

# State of Nebraska Tort & Miscellaneous Claim Form

This form is for Tort (Neb. Rev. Stat. § 81-8,209 - § 81-8,235) and Miscellaneous (Neb. Rev. Stat. § 81-8,294 - § 81-8,301) Claims against the **State of Nebraska**.

<b>FOR OFFICE USE ONLY</b>
<input type="checkbox"/> TORT <input type="checkbox"/> MISCELLANEOUS
Claim Number:

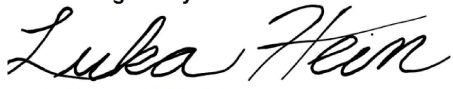
Only **COMPLETED** and **SIGNED** Claim Forms will be accepted by the Office of Risk Management.  
 \* Indicates a **REQUIRED** field. If required fields are not filled out, your Claim will not be processed.

Claimant's Name*: <b>Luka Hein</b>	Claimant's Phone Number*: <b>(402) 475-8230</b>	Alternate Phone Number:
Claimant's Mailing Address*: c/o Keating O'Gara law Firm P.O. Box 82248, Lincoln, NE 68501	Claimant's Email Address: <b>jd@keatinglaw.com</b>	Is Claim Work Related? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
	Is Claimant a State Employee? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If YES, What State Agency?
Is Claimant Medicare Eligible*? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Date of Occurrence*: <b>1/9/2018 to 1/10/2023</b>	Total Amount of Claim*: <b>\$2,250,000.00</b>
Do you have insurance covering this claim? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Place of Occurrence: <b>University of Nebraska Medical Center</b>
Insurance Deductible Amount:		
Name and Address of Insurance Company & Insurance Policy Number:		

Name, Address, and Phone Number of Attorney, if any:  
**Jefferson Downing, Keating O'Gara Law Firm, P.O. Box 82248, Lincoln, NE 68501-2248  
 (402) 475-8230, jd@keatinglaw.com**

In the below space, please provide a detailed itemization of all known facts/circumstances/damages leading to your claim. Identify all property, places, and people involved. Include names, addresses, and phone numbers of witnesses, if any. The information provided below, along with the findings of the investigating agency, will form the basis of any decision.\*

Please see attached.

DocuSigned by:  
  
 Claimant Signature\*: 31AB942244B44A6...

Date\*: **9/13/2023**

	Under Penalties of law, I declare that I have examined this statement and that it is, to the best of my knowledge and belief, true, complete, and correct, and that I am duly authorized to sign this statement.	
Please include copies of any supporting documents that may be relevant to your claim including, but not limited to, Photos, Invoices, Receipts, Police Reports, Estimates, Medical Bills, Expense Reports, etc.		
<b>Make and keep copies of all documentation submitted as copies will not be provided.</b>		

Claim form and supporting documents can be emailed to: [as.riskmanagement@nebraska.gov](mailto:as.riskmanagement@nebraska.gov)  
 Or mailed to: Office of Risk Management, PO Box 94974, Lincoln, NE 68509-4974  
 Questions? Call the Office of Risk Management at (402) 471-2551



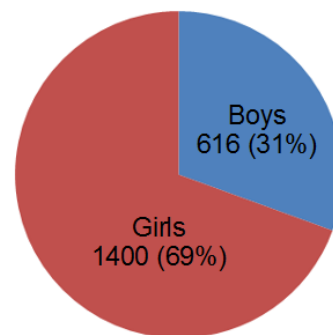
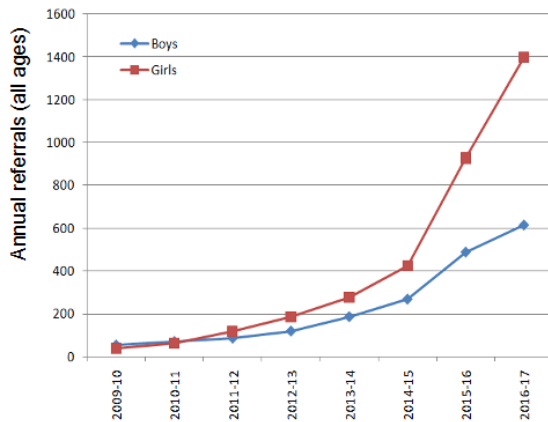
## TORT CLAIM OF LUKA HEIN

When Luka was just 16 years-old, her breasts were surgically amputated as the first step in her “gender care” at UNMC. This was not an act of medical care; it was an act of medical harm.

Luka brings this tort claim against the Board of Regents of the University of Nebraska, along with all affiliated providers and entities over which the Board has oversight including, but not limited to, UNMC Professors Dr. Jean Amoura and Dr. Perry Johnson, UNMC resident physician Dr. Stephan Barrientos, therapist Megan Smith-Sallans, the Nebraska Medical Center, Nebraska Medicine, and UNMC Physicians. Due to anonymous threats, Luka is proceeding under a pseudonym.

### INTRODUCTION

1. The rise in transgender identification over the last 10 years, especially among teen girls, is a well-documented social phenomenon. During the 2010’s, clinics across the West saw an explosion in girls who were suddenly gender dysphoric. England’s Tavistock clinic, discussed in more depth later, had a 4,000 percent rise in the number of gender dysphoric girls, from just a few cases in 2009-2010 to 1,400 in 2016-2017.



Annual referrals for 2016/17 (all ages)

(See Abigail Shrier, “Irreversible Damage: The Transgender Craze Seducing Our Daughters” (2020) and “Minister orders inquiry into 4,000 per cent rise in children wanting to change sex”

[https://www.telegraph.co.uk/politics/2018/09/16/minister-orders-inquiry-4000-per-cent-rise-children-wanting/.](https://www.telegraph.co.uk/politics/2018/09/16/minister-orders-inquiry-4000-per-cent-rise-children-wanting/))

2. Troubling cultural waves like this are not without precedent. In the 1970's, *anorexia nervosa* spread among young women in the West. Despite the reality of a body wasting away from starvation, the anorexic mind became disordered and saw an overweight body, even when it was down to skin and bones. Medical and mental health professionals recognized that anorexia usually had its roots in some form of trauma, sexual or otherwise, resulting in depression and a disordered body image. As the underlying psychopathologies were addressed through counseling, the anorexic regained a rightly ordered view of her body.

3. No one “affirmed” disordered eating. It would have been malpractice, not to mention the height of cruelty, for a counselor or medical provider to “affirm” a young woman’s anorexia and refer her to a weight loss clinic to starve. Yet, that is precisely what vast swaths of these medical and counseling professionals do by “affirming” trans-identifying teens toward harmful chemical and surgical procedures that permanently damage both body and brain. In so doing, these “professionals” are violating their primary ethical obligation to, “First, do no harm”.

4. The term “gender identity” was coined by Johns Hopkins psychologist John Money in 1957 as part of his novel theory that distinctions between men and women are mostly due to “nature, not nurture”. In 1965, a tragedy in Canada offered him a test subject when an identical twin boy’s anatomy was accidentally burned beyond recognition during circumcision. Money advised the distraught parents to raise the injured twin as a girl and the brother as a boy. In addition, he asked the parents to bring the twins to Johns Hopkins for annual assessments. In 1972, when the boys were 7 years-old, Money announced to great fanfare that their case confirmed his theory that, “Boys and girls are made, not born”. It was all a lie.

5. Throughout childhood the injured twin “Brenda” fought the false construct. He hated dressing femininely and enjoyed playing with his brother’s trucks more than dolls. When the twins were 14 years old, they learned the painful truth. “Brenda” was initially relieved to know that he was born male, but deeply resentful of Dr. Money and the failed experiment. He renamed himself “David” and revealed that he and his brother had been bullied and abused by Money during their visits to Johns Hopkins. After finding out they were human guinea pigs, the twins were devastated and never recovered. Brian, the non-injured twin, died by a drug overdose at age 36. David took his own life at age 38. (See John Colapinto, “As Nature Made Him: The Boy Who Was Raised as a Girl” (2000).)

6. Though exposed as a fraud, Money’s dangerous idea had taken root in the academy. From the time Money claimed sex was merely a social construct in 1957 until the 2010’s, the number of people who “identified” as the opposite sex was less than one percent of the population, and the majority were adult men. With the advent of addictive and highly influential forms of social media, the number of trans-identifying teens skyrocketed in the mid-2010’s. Inexplicably, the primary cohort shifted from boys and men to teenage girls.

7. Rather than explore the root causes of this profound shift, the mental health profession embraced it—and the medical establishment exploited it. So-called “transgender medical care”, particularly surgeries, are highly profitable. From being an almost non-existent source of revenue for most medical facilities in the 1990’s, transgender surgery now brings in \$1.9 billion per year in the U.S. alone. Over the next 5 years, that number will balloon to \$5.0 billion per annum. (See <https://www.grandviewresearch.com/industry-analysis/us-sex-reassignment-surgery-market>.)

8. From 1955 through the 1990’s, there were only two clinics in North America that offered transgender care. Unsurprisingly, the country’s first clinic was at Johns Hopkins.

Capitalizing on the rise in gender-confused teenage girls—and chasing profits—clinics offering some form of transgender “care” metastasized from 2 to more than 300 over the last decade and a half as depicted in this map:



## I. THE UNMC GENDER CLINIC: MAGICAL THINKING AND THE ROAD TO MEDICAL HELL

9. In the center of the map sits the University of Nebraska Medical Center (“UNMC”), Nebraska’s premier teaching and research hospital. UNMC is part of the University of Nebraska system governed by the Board of Regents, “a body corporate created by the people of Nebraska through the Constitution with power for general supervision over *all* elements of the University.” (See University of Nebraska Board of Regents Bylaws 1.2.) UNMC professors teach and train medical students as a part of their faculty responsibilities.

10. Two of UNMC’s self-proclaimed core values are “healing” and “accountability”. (See <https://www.unmc.edu/nursing/about/iteach-values.html>.) As discussed in detail below, UNMC failed in its mission to bring healing to Luka Hein when she went through a number of traumatic events that caused her to question her identity at age 15. This tort claim seeks to hold

UNMC “accountable” for the damage wrought on Luka’s mind and body over the course of 4 years of transgender “therapy”.

11. Sometime in 2017, UNMC faculty opened a “gender care” clinic on the premises of the Nebraska Medical Center in Omaha. The gender clinic’s website boasts that it provides care for “people of all ages” and has earned a “Top Performer” designation – not from an acclaimed medical society, but from the Human Rights Campaign, a lobbying group that advocates a transgender ideology known as “gender affirming” care. (See <https://www.nebraskamed.com/transgender-care>.)



Home / Gender Care Clinic

Providing care and support for people of all ages and genders in their transition.

The Human Rights Campaign, America's largest civil rights organization working to achieve equality for lesbian, gay, bisexual and trans\* (LGBT) folks, designated Nebraska Medicine as a Top Performer.

12. The clinic earned the Top Performer badge because UNMC faculty operate on the “gender affirming” model. This means that UNMC staff do not question a patient’s self-diagnosis of transgender identification, no matter their age or the root issues from which they suffer. Rather, UNMC faculty “affirm” the chosen gender identity of the patient and then undertake damaging pharmacological and surgical interventions based on what is known as the “Dutch Protocol”.

### **A. The Dutch Protocol: A Broken Model Leads to Broken Patients.**

13. Just as John Money’s conclusions were flawed, so is the study upon which the artifice of “affirming care” was constructed. The Dutch protocol was based on a poorly designed study of transgender patients who received puberty blockers, cross-sex hormones and/or surgery in the early 2000’s. The first obvious weakness of the study is that there was no control group. The second flaw was the “cherry picking” of subjects: beginning with 111 adolescents, researchers excluded those whose treatment with puberty-blockers “did not progress well”. Thus, the data set excluded precisely those patients who were harmed by or dissatisfied with their treatment. Thirdly, due to poor follow-up the study ended with an even smaller sample of 55 patients. Of these, only forty completed the study. (See “The evidence to support medicalized gender transitions in adolescents is worryingly weak”, The Economist, April 5, 2023 <https://www.economist.com/briefing/2023/04/05/the-evidence-to-support-medicalised-gender-transitions-in-adolescents-is-worryingly-weak>.)

14. The authors also excluded one male subject for whom treatment proved fatal. Due to puberty blockers, the patient’s penis was too small for “vaginoplasty”, so a portion of his intestine was harvested to fashion a faux vagina. When it subsequently became infected (an all-too common complication of “vaginoplasty”), the patient died from necrotizing fasciitis. With only 22 boys in the final analysis, the death would have revealed a fatality rate of 4.5% for male subjects. In any other context, this would have demonstrated that the protocol was a complete failure. Since the death cut against the authors’ affirming narrative, that patient’s experience was simply excluded from the study. He had to be buried—literally and figuratively. (See Michael Biggs (2023) “The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence”, Journal of

Sex & Marital Therapy, 49:4, 348-368, DOI: [10.1080/ 0092623X.2022.2121238](https://doi.org/10.1080/0092623X.2022.2121238) and Abigail Favale, “The Genesis of Gender”, at 183-184 (2022).)

15. On top of it all, Dutch investigative journalists reported that the studies were funded by Ferring Pharmaceuticals, the manufacturer of the puberty blocking drug who stood to profit from the study’s false, if favorable, conclusions. (See “Trans Care Must Also Meet Medical-Scientific Standards” (Dec. 22, 2022) <https://www.nrc.nl/nieuws/2022/12/30/ook-transzorg-moet-aan-medisch-wetenschappelijke-standaarden-voldoen-a4152945>.)

16. With these myriad deficiencies, outside reviewers concluded that the Dutch study was “very low quality”, a term of art in the world of academic literature. Based on the well-developed GRADE certainty rating system, “very low quality” is the worst possible ranking for a study and means, “The true effect is probably markedly different from the estimated effect.”

**Table 1. GRADE certainty ratings**

Certainty	What it means
Very low	The true effect is probably markedly different from the estimated effect
Low	The true effect might be markedly different from the estimated effect
Moderate	The authors believe that the true effect is probably close to the estimated effect
High	The authors have a lot of confidence that the true effect is similar to the estimated effect

(See <https://bestpractice.bmj.com/info/toolkit/learn-ebm/what-is-grade/>.) In other words, “very low” means the researchers are probably trying to pull the wool over your eyes.

17. Follow-up studies purporting to support gender affirming care have also ranked “very low” in the GRADE quality scale. In 2020, the National Institute for Health and Care Excellence (NICE), a British body which reviews the scientific underpinnings of medical treatments, looked at the case for puberty-blockers and cross-sex hormones. The Economist



reported: “The academic evidence it found was weak, discouraging and in some cases contradictory . . . For both classes of drug, NICE assessed the quality of the papers it analysed as ‘very low’, its poorest rating”. (See <https://www.economist.com/briefing/2023/04/05/the-evidence-to-support-medicalised-gender-transitions-in-adolescents-is-worryingly-weak>.)

18. “Replicability” means obtaining the same result when an experiment is repeated. It is foundational to medical research. Astonishingly, the results of the Dutch study have never been replicated. (See M. Grossman, “Lost in Trans-Nation”, p. 83.)

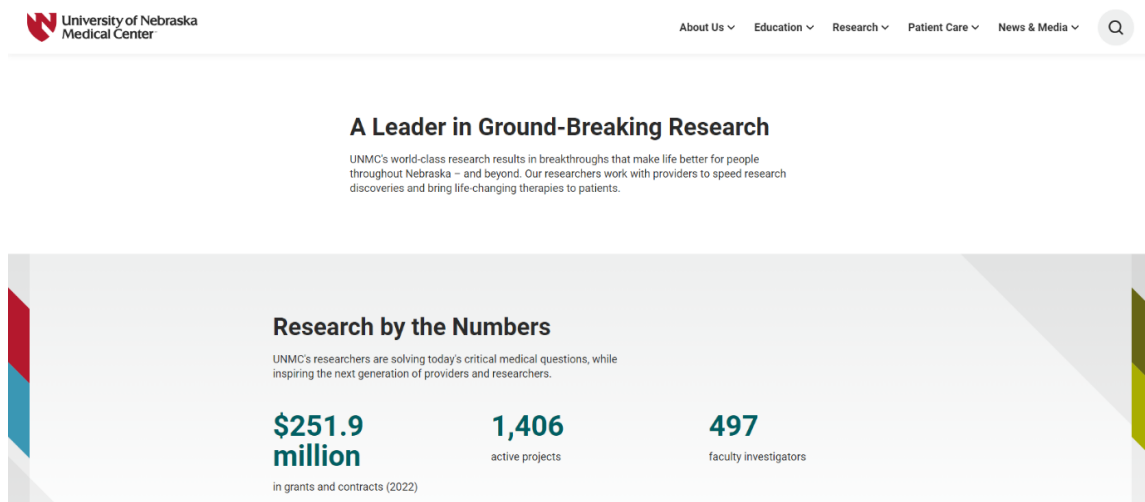
19. The Ferring-funded, “very low-quality” Dutch studies should have never been used as justification to scale up the protocol for widespread use. But like a virus that escapes the lab, the Dutch protocol spread like a contagion. “Runaway diffusion” is a phenomenon whereby innovative clinical practices are rushed to market without long-term, carefully controlled ethical research demonstrating that the benefits of the innovation outweigh the risks.

“Runaway diffusion” is exactly what has happened in pediatric gender medicine. “Affirmative treatment” with hormones and surgery rapidly entered general clinical practice worldwide, without the necessary rigorous clinical research to confirm the hypothesized robust and lasting psychological benefits of the practice. Nor was it ever demonstrated that the benefits were substantial enough to outweigh the burden of lifelong dependence on medical interventions, infertility and sterility, and various physical health risks.

(See E. Abbruzzese, Stephen B. Levine & Julia W. Mason (2023) “The Myth of Reliable Research in Pediatric Gender Medicine”, *Journal of Sex & Marital Therapy*, 49:6, 673-699, DOI: [10.1080/0092623X.2022.2150346](https://doi.org/10.1080/0092623X.2022.2150346) .)

20. UNMC, “a leader in ground-breaking research”, either failed to perform basic due diligence before adopting the Dutch protocol or looked at the “very low quality” study and embraced it anyway. Either way, UNMC is culpable. Like lemmings to the cliff, UNMC followed

the gender-affirming herd rather than sound scientific methodology. As Nebraska’s premier medical university, and with millions of research dollars at hand, UNMC should have put patient safety first and independently researched the underpinnings of the Dutch study before subjecting Nebraska children to its flawed protocols.



(See <https://www.unmc.edu/research/>.)

21. The gender affirming model was a seismic shift from the time-tested standard of care for the proper methodology of medically diagnosing patients. It is axiomatic that an accurate diagnosis is the key to help, rather than harm. Without the right diagnosis, a physician cannot provide the right care.

22. “Gender affirming” care is an ideology that distorts not only language, but sound medical practice. UNMC faculty owe a duty of care to independently examine and assess patients utilizing objective tests to rule out potential causes of a patient’s distress before resorting to irreversible procedures like double mastectomy or hysterectomy. Medically, this standard practice is known as “differential diagnosis”.

23. By immediately “affirming” Luka’s new gender identity, UNMC faculty developed a type of transgender tunnel vision that blocked out the other factors that were the cause or causes

of Luka's distress. In the Tavistock review, world-renowned pediatrician Dr. Hillary Cass called this "diagnostic overshadowing". (See "The Cass Review: Independent review of gender identity services for children and young people: Interim report" <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf>.)

24. The "gender affirming" model jettisons differential diagnosis thereby removing the most important tool from a doctor's diagnostic arsenal: Truth. The truth is that most rapid onset gender dysphoric teens suffer co-morbidities which cloud their self-perception: depression, anxiety, trauma, autism, etc. The truth is that these conditions need to be addressed through compassionate mental health counseling (i.e., talk therapy), not irreversible surgery. The truth is that with watchful waiting, most rapid onset gender dysphoria resolves over time. (See M. Grossman, "Lost in Trans-Nation", pp. 86-87 (2023).)

25. UNMC hides these truths and obscures others. UNMC does not disclose to prospective patients the shaky academic foundation upon which "gender affirming care" rests. UNMC does not tell patients that the studies favoring "gender affirming" care are methodologically weak, ideologically slanted, and of poor academic quality. UNMC does not disclose studies showing that transgender surgery increases suicidality and psychiatric morbidity, or studies showing that most gender-questioning kids will not identify as the opposite sex by the time they are through adolescence. This is crucial information that Nebraskans need in order to make informed decisions. In failing to disclose this data, UNMC prevents patients and parents from giving a fully informed consent.

26. "Gender dysphoria" is a mental health, not a medical, disorder. The term itself comes from the "Diagnostic and Statistical Manual of *Mental Disorders*" (DSM-5), published by the American *Psychiatric* Association. (See <https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/symptoms-causes/syc-20475255>.) This begs the question why

irreversible surgical interventions are being used by UNMC to “treat” patients who present with a mental disorder. The last time an irreversible procedure was used to “treat” mental disorders was when doctors tapped holes into the brains of the mentally ill. The unfolding catastrophe of gender affirming care is so much worse, because children were not the primary targets of lobotomies.

27. UNMC may claim good intentions. But the road to medical hell is paved with such pretensions as studying the progression of untreated syphilis, easing the morning sickness of pregnant mothers with an untested drug, and “curing” the mentally ill by tapping ice picks into their brains. Demented doctors do not pay the price for these highways. That price is always paid by innocent victims like the Tuskegee sharecroppers, the thalidomide babies of Great Britain, and the mentally ill who moldered in psychiatric hospitals decades after the inventor of lobotomy won the Nobel Prize. UNMC’s claimed good intentions leave Luka Hein with a disfigured and dysregulated body, now trapped in her own kind of medical hell.

### **B. Affirming Care Converts Healthy Patients into Medically Dysregulated Shadows of Their Former Selves.**

28. The 2011 Dutch study found that 97% of the participants were attracted either to their own sex or to both sexes. A group of ten doctors who resigned from Tavistock became worried that, “By turning children into simulacra of the opposite sex, the clinic was, in effect, providing a new type of ‘conversion therapy’ for gay children.” (See <https://www.economist.com/briefing/2023/04/05/the-evidence-to-support-medicalised-gender-transitions-in-adolescents-is-worryingly-weak>.)

29. Ironically, proponents of affirming care at UNMC believe it is “conversion therapy” to simply tell gender questioning children that they were not born in the wrong body. The real conversion therapy—using scalpels and surgery—is the so-called affirming care model.

30. Claiming the power to trans-mutate the human body, UNMC faculty attempt actual conversion. Yet, instead of transforming from one sex to another, UNMC transforms healthy patients like Luka into scarred, sterile, medically dysregulated shadows of their former selves.

31. UNMC’s affirming care is more akin to medieval alchemy than modern medicine. In operating the gender clinic, UNMC has forsaken its medical mission for a magical one: incantations of pronouns, potions of steroids and hormones, and surgical sorcery to transmogrify women into faux men and vice versa.

**C. The Gender Affirming Model is a Conditioning Tool that Coaxes Vulnerable Patients to Medical Harm with Deceptive Euphemisms and False Promises.**

32. Rather than helping to resolve dysphoria, gender affirming care exacerbates it due to the neuroplasticity of the adolescent brain. Neuroplasticity is the brain’s capacity to continue growing and adapting in response to life experiences. “Plasticity is the capacity to be shaped, molded, or altered; neuroplasticity, then, is the ability for the brain to adapt or change over time, by creating new neurons and building new networks.” (See <https://www.psychologytoday.com/us/basics/neuroplasticity>.)

33. Through the reinforcing words and actions of their affirming care, UNMC faculty condition children toward transgenderism. As a verb, “condition” means “to adapt, modify, or mold so as to conform to an enviroing culture”. (See <https://www.merriam-webster.com/dictionary/condition>.) That is precisely what UNMC faculty do by encouraging social transition, chest binding, opposite sex pronouns, puberty blockers, cross-sex hormones, and surgery. These practices mold impressionable gender-questioning children to conform to a trans-enviroing culture. UNMC conditions vulnerable children into believing that they can be “born in the wrong body”. Insidiously, UNMC coaxes along (i.e., “affirms”) the illness—and then proffers the cure.

34. UNMC entices gender-distressed teen girls with pleasant sounding treatments like “masculinizing hormone therapy,” “gender affirming hormones,” and “gender affirming surgery for chest”. These upbeat terms purposefully mask the devastating nature of these so-called “therapies”.

35. Physicians owe a duty to use accurate terminology, not deceptive euphemisms. If any profession should be rooted in reality, it is medicine. If any medical institution in Nebraska should provide reality-based care, it is the University of Nebraska Medical Center. If any vulnerable population deserves clarity in terminology, it is gender dysphoric Nebraska children and their distraught parents.

36. The use of misleading descriptions, especially with minors, may be a deceptive trade practice. Under the “gender affirming” model, deceptive descriptions are the standing order of UNMC’s physicians.

37. With the power, prominence and 150-year history of Nebraska’s greatest university behind them, UNMC faculty hold themselves out as experts and lead prospective patients to believe that chemical and surgical procedures will medically “transition” them. Leading patients toward a false horizon is not compassionate or affirming; it is deceptive. (i.e., “tending or having power to cause someone to accept as true or valid what is false or invalid”; ([See https://www.merriam-webster.com/dictionary/deceptive](https://www.merriam-webster.com/dictionary/deceptive).)

38. When UNMC professors, cloaked in the institutional prestige of the University of Nebraska, hold themselves out as experts and make these misleading claims, they manipulate impressionable children and their parents into damaging experimental procedures. That is precisely what they did to Luka and her parents. UNMC should not be engaged in poorly studied, poorly understood experimental transgender therapies with Nebraska children as their guinea pigs.

#### **D. UNMC Treats Puberty as a Disease with Chemical Castration Drugs and Anabolic Steroids as the Cure.**

39. As it relates to young women (referenced on the UNMC gender care website as “bodies with ovaries”), “gender affirming hormones” refers to the use of testosterone in large doses to impair and disrupt the natural development of the female reproductive system.

40. Normally, physicians do not recommend—let alone prescribe—anabolic steroids for healthy children. Yet that is what UNMC faculty prescribe at the gender clinic. Testosterone is an androgenizing anabolic steroid. More troublingly, the use of testosterone on teen girls is off-label and has not been approved by the Food and Drug Administration.

41. Puberty is one of the most important periods of development for both body and mind. To chemically interfere with puberty is to risk the introduction of diseased bodily processes and damage to the still developing adolescent brain.

42. The lack of long-term studies on puberty blockers should be enough to halt their use by UNMC on gender-distressed teens. The sole animal study on puberty blockers shows that they damage the developing hippocampus and may have “permanent effects on other brain areas and/or aspects of cognitive function”, even after blockers are discontinued. The study showed that puberty blockers impair memory. In addition, blockers might impair rational decision-making by damaging other parts of the developing brain. (See “A reduction in long-term spatial memory persists after discontinuation of peripubertal GnRH agonist treatment in sheep”, *Psychoneuroendocrinology* (2017) <https://ncbi.nlm.nih.gov/pmc/articles/PMC5333793/>.)

43. One of those “other” areas is the prefrontal cortex, which governs executive functioning (thinking and planning) and is the last area of the brain to fully mature. By damaging the teenager’s thinking and planning processes, UNMC professors impair their young patient’s ability to fully understand and consent to the very transgender procedures they advocate. The

Tavistock scandal led researchers to conclude that impaired thinking caused by blockers is why teens who start on them almost always continue on to cross-sex hormones. Rather than “pausing” puberty to give teenagers time to think, puberty blockers appear to damage their ability to think but keep them on the transition conveyor belt. (See H. Barnes, “Time to Think: The Inside Story of the Collapse of Tavistock’s Gender Service for Children” (2023) and “Tavistock puberty blocker study published after nine years”, <https://www.bbc.com/news/uk-55282113>.)

44. Puberty blockers carry FDA “black box” warnings that discuss side effects such as brain swelling and vision loss. Other complications include delusions, loss of bone density (osteoporosis), lung disease, sexual dysfunction, genital atrophy, depression, and suicidal ideation.

45. UNMC claims that puberty blockers “pause” puberty. This is a lie. Puberty blockers are not a remote control for the human body: They are disease-inducing compounds that, until recently, were reserved for the chemical castration of sex offenders.

46. Whistleblowing Tavistock psychiatrist Dr. David Bell believes that halting puberty only makes it more frightening to the child: “The child will never want to come off the hormones and 98% do now stay on them. This could be a dangerous collusion on the part of the doctor. The body is not a video machine. You can’t just press a pause button.” (See <https://www.theguardian.com/society/2021/may/02/tavistock-trust-whistleblower-david-bell-transgender-children-gids>.)

47. “Masculinizing hormone therapy” is another misleading euphemism for the administration of testosterone to girls. Testosterone is anything but “therapeutic” for the developing female reproductive system (i.e., “medicinal or curative”, see <https://www.merriam-webster.com/dictionary/therapeutic>.)

48. Instead of curing a diseased condition, testosterone induces the breakdown of a teen girl’s reproductive organs through the loss of estrogen and glucose. The artificial increase of



testosterone causes the vaginal epithelium to become dry and hardened. In some cases, it becomes fused, inflamed, painful and prone to infection. (See Baldassarre, M., Giannone, F., Foschini, M. *et al.* “Effects of long-term high dose testosterone administration on vaginal epithelium structure and estrogen receptor- $\alpha$  and - $\beta$  expression of young women” *Int. J. Impot. Res.* **25**, 172–177 (2013). <https://doi.org/10.1038/ijir.2013.9>.)

49. Among other hazards, testosterone drug labels warn of serious cardiovascular and adverse psychiatric reactions, increased or decreased libido, headache, anxiety, depression, paresthesia, pulmonary embolism (blood clots in the lungs), and liver dysfunction. The label for certain formulations of testosterone state: “Prolonged use of high doses of androgens ... has been associated with development of hepatic adenomas [benign tumors], hepatocellular carcinoma [cancer], and peliosis hepatis [blood-filled cavities in the liver]”. These are all potentially “life-threatening complications.” (See <https://www.pfizermedicalinformation.com/enus/testosterone/adverse-reactions>.)

50. In normal circumstances, a girl’s testosterone should not be above 45 ng/dL but girls placed on testosterone by a gender clinic might have levels up to 700 ng/dL. As difficult as it is to believe, no studies exist which support the use of testosterone at these levels for adolescent girls. None. (See M. Grossman, “Lost in Trans-Nation”, p. 74 (2023).) Therefore, no studies support such “therapy”.

51. Testosterone is known to induce high blood pressure and heart disease in young women. Studies of transitioned females show a nearly five-fold increased risk of myocardial infarction. Other effects include irreversible changes to the vocal cords, development of an Adam’s apple, deepening of the voice, abnormal hair growth, and male pattern balding of the scalp. Additional risks include polycystic ovaries, atrophy of the lining of the uterus, and increased risks of ovarian and breast cancer. (See M. Grossman, “Lost in Trans-Nation”, pp. 74-77 (2023).)

52. With these documented perils, it would be more accurate to describe the use of testosterone in teen girls as “medically catastrophizing” rather than “masculinizing” hormone therapy. UNMC should be held to account for such deceptive terminology.

53. “Gender affirming surgery for chest” and “top surgery” are alluring euphemisms for the barbaric procedure of cutting healthy breasts from the chests of distressed teenage girls. Known in normal medical parlance as “double mastectomy”, this surgery was, until recently, reserved almost exclusively for the removal of cancerous or pre-cancerous tissue. Its side effects include permanent disfigurement, scarring, nerve damage, loss of feeling, loss of erogenous pleasure, and inability to breastfeed.

54. As discussed in more detail below, the chief of the UNMC plastic surgery department rendered his “professional opinion” that lopping the healthy breasts off a 16-year-old mentally distressed female patient permanently changed her sex designation from female to male. This is not medicine, it is magical thinking: the poisonous fruit of a dangerous ideology known as “gender affirming care”.

55. UNMC claims that hormone therapy and surgery merely modify “secondary sex characteristics”. This too is misleading euphemistic language. Every so-called “secondary” sex characteristic that UNMC impairs or amputates can no longer serve its irreplaceable primary function within the perfectly balanced ecosystem known as the human body.

## **II. CLAIMS OF LUKA HEIN FOR NEGLIGENCE AND LACK OF INFORMED CONSENT**

56. Acting with the approval of UNMC professor Dr. Jean Amoura, who oversaw Luka’s care at the gender clinic, UNMC professor of plastic surgery Dr. Perry Johnson surgically removed Luka’s breasts as the first step in her “gender care”. Proceeding straight to breast

amputation in a depressed, anxiety-ridden, gender-confused adolescent, who was incapable of understanding the lasting consequences of her decision, constitutes negligence.

**A. Luka's Mental Health Spiral and History of Psychiatric Care.**

57. In 2015, when Luka was 13 years old, her world was upended by divorce. Splitting time between two households, life became chaotic. She often felt like she was in the middle of it all and began to question who she was.

58. By 2016, Luka was struggling in school. She could not concentrate and lost motivation. Anxiety and panic attacks immobilized her. She lost her appetite, became easily angered, started cutting, and expressed suicidal ideation. She began counseling with a therapist and a psychiatrist who diagnosed depression and generalized anxiety disorder. Her psychiatrist put her on antipsychotic medication, but she continued to spiral downward.

59. In February 2017, Luka's mental health deteriorated further and she was hospitalized in a "partial care psychiatric program". She was again diagnosed with depression and generalized anxiety disorder.

60. Around this same time, Luka was groomed online and preyed upon by an older man from out of state who enticed her to send him sexually explicit pictures. When she refused to send more, he threatened her. She became terrified and law enforcement was notified. An upsetting and difficult investigation followed. The entire incident was traumatizing for Luka and her mental health declined further. Her psychiatrist returned Luka to the intensive partial care psychiatric program in May 2017. During her stay, her antipsychotic medication was increased, and an SSRI was added to her daily regimen.

61. Additional factors complicated Luka's fragile mental health. When she entered puberty, she hated menses and was extremely uncomfortable with her developing breasts.

Traumatized by the dangerous online encounter, Luka wondered whether it would be best to have no breasts at all. She started researching matters of sexuality online and found transgender influencers who extolled the virtues of hormones and surgery. She ordered a chest binder, transferred from an all-girls school, and changed her name. She began identifying as male, and advised her mental health providers and her parents that she was transgender. Based on what she found online, Luka believed “top surgery”, i.e., having her breasts surgically removed, would ease her mental distress.

**B. Luka Enters the Closed Feedback Loop of Her Affirming Therapist and the UNMC Gender Clinic.**

62. When she expressed an interest in surgery, Luka’s psychiatrist referred her to Megan Smith-Sallans, a mental health therapist in Omaha married to transgender activist Ryan Sallans. Ryan Sallans has worked closely with the UNMC faculty at the gender clinic and appears in numerous informational videos with Dr. Jean Amoura discussing, among other things, “pap smears for guys” and “affirming healthcare facilities for transgender patients”. (*See [https://www.youtube.com/watch?v=3mA93\\_8SScM&ab\\_channel=NebraskaMedicineNebraskaMedicalCenter](https://www.youtube.com/watch?v=3mA93_8SScM&ab_channel=NebraskaMedicineNebraskaMedicalCenter).*)

63. During the relevant timeframe, Megan Smith-Sallans worked with Dr. Amoura and the gender clinic as an “affirming” therapist. The tandem of Amoura and Smith-Sallans created a closed feedback system that manipulated patients to deeper—and more damaging—levels of transgender medical intervention. Smith-Sallans referred patients (including Luka) to Dr. Amoura for transgender care. In turn, Dr. Amoura referred patients (including Luka) back to Smith-Sallans for evaluation of whether they were “ready” for the next step in the transgender process. Thanks to this “affirming” feedback loop, UNMC was assured that vulnerable, gender-distressed patients stayed on the clinic’s transgender conveyor belt.

64. Megan Smith-Sallans views herself as an advocate for transgender teens in rural areas. She encourages them to connect online and have internet “sleepovers” in their pajamas. Apparently believing that she is liberating gender-confused teens from the slavery of their own biology, she has dubbed these connections “the underground railroad system”. (See <https://www.genderspectrum.org/stories/megans-story>.)

65. As of this writing, Dr. Amoura and Megan Smith-Sallans publish an online fillable form, ostensibly for 13-to-18-year-olds but accessible to any child with internet access. (See <https://www.nebraskamed.com/sites/default/files/documents/transgender/0Fillable%20PT20questionnaire%2013%2B.pdf>.)



***Dr. Jean Amoura / Megan Smith-Sallans, LIMHP***

***13 to 18 years Form***

**Please do your best to fill out the following information. Bring to your appointment and give to the medical personnel once in exam room (not the front desk at check in).**

The form encourages curious teens to select from a variety of transgender surgeries, with no warning to these vulnerable children of the profound risks, dangers, and permanent consequences inherent in the listed procedures.

Do you have a desire to have surgery in the future?       yes  no  
If yes, what kind of surgery are you interested in? (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Chest reconstruction (top surgery) | <input type="checkbox"/> Breast augmentation (implants)  |
| <input type="checkbox"/> Hysterectomy (removal of uterus)   | <input type="checkbox"/> Orchiectomy (removal of testes) |
| <input type="checkbox"/> Oophorectomy (removal of ovaries)  | <input type="checkbox"/> Vaginoplasty                    |
| <input type="checkbox"/> Metoidioplasty                     | <input type="checkbox"/> Tracheal shave                  |
| <input type="checkbox"/> Phalloplasty                       | <input type="checkbox"/> Facial feminization surgery     |

Other: \_\_\_\_\_

If there anything else you would like to disclose, please use the space below.

66. On July 18, 2017, Megan Smith-Sallans began meeting regularly with Luka. Just 55 minutes into their initial session, Megan Smith-Sallans diagnosed Luka with gender identity disorder and began steering her toward transgender medical treatment at UNMC.

67. In August 2017, Megan Smith-Sallans noted a plethora of “precipitating stressors” in Luka’s personal life: change in residence, change of school, divorce of parents, family conflict, parental discord, and gender dysphoria.

68. On August 23, 2017, Luka’s psychiatrist recorded that she refused to go to school, was feeling isolated, had worsening depression, felt no peer support, and had recently moved from her childhood home, as well as “transgender issues”. Her psychiatrist increased Luka’s medications, adding Xanax to her regimen, and readmitted her to the partial care psychiatric program for the third time in six months.

69. Luka was in the partial care program until September 7, 2017. The progress notes from the program are replete with references to family conflict, social isolation, anxiety, depression, and difficulty attending school. The treating therapists spent their time addressing “family relationships, strategies to decrease anxiety at home, and strategies to complete homework”. The partial care program psychiatrist prescribed ADHD medication and diagnosed Luka with: (1) severe recurrent major depression without psychotic features; (2) generalized anxiety disorder; and (3) attention deficit disorder without hyperactivity.

70. Though Luka’s primary issues in the partial care psychiatric program revolved around family turmoil and school difficulties, when she resumed meeting with Megan Smith-Sallans, the focus shifted back to gender identity issues.

71. On September 19, 2017, Megan Smith-Sallans “explored more of client’s gender history”, encouraged Luka to attend an LGBTQ support group, and discussed chest-binding. They

also discussed online activity where Luka “found more information about transgender people and began reading and listening to their stories.”

72. In October 2017, Megan Smith-Sallans recorded that Luka felt overwhelmed by the custody arrangements and ongoing family issues. She reported that Luka was lonely at her new school and had “anxiety around starting her period as well as chest dysphoria”. Rather than counsel Luka through these difficulties, Megan Smith-Sallans discussed referring her to the UNMC gender clinic.

### **C. Breaching the Standard of Care, UNMC Performed Irreversible Double Mastectomy as the First Step in Luka’s Gender Care.**

73. On her first visit to the gender clinic in January 2018, when she was just 15 years old, UNMC doctors put Luka on the fast track for breast removal surgery. On that initial visit, Luka met with UNMC professor of plastic surgery, Dr. Perry Johnson. Despite never having seen Luka before, Professor Johnson immediately diagnosed “gender identity disorder” and began planning for double mastectomy.

74. Tellingly, Dr. Johnson noted: “*Typically, we would wait until the patient is a little bit older, but this would be influenced by the potential negative impact psychologically on the patient by prolonging the transition.*” Nothing in Luka’s mental health or medical records indicated any “potential negative psychological impacts” of delaying the amputation of her breasts.

75. Knowing she was too young for surgery, Dr. Johnson crafted the initial medical entry to avoid responsibility for wielding the scalpel: “Ultimately, this would be a decision between Luka, his [sic] parents, and their therapist. *I would require a letter from the patient’s therapist regarding the appropriateness of the operation and the appropriateness of the timing of the procedure.* Again, those decisions are going to be made in what is Luka’s best interest as determined by Luka, his [sic] parents, and their therapist.”

76. After meeting with Dr. Johnson, Luka and her parents met with Dr. Jean Amoura. Dr. Amoura recorded in the official UNMC medical record that the reason for the appointment was an “endocrine disorder”. This was false. Luka’s endocrine system was functioning perfectly. The entry exposed Dr. Amoura’s ultimate plan to chemically induce an endocrine disorder in Luka’s otherwise healthy body.

77. From January to July 2018, Luka continued to meet with Megan Smith-Sallans who failed to explore with Luka how to become more comfortable with her developing body. Instead, she “affirmed” her toward a surgical solution at UNMC.

78. When Luka’s parents expressed hesitancy about breast removal surgery, it was implied that if they did not consent, Luka would take her own life. This was a manipulative tactic to get Luka’s parents on board with surgery. Luka had no suicidal ideation for almost one year prior to surgery. From September 2017 to July 2018, Megan Smith-Sallans recorded over and over again in her notes, “Suicide Risk: Not Evident”. Trusting that the UNMC faculty were experts in gender care, Luka’s parents consented to surgery.

79. On July 3, 2018, Luka was seen by Dr. Johnson for a preoperative evaluation for “transgender mastectomy”. In that note, he claimed to have documentation from Luka’s therapist attesting to the appropriateness of the operation for Luka “*even at this young age.*”

80. While Megan Smith-Sallans authored a letter dated June 25, 2018, it did not attest to the appropriateness of double mastectomy for Luka at the “young age” of 16. Megan Smith-Sallans merely stated what Dr. Johnson already knew: Luka had a desire for “top surgery”. The letter contained no recommendation for surgery and no statement that the planned surgery was in Luka’s best interest.

81. Rather than confirming that Luka was a good candidate for breast removal surgery, multiple red flags in Megan Smith-Sallans’s letter should have given Dr. Johnson pause: dysphoria



around puberty and chest development; online immersion into “transgender topics”; multiple partial hospitalizations for psychiatric care; transferring high schools; the fact that she had not first been tried on testosterone; psychiatric diagnoses of anxiety disorder and ADD; multiple psychotropic medications; and a traumatic history of sending nude photos to an adult man, as well as the ensuing police involvement and forensic interviews. This litany of psycho-social factors set forth in the letter should have caused a reasonably prudent plastic surgeon to refuse to perform a double mastectomy on his troubled teenage patient. Instead, Dr. Johnson read the letter as a green light.

82. Dr. Johnson did review the following risks of plastic surgery with Luka and her parents: “infection, bleeding, scarring, loss of the nipple-areolar skin grafts, the possibility of suboptimal aesthetic result.” Dr. Johnson failed to discuss the most consequential risk of double mastectomy at age 16: that Luka might regret the loss of her breasts when she was older and more mature in her thinking. Dr. Johnson also failed to advise Luka that historically most gender-questioning adolescents become comfortable in their bodies by the time they are through their teen years.

**D. UNMC Professor Dr. Perry Johnson Amputates Luka’s Breasts and Claims to Transform Her from Female to Male.**

83. On July 26, 2018, Dr. Johnson was training UNMC resident physician Dr. Stephan Barrientos in plastic surgery. On that date, Drs. Johnson and Barrientos surgically removed the healthy breasts of 16-year-old Luka Hein. After surgery, the pathology report showed no lesions, masses or nodules were identified. In other words, the pathology report confirmed that Drs. Johnson and Barrientos permanently removed the healthy breasts from a 16-year-old girl who, due to her age and confounding psycho-social situation, was incapable of consenting to this irreversible procedure.

84. Despite the biological reality that Luka was still female, Dr. Johnson claimed that surgically removing her breasts transformed Luka from female to male. In an affidavit contained in the official UNMC medical record, under penalty of perjury, he stated:

I have treated Luka O. [Hein] for the purpose of completing gender transition and a permanent sex designation change from female to male. This treatment included a bilateral mastectomy and male chest reconstruction, as well as post-operative care. The procedure irreversibly altered Luka O. [Hein]'s body by removing breast tissue, and in accord with the standards and guidelines of the World Professional Association Health, American Medical Association, American Psychiatric Association, American Psychological Association, and the American College of Obstetricians and Gynecologists. In my professional medical opinion and judgment, the sex designation change of Luka O. [Hein] has been permanently changed to male. Please contact me if you have questions or require additional information.

85. Dr. Johnson's rush to surgery was in direct violation of the then-existing American Society of Plastic Surgeons' recommendation that, due to their emotional maturity, girls should be "at least 18 years of age" for aesthetic breast surgery. (*See American Society of Plastic Surgeons, Policy Statement Breast Augmentation in Teenagers*, approved 2004, reaff'd 2015.) Although Luka was not seeking breast augmentation, the Society's recommendation applies with even more force to a mentally distressed teenage patient seeking breast elimination.

86. By rushing Luka to surgery without first placing her on testosterone for at least one year, UNMC faculty violated even the pro-transgender World Professional Association for Transgender Health ("WPATH") standard of care for breast removal surgery. (*See [https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7\\_English.pdf](https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf)*.)

**E. UNMC Recommends Hysterectomy and Places Luka on Testosterone, Causing Additional Damage to Her Over the Next 4 Years.**

87. On November 8, 2018, Luka was referred by Dr. Amoura to therapist Megan Smith-Sallans “for an evaluation regarding readiness for hormone therapy”. Predictably, Smith-Sallans “affirmed” Luka’s readiness for testosterone and referred Luka back to Dr. Amoura. Without fully explaining the long-term ramifications, Dr. Amoura placed Luka on testosterone for the next four years, putting Luka at risk for a multitude of damaging consequences and side effects.

88. In addition to branching out into the field of “transgender care”, Dr. Amoura is a professor of obstetrics and gynecology at UNMC. About a year after Luka was started on testosterone, Dr. Amoura matter-of-factly recommended that she surgically amputate Luka’s uterus in a partial hysterectomy – as the next step in “transition”. Normally, hysterectomy (partial or total) is reserved for women whose reproductive systems are so dysregulated that the benefits of surgery outweigh the considerable risks and consequences. Among other things, hysterectomy permanently sterilizes the patient and creates hormonal imbalances that require long-term medical follow up. Rather than healing Luka of a diseased condition, it was Professor Amoura’s plan to remove Luka’s healthy uterus, leaving her sterile and even more medically dysregulated.

89. Luka’s parents voiced tremendous concern about hysterectomy and immediately asked to meet with Dr. Amoura. As Luka sat outside the meeting at the medical center, she heard the discussion escalate. Heroically, her father put his foot down and thundered: “Lots of kids have mental health issues. That doesn’t mean we sterilize them!” Rejecting Dr. Amoura’s alarming recommendation, Luka’s parents refused to consent, so the hysterectomy was not performed.

90. However, Dr. Amoura continued Luka on testosterone, causing substantial damage to her mental and physical health. Naturally, Luka initially felt exhilaration when placed on the anabolic steroid known as testosterone. Eventually, she began to experience troubling symptoms.

After the prescribed four years, Luka quit taking testosterone due to heart irregularities, aching joints, and pelvic pain. By this time, she had deteriorated physically and mentally, so much so that on many days she could not function or even get out of bed.

91. On January 10, 2023, Luka announced to Dr. Amoura in a telehealth visit that she was no longer taking testosterone and was in pain all over her body. Luka also told Dr. Amoura that she no longer identified as male and was not old enough to have consented to the transgender treatments she received as a minor. Dr. Amoura casually replied: “I guess this is just part of your gender journey,” and recommended that Luka seek mental health counseling.

92. After irreversible surgery and a four-year cascade of testosterone, Dr. Amoura had no medical solutions for restoring Luka’s womanhood. Having broken her, Dr. Amoura had no idea how to fix her.

**F. UNMC’s Failure to Warn of Desistance, Adverse Mental Health Outcomes of Surgically Transitioned Patients, and the Dangers of Testosterone.**

93. UNMC faculty knew but failed to adequately disclose, discuss with, or warn Luka and her parents that most trans-identifying teens desist by the time they are through adolescence. “In children who express gender discordance, the majority will experience reintegration of gender identity with biological sex by the time of puberty *in the absence of directed medical or societal intervention*. This is supported by nearly a dozen published studies over the past forty years.” (See “Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria” <https://journals.sagepub.com/doi/10.1177/0024363919873762>.)

94. UNMC knew—but failed to disclose, discuss with, or warn Luka and her parents—that the mental health of transgender patients often worsens after surgery. In the only long-term follow-up study of transgender surgery, Swedish researchers followed a group of patients for 30 years (1973 to 2003). Long before UNMC professors began surgically mutilating gender-confused

teenagers, the troubling results of the Swedish study were published and should have been well-known by UNMC faculty operating the gender clinic. Researchers found: “*Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population.*” (See <https://pubmed.ncbi.nlm.nih.gov/21364939/>.) But, the Swedish study cut against UNMC’s narrative of “affirming” care, so it was not disclosed to Luka and her parents.

95. UNMC faculty knew—but failed to adequately disclose, discuss with, or warn Luka and her parents—of the health risks associated with long-term, high-dose testosterone use, including but not limited to: pulmonary embolism (blood clots in the lung), high blood pressure, high cholesterol, heart problems (including increased risk of myocardial infarction), permanent fertility loss, painful intercourse, impairment of orgasm, stunted widening and growth of the pelvic bones for reproductive purposes, increased risk of osteoporosis and debilitating spine and hip fractures as an adult, increased morbidity and death in older age due to increased risk of hip fracture, negative and unknown effects on brain development, emotional lability such as crying, irritability, impatience, anger, and aggression, and increased suicidal ideation.

96. By not providing Luka with information on the dangers of long-term use of testosterone, rates of desistance, and on the poor mental health outcomes related to transition surgeries, UNMC faculty failed to obtain a free and fully informed consent from Luka and her parents.

97. To imply to Luka’s parents that breast removal surgery was necessary to prevent Luka from taking her own life was undue duress and manipulated the consent process. Under the law, consent to a medical procedure must be both fully informed and freely given. In Luka’s case, it was neither. This unethical manipulation makes Luka’s parents victims of a dishonest process, every bit as much as Luka.

98. Regardless of the information UNMC provided to Luka, due to her age and confounding mental health issues, she was simply unable to consent to breast amputation and the damaging effects of long-term testosterone “therapy”.

99. After many years of “gender affirming” therapy, Finland, France, Norway and Sweden now support “talking therapy” (i.e., counseling) for gender dysphoric teens—and they discourage pharmacological and surgical interventions for rapid onset gender dysphoria. A 2020 Finnish review concluded that gender reassignment in children is “experimental” and treatment should seldom proceed beyond talking therapy. Swedish authorities found that the risks of physical interventions “currently outweigh the possible benefits” and should only be offered in “exceptional cases”. (See “The evidence to support medicalized gender transitions in adolescents is worryingly weak”, The Economist, April 5, 2023 <https://www.economist.com/briefing/2023/04/05/the-evidence-to-support-medicalised-gender-transitions-in-adolescents-is-worryingly-weak>.)

100. England recognized the inability of minors to fully understand the complexity and risks of transgender procedures. There, a British court recently ruled in favor of teenager Keira Bell, who had been rushed through transition at London’s notorious Tavistock Clinic. That court found: “There is no age-appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years.” (See <https://www.judiciary.uk/wpcontent/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>.) The same is true here in Nebraska. There is no age-appropriate way to explain to a distressed teenage girl what losing her fertility—or her breasts—may mean to her in later years. No way at all.

101. In the wake of the Tavistock scandal, England rolled back treatment for trans-identifying teens to protect them from doing something they might come to regret. The British National Health Service has now ordered Tavistock closed. Because UNMC has strayed far from

its educational mission, the Board of Regents should follow suit and shutter the UNMC gender clinic.

102. During the last legislative session, Nebraska lawmakers vigorously debated a law to protect gender-questioning minors from irreversible surgeries. Luka provided key testimony in



the committee hearing relaying what happened to her at the hands of UNMC faculty at the gender clinic. Despite her courage and personal testimony, a Nebraska senator argued against LB 574 on the floor of the legislature claiming the bill was unnecessary because transgender surgeries “never happen in Nebraska anyway.” In response, Luka tweeted: “HEY @NebraskaMegan I want you to

come say it to my face that this isn’t happening in Nebraska. Look me in the eyes and tell me this didn’t happen. I WAS 16.” (See <https://twitter.com/onedonebun/status/1630632784581541895>.)

On the strength of Luka’s and other witnesses’ testimony, Nebraska lawmakers overwhelmingly voted to pass LB 574.

## CONCLUSION

103. Dr. Jean Amoura and Dr. Perry Johnson are UNMC professors. At all times material herein, they engaged in the training of medical students and resident physicians (like Dr. Barrientos) as a part of their negligent care and failed “treatment” of Luka Hein. Because it wields “power for general supervision over *all* elements of the University,” the Board of Regents is

responsible for the negligence of the UNMC faculty. The Board of Regents failed in its primary supervisory mission over the University of Nebraska and is responsible for the damage done to Luka.

104. As a result of UNMC's negligence, Luka's breasts were surgically amputated leaving her physically and psychologically scarred. If she has not already suffered the loss of her fertility, Luka has permanently lost the ability to breastfeed thereby robbing her future children of the vast nutritional benefits of breastmilk, the irreplaceable bonding effect of nursing, as well as the profound post-partum benefits to Luka as a new mother. In the rush to surgery, none of these impacts were explained to Luka so she could not have understood, let alone consented to, these losses.

105. As a proximate result of the negligence of UNMC, Luka was on testosterone for 4 years increasing her risk of myocardial infarction, heart disease, anxiety, depression, paresthesia, pulmonary embolism, liver dysfunction, hepatic adenomas, hepatocellular carcinoma, peliosis hepatitis, high blood pressure, polycystic ovaries, atrophy of the lining of the uterus, loss of fertility, as well as ovarian and breast cancer.

106. Luka's body bears the permanent scars of the negligence of her "affirming" medical providers at UNMC. In addition, Luka suffers from an induced endocrine disorder, heart damage, pain in her vocal cords, joints, pelvic area, lumbar spine, hands, wrists, and elbows. Accordingly, she makes claim for the following damages:

- a. Physical pain and mental suffering, past and future;
- b. Medical expenses, past and future;
- c. Permanent impairment of her earning capacity;
- d. Inconvenience and loss of enjoyment of life; and
- e. Permanent scarring, injury and disability.



107. Having attained the age of 21 years in January 2023, Luka brings this claim for damages within the tolling protections set forth in Neb. Rev. Stat. § 25-213. Pursuant to Neb. Rev. Stat. § 44-2801, *et. seq.*, claimant makes demand for \$2,250,000, (the statutory maximum under the Nebraska Hospital-Medical Liability Act), reasonable attorneys' fees, and the costs of this action.