

February 10, 2023

To: Kansas House Education Committee
Regarding: **Testimony in Opposition of HB 2238**

Chair Thomas and Members of the Committee, thank you for the opportunity to provide testimony in opposition to HB 2238.

I, Amanda L. Mogoi, APRN, am a primary care and hormone therapy provider in Wichita, Kansas. I am a member of and certified in family practice through the American Association of Nurse Practitioners. I am World Professional Association for Transgender Health (WPATH) trained and one of the few registered WPATH clinical providers in the state. I am the co-owner of M-Care Healthcare, LLC where I currently provide care to over 800 gender diverse individuals, including people that would be directly impacted by this bill. I practice explicitly within the WPATH guidelines for the medical treatment of Gender Incongruence and within the limitations of my state licensure and professional association certification. I have obtained over 300 hours of transgender healthcare specific continuing education hours and I have over 4 years of experience providing care for transgender patients.

As a medical provider, I understand that bodily autonomy, self-determination, and respecting human dignity is imperative to providing quality care. The ability for a transgender person to speak for themselves and affirm their own identity is imperative. I am thankful for those who provide testimony about their own lived experience and on behalf of their community. I cannot speak for the transgender community as I do not share their lived experience, however, my experience providing care for the community and my medical expertise validates the need for my testimony to be heard in opposition to this legislation. My testimony is based on my education, experience, and the research currently available.

Great strides have been made in the medical community regarding the understanding of sex and gender. It is now well known that while sex determination may seem black and white, but there is an expansive and complex gray area between. Sex is not a simple binary. Karyotypic variations, genital variations, and hormonal variations exist within humanity that make it clear to us that classification of individuals as male or female is not as simple as it seems. HB 2238 speaks to “biological sex” as “the biological indication of male and female in the context of reproductive potential or capacity, such as sex chromosomes, naturally occurring sex hormones, gonads and nonambiguous internal and external genitalia present at birth, without regard to an individual’s psychological, chosen or subjective experience of gender”. A person’s biological sex is assigned at birth, or often before birth due to medical technologies, based on visual interpretation of external genitalia, however, medical professionals know that external genitalia is not always reflective of a person’s reproductive potential or capacity, sex chromosomes, naturally occurring sex hormones, gonads, or internal organs that are present. We all know that bodies are different from person to person and external genitalia, like every other part of humanity, should be seen as a spectrum of normal presentations. In fact, the latest clinical guidance for physicians regarding assigning sex in children born with ambiguous external

genitalia is to not assign a sex at birth and allow the child to define their gender based on their own life experience (Grimstad et. al, 2021).

Genetics are even more complicated. Several genetic conditions result in androgen insensitivity leading to variations in human development. Consider karyotype variations- There are more than just XX or XY chromosomes. This includes individuals with Klinefelter Syndrome and Turner Syndrome. Turner Syndrome results in a single X chromosome, known as 45XO. Physical effects vary from person to person. To further complicate things, some individuals may not have any physical manifestations that would clue medical professionals, family members, or the individual in to the fact that their sex chromosomes differ from XX or XY. Individuals with Klinefelter Syndrome have an XXY karyotype. Klinefelter is quite common, occurring in 1/500 to 1/1,000 male assigned births. The syndrome results in what is often perceived as “normal” male external genitalia at birth, but lack of thorough virilization and possible need for exogenous testosterone to be given at/after puberty.

Hormone exposure is the cause of the secondary sex characteristics commonly thought of as feminizing or masculinizing features. Androgen levels are grossly similar until the onset of puberty. However, even after that time, classifying people as male or female based on hormone levels is not clear. Some conditions, such as Androgen Insensitivity Syndrome and Congenital Adrenal Hyperplasia result in hormone variations which affect physical development. Dr. Frances Grimstad, a gynecologist at Boston Children’s Hospital and Assistant Professor at Harvard Medical School, said that there is large “testosterone variations among XX individuals” including those with polycystic ovarian syndrome, which affects up to 20% of cisgender women (Burns, 2019). I agree with Dr. Grimstad’s position that “If you were to all of a sudden take all of my PCOS patients and tell them that because they have elevated testosterone, they are not considered female enough to compete with other females, I think that would open a social can of worms” (Burns, 2019).

When considering transgender individuals, it is important to remember that not all trans girls have ever went through a testosterone dominant puberty. If puberty blockers are accessed, trans girls will not develop the testosterone- related changes that are being discussed by those in favor of HB 2238. Puberty suppression allows adolescents a completely reversible option to medically stall puberty and develop their gender identity without unwanted physical developments (Grift et al, 2020). Puberty suppression has been well studied and the positive psychological benefits are well documented. The American Academy of Pediatrics, The American College of Obstetricians and Gynecologists, The American Psychological Association, The Endocrine Society, The Pediatric Endocrine Society, and The World Professional Association for Transgender Health, among many others have affirmed their support for gender affirming care for minors including puberty suppression and gender affirming hormone therapies.

Allowing transgender students to participate in sports, on teams that affirm their gender identity, is imperative. We know that these affirmative steps are life changing and they are life saving for student athletes. Dr. Joshua Safer, an endocrinologist at Mt. Sinai has been quoted that “A person’s genetic make-up and internal and external reproductive anatomy are not useful indicators of athletic performance.” For a trans woman athlete who meets NCAA standards, “there is no inherent reason why her physiological characteristics related to athletic performance

should be treated differently from the physiological characteristics of a non-transgender woman.” Further, research shows that the inclusion of transgender individuals has no proven effect on competitive equality (Goldberg, 2021).

It is my professional opinion that the healthcare privacy of individuals will be directly infringed upon by the passage of this bill. Visual assessment of genitalia, accessing medical records, or requiring costly lab and genetic testing is a direct attack of healthcare privacy and is aimed at harming transgender individuals. Medical treatment is a crucial and very personal service that virtually everyone depends upon at some point in their lives, and the details of patient’s healthcare records are protected under federal HIPAA guidelines. Medical care should not be ordered or restricted according to the whims of distant lawmakers who know little or nothing about the circumstances of an individual’s life. And frankly, have no rights to people’s protected health information.

According to The Trevor Project, 86% of LGBTQ youth said that recent politics have negatively affected their well-being (2021). I am calling on you to shut down this direct attack on Kansas youth. The bill is not designed to protect girls. It is blatantly transphobic and only further marginalizes a community that requires protection. It is imperative that you reject this bill to demonstrate that the health equity and well-being of your transgender constituents and their families is just as important as your own. I’m calling on you today to protect all Kansans by affirming who they are and allowing them to play sports on the teams that align to their gender.

Thank you,

Amanda Mogoi, MSN, APRN, FNP-C

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