

# DEMYSTIFYING GENDER- AFFIRMING ASSESSMENT

REMOVING BUREAUCRATIC BARRIERS TO ESSENTIAL CARE

MOIRA RYAN, LPC, WPATH GEI SOC 8

## DR. ALAN HART'S HYSTERECTOMY (1917)



- Obtained first GAS on record
- Invented a method of using X-rays to detect tuberculosis
- Outed and forced to move his practice several times
- Published several short stories and four novels
  - *Doctor Mallory* – named one of Oregon's most significant books by the OCHC

# THE INSTITUTE FOR SEXUAL SCIENCE (1919-1933)



- Founded by Magnus Hirschfeld (1868-1935)
- Research: anthropology, psychology, sexuality
- Advocacy: decriminalization of consensual sex acts
- Health clinic: contraceptive advice and affirming care
  - Modernized MTF gender affirming surgeries (orchiectomy → penectomy → vaginoplasty)
  - Performed first two modern penectomies
- Publish: countered old myths about sex and gender
  - First publication to distinguish homosexuality from transitude
- Destroyed by the Nazi party in 1933 for immorality

# PLASTIC SURGERY (1946-1951)



Dillon & Cowell

- Sir Harold Gillies is the father of plastic surgery
- Michael Dillon was referred to Gillies, who gives him world's first phalloplasty (13 surgeries begun in 1946)
- Michael Dillon legally changes his identity and becomes heir to his father's baronetcy
  - Publishes *Self* in 1946, becomes doctor in 1951
- Roberta Cowell meets Dillon in 1950 – he performs her orchiectomy and Gillies makes her the first British woman to have a vaginoplasty
- Paid \$223,000 by *Picture Post* to publish her story (1954)

# “GOING TO CASABLANCA” (1956-1989)



- Georges Burou, a French gynecologist, performed his first GAS in 1956
- Georges Burou invented the method of vaginoplasty (“skin flap inversion”) still used today
- Georges Burou performed 800-3,000 vaginoplasties in his “Clinique du Parc”
  - Didn’t ask questions or worry about diagnosis, but refused care to minors and to women he suspected wouldn’t pass
  - Patients were admitted in the afternoon and prepped for surgery that evening

# ERICKSON EDUCATIONAL FOUNDATION (1964-1977)



With girlfriend Daisy (left) and Michelle, 1963.  
Photo from the USC Libraries

- 1962: Reed Erickson inherits multimillion dollar companies after his father's death
- 1963: Reed Erickson meets Harry Benjamin
  - 1965: Gender affirming surgery
- 1964: creates the EEF to fund peer support, referral networks and to fund the Benjamin group
  - "If a physician was interested in working with trans patients, the EEF would send [physicians] educational information in an attempt to build competence in this new area."

# GENDER IDENTITY CLINICS (1960S)

## AGAINST SURGERY

“Unwittingly, many a physician does not treat the disease as such but treats, rather, the fantasy a patient develops about his disease... I believe the surgical treatment of transsexual yearnings easily falls into this trap... **What about our medical responsibility and ethics? Do we have to collaborate with the sexual delusions of our patients?**”

- Dr. Joost Meerloo, American Journal of Psychiatry, 1967

## CLINICS ANSWER THEIR CRITICS

- Extremely selective standards varied by clinic
- Surgeons preoccupied with proving “good results”
- Patients required to “live full-time” as themselves for 2-5 years, depending on the clinic’s requirements
- “Attractive” patients deemed “more likely to pass” considered better surgical candidates
- 1966-1968:
  - 2,000 applicants to Johns Hopkins’ new clinic
  - 24 approved for surgery
- 1966-1979: 30 total surgeries performed



THE UNIVERSITY OF TEXAS MEDICAL BRANCH  
GALVESTON, TEXAS 77550

April 17, 1979

Paul A. Walker, Ph.D.  
Director, The Gender Clinic

(713) 765-2326

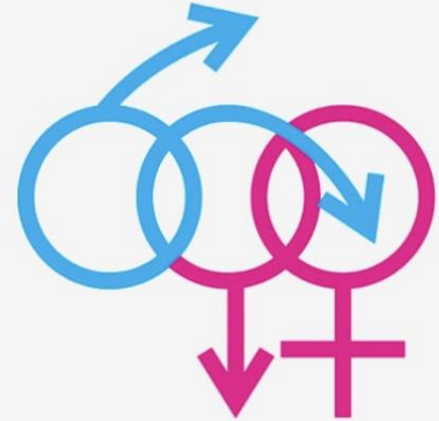
MEMO TO: Persons interested in the Harry Benjamin  
International Gender Dysphoria Association

FROM: Paul A. Walker, Ph. D.  
Chairperson Founding Committee

RE: The Harry Benjamin International Gender  
Dysphoria Association

As explained on the attached, we have recently founded  
the Harry Benjamin International Gender Dysphoria  
Association. Membership dues are \$60 annually.

The Harry Benjamin International Gender Dysphoria  
Association will take over the information provision  
and referral making services of the Janus Information  
Facility (formerly the Erickson Educational Foundation).

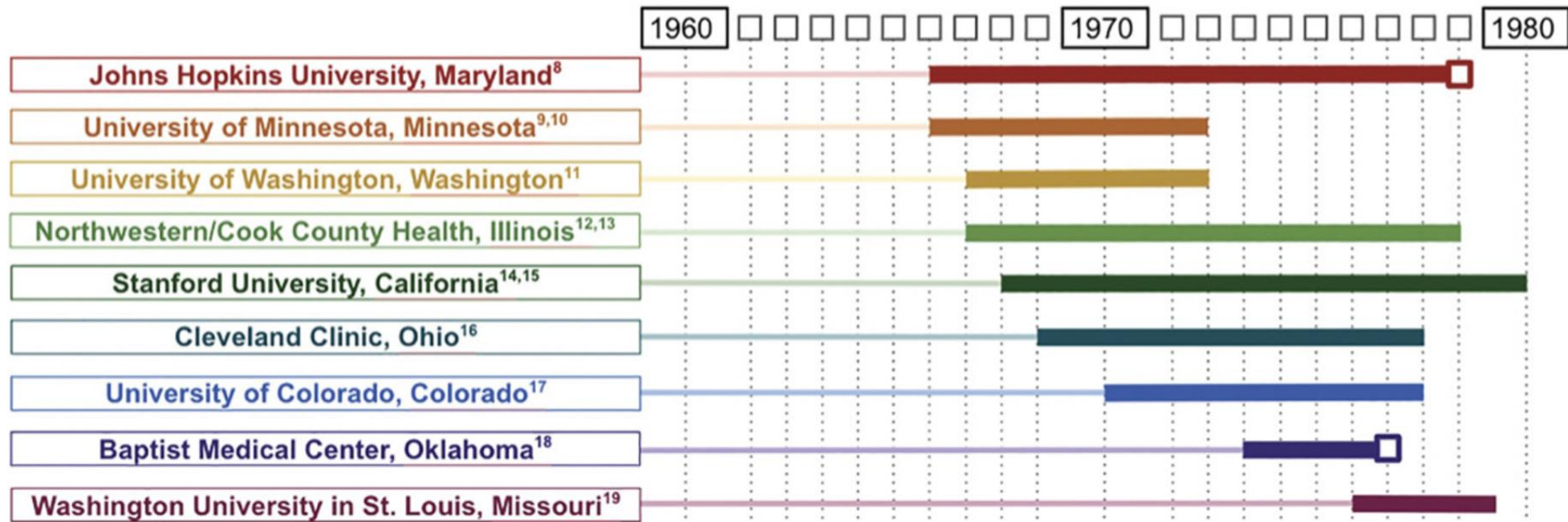


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# WPATH

WORLD PROFESSIONAL  
ASSOCIATION for  
TRANSGENDER HEALTH

## Gender Identity Clinic Timeline



# “TAKING A TRIP TO TRINIDAD” (1969-2003)



Photo by Carol Highsmith

- “Sex Change Capital of the World”
- Stanley Biber, a surgeon who worked in a MASH unit during the Korean War, performed his first GAS in 1969
- Stanley Biber performed 6,000 affirming surgeries and trained several proteges (including Marci Bowers, WPATH’s former president)

# WPATH EVOLVES

## 1979 (SOC 1)

1. Psychiatrist/psychologist must diagnose transsexualism with “persistent” dysphoria
2. Assess capacity to consent for surgery
3. Psychiatrist/psychologist must “have knowledge, independent of the patient’s verbal claim” of dysphoria lasting at least 2 years
4. Patient must “live full-time” for 6-12 months prior to letter (depending on procedure)
5. Surgeon must obtain both letter of recommendation and a second opinion from a psychiatrist
6. Provider must provide counseling for 3-6 months prior to letter (depending on procedure)

## 2012 (SOC 7)

1. Counselor/PCP/provider must document “severe and persistent” gender dysphoria
2. Are co-existing conditions well-controlled?
3. Assess capacity to consent for surgery
4. Assist in exploration of reproductive options prior to initiation of GAHT
5. 12 months of GAHT recommended for those seeking bottom surgery
6. 12 months of living in congruent gender role for those seeking bottom surgery
7. 2<sup>nd</sup> letter required for bottom surgery
8. “The SOC do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery” (p. 28)

## 2022 (SOC 8)

1. Counselor/PCP/provider must document “marked and sustained” gender incongruence
2. Will co-existing conditions negatively impact the outcome of GAS?
3. Assess capacity to consent for surgery
4. Assess capacity to understand the effect of GAS on reproduction, and explore reproductive options
5. 6 months of GAHT recommended for those seeking bottom surgery
6. “[H]ealth care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment” (WPATH SOC 8 p. S175).

# DIAGNOSIS

## 2023 (SOC 8)

1. Counselor/PCP/provider must document “marked and sustained” gender incongruence
2. Diagnose co-existing conditions – could these negatively impact the outcome of GAS?
3. Assess capacity to consent for surgery
4. Assess capacity to understand the effect of GAS on reproduction, and explore reproductive options
5. 6 months of GAHT recommended for those seeking gonadectomy (orchiectomy/oophorectomy)
6. **“[H]ealth care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment” (WPATH SOC 8 p. S175).**

- Are you transgender?
- Do you have any worry or concern that you’re really cisgender?

# CO-EXISTING CONDITIONS

2022 (SOC 8)

1. ~~Counselor/PCP/provider must document “marked and sustained” gender incongruence~~
  2. Are co-existing conditions likely to negatively impact the outcome of GAS?
  3. Assess capacity to consent for surgery
  4. Assess capacity to understand the effect of GAS on reproduction, and explore reproductive options
  5. 6 months of GAHT recommended for those seeking bottom surgery
  6. “[H]ealth care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment” (WPATH SOC 8 p. S175).
- Do you have any mental health struggles that impact your day-to-day life?
  - How do you usually assess at intake?
    - Full symptom checklist?
    - More casual interview?
  - Why would history-taking look differently for people interested in counseling vs. people interested in surgery?

# CAPACITY TO CONSENT TO SURGERY

2022 (SOC 8)

- ~~1. Counselor/PCP/provider must document “marked and sustained” gender incongruence~~
  - ~~2. Are co-existing conditions likely to negatively impact the outcome of GAS?~~
  3. Assess capacity to consent for surgery
  4. Assess capacity to understand the effect of GAS on reproduction, and explore reproductive options
  5. 6 months of GAHT recommended for those seeking bottom surgery
  6. “[H]ealth care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment” (WPATH SOC 8 p. S175).
- Adequate knowledge of surgical process?
  - Realistic expectations of outcome?
  - Aware of risks and potential complications?
  - Committed to following through on all aftercare instructions?
  - Supportive, safe aftercare plan?

## AFTERCARE PLANNING

- Do you have access to a local mental health provider?
- Are you concerned about loss of income during the recovery period?
- Do you smoke? Willing to quit a couple weeks before and after surgery?
- How'll you get home from surgery?
- Will you be staying at an aftercare facility, with friends, or flying solo?
- Who'll help with hygiene and nutritional supports?

# FERTILITY

2022 (SOC 8)

- ~~1. Counselor/PCP/provider must document “marked and sustained” gender incongruence~~
- ~~2. Are co-existing conditions likely to negatively impact the outcome of GAS?~~
- ~~3. Assess capacity to consent for surgery~~
4. Assess capacity to understand the effect of GAS on reproduction, and explore reproductive options
5. 6 months of GAHT recommended for those seeking bottom surgery
6. “[H]ealth care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment” (WPATH SOC 8 p. S175).

- Are you aware that this surgery will impact your fertility?
- Would you like to hear about fertility preservation resources?

<b>Fertility Preservation Options – Female</b>	<b>Service Cost Range</b>	<b>Storage Cost Range</b>
Egg Freezing	\$10,000 – \$15,000	\$500 – \$1,000/year
Embryo Freezing	\$11,000 – 45,000	\$2,000 – \$15,000/year
Ovarian Tissue Cryopreservation	\$10,000 – \$15,000	\$300 – \$500/year
Ovarian Transposition	Cost unknown	N/A
Ovarian Suppression	\$500/month or \$6,000/year	N/A
<b>Fertility Preservation Options – Male</b>		
<b>Fertility Preservation Options – Male</b>	<b>Service Cost Range</b>	<b>Storage Cost Range</b>
Sperm banking	\$500 – \$1,000	\$200 – \$500/year
Testicular Sperm Extraction	\$6,000 – \$16,000	\$200 – \$500/year
Electroejaculation	\$1,500 – \$6,500	\$200 – \$500/year
<b>Third Party Reproduction Options</b>		
<b>Third Party Reproduction Options</b>	<b>Service Cost Range</b>	<b>Storage Cost Range</b>
Donor Embryos	\$5,000 – \$15,000	N/A
Donor Eggs	\$11,000 – \$60,000+	N/A
Donor Sperm	\$400 – \$4,000	N/A
Surrogacy	\$160,000 – \$230,000	N/A

# GENDER-AFFIRMING HORMONE THERAPY

2022 (SOC 8)

- ~~1. Counselor/PCP/provider must document “marked and sustained” gender incongruence~~
- ~~2. Are co-existing conditions likely to negatively impact the outcome of GAS?~~
- ~~3. Assess capacity to consent for surgery~~
- ~~4. Assess capacity to understand the effect of GAS on reproduction, and explore reproductive options~~
5. 6 months of GAHT recommended for those seeking bottom surgery
6. “[H]ealth care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment” (WPATH SOC 8 p. S175).

- GAHT isn’t required prior to most surgeries, but is recommended
- Is GAHT right for you?
- If you’re taking it, how long have you been taking it with no stops and starts?
- Can I help you find other resources?



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## Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

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# Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

Center of Excellence for Transgender Health

Department of Family & Community Medicine

University of California, San Francisco

2<sup>nd</sup> Edition – Published June 17, 2016

Editor - Madeline B. Deutsch, MD, MPH

UCSF



- Are you board certified by the American Board of Plastic Surgery? Are you a member of WPATH?
- What are your credentials? How many years of plastic surgery training have you had?
- How many instances of this particular surgery have you done in the past? How many do you perform per month?
- Do you perform surgery in a state-recognized or nationally-accredited facility?
- What technique do you specialize in for this surgery? Who do you recommend for alternative techniques?
- Which surgical technique do you recommend for me? What results are reasonable for me to expect?
- May I see your portfolio of before-and-after photos? If not, why not?
- What is your BMI (body mass index) requirement for this surgery?
- What are the risks associated with this particular procedure? How are complications handled?
- What are my options if I'm dissatisfied with the results?
- Can I expect every staff member in your office to refer to me with my correct name and pronouns?

## WHAT TGD PEOPLE WANT YOU TO KNOW

1. Ask basic questions, and show clients their letter
2. Don't use cognitive tests unless actually warranted
3. Understand the power imbalance you're operating in
4. Don't withhold letters because you think they need more therapy first

# Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence

[Valeria P Bustos](#)<sup>\*</sup>, [Samyd S Bustos](#)<sup>†</sup>, [Andres Mascaro](#)<sup>‡</sup>, [Gabriel Del Corral](#)<sup>§</sup>, [Antonio J Forte](#)<sup>¶</sup>, [Pedro Ciudad](#)<sup>||</sup>,  
[Esther A Kim](#)<sup>\*\*</sup>, [Howard N Langstein](#)<sup>††</sup>, [Oscar J Manrique](#)<sup>††,∞</sup>

## Methods:

A systematic review of several databases was conducted. Random-effects meta-analysis, meta-regression, and subgroup and sensitivity analyses were performed.

## Results:

A total of 27 studies, pooling 7928 transgender patients who underwent any type of GAS, were included. The pooled prevalence of regret after GAS was 1% (95% CI <1%–2%). Overall, 33% underwent transmasculine procedures and 67% transfeminine procedures. The prevalence of regret among patients undergoing transmasculine and transfeminine surgeries was <1% (IC <1%–<1%) and 1% (CI <1%–2%), respectively. A total of 77 patients regretted having had GAS. Twenty-eight had minor and 34 had major regret based on Pfäfflin's regret classification. The majority had *clear regret* based on Kuiper and Cohen-Kettenis classification.

## Conclusions:

Based on this review, there is an extremely low prevalence of regret in transgender patients after GAS. We believe this study corroborates the improvements made in regard to selection criteria for GAS. However, there is high subjectivity in the assessment of regret and lack of standardized questionnaires, which highlight the importance of developing validated questionnaires in this population.

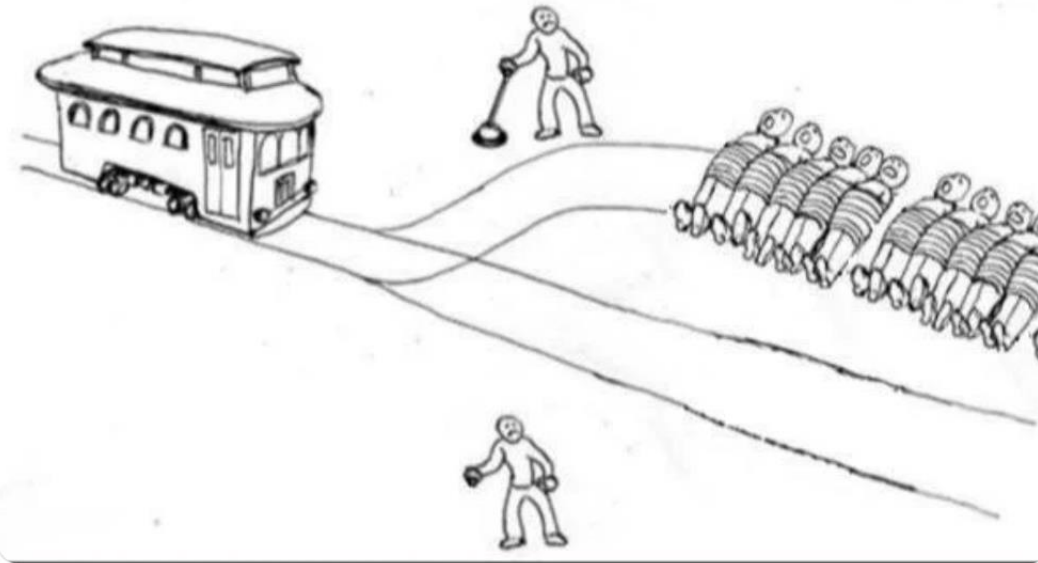


Divine Feminine Daughter of Lilith  
@TheSeptet



## Trans healthcare trolley problem

An unknown number of trans people have been tied to one of the train tracks, while a runaway trolley is set to roll down the empty track, saving the trans people. However, that guy over there might voluntarily walk onto the train track. Do you pull the lever, sacrificing the trans people to protect that one guy from possibly making a mistake?



4:58 PM · Sep 30, 2021 · Twitter Web App



# SAIGE Position Statement on Gender-Affirming Healthcare Bans

As of May 2024, 54 bills have been proposed to ban aspects of gender affirming medical care for transgender and gender expansive Americans.<sup>1</sup> Additionally, in 2023 153 similar pieces of legislation were introduced in state legislatures, with 22 of them passing.<sup>2</sup> Transgender and gender expansive individuals experience significant mental health disparities, including increased depression, anxiety, and suicidality, not because of their identity but because of the way that people respond to their authenticity.<sup>3</sup> Restricting access to gender affirming care is discrimination. This legislation seeking to ban or restrict access to care further perpetuates discriminatory attitudes towards transgender and gender expansive individuals. Significantly, many of these bills and laws directly impact counselors' scope of practice and attempt to cast doubt on the professional expertise of mental health care professionals. In the face of these bills and laws, the Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE) upholds the American Counseling Association's commitment to the prevention of harassment in all forms - verbal, physical, sexual, emotional, and psychological - including defending the fundamental human rights of transgender, gender expansive, and LGBTQ+ individuals.<sup>4</sup>

Gender-affirming interventions are not new or novel and have a well-established use for both cisgender and transgender youth.<sup>5</sup> Gender-affirming medical procedures and mental health care are essential and endorsed by the American Academy of Pediatrics, the Endocrine Society, the American Academy of Family Physicians, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Medical Association, the United States Association for Transgender Health, and the World Professional Association of Transgender Health.<sup>6</sup> SAIGE's own *Competencies for Counseling Transgender Clients*,<sup>7</sup> which have been endorsed by the American Counseling Association, call for counselors to embrace the full spectrum of gender identity and expression, affirm transgender mental and medical care, and serve as advocates for transgender individuals. Provision of affirming medical care is evidence-based best practice when working with transgender individuals.<sup>8</sup>

## Gender-Affirming Health Care Saves Lives

Mar 28, 2023

**WASHINGTON, D.C.** – The National Association of Social Workers (NASW) asserts that discrimination and prejudice directed against any individuals on the basis of gender identity or expression are damaging to the social, emotional, psychological, physical and economic well-being of transgender and gender diverse (TGD) people and society as a whole.

The unprecedented increase in legislation focused on TGD youth seeking affirming health care, the professionals who provide their medical care, and the families and social supports that offer resources to them is an unfortunate indicator of the lack of understanding and misinformation that currently exists. The Equality Federation is currently tracking 325 anti-transgender pieces of legislation across the nation that continue to threaten the livelihood of TGD people and substantially reduce access to services they need to stay alive. Consequences of misinformed legislation will increase threats of violence, perpetuate prejudice, promote health inequity, and increase incarceration rates for TGD people simply being themselves.

Social determinants affecting the health of TGD people are rooted in discrimination and oppression. Despite increased public awareness, every day TGD individuals and communities experience unprecedented and intolerable amounts of social judgement, stigma, verbal harassment, physical violence, and trauma.

Research tells us that no one is confronted with more hate crimes and intolerance than TGD people who also hold Black, Brown and Indigenous identities.

NASW calls on all members of the social work profession to support, promote, affirm and “protect the rights, legal benefits, and privileges of people of all gender identities and expressions.” NASW will work to repeal discriminatory legislation and regulations that do not honor someone’s self-identified gender identity, transgender-inclusive health care access, health insurance options, or use of language promoting health equity and inclusive communication.



## Questions for Clinicians

1.

What do you do if a client refuses to engage in gender exploration with you? Do you refuse them gender-affirming care, even if it may be necessary to their well-being?

2.

How long does gender-exploratory therapy last? How do you know if it has gone on long enough? Do you go until you find a "root cause" of the client's trans identity or gender dysphoria?

3.

How do you distinguish, for example, trauma that caused someone to be trans from trauma that a trans person happens to have? Do you trust the client's views? Would you equally trust clients' view that their gender identity or gender dysphoria is and is not grounded in trauma? Why or why not?

4.

If you conclude that trans identity or gender dysphoria is rooted in, for example, trauma, how do you assess whether this response is adaptive or maladaptive? How do you determine whether the person can safely and effectively be encouraged or helped to reidentify with the gender they were assigned at birth? Is there any evidence that gender-exploratory therapy is safe or effective?

5.

If clients eventually come to identify as cisgender, do you wind down gender-exploratory therapy, or do you continue at a similar pace to ensure that their reidentification is genuine and not itself a coping or adaptive/maladaptive response? Why or why not?

6.

Relatedly, do you consider self-identification as transgender more suspect or deserving of exploration than self-identification as cisgender? Why or why not? How is this reflected in gender-exploratory therapy?

7.

Is it possible that the, for example, trauma permanently altered the person's sense of self?

8.

If the psychotherapeutic attempt to treat gender identity and/or gender dysphoria proves unsuccessful, would you consider recommending gender-affirming care? Under what conditions?

9.

Do you see refusing to affirm someone's expressed sense of self and experiences of gender as an appropriate response to individuals who may be experiencing trauma? Does nonaffirmation conflict with trauma-informed care's emphasis on fostering clients' sense of choice, empowerment, and acceptance (Levenson et al., 2021)? Do you think nonaffirmation poses risks of retraumatization?

10.

Is there any evidence that gender-exploratory therapy leads to better outcomes, however you define them, than gender-affirming approaches? Is there any evidence that it can successfully identify youths who are not "truly" trans, whose identification is maladaptive, or who would be harmed by gender-affirming interventions?

11.

Do you believe that gender-exploratory therapy can create psychological, social, and emotional pressures to reidentify with one's gender assigned at birth? Do you believe that it can create pressures to misreport reidentification or alleviation of gender dysphoria? Do you believe that it can create pressures to identify specific factors, for example, trauma as a cause of trans identity or gender dysphoria?

12.

Do you believe that gender-exploratory therapy can create pressures to lie, misrepresent, or otherwise engage in gender-exploratory therapy in bad faith to obtain gender-affirming care? Do you believe it can lead clients to suppress their doubts and worries and, as a result, make decisions regarding gender-affirming care that are less informed and thoughtful?

13.

What do you make of the distress of the numerous youths who are "truly" trans, who will experience ongoing distress during gender-exploratory therapy, and who form a strong majority of individuals seeking gender-affirmative care? High-end estimates of detransition are around 3% (Brik et al., 2020; Narayan et al., 2021). There are some suggestions that up to 76% of people who detransition do not tell their clinicians that they have done so (Littman, 2021). Even if one assumes, for the sake of argument, that these upper-bound estimates are accurate, one is left with a large 88% of individuals who do not detransition. Detransition seems rare.

14.

What pronouns and gendered terms do you use during gender-exploratory therapy? Do you use terms desired by clients or terms that reflect their gender assigned at birth, or do you avoid pronouns and gendered terms altogether? Do you see using terms reflecting the client's gender assigned at birth as a neutral option? Why or why not?

15.

Do you believe that transition-related medical interventions, such as hormones, can be offered in parallel to exploratory therapy either as a means of reducing current gender dysphoria and/or as a way of helping clients explore their gender identity and ascertain whether gender-affirming care is right for them? Do you think social and medical transition being temporary is an inherently undesirable outcome? Why or why not? Is this related to a belief that bodies that have undergone medical transition are less desirable and should be avoided if possible?

16.

Given concerns that premature affirmation may foreclose gender identity and exploration and considering that puberty blockers arguably have far less of a foreclosing impact on gender than endogenous puberty, do you think that clinicians should offer and encourage puberty blockers for all questioning and even perhaps all cisgender kids? Would your answer change if you were absolutely certain that puberty blockers had no negative long-term side effects?

DATE

SURGEON  
SURGEON'S ADDRESS  
SURGEON'S ADDRESS

RE: SURNAME, DEADNAME ("P.")  
DOB: XX/XX/XXXX

Dear Dr. SURGEON:

I am writing to provide this mental health referral/letter of recommendation for top surgery for DEADNAME "P." SURNAME. This is a medically necessary procedure. I met with P. SURNAME on DATE for assessment for gender incongruence as well as discussion related to the requirements for informed consent for surgery; they participated actively.

I have been accompanying TGNB persons and writing referrals for gender affirming treatments since YEAR.

P. SURNAME currently meets the WPATH's Standards of Care for surgery for people dealing with gender incongruence. P.'s mental health is stable, and they do have access to a local mental health provider. There are no substance abuse issues. They have experienced significant benefit from the steps they have taken so far, including reduced dysphoria and improved mental health. However, they continue to experience incongruence related to their chest and, therefore, want to proceed with chest reconstruction. They have a family-approved plan of taking six weeks of FMLA to recover at their sister's house; their sister will provide nutritional and hygiene supports. They have a close circle of friends who will be on hand for emotional support.

P. SURNAME has met the requirements of these standards of care and, therefore, it is recommended that they undergo top surgery (chest reconstruction) at this time. The following criteria has been met:

- P. SURNAME has marked and sustained gender incongruence.
- P. SURNAME has the capacity to make fully informed decisions and to consent to treatment. They have received information regarding fertility preservation and report they have made a decision for themselves on this issue.
- P. SURNAME is of the age of majority (age 19).
- P. SURNAME's mental and physical health is stable.
- P. SURNAME is uninterested in GAHT at this time.

If you have any questions, or need further information, please do not hesitate to contact me at PHONE NUMBER. I am available for coordination of care via phone.

Sincerely,

NAME, CREDENTIAL