' residency reform paper, will help to focus our efforts and identify components of quality that are universal to residency training irrespective of specialty.

We will keep you updated on our progress through the year. We expect to have documents to present to you at the 1995 Annual Meeting in Washington, D.C. See you there! ▼

The Residents' Report

Published For The AAMC Organization Of Resident Representatives

Winter 1995

Volume 2, Number 2

Chair's Message

Denise Dupras, M.D., Ph.D.

Thanks to all of you who attended the 105th Annual Meeting of the AAMC and the 4th Meeting of the ORR. Your presence and ideas made the meeting a success. To those of you who could not attend, I hope this will serve to update you on our Meeting.

The meeting began with an informal assembly of some of the Administrative Board on Friday night. I think it was useful to begin the planning for the year ahead. Dr. Michelle Parker, now on an Indian Reservation in New Mexico, presided over the meeting as we welcomed two new members and societies on Saturday Morning. Dr. Natalie Bera and Dr. John Shumko joined the ORR representing the Society of Teachers of Preventive Medicine and the Association of Academic Physiatrists. Their addition resulted from the recent change in our by-laws. The rest of the morning was spent in a business meeting hearing reports from Dr. Jordan Cohen, AAMC President, and resident representatives to other AAMC task forces, groups, and advisory panels. During lunch we held round-table discussions related to topics of interest identified at last year's Annual Meeting.

The afternoon program included a historical perspective on residency training presented by Dr. Ed Stemmler, former Executive Vice-President of the AAMC, and a provocative program on "The Effect of Managed Care on Residency Training" presented by Dr. Gordon Moore from the Harvard Community Health Plan. This year our joint session with the Council of Academic Societies, held in the latter half of the afternoon, focused on workforce issues, specifically "Rightsizing the Resident Physician Workforce: Implications for Education and Career Choice." The distinguished panel included Dr. Jack Colwill, Dr. Michael Whitcomb, and Dr. Julien Biebuyck. The debate was lively and highlighted many concerns for the future of the resident workforce. The day finished with a reception for the ORR.

Sunday morning was business as usual. I want to thank all of you who volunteered of your time to serve as Administrative Board members or Liaisons to various AAMC groups.

The ORR expressed thanks to Michelle Reddie and Dr. David Altman for their help over the past year. Gifts will be presented to retiring members of the Ad Board and Immediate-Past Chair, Dr. Michelle Parker in recognition of their contributions.

On to 1995!! I am very enthusiastic that this year will prove to be productive for the ORR. This is a time in which issues of critical importance to residents, including workforce reform, are likely to be prominent in the health care debate. We can have a voice within the AAMC, and while our comments may not impact upon our own careers, they are vital to the continued health of graduate medical education and the residents of tomorrow. ▼

ELECTION RESULTS 1994 ADMINISTRATIVE BOARD

Chair - Denise Dupras, IM
Chair-elect - Nick Gideonse, FP
- Deborah Baumgarten, Radiology *
- Fernando Daniels, Emergency Med. *
- Julia Corcoran, Plastic Surgery
- David Jones, Thoracic Surgery
- Judith Hoover, Ophthalmology
- Nathalie Bera, Preventive Medicine
(* Returning Ad Board Members)

Liaisons

ERAS
- Michael Greenberg, Ped
SRE
- Christina Gutierrez, Anes.
OSR/ORR - Marci Roy, Neurology
OGPP - Steven Schultz, FP
Newsletter Coord. - Denise Dupras, IM

Update on the Advisory Panel on Strategic Positioning for Health Care Reform

Denise Dupras, M.D., Ph.D.

The final meeting for 1994 of the APSPHCR was held in Boston on November 3. Denise Dupras, ORR Chair, attended the meeting. AAMC Vice Presidents Richard Knapp and Robert Dickler updated the Panel on health care reform and events in Washington. In brief, although no legislation passed prior to the fall elections, both speakers said that we will hear about reform in the context of the budgetary process. The Advisory Panel went on to reflect on the role and advocacy of the AAMC during the past year. Issues discussed included GME funding, workforce regulation, contracting, Medicare, Medicaid, Disproportionate Share Hospitals, malpractice, and antitrust. Concern was raised about the ability of our database to reflect the current rapidly changing climate in health care at our academic institutions. It is likely that workforce issues will continue to be important and may be intimately tied to future changes in the financing of GME.

Dr. Malcolm Cox, on sabbatical at the AAMC from the University of Pennsylvania, discussed his plan to develop a "how to" compendium on GME Consortia. The first portion would involve defining the models and characterizing consortia. The next step would be evaluating the implementation of the various models.

Discussion then ensued about the future role and goals of the Advisory Panel. Dr. Cohen reaffirmed the importance of the

Panel to the AAMC. The Advisory Panel will reconvene early in 1995. Please send any comments or questions to Denise. ▼

Report of the Officers' Retreat

Denise Dupras, M.D., Ph.D.

Denise Dupras, chair, and Nick Gideonse, chair-elect, attended the AAMC Officers' Retreat, held December 12-14 at the Aspen Wye Center in Queenstown, Maryland. A significant portion of the time was devoted to strategic planning and planning for the 1995 Annual Meeting.

Dick Knapp, Executive VP and head of the Office of Governmental Relations provided a legislative update. The widespread Republican victories in the November election create a new challenge for the AAMC. Many of the new members of congress are freshmen, and their views and beliefs about academic medicine unknown. It is recognized that one role of the AAMC is to educate the elected officials about the roles of academic medicine in providing health care, educating physicians, and conducting research. While it is very unlikely that any major health care reform bills will be enacted in the next Congress, it is recognized that there will be increasing pressure to cut Medicare and particularly the Indirect Medical Education support now provided to teaching hospitals. The AAMC will be enlisting the efforts of many key individuals to establish the essential role of academic medicine and the

importance of federal support in "making it happen."

The Annual Meeting theme for 1995 will be "Academic Medicine: Taking Charge of the Future." While the exact wording of the title may be modified, the concept of a rapidly evolving medical environment and the need for change on the part of academic medicine was recognized as the major challenge facing all of us.

Additionally, being pro-active, not re-active, is felt to be essential to being successful in this endeavor. The changes are affecting us as residents as we look to the future of employment opportunities - will there be the job we were trained for or will we be part of an over-supplied field? Will our education meet our needs in a new medical environment? Since the meeting will be in Washington this year, we can expect one or more high-ranking officials from the Democratic and Republican parties to be speaking.

There was also discussion of the format of the Annual Meeting. Traditionally, the Sunday plenary sessions have been late in the day, which unfortunately means many ORR members have left. The good news is that this year it is likely the plenary sessions will be held earlier in the day. We hope that many of you will be able to stay.

Denise spoke with Stacy Tessler, OSR chair, during the retreat about potential joint projects for the coming year and the possibility of a joint program at the Annual Meeting. We will keep you informed about any developments. ▼

Annual Meeting Discussion Groups

As part of last October's ORR Annual Meeting activities, discussions took place over lunch on issues of interest to members. The following are reports from two of the discussion groups.

GME Funding Discussion Group

Nicholas L. Gideonse, MD

After a brief review of the past year's legislative events, particularly the failure to pass comprehensive GME reform, and education of the group regarding the AAMC's role in the debate on the physician workforce and education, the following observations were made. It is our hope that leaders within and outside residency training recognize that current changes in health care delivery are already having profound and unsettling effects on residencies, and this must be responded to.

Residents are losing the opportunity to care for whole groups and categories of patients as sites of care shift. There were many examples discussed such as the loss of pediatrics in anesthesiology and ENT, and indigent patients who are now fully funded in Northwestern "reform" states no longer seeking care at teaching institutions thus decreasing the patient base for family practice training.

Non-hospital based training, for example residencies in preventive medicine, is under- or unfunded in the current system. This also creates barriers to ambulatory care training for primary care specialties.

Practice productivity pressures on residency faculty are adversely affecting both patient-centered teaching and research mentorship. At some programs, this is approaching crisis concern.

While there may be state-based efforts to address workforce training (e.g. California and New York efforts), the NRMP Match and the GME "market" is essentially national. Most residents chose programs based on specialty and quality, rather than region. Other barriers exist to the states effectively acting, e.g. ERISA regulations.

The residents present felt that their own residency program faculty were the best able and most willing to maintain as of paramount importance their trainees' best interests and the quality of education, and, as a result, their program's marketability. Therefore, GME funding is best directed to the programs, rather than through teaching hospitals or medical schools. There was some interest in, but little knowledge of, the Canadian voucher system. Consortia for the purpose of allocation of specialty slots may make sense, but it seems clear that our experience with funding residencies through teaching hospitals has meant that service requirements have sometimes overshadowed both educational quality and the community's need for program graduates (c.f. anesthesiology at present). ▼

Mistreatment in the Workplace Discussion Group

Michael Greenberg, M.D.

As a point of departure, the OSR document "Preservation of Student Rights and Confirmation of Student Responsibilities: Recommendations and Guidelines for Students from the Organization of Student Representatives" was briefly discussed. This document set out to define clearly the expected standards of behavior for students, teachers, and administrators, as well as to establish examples of unacceptable behavior. It recommends procedures for airing grievances and ways to implement education and prevention. Also included as appendices were four case studies and a statement from the Council of Deans and the Group on Student Affairs entitled "Reaffirming Institutional Standards of Behavior in the Learning Environment."

The lunch group discussed ways in which these issues are applicable to residents and how the ORR might respond with a similar set of recommendations. As residents are intimately involved with teaching medical students, the role of the housestaff in medical student mistreatment was also felt to be important. In addition, residents may also be subject to the same types of abuse from faculty members.

What constitutes mistreatment or abuse was another important topic. It was felt by those present that while there are clearly defined types of misconduct (e.g. sexual harassment, physical abuse, racial discrimination), there were many

AN UPDATE FROM THE WORKING GROUP ON MOMENTUM

Deborah Baumgarten, MD

Fernando Daniels, M.D. and Deborah Baumgarten, M.D. have been actively involved with strategic planning efforts of the AAMC as part of the Working Group on Momentum. The group has met three times thus far, in November, December, and January. Here are the highlights from each meeting.

In November, the group spent some time getting acquainted with each other and the task at hand. Small as well as full group discussions were utilized to ascertain what each member perceives about the AAMC, how each member is currently served by the AAMC and how might this be improved, what are considered the core tasks of the AAMC and what are the key tensions within the organization. There was surprising consensus about the core tasks of the organization which included:

- Information and data provider
- Advocacy
- Education and professional development
- Provider of guidelines, standards, policies
- Builder of coalitions and networks
- Spokesman for academic medicine

There was less agreement about the key areas of tension facing the AAMC, with many more areas identified. Here are a few of particular interest to the ORR:

- Basic vs. clinical science
- Service vs. education in residency
- Moving medical education outside of the academic health center
- Uniform pathway to licensure

The meeting concluded with a discussion of specific programs and services that the AAMC offers.

In December, the meeting began with a discussion of specific strategic issues selected from a larger group on the basis of a mail-in ballot. These issues included:

- What programs should the AAMC develop to support academic medicine as it labors to bridge the divisions within it?
- How can the AAMC better serve its diverse members given their different missions, resources, etc.?
- How can the AAMC be made more valuable to the clinical mission of academic medicine?
- Should the AAMC develop the expertise to become a resource for information on the "super-highway" for curricular materials, etc.?
- What can the AAMC do when the interests of members conflict?

- What criteria should the AAMC use to decide if it should expand into a new area?

The afternoon was spent working on a SWOT (strengths, weaknesses, opportunities, threats) analysis of academic medicine in general. The end result of this process should give a clearer idea of where resources should be allocated based on the following matrix:

	External factors	
Internal factors	OPPORTUNITIES	THREATS
STRENGTHS	comparative advantage	mobilization
WEAKNESSES	investment/divestment	damage control

For example, if the fact that the environment is fast changing is considered a threat and if the fact that academic medicine is slow to change is considered a weakness, then steps need to be taken to lessen the damage from such a combination of factors.

The January meeting began with presentations from representatives of four of the AAMC's groups (GIA, GEA, GRR, AND GBA) and one section (SRE). The representatives addressed several questions including:

- Whom does the group or section serve?
- What are the members' key concerns?
- What are the key services the AAMC provides?
- What other organizations serve the members?
- What can the AAMC change to better serve the membership?

Services each group valued were networking, database sharing, and electronic information. The remaining groups and sections will give presentations at the March meeting.

The afternoon was spent examining the core competencies of the AAMC in order to evaluate its services against those of other "rival" organizations. This exercise helped to focus the group on what the AAMC is already doing well (e.g., information services, integrating force among various interest groups) and what challenges the AAMC faces. In addition work continued on the SWOT analysis of academic medicine with discussion of the role of the AAMC as well as other key players affecting various issues.

The next meetings are planned for March and May and will, we hope, prove as productive as the others. And, if this necessarily brief overview of the strategic planning process leaves you hungry for more "meaty" details, feel free to contact either Deborah Baumgarten or Fernando Daniels. ▼

The Residents' Report

Published For The AAMC Organization Of Resident Representatives

Spring 1995

Volume 2, Number 3

Chair's Message

Denise Dupras, MD, PhD

February marked the first Administrative Board meeting for 1995. Attendance at the meeting was outstanding! The energy level of the Ad Board remains high and we expect 1995 to be a productive year. Topics discussed briefly at the end of the Annual Meeting were further clarified. The minutes reflect the discussions and issues raised during the meeting.

Highlights include: the appointment of Dr. Michael Whitcomb as the Vice-President for Education Policy, Joint Boards luncheon with invited speaker Congressman Pete Stark (see brief report), Annual Meeting planning, and identification of ORR projects. Many of you may recall Dr. Whitcomb was one of our panelists on workforce issues at the 1994 Annual Meeting and previously was with the section of Graduate Medical Education at the AMA. Dr. Altman will continue to work directly with the ORR for the foreseeable future.

The Annual Meeting planning was productive. A reminder: the Annual Meeting is October 27-29th in Washington, D.C. Friday will likely be optional, as the business meeting of the ORR will begin on Saturday. Preliminary schedule of events: Friday - Visit to the "Hill", Transition to Residency Forum; Saturday - Orientation, Business Meeting, ORR/CAS Joint Session (possibly on Quality in Residency

Education), and Joint Reception and Speaker with OSR; Sunday - Continue Business Meeting, Elect new Administrative Board members, AAMC Plenary session.

Finally, projects for 1995: For this year the Ad Board has identified 3 projects and project leaders. Your input and help is needed. They are as follows: 1) Develop an ORR Resource Manual to serve as an orientation manual and be upgraded as needed (Nick Gideonse/Nathalie Bera); 2) Develop/identify issues important for quality in graduate education (David Jones*); 3) Develop/identify issues important in decisions about practicing in rural or underserved areas of the U.S. (Judith Hoover*). The items with a "*" particularly require your input. Later in this newsletter are requests that you send in your thoughts to the appropriate person. This is an opportunity for your voice to be heard. The next newsletter will be sent after the June Ad Board meetings. ▼

Luncheon with Congressman Pete Stark

On Thursday, Congressman Pete Stark joined the AAMC leadership at lunch time to discuss the state of affairs on the Medicare Indirect Medical Education (IME) adjustment. Congressman Stark was a lively and entertaining speaker, but the message was clearly disheartening. He stated that "the government is looking for

\$\$\$ and you ladies and gentlemen will provide these \$\$\$." Once again the fact that few individuals in Government understand the vital role of those dollars in our teaching hospitals and the increasing need to "level the playing field" to keep these hospitals competitive was never more evident than during his remarks. The AAMC continues to recommend that the IME be 7.7%, but after listening to Congressman Stark this seems unlikely. I left the room wondering no longer whether the IME will be decreased, but rather by how much ????? and what will the impact be ????? ▼

Quality in Residency Education

David R. Jones, MD

Residency "training" has always been a challenge in balancing service responsibilities and education of the resident. With the concern over GME funding and attempts to right-size the physicians workforce, maintaining this balance will become increasingly difficult. Residency programs will be critically evaluated with respect to those issues and continuance of their missions may be jeopardized if certain issues have not been addressed. One of the issues which will most certainly be examined is the quality of resident education.

Quality, as it relates to resident education, is very much an issue in which the input of residents should be heard. One of the goals of the ORR this year is to identify

characteristics and/or definitions of quality. While each residency program is structured differently, we believe there are issues of quality which are central to the process of graduate medical education regardless of program type or design.

A survey questionnaire regarding quality in resident education is being developed and will be distributed to all ORR members. In an effort to achieve input regarding this issue, I would appreciate any suggestions from the ORR members. Specifically, I welcome information regarding components of your program, faculty, conferences, curriculum, and educational experience. Deadline for submission of this information is May 15. I can have a rough draft of the questionnaire available for review at the June Ad Board meeting. Please send your comments to David R. Jones, MD, Department of Surgery, P.O. Box 9238 HSCN, Morgantown, WV 26506-9238, FAX (304) 293-4711 (Sorry no E-mail). ▼

ORR Resource Manual

Nicholas Gideonse, MD

At the Annual Meeting we decided that an orientation manual would be good for new members, of which there will be many next year. During the board meeting we discussed further details and decided it would be useful to use this as a source book format, with components that change over the year or more that folks are ORR members, with updates, replacements, etc., and that would be handed on to new ORR members as a continuity tool between representatives from our various CAS parent organizations. Thus, we are now calling the project the Source Book. Of course, any volunteers for composing specific parts

would be appreciated. Our time line is a first draft by the June Ad Board meeting.

- I. Welcome letter (Dr. Dupras)
- II. AAMC Overview
 - A. History, organizational chart and mission
- III. ORR Overview and History (Dr. Gideonse)
 - A. Mission and Bylaws
 - B. Minutes of 1994 meeting
 - C. Agenda for 1995 meeting
 - D. Officer's descriptions
 - E. Sample newsletter
 - F. Sample AAMC Highlights
- IV. Address list of members by organization and city
 - A. Full addresses for Administrative Board
- V. Additional Committee Representation
 - A. Opportunities
 - B. Advisory panels
 - C. Additional representation opportunities and committee roles with descriptions and required time
 - D. Advisory panels, strategic planning, liaison committees
- VI. Reimbursement policy and form
- VII. Response form, probably specific for this year's annual meeting
 - A. Legislative visit Friday, October 27
 - B. Ad Board (self) nominations, request for CV's
 - C. Interest group (Bolz) as needed

Any comments are greatly appreciated and may be sent to me at 78161 Rat Creek Road, Cottage Grove, OR 97424-9421. ▼

Advisory Panel on Strategic Positioning for Health Care Reform

Denise Dupras, MD, PhD

The Advisory Panel held its first meeting of 1995 on March 2 in Washington, DC at the AAMC

headquarters. The meeting began with introductions of the members, as some members were newly appointed since the November meeting. Panel Chairman, William Kerr from UCSF, reviewed the role and charge of the panel. Dr. Knapp provided the group with a legislative update. Dr. Gail Wilensky, former Deputy Assistant to President Bush and former director of HCFA, discussed the current pressures on academic medicine. She summarized our current environment as "difficult times" and "a relative excess of supply of most things allowing aggressive purchasers to impact prices for health services." She further discussed the issues surrounding DME, IME, DSH, and AAPCC. She recommended academic medicine be proactive and suggest alternatives to meeting the budgetary cuts while preserving our academic missions.

The Panel discussed workforce issues and the positions currently adopted by the AAMC. Issues surrounding workforce include 1) incentives for career choice, 2) all-payor funding, 3) supply and mix/voluntary planning versus regulation, 4) generalist physician initiative, 5) consortia for GME, 6) quality of GME and 7) IMG/FMG. Overall, there was a consensus that issues related to the increasing pool of residents in training and IMGs will need to be addressed during the coming year.

During the afternoon, representatives from the Intergovernmental Health Policy Project (IHPP) at George Washington University discussed their state legislative tracking projects. Prior discussions at the Advisory Panel had identified the need for the constituency to know more about state health care reform legislation. The IHPP was contracted with to provide information to the AAMC and its

members on delivery system reform, health insurance, Medicaid/indigent care, scope of practice (non-physician providers), and universal access. The AAMC will in turn summarize the materials and distribute quarterly reports to members.

The Panel reviewed a proposal for an AAMC "InformationNet." This project would provide a mechanism by which the members of the Association could share information about their activities in a number of areas, for example, efforts to develop primary care capacity or the type and magnitude of capitation activity.

Mr. Dickler asked the panel to consider other opportunities that the AAMC might pursue. Should the AAMC develop limited research projects in particular areas? If so, which projects would be useful? The panel strongly supported the concept of a longitudinal study of academic medicine as we change in response to the altered health care environment. A limitation of previous studies is that they capture only a single moment, while medicine continues to evolve. A study done even five years ago may no longer be valid in the current environment. Additionally, the Panel supported and endorsed the development of educational programs to work with and assist the leadership of specific institutions in this time of a changing health delivery system. The next panel meeting will be held in May. ▼

Incentives and Disincentives for Rural Health Care

Judith Hoover, MD

Government health care reform initiatives are intended to assure that every American citizen has access to basic health care

and to decrease health care costs at the same time. Health care in rural populations has been threatened in recent years by a significant number of hospital closures and a scarcity of primary care providers. In fact, some of the population is beginning to suffer from a lack of medical care that is comparable to that of underdeveloped countries. Improving this situation requires identifying possible causes of this disparity of resources.

First, there is a sense of isolation among rural health care providers which could be reduced by linking and enhancing providers and services. The use of telemedicine is a partial solution. Besides serving patients, these systems provide continuing medical education and support to reduce the isolation of rural health care professionals. This may require evaluation of telemedical training and analysis of the cost feasibility of telemedical services.

Second, characterizations of rural communities are based largely on population density, with little attention to contextual patterns of lifestyles, i.e. utilization patterns of services, migration patterns, and diversity among rural communities.

Third, rural health care centers have a small economic base and a more complex service area. They may need to explore such alternatives to the traditional fee-for-service medical practice as recruiting older providers, establishing a community-based health maintenance organization, or founding a community-owned and -operated medical clinic staffed by primary care providers. They may require external government assistance to accomplish these goals.

Fourth, they need to increase the number of health care

providers to these areas. This may be facilitated in two ways. One would be to develop financial incentive packages to attract and retain already trained primary care providers. And two, educational systems need to recruit students from rural areas and provide more training experiences in rural areas. This approach, spearheaded by an academic health center "without walls," may increase support for rural provider education and migration to rural practice.

We want the ORR members to provide input on what are incentives and disincentives to practice in rural or underserved areas. Please send your input via e-mail to jhoover@bcm.tmc.edu or by standard mail to 1729 Wroxtton Court, Houston, TX 77005. Your input will serve as the basis for a future survey of the ORR membership. ▼

ORR Visits to the Hill

Judith Hoover, MD

This year, we will try to organize visits to Capitol Hill where we can directly lobby our representatives from our perspective as residents. I will be working with David Altman, MD to see how to arrange this. If any of you were able to attend the joint lobbying session with the OSR two years ago, you may agree that it was a worthwhile experience. I was able to attend and thought it would be a great idea for the ORR alone to vocalize resident issues (which are not necessarily the same as those of the OSR). If any of you have suggestions about whom you would like to "lobby," or which issues we should prioritize, let me know. ▼