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## Deducting the Cost of Smoking Cessation Programs Under Internal Revenue Code Section 213

Erratum

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## Deducting the Cost of Smoking Cessation Programs Under Internal Revenue Code Section 213

Internal Revenue Code Section 213 allows individual taxpayers to deduct "amounts paid . . . for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."<sup>1</sup> The scope of this deduction has not proved susceptible to precise definition.<sup>2</sup> The relevant Treasury Regulations "confine" the deduction "strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness," and disqualify expenses that are "merely beneficial to [one's] general health."<sup>3</sup>

The courts and the Internal Revenue Service have relied on this distinction between combating a specific illness and promoting general health to differentiate deductible medical expenses from nondeductible personal expenses.<sup>4</sup> Both apply a two-part test to determine whether an expense qualifies for a section 213 deduction. The taxpayer must show (1) the existence or imminent probability of a disease or defect, and (2) that the expense related directly and proximately to the diagnosis, cure, mitigation, treatment or prevention of that disease or defect.<sup>5</sup>

The IRS does not currently permit a medical expense deduction for the costs of participation in a smoking cessation program ("SCP").<sup>6</sup> These programs offer a variety of treatments to enable smokers to end their dependence on cigarettes.<sup>7</sup> The Service does

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1. I.R.C. § 213(e)(1)(A) (1982). Regarding amounts paid for "the purpose of affecting any structure or function of the body," see *Mattes v. Commissioner*, 77 T.C. 650 (1981) (hair transplant operation constitutes medical care); Rev. Rul. 76-332, 1976-2 C.B. 81 (facelift constitutes medical care). The Code also allows a medical deduction for transportation costs incurred in connection with medical care, I.R.C. § 213(e)(1)(B) (1982), and for amounts paid for health insurance, I.R.C. § 213(e)(1)(C) (1982).

2. See, e.g., B. BITTKER & L. STONE, *FEDERAL INCOME TAXATION* 219-20 (5th ed. 1980) ("Obviously, the medical expense deduction, and its close relatives, is very difficult to administer and gives rise to results not easily reconcilable."). The problem results, in part, from the breadth of the statutory definition, which technically includes ordinary living expenses necessary to maintain one's health, such as rent and groceries. See Hodgkin, *If You Eat to Stay Healthy — Here's New Light on the Medical Deduction*, 30 TAXES 206 (1952).

3. Treas. Reg. § 1.213-1(e)(1)(ii) (1957).

4. See *Jacobs v. Commr.*, 62 T.C. 813, 818 (1974); *Stringham v. Commr.*, 12 T.C. 580, 584 (1949), *affd. per curiam*, 183 F.2d 579 (6th Cir. 1950); *Havey v. Commr.*, 12 T.C. 409, 412 (1949); Rev. Rul. 79-162, 1979-1 C.B. 116; Rev. Rul. 55-261, 1955-1 C.B. 307.

5. See note 4 *supra*.

6. See Rev. Rul. 79-162, 1979-1 C.B. 116; Ltr. Rul. 7906009 (Aug. 10, 1978); Ltr. Rul. 7601150610A (Jan. 15, 1976); Andrews, *Taxes*, N.Y. Times, June 5, 1979, § D, at 2, col. 1; Rankin, *Taxes*, N.Y. Times, Feb. 27, 1979, § D, at 2, col. 3.

7. See Schwartz, *Review and Evaluation of Methods of Smoking Cessation, 1969-77*, 94 PUB. HEALTH REP. 558 (1979).

not view tobacco addiction as a disease itself, nor does it view the cessation of smoking as preventing the onset of imminent, smoking-related diseases. Consequently, the Service concludes that the cost of such a program is a nondeductible, personal expense under I.R.C. § 262.<sup>8</sup>

This Note argues that enrollment fees for a smoking cessation program should be classified as deductible<sup>9</sup> medical expenses.<sup>10</sup> Part I defends this conclusion without questioning the accepted interpretation of section 213(e). Recent medical evidence indicates that the nicotine addiction that cessation program patients seek to break is itself a disease. And even prior to the onset of more serious health consequences, sustained cigarette smoking significantly impairs the functioning of the lungs and heart. Under this analysis, enrollment fees should be deductible as expenses for the treatment of an existing disease or defect, and as "amounts paid . . . for the purpose of af-

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8. I.R.C. § 262 (1982) provides: "Except as otherwise expressly provided in this chapter, no deductions shall be allowed for personal, living, or family expenses."

9. Throughout this Note, the term "deductible" refers to an expense that falls within the I.R.C. § 213(e) definition of medical care. Medical expenses, however, are deductible only to the extent they are "not compensated for by insurance or otherwise" and exceed three percent of a taxpayer's "adjusted gross income" as defined in I.R.C. § 62. A taxpayer may deduct one half the cost of health insurance, up to \$150. *See* I.R.C. § 213(a)(2) (1982). Additional amounts for insurance are included when calculating whether the taxpayer has exceeded the three percent threshold. *Treas. Reg. 1.213-1(e)(4)* (1982). Medicine and drug purchases up to 1% of adjusted gross income are not deductible. *See* I.R.C. § 213(a)(1) (1982). Amounts above one percent of adjusted gross income are included with other expenses when calculating whether the taxpayer has exceeded the three percent threshold. *See* I.R.C. § 213(b) (1982). As of January 1, 1983, medical expenses will be deductible under § 213(a) to the extent they exceed five percent of adjusted gross income. I.R.C. § 213(a)(2) (1982), which allowed a deduction of one half of medical insurance premiums, up to \$150, irrespective of the percentage of adjusted gross income limitation, has been repealed. Thus, these insurance premiums will be included in the deduction when expenses exceed the 5% threshold.

10. This Note attempts to determine only whether the allowance of a deduction for such fees is consistent with § 213. The larger issue of whether the entire medical deduction scheme is theoretically sound is beyond the scope of this Note, but has evoked considerable debate. *See Andrews, Personal Deductions or an Ideal Income Tax*, 86 HARV. L. REV. 309 (1972); *Kelman, Personal Deductions Revisited: Why They Fit Poorly in an "Ideal" Income Tax and Why They Fit Worse in a Far From Ideal World*, 31 STAN. L. REV. 831, 832-33 (1979). Professor Kelman views medical expenses as personal consumption; Professor Andrews perceives them as involuntary expenditures and thus justly excluded from personal income. Part of Professor Kelman's analysis identifies the pursuit of dangerous consumption, such as that of cigarettes, as deliberate gratification with adverse medical consequences. Part of Professor Andrews' analysis argues that the percentage threshold requirement subsumes any voluntary medical expenses. A general consensus maintains that the deduction is an inefficient and inequitable approach to subsidizing health care.

Congress adopted the medical deduction in 1942 to distribute more equitably the increased tax burden occasioned by World War II. *See* S. REP. NO. 1631, 77th Cong., 2d Sess. 6 (1942), reprinted in 1942-2 C.B. 504, 508; 88 CONG. REC. 8469 (1942) (remarks of Rep. Hinshaw). Its continued existence may signal a congressional purpose to encourage health care with an admittedly inferior type of subsidy, as a theoretically justified exclusion from income, as Professor Andrews argues, or simply an unwillingness to mandate the line drawing between the discretionary and nondiscretionary components of medical expenses, as Professor Kelman's analysis would demand. Allowing a deduction for smoking cessation programs, however, is consistent with all of these rationales. *See* notes 85-86 *supra* and accompanying text.

fecting any structure or function of the body." Part II reconsiders whether the language or logic of section 213 requires the demonstration of imminent probability of disease to justify deducting the cost of a preventive health measure. This Part argues that cessation program costs qualify as "amounts paid . . . for the prevention of disease" within the meaning of the Code, notwithstanding the delay between smoking and the onset of smoking-related diseases. Thus, the Note concludes that the cost of a smoking cessation program, whether viewed as treatment or prevention, should qualify for a medical expense deduction under I.R.C. § 213.

### I. PRESENT ILLNESS OR BODILY FUNCTION

A taxpayer who suffers from an existing disease or defect may deduct expenses for the diagnosis, treatment, mitigation, or cure of that disease or defect.<sup>11</sup> In an early medical deductions case,<sup>12</sup> the Tax Court announced the general rule that courts and the Internal Revenue Service continue to follow: "[a]bsent special circumstances of illness, accident, or physical or mental defects, . . . normal, personal, and parental" expenses are not deductible under section 213.<sup>13</sup>

The IRS has concluded that since smoking is not a disease, the cost of a smoking cessation program does not qualify as a deductible treatment expense. In a recent Revenue Ruling, the Service assumed that "participation in [a cessation program] was not for the purpose of curing any specific ailment or disease, but for the purpose of improving [the participant's] general health and sense of well-being."<sup>14</sup> Without considering whether habitual smoking is itself a disease, the Service simply noted the lack of a specific illness. Although the program had been prescribed by a doctor,<sup>15</sup> the Service concluded that the enrollment fees were not medical expenses under section 213.<sup>16</sup> Similarly, in two Letter Rulings<sup>17</sup> on smoking cessation programs, the IRS relied upon the lack of a specific illness in ruling their costs nondeductible.<sup>18</sup> The 1979 Ruling, citing studies conducted in

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11. See note 1 *supra*.

12. *Wendell v. Commr.*, 12 T.C. 161 (1949).

13. 12 T.C. at 163.

14. Rev. Rul. 79-162, 1979-1 C.B. 116.

15. Even if a program is run by doctors, a deduction may be denied. See *Wendell v. Commr.*, 12 T.C. 161, 163 (1949) (nurse's care expenses not deductible) ("The issue turns on the nature of the services rendered, not on the experience or qualifications or title of the person employed."); Rev. Rul. 63-91, 1963-1 C.B. 54; see note 52 *infra*.

16. Although there are no rulings on point, an SCP would presumably be deductible if the taxpayer shows that he presently suffers from a smoking-related disease.

17. Letter Rulings are issued by the Internal Revenue Service in response to taxpayers' requests for decisions with respect to past or contemplated transactions. See J. CHOMMIE, *FEDERAL INCOME TAXATION* 11 (1968). Although they indicate the Service's position on specific areas, they have no formal precedential value. See I.R.C. § 6110(j)(3) (1982).

18. See Ltr. Rul. 7906009 (Aug. 10, 1978); Ltr. Rul. 7601150610A (Jan. 15, 1976).

1975<sup>19</sup> and 1971,<sup>20</sup> stated that “[o]ur research indicates that medical authorities do not at this time recognize smoking itself as a disease.”<sup>21</sup> The Ruling denied the relevance of the stipulated fact that the taxpayer undertook the program for reasons which included mitigation of existing health defects, including a persistent “smoker’s cough.”<sup>22</sup> But the available medical evidence indicates that either the addictive or the bronchopulmonary consequences of smoking suffice to bring the costs of smoking cessation programs within the ambit of section 213.

#### A. *Nicotine Addiction as a Disease*

The Service’s conclusion that cigarette smoking is not itself a disease accords insufficient importance to the tobacco dependence which motivates smokers to seek professional help. Overwhelming clinical evidence supports characterizing smoking as a physical addiction, one that persists even though the addict knows it subjects him to serious risk of death. Both medical and legal authorities now recognize such a condition as a disease.

The very existence of professional programs to help people quit smoking suggests that the habit’s persistence results from more than mere social convention. Survey research documenting that most smokers have tried to quit and failed, and that a still larger majority expresses the desire to quit but believes that it is impossible, makes the characterization of smoking as an addiction difficult to avoid.<sup>23</sup> The nearly universal awareness of the adverse health consequences of continued tobacco use indicates the strength of this dependence.<sup>24</sup>

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19. U. S. DEPT. OF HEALTH, EDUCATION, & WELFARE, THE HEALTH CONSEQUENCES OF SMOKING: A REPORT OF THE SURGEON GENERAL (1975).

20. ROYAL COLLEGE OF PHYSICIANS OF LONDON, SMOKING AND HEALTH NOW: A NEW REPORT AND SUMMARY ON SMOKING AND ITS EFFECTS ON HEALTH (1971).

21. Ltr. Rul. 7906009 (Aug. 10, 1979).

22. *Id.*

23. See, e.g., *Antismoking Initiatives of the Department of Health, Education, and Welfare: Hearing on Secretary Califano’s Announcement of the Department of Health, Education, and Welfare’s New Antismoking Effort Before the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 95th Cong., 2d Sess. 320 (1978) [hereinafter cited as *1978 Hearings*] (statement of John Banzahf, Executive Director) (“For the great majority of Americans . . . smoking is hardly a voluntary act. The most recent HEW survey indicated that fully six out of every ten adult smokers has made one or more serious attempts to quit smoking, and that an additional three out of ten would like to quit if only it weren’t so difficult.”); Russell, *Nicotine Intake and Its Regulation*, 24 J. PSYCHOSOMATIC RESEARCH 253, 253-54 (1980) (70% of British smokers have tried to quit and failed).

24. See U.S. DEP’T. OF HEALTH, EDUCATION, & WELFARE, OFFICE ON SMOKING AND HEALTH, SMOKING AND HEALTH: A REPORT OF THE SURGEON GENERAL 1-34 (1979) [hereinafter cited as *SURGEON GENERAL’S REPORT*] (90% of teenage smokers are aware of the risks to health); *1978 Hearings*, *supra* note 23, at 320 (statement of John Banzahf) (“[I]n extreme cases people have been unable to quit even when smoking was causing their death. . . .”); Russell, *supra* note 23, at 253 (equating attempts to quit with knowledge of the risks to health); Schachter, *Pharmacological and Psychological Determinants of Smoking*, 88 ANNALS OF IN-

The clinical evidence now suffices to identify the pharmacological effect of nicotine as the primary, if not the sole, cause of the addiction.<sup>25</sup>

Physical dependence, by itself, does not amount to a disease. But behavior continued despite the desire to quit and potentially fatal consequences cannot reasonably be described as healthy. In the case of smoking, medical authorities now recognize such behavior as symptomatic of an independent illness. The 1980 edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders<sup>26</sup> (DSM-III) identifies, for the first time,<sup>27</sup> "Tobacco Dependence" as a substance use disorder.<sup>28</sup> The disorder's essential features are continuous tobacco use for one month coupled with one of three phenomena: (1) unsuccessful attempts to stop or significantly cut down on tobacco use, (2) development of Tobacco Withdrawal, or (3) the presence of a serious disorder, such as heart or lung disease, that the smoker knows will become aggravated by continued smoking.<sup>29</sup> By these criteria, even a heavy

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TERNAL MED. 104, 111 (1978) ("Certainly all smokers are aware of the dangers and expense of smoking.").

25. See SURGEON GENERAL'S REPORT, *supra* note 24, at 1-32 ("Nicotine, the most powerful pharmacological agent in cigarette smoke, has been proposed as the primary incentive in smoking and may be instrumental in the establishment of the smoking habit."); Kozlowski, *Applications of Some Physical Indicators of Cigarette Smoking*, 6 ADDICTIVE BEHAVIORS 213 (1981); Russell, *supra* note 23; Schachter, *supra* note 24. Schachter summarizes the clinical evidence as follows:

1. The psychological and probably the sensory gratifications of smoking are illusory. Serious smokers smoke to prevent withdrawal.
2. Smokers regulate nicotine intake.
3. Variations in smoking rate, which customarily have been interpreted in psychological terms, seem better understood as an attempt to regulate nicotine.
4. Apparent exceptions to a regulatory model of smoking seem understandable in terms of withdrawal. The smoker who fails to regulate suffers withdrawal.

Schachter, *supra* note 24, at 112. The clinical evidence, however, is not without inconsistencies. See SURGEON GENERAL'S REPORT, *supra* note 24, at 16-5 to 16-9. These inconsistencies may be explained either by a psychological component to the addiction to cigarettes, or by the willingness of individuals to suffer withdrawal symptoms rather than to smoke without inhibition in a clinical setting. Schachter adopts the latter interpretation, pointing to evidence of stress and discomfort on the part of the subjects of those experiments which did not show effective compensation (by deeper inhalation, smoking down to a shorter butt, etc.) of smokers given lower nicotine cigarettes. See Schachter, *supra* note 24, at 111. Whether the addiction is purely physiological or contains a significant psychological component is irrelevant for the purposes of tax law, which permits a medical deduction for mental as well as physical illness. See Treas. Reg. § 1.213-1(e)(1)(ii) (1957) (deduction confined to "prevention or alleviation of a physical or mental defect or illness").

26. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980) [hereinafter cited as DSM-III].

27. H. KAPLAN, A. FREEDMAN & B. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/III 1650 (3d ed. 1980).

28. DSM-III, *supra* note 26, at 176-78. *Accord*, H. KAPLAN, A. FRIEDMAN & B. SADOCK, *supra* note 27, at 1650.

29. Russell, *Cigarette Smoking: Natural History of a Dependence Disorder*, 44 BRIT. J. MED. PSYCHOLOGY 1, 1 (1971). See also Mirkin, *Nicotine Addiction*, 13 FAMILY HEALTH 20 (1981).

smoker who does not suffer from a serious physical illness related to tobacco use, and who has never tried to quit or reduce his smoking, does not suffer from the disorder even though "physiologically the individual is almost certainly dependent on tobacco."<sup>30</sup> But an individual who desires to quit and cannot, or who can do so only at the cost of withdrawal symptoms, need not suffer from an independent smoking-related disease to be diagnosed as afflicted with the disorder.

Both the Surgeon General and the American Psychiatric Association ("APA") also classify tobacco withdrawal as an independent disease. The Surgeon General concluded that "withdrawal from tobacco does produce a variety of signs and symptoms which can be characterized as a *tobacco withdrawal syndrome*."<sup>31</sup> The APA identifies "Tobacco Withdrawal" as an organic mental disorder.<sup>32</sup> Clinical studies on the effects of nicotine suggest that the typical symptoms result from physical rather than psychosomatic sources.<sup>33</sup> And the classification of withdrawal from nicotine as a distinct disease will come as small surprise to those who have had contact with individuals attempting to give up cigarettes.

30. DSM-III, *supra* note 26, at 177. Nevertheless a majority of smokers probably have this disorder. See H. KAPLAN, A. FREEDMAN & B. SADOCK, *supra* note 27, at 1649 (the large percentage of smokers who have tried or would like to quit indicates the widespread prevalence of the disorder). *Accord*, Russell, *The Smoking Habit and Its Classification*, 212 THE PRACTITIONER 791 (1974). Only two percent of smokers smoke occasionally or intermittently. *Id.* at 791.

31. SURGEON GENERAL'S REPORT, *supra* note 24, at 15-25 (emphasis in original). See E. BRECHER, LICIT AND ILLICIT DRUGS 225-28 (1972); Russell, *supra* note 29, at 4.

The Surgeon General, in a recent report, stressed the need for measures "[t]o increase the number of smokers who quit," and advocated implementation of an "income tax deduction policy for the cost of smoking cessation programs." U.S. DEPT. OF HEALTH & HUM. SERVICES, PROMOTING HEALTH/PREVENTING DISEASE: OBJECTIVES FOR THE NATION 117, 121 (1980).

32. DSM-III, *supra* note 26, at 159-60. The Manual states that [T]he essential characteristic is a withdrawal syndrome due to recent cessation of or reduction in tobacco use . . . . The syndrome includes craving for tobacco, irritability, anxiety, difficulty concentrating, restlessness, headache, drowsiness, and gastrointestinal disturbances. It is assumed that this syndrome is caused by nicotine since nicotine is the major pharmacologically active ingredient in tobacco. *Accord*, H. KAPLAN, A. FREEDMAN, & B. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/III 1650 (3d ed. 1980). Dr. G. Burton Friden discusses nicotine addiction and medical deductions for the cost of participating in smoking cessation programs in a letter published in the *Journal of the American Medical Association*.

Nicotine has been shown responsible for the strong addictiveness of cigarette smoking. Chronic users experience physical withdrawal syndromes of relatively short duration (three to four days), generally followed by prolonged periods of recurrent craving that may last for years. . . .

Nevertheless, a recent Internal Revenue Service ruling disallowed medical expense deduction of those costs incurred by a person's enrollment at a smoking treatment center (on the advice of his physician). . . . Perhaps the contribution of medical opinion will support reversal of this ruling.

Friden, *Nicotine Addiction*, 242 J.A.M.A. 1361, 1361-62 (1979) (footnotes omitted).

33. See note 25 *supra*.



Neither tobacco dependence nor tobacco withdrawal characterizes every smoker, but both almost invariably apply to those who enroll in smoking cessation programs. Such smokers plainly attempt to quit, but are unsuccessful absent professional help. The decision to participate in a cessation program "exhibit[s] concern about an inability to stop smoking [thus satisfying] the criteria for a disorder."<sup>34</sup> The American Psychiatric Association diagnoses tobacco dependence when "the individual is seeking professional help to stop smoking."<sup>35</sup> The programs, moreover, assist their participants in coping with tobacco withdrawal, whose ill effects almost certainly afflict smokers who enroll in SCP's befall those who seek medical care to mitigate them. Whatever the label, it is not unreasonable to classify the inability to break a dangerous physical addiction as a disease.

The law has long allowed medical deductions for the costs of treating less adamant and less dangerous addictions. The Service permits a deduction for the cost of treatment programs intended to cure alcoholism or drug abuse.<sup>36</sup> Nicotine addiction resembles these diseases, because it involves a pharmacologically-induced physical dependence.<sup>37</sup> Nicotine addiction differs from alcohol and drug abuse, however, in the strength of the dependence and the physical dangers which attend it. Neither alcohol nor even heroin exerts a more powerful addictive effect than nicotine.<sup>38</sup> Neither imposes so

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34. TASK FORCE ON NOMENCLATURE AND STATISTICS OF THE AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS III B:21 (draft 1978).

35. DSM-III, *supra* note 26, at 176. The APA also diagnoses tobacco dependence when, "in the judgment of the diagnostician, the use of tobacco is seriously affecting the individual's physical health." *Id.*

36. Rev. Rul. 73-325, 1972-2 C.B. 75; Rev. Rul. 72-226, 1972-1 C.B. 96 (citing *Linder v. United States*, 268 U.S. 5, 18 (1925)) (persons addicted to narcotics "are diseased and proper subjects for [medical] treatment.").

37. See E. BRECHER, *supra* note 31, at 207; Harrup, Hansen & Soghikian, *Clinical Methods in Smoking Cessation: Description and Evaluation of a Stop Smoking Clinic*, 69 AM. J. PUB. HEALTH 1226, 1230 (1979); *Less Tar, Less Nicotine: Is That Good?*, 1976 CONSUMER REP. 274, 274; Russell, *The Smoking Habit and Its Classification*, 212 PRACTITIONER 791, 791 (1974); Russell, *supra* note 29, at 3.

38. See Russell, *supra* note 29, at 3:

*It is far easier to become dependent on cigarettes than alcohol or barbituates. Most users of alcohol or sleeping tablets are able to limit themselves to intermittent use and to tolerate periods free of the chemical effect. If dependence occurs it is usually in a setting of psychological or social difficulty. Not so with cigarettes; intermittent or occasional smoking is a rarity — about 2 percent of smokers. [Citation omitted.] If he smokes at all, the most stable well adjusted person sooner or later becomes a regular dependent user (or misuser) — in other words, he is hooked.*

(Emphasis added.)

The experience of American servicemen returning from Southeast Asia offers an illuminating contrast. In one study of 500 servicemen who had positive urine tests before they left Vietnam, 96% of whom admitted experimenting with heroin, only 7% of the cohort were addicted to any kind of narcotics one year later, according to follow-up interviews and urine tests. STRATEGY COUNCIL ON DRUG ABUSE, FEDERAL STRATEGY FOR DRUG ABUSE AND

high a risk of death.<sup>39</sup> Given that the relevant distinctions strengthen the argument for deeming nicotine addiction a disease, these rulings add to the difficulties of justifying the Service's current approach to smoking cessation programs. In light of both medical and legal authorities, then, the cost of smoking cessation programs should be deductible as an expense undertaken for the treatment of an existing illness.

B. *Smoking Cessation and the Purpose To Affect a Function or Structure of the Body*

The Code provides that "medical care" expenses include amounts paid "for the purpose of affecting any structure or function of the body."<sup>40</sup> The Treasury Regulations interpret these words to mean that "[a]mounts paid for operations or treatments affecting any portion of the body" are deductible.<sup>41</sup> The taxpayers who requested the 1978 Letter Ruling suffered from recurring coughing; their physician advised them that quitting smoking would improve this condition.<sup>42</sup> The Service did not find this fact dispositive, because "not every expenditure prescribed by a physician is to be catalogued" as medical care.<sup>43</sup> This analysis does not consider the possibility of classifying smoking cessation programs as "treatment" for the purpose of affecting certain structures and functions of the body.

Smoking adversely affects several "structures and functions of the body." Nicotine exerts physiological effects on heart rate, metabolism, and (as would be expected from its addictive influence) on the

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DRUG TRAFFIC PREVENTION 1973 at 11-12 (1973). See also E. BRECHER, *supra* note 31, at 216 (quoting a personal communication of Vincent P. Dole: "Cigarette smoking is a true addiction. The confirmed smoker acts under a compulsion which is quite comparable to that of the heroin user"); *id.* at 217 (quoting a former heroin addict: "It was much easier to quit heroin than cigarettes").

39. Russell, *supra* note 23, at 253 (noting that cigarette smoking is the most dangerous habit which would be studied at a conference on addictive behavior, and citing a Royal College of Physicians estimate that "one in three cigarette smokers die as a result of smoking"). The available statistics reinforce this somewhat striking conclusion. There are about 54.1 million regular smokers in the United States. SURGEON GENERAL'S REPORT, *supra* note 24, at A-11. The government attributes 320,000 annual deaths to smoking, *see* note 70 *infra*, or an annual per capita mortality rate of 1 in 167. By contrast, government estimates for 1973 placed the number of heroin addicts at 600,000, with 2,000 deaths attributable to heroin as the "direct cause." STRATEGY COUNCIL ON DRUG ABUSE, *supra* note 38, at 12-14. These numbers yield a per capita mortality rate of 1 in 300 — or about half that for cigarettes. Such statistics are of course imprecise, but the estimates of a government committed to an enforcement approach to the narcotics problem, if anything, are likely to underestimate the number of addicts and overestimate the number of deaths directly caused by heroin. In addition, these estimates attempt to account only for heroin addicts, and not the considerable number of irregular users. There are virtually no nicotine "chippers."

40. See note 1 *supra*.

41. Treas. Reg. § 1.213-1(e)(1)(ii) (1957).

42. Ltr. Rul. 7906009 (Aug. 10, 1978).

43. *Id.* (citing *Seymour v. Commr.*, 14 T.C. 1111 (1950)).

brain.<sup>44</sup> Smoking has a more pernicious effect upon the lungs. Cigarette smoke tends to constrict airways and blood vessels, and to impair the lungs' self-cleaning and immune systems.<sup>45</sup> These consequences play a significant role in the etiology of a variety of respiratory malfunctions, ranging from "smoker's cough" to fatal cases of emphysema.<sup>46</sup> More relevant to the present interpretation of section 213, these impacts on the structure and function of the heart, lungs, and brain occur immediately with every cigarette consumed.<sup>47</sup>

The expense of a smoking cessation program is undertaken for the purpose of affecting these bodily structures and functions. Participants hope to eliminate and reverse the deterioration of the structure of their lungs and the accompanying impairment of respiratory functions. They hope also to alter bodily functions by successfully abstaining from tobacco, thereby attenuating the addictive impact of nicotine upon the brain.

Such purposes are at least as medical as plastic surgery or hair transplants, whose costs are deductible as amounts paid for the purpose of affecting a structure or function of the body.<sup>48</sup> Those rulings pose a considerably greater risk of permitting abuse of the medical deduction than would inhere in any decision to allow a deduction for smoking cessation programs, especially given the availability of familiar limiting doctrines. Restricting deductions to expenses which do not yield nonmedical rewards, and to the amount minimally suffi-

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44. See, e.g., SURGEON GENERAL'S REPORT, *supra* note 24, at 15-16 to 15-19; sources cited in note 25 *supra*; Russell, *supra* note 23.

45. See, e.g., SURGEON GENERAL'S REPORT, *supra* note 24, at 14-76-77 (animal studies reveal pulmonary and cardiovascular damage to structure and functions of lungs, heart, and blood vessels); *Cigarette Smoking and Disease, 1976: Hearings on S. 2902 Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess. 534-37 (1976)* [hereinafter cited as *1976 Hearings*] (statement of Benjamin Byrd, Jr., M.D., President, American Cancer Society) ("A pack-a-day smoker inhales about a cup, eight ounces, of 'tar' or smoke condensate each year. This not only corrodes the extremely delicate lining of the lungs, but defeats the lungs' . . . attempts to expel the poison. . . . These poisons, deposited with every inhalation, combined with the attack on the lungs' defense mechanisms, are probably the reason why 99 percent of pack-a-day smokers have some emphysema . . ."); Cosio, Hale & Niewoehner, *Morphologic and Morphometric Effects of Prolonged Cigarette Smoking on the Small Airways*, 122 AM. REV. OF RESPIRATORY DISEASE 265 (1980) (smokers suffer greater structural damage to small airways than nonsmokers); Hale, Niewoehner & Cosio, *Morphologic Changes in the Muscular Pulmonary Arteries: Relationship to Cigarette Smoking, Airway Disease, and Emphysema*, 122 AM. REV. OF RESPIRATORY DISEASE 273 (1980) (smokers suffer structural damage to the pulmonary blood vessels).

46. See SURGEON GENERAL'S REPORT, *supra* note 24, at 6-23 to 6-32.

47. See Russell, *supra* note 23, at 254 (reporting that each inhalation delivers a nicotine stimulus to the brain); *1976 Hearings*, *supra* note 45, at 534-37 (Statement of Benjamin Byrd) (each inhalation delivers nicotine stimulus, and deposits damaging tar in the lungs: "Within seconds after a smoker inhales cigarette smoke, his blood pressure starts rising by ten to 20 points, his heart rate increases by 25 beats per minute, his skin temperature drops five or six degrees . . .").

48. *Mattes v. Commr.*, 77 T.C. 650 (1981) (hair transplant deductible); Rev. Rul. 76-332, 1976-2 C.B. 81 (facelift deductible).

cient to fulfill medical purposes, will effectively prevent abuse of section 213.<sup>49</sup> The apprehension of such abuse, in any event, does more to justify denying a future claim because the taxpayers would enjoy a medical deduction for a personal expense, or have claimed an extravagant amount, than it does to justify denying a legitimate deduction for fear that courts will prove unable to articulate the distinctions between deductions perceived as abusive and those seen as legitimate.

### C. *Direct Relation Between Medical Purpose and Expense*

The fact that cessation program participants suffer from a disease, however, does not suffice to render the programs' enrollment fees deductible medical expenses. The claimed deduction must also "directly and proximately" relate to diagnosing, curing, treating, or mitigating a specific illness.<sup>50</sup> Courts have not always agreed on the meaning of "direct and proximate." While early cases listed a set of factors to consider in determining whether the requisite relationship between expense and disease existed,<sup>51</sup> decisions have not consistently rested on any single factor or combination of factors.<sup>52</sup> Recent cases, in an effort to avoid confusion, have developed a modified "but for" test: A taxpayer must "prove *both* that the expenditures were an essential element of the treatment *and* that they would not have otherwise been incurred for nonmedical reasons."<sup>53</sup>

Payments for smoking cessation programs satisfy both requirements of the "but for" test. The participants accrue no significant

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49. The most obvious claim for a deduction similar to that defended here would involve the costs of exercise. The Service could defeat such a claim by relying on either analytical limitation. Nonmedical benefits motivate the taxpayer to exercise, and the typical therapeutic exercise regime — running — costs virtually nothing of itself.

50. See note 5 *supra* and accompanying text.

51. See *Havey v. Commr.*, 12 T.C. 409, 412 (1949), which suggests the following factors be considered in determining the existence of the requisite relationship: taxpayer's motive; whether there was a doctor's recommendation; whether the belief that the treatment would be efficacious was reasonable; temporal proximity to the onset of the disease as to make one the true occasion of the other.

52. For example, courts have denied deductions for treatments recommended by a physician, and allowed deductions for expenses incurred without such recommendation. Compare *France v. Commr.*, 40 T.C.M. (CCH) 508 (1980) (denying medical deductions for amounts taxpayer paid for dancing lessons, upon doctor's recommendations, for treatment of arthritis), and *Rabb v. Commr.*, 31 T.C.M. (CCH) 476 (1972) (denying medical deduction for amounts spent on shopping excursions recommended by taxpayer's psychiatrist), with *Rev. Rul. 76-332*, 1976-2 C.B. 81 (allowing deduction for the cost of facelift operation not recommended by physician).

53. *Jacobs v. Commr.*, 62 T.C. 813, 819 (1974) (emphasis in original). See *Estate of Marantz v. Commr.*, 39 T.C.M. (CCH) 516 (1979). In *Jacobs* the taxpayer claimed as a medical expense the legal expenses of his divorce, which his psychiatrist had recommended as necessary for treating the taxpayer's mental illness. The court held that these payments arising from the divorce proceeding were not amounts paid for medical care, because the court was convinced that the taxpayer would have made these expenditures even if he had not been ill.

nonmedical benefits. But for the addiction to cigarettes and the resulting risk of contracting smoking-related diseases,<sup>54</sup> no significant reason exists to pay the price, in dollars and in effort, of professionally assisted abstinence from tobacco.<sup>55</sup> While significant nonmedical incentives may make incurring the costs of a vacation,<sup>56</sup> a vacuum cleaner,<sup>57</sup> dancing lessons,<sup>58</sup> or a health spa<sup>59</sup> more attractive, smoking cessation programs are "wholly medical in nature and [serve] no other legitimate function in everyday life."<sup>60</sup>

Nor should any doubt exist about the connection between smoking cessation programs and the health consequences which motivate their participants. The programs offer essential treatment for curing, or at least mitigating,<sup>61</sup> tobacco dependence for those unable to quit

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54. See notes 104-09 *infra* and accompanying text.

55. It is, of course, possible that a few individuals will attend for other reasons. For example, *A*, who has never smoked, may attend only because his friend *B*, a heavy smoker, has asked him to come along to the sessions. Given enrollment fees of \$250 or more, such instances are likely to be rare. See Schwartz, *Review and Evaluation of Methods of Smoking Cessation, 1969-77*, 94 PUB. HEALTH REP. 558, 560 (1979).

56. See *Havey v. Commr.*, 12 T.C. 409 (1949). In *Havey* the taxpayer claimed a medical expense deduction on his 1945 income tax return which included the cost of room and board at two New Jersey hotels and a ranch in Arizona. In 1943 the taxpayer's wife suffered a coronary occlusion and had been critically ill. A doctor had advised the taxpayer to take his wife to the seashore during the humid summer months and to Arizona during the winters. The Tax Court denied the deduction, noting that the Haveys had vacationed at the Arizona ranch before the wife had become ill in 1943, and that the expense came two years after the wife's coronary occlusion. The court declared: "We do not question the fact that the trips may have been beneficial to petitioner's wife. . . . The record fails to show, however, that the benefit derived by the wife was in any respect different from that enjoyed by any vacationer at the same resorts at the same time." See also *Tautolo v. Commr.*, 34 T.C.M. (CCH) 1198 (1975) (expense of trips to Samoa for healing of paralysis held not deductible); *Foyer v. Commissioner*, 19 T.C.M. (CCH) 1370 (1960) (trips to Arizona and Hawaii for alleviation of respiratory ailments not deductible); *Dobkin v. Commr.*, 15 T.C. 886 (1950) (annual Florida trip, advised by physician, several years after coronary occlusion not deductible). But see Rev. Rul. 58-110, 1958-1 C.B. 155 (transportation costs for taxpayer and nurse to a specified location predetermined by physician for sole purpose of alleviating chronic respiratory ailment deductible); Rev. Rul. 55-261, 1956-1 C.B. 307 (cost of trip to Florida solely for benefit of taxpayer's postoperative throat and lung condition deductible).

57. See Rev. Rul. 76-80, 1976-1 C.B. 71.

58. See *France v. Commr.*, 40 T.C.M. (CCH) 508 (1980).

59. See Rev. Rul. 55-261, 1955-1 C.B. 307, 310.

60. *Stringham v. Commr.*, 12 T.C. 580, 584 (1949), *affid. per curiam*, 183 F.2d 579 (6th Cir. 1950).

61. Success rates for SCPs vary widely. Generally, success rates at the end of the program are quite high, approximately 80%. After one year, the success rates are approximately 35-40%. See SURGEON GENERAL'S REPORT, *supra* note 24, at 21-14 to 21-15; Evans & Lane, *Long-Term Outcome of Smoking Cessation Workshops*, 70 AM. J. PUB. HEALTH 725 (1980); Harrup, Hansen & Soghikian, *Clinical Methods in Smoking Cessation: Description and Evaluation of a Stop Smoking Clinic*, 69 AM. J. PUB. HEALTH 1226 (1979); Schwartz, *Review and Evaluation of Methods of Smoking Cessation, 1969-77*, 94 PUB. HEALTH REP. 558 (1979).

Whether an individual smoker is cured of his addiction by an SCP is not dispositive. What matters for deductibility is that a person undertake the expense with a reasonable belief that the treatment can be successful. Cf. *Tautolo v. Commissioner*, 34 T.C.M. (CCH) 1198 (1975) (denying a medical deduction for the cost of travel to Samoa for treatment by native Samoan doctors). The court found that the taxpayer could not have held a reasonable belief that the

without professional help. Facilitating the cessation of smoking addresses nicotine addiction as directly as medical science currently permits. Similarly, the impact of cessation on the structure and functioning of the lungs and brain follows directly from eliminating the intake of cigarette smoke.

## II. PREVENTION

I.R.C. Section 213 and Treasury Regulation 1.213-1(e)(1)(i) include "prevention of disease" within the meaning of medical care.<sup>62</sup> Neither the Code nor the Regulations, however, defines prevention. Therefore, distinguishing between deductible medical expenditures incurred "primarily for the prevention . . . of a physical or mental defect or illness"<sup>63</sup> and those nondeductible, personal expenses that are "merely beneficial to [one's] general health"<sup>64</sup> has remained within the purview of judicial interpretation.

In *Stringham v. Commissioner*,<sup>65</sup> the Tax Court looked to congressional intent as embodied in the Code, the Regulations, and Senate Reports and interpreted the medical expense deduction provisions. Although the case involved treatment of an existing ailment,<sup>66</sup> the court, in dicta, declared that "Congressional intent is sufficiently evident to require the showing of . . . the imminent probability of a disease, physical or mental defect, or illness as the initial step in qualifying an expenditure as a medical expense."<sup>67</sup> The Court then reiterated the condition announced in the Regulations that "a deduction may be claimed only for such expenses incurred primarily for the prevention . . . of [a] particular physical or mental defect or illness."<sup>68</sup>

Later cases and IRS rulings have generally followed the *Stringham* court's conclusion that a taxpayer must show the imminent probability of a specific disease or defect before a preventive

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treatment, consisting of prayers and massages with plant leaves, would be effective for his wife's stroke. 34 T.C.M. (CCH) at 1200. For criticism of this requirement, see Note, *Defining "Medical Care": The Key to Proper Application of the Medical Expense Deduction*, 1977 DUKE L.J. 909, 924-32.

62. See I.R.C. § 213(e)(1)(A) (1982); Treas. Reg. § 1.213-1(e)(1)(i) (1957).

63. See Treas. Reg. § 1.213-1(e)(1)(ii) (1957).

64. *Id.*

65. 12 T.C. 580 (1949), *affd. per curiam*, 183 F.2d 579 (6th Cir. 1950).

66. The court held that expenses incurred in connection with the transportation to, and maintenance of, the taxpayer's daughter at a boarding school in Arizona, exclusive of expenses attributable to her education were deductible. The court noted the existence of the child's chronic respiratory ailments that could be ameliorated by the favorable Arizona climate, and declared that the taxpayer's only purpose in sending his daughter to Arizona was to make it "possible for her to recover from her then present illness." 12 T.C. at 585.

67. 12 T.C. at 584.

68. 12 T.C. at 584; see note 63 *supra* and accompanying text.

health measure may qualify for a deduction.<sup>69</sup> Because smoking does not present a smoker with an imminent probability of disease, the IRS has denied medical deductions for smoking cessation programs, even though such programs address the most preventable cause of death and disease in the United States.<sup>70</sup>

Further analysis of the language and legislative history of the medical deduction, however, reveals that the courts and the IRS have unwisely relied on the *Stringham* dicta which read an imminence requirement into the statutory meaning of "prevention." Part A reconsiders the current construction of section 213, and concludes that the section's language, regulations and legislative history do not require, and may forbid, the imposition of an imminence prerequisite to a medical deduction. Part B reformulates the two-part test articulated in *Stringham*, emphasizing the causal relationship of the expense to the prevention of the feared disease, without requiring temporal proximity of the threatened illness. The reformulated test is then evaluated to determine if the absence of an imminence requirement unduly broadens the definition of prevention. Part C applies the reformulated test to smoking cessation programs, and concludes they should qualify as deductible preventive medical expenditures.

#### A. Statutory Construction

This Note advances two objections to the current interpretation of section 213, which requires that an expense be incurred shortly before the threatened onset of a specific disease to qualify for the deduction. First, the statutory language does not impose this requirement. Second, advances in epidemiology have significantly clarified the precision with which medical science can define the impact of preventive health measures. Consequently, the apprehension

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69. See *Hollander v. Commr.*, 219 F.2d 934, 935 (3d Cir. 1955) (cost of stair climbing device installed to prevent further heart damage after initial heart attack deductible); *Daniels v. Commr.*, 41 T.C. 324, 328 (1963) (cost of fallout shelter constructed to protect taxpayers against sickness from fallout radiation not deductible since imminent probability of disease not shown); *Dobkin v. Commr.*, 15 T.C. 886, 888 (1950) (annual Florida trip, advised by physician, not deductible where existing or imminent probability of disease or defect not shown).

70. See U.S. DEPT. OF HEALTH & HUM. SERVICES, PROMOTING HEALTH/PREVENTING DISEASE: OBJECTIVES FOR THE NATION 117 (1980); SURGEON GENERAL'S REPORT, *supra* note 24, at 2-9. See also Mahler, *Smoking or Health, The Choice is Yours—*, WORLD HEALTH, Feb.-Mar. 1980, at 3 ("Smoking is probably the largest single preventable cause of ill health in the world.")

For a discussion of the recent growth in the practice of preventive medicine, see U.S. PUBLIC HEALTH SERVICE OFFICE OF THE SURGEON GENERAL REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION, HEW PUB. NO. 79-55071A (1979); Yankauer, *The Ups and Downs of Prevention*, 71 AM. J. PUB. HEALTH 6 (1981) (editorial); Sheps, *Preventive Medicine*, 241 J. A.M.A. 1384 (1979); Seward & Sorensen, *The Current Emphasis on Preventive Medicine*, 200 SCI. 889 (1978). See generally G. ROSEN, PREVENTIVE MEDICINE IN THE UNITED STATES (1975).

of abusive deductions for personal expenses claimed to be undertaken for speculative medical purposes, although perhaps valid at the time of the *Stringham* decision, no longer justifies barring deductions for expenses incurred solely because of a scientifically demonstrable, but long-term, relationship between individual behavior and serious illness. Congress intended section 213 to exempt personal income expended in a choice between dollars and disease from the individual wealth which is subject to taxation. Because modern epidemiology defines that dilemma decades before the actual symptoms of cancer or heart disease, the courts should revise their interpretation of "prevention" by abandoning the imminence requirement.

"The starting point in every case involving the construction of a statute is the language itself."<sup>71</sup> But neither the language of section 213 nor the Regulations requires temporal proximity between the expense giving rise to the deduction and the disease that the taxpayer hopes to avoid. The Code simply states that "prevention of disease" falls within the definition of medical care.<sup>72</sup> Treasury Regulation 1.213-1(E)(1)(ii) refines congressional intent, but only emphasizes that section 213 deductions "will be confined strictly to expenses incurred primarily for the prevention . . . of a physical or mental defect or illness. . . . However, an expenditure which is merely beneficial to . . . general health . . . is not an expenditure for medical care."<sup>73</sup> Based on these two instructions — and no more — the *Stringham* court decided, and later cases have agreed,<sup>74</sup> to require imminence of disease before classifying an expenditure as preventive.<sup>75</sup>

Generally, "the words of statutes — including revenue acts — should be interpreted . . . in their ordinary, everyday sense."<sup>76</sup> The IRS and Tax Court's interpretation of "prevention" as including the notion of imminence departs from both the common usage and the

71. *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756 (1975) (Powell, J., concurring). See *Consumer Prod. Safety Commn. v. GTE Sylvania*, 447 U.S. 102, 108 (1980); *Greyhound Corp. v. Mt. Hood Stages*, 437 U.S. 322, 330 (1978); *Santa Fe Indus. v. Green*, 430 U.S. 462, 472 (1977). See generally 2A J. SUTHERLAND, *STATUTES AND STATUTORY CONSTRUCTION* § 46.01 (4th ed. C. Sands 1973).

72. I.R.C. § 213(e)(1)(A) (1982).

73. Treas. Reg. § 1.213-1(e)(1)(ii) (1957).

74. See note 69 *supra* and accompanying text.

75. The Tax Court in *Stringham* also took note of a Senate Finance Committee Report, S. REP. No. 1631, 77th Cong., 2d Sess., 6, 96 which stated:

It is not intended . . . that a deduction should be allowed for any expense that is not incurred primarily for the prevention or alleviation of a physical or mental defect or illness."

12 T.C. at 583.

76. *Crane v. Commr.*, 331 U.S. 1, 6 (1947). See *Consumer Prod. Safety Commn. v. GTE Sylvania*, 447 U.S. 102, 108-09 (1980); *Malat v. Riddell*, 383 U.S. 569, 571 (1966) (per curiam); *Hanover Bank v. Commr.*, 369 U.S. 672, 687 (1962); *Commissioner v. Korell*, 339 U.S. 619, 627-28 (1950).



medical usage of prevention. "Prevent" commonly means "to stop, keep, or hinder (a person or agent) from doing something."<sup>77</sup> In medical usage, "preventive" means "[a] prophylactic, or anything that arrests the threatened onset of disease."<sup>78</sup> Neither of these definitions refers to the temporal proximity of the threatened action or disease. They refer to a cause and effect relationship: without a given "preventive" action, an occurrence or disease would ensue. When the action or disease sought to be avoided would ensue seems irrelevant in these definitions. Where courts have considered the meaning of "prevention" in other contexts, they have accorded the word its common meaning, without any temporal limitation.<sup>79</sup> Too much can be made of the plain meaning rule, especially in the context of the Internal Revenue Code.<sup>80</sup> But surely the specific inclusion of prevention, and the absence of any time limit on the causal sequence initiated by preventive health measures, in the statutory language creates at least a rebuttable presumption that expenses clearly linked to the prevention of serious illness should be no less deductible than other accepted medical treatments.

The accepted justification of the imminence requirement no longer provides a persuasive reason to depart from the language of the Code and Regulations. There is no indication in the legislative history of the medical deduction that Congress intended to ascribe to prevention a meaning other than its common usage.<sup>81</sup> Rather, the

77. VIII THE OXFORD ENGLISH DICTIONARY 1337 (1933).

78. STEDMAN'S MEDICAL DICTIONARY 1138 (4th Unabr. Lawyer's Ed. 1976).

79. See, e.g., *Walker v. Equitable Life Assur. Soc. of United States*, 123 F. Supp. 306, 307-08 (E.D. Ill. 1954); *Green v. State*, 109 Ga. 536, 539-40, 35 S.E. 97, 99 (1900); *Lake Erie & W.R. v. McFall*, 165 Ind. 574, 579, 76 N.E. 400, 402 (1905); *Orme v. Atlas Gas & Oil*, 217 Minn. 27, 32, 13 N.W.2d 757, 761 (1944); *City of Clovis v. Archie*, 60 N.M. 239, 241, 290 P.2d 1075, 1076 (1955); *Luton v. Bedham*, 127 N.C. 96, 105, 37 S.E. 143, 146 (1900) (Douglas J., dissenting); *Edgar v. Schmidt*, 221 S.W.2d 867, 869 (Tex. Civ. App. 1949); *Fidelity & Casualty v. Joiner*, 178 S.W. 806, 809 (Tex. Civ. App. 1915); *Brodde v. Grosenick*, 14 Wis. 2d 341, 346, 111 N.W.2d 165, 168 (1961).

80. See, e.g., *Watt v. Alaska*, 451 U.S. 259, 266 (1981); *Boston Sand & Gravel Co. v. United States*, 278 U.S. 41, 48 (1928); Note, *Tax Treatment of Previously Expensed Assets in Corporate Liquidations*, 80 MICH. L. REV. 1636, 1658 nn.103-05 (1982).

81. The legislative history indicates only a concern for the equitable distribution of the wartime tax burden, and does not deal with the definition of medical care. See *Revenue Revision of 1942: Hearings Before the House Committee on Ways and Means*, 77th Cong., 2d Sess. 1612 (1942) (Statement of Randolph E. Paul, Tax Advisor to the Secretary of the Treasury):

[W]e feel that in some respects [the existing] exemptions and credits are now inadequate. We therefore suggest to the committee that to achieve a more equitable distribution of the tax burden, it would be desirable to enact the following changes:

1. *Medical expenses*. — A deduction should be allowed for extra-ordinary medical expenses that are in excess of a specified percentage of the family's net income; . . . S. REP. NO. 1631, 77th Cong., 2d Sess. 6 (1942), reprinted in 1942-2 C.B. 504, 508 ("This allowance is recommended in consideration of the heavy tax burden that must be borne by individuals during the existing emergency. . . ."; 88 CONG. REC. 8469 (1942) (Remarks of Rep. Hinshaw).

Both the House and Senate Reports on the 1954 Code state that with the exception of changing the provisions for medically required travel, subsection 213(e) "is not intended other-

imminence requirement is completely a creature of the Tax Court, inspired by the fear of permitting medical deductions for personal living expenses.<sup>82</sup> The requirement has functioned chiefly to disallow expenses undertaken for diseases which will probably not occur.<sup>83</sup>

Temporal proximity, however, is only relevant to the extent it measures causal relationships. The analytical difficulty presented by the sort of preventive health measures typified by smoking cessation programs concerns probability, not proximity; most smokers will not contract the diseases which smoking causes.<sup>84</sup> An individual's risk of

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wise to change the existing definitions of medical care, to deny the cost of ordinary ambulance transportation nor to deny the cost of food or lodging provided as part of a hospital bill." H. REP. NO. 1337, 83d Cong., 2d Sess., A60, reprinted in 1954 U.S. CODE CONG. & AD. NEWS 4017, 4197; S. REP. NO. 1622, 83d Cong., 2d Sess., 220, reprinted in 1954 U.S. CODE CONG. & AD. NEWS 4621, 4856.

The Reports, and subsequent congressional inaction regarding the definition of medical care, may imply legislative ratification of the Tax Court's interpretation. See *Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran*, 102 S.Ct. 1825, 1841 (1982); *Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978). The ratification doctrine, however, is far from compelling, as indicated by the Supreme Court's refusal to apply it in many cases. See *W. DOUGLAS, STARE DECISIS* 21 (1949) ("The Court [has] rejected numerous pleas to let Congress correct mistakes that the Court had created. It was also reluctant to find in the silence of Congress approval of the statutory interpretations which it had adopted."). Douglas argues that legislative inertia makes congressional redress of judicial misinterpretation difficult, and that "responsible government should entail the undoings of wrongs committed by the department in question." *Id.* at 21. It also seems most unlikely that Congress has given serious consideration to the incompatibility of the imminence requirement and the deductibility of modern preventive health practices, a tension which did not surface, in the case of cigarettes, until the late 1970s. See *McGill v. EPA*, 593 F.2d 631, 636 (5th Cir. 1979) ("It would be sophistry for us to divine a congressional intent on a subject it did not consider."); *J. GRAY, THE NATURE AND SOURCES OF THE LAW* 165 (1909) (true difficulty of interpretation is not identifying legislative intent, but deciding what the legislature would have intended on a point it did not consider). In light of these criticisms, applying the ratification doctrine to the imminence requirement would accord legislative force to a Tax Court dictum over thirty years of age. Even the jurisprudence of revenue laws should enjoy more scope for growth than this would allow.

82. The facts in *Stringham* suggest this very strongly. The taxpayer had sent their kindergarten-age daughter, who suffered from chronic bronchitis, to a school in Arizona, based on the belief that the climate there would improve her condition. The Tax Court upheld the deduction, but desired to limit the scope of the deduction to prevent opening a loophole for personal vacations, before the current travel provisions were included in § 213. The court derived its formula by equating "primarily for and essential to . . . prevention" in the Regulations with a required showing of the "imminent probability of a disease." *Stringham v. Commr.*, 12 T.C. 580, 584 (1949), *affd. per curiam*, 183 F.2d 579 (6th Cir. 1950). Both the concurring and dissenting opinions stress the risk of abuse as a prime concern. See 12 T.C. 580, 586-89.

83. See, e.g., *Daniels v. Commr.*, 41 T.C. 324, 329 (1963), where a taxpayer was denied a deduction for the cost of a fallout shelter on the grounds that there was, at best, a remote possibility of any disease occurring which would be prevented by a shelter. See note 69 *supra* and accompanying text.

84. The epidemiological relationships usually are expressed as relative risk factors, *i.e.*, smokers increase their risk of death from lung cancer by a factor of ten, of overall mortality by a factor of two, etc. But because these risks in any given year are slight for nonsmokers, even dramatic increases in relative risk do not bring the chance of contracting a smoking-related disease within the meaning of "imminent probability." Russell, *supra* note 23, at 253, translates the figures into actual risks run by smokers and concludes that "[t]hose who smoke 25 or more cigarettes a day at the age of 35, and continue to do so, stand a one in five chance of

lung cancer, even when increased an order of magnitude by smoking, remains relatively small. But some individuals will certainly die from lung cancer, and almost all of them would not have but for cigarettes. The law must choose between denying the medical deduction for many people whose preventive measures do in fact interdict the etiology of a developing disease or allowing a deduction for many more whose preventive measures do not.

Whether the congressional purpose of the deduction is to exclude involuntary expenditures from taxable income or to subsidize quality health care,<sup>85</sup> the courts should resolve this choice in the taxpayer's favor. Individuals who incur expenses by changing their behavior due to the fear of lung cancer do so as reluctantly as their counterparts who bear the expense of treating existing illnesses. This is especially true of smoking cessation, where the taxpayer must overcome the added obstacle of nicotine addiction. And insofar as Congress has adopted a subsidy (however inegalitarian or inefficient) to encourage adequate health care, an even stronger case exists for interring the imminence requirement. For smoking-related diseases, for example, prevention offers a far more efficacious approach than treatment.<sup>86</sup> The Service's approach denies a deduction for the cost of facilitating the personal behavior change (smoking cessation) which can save more lives than any other, while allowing a deduction for the cost of surgery and chemotherapy that do little to avert needless fatalities. From the standpoint of tax theory and of public health, this is perverse policy.

Reforming this approach would not require an unprincipled deviation from *stare decisis*. After all, epidemiologists did not begin to recognize long-term links between human behavior and disease until after the original interpretation of the medical deduction provision.<sup>87</sup> The admission that times have changed — that confident scientific predictions may now motivate expenses for preventive health measures with long term consequences for specific diseases — reflects no disrespect for precedent.<sup>88</sup> It remains to be seen whether a

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dying as a result of it before the age of 65." Such risks, moreover, increase geometrically in proportion to the duration of smoking. Wald, *Smoking as a cause of disease*, 1 RECENT ADVANCES COMMUNITY MED. 73, 81 (1978). These dangers, while obviously grave, are nonetheless not "imminent."

85. See note 10 *supra*.

86. The American Cancer Society, for example, estimates that smoking causes eighty percent of lung cancer, which once contracted is ninety-four percent fatal. 1976 Hearings, *supra* note 45, at 535-537 (Statement of Benjamin Byrd).

87. The association between smoking and lung cancer was the first major recognized line between human behavior and disease. See SURGEON GENERAL'S REPORT, *supra* note 24, at 5-9, identifying the early fifties as the period of the first general awareness of an association between lung cancer and cigarettes, based on early retrospective studies.

88. *Stare decisis* is "a principle of social policy rather than an inflexible rule of law," which does not "bar coordination of legal philosophy with that of new and commanding facts." R. POUND, *Stare Decisis*, in LAW FINDING THROUGH EXPERIENCE AND REASON 39 (1960) (quot-

responsible reformulation of the current interpretation can accommodate a deduction for such expenses without permitting deductions for personal expenses.

### B. *Reformation of the Two-Part Test*

Absent an imminence requirement, a taxpayer who demonstrates the threatened onset of a specific disease will enjoy a deduction for expenses directly and proximately related to the prevention of such illness.<sup>89</sup> Without the narrowing influence that imminence imparts to the analysis, however, a strong showing of the relationship of the expense to the prevention of disease is needed to ensure that general health expenditures cannot be deducted. A further two-step test, similar to that employed in treatment situations,<sup>90</sup> should ensure that an expense is directly and proximately related to disease prevention: (1) The expenditure is necessary if the taxpayer hopes to avoid a specific disease; and (2) But for the likelihood of disease, there are no other significant reasons for the particular taxpayer to incur the expense. Additionally, the familiar limitation of the deduction to the amount needed to fulfill adequately the medical purpose would, of course, remain.<sup>91</sup>

Under this test, taxpayers could still claim deductions for expenses hitherto upheld. Deductions have been allowed for the cost of removing lead-based paint to prevent small children from contracting lead poisoning,<sup>92</sup> the cost of a stair climbing device to prevent further heart damage after a heart attack,<sup>93</sup> and the additional

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ing Park Constr. Co. v. Independent School Dist., 209 Minn. 182, 187, 296 N.W. 475, 478 (1941)). Indeed, of all the justifications for reforming a settled interpretation, advances in the scientific understanding of the subject matter express the least disrespect for the authority of prior cases. A more rigid adherence to precedent would require common-law rules to remain fixed regardless of the continued validity of the assumptions underlying them, until the legislature chose to revise them. American experience has been the reverse; the courts, and not the legislatures, have provided the continuous updating of legal rules required to prevent jurisprudential atrophy. See G. CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 3-7 (1982).

89. See note 5 *supra*.

90. See notes 50-53 *supra* and accompanying text.

91. See *Ferris v. Commr.*, 582 F.2d 1112, 1116 (7th Cir. 1978) (upholding deduction for therapeutically motivated swimming pool, but confining the deduction to "the minimum reasonable cost of a functionally adequate" facility). The court reasoned that, while individuals are not required to seek the cheapest available care with respect to such health-related expenditures as structural changes in the home, the excess over the minimum reasonable cost is not related to medical care. This limitation would assume more importance with the demise of the imminence test, for its effect is to limit deductions for such things as exercise and special diets to their minimum reasonable cost.

92. Rev. Rul. 79-66, 1979-1 C.B. 114.

93. *Hollander v. Commr.*, 219 F.2d 934 (3d Cir. 1955). Under Treas. Reg. § 1.213(e)(1)(ii) (1957), a capital expenditure may qualify as a medical expense to the extent that the expenditure exceeds the increase in value of the property. In this case, the increase in the value was found to be zero, so the entire expenditure was deductible. 219 F.2d at 936.

cost of purchasing additive-free food to prevent allergic reactions.<sup>94</sup> In each of these cases the taxpayer demonstrated the threatened onset of a specific disease, and that the expenses incurred related directly and proximately to the prevention of that illness. An imminence requirement in these cases is redundant.

More importantly, many cases where the Service legitimately has denied deductions under an imminence test would still fail the proposed test. This suggests that eliminating the imminence requirement would not create a broad loophole through which mere general health expenditures, which the Treasury has determined are personal,<sup>95</sup> can be deducted as preventive.

One of the few relevant cases illustrates the effect of the proposed standard. The Tax Court denied a deduction for the cost of constructing a fallout shelter as a preventive measure against radiation injury on the grounds that no showing of imminent disease was made.<sup>96</sup> This result would survive the abandonment of the imminence requirement, however, since the taxpayer could only show "a remote possibility, if any" of the threatened disease.<sup>97</sup> This result might vary with the fact finder's perception of the risks of nuclear war, but in any event presents no inconsistency with upholding deductions for more mundane prevention measures, such as smoking cessation. Even though no particular smoker can establish a certainty of contracting lung cancer absent cessation, some lung cancer will certainly occur and smoking will cause almost all of it. No such prediction describes the real but speculative risks addressed by civil defense precautions.

The test of direct and proximate relation between the expense and the prevention of the disease provides a similar safeguard against the deduction of personal expenses. Deductions have been denied for such expenditures as the costs of attending a health institute,<sup>98</sup> or of taking a vacation,<sup>99</sup> on the ground that these merely promote general health. Under a prevention rationale, they would still be denied, because a taxpayer could probably not show both the necessity of incurring the expense to avoid a specific threatened disease *and* that he had no other significant reason to incur the expense other than avoiding the disease.<sup>100</sup> Should the taxpayer surmount

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94. *Randolph v. Commr.*, 67 T.C. 481 (1976).

95. I.R.C. § 262 (1982).

96. *Daniels v. Commr.*, 41 T.C. 324 (1963).

97. 41 T.C. at 329.

98. *See* Rev. Rul. 55-261, 1955-1 C.B. 307, 310.

99. Treas. Reg. § 1.213-1(e)(1)(ii) (1957) uses a vacation as an example of an expenditure which does not qualify as a medical expense because it is merely beneficial to the general health of a taxpayer. *See* note 56 *supra*. These cases are almost always decided on treatment grounds.

100. Naturally, many cases of this type would depend on the facts. Many expenses which

these obstacles, the limitation of the amount deductible to that sufficient to fulfill adequately the medical purpose would restrict the deduction to those expenses purely medical in motive and effect.<sup>101</sup>

One Revenue Ruling which neglects to apply the imminence test illustrates the factors relevant to deductibility under the proposed standard. The taxpayer succeeded in deducting the cost of fluoridating his family's water supply to prevent tooth decay.<sup>102</sup> The Service mentioned that fluoride strengthens dental enamel in developing teeth, making them more resistant to decay, and then stated that "since the primary and only purpose of the installation . . . is to prevent tooth decay, its use falls within the definition of medical care."<sup>103</sup> The Service never considered whether tooth decay was imminent without fluoride. Instead, it looked to the great likelihood of disease (tooth decay) at some point in the future, the causal link between the expenditure (fluoride) and avoidance of the disease, and the lack of any significant reasons for the expense other than avoidance of the disease. Such an approach, emphasizing causal rather than temporal relationships between an expenditure and avoidance of disease, makes good sense, and deserves general application.

### C. *Application of the Test to Smoking Cessation Programs*

A smoking cessation program satisfies the first requirement of the two-part test: smoking imposes a significant risk of several specific diseases. Medical evidence has proved that cigarette smoking is a causal factor in heart disease, cancers of the lung, larynx, mouth, esophagus, pancreas, and bladder, as well as chronic bronchitis and emphysema.<sup>104</sup> The American Cancer Society's research indicates that smoking causes at least eighty percent of lung cancer,<sup>105</sup>

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are generally thought of as personal "may . . . in rare situations lose their identity as ordinary personal expenses and acquire deductibility as amounts claimed primarily for the prevention or alleviation of disease." *Stringham v. Commr.*, 12 T.C. 580, 584 (1949), *aff'd per curiam*, 183 F.2d 579 (6th Cir. 1950). *Compare, e.g.*, *Rev. Rul. 79-151*, 1979-1 C.B. 116 (weight loss program not deductible), and *Dobkin v. Commr.*, 15 T.C. 886 (1950) (trip to Florida not deductible), with *Ltr. Rul. 8004111* (Oct. 31, 1979) (weight loss program deductible) and *Rev. Rul. 58-110*, 1958-1 C.B. 155 (cost of trip deductible). *See* notes 52, 56 *supra*.

101. *See* note 91 *supra*.

102. *Rev. Rul. 64-267*, 1964-2 C.B. 69.

103. *Id.* at 70.

104. U.S. DEPT. OF HEALTH & HUMAN SERVICES, PROMOTING HEALTH/PREVENTING DISEASE: OBJECTIVES FOR THE NATION 117 (1980); *see also* SURGEON GENERAL'S REPORT, *supra* note 24, at 1-12 to 1-18, 5-9; Anderson, *Slow-Motion Suicide*, WORLD HEALTH 14 (Feb.-Mar. 1980)

105. AMERICAN CANCER SOCIETY, 1978 CANCER FACTS AND FIGURES 18 (1977); P. LEVITT & E. GURALNICK, THE CANCER REFERENCE BOOK 13 (1979); *see also* Wald, *supra* note 84, at 81 ("The risk of lung cancer rises with increased cigarette consumption, and for men who smoked 1 to 9, 10 to 19, 20 to 30 and 40 or more cigarettes a day, and were aged between 55 and 69 years, the mortality ratios were 4.7, 10.0, 16.7 and 21.0 respectively."). *See generally* SURGEON GENERAL'S REPORT, *supra* note 24, at 5-1 to 5-32.

accounting for 80,000 deaths annually.<sup>106</sup> Figures for heart disease are no more promising. "The consumption of 20 or more cigarettes daily is associated with a hazard of [heart disease] up to three times greater than that found in nonsmokers"<sup>107</sup> and accounts for nearly 225,000 deaths annually.<sup>108</sup> In short, the overwhelming medical evidence indicates that a smoker runs a substantial risk of developing lung cancer, heart disease, and a variety of other illnesses.<sup>109</sup>

Cessation programs also satisfy the proposed standard's second criterion, because the programs bear a direct and proximate relation to the prevention of the apprehended diseases. Cessation of smoking greatly reduces the likelihood of contracting smoking-related diseases.<sup>110</sup> Persistent smokers have a mortality rate double that of nonsmokers.<sup>111</sup> However, the Surgeon General reports that "[t]en years after quitting cigarette smoking, the death rates for lung cancer and other smoking-related causes of death approach those of nonsmokers.<sup>112</sup> Thus, smoking cessation contributes directly, significantly, and uniquely to the prevention of a host of diseases. Since professional help is essential to enable many people to quit smoking,<sup>113</sup> its cost is an essential element of prevention of specific illnesses.

Moreover, no significant reasons exist for attending a smoking cessation program other than avoidance of disease.<sup>114</sup> But for the risk of specific illnesses, the financial and physiological costs of tobacco withdrawal would not be undertaken. In sum, since the expense of a cessation program is directly and proximately related to or, as the Treasury Regulations put it, primarily for the purpose of,<sup>115</sup> prevention of specific diseases that the taxpayer is likely to contract, its costs should qualify as a deductible medical expense.

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106. See SURGEON GENERAL'S REPORT, *supra* note 24, at ii.

107. THE HEART 1822 (J. Hurst 4th ed. 1978). See N. SAHETA, CORONARY HEART DISEASE 106-07 (1969); 2 HEART DISEASE 1260 (E. Braunwald ed. 1980); Friedman, Petitti, Bawol & Siegel, *Mortality In Cigarette Smokers and Quitters*, 304 NEW ENG. J. MED. 1407, 1407 (1981); See generally, SURGEON GENERAL'S REPORT, *supra* note 24, at 4-1 to 4-76.

108. See SURGEON GENERAL'S REPORT, *supra* note 24, at ii.

109. See SURGEON GENERAL'S REPORT, *supra* note 24, at vii. This conclusion is supported by thousands of studies, *id.* and tens of thousands of articles. *Id.* at 1-5.

110. See notes 104-09 *supra* and accompanying text.

111. Friedman, Petitti, Bawol & Siegel, *Mortality In Cigarette Smokers and Quitters*, 304 NEW ENG. J. MED. 1407, 1408 (1981).

112. U.S. DEPT. OF HEALTH & HUM. SERVICES, PROMOTING HEALTH/PREVENTING DISEASE: OBJECTIVES FOR THE NATION 118 (1980).

113. See note 61 *supra* and accompanying text.

114. See notes 54-60 *supra* and accompanying text.

115. Treas. Reg. § 1.213-1(e)(1)(ii) (1957).

## CONCLUSION

Viewed as treatment of the addiction to smoking, cessation programs satisfy the current two-part test for deductibility under section 213: (1) for program participants, nicotine addiction is a medically recognized disease, and (2) the programs are directly and proximately related to treatment of the disease. Therefore, just as an alcoholic may deduct the cost of an alcoholism clinic, an addicted smoker should be entitled to deduct the cost of a smoking cessation program. A similar analysis applies when cessation programs are considered as treatment "for the purpose of affecting any structure or function of the body."

Under a revised interpretation of section 213, the programs can also be viewed as prevention of smoking related diseases. An examination of section 213's language and logic indicates that a smoking cessation program is "prevention of disease" notwithstanding the delay between smoking and the onset of the diseases it causes. As a preventive health measure, a cessation program satisfies the two-part test for deductibility: (1) a participant is threatened with the onset of smoking related diseases, and (2) the expense is directly and proximately related to prevention of these diseases. Therefore, the cost of participation in a smoking cessation program should be considered a deductible preventive medical expense under section 213.