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## The Tax Definition of "Medical Care:" A Critique of the Startling IRS Arguments in *O'Donnabhain V. Commissioner*

Katherine Pratt  
*Loyola Law School*

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THE TAX DEFINITION OF “MEDICAL CARE:” A  
CRITIQUE OF THE STARTLING IRS ARGUMENTS  
IN *O’DONNABHAIN V. COMMISSIONER*

*Katherine Pratt\**

ABSTRACT

*This Article critiques the startling arguments made by the Internal Revenue Service (“IRS”) in *O’Donnabhain v. Commissioner*, a case in which the issue was whether a person diagnosed with gender identity disorder (“GID”) could take a federal tax deduction for the costs of male-to-female medical transition, including hormone treatment, genital surgery, and breast augmentation. Internal Revenue Code § 213 allows a deduction for the costs of “medical care,” which (1) includes costs incurred for “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,” but (2) generally excludes “cosmetic surgery” and “similar procedures.” Courts and the IRS interpreted the statutory definition of “medical care” consistently for decades until the IRS made a series of radical arguments in *O’Donnabhain v. Commissioner*. IRS opposition to *O’Donnabhain’s* medical expense deduction tracked the views of Dr. Paul McHugh, an outspoken opponent of medical transition for transgender persons and a member of President George W. Bush’s Council on Bioethics. In his writings, Dr. McHugh, a psychiatrist, asserts that (1) persons who “claim” to be transgender are delusional, (2) GID is deviant “behavior,” not a disease, and (3) gender confirmation surgery (“GCS”) should be prohibited as “collaborating with madness” and a moral “abomination.” Views expressed by Dr. McHugh in an article, *Surgical Sex*, appeared in a 2004 letter that the Traditional Values Coalition sent IRS Commissioner Everson, to demand that the IRS not allow *O’Donnabhain* a deduction, and in Chief Counsel Advice issued by the IRS Office of Chief Counsel. Dr. McHugh’s views also featured prominently in IRS arguments throughout the subsequent tax litigation.*

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\* Professor of Law, Loyola Law School Los Angeles. Email: [katherine.pratt@lls.edu](mailto:katherine.pratt@lls.edu). SSRN author page: <http://ssrn.com/author=243531>. Faculty webpage: [www.lls.edu/pratt](http://www.lls.edu/pratt). Thanks to Simone Darakjian and Sahar Bayat for research assistance. Thanks also to Ellen Aprill, Brietta Clark, David Cruz, Tony Infanti, Spencer Klein, Alexandra Markel, Yxta Maya Murray, Alexandra Natapoff, Sarah Precup, and Adam Zimmerman for helpful corrections, comments, suggestions, and questions.

*Incorporating excerpts from the extensive O'Donnabhain trial record (over 1,000 pages), this Article critiques the arguments made by the IRS in the case, and considers the implications of the case and the IRS's arguments going forward—not just in the context of GCS, but also in the context of other types of medical care, including reproductive medical care. Part I analyzes the statutory definition of “medical care” and the “general well-being” and “cosmetic surgery or other similar procedures” limitations on the definition of “medical care.” Part II provides background on the facts of the case and the administrative tax controversy between O'Donnabhain and the IRS, reveals the significant influence of Dr. McHugh on the tax case, summarizes the arguments made by O'Donnabhain and the IRS in the United States Tax Court case, and discusses the Tax Court's 2010 reviewed decision. Part III analyzes and critiques specific IRS arguments, some of which were radical departures from long-standing case law and IRS practices, and highlights similarities between (1) GCS and (2) breast reconstruction following mastectomy or lumpectomy, which the IRS acknowledges is medical care, not cosmetic surgery. Part III also considers the IRS's arguments as a whole and concludes that the arguments the IRS made in the case are quite puzzling as a matter of tax law—but less puzzling when viewed as a covert attempt by the IRS to discourage GCS on moral grounds. In addition, Part III objects to the IRS's negative stereotyping of O'Donnabhain, medical professionals who specialize in GID, and transgender persons in general. Part IV distills a series of rules for interpreting the § 213(d) definition of “medical care” and explores the implications of the O'Donnabhain case beyond its specific facts. Part IV also voices a concern that the IRS might deploy similar tax arguments in the future to deny deductions for other controversial medical care on covert moral grounds, particularly in the context of reproductive medical care.*

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## INTRODUCTION

This Article critiques the startling arguments made by the Internal Revenue Service (“IRS”) in *O'Donnabhain v. Commissioner*, a case in which the issue was whether a person diagnosed with gender identity disorder (“GID”) could take a federal tax deduction for the costs of male-to-female medical transition, including hormone treatment, genital surgery, and breast augmentation.<sup>1</sup> Internal Revenue Code § 213 allows a limited

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1. *O'Donnabhain v. Comm'r*, 134 T.C. 34 (2010). The *O'Donnabhain* decision generated interesting scholarly commentary, especially from critical tax scholars. See, e.g., Anthony C. Infanti, *Dissecting O'Donnabhain*, 126 TAX NOTES 1403 (2010); Anthony C. Infanti, *LGBT Taxpayers: A Collision of "Others"*, 13 GEO. J. GENDER &

medical expense deduction for the costs of “medical care.”<sup>2</sup> Although personal living expenses generally are nondeductible,<sup>3</sup> taxpayers can deduct their expenses for “medical care” to the extent those expenses exceed ten percent of the taxpayer’s adjusted gross income.<sup>4</sup> Section 213(d) defines medical care to include costs incurred for “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”<sup>5</sup> Medical care does not include “cosmetic surgery” and “similar procedures,” “unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.”<sup>6</sup> “Cosmetic surgery” is defined as “any procedure which is directed at improving the taxpayer’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.”<sup>7</sup>

Courts and the IRS interpreted the statutory definition of “medical care” consistently for decades until the IRS made a series of radical arguments in *O’Donnabhain v. Commissioner*.<sup>8</sup> In this case, the IRS denied O’Donnabhain a deduction for the costs of her medical transition and asserted a tax deficiency of \$5,000. During the *O’Donnabhain* tax controversy, IRS opposition to O’Donnabhain’s medical expense deduction tracked the views of Dr. Paul McHugh, an outspoken opponent of medical transition for transgender persons and a member of President George W. Bush’s Council on Bioethics. In his writings, Dr. McHugh, a psychiatrist, asserted that (1) persons who “claim” to be transgender are delusional, (2) gender identity disorder is deviant “behavior,” not a disease, and (3) sex reassignment surgery (now more commonly referred to as gender confirma-

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L. 1 (2011). Numerous student-authored case notes also focused on the *O’Donnabhain* case. See, e.g., Lauren Whitney Herman, *A Non-Medicalized Medical Deduction?: O’Donnabhain v. Commissioner & the I.R.S.’s Understanding of Transgender Medical Care*, 35 HARV. J.L. & GENDER 487 (2012); Tamar E. Lusztig, *Deducting the Cost of Sex Reassignment Surgery: How O’Donnabhain v. Commissioner Can Help Us Make Sense of the Medical Expense*, 3 COLUM. J. TAX L. 86 (2011).

2. 26 U.S.C.S. § 213 (Westlaw through Pub. L. No. 114-219).

3. 26 U.S.C.S. § 262 (Westlaw through Pub. L. No. 114-219).

4. 26 U.S.C.S. § 213 (Westlaw through Pub. L. No. 114-219).

5. 26 U.S.C.S. § 213(d)(1)(A) (Westlaw through Pub. L. No. 114-219).

6. 26 U.S.C.S. § 213(d)(9)(A) (Westlaw through Pub. L. No. 114-219).

7. 26 U.S.C.S. § 213(d)(9)(B) (Westlaw through Pub. L. No. 114-219).

8. 134 T.C. 34 (2010).

tion surgery<sup>9</sup>) should be prohibited as “collaborating with madness” and a moral “abomination.”<sup>10</sup>

Views expressed by Dr. McHugh in a 2004 article, *Surgical Sex*,<sup>11</sup> appeared in a 2004 letter that the Traditional Values Coalition (“TVC”) sent IRS Commissioner Everson to demand that the IRS not allow a deduction for O’Donnabhain’s costs of medical transition.<sup>12</sup> The IRS Office of Chief Counsel (headquartered in Washington, D.C.) also cited *Surgical Sex* in advice that it issued to the Boston IRS Appeals Office, where O’Donnabhain’s case was pending.<sup>13</sup> Dr. McHugh’s views also featured prominently in IRS arguments throughout the ensuing tax litigation, and in the testimony and reports of two IRS expert witnesses. Both of the IRS expert witnesses were Dr. McHugh’s colleagues at Johns Hopkins Hospital, which stopped performing gender confirmation surgery (“GCS”) during Dr. McHugh’s tenure as psychiatrist-in-chief.<sup>14</sup> In 2010, after years of contentious litigation, a majority of a sixteen-judge panel of the United States Tax Court held that O’Donnabhain could deduct the costs of feminizing hormones and genital surgery as medical expenses but could not deduct the cost of breast augmentation, which the court held was a cosmetic procedure in her case.<sup>15</sup>

This Article analyzes the extensive trial record in the *O’Donnabhain* case, critiques the arguments made by the IRS in the case, and considers the implications of the case and the IRS’s arguments going forward. Part I analyzes the statutory definition of the term “medical care,” drawing on the

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9. See, e.g., Loren S. Schechter, ‘Gender Confirmation Surgery’: What’s in a Name?, HUFFINGTON POST (Apr. 20, 2012), [http://www.huffingtonpost.com/loren-s-schechter-md-facs/gender-confirmation-surgery\\_b\\_1442262.html](http://www.huffingtonpost.com/loren-s-schechter-md-facs/gender-confirmation-surgery_b_1442262.html) (board certified plastic surgeon argues that the terms “sex reassignment surgery” and “sex change operation” are misnomers, and the term “gender confirmation surgery” better captures the goal of the surgery, *i.e.*, to bring the patient’s body into congruence with the patient’s long-identified gender). This Article generally uses “gender confirmation surgery” (GCS) instead of the term “sex reassignment surgery.”

10. See *infra* Part II.B.

11. Paul McHugh, *Surgical Sex: Why We Stopped Doing Sex Change Operations*, FIRST THINGS (2004), <http://www.firstthings.com/article/2004/11/surgical-sex> [hereinafter *Surgical Sex*].

12. Katherine T. Phan, *TVC Asks IRS to Reverse Tax Deduction for Sex-Change Operation*, CHRISTIAN POST (Dec. 15, 2004), <http://www.christianpost.com/news/tvc-asks-irs-to-reverse-tax-deduction-for-sex-change-operation-20790/>.

13. I.R.S. Chief Coun. Advice 200603025 (Oct. 14, 2005) (released Jan. 20, 2006) [hereinafter CCA], <https://www.irs.gov/pub/irs-wd/0603025.pdf> (formal written advice from the IRS Office of Chief Counsel, in Washington DC, to the Boston IRS office in which O’Donnabhain’s case was being considered by the IRS Appeals Office).

14. Brief for Respondent, 154–71, *O’Donnabhain v. Comm’r*, 134 T.C. 34 (2010) [hereinafter Respondent’s Opening Brief].

15. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 55–76 (2010).

statutory language of § 213(d)(1)(A) and decades of § 213 cases, Treasury regulations, administrative rulings, and other administrative pronouncements. In addition, Part I analyzes the “general well-being” limitation and the § 213(d)(9) “cosmetic surgery or other similar procedures” limitation on the definition of “medical care.”

Part II provides background on the facts of the case and the administrative tax controversy between O’Donnabhain and the IRS. Part II also reveals the significant influence of Dr. McHugh on the tax case, summarizes the arguments made by O’Donnabhain and the IRS in the United States Tax Court case, and discusses the Tax Court’s reviewed decision.

Part III begins with a critique of specific IRS arguments: (1) the § 213(d) term “disease” is defined very narrowly as internal pathology at the cellular or molecular level;<sup>16</sup> (2) the § 213(d)(9) “cosmetic surgery or other similar procedures” limitation is applied very broadly to any medical procedures that “improve” “appearance”;<sup>17</sup> and (3) the deduction for medical care also requires that the taxpayer establish that the care was “medically necessary” and “efficacious” (*i.e.*, that the care actually cured the disease and that the medical care administered is not “controversial”).<sup>18</sup> Part III also critiques the IRS’s arguments as a whole and concludes that the IRS arguments are quite puzzling as a matter of tax law—but less puzzling when viewed as a covert attempt by the IRS to discourage GCS and deny it government funding, consistent with Dr. McHugh’s views.

The hyper-technical tax arguments made by the IRS in the *O’Donnabhain* case are objectionable for several reasons. First, the arguments would have radically altered the medical expense deduction, producing uncertain and arbitrary outcomes. Second, the IRS appears to have singled out a transgender taxpayer for unfair and dehumanizing treatment—violating its mission statement in the process—by treating O’Donnabhain like a deceiver and criminal and by making implausible tax arguments that were “a mask for the politics of disgust.”<sup>19</sup> Third, the IRS’s overt technical arguments for denying the deduction (based on the IRS’s covert moral objections to the medical procedures involved in the case) could serve as a blueprint for the future denial of deductions for other medical expenses on covert moral grounds.

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16. Respondent’s Opening Brief, *supra* note 14, at 160–78.

17. *Id.* at 41.

18. *Id.* at 181–91.

19. See MARTHA C. NUSSBAUM, FROM DISGUST TO HUMANITY: SEXUAL ORIENTATION & CONSTITUTIONAL LAW 26 (2010) (concluding that anti-gay arguments “are too flimsy to do much work without disgust as a backdrop, or . . . are merely a mask for the politics of disgust”).

Part IV distills a series of rules for interpreting the § 213(d) definition of medical care, as illustrated by the *O'Donnabhain* case, and explores the implications of the case beyond its specific facts. For example, Part IV addresses the deductibility of the costs of other types of medical transition for transsexual taxpayers, including “top” surgery for transsexual men and facial feminization surgery for transsexual women. Part IV also voices a concern that the IRS might make hyper-technical tax arguments as a pretense for covertly denying medical expense deductions on ethical grounds, particularly in the context of reproductive expenses. For example, the IRS might challenge deductions for the costs of contraceptives, vasectomies, tubal ligations, fertility treatments (*e.g.*, in vitro fertilization, egg donor, and surrogacy), and legal abortions by making the types of hyper-technical—but implausible—arguments that it made in the *O'Donnabhain* case.

## I. THE STATUTORY DEFINITION OF “MEDICAL CARE”

### A. *The § 213(d)(1)(A) Definition of “Medical Care”*

The *O'Donnabhain* case focuses on the meaning of the § 213 term “medical care.” Section 213(a) allows taxpayers to deduct expenses for “medical care,” to the extent such expenses exceed ten percent of the taxpayer’s adjusted gross income.<sup>20</sup> The § 213(d)(1)(A) definition of “medical care” provides that deductible medical expenses include costs incurred for “the diagnosis, cure, mitigation, treatment, or prevention of *disease*, or for the purpose of affecting any *structure or function* of the body.”<sup>21</sup> The deduction allowed by § 213 is an exception to the general rule, in § 262, that personal expenses are not deductible.<sup>22</sup>

Various rationales are posited for the special tax deduction for medical expenses. The dominant rationale, an *ex post* fairness or equity rationale, is that taxpayers who incur significant medical expenses are less able to pay taxes (the “ability-to-pay” rationale).<sup>23</sup> If taxpayer A earns \$100,000, taxpayer B earns \$100,000 but must pay \$20,000 of medical expenses, and taxpayer C earns \$80,000, the argument is that fairness requires that taxpayers B and C (not A and B) be treated similarly.<sup>24</sup> In effect, the binary tax

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20. 26 U.S.C.S. § 213 (Westlaw through Pub. L. No. 114–219).

21. *Id.* (emphasis added).

22. 26 U.S.C.A. § 262 (Westlaw through Pub. L. No. 114–219).

23. Katherine Pratt, *Inconceivable? Deducting the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1162, n. 231 (2004) [hereinafter Pratt, *Inconceivable*] (the “ability-to-pay” normative approach “dominates the theoretical literature on the medical expense deduction”).

24. *Id.* at 1165 (citing William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309 (1972)).



rule assumes that all medical care is involuntary.<sup>25</sup> Medical care qualifies for the special tax rule whether it is “elective” or not.<sup>26</sup> (Virtually all medical care requires informed consent and thus is elective.) Similarly, a tax reduction for catastrophic medical expenses incurred by a taxpayer who suffers from disease or injury might be justified as a gesture of sympathy for such taxpayers.<sup>27</sup> A broader rationale for the medical expense deduction is that the tax law should promote well-being, and health is central to well-being.<sup>28</sup> Some policy commentators have challenged the medical expense deduction, however, on the grounds that, from an *ex ante* perspective, the deduction

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25. See, e.g., Mark G. 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, 859, 863–64 (1979).

26. See, e.g., Katherine Pratt, *Deducting the Costs of Fertility Treatment: Implications of Magdalin v. Commissioner for Opposite-Sex Couples, Gay and Lesbian Same-Sex Couples, and Single Women and Men*, 2009 WIS. L. REV. 1283, 1293–94 [hereinafter Pratt, *Magdalin*]:

The fact that a medical procedure is “elective” does not take the procedure out of the definition of “medical care”; what matters is whether the procedure is for the diagnosis, cure, mitigation, treatment, or prevention of “disease” (broadly construed), or for the purpose of affecting bodily functioning. Although specific medical procedures . . . are clearly life-saving emergency procedures, many medical procedures that diagnose, cure, mitigate, treat, or prevent disease—or potentially affect functioning—are not life-saving emergency procedures . . . . An example is elective knee replacement surgery, a procedure that is frequently performed on elderly patients. The procedure constitutes “medical care,” even if the taxpayer’s motivation is to be able to play recreational golf or tennis, because the surgery mitigates a disease or condition. Although playing golf is a personal recreational activity that does not give rise to tax deductions, the cost of knee surgery to enable the taxpayer to play golf is “medical care” under section 213.

27. See, e.g., Ellen P. Aprill & Richard Schmalbeck, *Post-Disaster Tax Legislation: A Series of Unfortunate Events*, 56 DUKE L.J. 51 (2006) (the public feels sympathy towards disaster victims, and legislators extend tax benefits to such victims to express public sympathy and solidarity); George Loewenstein et al., *Statistical, Identifiable and Iconic Victims and Perpetrators* [hereinafter *Identifiable Victims*] (John M. Olin Program in Law and Econ., Working Paper No. 301, 2005) (people are “more beneficent toward [identifiable] victims” even if they do not know the victim). Tax commentators have debated whether sympathy for personal injury victims justifies the income tax exclusion for personal injury recoveries. See, e.g., Thomas D. Griffith, *Should “Tax Norms” Be Abandoned? Rethinking Tax Policy Analysis and the Taxation of Personal Injury Recoveries*, 1993 WISC. L. REV. 1115, 1159–60 (1993) (“[t]ax scholars are split on whether sympathy for the victim can justify a tax exemption for personal injury recoveries”).

28. See, e.g., Thomas D. Griffith, *Theories of Personal Deductions in the Income Tax*, 40 HASTINGS L. J. 343, 366 (1989).

discourages taxpayers from adequately insuring against medical risk and shifts some of that risk to the federal government.<sup>29</sup>

The rationales for the medical expense deduction assume that largely involuntary medical expenses are distinguishable from run-of-the-mill personal expenses, which are nondeductible under the general rule of § 262. The fact that a taxpayer may try to classify an otherwise nondeductible personal expense as a deductible medical expense raises classification issues that have been explored in cases and administrative pronouncements. Dating back to the 1950s, the IRS consistently has allowed deductions for expenses that are inherently medical, such as “[h]ospital services, nursing services. . . , medical, laboratory, surgical, dental, and other diagnostic and healing services, X-rays, medicine and drugs. . . , artificial teeth or limbs, and ambulance hire.”<sup>30</sup> More difficult classification issues arise, however, with respect to expenses that taxpayers incur—ostensibly as medical care—for items (*e.g.*, a pool, vacation, or gym membership) that are usually purchased for non-medical personal reasons.<sup>31</sup> In distinguishing between nondeductible personal expenses and deductible medical expenses for items that generally are personal, not medical, courts consider various factors and look for a “direct and proximate relation” between the expense and the medical care.<sup>32</sup> An example is *Havey v. Commissioner*, a case in which a taxpayer who lived in Pittsburgh and had heart disease claimed a medical expense deduction for the costs of vacations to Arizona and the New Jersey shore. The United States Tax Court stated:

In determining allowability, many factors must be considered. Consideration should be accorded the motive or purpose of the taxpayer, but such factor is not alone determinative. . . . [A]lso it is important to inquire as to the origin of the expense. Was it

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29. See, *e.g.*, Louis Kaplow, *The Income Tax as Insurance: The Casualty Loss and Medical Expense Deductions and the Exclusion of Medical Insurance Premiums*, 79 CAL. L. REV. 1485, 1487 (1991) (under this view of the medical expense deduction, the federal government, acting as an insurer, pays a portion of taxpayers’ medical expenses, arguably creating a government insurance subsidy in the form of medical expense deductions).

30. Treas. Reg. § 1.213-1(e)(1)(ii) (1957) (“payments for the following are payments for medical care: hospital services, nursing services . . . medical, laboratory, surgical, dental, and other diagnostic and healing services, X-rays, medicine and drugs . . . artificial teeth or limbs, and ambulance hire”). Courts interpreting § 213 distinguish between “inherently medical” expenses and “nonmedical” expenses. See, *e.g.*, Huff v. Comm’r, 1995 Tax Ct. Memo LEXIS 200 (1995) (surgical expense is “inherently medical” but massage expense is “nonmedical”).

31. See Pratt, *Inconceivable*, *supra* note 23, at 1141 (IRS has broadly construed the § 213 term “disease” to include conditions, impairments, and disorders.).

32. *Id.* at 1141.

incurred at the direction or suggestion of a physician; did the treatment bear directly on the physical condition in question; did the treatment bear such a direct or proximate therapeutic relation to the body condition as to justify a reasonable belief the same would be efficacious; was the treatment so proximate in time to the onset or the recurrence of the disease or condition as to make one the true occasion for the other, thus eliminating expense incurred for general, as contrasted with some specific, physical improvement?<sup>33</sup>

Treasury Regulation §1.213-1 provides that the medical expense deduction is only for “expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness. . . . [A]n expenditure which is merely beneficial to the general health of an individual, such as an expenditure for a vacation, is not [deductible].”<sup>34</sup> For example, the cost of a gym membership is not a medical expense, despite the fact that exercise will improve the taxpayer’s health.<sup>35</sup> The cost of a medically supervised weight loss program for a taxpayer diagnosed as “obese” is a medical expense, however, because obesity is recognized by doctors as a disease or condition.<sup>36</sup>

Although the regulation, on its face, seems to require that the taxpayer establish that she suffered from a “disease,” the § 213(d)(1)(A) definition is written in the disjunctive; an expense that satisfies either the “disease” prong *or* the “structure or function” prong is “medical care.” In addition, the IRS and courts have consistently allowed medical expense deductions—even in

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33. *Havey v. Comm’r*, 12 T.C. 409, 412–13 (1949) (holding that the taxpayer, a resident of Pittsburgh, could not deduct the cost of vacations in New Jersey and Arizona as medical care, despite her doctor’s recommendation that she go to the seashore in the summer and Arizona in the winter, and noting that the taxpayer vacationed in New Jersey and Arizona before she was diagnosed with heart disease, traveled to Arizona in late November and December, not in the coldest months of winter, and did not require the services of any medical professionals during the trips; the court further noted that the vacations probably improved Mrs. Havey’s health, but concluded that the medical benefit of the vacations was incidental and she could not deduct the cost of the vacations as medical expenses).

34. Treas. Reg. § 1.213-1(e)(1)(ii) (1957). *See also* Respondent’s Opening Brief *supra* note 14, at 185 (citing cases involving shopping sprees and around-the-world cruises).

35. Rev. Rul. 79-151, 1979-1 C.B. 116.

36. Rev. Rul. 2002-19, 2002-1 CB 778 (obese taxpayer can take a medical expense deduction for the cost of a medically-supervised weight loss program). Rev. Rul. 2002-19 superseded a prior revenue ruling that concluded that taxpayers could not deduct the costs of such weight loss programs. The IRS’s change in position was attributable to the fact that obesity was not recognized as a “disease” when the first revenue ruling was issued, but was recognized as a “disease” when the second revenue ruling was issued. *See id.*

the absence of “disease”—for the costs of procedures or items that are inherently medical.<sup>37</sup> For example, reproductive, obstetric, and preventive medical procedures performed on healthy patients are classified as medical care.<sup>38</sup> In addition, the IRS for decades has interpreted the term “disease” *very broadly* to include physical conditions, mental conditions, injuries, impairments, and disorders.<sup>39</sup> The implicit and long-standing § 213(d)(1) baseline for characterization of medical expenses is whether the expense is incurred primarily to address physical or mental *dysfunction* and help the patient resume or approximate “normal” functioning.<sup>40</sup>

### 1. The § 213(d)(1)(A) Core Concept of Functioning

The concept of functioning plays a central role in the classification of expenses as medical or nonmedical. An expense is medical if it is incurred primarily to address *dysfunction* and help the patient resume or approximate “normal” functioning.<sup>41</sup> Significantly, this Article asserts that functioning includes *internal biological functioning*, *internal psychological functioning*, and *social functioning*.

The baseline of normal functioning is implicit in Treasury regulations and cases that interpret § 213. For example, the regulations provide that a blind taxpayer can take a medical expense deduction for the cost of a seeing-eye dog,<sup>42</sup> and “the cost of medical care includes the cost of attending a special school designed to compensate for or overcome a physical handicap, in order to qualify the individual for future normal education or for normal

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37. See Pratt, *Inconceivable*, *supra* note 23, at 1140.

38. See, e.g., Treas. Reg. 1.213-1(e)(1)(ii) (obstetrical expenses are amounts paid for medical care); Rev. Rul. 73-200, 1973-1 C.B. 140 (cost of birth control pills is an amount paid for medical care); Rev. Rul. 73-201, 1973-1 C.B. 140 (cost of legal vasectomy or abortion is an amount paid for medical care); Rev. Rul. 2007-72, 2007-2 C.B. 1154 (costs of annual physical exam, whole-body scan, and pregnancy test kit are amounts paid for medical care notwithstanding the absence of disease). Such reproductive care procedures must be legal to constitute medical care, but the morality of such procedures otherwise is irrelevant for purposes of classifying the procedures as medical care. *O'Donnabhain v. Comm'r*, 134 T.C. 34, 110 (2010) (Gustafson, J., concurring in part and dissenting in part) (expressing concerns about GCS, but conceding that “otherwise deductible medical expenses are not rendered non-deductible on ethical grounds,” citing to a ruling that the costs of a legal abortion are deductible).

39. See Pratt, *Inconceivable*, *supra* note 23.

40. See *id.* at 1141–43.

41. See *id.* at 1143.

42. Treas. Reg. § 1.213-1(e)(1)(iii) (1960). It is irrelevant whether the blindness was caused by disease or injury, or was congenital. *Id.*

living, such as a school for the teaching of braille or lip reading.”<sup>43</sup> Having a guide dog or learning to read braille does not alter the student’s internal biological functioning because it does not restore the student’s vision, but it does improve the student’s social functioning in the world. Similarly, the costs of a note-taker for a deaf student are deductible,<sup>44</sup> not because the expense restores the student’s internal biological functioning, but because the note-taker helps the student approximate the functioning of a person who can hear.

In addition, the very fact that a body does not *appear* to conform to cultural norms can stigmatize an individual and create social dysfunction. For example, the cost of a wig is deductible as medical care if the wig is purchased for a child or woman who loses hair due to disease.<sup>45</sup> Allowing a deduction for a wig in such cases is consistent with the § 213 emphasis on functioning because a bald child or woman may face public stigmatization; baldness thus impairs the child’s or woman’s social functioning.<sup>46</sup> On the other hand, male baldness is not presumed to violate cultural norms or impair social functioning.<sup>47</sup> Bald men—unlike bald children and women—

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43. Treas. Reg. § 1.213-1(e)(1)(v)(a). Also, in Revenue Ruling 64-173 the IRS ruled that the taxpayers could deduct the amounts they paid to a person who served as a guide for their blind child at school. Rev. Rul. 64-173, 1964-1 C.B. 121 (1964).

44. Baer Est. v. Comm’r, 26 T.C.M. (CCH) 170 (1967).

45. See, e.g., Rev. Rul. 62-189, 1969-2 C.B. 88 (taxpayer whose daughter had a disease that caused hair loss could deduct the cost of a wig for her); I.R.S. Pub. 502 (Jan. 11, 2016), <https://www.irs.gov/pub/irs-pdf/p502.pdf> [hereinafter Pub. 502] (stating that the cost of a wig for a taxpayer who lost all hair “from disease” is deductible as medical care). Hair loss “from disease” may be caused by the disease or by treatment of the disease (e.g., chemotherapy treatment of cancer).

46. See, e.g., MEREDITH NORTON, LOPSIDED: HOW HAVING BREAST CANCER CAN BE REALLY DISTRACTING 74 (2008). Norton, who lost her hair during chemotherapy, describes the awkward, stigmatizing public reaction to a woman appearing bald in public:

It soon became clear, though, that wearing a wig wasn’t always about my own comfort. My bald head was like the elephant in the room. People had a hard time acting normal around me when I was bald. They tended to move slowly, as if quick motion might reactivate tumor growth, and they spoke carefully, often whispering and avoiding certain words.

I felt like the whole world had gone mad.

*Id.*

47. See, e.g., Albert E. Mannes, *Shorn Scalps and Perceptions of Male Dominance*, SOC. PSYCHOL. & PERSONALITY SCI. 1 (2012) (male pattern baldness, which affects fifty percent of men by age fifty, is “common and normal”). Although male pattern baldness is quite common, Mannes notes that it “has important psychological, social, and economic consequences.” Male pattern baldness has been associated with “poorer self-esteem and body image [and] depression. Balding men are perceived by others to be older than their peers by five to ten years and to be less agreeable, less assertive, and less attractive. Accordingly, men go to great lengths to hide or reverse their

are not stigmatized as social pariahs because male pattern baldness is so common. Consistent with this thinking, the IRS takes the position that hair transplants for bald men are “cosmetic surgery” and thus not medical care under § 213, notwithstanding the fact that hair transplants affect the “structure” of the body.<sup>48</sup>

*B. The § 213(d)(9) “Cosmetic Surgery or Other Similar Procedures”  
Limitation*

Under the second prong of the § 213(d)(1)(A) definition of “medical care” (the “structure-or-function prong”), the costs of any procedures that change the structure or function of a taxpayer’s body literally are within the definition of medical care—even if the taxpayer is healthy and does not undertake the procedures to reduce dysfunction. During the 1970s and 1980s, the IRS ruled that elective cosmetic surgery expenses, including face-lifts and electrolysis, were within the structure-or-function prong of the § 213(d)(1)(A) definition of medical care, and taxpayers thus could deduct the costs of such procedures.<sup>49</sup> These rulings were consistent with the IRS assumption that *inherently medical* surgical procedures (as opposed to inherently non-medical items or procedures) are “medical care.”<sup>50</sup> The IRS allowed deductions for the costs of purely cosmetic surgery procedures undertaken by healthy taxpayers, despite the fact that allowing such deductions is inconsistent with the “ability-to-pay,” involuntary-expenditure policy rationale for § 213.

In 1990, Congress amended § 213(d) to eliminate a medical expense deduction for such purely cosmetic procedures—meaning procedures that *improve appearance, but are not undertaken to reduce dysfunction*.<sup>51</sup> As

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natural hair loss.” *Id.* (citations omitted). Based on empirical research, however, Mannes concludes that (1) balding men can reverse the negative effects of balding by shaving their heads, and (2) men with shaved heads are perceived as taller, stronger, and more dominant. *Id.*

48. *See, e.g.*, Pub. 502, *supra* note 45 at 15 (medical expense deduction is not allowed for costs of hair transplant, which is “cosmetic surgery”). The 1990 cosmetic surgery amendment legislatively reversed Rev. Rul. 1982-111, 1982-1 C.B. 48 (1982), in which the IRS had ruled that a hair transplant was medical care under § 213, because hair transplants affect the structure or function of the body.

49. *See, e.g.*, Rev. Rul. 76-332, 1976-2 C.B. 81 (1976) (cost of purely cosmetic “face-lift” was deductible as a medical expense), Rev. Rul. 82-111 (cost of electrolysis was deductible as a medical expense).

50. *See* Treas. Reg. § 1.213-1(e)(1)(ii) (“Payments for the following are payments for medical care: hospital services, nursing services . . . , medical, laboratory, surgical, dental, and other diagnostic and healing services, X-rays, medicine and drugs . . . , artificial teeth or limbs, and ambulance hire.”).

51. *See infra* note 153.

amended, § 213(d)(9) excludes “cosmetic surgery or other similar procedures” from the § 213(d)(1)(A) definition of medical care. Section 213(d)(9)(A) provides: “The term ‘medical care’ does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.”<sup>52</sup> Cosmetic surgery is defined as “any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body.”<sup>53</sup>

The legislative history of the 1990 cosmetic surgery amendment refers to a few specific medical procedures in a binary, dichotomous fashion—as either “medically necessary” or “purely” cosmetic—but does not thereby *require* or define “medical necessity.”<sup>54</sup> The legislative history’s example of a necessary treatment that is deductible “medical care”—breast surgery following mastectomy<sup>55</sup>—is instructive. Numerous federal and state statutes mandate insurance coverage for breast reconstruction following mastectomy, notwithstanding the conclusion of the insurance industry that breast reconstruction is not “medically necessary.”<sup>56</sup> The rationale for such statutes

52. 26 U.S.C.S. § 213(d)(9)(A) (Westlaw through Pub. L. No. 114-219).

53. 26 U.S.C.S. § 213(d)(9)(B) (Westlaw through Pub. L. No. 114-219).

54. 136 CONG. REC. 30, 570 (1990).

55. *Id.*

56. *See, e.g.*, Women’s Health and Cancer Rights Act (“WHRCA”) of 1998, 29 U.S.C. § 1185(b) (Westlaw through Pub. L. No. 114-221), 42 U.S.C. § 300(gg)-52 (Westlaw through Pub. L. 114-221) (federal statute mandating coverage of breast reconstruction after mastectomy). For state coverage mandates (requiring post-mastectomy breast reconstruction for various types of insurance plans), see ALA. CODE § 22-6-10 (Westlaw through Act 2016-429 of the 2016 First Special Sess.); DEL. CODE. ANN. tit. 18, § 3347 (Westlaw through 80 Laws 2016, ch. 427); DEL. CODE. ANN. tit. 18, § 3563 (Westlaw through 80 Laws 2016, ch. 427); D.C. CODE § 31-3832 (2012); FLA. STAT. ANN. § 627.6417 (Westlaw through 2016 Reg. Sess.); FLA. STAT. ANN. § 627.6612 (Westlaw through 2016 Second Reg. Sess.); FLA. STAT. ANN. § 641.31 (Westlaw through 2016 Second Reg. Sess.); 65 ILL. COMP. STAT. ANN. 5/10-4-2(d-15) (Westlaw through P.A. 99-872 of the 2016 Reg. Sess.); 215 ILL. COMP. STAT. ANN. 5/356g(b) (Westlaw through P.A. 99-872 of the 2016 Reg. Sess.); 215 ILL. COMP. STAT. ANN. 125/4-6.1 (Westlaw through P.A. 99-872 of the 2016 Reg. Sess.); IND. CODE. ANN. § 27-8-5-26 (Westlaw through 2016 Second Reg. Sess.); IND. CODE. ANN. § 27-13-7-14 (Westlaw through 2016 Second Reg. Sess.); IOWA ADMIN. CODE r. 191-35.35(509) (Westlaw through 2016); IOWA ADMIN. CODE r. 191-71.23(513B) (Westlaw through 2016); IOWA ADMIN. CODE r. 191-75.17(513C) (through 2016); KAN. STAT. ANN. § 40-2,166 (Westlaw through 2016 Reg. and Special Sess.); KY. REV. STAT. ANN. § 304.17-3163 (Westlaw through 2016 Reg. Sess.); KY. REV. STAT. ANN. § 304.17A-134 (Westlaw through 2016 Reg. Sess.); KY. REV. STAT. ANN. § 304.18-0983 (Westlaw through 2016 Reg. Sess.); KY. REV. STAT. ANN. § 304.32-1593 (Westlaw through 2016 Reg. Sess.); KY. REV. STAT. ANN. § 304.38-1934 (Westlaw through 2016 Reg. Sess.); LA. REV.

is that breast reconstruction surgery not only is necessary, but is “essential” or even “life-saving”;<sup>57</sup> such breast surgery is not—as insurance companies asserted—cosmetic surgery.<sup>58</sup> The breast surgery mandates require coverage of the costs of reconstruction of a breast that is surgically removed due to a malignancy.<sup>59</sup> Such statutes also frequently mandate coverage for the costs of reducing or removing a *healthy* breast (where one breast is removed, due to cancer, but the other breast is healthy) and reconstructing the healthy breast to create symmetry between the two breasts.<sup>60</sup> In addition, some

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STAT. ANN. § 22:272(E) (Westlaw through 2016 Reg. Sess.); LA. REV. STAT. ANN. § 22:1077 (through 2016 Reg. Sess.); LA. REV. STAT. ANN. § 40:2209 (repealed 2016); ME. STAT. tit. 24, § 2837-C(2) (2015); ME. STAT. tit. 24, § 4237(2) (2015); ME. STAT. tit. 24, § 2320-C(2) (2015); MD. CODE ANN., Ins. § 15-815 (LexisNexis 2016); MISS. CODE ANN. § 83-1-43 (2000); MO. REV. STAT. § 376.1209 (2016); MONT. CODE ANN. § 33-22-135 (2015); NEB. REV. STAT. § 44-797 (2016); NEV. REV. STAT. § 608.157 (2016); NEV. REV. STAT. § 616C.185 (2016); NEV. REV. STAT. § 617.395 (2016); NEV. REV. STAT. § 689A.041 (2016); NEV. REV. STAT. § 689B.0375 (2016); NEV. REV. STAT. § 695B.191 (2016); NEV. REV. STAT. § 695C.171 (2016); N.H. REV. STAT. ANN. § 417-D:2-b (2016); N.J. STAT. ANN. § 17:48-6b (2015); N.J. STAT. ANN. § 17:48A-7b (2015); N.J. STAT. ANN. § 17:48E-35 (2015); N.J. STAT. ANN. § 17B:26-2.1(a) (2015); N.J. STAT. ANN. § 17B:27-46.1a (2015); N.J. STAT. ANN. § 26:2J-4.14, N.Y. INS. LAW § 3216(i)(20) (Consol. 2015); N.Y. INS. LAW § 3221(k)(10) (Consol. 2015); N.Y. INS. LAW § 4303(x)(1) (Consol. 2015); N.C. GEN. STAT. § 58-51-62 (2015); N.C. GEN. STAT. § 58-65-96 (2015); N.C. GEN. STAT. § 58-67-79 (2015); OKLA. STAT. tit. 36, § 6060.5 (2016); OR. REV. STAT. § 743A.110 (2012); R.I. GEN. LAWS § 27-18-39 (2016); R.I. GEN. LAWS § 27-19-34 (2016); R.I. GEN. LAWS § 27-20-29 (2016); R.I. GEN. LAWS § 27-41-43 (2016); S.D. ADMIN. R. 20:06:39:25(23) (2016); S.D. ADMIN. R. 20:06:39:28(23) (2016); TENN. CODE ANN. § 56-7-2507 (2015); TEX. INS. CODE ANN. § 1357.004 (West 2015); UTAH CODE ANN. § 31A-22-630 (LexisNexis 2015); VA. CODE ANN. § 2.2-2818(B)(9) (2016); VA. CODE ANN. § 38.2-3418.4 (2016); WASH. REV. CODE ANN. § 48.20.395 (2015); WASH. REV. CODE ANN. § 48.21.230 (2015); WASH. REV. CODE ANN. § 48.44.330 (2015); WASH. REV. CODE ANN. § 48.46.280 (2015); W. VA. CODE § 5-16-7(c) (2002); W. VA. CODE § 33-15-4g (2015); W. VA. CODE § 33-16-3p (2015); W. VA. CODE § 33-24-7g (2015); W. VA. CODE § 33-25A-8f (2015).

57. *See, e.g.*, 144 CONG. REC. 27, 499 (1998) (statement of Sen. D’Amato) (describing breast reconstruction after mastectomy as “critical,” “essential,” and “life saving”).
58. *Id.* (recounting the story of Janet Franquet, whose insurer denied coverage of breast reconstruction surgery on the grounds that the procedure was “cosmetic surgery” and not “medically necessary”). Senator D’Amato described the insurer’s position as “outrageous” and argued that “[i]t is absolutely unacceptable and wrong that many insurers have decided that this essential surgery is ‘cosmetic.’” *Id.*
59. *See, e.g.*, 29 U.S.C.S. § 1185(b) (Westlaw through Pub. L. No. 114-219) (federal mandate to cover breast reconstruction following mastectomy); OR. REV. STAT. § 743A.110 (2012) (Oregon’s state insurance mandate to cover breast reconstruction after mastectomy).
60. *See, e.g.*, N.H. REV. STAT. § 417-D:2-b (2016) (requiring insurers who provide coverage for mastectomy surgery to also provide coverage for “reconstruction of the



breast surgery mandates require coverage of the costs of surgically constructing a simulated (although non-sensate) areola on the surgically constructed breast.<sup>61</sup> Patients who want breast reconstruction, but do not want artificial silicone or water implants, sometimes opt for complex “tissue flap” or “trans flap” procedures, in which *healthy* tissue is removed from the patient’s abdomen, buttocks, thigh, or back to reconstruct a breast.<sup>62</sup>

Why is breast reconstruction surgery following mastectomy described as “necessary,” “essential,” or “life-saving”? If such surgery is necessary, it is because it is *psychologically necessary* and perhaps *socially necessary*—not because it is internally, biologically necessary for life.<sup>63</sup> A patient whose breast is removed will not die without breast reconstruction; such a patient may suffer psychologically and socially, however, if the breast is not reconstructed.<sup>64</sup> In addition, if only one breast is removed due to a malignancy, the patient may suffer distress unless the healthy breast also is removed and reconstructed to achieve “symmetry” with the new breast that replaced the diseased breast.<sup>65</sup> The distress of post-mastectomy patients is a form of body dysmorphia that breast reconstruction can address.<sup>66</sup>

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breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance . . .”).

61. See, e.g., N.C. GEN. STAT. § 58-67-79 (2015) (requiring HMOs to cover “reconstructive breast surgery” following mastectomy and defining “reconstructive breast surgery” to include “creation of a new nipple/areolar complex”); see also AM. CANCER SOC’Y, BREAST RECONSTRUCTION AFTER MASTECTOMY, <http://www.cancer.org/acs/groups/cid/documents/webcontent/002992-pdf.pdf> [hereinafter BREAST RECONSTRUCTION] (describing surgical and tattooing processes for creating a simulated areole).
62. See BREAST RECONSTRUCTION, *supra* note 61 (describing various types of “tissue flap” procedures in which non-breast tissue from the patient’s body is used to create a reconstructed breast).
63. Prior to the enactment of breast reconstruction mandates, insurance companies denied coverage of breast reconstruction surgery on the grounds that the surgery is not medically necessary for the body to function. See, e.g., 144 CONG. REC. 27,499 (1998) (statement of Sen. D’Amato) (insurance executive told Senator D’Amato “replacement of a breast is not medically necessary and not covered under the plan. This is not a bodily function and therefore cannot and should not be replaced.”).
64. See, e.g., Drew B. Metcalfe et al., *Prevalence of Body Dysmorphic Disorder Among Patients Seeking Breast Reconstruction*, 34 AESTHETIC SURGERY J. 733 (2014) (finding post-mastectomy patients suffer disproportionately from body dysmorphia); see also Mary Armao McCarthy, *Re-Imagining*, in VOICES OF BREAST CANCER: THE HEALING COMPANION: STORIES FOR COURAGE, COMFORT AND STRENGTH, 181–82 (The Healing Project, 2007) (removal of diseased breast was followed by “clinically curative” mastectomy of healthy breast and “emotionally healing” breast reconstruction).
65. McCarthy, *supra* note 64.
66. *Id.*

Post-mastectomy breast reconstruction addresses the internal psychological dysfunction and social dysfunction caused by a disfiguring mastectomy.<sup>67</sup> Post-mastectomy patients also undertake breast reconstruction, especially reconstruction to achieve symmetry, in part to improve appearance.<sup>68</sup> According to the legislative history, the fact that breast reconstruction is partially motivated by a desire to improve a patient’s appearance does not render the reconstruction “cosmetic,” for purposes of § 213(d)(9).<sup>69</sup>

The definition of “medical care” and the scope of the “cosmetic surgery” exception were the central legal issues in *O’Donnabhain v. Commissioner*.<sup>70</sup> Part II provides background on the case, explanation of the parties’ arguments in the Tax Court litigation, and a summary of the majority, concurring, and dissenting opinions in the case.

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67. See, e.g., Metcalfe, *supra* note 64, at 735 (concluding that “women who undergo mastectomy experience a psychologically fragile period with psychosocial sequelae, including loss of femininity, mood disturbances, and interpersonal, sexual and marital dysfunction,” and a significant percentage of such women develop body dysmorphic disorder).

68. See, e.g., NORTON, *supra* note 46, at 198. Norton provides this account of a conversation with her doctor, which illustrates the mixed appearance-and-functioning concerns of post-mastectomy patients who want breast reconstruction:

At my next appointment I asked Dr. Stone about getting breast reconstruction. He’d just given me a breast (singular) exam and I sat in front of him topless.

“I was thinking about getting a new one, and the old one fixed up. I wouldn’t want a new saggy one to match the old saggy one; and I sure don’t want a perky new one to mismatch the old saggy one.”

“What are you talking about?” he asked.

“The old boob is not cute. I want two cute boobs.”

*Id.* As this passage illustrates, wanting breast “symmetry” is partly about the desire to improve appearance, but breast reconstruction and post-mastectomy symmetry also significantly affect internal psychological functioning and social functioning in public and private settings. The widespread adoption of breast reconstruction mandates constitutes a public recognition of the critical importance of breast reconstruction for post-mastectomy functioning.

69. 136 CONG. REC. 30,485 (1990).

70. *O’Donnabhain v. Comm’r*, 134 T.C. 34 (2010).

## II. O'DONNABHAIN V. COMMISSIONER OF INTERNAL REVENUE<sup>71</sup>

### A. *The Facts*

Rhiannon G. O'Donnabhain is a transsexual woman.<sup>72</sup> Although she was born a biological male,<sup>73</sup> she experienced psychological discomfort in the male gender role from an early age.<sup>74</sup> O'Donnabhain eventually married and had children, but her feeling that “she was woman who was trapped in a male body” persisted throughout her twenty-year marriage.<sup>75</sup> After her

71. 134 T.C. 34.

72. The briefs and opinion in the *O'Donnabhain* case characterize the taxpayer as a “transsexual woman.” See, e.g., *O'Donnabhain*, 134 T.C. at 34; Post-Trial Brief of Petitioner Rhiannon G. O'Donnabhain at 21, *O'Donnabhain v. Comm'r*, 134 T.C. 34 (2010) (No. 6402-06) [hereinafter Post-Trial Brief of Petitioner]. The term “transsexual” typically refers to individuals who transition from assigned-female-at-birth to male (“FTM”) or from assigned-male-at-birth to female (“MTF”). Shawn Thomas Meerkamper, *Contesting Sex Classification: The Need for Genderqueers as a Cognizable Class*, WILLIAMS INST. DUKEMINIER AWARDS J. (2013), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Meerkamper-Dukeminier-Student-Note-2013.pdf>. The term sometimes is defined more narrowly to refer only to individuals who undertake medical treatment (for example gender-related hormone therapy and surgery) to transition. *Id.* The more inclusive terms “transgender” or “trans” often are used to refer to individuals who do not conform to the assigned-at-birth gender, including transsexuals as well as individuals who do not identify as male or female or who reject binary gender classification. See Franklin H. Romeo, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713, 713 n.1 (2005). The term “cisgender” is used to refer to individuals who are not transgender. FENWAY HEALTH, GLOSSARY OF GENDER AND TRANSGENDER TERMS (2010), [www.lgbthealtheducation.org/wp-content/uploads/Handout\\_7-C\\_Glossary\\_of\\_Gender\\_and\\_Transgender\\_Terms\\_\\_fi.pdf](http://www.lgbthealtheducation.org/wp-content/uploads/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf) [hereinafter GLOSSARY].

73. *O'Donnabhain*, 134 T.C. at 35. “Biological sex” is “the configuration of chromosomes, internal organs, external genitalia, hormonal output of the endocrine glands, secondary sex characteristics, and other somatic indicia of male, female, and intersex conditions.” Respondent’s Opening Brief, *supra* note 14, at 120 (Dietz testimony). Some transgender activists challenge references to a transgender person’s “biological sex,” because use of the term discounts the lived experience of transgender persons. See, e.g., Charlotte Allen, *The Transgender Triumph*, WEEKLY STANDARD (Mar. 2, 2015), <http://www.weeklystandard.com/the-transgender-triumph/article/859614> (MTF activist Mari Brighe objects to references to genes or biology and asserts: “I wasn’t born a boy, and I’ve never been a boy, and it’s like a knife to my heart every time I hear that phrase.”).

74. *O'Donnabhain*, 134 T.C. at 35. Gender roles are “the male, female and cross-gender social roles that people adopt in their public behavior, sometimes only in particular settings or on particular occasions.” Respondent’s Opening Brief, *supra* note 14, at 120 (Dietz testimony).

75. *O'Donnabhain*, 134 T.C. at 35.

marriage ended, her feeling that she was female intensified.<sup>76</sup> In August 1996, she began psychotherapy with Diane Ellaborn, a licensed independent clinical social worker who specialized in gender-related disorders and was authorized under state law to diagnose and treat psychiatric illnesses.<sup>77</sup>

In January 1997, after twenty therapy sessions, Ellaborn diagnosed O'Donnabhain as “a transsexual suffering from severe Gender Identity Disorder (GID),”<sup>78</sup> a psychiatric diagnostic code in the Diagnostic and Statistical Manual of Mental Disorders, which is widely used by mental health professionals.<sup>79</sup> Patients suffering from severe GID experience profound distress or impairment in functioning as a result of the incongruence between their persistent perceived gender identity and their biological sex.<sup>80</sup>

Ellaborn recommended the GID treatment protocol known as the Harry Benjamin standards of care,<sup>81</sup> which, among medical experts who treat GID, is the consensus view regarding appropriate care for GID

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76. *O'Donnabhain*, 134 T.C. at 35.

77. *O'Donnabhain*, 134 T.C. at 36.

78. *O'Donnabhain*, 134 T.C. at 34.

79. The last three versions of the DSM are: (1) AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., 1994) [hereinafter DSM-IV]; (2) AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter DSM-IV-TR]; and (3) AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5]. This Article generally refers to DSM-IV-TR, the version that was cited in the case. See, e.g., *O'Donnabhain*, 134 T.C. at 36–37 (citing DSM-IV-TR repeatedly).

80. DSM-IV-TR, *supra* note 79, at 586–82 (defining and providing diagnostic criteria for Gender Identity Disorder). “Gender identity” is defined as “[a] person’s innate, deeply-felt psychological identification as a man, woman, or something else, which may or may not correspond to the person’s external body or assigned sex at birth (*i.e.*, the sex listed on the birth certificate).” See GLOSSARY, *supra* note 72. DSM-5 replaced the term “gender identity disorder” with the term “gender dysphoria.” The DSM-5 diagnostic criteria for gender dysphoria are similar to the DSM-IV-TR diagnostic criteria for GID (including “clinically significant distress or impairment in social, occupational, or other important areas of functioning”). See also AM. PSYCHIATRIC ASS'N, DSM-5 GENDER DYSPHORIA FACT SHEET (2003), <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf> [hereinafter DSM-5 FACT SHEET].

81. *O'Donnabhain*, 134 T.C. at 39. The Benjamin standards of care were developed by the Harry Benjamin International Gender Dysphoria Association, which later was renamed the World Professional Association for Transgender Health (“WPATH”). WPATH is an international organization with around 350 members, all of whom work (in clinical or research settings) with patients who have “the full spectrum of gender problems, including GID . . .” Transcript of Record, at 269, *O'Donnabhain v. Comm'r*, 134 T.C. 34 (2010) (No. 6402-06) [hereinafter Trial Transcript] (direct examination of Dr. George Brown, a member of WPATH).

patients.<sup>82</sup> The Benjamin standards of care include a “triadic” sequence of care for GID patients who choose to undertake gender transition. Under the first step of this sequence, the patient begins with hormone treatment, *i.e.*, by taking prescription sex-specific hormones that reduce the incongruence between the patient’s body and the patient’s perceived gender. O’Donnabhain, who was referred by Ellaborn to an endocrinologist in February 1997, began taking feminizing hormones in September 1997, and has taken them continuously since that time.<sup>83</sup>

O’Donnabhain’s positive response to the hormone treatment, coupled with her strong desire to further reduce the incongruity between her perceived gender and biological sex, led Ellaborn to recommend that O’Donnabhain proceed to the second step of the triadic sequence: the “real-life” experience. At this stage of the treatment, the patient presents as the perceived gender full-time in public. In the spring of 2000, O’Donnabhain changed her legal name, had surgical facial feminization (“FFM”) (a tracheal shave to reduce the size of her Adam’s apple), and began the real-life experience.<sup>84</sup> During the FFM surgery, and in a subsequent surgery in December 2000, O’Donnabhain also underwent various other medical procedures that altered her appearance.<sup>85</sup> She also changed her gender designation on her driver’s license, in July 2000,<sup>86</sup> and carried with her a letter from Ellaborn, “to be used in the event she was confronted by authorities for using a sex-segregated facility such as a restroom or a changing room.”<sup>87</sup> O’Donnabhain had a positive response to the real-life experience, which included presenting as a woman at her project manager job in the construction industry. Her distress regarding her male anatomy persisted, however. Ellaborn concluded that O’Donnabhain’s impairment from her severe GID would persist unless she had sex reassignment surgery,<sup>88</sup> more commonly referred to now as “gender-confirmation surgery” (“GCS”).<sup>89</sup> GCS is the third and final step in the triadic sequence for gender transition.

In November 2000, Ellaborn wrote to Dr. Meltzer, a plastic and reconstructive surgeon who specialized in GCS. Dr. Meltzer’s office put O’Donnabhain’s name on the doctor’s waiting list for an initial appointment. In June 2001, O’Donnabhain travelled to Portland, Oregon, for an

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82. Trial Transcript, *supra* note 81, at 286 (Benjamin standards of care are the international standard of care).

83. *O’Donnabhain*, 134 T.C. at 39.

84. *O’Donnabhain*, 134 T.C. at 39.

85. Respondent’s Opening Brief, *supra* note 14, at 139–40.

86. *Id.* at 16 (referring to Stipulation Paragraph 58).

87. *O’Donnabhain*, 134 T.C. at 40 n.15.

88. *O’Donnabhain*, 134 T.C. at 39–40.

89. *See, e.g.*, Schechter, *supra* note 9.

initial examination and consultation with Dr. Meltzer, who concluded that O'Donnabhain was a good candidate for the surgery. In July 2001, Ellaborn wrote to Dr. Meltzer to (1) certify that O'Donnabhain met all of the requisite criteria for the third stage of care, GCS, and (2) formally recommend that O'Donnabhain have GCS.<sup>90</sup> Dr. Coleman, a Ph.D. clinical psychologist, also examined O'Donnabhain and recommended GCS.<sup>91</sup>

Dr. Meltzer performed O'Donnabhain's GCS on October 19, 2001. The surgery included: (1) penectomy and bilateral orchiectomy (the surgical removal of O'Donnabhain's penis and testicles); (2) vaginoplasty, clitoroplasty, and labiaplasty (construction of a vagina, clitoris, and labia, using sensitive tissue from the penis, scrotum, and glans, to create genitalia that appear and function as female genitalia); and (3) breast augmentation and shaping (at a cost of \$4,500), to enlarge O'Donnabhain's breasts and make the placement of the breasts on O'Donnabhain's chest look more feminine.<sup>92</sup> In 2002, O'Donnabhain took a medical expense deduction for her gender transition medical costs on her 2001 tax return.<sup>93</sup> These deductions subsequently were disallowed by the IRS.

Part II.B. explains the political context within which the tax controversy arose between O'Donnabhain and the IRS, focusing on the views of Dr. Paul McHugh, a psychiatrist and member of President George W. Bush's Counsel on Bioethics, who espouses controversial opinions that are hostile to transgender persons and GCS. Parts II.C. and II.D. chronicle the *O'Donnabhain* tax controversy and the extent to which Dr. McHugh's controversial ethical and moral views on GCS and transgender persons influenced the tax arguments made by the IRS in the case.

### B. *The Political Context*

In 2002, the year in which the *O'Donnabhain* tax controversy began, Dr. Paul McHugh, a vocal opponent of medical transition for transgender patients, was serving as a member of the President's Council on Bioethics

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90. *O'Donnabhain*, 134 T.C. at 34.

91. *O'Donnabhain*, 134 T.C. at 41. A second letter was required for O'Donnabhain because Linda Ellaborn was a licensed independent clinical social worker, not an M.D. or Ph.D. Under the Benjamin standards of care, if the initial letter formally recommending GCS is not from an M.D. or Ph.D. psychologist, a second letter from either a psychiatrist or Ph.D. clinical psychologist must be submitted to authorize the GCS. See Trial Transcript, *supra* note 81, at 446 (cross-examination of expert witness Dr. George Brown).

92. *O'Donnabhain*, 134 T.C. at 41. The medical terms for the various surgical procedures are defined in Respondent's Opening Brief, *supra* note 14, at 71.

93. *O'Donnabhain*, 134 T.C. at 42.

under President George W. Bush.<sup>94</sup> Dr. McHugh's powerful influence on the medical treatment of transgender persons dates back to 1975, when he became psychiatrist-in-chief at Johns Hopkins Hospital, which had pioneered GCS in the 1960s.<sup>95</sup> From the time he started working there, Dr. McHugh questioned the morality of GCS and intended to end the GCS program at Johns Hopkins.<sup>96</sup> He objected to the removal of healthy tissue, asserting that "moral matters," including "the ghastliness of the mutilated anatomy," "should have some salience."<sup>97</sup> In McHugh's view, inviolate moral standards are a necessary constraint on autonomy and the practice of psychiatry;<sup>98</sup> he saw GCS as the worst example of "cultural antinomianism" and "psychiatric misdirection."<sup>99</sup> His characterization of GCS as "cultural

94. Press Release, Office of the Press Secretary, The White House, President Names Members of Bioethics Council (Jan. 16, 2002), <http://georgewbush-whitehouse.archives.gov/news/releases/2002/01/20020116-9.html> [hereinafter Bush Bioethics Council Press Release] ("The Council's paramount objective will be to develop a deep understanding of the issues that it considers and to advise the President of the complex and often competing moral positions associated with biomedical innovation."). The press release highlights Dr. McHugh's writings on "assisted suicide and the misuse of psychiatry." Dr. McHugh's writings on the misuse of psychiatry argue that GCS is immoral and should not be performed. *See, e.g.*, Paul R. McHugh, *Psychiatric Misadventures*, AM. SCHOLAR, Autumn 1992 [hereinafter *Psychiatric Misadventures*] (concluding that GCS is the "grimmiest" example of psychiatric misdirection combined with a lawless ethic of autonomy).

95. *Psychiatric Misadventures*, *supra* note 94.

96. *Id.* (GCS started at Johns Hopkins and "[i]t was part of my intention, when I arrived in Baltimore in 1975, to help end it.").

97. *Id.* at 502. In McHugh's view, Hopkins' plastic surgeons obtained their skills in reconstructing the genito-urinary tract "not to treat the gender identity problem, but to repair congenital defects, injuries and the effects of destructive diseases such as cancer in this region of the body."

98. *Id.* at 503 (Although a culture of autonomy encourages GCS, "[m]oral matters should have some salience here.").

99. *Id.* at 501 ("This interrelationship of cultural antinomianism and a psychiatric misplaced emphasis is seen at its grimmiest in the practice known as sex-reassignment surgery."). At Johns Hopkins, Dr. McHugh liked to remind his colleagues of the Serenity Prayer: "God, give me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." *Surgical Sex*, *supra* note 11. The moral standards he espouses are consistent with the Christian conception of the human body as sacred—and starkly inconsistent with the notion of unfettered autonomy to alter the body.

Jonathan Haight astutely observes that many controversies between liberals and conservatives can be understood fundamentally as conflicts between an ethic of autonomy and an ethic of divinity:

On issue after issue, liberals want to maximize autonomy by removing limits, barriers, and restrictions. The religious right, on the other hand, wants to structure personal, social, and political relationships in three dimensions and so create a landscape of purity and pollution where restrictions maintain the separation of the sacred and the profane. For the religious right,

antinomianism” is telling. In its original theological context, antinomianism “is a pejorative term for the teaching that Christians are under no obligation to obey the laws of ethics . . . or morality,” because their sins are forgiven by the grace of God:<sup>100</sup> “Theological charges of antinomianism typically imply that the opponent’s doctrine leads to various sorts of licentiousness, and imply that the antinomian chooses his theology in order to further a career of dissipation.”<sup>101</sup>

Dr. McHugh also doubted the therapeutic benefits of GCS and encouraged his colleagues to “test the claim that men who had undergone sex-change surgery found resolution for their many general psychological problems.”<sup>102</sup> In 1979, Dr. Jon Meyer (Dr. McHugh’s colleague at Johns Hopkins) published a controversial study in which he concluded that the psycho-social condition of post-operative GCS patients was no better than before the surgery, although most of the patients expressed satisfaction with the surgery and had no regrets about it.<sup>103</sup> That year, Dr. McHugh ended the GCS program at Johns Hopkins,<sup>104</sup> based on his conclusion that “producing a ‘satisfied’ but still troubled patient seemed an inadequate reason for surgically amputating normal organs.”<sup>105</sup>

Dr. McHugh also opposed the “medicalization” of “destructive behaviors where choices play a role,” including deviant sexual behavior.<sup>106</sup> He

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hell on earth is a flat land of unlimited freedom where selves roam around  
with no higher purpose than expressing and developing themselves.

JONATHAN HAIGHT, *THE HAPPINESS HYPOTHESIS: FINDING MODERN TRUTH IN ANCIENT WISDOM* 209–10 (2006).

100. *Antinomianism*, THEOPEDIA, <http://www.theopedia.com/antinomianism> (last visited March 26, 2016).

101. *Id.*

102. *Surgical Sex*, *supra* note 11.

103. *Surgical Sex*, *supra* note 11; Paul McHugh, *Transgender Surgery Isn’t the Solution*, WALL ST. J. (June 12, 2014), <http://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120> [hereinafter *Transgender Surgery*] (most of the post-surgical patients “described themselves as ‘satisfied’ with the results, but their subsequent psycho-social adjustments were not better than those who didn’t have the surgery.”).

104. Rachel Witkin, *Hopkins Hospital: A History of Sex Reassignment*, JOHNS HOPKINS NEWSLETTER (May 1, 2014), <http://www.jhunewsletter.com/2014/05/01/hopkins-hospital-a-history-of-sex-reassignment-76004/>. Dr. McHugh, the Psychiatrist-in-Chief at Johns Hopkins “who never supported the University offering the surgeries . . . shut the program down” following the publication of a study written by Johns Hopkins psychiatrist Dr. Jon Meyer. *Id.*

105. *Transgender Surgery*, *supra* note 103.

106. See Letter from Paul McHugh, Prof. of Psychiatry, Johns Hopkins Univ. Sch. of Med., to Leon Kass, Chairman, President’s Council on Bioethics (June 3, 2003), [https://bioethicsarchive.georgetown.edu/pcbe/background/kass\\_mchugh.html](https://bioethicsarchive.georgetown.edu/pcbe/background/kass_mchugh.html) [hereinafter *Kass-McHugh Letters*] (in discussing what should not be medicalized, Mc-



posited a topology of four “classes” of psychiatric problems “to help limit the medicalization of mental life.”<sup>107</sup> Dr. McHugh’s classes include: “*diseases*” (*i.e.*, “[internal, biological] conditions encompassing the diseases of the brain such as dementia, manic-depression, [and] schizophrenia”); and “*behaviors*” (*i.e.*, “conditions encompassing destructive behaviors where choices play a role, such as sexual paraphilias and drug addictions”).<sup>108</sup> According to Dr. McHugh, disorders within each class “share a common identifiable basic nature,” and the treatments that are “appropriate” vary based on the class.<sup>109</sup> In his view, a patient’s claimed “transgenderism” is “behavior” (*i.e.*, sexual deviance and paraphilia<sup>110</sup>) chosen by the patient, not a “disease.”<sup>111</sup>

Dr. McHugh’s writings on the “medicalization” of behavior further express his moral misgivings about alterations of the body in the name of autonomy. He expressed his views on the topic during the time he served on

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Hugh refers to “destructive behaviors where choices play a role such as sexual paraphilias”).

107. *Id.*

108. *Id.* (emphasis added). The third class is “dimensions,” (*i.e.*, “conditions encompassing the problematic dispositions such as the mentally subnormal, the histrionic, and the immature who face emotional problems because of their dispositional vulnerabilities”). *Id.* The fourth class is “life stories” (*i.e.*, “conditions derived from troubled life experiences, social maladjustments, and disruptive assumptions such as grief, jealousy, homesickness and demoralization”). *Id.*

109. *Id.* Dr. McHugh asserts that his proposed classification system “permits an honest conversation with patients as to what are truly beneficial treatments and what may cheat them. The aim is to identify both the place and the limits of psychiatric expertise and restrict the medical treatment of human mental life to those limits.” *Id.*

110. A paraphilia is “a sexual disorder characterized by recurrent intense sexual urges, sexually arousing fantasies, or behavior involving use of a nonhuman object, the suffering or humiliation of oneself or one’s partner, or children or other nonconsenting partners.” MILLER-KEANE & MARIE T. O’TOOLE, MILLER-KEANE ENCYCLOPEDIA AND DICTIONARY OF MEDICINE, NURSING, AND ALLIED HEALTH (7th ed. 2003). For example, paraphilias include “fetishism, frotteurism, pedophilia, exhibitionism, voyeurism, sexual masochism, and sexual sadism.” *Id.*

111. For a discussion of Dr. McHugh’s “behavioral” perspective, see Philip J. Overby, *Psychiatry’s Healer*, 15 NEW ATLANTIS 99 (2007). Overby states in relevant part:

The *Behavior* perspective highlights the fact that in certain disorders the patient’s behavior itself contributes to or is itself the disorder, *e.g.*, alcoholism. The immediate goal is to stop the behavior, and only later to address the co-morbid conditions such as depression. To do otherwise is to treat the symptoms and ignore the root disease. Because no cure can be offered in the absence of the minimum condition of stopping the behavior, the importance of behavior as distinct from the disease requires emphasis.

*Id.* at 103 (emphasis in original).

President Bush’s Council on Bioethics.<sup>112</sup> A recurring theme in correspondence between Dr. McHugh and Dr. Kass (Chair of the Council) is their shared ethical concerns about the increasing “medicalization” of various conditions and disorders, in particular mental conditions and disorders.<sup>113</sup> Their correspondence “define[s] ‘medicalization’ as that view reducing all forms of human distress and disorder to aspects of ‘sickness’, expressions of ‘patient-hood’ and thus expressly open to technical, mostly bio-medical, correction at the hands of experts for whom ideas of good and evil, freedom and responsibility, sanctity and sin, approval and reprobation are meaningless.”<sup>114</sup> In keeping with these views, Dr. McHugh drew ethical distinctions between various types of medical and dental procedures that alter appearance:

We offer some medical/surgical treatments to people who are “whole” but would like help to “fit in.” We see no ethical concern in such practices as orthodontia because both dental function and appearance are enhanced. Face-lifts and “tummy-tucks” begin to provoke concern that we are going beyond the sick, but we accept them—sometimes with an embarrassed laugh over our vanities. Finally, *sex change operations and limb amputations for sexual desirability* we sometimes see as *abominations*.<sup>115</sup>

Dr. McHugh has campaigned against GCS for decades. He argues that what he terms “transgenderism” is a mental disorder of “assumption”: just as a patient with anorexia nervosa has a disordered assumption that she is overweight, contrary to “physical reality”, a trans woman has a disordered assumption that “he” is female, contrary to the “physical reality” of “his” male sex.<sup>116</sup> McHugh posited that “sexual identity” (assumed to be rigidly binary) is biologically and immutably determined by genes and prenatal hormonal milieu (*i.e.*, the embryonic exposure to sex hormones during

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112. See Bush Bioethics Council Press Release, *supra* note 94; Kass-McHugh Letters, *supra* note 106.

113. See Kass-McHugh Letters, *supra* note 106.

114. *Id.*

115. *Id.* (emphasis added). See also *infra* note 133–34.

116. See *Transgender Surgery*, *supra* note 103. Dr. McHugh used the term “transgenderism” in his writings. See *id.* In describing his writings, this Article uses his terminology. Note, however, that transgender persons generally do not use this term. Transgenderism “is a term used by anti-transgender activists to dehumanize transgender people and reduce who they are to ‘a condition.’” GLAAD MEDIA REFERENCE GUIDE—TRANSGENDER ISSUES, <http://www.glaad.org/reference/transgender> (last visited Sept. 14, 2016).

gestation).<sup>117</sup> He concluded that GCS should not be performed on a biologically “normal”—but mentally disordered—male who wants to become a woman:<sup>118</sup>

It is not obvious how this patient’s feeling that he is a woman trapped in a man’s body differs from the feeling of a patient with anorexia nervosa that she is obese despite her emaciated cachectic state. We don’t do liposuction on anorexics. Why amputate the genitals of these poor men? Surely the fault is in the mind, not the member.<sup>119</sup>

Dr. McHugh’s conclusion was that patients who “claim”<sup>120</sup> to be transgender need their minds fixed, not their genitals.<sup>121</sup> In his view, performing GCS on such patients is “fundamentally cooperating with a mental illness,” and “collaborating with madness.”<sup>122</sup>

Over several decades, Dr. McHugh has taken many controversial positions on transgenderism, GCS, and the classification and treatment of various types of mental illness. For example, he opined that biological men who want to medically transition to being female can be divided into two groups: (1) homosexual men who are conflicted about their homosexuality and want to become female so they can feel less conflicted about being with male sexual partners; and (2) men (typically older men who have lived their adult lives as heterosexuals) with “autogynephilia,”<sup>123</sup> which is defined as “a male’s paraphilic tendency to be sexually aroused by the thought or image

117. See *Surgical Sex*, *supra* note 11.

118. *Id.*

119. *Psychiatric Misadventures*, *supra* note 94, at 503. This quote focuses entirely on trans women and ignores trans men. Discussions about transgender persons, even among feminist writers, tend to be dominated by the MTF model. See Talia Bettcher, *Feminist Perspectives on Trans Issues*, 31 STAN. ENCYCLOPEDIA PHILOSOPHY 39, 45, Spring 2014, <http://plato.stanford.edu/archives/spr2014/entries/feminism-trans> (noting “the over-emphasis on MTFs” and the “the male-to-female dominance in trans contexts”).

120. *Id.* at 502 (“[T]he patient [who wants GCS] *claims* it is a torture for him to live as a man. . . . The patient’s *claim* that this has been a lifelong problem is seldom checked with others who have known him since childhood.”) (emphasis added); Paul McHugh, *Transgenderism: A Pathogenic Meme*, PUB. DISCOURSE (June 10, 2015), <http://www.thepublicdiscourse.com/2015/06/15145/> (last visited Mar. 26, 2016) [hereinafter *Pathogenic Meme*] (“[f]or forty years [as a psychiatrist at Johns Hopkins] I’ve been studying people who claim to be transgender”).

121. *Surgical Sex*, *supra* note 11.

122. *Id.*

123. See, e.g., *Surgical Sex*, *supra* note 11. (opining that men with autogynephilia “found intense sexual arousal in cross-dressing as females” and wanted GCS “to add more verisimilitude to their costumes”); *Pathogenic Meme*, *supra* note 120 (commenting

of himself as a woman."<sup>124</sup> Dr. McHugh is a strong proponent of autogynephilia theory, despite the fact that the theory has been questioned from many quarters.<sup>125</sup> The tenets of autogynephilia theory, including the following, are categorical and extreme:

Autogynephilia is always present in non-homosexual male-to-female transsexuals (MTFs) and always absent in homosexual MTFs; those non-homosexual MTFs who deny autogynephilia and those homosexual MTFs who report autogynephilia are mistaken or in denial; autogynephilia is a paraphilia; autogynephilia is an orientation; autogynephilia is *the* motivation of non-homosexual MTFs to seek [GCS]; autogynephilia is clinically important; and non-homosexual MTFs have difficulty with pair bonding due to their autogynephilic interests.<sup>126</sup>

Autogynephilia theory has been contested by medical experts, clinicians, researchers, and transgender persons. For example, in a 2010 peer-reviewed article, Dr. Charles Moser concludes that many aspects of the theory are flawed, although it "can explain the motivation of some MTFs."<sup>127</sup> He reviews the empirical evidence for and against each of the posited implications of autogynephilia theory and concludes that "[c]ontrary to the conclusions of [the theory's] proponents, many of the tenets of the theory are not supported by the existing data, or both supporting and contradictory data exist."<sup>128</sup> Among his arguments, Dr. Moser concludes that autogynephilia is not a paraphilia because anti-androgens, which reduce sex drive, do not reduce the desire of MTFs to transition, but do reduce the desire of paraphiliacs to act on their sexual desires.<sup>129</sup> Transwomen also adamantly reject autogynephilia theory, especially its singular focus on erotic sex, as inconsistent with their lived experience.<sup>130</sup>

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that photo of Caitlyn Jenner on the cover of Vanity Fair "suggests" that Jenner suffers from autogynephilia).

124. Charles Moser, *Blanchard's Autogynephilia Theory: A Critique*, 57 J. HOMOSEXUALITY 790, 791 (2010) [hereinafter *Autogynephilia Critique*] (peer-reviewed article evaluating and critiquing Dr. Blanchard's autogynephilia theory).

125. *Id.* at 791 (citation omitted) (noting that "professionals, researchers and transsexuals have been very critical of this theory").

126. *Id.* at 792 (emphasis in original).

127. *Id.* at 790 (concluding that "although autogynephilia exists, the theory is flawed").

128. *Id.* at 805.

129. *Id.* at 800.

130. See, e.g., Anna Magdalena, *A Critique of Paul McHugh's 'Surgical Sex'*, CATHOLIC TRANS BLOG (Feb. 9, 2014), <https://catholictrans.wordpress.com/2014/02/09/a-critique-of-paul-mchughs-surgical-sex/> (theory of autogynephilia "ignores the majority

Dr. McHugh also has taken other controversial positions on transgenderism, GCS, and sexual deviance. He maintains that the focus of treatment for patients with sexual deviations should be on prevention, counseling, and medication,<sup>131</sup> and has argued that the field of psychiatry should “close down the practice [of GCS] everywhere.”<sup>132</sup> Extending the notion that the *entire* motivation for GCS is sexual arousal, his writings repeatedly pair GCS with “[amputations of] the legs of patients who claim to find sexual excitement in gazing at and exhibiting stumps of amputated legs.”<sup>133</sup> The amputation of limbs for sexual arousal violates “deep moral convictions . . . about what is right or wrong,” “commandeers our thinking,” generates a “sense of outrage, disruption, and disorientation,” and “trigger[s] a deep-seated response . . . that overrides traditional notions of process and procedure.”<sup>134</sup> Dr. McHugh’s rhetorical pairing of GCS and erotically motivated limb amputations seems designed to elicit similar visceral revulsion and disgust towards GCS.<sup>135</sup>

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of the transgender experience for the sake of providing a neat sexualized explanation”).

131. See, e.g., *Pathogenic Meme*, *supra* note 120 (expressing the view that Caitlyn Jenner’s “psychological serenity in the future is doubtful” because “his” doctors performed GCS and other feminizing surgeries on “him,” instead of treating “him” properly, with psychotherapy and medication).
132. *Surgical Sex*, *supra* note 11.
133. See, e.g., *Surgical Sex*, *supra* note 11 (expressing disappointment that foreign surgical centers perform GCS and other surgeries requested by “patients with sexual deviations,” including the “astonishing” leg amputation surgery).
134. STEVEN M. SHEFFRIN, *TAX FAIRNESS AND FOLK JUSTICE* 44 (2013) (quoting Steven Pinker, *The Moral Instinct*, N.Y. TIMES MAG., Jan. 13, 2008, at 638). Moralization is a psychological state that can be turned on and off like a switch, and when it is on, a distinctive mind-set commandeers our thinking. This is the mind-set that makes us deem actions immoral (“killing is wrong”) rather than merely disagreeable (“I hate brussels sprouts”), unfashionable (“bell-bottoms are out”), or imprudent (“don’t scratch mosquito bites”).

According to [the theory of moral mandates], individuals hold deep moral convictions, which are subjective beliefs about what is right or wrong. The broad moral categories identified by the anthropologists – and the sense of outrage, disruption, and disorientation when they are violated – set the background for individual moral convictions that people hold in their lives. . . . [T]hey have to be “experienced as a psychologically nonnegotiable and as a fundamental truth about right and wrong.” . . . [I]f an issue touches directly on a moral mandate, it will trigger a deep-seated response – drawing on our moral instincts and self-definition – that overrides traditional notions of process and procedure.

*Id.* at 44–45 (internal citations omitted).

135. Martha Nussbaum notes that “[d]isgust is like racial hatred: it does not always announce itself in polite company.” NUSSBAUM, *supra* note 19, at 26.

Dr. McHugh’s influential yet controversial bioethical views on transgenderism and GCS featured prominently in the tax controversy between O’Donnabhain and the IRS. One could even say that McHugh’s writings on GCS—which of course say nothing about how the tax law defines “medical care”—served as the IRS “playbook” in the ensuing tax litigation, notwithstanding that the litigation should have centered narrowly on the interpretation under existing tax law of the term “medical care” in § 213.

### C. *The Administrative Tax Controversy*

During the 2002 IRS examination of O’Donnabhain’s 2001 tax return, the IRS examiner took the position that O’Donnabhain’s 2001 medical expenses were nondeductible cosmetic surgery expenses,<sup>136</sup> not deductible medical expenses, and asserted a \$5,679 tax deficiency,<sup>137</sup> \$5,115 of which was attributable to the disallowance of medical expenses.<sup>138</sup> During the next phase of the administrative tax controversy, in the Boston IRS Office of Appeals,<sup>139</sup> O’Donnabhain was represented by attorneys from Gay and Lesbian Advocates and Defenders (“GLAD”). In November of 2004, GLAD issued a press release about an anticipated resolution of the appeal in favor of O’Donnabhain. (The IRS appeal still was pending at the time GLAD issued the press release. The GLAD attorneys apparently understood that the Appeals Officer would allow the deduction, but the IRS later reversed course and denied O’Donnabhain the deduction.) In the press release, GLAD attorney Karen Loewy stated that the IRS Appeals Officer’s decision to allow O’Donnabhain the medical expense deduction “recognizes that sex reassignment can be as medically necessary for some people as an appendectomy or heart bypass surgery.”<sup>140</sup>

The GLAD press release prompted a firestorm of conservative backlash.<sup>141</sup> In a December 2004 open letter to IRS Commissioner Mark

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136. Kelley Winters, *A Taxing Question of Medical Necessity*, GID REFORM WEBLOG (Feb. 6, 2010), <https://gidreform.wordpress.com/2010/02/06/a-taxing-question-of-medical-necessity/> (stating tax examiner denied O’Donnabhain’s 2001 medical expense deduction on the grounds that GCS and hormonal treatment were “cosmetic” expenses).

137. See also Alesdair H. Ittelson, *Trapped in the Wrong Phraseology: O’Donnabhain v. Commissioner – Consequences for Federal Tax Policy and the Transgender Community*, 26:2 BERKELEY J. GENDER L. & JUST. 356, 358 (2011).

138. Post-Trial Brief of Petitioner, *supra* note 72.

139. The Office of Appeals is part of the IRS and functions like a mediation service to resolve tax controversies without litigation. Settlements made by Appeals Officers are not made public.

140. See Phan, *supra* note 12.

141. *Id.* (describing public response of Traditional Values Coalition to the GLAD announcement).

Everson, the chairman of the Traditional Values Coalition (“TVC”), Reverend Louis Sheldon, demanded that the IRS reverse its position “[o]n behalf of the 43,000 churches that are associated with the Traditional Values Coalition.”<sup>142</sup> Criticizing the “homo-trans” agenda as “a sure recipe for sexual confusion and life-long despair,” Sheldon asserted that “[a] man can no more become a woman than he can become a Dodge Minivan. A person who thinks otherwise is delusional.”<sup>143</sup> The Sheldon TVC letter asserted that encouraging sex reassignment surgery is “collaborating with madness,”<sup>144</sup> an expression Dr. McHugh used in his 2004 article, *Surgical Sex*,<sup>145</sup> which appeared in the religiously affiliated publication *First Things*.<sup>146</sup> Sheldon warned Commissioner Everson that the decision of the IRS made it a “pawn” in the “homosexual/transgender movement,” which advocates for allowing individuals to determine their own gender identity.<sup>147</sup> Conservative Christian news outlets spread the word about the TVC letter to Everson.<sup>148</sup> In February 2005, more than two dozen members of Congress wrote to Commissioner Everson, expressing outrage about the decision of the IRS Office of Appeals to allow the deduction, which they said “smacks in the face of the law-abiding tax examiner” who classified the GCS and hormone therapy expenses as nondeductible “cosmetic” expenses.<sup>149</sup> The letter demanded that Everson explain the IRS decision.<sup>150</sup> Both the TVC letter to Commissioner Everson, which displays some of Dr. McHugh’s rhetoric, and the subsequent letter that members of Congress sent to Commissioner Everson express the moral outrage these groups felt about the IRS allowing O’Donnabhain a medical expense deduction.

Several months later, the IRS Office of Chief Counsel issued Chief Counsel Advice (the “CCA”) regarding the *O’Donnabhain* controversy.<sup>151</sup>

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142. *Id.* (quoting TVC Chairman Sheldon’s letter of concern).

143. *Id.* (quoting TVC Chairman Sheldon’s letter of concern).

144. *Id.* (arguing “[t]he IRS is collaborating with madness by giving tax deductions for unneeded ‘sex change’ operations”).

145. *Surgical Sex*, *supra* note 11.

146. See *Masthead*, FIRST THINGS, <https://www.firstthings.com/masthead> (last visited Sept. 13, 2016) (“First Things is published by The Institute on Religion and Public Life, an interreligious, nonpartisan research and education institute whose purpose is to advance a religiously informed public philosophy for the ordering of society.”)

147. Phan, *supra* note 12.

148. See, e.g., *id.*

149. John McCaslin, *Under the Beltway*, WASH. TIMES (Feb. 16, 2005), <http://www.washingtontimes.com/news/2005/feb/16/20050216-123422-6559t/> (quoting letter from congressmen: “[a]s members of the United States House of Representatives, we view this as an outrage and believe it sets a precedent that both the IRS and the American taxpayer at large will not be comfortable with”).

150. *Id.*

151. CCA, *supra* note 13.

The CCA, citing Dr. McHugh's article, *Surgical Sex*, concluded that *O'Donnabhain's* GCS and hormonal therapy expenses were nondeductible cosmetic surgery expenses, not deductible medical expenses.<sup>152</sup> The Office of Chief Counsel also cited relevant federal income tax sources including § 213(d)(1)(A) and (d)(9)(A), Treasury Regulation § 1.213-1(e) (1), and the legislative history of the 1990 cosmetic surgery amendment to §213.<sup>153</sup> Construing the legislative history to create "strict" and very specific requirements for deducting the costs of medical procedures that alter appearance, the CCA concludes:

[T]he taxpayer has not satisfactorily demonstrated that the expenses incurred for the taxpayer's [GCS] fit within the strict boundaries for [a medical expense deduction]. There is nothing to substantiate that these expenses were incurred to promote the proper function of the taxpayer's body and only incidentally affect the taxpayer's appearance. The expenses also were not incurred for treatment of a disfiguring condition arising from a congenital abnormality, personal injury, trauma, or disease (such as reconstructive [breast] surgery following the removal of a malignancy).<sup>154</sup>

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152. *Id.* at 5.

153. See CCA, *supra* note 13, at 4; see also Omnibus Budget Reconciliation Act of 1990, P.L. 101-508 § 11342(a), 104 Stat. 1388 § 11342(a) (amending § 213 to add § 213(d)(9), the cosmetic surgery exception, to the § 213(d)(1) definition of medical care). The cosmetic surgery exclusion was added to the bill in the Senate and the Senate Report was printed in the Congressional Record (instead of being reported separately). See CCA, *supra* note 13, at 4; see also 136 CONG. REC. S15629, S15711 (October 18, 1990). The CCA states that the Senate committee:

[D]etermined that expenses for cosmetic surgery should not be eligible for the medical expense deduction absent certain circumstances clearly not present in the case of [GCS] (*i.e.*, a congenital abnormality, an accident or trauma, or a disfiguring disease). The Senate Report states that expenses for purely cosmetic procedures that are not medically necessary are, in essence, voluntary personal expenditures, which like other personal expenditures (*e.g.*, food and clothing) generally should not be deductible in computing taxable income. In discussing the types of surgery which are deemed to be medically necessary, the Senate Report lists only: (1) procedures that are medically necessary to promote the proper function of the body and which only incidentally affect the patient's appearance; and (2) procedures for treatment of a disfiguring condition arising from a congenital abnormality, personal injury, trauma, or disease (such as reconstructive surgery following the removal of a malignancy). . . .

CCA, *supra* note 13, at 4.

154. CCA, *supra* note 13, at 5.



Although the Benjamin standards of care are the consensus approach among medical experts who diagnose and treat patients with gender identity disorders,<sup>155</sup> the Office of Chief Counsel expressed concern that the question of “whether [GCS] is a treatment for an illness or disease is *controversial*,” citing Dr. McHugh’s *Surgical Sex* article.<sup>156</sup> The Office of the Chief Counsel opined that the costs of GCS and hormone therapy could not be deducted as medical expenses without an “unequivocal expression of Congressional intent that expenses of this type qualify,” and concluded that allowing such medical expense deductions without express authority “would be moving beyond the generally accepted boundaries that define this type of deduction.”<sup>157</sup> The IRS Office of Appeals subsequently reversed course and denied O’Donnabhain the medical expense deduction for the costs of the GCS and hormone therapy.<sup>158</sup>

#### *D. The Case in the United States Tax Court*

In 2006, O’Donnabhain filed a petition in the United States Tax Court to challenge the IRS classification of the disputed expenses and as-

155. Trial Transcript, *supra* note 81, at 286 (direct testimony of Dr. George Brown, explaining that the Benjamin standards of care are the international standard of care). Dr. Brown notes that the goal of hormone treatment and GCS is to relieve the complex of GID symptoms:

[W]e’re looking at changes in mood, changes in satisfaction with life, ability to get beyond the symptoms that they had prior to the treatment that they have received.

So, we’re looking at emotional, affective if you will, components as well as things like employment . . . housing, family relationships, sexual relationships.

*Id.* at 289.

156. CCA, *supra* note 13, at 5 (citing *Surgical Sex*, *supra* note 11) (emphasis added).

157. CCA, *supra* note 13, at 5:

To our knowledge, there is no case law, regulation, or revenue ruling that specifically addresses medical expense deductions for GRS or similar procedures. In light of the Congressional emphasis on denying a deduction for procedures relating to appearance in all but a few circumstances and the controversy surrounding whether GRS is a treatment for an illness or disease, the materials submitted do not support a deduction. Only an unequivocal expression of Congressional intent that expenses of this type qualify under section 213 would justify the allowance of the deduction in this case. Otherwise, it would seem we would be moving beyond the generally accepted boundaries that define this type of deduction).

*Id.*

158. O’Donnabhain v. Comm’r, 134 T.C. 34, 96 (2010) (stating that IRS denied the deduction).

serted a tax deficiency of \$5,679.<sup>159</sup> The Tax Court trial before Judge Gale began on July 24, 2007. The main legal issue concerned the statutory construction of § 213(d)(1)(A) and (d)(9) and the application of § 213(d) to the facts of the case.<sup>160</sup> Some of the facts were hotly contested. For example, the IRS argued that the GID diagnoses made by Ellaborn and Coleman were a "sham" because: (1) Ellaborn and Coleman did not independently verify what O'Donnabhain told them about her GID symptoms; (2) "patient deception" made such third-party corroboration of her symptoms "essential" in the case; and (3) O'Donnabhain lied to them and manipulated them.<sup>161</sup> O'Donnabhain, Dianne Ellaborn, Dr. Coleman, and Dr. Meltzer all testified as fact witnesses at the trial.<sup>162</sup> Dr. Brown testified as an expert witness and submitted an expert witness report on behalf of O'Donnabhain.<sup>163</sup> Dr. Dietz and Dr. Schmidt, both of whom were Dr. McHugh's colleagues at Johns Hopkins,<sup>164</sup> testified and submitted expert reports on behalf of the IRS. The trial briefs, transcript, and expert witness reports total over 1,000 pages. Eight lawyers were listed on the IRS briefs<sup>165</sup> and five lawyers were listed on O'Donnabhain's briefs.<sup>166</sup>

## 1. The Parties' Arguments

### a. O'Donnabhain's Arguments

O'Donnabhain argued that: (1) the § 213(d) term "disease" is construed broadly and includes mental disorders;<sup>167</sup> (2) GID is a "disease" according to standard medical references, including the DSM-IV and

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159. *O'Donnabhain*, 134 T.C. at 34.

160. *See O'Donnabhain*, 134 T.C. at 34.

161. Respondent's Opening Brief, *supra* note 14, at 197–98, 201–02 (noting practice of "patient deception" in GID cases, insisting that independent verification of O'Donnabhain's symptoms was "essential," and arguing that "statements to her evaluators were not forthright [and] in fact, they were a manipulation of her health care providers").

162. *O'Donnabhain*, 134 T.C. at 41–42.

163. *O'Donnabhain*, 134 T.C. at 41–42.

164. Respondent's Opening Brief, *supra* note 14, at 96 (Dr. McHugh was Dr. Schmidt's colleague at Johns Hopkins), 106, 155 (while Dr. Dietz was a resident at Johns Hopkins, he was Dr. McHugh's student).

165. IRS briefs lists Donald Korb (IRS Chief Counsel), Thomas Thomas, Frances Regan, Maureen O'Brien, Mary Hamilton, John Mikalchus, Erika Cormier, and Molly Donahue. Respondent's Opening Brief, *supra* note 14.

166. O'Donnabhain was represented in the case by three attorneys from Gay and Lesbian Advocates and Defenders, Ben Klein, Karen Loewy, and Jennifer Levi, and two pro bono attorneys, David Nagle and Amy Sheridan. Trial Transcript, *supra* note 81, at 1–2.

167. *See* Post-Trial Brief of Petitioner, *supra* note 72, at 51–52 n.10.

standard psychiatric texts;<sup>168</sup> (3) the mental health professionals who treated O'Donnabhain were licensed to diagnose and treat mental health disorders and were experts in gender disorders;<sup>169</sup> (4) GCS and hormone therapy are standard medical therapies that are widely accepted within the expert medical community as treatments for severe GID;<sup>170</sup> (5) the medical procedures undertaken by O'Donnabhain changed her functioning, not just her appearance;<sup>171</sup> (6) neither GCS nor hormone therapy is § 213(d)(9) cosmetic surgery because the procedures were undertaken for the purpose of relieving the psychological distress and impairment caused by O'Donnabhain's severe GID to permit her to function more normally; and (7) the expenses were incurred to affect the structure or function of her body.<sup>172</sup> Quoting from the Benjamin standards of care, O'Donnabhain asserted that GCS to treat severe GID "is medically indicated and medically necessary. Sex reassignment is not . . . 'elective,' 'cosmetic,' or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID."<sup>173</sup>

O'Donnabhain argued that the feminizing hormones and GCS were necessary for her to function and flourish. Medical transition reduces the incongruence between a GID patient's internal sense of gender and the patient's body.<sup>174</sup> The therapeutic goals of reducing this incongruence are (1)

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168. Trial Transcript, *supra* note 81, at 283–84 (direct testimony of Dr. George Brown); Post-Trial Brief of Petitioner, *supra* note 72, at 6–7, 47.

169. Post-Trial Brief of Petitioner, *supra* note 72, at 12, 43–45.

170. Trial Transcript, *supra* note 81, at 284–85 (direct testimony of Dr. George Brown); Post-Trial Brief of Petitioner, *supra* note 72, at 12.

171. Post-Trial Brief of Petitioner, *supra* note 72, at 12 (surgery created "functioning, sensate clitoris" and vaginal vault).

172. Trial Transcript, *supra* note 81, at 14–22 (Loewy's opening statement on behalf of Petitioner); *id.* at 70 (O'Donnabhain testimony that purpose of gender transition medical procedure was "[n]ot for improving my appearance, but so that I would look to the outside world that I was female"). Expert witness Dr. George Brown testified that surgery may be important to pass "with intimate partners or going to a gym using a locker room, and other places where you might have to be naked in public, or an emergency room or a doctor's office." *Id.* at 424. See also Post-Trial Brief of Petitioner, *supra* note 72, at 14, 45–46, 57 (The taxpayer's "purpose was to alter her body to bring it into conformity with her female gender identity so as to enable her to fully function as a woman."). *Id.* (emphasis added).

173. Post-Trial Brief of Petitioner, *supra* note 72, at 14.

174. The diagnostic criteria for GID under DSM-IV-TR include: (1) a strong and persistent cross-gender identification; (2) persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex; (3) the absence of a biological intersex condition; and (4) "clinically significant distress or impairment in social, occupational, or other important areas of functioning." DSM-IV-TR, *supra* note 79. DSM-5, which uses the term "gender dysphoria" instead of "gender identity disorder," has similar diagnostic criteria, including "clinically significant distress or impairment in social, occupational, or other important areas of functioning," but

to reduce the patient’s clinical levels of internal psychological distress, and (2) to reduce the patient’s functional impairments, including impairments in social functioning.<sup>175</sup> Transgender persons who transition thus have dual goals, one of which is entirely internal and psychological, and the other of which is to be able to function in their gender. O’Donnabhain had both goals.<sup>176</sup>

The first goal of medical transition is to reduce the patient’s internal distress. Persons with GID express the internal feeling of having a “birth defect”<sup>177</sup> or that they are “in the wrong body.”<sup>178</sup> O’Donnabhain testified, “I wanted my male body to go away.”<sup>179</sup> The internal feelings of distress are so intense that patients with GID sometimes attempt to castrate themselves.<sup>180</sup> In addition, suicide rates for transgender persons are significantly higher than for the general population.<sup>181</sup> At trial, O’Donnabhain testified:

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eliminates the designation of the condition as a “disorder.” DSM-5, *supra* note 79; DSM-5 FACT SHEET, *supra* note 79 (“[G]ender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.”).

175. Trial Transcript, *supra* note 81, at 359–60 (cross examination of Dr. George Brown, explaining that patients seek treatment to reduce conflicts with society and internal psychological distress).
176. *Id.* at 70–71 (direct testimony of O’Donnabhain, explaining both her desire to function as a woman in public spaces and her desire to relieve her internal psychological distress). *See also* Post-Trial Brief of Petitioner, *supra* note 72, at 55–56 (O’Donnabhain’s “consistent purpose” was “to treat her GID and alleviate her clinically significant distress and impairment by bringing her gender identity and her body into conformity, and enabling her to live and function as the woman she is.”).
177. *See, e.g.*, SUSIE ORBACH, BODIES 26 (2009) (stating that the genitals with which a trans woman was born were a “life-threatening birth defect”).
178. *See, e.g.*, Talia Bettcher, *supra* note 119, at 31, 63 (describing Jay Prosser’s argument that “transsexuals appeal to the notion of the ‘wrong body’ because it simply feels that way,” but rejecting the “wrong-body” theory because it assumes that gender is innate).
179. Trial Transcript, *supra* note 81, at 62.
180. Report of Plaintiff’s Expert Dr. George R. Brown at 11, O’Donnabhain v. Comm’r of Internal Revenue, 134 T.C. 34 (2010) (No. 6402-06) [hereinafter Brown Expert Report] (stating that “[a]utocastration, autopenctomy, or impulses to perform genital self-surgery have been reported in patients who have not received appropriate medical care for their GID”).
181. ANNE P. HAAS ET AL., AM. FOUND. FOR SUICIDE PREVENTION AND WILLIAMS INST., UCLA SCH. OF L., SUICIDE ATTEMPTS AMONG TRANSGENDER AND GENDER NON-CONFORMING ADULTS: FINDINGS OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY, (2014) [hereinafter TRANSGENDER SUICIDE ATTEMPTS]. The authors conclude:

Overall, the most striking finding of our analysis was the exceptionally high prevalence of lifetime suicide attempts reported by [National Transgender Discrimination Survey] respondents across all demographics and experiences. Based on prior research and the findings of this report, we find that

“If I didn’t have surgery . . . I would either be on drugs or an alcoholic, or I would have killed myself. It’s as simple as that. There was no other way.”<sup>182</sup> She sought out medical treatment of her GID to try to “end [the] pain that [she] was in.”<sup>183</sup> O’Donnabhain also undertook medical transition to be able to approximate normal social functioning as a woman in public spaces and in private.<sup>184</sup>

#### b. The IRS’s Arguments

The IRS asserted that an expense for a medical procedure is deductible only if the procedure “treats” a “disease” and is not “cosmetic surgery or other similar procedures.”<sup>185</sup> The specific arguments made by the IRS closely tracked Dr. McHugh’s writings on GID and GCS.

First, the IRS argued that GID is not a “disease.” Specifically, the IRS argued that: (1) the term “disease” in § 213(d)(1)(A) is interpreted very narrowly; (2) GID is not a “disease,” because “disease” requires a showing of internal, biological (*e.g.*, cellular) pathology and established disease etiology;<sup>186</sup> (3) GID is not a mental disorder because it is an individual’s deviant sexual behavior or a conflict between the individual and society, not dysfunction within the individual;<sup>187</sup> and (4) even if GID were a valid diagnosis in some cases, the mental health professionals who treated O’Donnabhain were incompetent, misguided, or biased.<sup>188</sup>

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mental health factors and experiences of harassment, discrimination, violence and rejection may interact to produce a marked vulnerability to suicidal behavior in transgender and gender non-conforming individuals.

*Id.* at 2.

182. Trial Transcript, *supra* note 81, at 65.

183. *Id.* at 58.

184. See Trial Transcript, *supra* note 81, at 359.

185. Respondent’s Opening Brief, *supra* note 14, at 147–54.

186. *Id.* at 161–62.

187. *Id.* at 171. According to the IRS, DSM-IV-TR provides that a mental disorder must be “a manifestation of a behavioral, psychological, or biological dysfunction *in the individual*. Neither deviant sexual behavior . . . nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction *in the individual*.” *Id.* The IRS noted that DSM-IV-TR, unlike earlier versions of the DSM, requires “clinically significant distress or impairment” for a GID diagnosis. See *id.* at 174. Likening GID to homosexuality, which at one time had a diagnostic code that was later removed from the DSM, the IRS asserted that “social deviance in the absence of [internal biological] dysfunction is not a mental disorder”; the desire to “pass” in the preferred gender role expresses a need to reduce the conflict between society and non-gender-conforming individuals. *Id.* at 174, 178 (emphasis added). The IRS thus questioned whether GID is a mental disorder at all.

188. Reply Brief for Respondent, at 48, O’Donnabhain v. Comm’r, 134 T.C. 34 (2010) (No. 6402-06) [hereinafter Respondent’s Reply Brief] (arguing “incompetence of

The IRS impugned the credibility of O'Donnabhain, and the competence and credibility of the licensed mental health professionals who treated her, O'Donnabhain's expert witness, and the 350 members of WPATH (who periodically revise the Benjamin standards of care for GID).<sup>189</sup> For example, IRS attorney Hamilton, in her cross-examination of Dr. Alex Coleman (the Ph.D. psychologist who provided the GCS second opinion) asked the witness a series of questions ending with "so, you are transgender?" Coleman responded, "Yes."<sup>190</sup> Hamilton argued that Dr. Coleman's transgender status "goes to his bias."<sup>191</sup> In its briefs, the IRS also asserted that: (1) Dr. Brown was biased by his desire to collect insurance reimbursement for GID treatment;<sup>192</sup> (2) O'Donnabhain's GID diagnosis by Diane Ellaborn and Dr. Alex Coleman was a "sham";<sup>193</sup> and (3) Dr. Coleman was biased "as a transgender person who was previously a woman."<sup>194</sup>

The IRS attacked O'Donnabhain as well, asserting that she deceived and manipulated her health care providers to obtain GCS.<sup>195</sup> The IRS also argued that she "misrepresented her medical condition to the court"<sup>196</sup> and was not credible because she gave interviews about her case and allowed GLAD to publicize her case, yet sought a protective order to prevent her contact information and home address from being disclosed to the public.<sup>197</sup>

In addition to attacking O'Donnabhain and her witnesses, the IRS challenged the professional credibility of WPATH. According to the IRS, WPATH "*purports* to be a professional organization devoted to the

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Ellaborn and Coleman" resulted in "unprofessional" treatment of taxpayer and asserting that Dr. Brown was biased).

189. Although the IRS expressed skepticism about the taxpayer's diagnosis, noting that Diane Ellaborn, LICSW, and Alex Coleman, Ph.D., are not "medical" doctors, both Ellaborn and Coleman are professionally licensed to diagnose and treat mental health disorders. *See, e.g.*, Post-Trial Brief of Petitioner, *supra* note 72, at 28 (Ellaborn has been fully licensed "to diagnose and treat psychiatric illnesses" since 1980), 34 (Coleman "is a licensed psychologist who specializes in working with clients with gender identity issues.").

190. Trial Transcript, *supra* note 81, at 224–25.

191. *Id.* at 224. Hamilton also questioned whether Dr. Coleman had complied with professional recording-keeping requirements. *Id.* at 226–28.

192. Respondent's Opening Brief, *supra* note 14, at 193–94.

193. *Id.* at 197–98.

194. *Id.* at 200.

195. *Id.* at 200–01.

196. *Id.* at 206–07. The IRS argued that O'Donnabhain's testimony about her psychological distress and impairment was inconsistent with the fact that she was "high functioning" before her surgery (she had a job and waited several years to have GCS, until her children were older). *See id.*

197. *Id.* at 207.

understanding and treatment of gender identity disorders.”<sup>198</sup> Furthermore, the IRS argued that the Benjamin standards of care make mental health professionals the “gatekeepers” for access to medical gender transition, which furthers the financial interests of WPATH members.<sup>199</sup> The IRS also asserted that “GID was added to the DSM by way of a process that was devoid of scientific rigor,” to allow GID patients and mental health professionals to seek reimbursement of GID treatment expenses by insurance companies.<sup>200</sup>

In a bizarre twist, the IRS went so far as to suggest that O’Donnabhain was misdiagnosed and “may have suffered from transvestic fetishism” or “autogynephilia,”<sup>201</sup> instead of GID, parroting Dr. McHugh’s controversial, categorical views on autogynephilia.<sup>202</sup> Based on its new diagnosis of O’Donnabhain, the IRS concluded that GCS and hormones were not appropriate forms of treatment for her.<sup>203</sup>

Second, the IRS argued that all of O’Donnabhain’s medical procedures, including hormone treatment and GCS, were § 213(d)(9) “cosmetic surgery or other similar procedures” because: (1) O’Donnabhain undertook all of the procedures “to improve her appearance”;<sup>204</sup> (2) hormone therapy and GCS do not “meaningfully promote the proper function of the body” and “prevent or treat illness or disease”;<sup>205</sup> (3) O’Donnabhain did not have a

198. *Id.* at 29–30 (emphasis added).

199. *Id.* at 31. The IRS argued that WPATH members “have a financial and professional interest in maintaining the legitimacy of GID as a mental disorder and GCS as its treatment.” *Id.* at 143. In the United States, plastic surgeons will not perform GCS without mental health professionals’ letters of recommendation, which are required by the Benjamin standards of care. *Id.* at 33.

200. *See id.* at 135.

201. *Id.* at 27–28 (arguing that “petitioner may have suffered from transvestic fetishism,” not GID, and autogynephilia “may link transvestic fetishism with non-homosexual forms of GID”); *see also* Trial Transcript, *supra* note 81, at 391–92 (IRS questioning Dr. Brown about connection between transvestic fetishism, autogynephilia, and GID).

202. *See Surgical Sex*, *supra* note 11 (People assigned male at birth who have lived as men in their adult lives and transition late in life have autogynephilia and undertake medical transition “to add more versimilitude to their [sexually arousing] costumes.”).

203. Respondent’s Opening Brief, *supra* note 14, at 27 (arguing that “petitioner may have suffered from transvestic fetishism,” “gender dysphoria of transvestites is due to depression and should be treated through psychotherapy,” not hormonal treatment and “needless, irreversible surgery, which would provoke further suffering in these troubled individuals”).

204. Respondent’s Reply Brief, *supra* note 188, at 41 (O’Donnabhain “chose to treat her mental disorder by changing her physical appearance from male to female.”).

205. Respondent’s Opening Brief, *supra* note 14, at 180–81.

deformity or disfiguring disease;<sup>206</sup> (4) feminizing hormone therapy and GCS are not within the narrow exception described in the 1990 legislative history of the cosmetic surgery amendment;<sup>207</sup> and (5) the medical procedures were not “medically necessary.”<sup>208</sup> The IRS also argued that the cosmetic surgery amendment limits all of the § 213(d)(1)(A) definition of medical care, not just the “structure or function” part of the definition.<sup>209</sup> Under this interpretation of the statute, a medical procedure that changes appearance is not medical care, even if the medical procedure has a therapeutic effect (*i.e.*, it reduces dysfunction).

Third, the IRS asserted that the feminizing hormones and GCS did not “treat” GID because the procedures were not efficacious.<sup>210</sup> The IRS argued that a taxpayer cannot deduct the cost of a medical procedure unless the taxpayer can establish that the procedure was efficacious.<sup>211</sup> At trial, the IRS asserted that GCS “doesn’t change the patient’s belief that their psychological gender doesn’t match their biological sex.”<sup>212</sup> Taking a page from Dr. McHugh’s playbook,<sup>213</sup> the IRS argued that a doctor would not give liposuction to a patient with anorexia and questioned whether the alteration of a patient’s body ever can be efficacious treatment for a psychiatric disorder.<sup>214</sup>

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206. Respondent’s Reply Brief, *supra* note 188, at 41 (“petitioner stipulated that she did not have a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease”).

207. Respondent’s Opening Brief, *supra* note 14, at 147–153 (arguing that breast reconstruction after cancer treatment is within the exception in the cosmetic surgery amendment legislative history, but O’Donnabhain’s GCS and hormone treatments were not because they were directed at improving her appearance).

208. *Id.* at 181–86.

209. Respondent’s Reply Brief, *supra* note 188, at 40–41.

210. *Id.* at 66, 48 (hormone treatment and GCS were “not curative”).

211. Trial Transcript, *supra* note 81, at 32 (arguing GCS is not medical care because it is not “meaningful treatment” of GID).

212. *Id.* at 388 (Mikalchus cross-examination of Dr. Brown).

213. *Surgical Sex*, *supra* note 11.

214. Trial Transcript, *supra* note 81, at 417–18 (Mikalchus cross-examination of Dr. Brown, during which Mikalchus asked Dr. Brown whether he agreed that GID “is the only psychiatric disorder in which the alleged treatment reinforces the core symptom of the disorder,” followed by “You wouldn’t recommend liposuction for somebody who is anorexic; would you?”). *See also id.* at 420 (During cross-examination, Dr. Brown testified that post-surgical transgender persons “no longer have a body [that] they loathe because they have had an alignment of their body to match their psychological sex. . . . We can’t operate on the brain and change the brain. So, we are operating on the body.”); Respondent’s Opening Brief, *supra* note 14, at 102–03 (stating that “SRS cannot cure GID” and observing it was Dr. Brown’s opinion that a doctors do not prescribe liposuction for anorexic patients), 144 (“SRS does not cure GID, because SRS does not change a person’s underlying belief that his or her psychological gender does not match their biological sex.”).



In the case of GID, mental health professionals eschew the capacity to treat the patient's mind, and instead refer the patient for surgery to alter the body so that it is in conformity with the patient's mind. Thus [GCS] only reinforces the patient's cross-gender identification in their mind, by changing their physical appearance to that of the opposite gender.

[GCS] cannot cure GID, since GID patients will continue to experience a strong and consistent cross-gender identification even after the surgery.<sup>215</sup>

In addition to making a categorical argument that feminizing hormones and GCS cannot be efficacious treatment of GID, the IRS asserted that the procedures in fact were not "efficacious" in O'Donnabhain's case because they did not cure her "depression and other mental problems."<sup>216</sup>

## 2. The Decision and Opinions

The Tax Court decision and opinion in the case were issued on February 2, 2010, almost two years after the last trial documents were filed by the parties.<sup>217</sup> The O'Donnabhain opinion was a "reviewed" opinion, with sixteen Tax Court judges participating on the panel.<sup>218</sup> The majority opinion, written by Judge Gale,<sup>219</sup> held that the costs of the hormone therapy and GCS were deductible medical expenses,<sup>220</sup> but the costs of the breast augmentation were nondeductible cosmetic surgery expenses.<sup>221</sup> Specifically, the majority concluded that: (1) GID is a "disease" (in part based on the DSM-IV-TR classification of GID);<sup>222</sup> (2) hormone therapy and GCS are medically accepted—albeit controversial—"treatments" for severe GID;<sup>223</sup> (3) O'Donnabhain's breast augmentation was "cosmetic surgery" because it

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215. Respondent's Opening Brief, *supra* note 14, at 191–92.

216. *Id.* at 147 ("Even assuming [O'Donnabhain] had GID, [GCS] and feminizing hormones did not cure or mitigate her GID. Clearly, [GCS] and cross-gender hormones were not effective treatments for petitioner's depression and other mental problems."). *See also id.* at 73–78 (The IRS emphasized that important aspects of the taxpayer's life deteriorated after her transition; she lost her engineering job in 2003 and was still unemployed in 2007, and she became so depressed that she required medical treatment for depression.).

217. Press Release, GLAD, GLAD Wins Case vs IRS on Sex Reassignment Deductions (Feb. 2, 2010), <http://www.glad.org/current/press-release/glad-wins-case-vs-irs-on-sex-reassignment-deductions>.

218. *O'Donnabhain*, 134 T.C. at 35, 77.

219. *O'Donnabhain*, 134 T.C. at 35.

220. *O'Donnabhain*, 134 T.C. at 77.

221. *O'Donnabhain*, 134 T.C. at 73.

222. *O'Donnabhain*, 134 T.C. at 59–63.

223. *O'Donnabhain*, 134 T.C. at 70.

improved her appearance, and she failed to show that the breast surgery “treated” her GID under the Benjamin standards of care;<sup>224</sup> and (4) the court did not have to decide whether § 213 requires a showing of medical necessity, because O’Donnabhain demonstrated the medical necessity of the treatment she received.<sup>225</sup>

Judge Halpern, concurring, interpreted the language of § 213(d)(9) to classify a medical procedure as “cosmetic” only if meets three requirements: (1) it “is directed at improving appearance”; *and* (2) “it does not meaningfully promote the proper function of the body”; *and* (3) it “does not prevent or treat illness or disease.”<sup>226</sup> Under this approach, he concluded that the hormone therapy and GCS were not “cosmetic,” because they reduced the symptoms of GID and thus “treated” the disease.<sup>227</sup> Judge Holmes, separately concurring, concluded that O’Donnabhain’s hormone treatment and GCS were not “cosmetic” because (1) they “treated” GID and (2) created an entirely *new appearance*, instead of improving O’Donnabhain’s old appearance.<sup>228</sup> Judge Holmes also opined that § 213 does not require a showing of medical necessity and criticized the majority’s “overreach in finding [GCS] medically necessary.”<sup>229</sup> Judge Goeke, also separately concurring, concluded that (1) the GCS was not “cosmetic,” because O’Donnabhain undertook the GCS to alter her *functioning*—not her appearance;<sup>230</sup> but (2) the breast surgery was “cosmetic,” because surgery “on healthy tissue” is always cosmetic, even if it is undertaken to relieve extreme mental distress.<sup>231</sup>

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224. *O’Donnabhain*, 134 T.C. at 72–73.

225. *O’Donnabhain*, 134 T.C. at 74–76.

226. *O’Donnabhain*, 134 T.C. at 83–84 (Halpern, J., concurring).

227. *O’Donnabhain*, 134 T.C. at 84.

228. *O’Donnabhain*, 134 T.C. at 99–100 (Holmes, J., concurring, joined by Goeke, J.) (Judge Holmes concluded that the breast augmentation was “cosmetic” because it was undertaken to improve the taxpayer’s new female appearance).

229. *O’Donnabhain*, 134 T.C. at 97 (Holmes, J., concurring). Judge Holmes expressed concern that the “medical necessity” of GCS is much more controversial than the majority acknowledges. *Id.* at 93–95 (defending Dr. Schmidt and Dr. McHugh and noting that university-based clinics stopped performing GCS in the 1980s, following the closure of the Johns Hopkins clinic). Also, he observed that the majority’s legal finding—that GCS is medically necessary—potentially has significant implications beyond tax law, for example in Eighth Amendment prisoner’s rights cases, cases involving GCS exclusions in employer-provided health care plans, and cases involving Medicare and Medicaid exclusions for GCS. *Id.* at 92–97. These cases center on whether a third party (a prison, a health insurer, Medicare, or Medicaid) must fund costly GCS for a person with severe GID.

230. *O’Donnabhain*, 134 T.C. at 101 (Goeke, J., concurring, joined by Holmes J.).

231. *O’Donnabhain*, 134 T.C. at 103 (Goeke, J., concurring). Judge Goeke opined that “physically altering a patient’s appearance to relieve extreme mental distress” is always “cosmetic.” *Id.* In his view, a procedure is undertaken to relieve mental distress

Judges Foley, Gustafson, Kroupa, Vasquez, and Wells concurred regarding the nondeductibility of the breast augmentation surgery, but dissented regarding the deductibility of the hormone therapy and GCS costs.<sup>232</sup> Judge Foley, dissenting, interpreted § 213(d)(9) to mean that a medical procedure directed at improving appearance is “cosmetic” unless the procedure “meaningfully promotes the proper function of the body,” *and* prevents or treats illness or disease.<sup>233</sup> Under his reading of the statute, a procedure can be “cosmetic” even if it was undertaken to treat a disease.<sup>234</sup> Judge Gustafson, dissenting separately,<sup>235</sup> concluded that GCS did not “treat” O’Donnabhain’s disease.<sup>236</sup>

A procedure that changes the patient’s healthy male body (in fact, that disables his healthy male body) and leaves his mind unchanged (*i.e.*, with the continuing misperception that he is female) has not treated his mental disease. On the contrary, that procedure has given up on the mental disease, has capitulated to the mental disease, has arguably even changed sides and joined forces with the mental disease.<sup>237</sup>

Judge Gustafson’s dissent is consistent with Dr. McHugh’s “collaborating with madness” argument against GCS. Although Judge Gustafson expressed

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if the tissue on which the procedure is performed is “healthy tissue.” *Id.* On the other hand, a medical expense deduction is allowed for plastic surgery “to correct physical maladies resulting from disease [*i.e.*, malignancy] or disfigurement, as opposed to cosmetic surgery on healthy tissue.” *Id.* He suggested a bright-line classification rule to avoid difficult line-drawing problems in classifying plastic surgeries and similar procedures because “[t]he nuances of feminine appearances are virtually without bounds and expenses for efforts to conform petitioner’s entire body to a feminine ideal are indistinguishable from excluded expenses regardless of petitioner’s mental health.” *Id.*

232. *O’Donnabhain*, 134 T.C. at 104, 109, 122.

233. *O’Donnabhain*, 134 T.C. at 105 (Foley, J., dissenting).

234. *O’Donnabhain*, 134 T.C. at 105–06.

235. *O’Donnabhain*, 134 T.C. at 109, 122.

236. *O’Donnabhain*, 134 T.C. at 110 (Gustafson, J., dissenting) Judge Gustafson agreed with the majority regarding the following conclusions: O’Donnabhain suffered from GID, which “is a serious mental condition”; certain medical professional groups in good faith approve of GCS for patients with severe GID; and the taxpayer’s health care professionals followed “prevailing standards of care.” *Id.* He disagreed, however, with the majority’s conclusion that the GCS “treated” the taxpayer’s disease. In his view, a procedure that changes a patient’s body without altering the patient’s mental disease does not “treat” the patient’s disease; a procedure that merely reduces the effects of disease is “mitigation” not “treatment” of disease. *Id.* at 122. Based on the DSM characterization of GID as a mental disorder, he concludes that GCS did not “treat” the taxpayer’s disease. *Id.*

237. *O’Donnabhain*, 134 T.C. at 122.

concern about the “startling” surgical procedures at issue in the case, he conceded in his dissent that “neither the tax collector nor the Tax Court passes judgment on the ethics of legal medical procedures, since otherwise deductible medical expenses are not rendered non-deductible on ethical grounds.”<sup>238</sup>

### III. A CRITIQUE OF THE IRS’S § 213 ARGUMENTS

This Part critiques three specific aspects of the IRS’s arguments in the *O’Donnabhain* case: (1) the IRS’s extremely narrow construction of the § 213 (d)(1)(A) term “disease”; (2) the IRS’s extremely broad construction of the § 213(d)(9) cosmetic surgery exception to the §213(d)(1)(A) definition of medical care; and (3) the IRS’s assertion that taxpayers must prove additional requirements to deduct the costs of medical care, including (a) the “medical necessity” of the care; and (b) the “efficacy” of the care. In addition, this Part critiques the IRS’s arguments in the case, taken as a whole, and voices concerns about the IRS’s treatment of O’Donnabhain and other transgender persons.

#### A. Defining “Disease”

Consistent with Dr. McHugh’s views, the IRS argued that *GID* is not a disease.<sup>239</sup> In a significant departure from decades of case law and IRS administrative practice,<sup>240</sup> the IRS advocated for a very narrow construction of the term “disease” in the *O’Donnabhain* case. This narrow construction of disease is consistent with Dr. McHugh’s writings on the “medicalization” of mental health disorders, in which Dr. McHugh advocates for a narrow definition of disease. Specifically, the IRS argued that the § 213(d)(1)(A) term “disease” should be construed to require taxpayer proof of a scientifically established disease pathology or etiology *within* the individual, and “abnormal structure or function of the body at the gross, microscopic, molecular, biochemical, or neuro-chemical levels.”<sup>241</sup> This interpretation would exclude from the definition of “disease” injuries, physical and mental

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238. *O’Donnabhain*, 134 T.C. at 110 (citation omitted) (noting, as an example, that the cost of a legal abortion is deductible despite ethical controversy about abortion).

239. Respondent’s Opening Brief, *supra* note 14, at 153–54 (Although the IRS conceded that the Tax Court has held that “mental disorders can be diseases,” the IRS argued that *GID* is not a disease.).

240. See Pratt, *Inconceivable*, *supra* note 23 (courts and the IRS have interpreted “medical care” broadly).

241. Respondent’s Opening Brief, *supra* note 14, at 160 (Dietz testimony).

conditions, and disorders for which internal disease pathology and etiology have not been established.<sup>242</sup>

The IRS proffered the testimony and report of its expert witness, Dr. Dietz, in support of its extremely narrow, technical interpretation of the term “disease.”<sup>243</sup> The IRS argued: (1) “there is no known organic pathology for GID”;<sup>244</sup> (2) there is no scientific consensus that GID has a biological basis;<sup>245</sup> and (3) “there is no scientific evidence of a genetic or congenital abnormality associated with GID.”<sup>246</sup> The IRS argued that GID was listed in the DSM “without any compelling evidence.”<sup>247</sup>

Consistent with Dr. McHugh’s view that GID is a type of deviant behavior, not a disease, the IRS took the position that “the DSM-IV includes many non-diseases which are merely undesirable behavior patterns.”<sup>248</sup> In his testimony and expert report, Dr. Dietz used his narrow definition of “disease” to classify as *non*-diseases various DSM disorders, including: post-traumatic stress disorder;<sup>249</sup> obsessive compulsive personality disorder;<sup>250</sup> pathological gambling;<sup>251</sup> intermittent explosive disorder;<sup>252</sup> impulse control disorder;<sup>253</sup> factitious disorders and Munchausen’s Syndrome;<sup>254</sup> conduct disorder;<sup>255</sup> oppositional defiant disorder;<sup>256</sup> alcohol abuse;<sup>257</sup> adjustment disorders;<sup>258</sup> and a broad array of paraphilias, including

242. *Id.* at 160–61 (distinguishing between “disease,” “illness,” and “disorder”).

243. *Id.* at 160. During his testimony, Dr. Dietz expressed his views on defining disease: “To be a disease, a condition must arise as a result of a pathological process. . . . [I]t is necessary that the pathology occur within the individual and reflect abnormal structure or function of the body at the gross, microscopic, molecular, biochemical, or neurochemical levels.”

244. *Id.* at 161.

245. *Id.*

246. *Id.* at 97 (referring to testimony of Dr. Schmidt).

247. *Id.* at 167.

248. *Id.* at 165 (listing exhibitionism, fetishism, transvestic fetishism, voyeurism, and substance abuse as examples of mental disorders that are undesirable behavior patterns, but not diseases).

249. Trial Transcript, *supra* note 81, at 849 (Dietz testimony) (PTSD is an “injury,” not a “disease”).

250. *Id.* at 860 (obsessive compulsive personality disorder is a “personality style” and “set of habits” that are “within the voluntary control of the person,” not “reflecting any pathology”).

251. *Id.* at 862 (pathological gambling is undesirable behavior and choices, not disease).

252. *Id.* at 866 (not a disease and “[t]here is no such thing in my view”).

253. *Id.* at 867.

254. *Id.* at 868–71 (“it’s purposeful and intentional behavior” and “a choice patients make,” not a disease).

255. *Id.* at 874.

256. *Id.* at 875.

257. *Id.* at 878.

258. *Id.* at 889.

exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, and voyeurism.<sup>259</sup> Conversely, he classified as "diseases" obsessive compulsive disorder,<sup>260</sup> major depressive disorder,<sup>261</sup> and Asperger's disorder.<sup>262</sup>

Dr. Dietz appeared in the case to provide expert witness testimony and to defend an expert report on the meaning of "disease" and classification of mental disorders as "diseases" or non-diseases.<sup>263</sup> Nevertheless, he was unsure of the classification of many of the disorders about which O'Donnabhain's lawyers inquired during the trial. For example, upon questioning, Dr. Dietz equivocated about the disease/non-disease classification of the following disorders: anorexia nervosa;<sup>264</sup> bulimia nervosa;<sup>265</sup> panic disorder with agoraphobia;<sup>266</sup> attention deficit hyperactivity disorder;<sup>267</sup> separation anxiety disorder;<sup>268</sup> mutism;<sup>269</sup> alcohol dependence;<sup>270</sup> dysthymic disorder (low-level depression); personality disorders;<sup>271</sup> and fibromyalgia.<sup>272</sup>

Several aspects of the IRS's argument about interpreting "disease" narrowly are noteworthy. First, the IRS's expert witness, Dr. Dietz, is a forensic psychiatrist who famously has testified as a government witness in high-profile *criminal* cases, to assert that a criminal defendant's alleged mental disorder does not absolve the defendant of criminal responsibility for heinous actions.<sup>273</sup> A large font heading on the home page of the Park Dietz & Associates website says "WE KNOW CRIME" and prominently features photographs of some of America's most notorious serial killers, against

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259. Expert Report of Dr. Park Dietz for Respondent, at 18, O'Donnabhain v. Comm'r, 134 T.C. 34 (2010) (No. 6402-06) [hereinafter Dietz Expert Report].

260. Trial Transcript, *supra* note 81, at 854–56 (Dietz testimony).

261. *Id.* at 887.

262. *Id.* at 891 (first noting that he would label it a "congenital defect or a congenital abnormality rather than a disease," but later concluding that it is within his definition of disease because it has "a pathological and physical basis").

263. Dietz Expert Report, *supra* note 259, at 7.

264. Trial Transcript, *supra* note 81, at 829–32 (Dietz testimony).

265. *Id.* at 832–36.

266. *Id.* at 842–46.

267. *Id.* at 873–74.

268. *Id.* at 876.

269. *Id.*

270. *Id.* at 878.

271. *Id.* at 889.

272. *Id.* at 890–91.

273. *See id.* at 798 (describing numerous criminal trials at which Dr. Dietz testified, to hold a criminal defendant responsible for heinous conduct). *See also* Respondent's Opening Brief, *supra* note 14, at 107–08 (cases in which Dr. Dietz has testified involve "murders, serial murders, sexual abuse and rape claims . . . and civil commitment of sex offenders and mental patients").

whom Dr. Dietz testified.<sup>274</sup> “Half or more” of Dr. Dietz’s work as a forensic psychiatrist has been in cases involving violent behavior.<sup>275</sup> In his testimony, Dr. Dietz explained that the duty of a forensic psychiatrist is to question and challenge testimony about alleged mental disorders.<sup>276</sup> In this professional context, he construes the term “disease” very narrowly, to require a criminal defendant to establish a disease pathology or etiology to escape responsibility for criminal conduct.<sup>277</sup>

In the civil tax context of the *O’Donnabhain* case, Dr. Dietz applied the same narrow construction of the term “disease.” During the trial, O’Donnabhain’s lawyer asked Dr. Dietz whether the opinions he expressed in his expert report about the definition of “disease” were specific to § 213 or were generic.<sup>278</sup> Dietz replied: “I wasn’t trying to interpret the tax code. But I was trying to address the language used in the tax code [the § 213(d)(1)A term “disease”] in a generic way.”<sup>279</sup> According to Dietz, the IRS instructed him to address his expert opinion to the question of “whether transsexualism or [GID] is a disease or illness.”<sup>280</sup> Although he testified that he was familiar with the language in § 213,<sup>281</sup> Dietz seemed unaware of the consistently broad IRS and judicial construction of the term “disease,” which encompasses physical and mental conditions, disorders, injuries, and congenital defects. For example, he assumed that his narrow definition of “disease” would not preclude a medical expense deduction for a taxpayer who had an “injury” but not a “disease.”<sup>282</sup> Moreover, contrary to the IRS “disease” argument for which he was providing expert testimony, he testified: “It looks to me as though, in general, the IRS presumes that when doctors . . . try to minister treatments to patients to make them better . . . that it is generally deductible without anyone scrutinizing whether it is a disease or not.”<sup>283</sup>

Consistent with the views of his teacher, Dr. McHugh, Dietz’s expert report includes a polemic on the “medicalization” of undesirable behaviors

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274. PARK DIETZ & ASSOCIATES, <http://www.parkdietzassociates.com/> (last visited Mar. 19, 2016).

275. Trial Transcript, *supra* note 81, at 803 (Dietz testimony).

276. *See id.* at 797–98.

277. *Id.* at 923–24. Judge Gale asked Dr. Dietz “what is the purpose of attaching or withholding your label of disease on a mental disorder in the DSM?” Dr. Dietz responded that, in his forensic psychiatric practice, a narrow definition of disease is necessary to make people who are accused of crimes—but claim mental incompetence or insanity—accountable for their behavior. *Id.*

278. *Id.* at 835.

279. *Id.*

280. *Id.* at 825.

281. *Id.* at 834–35, 881–82.

282. *See id.* at 849–50 (“I assume treatment of injuries is deductible.”).

283. *Id.* at 857–58.

and non-disease conditions.<sup>284</sup> Throughout his report and testimony, Dr. Dietz used words and expressions that highlighted his professional inclination to hold persons “accountable” for their “bad behavior” by discounting their mental disorders.<sup>285</sup> His critical frame of reference might be understandable in the criminal context, within which Dr. Dietz testifies against criminal defendants, but makes no sense in the context of interpreting § 213. When Judge Gale asked Dr. Dietz whether his work on the topics of sexuality and gender generally pertained to matters of criminal liability, Dr. Dietz replied:

[F]ar more of my experience concerns the conditions known as [sexual] paraphilias that often come in conflict with the law. And more of my experience is among those who already have come in conflict with the law than those who have the same condition, but haven’t offended or been caught for offending. Then, to a lesser degree . . . I have experience with the other range of human sexual problems, including sexual dysfunctions and gender identity problems and sexual orientation issues.<sup>286</sup>

Judge Gale also inquired about Dr. Dietz’s qualifications as an expert on GID and human sexuality and the basis for Dr. Dietz’s opinions in his expert report.<sup>287</sup> Dr. Dietz conceded that he did not evaluate or treat patients with GID,<sup>288</sup> but said that he knew more about GID than the average psychiatrist by virtue of working at Johns Hopkins, where transgender persons were treated, and by virtue of reading the “literature” on GID:<sup>289</sup> “I’m aware of the search for causation. I’m aware of the *professional controversies*

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284. O’Donnabhain’s lawyers objected to this portion of the Dietz expert report on the grounds that Dr. Dietz is not an expert in philosophy. *Id.* at 810–11 (Dietz testimony). Judge Gale’s response was to admit the entire report, but also assess the weight it should be given. *Id.* at 816.

285. *See, e.g., id.* at 867 (Dietz testimony). When asked whether the diagnoses under the heading of “impulse control disorders” are taught in medical schools, Dr. Dietz testified, “I don’t know if taught is the right thing so much as made fun of.” When asked whether patients who are diagnosed with impulse control disorders receive treatment for their disorder, Dr. Dietz replied, “Once they get caught.” *Id.* See also Respondent’s Opening Brief, *supra* note 14, at 118. According to Dietz, if society did not distinguish between diseases and non-diseases, “we would lose all *accountability* for human behavior.” *Id.* (emphasis added). Also he expressed the opinion that “if all bad habits and maladaptive behavior are considered diseases, it becomes difficult to think clearly as a society about human autonomy and human *accountability*.” *Id.* (emphasis added).

286. Trial Transcript, *supra* note 81, at 819–20 (Dietz testimony).

287. *Id.* at 819–21.

288. *Id.* at 819.

289. *Id.* at 819–20.



that have always surrounded the concept.”<sup>290</sup> Dr. Dietz had not published papers on the classification of diseases,<sup>291</sup> but had published papers on the narrower topic of classification of “certain paraphilias.”<sup>292</sup>

The second noteworthy aspect of the IRS “disease” argument in the *O’Donnabhain* case is that severely narrowing the definition of disease, to require a showing of internal cellular pathology, is antithetical to recent federal and state legislation that was enacted to achieve parity between treatment of mental health disorders (including substance abuse disorders) and treatment of other types of disorders.<sup>293</sup> In addition, the Affordable Care Act “defined coverage of mental health and substance abuse treatment as one of the ten essential health benefits,” thus mandating coverage for treatment of mental health disorders, including substance abuse disorders.<sup>294</sup> States also have enacted mental health parity statutes, some of which are even stricter than the federal statutes.<sup>295</sup>

The third noteworthy aspect of the IRS “disease” argument in the *O’Donnabhain* case is the IRS’s radical departure from decades of settled case law and IRS administrative practice. Both courts and the IRS consistently have construed the § 213(d)(1)(A) term “disease” broadly to include physical and mental conditions, injuries, and disorders, even following the amendment of § 213(d) in 1990.<sup>296</sup> Until the *O’Donnabhain* trial, the IRS

290. *Id.* at 820 (emphasis added).

291. *Id.* at 817–18.

292. *Id.* at 812 (Dr. Dietz’s “contributions to the literature [are on] the classification of certain paraphilias.”).

293. Sarah Goodell, *Health Policy Brief: Mental Health Parity*, HEALTH AFFAIRS (Apr. 3, 2014), [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=112](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=112) (describing recently enacted federal mental-health-parity statutes, including the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 1998).

294. *See id.*

The Affordable Care Act (ACA) applied the [Mental Health Parity and Addiction Equity Act] to issuers in the individual market and qualified health plans offered through an exchange or marketplace, including the small business exchange . . . . Importantly, the ACA defined coverage of mental health and substance use treatment as one of the ten essential health benefits (EHBs). As a result, all health insurance plans in the individual and small-employer market—both inside and outside Marketplaces—must include coverage for the treatment of mental health and substance use disorders. In this way, the ACA went beyond the MHPAEA by mandating coverage rather than requiring parity only if coverage is provided.

*Id.*

295. *Id.* (“In the decade after the passage of the [Mental Health Parity Act], many states passed their own mental health parity laws, some going further than the MHPA toward full parity”).

296. *See Pratt, Inconceivable, supra* note 23.

had not narrowly construed the term “disease” or asserted that taxpayers claiming the deduction are required to prove internal disease pathology or etiology. Such a narrow, hyper-technical approach is insupportable in the context of interpreting § 213, particularly when a taxpayer incurs costs for procedures that are inherently medical.

For decades, the IRS has classified expenses for *inherently medical* procedures (*i.e.*, for procedures that are recommended by health care professionals and are medical in nature, including fees for doctors’ services, hospital charges, fees for diagnostic tests, surgical fees, or prescription drugs) as medical expenses.<sup>297</sup> In contrast, the IRS has been more inclined to challenge taxpayers’ classification of *personal* expenses that are *not inherently medical* (*e.g.*, the cost of a pool, vacation, or gym membership) as deductible medical care. Oddly, in the *O’Donnabhain* case, the IRS cites cases involving expenses that are not inherently medical (including cases involving the cost of lawn care and the cost of transportation to play golf) for the proposition that *O’Donnabhain* cannot deduct the cost of *inherently medical procedures*—prescription hormones and surgery—both undertaken on the advice of multiple licensed mental health and medical professionals.<sup>298</sup>

The IRS “disease” argument also failed to fully address the § 213(d)(1)(A) core concept of functioning. The narrow “disease” definition offered by the IRS in the *O’Donnabhain* case inexplicably construed functioning to involve only *internal, biological* functioning—and failed to address the effects of GCS on *psychological functioning, sexual functioning, and social functioning*. GCS fundamentally alters intimate sexual functioning. GCS also makes it more likely that a transgender person can perform activities of daily living and have positive relationships and other requisites for human flourishing.<sup>299</sup> By failing to consider how difficult daily life can be for transgender persons, the IRS failed to comprehend how important GCS can be for functioning.

Functioning in a world with rigid binary gender classification creates particularly daunting challenges for transgender persons. Societal norms generally impose a rigid gender classification system, presenting only the binary choice between a male or female gender classification, with a focus

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297. Treas. Reg. § 1.213-1(e)(1)(ii) (“Payments for the following are payments for medical care: hospital services, nursing services . . . , medical, laboratory, surgical, dental, and other diagnostic and healing services, X-rays, medicine and drugs . . . , artificial teeth or limbs, and ambulance hire.”). The description of certain expenses as “inherently medical” derives from cases interpreting § 213(d)(1)(A). *See, e.g.*, *Huff v. Comm’r*, 1995 Tax Ct. Memo LEXIS 200 (1995) (surgical expense is “inherently medical”).

298. Respondent’s Opening Brief, *supra* note 14, at 206.

299. *See, e.g.*, MARTIN E. P. SELIGMAN, *FLOURISH: A VISIONARY NEW UNDERSTANDING OF HAPPINESS AND WELL-BEING* 238–39 (2011).

on natal sex, chromosomes, and anatomical differences.<sup>300</sup> The entrenched body-focused system segregates genders in many spaces: public restrooms, locker rooms, schools, TSA airport screening areas, and homeless shelters.<sup>301</sup> Identification documents, including birth certificates, drivers' licenses, and passports all specify a person's gender to allow enforcement of gender specific classification rules.<sup>302</sup> Where a person's biological markers (including anatomy and chromosomes) are consistent with internally perceived gender, as is typically the case, this body-focused, binary system seems unremarkable. For gender-nonconforming individuals, however, this rigid binary classification system creates ever-present challenges and threats—including threats of bullying, humiliation, marginalization, discrimination, detention, arrest, sexual violence, and other forms of violence.<sup>303</sup>

Marginalization of transgender persons begins at an early age, in school, and continuing into adulthood.<sup>304</sup> As adults, transgender persons are disproportionately likely to face discrimination in employment<sup>305</sup> and housing,<sup>306</sup> and thus face increased risk of being unemployed and homeless.<sup>307</sup> The pervasive inability to find traditional employment drives transgender persons into illegal, underground forms of employment, including sex work, which further exposes transgender persons to physical risks, including the risk of contracting sexually transmitted diseases.<sup>308</sup> Compared to persons who are not transgender ("cisgender" persons), transgender persons are significantly more likely to be the victims of sexual violence and other forms of violence.<sup>309</sup>

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300. *E.g.* Jody L. Herman, *Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives*, 19 J. PUB. MGMT. & SOC. POL'Y 65 (2013) (reporting that seventy percent of transgender and gender nonconforming survey respondents were denied access to gendered public restrooms or experienced "verbal harassment, and/or physical assault when trying to access or while using gendered public restrooms").
301. *See, e.g.*, Dean Spade, *Documenting Gender*, 59 HASTINGS L. J. 731, 751 (2008) (noting that many necessary or mandatory facilities are sex-segregated, which makes classification critical for transgender persons).
302. *Id.* at 764–75 (discussing rules and requirements for changing gender designation on birth certificates, drivers licenses, and passports).
303. *See generally*, JAIME M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY (2011) [hereinafter INJUSTICE AT EVERY TURN].
304. *See, e.g.*, HUMAN RIGHTS WATCH, HATRED IN THE HALLWAYS: VIOLENCE AND DISCRIMINATION AGAINST LESBIAN, GAY, BISEXUAL, AND TRANSGENDER STUDENTS IN U.S. SCHOOLS, 85–93 (2001).
305. INJUSTICE AT EVERY TURN, *supra* note 303, at 3, 50–70.
306. *Id.* at 4, 106–23.
307. *Id.* at 3, 51, 106–07.
308. *Id.* at 3, 51, 64–65, 72, 80–81.
309. *Id.* at 6, 33, 80, 100, 106, 127, 158.

Core types of human functioning (*e.g.*, social affiliation, bodily integrity, health, control over one’s environment, relative status in social hierarchies) often cluster together, such that impairment of one type of functioning can impair other types of functioning.<sup>310</sup> Transgender persons live in a pervasive environment of “corrosive disadvantage,”<sup>311</sup> from which it is difficult to escape. Given the difficulty of daily life as a transgender person, perhaps it is not surprising that transgender persons have much higher rates of attempted suicide than cisgender persons.<sup>312</sup> Among transgender persons, the highest attempted suicide rates are among the subset of transgender persons who report that others always are able to tell that the person is transgender.<sup>313</sup>

The need for GCS is created in part by legal rules and norms that divide sexes into binary male/female classifications in contexts that are encountered in daily life. Many jurisdictions require proof of genital surgery to change a gender classification on identification documents, *e.g.*, birth certificates.<sup>314</sup> Gender-based legal rules and documents dictate which public restrooms or locker rooms a person legally can use, or whom a person can marry. Opportunities to flourish and participate in society are denied to persons who cannot obtain legal documentation of the gender in which they live full-time. As Anne Bloom notes,

American Law continues to enforce sex- and gender-based distinctions which are believed to be grounded in “nature” or a pre-political biological reality. . . . [T]he law itself is playing a part in both enforcing and generating norms of sexual identity. The

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310. JONATHAN WOLFF & AVNER DE-SHALIT, *DISADVANTAGE* 122–25 (2007) (describing empirical research on clustering of “high-weight” functionings and social determinants of health).

311. *Id.* at 133 (explaining that “disadvantage in one [type of] functioning leads to disadvantages in [other types of functioning]” and describing the compound effect of multiple forms of disadvantage as “corrosive disadvantage”).

312. *TRANSGENDER SUICIDE ATTEMPTS*, *supra* note 181, at 2.

313. *Id.*

314. *See* Spade, *Documenting Gender*, *supra* note 301, at 762, 768 (detailing the processes by which Social Security gender reclassification, and state birth certificate gender reclassification require proof of genital surgery). *But see, e.g.*, N.Y. Comp. Codes Rules & Regs. Title 10, § 35.2 (2014) (allowing birth certificate gender reclassification without proof of genital surgery, and instead allowing a notarized affidavit from a licensed medical professional stating that the applicant has been treated or evaluated clinically for a gender-related condition). For a list of state law requirements for birth certificate gender reclassification, *see generally Know Your Rights, Changing Birth Certificate Sex Designations: State-By-State Guidelines*, LAMBDA LEGAL (Feb. 3, 2015), <http://www.lambdalegal.org/know-your-rights/transgender/changing-birth-certificate-sex-designations>.

emphasis on “natural” or biological sex differences in American jurisprudence reveals an important way in which the law plays a role in shaping what it means to be a man or a woman. Furthermore, these cases indicate the importance of the body in the enforcement and reproduction of legal norms.<sup>315</sup>

*B. Defining “Cosmetic Surgery or Other Similar Procedures”*

According to the IRS, O’Donnabhain’s hormone therapy and GCS are “cosmetic”—not “medical care”—because she undertook the procedures for the purpose of “transforming herself from *looking* like a man to *looking* like a woman.”<sup>316</sup> The IRS characterized various appearance-improving procedures undertaken by O’Donnabhain, including the facial feminization surgery, the breast augmentation surgery, and the surgical construction of “female *looking* genitalia” as “the epitome of cosmetic procedures.”<sup>317</sup> The IRS even argued that the vaginal dilator that O’Donnabhain was required to use after the surgery “had a cosmetic purpose,” *i.e.*, was intended to change O’Donnabhain’s “*appearance*.”<sup>318</sup> To the contrary, the purpose of the vaginal dilator was functional—to keep O’Donnabhain’s post-operative vagina open, not to improve her appearance.

Under the IRS’s broad interpretation of the § 213(d)(9) cosmetic surgery rule, a medical procedure that changes appearance is not medical care, *even if it promotes proper functioning*, unless the procedure is exactly within the narrow example mentioned in the legislative history of the cosmetic surgery amendment. The IRS characterized the legislative history as requiring that a taxpayer prove (1) “medical necessity”<sup>319</sup> and (2) that the expenses were incurred for “procedures for treatment of a disfiguring condition arising from a congenital abnormality, personal injury, trauma, or disease, such as reconstructive surgery following the removal of a malignancy.”<sup>320</sup> The IRS took the position that the exception in the legislative history did not

315. Anne Bloom, *Rupture, Leakage, and Reconstruction: The Body as a Site for the Enforcement and Reproduction of Sex-based Legal Norms in the Breast Implant Controversy*, 14 COLUM. J. GENDER & L. 85, 88 (2005). See also David B. Cruz, *Disestablishing Sex and Gender*, 90 CAL. L. REV. 997 (2002) (making similar points about invocation of (gendered) “nature”).

316. Respondent’s Opening Brief, *supra* note 14, at 139 (emphasis added).

317. *Id.* at 140 (emphasis added).

318. *Id.* at 147 (emphasis added).

319. Trial Transcript, *supra* note 81, at 26 (Hamilton opening statement on behalf of Respondent) (“medical necessity” requires a showing that the procedure “[promotes] the proper function of the body and which only incidentally affect the patient’s appearance.”).

320. *Id.* at 26.

apply in the *O'Donnabhain* case, because the procedures were undertaken by O'Donnabhain primarily to change "her *appearance* from male to female"<sup>321</sup> and did not promote the "proper function" of O'Donnabhain's body, which *functioned normally as a male body* prior to the medical transition.<sup>322</sup>

The IRS distinguished Revenue Ruling 2003-57, in which it interpreted the cosmetic surgery amendment and concluded that taxpayers could deduct the costs of "breast reconstruction after mastectomy surgery as part of a treatment for cancer," because breast reconstruction "ameliorated a deformity directly related to the taxpayer's treatment for cancer."<sup>323</sup> The cost of a medical procedure that improves appearance is deductible only if the taxpayer has a "primarily medical purpose" in undertaking the procedure.<sup>324</sup> The IRS argued that O'Donnabhain's primary goal in undertaking the feminizing hormone therapy and GCS was to improve her appearance; she wished to appear more feminine so that she could "pass" as a woman and

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321. *Id.* at 24 (emphasis added).

322. *Id.* at 23 (Hamilton opening statement on behalf of Respondent) (noting that O'Donnabhain had male anatomy and had fathered children). *See also* Respondent's Opening Brief, *supra* note 14, at 8 (referring to Stipulation Paragraph 16; Trial Transcript at 48). *See also id.*, at 139 (O'Donnabhain had "functioning male anatomy" prior to the GCS), 134 (IRS did not concede that removal of male genitalia and construction of female genitalia "promoted the proper function of petitioner's body or prevented or treated illness or disease"). "Petitioner admits that her appearance as a man had not been defective. [GCS] removed petitioner's healthy male organs and replaced them with structures created by a plastic surgeon to appear like female sex organs." *Id.* at 181.

323. Respondent's Opening Brief, *supra* note 14, at 151, citing and distinguishing Rev. Rule. 2003-57, 2003-1 C.B. 959 (2003). The ruling discussed the post-1990 deductibility of the costs of three medical or dental procedures that improve appearance: breast reduction after mastectomy, laser eye surgery, and teeth whitening. The IRS concluded that (1) costs for breast reconstruction after mastectomy were deductible because breast reconstruction ameliorated a cancer-related deformity; (2) costs for laser eye surgery to treat myopia were deductible because the surgery meaningfully promoted the proper function of the taxpayer's body; and (3) costs for professional teeth whitening, to reverse age-related yellowing, were not deductible because teeth whitening is "directed at" improving appearance, not at treating disease or promoting proper functioning of the body. *Id.* Note that breast reconstruction is not required by a "disfiguring disease" so much as the disfiguring effects of medical treatment for disease, typically the disfiguring effects of mastectomy undertaken to treat breast cancer.

324. Respondent's Opening Brief, *supra* note 14, at 152. For this proposition, the IRS cites cases and Treas. Reg. §1.213-1(e)(1)(ii), which states that § 213 medical expense deductions "will be confined strictly to expenses incurred primarily for the prevention or *alleviation* of a physical or mental defect or illness." Treas. Reg. §1.213-1(e)(1)(ii) (emphasis added).

“the purpose of the GCS was . . . to create the *appearance* of female genitalia.”<sup>325</sup>

Although the IRS asserted that § 213(d)(9) limits both prongs of the § 213(d)(1)(A) definition of medical care, the legislative history of the cosmetic surgery amendment suggests that the Congressional focus was on limiting the “structure” part of the “structure or function prong.” The 1990 amendment reversed earlier IRS rulings that allowed deductions for face lifts and electrolysis.<sup>326</sup> In these rulings, the procedures were not within the “disease” prong of § 213(d)(1)(A), because they were performed on patients who did not suffer from dysfunction, but were within the “structure or function” prong of § 213(d)(1)(A).<sup>327</sup>

The legislative history provides no indication that Congress intended to alter the core “functioning” concept of § 213(d)(1)(A) and deny deductions for appearance-improving procedures that reduce dysfunction.<sup>328</sup> The breast reconstruction surgery example in the legislative history supports this interpretation of the cosmetic surgery limitation.<sup>329</sup> A medical procedure that incidentally improves a patient’s appearance *and reduces dysfunction* is not “cosmetic surgery,” even if insurance companies do not regard the procedure as “medically necessary”;<sup>330</sup> such a procedure is not within the § 213(d)(9) cosmetic surgery exclusion and is § 213(d)(1)(A) medical care.<sup>331</sup> Conversely, a “purely” cosmetic procedure, *i.e.*, a medical procedure that improves a patient’s appearance *and does not reduce dysfunction*, is within the § 213(d)(9) cosmetic surgery exclusion and is not § 213(d)(1)(A) medical care.<sup>332</sup> The example of teeth whitening, which improves appearance and does not promote proper functioning, illustrates this limitation.<sup>333</sup>

Whether a breast augmentation surgery is “cosmetic” depends on the reason for the surgery. If a patient’s pre-surgical breasts are within a broad

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325. Respondent’s Opening Brief, *supra* note 14, at 180.

326. 136 CONG. REC. S30,570 (daily ed. Oct. 18, 1990).

327. *Id.*

328. *Id.*

329. The cosmetic surgery amendment refers to “necessary” treatment as being outside the definition of cosmetic surgery, meaning treatment that promotes the proper function of the body. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 11342(a), 104 Stat. 1388-471 (1990) (“Denial of Deduction for Unnecessary Cosmetic Surgery”). The legislative history of the cosmetic surgery amendment provides, as an example of “necessary” treatment, breast reconstruction following mastectomy. Insurance companies classified such breast reconstruction surgery as not “medically necessary.”

330. Rev. Rul. 2003-57, 2003-1 C.B. 959.

331. 27 U.S.C.A. § 213(d)(1)(A) (Westlaw through P.L. 114-219), § 213(9).

332. *Id.*

333. Rev. Rul. 2003-57, 2003-1 C.B. 959.

range of “normal” (determined statistically), the breast augmentation surgery is cosmetic. If, however, the patient suffers from micromastia, or is reconstructing a breast following lumpectomy or mastectomy, the breast augmentation is functional—not cosmetic. Similarly, whether a Botox injection is a § 213(d)(9)(B) “other similar procedure” depends on whether the injection is “purely” cosmetic or is functional, for example, to treat chronic migraine headaches or muscle spasms.<sup>334</sup> Even liposuction is not “cosmetic surgery” or a “similar procedure” if the liposuction is undertaken for a *functional* purpose. For example, in 2001, Tax Court Special Trial Judge Powell held that a taxpayer could deduct the cost of three related procedures (liposuction, excess skin removal, and fluid removal) to remove an unwieldy “mass” that resulted from her 100-pound weight loss.<sup>335</sup> After reviewing the legislative history of the cosmetic surgery amendment, Judge Powell opined: “It is clear from the Senate Finance Committee report that Congress did not intend that the expenses of all so-called cosmetic surgeries would be nondeductible.”<sup>336</sup> Judge Powell held that the procedures were medical care because the taxpayer was obese and the mass “was prone to infection and disease and interfered with [her] daily life,” including her work as an emergency room nurse.<sup>337</sup> Although the procedures significantly improved the taxpayer’s appearance, their primary purpose was to improve the taxpayer’s functioning.<sup>338</sup> The procedures thus were not “cosmetic” and were within the § 213(d)(1)(A) definition of medical care.<sup>339</sup>

Contrary to the IRS’s arguments in *O’Donnabhain*, the goals and methods of breast reconstruction surgery are in many ways similar to the goals and methods of GCS. Of course, a reconstructed breast often takes the place of a diseased breast (the malignancy on which is tangible and can be proven scientifically), whereas genitalia constructed through GCS take the place of “healthy” genitalia that are surgically removed. Whether that difference is relevant depends on whether one believes that GID is “real” and

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334. See, e.g., *BOTOX*, DRUGS.COM (last visited Mar. 24, 2016) <http://www.drugs.com/mtm/botox.html> (listing medical conditions for which Botox is prescribed as treatment, including chronic migraine headaches, various types of muscle spasms, and severe underarm sweating).

335. *Al-Murshidi v. Comm’r*, T.C. Summary Op. 2001-185, No. 4230-00S (2001). The case was designated as an “S” (“small”) tax case. Although small tax case opinions have no precedential value and are not treated as “authority,” under § 7463, the case is instructive regarding the contexts within which a procedure that might seem to be categorically “cosmetic” is not “cosmetic” under § 213(d).

336. *Al-Murshidi*, T.C. Summary Op. 2001-185 at 5.

337. *Al-Murshidi*, T.C. Summary Op. 2001-185 at 6.

338. See *Al-Murshidi*, T.C. Summary Op. 2001-185 (observing that the medical procedures undertaken by the taxpayer “meaningfully promoted the proper function of her body”).

339. See *Al-Murshidi*, T.C. Summary Op. 2001-185.



causes psychological suffering that is comparable to the suffering of a woman whose breast has been removed. Transgender persons commonly refer to their pre-GCS genitalia as deformities, even going so far as to describe them as “life-threatening deformities.”<sup>340</sup> Also, like GCS, breast reconstruction often involves removal of *healthy* tissue (*e.g.*, removal of a non-diseased breast, followed by reconstruction to achieve symmetry, or removal of abdominal, buttock, or back tissue to construct a breast).<sup>341</sup> Removal of healthy tissue seems to be one of the chief moral objections to GCS, but no comparable moral objection seems to have erupted in the context of breast reconstruction symmetry surgeries or trans flap surgeries. Breast cancer patients and GID patients both keenly feel the need to function normally in public and private spaces. For a breast cancer patient, the risks of not passing in public spaces are primarily psychological.<sup>342</sup> For transgender persons, the risks of not passing in public spaces are far more severe and potentially include verbal harassment, physical assault, sexual assault, and arrest.<sup>343</sup>

### C. Additional § 213 Requirements

The IRS also argued that a taxpayer cannot deduct the cost of a procedure—including an inherently medical procedure—unless the taxpayer can

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340. *See, e.g.*, ORBACH, *supra* note 177, at 26 (trans woman “described the male genitalia she was born with as ‘an embarrassing often life-threatening birth defect’”). Breast reconstruction following mastectomy also is characterized as “life-saving.” *See* 144 CONG. REC. 27,499 *supra* note 57.

341. *See supra* text at note 60 and note 62.

342. *See, e.g.*, NORTON, *supra* note 46, at 147–48 (describing a humiliating post-mastectomy breast prosthesis incident in a public pool):

My range of motion was so limited, I couldn’t lift my arm out of the water. It took me thirty gimpy strokes . . . drag . . . stroke . . . drag to get only halfway across the pool and I’d swum blindly into the lane dividers multiple times. I was out of breath, swallowing water, and embarrassing myself. I . . . turned back, hoping to reach the edge by doing the breaststroke. That is when I swam into a blurry mass of tawny-colored silicone, a nippleless blob bobbing like a big cow patty in the water. My falsie. I stuffed it back into my suit, frantically dog-paddled across two lanes to the edge, got out of the water, and drove home soaking wet.

*Id.*

343. *See, e.g.*, Herman, *supra* note 300. *See also* Trial Transcript, *supra* note 81, at 576 (Dr. Brown redirect) (if transsexual woman using a restroom does not pass, she “can be arrested in many jurisdictions for using the wrong restroom [and] publicly humiliated.”). There is a heated debate among race, feminist, and transgender scholars about whether transgender “passing” should be condemned in the same way that transracial passing historically has been condemned. In the racial context, “passing” has a negative connotation and is viewed by some as a form of “racial betrayal.” *See, e.g.*, Bettcher, *supra* note 119, at 52.

establish that the procedure was (1) efficacious and (2) medically necessary.<sup>344</sup> The IRS asserted that a medical procedure is *not* efficacious if (1) it did not, in fact, *cure* the taxpayer or (2) if the diagnosis or procedure is controversial within the medical community.<sup>345</sup> In addition, the IRS took the position that a medical procedure does not cure the taxpayer if the medical diagnosis for which the taxpayer was treated was a misdiagnosis.

To the contrary, § 213(d)(1)(A) provides that an expense is medical care if it is “‘*for*’ treatment of a disease or ‘*for*’ the purpose of affecting the structure or function of the body.”<sup>346</sup> Consistent with this statutory language, the § 213(d) test does *not* require a taxpayer to establish that the diagnosis was correct (*i.e.*, that no other diagnosis was plausible),<sup>347</sup> the medical procedure cured the taxpayer,<sup>348</sup> or that the treatment is not controversial within the medical community.<sup>349</sup> Section 213 simply requires that the taxpayer—*ex ante*, before undertaking the medical treatment—subjectively and reasonably believe that the treatment will be efficacious; it does not require a successful health outcome *ex post*.<sup>350</sup> The IRS argument that § 213 allows deductions only for medical procedures that “cure” the taxpayer is untenable. Such an approach would deny deductions for most medical procedures to treat diseases with low survival or cure rates (*e.g.*, pancreatic cancer) or progressively debilitating diseases (*e.g.*, multiple sclerosis). Such an approach also ignores the dominant rationales for the medical expense deduction: taxpayers spend money on medical procedures because health is critical for functioning and taxpayers believe that the care will be efficacious. Whether the care is or is not efficacious is irrelevant. Nor does § 213 require that IRS agents or the Office of Chief Counsel believe that the treatment would be efficacious. A patient’s subjective and reasonable beliefs are based on the expert recommendations of health care professionals. If a health care professional recommends a medical procedure to address dysfunction and improve the patient’s internal psychological functioning

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344. Respondent’s Opening Brief *supra* note 14, at 192 (arguing that O’Donnabhain cannot deduct the cost of GCS because GCS “neither cures GID, nor is medically necessary for GID, nor is medically effective treatment for GID”).

345. Respondent’s Reply Brief, *supra* note 188, at 47 (although the Benjamin standards of care represent the consensus view of GID specialists, they are not “established” “within mainstream medicine,” and “GID is not universally accepted as a diagnosis.”).

346. I.R.C. § 213(d)(1)(A).

347. Post-Trial Brief of Petitioner, *supra* note 72, at 51 (deduction is allowed even if the taxpayer is misdiagnosed).

348. *Id.* at 71–73.

349. *Id.* at 41.

350. *See, e.g., Havey*, 12 T.C. 409 (focusing on whether a taxpayer primarily incurred an expense for medical care based on the *ex ante* belief that the procedure would be efficacious, not on the *ex post* outcome of the procedure).

and social functioning, such a procedure is medical care, even if the diagnosis is incorrect.

Equally untenable is the IRS argument that a medical procedure is efficacious (and therefore can be medical care) only if the procedure is not controversial within the medical community.<sup>351</sup> For example, the costs of a Christian Science Practitioner are deductible as medical care despite the fact that such treatment is at odds with standard medical practices.<sup>352</sup> Adriamycin, a drug that is used to treat breast cancer, is controversial within the medical oncology community.<sup>353</sup> However, if a patient's doctor prescribes Adriamycin, that controversy does not remove the drug from the definition of medical care. Again, all that is required is that the taxpayer reasonably and subjectively believe that the care will be efficacious.

Section 213 also does not require a taxpayer to establish that a medical procedure is "medically necessary."<sup>354</sup> Showing that a medical procedure is medically necessary is sufficient, although not required, to establish that the procedure is § 213(d)(1)(A) "medical care." A medical procedure can be medical care even if the taxpayer cannot establish that the procedure is regarded by insurance plans as medically necessary. Medical necessity is a mal-

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351. The IRS argued that GCS is controversial (and does not "treat" severe GID), based on Dr. McHugh's assertion that GCS is "collaborating with madness," in spite of Dr. Brown's expert testimony that there is evidence of "quite impressive" measures of the success of hormone treatment and GCS in treating GID. Trial Transcript, *supra* note 81, at 291–92 (direct examination of Dr. Brown, indicating that comparisons of the success of GCS to treat GID and medical treatments for other medical conditions such as heart disease are "substantially favorable" to GCS). Conversely, in response to IRS questioning, Dr. Brown testified that, although clinicians repeatedly have tried to talk patients out of their persistent gender identity, the talk therapy approach "doesn't work." *Id.* at 387 (adding: "[I]f that worked, we'd still be doing it today. But that doesn't work."). See also *id.* at 396. The IRS conceded the positive results described in the famous Mate-Kole study, which concluded that patients who received GCS "showed decreased neurotic symptoms and were more socially active" than the control group, but asserted that patients who receive various types of elective cosmetic surgery, such as nose jobs, also are satisfied with the results. Respondent's Opening Brief, *supra* note 14, at 188.

352. See Rev. Rul. 55-261, 1955-1 C.B. 307 (ruling that deductible medical expenses include payments for services rendered by Christian Science practitioners).

353. Research established that the drug increases the risk of congestive heart failure. See, e.g., Rowan T. Chlebowski, *Adriamycin (Doxorubicin) Cardiotoxicity: A Review*, 131 WESTERN J. MED. 364 (1979). Some oncologists discontinued use of the drug, due to its cardiotoxicity, but other oncologists continued to administer the drug, based on its proven track record in treating cancer. See, e.g., Dennis Slamon et al., *Adjuvant Trastuzumab in HER2-Positive Breast Cancer*, 365 NEW ENG. J. MED. 1273 (2011) (authors argue for discontinuing use of Adriamycin due to cardiotoxicity of the drug).

354. See I.R.C. § 213.

leable, indeterminate, context-dependent term.<sup>355</sup> To deny insurance coverage of a procedure, insurance companies often argue that the procedure is not medically necessary.<sup>356</sup> However, such denial of coverage for a procedure does not establish that the procedure is not “medical.” The best example of this is the nearly universal denial of insurance coverage for breast reconstruction following mastectomy (prior to the enactment of breast reconstruction mandates), on the grounds that breast reconstruction is not medically necessary. Notwithstanding insurance company consensus that breast reconstruction surgery is not medically necessary, Congress and state legislatures enacted breast reconstruction mandates to reverse the denial of coverage for breast reconstruction. The 1990 legislative history of the cosmetic surgery amendment also gives breast reconstruction surgery as an example of appearance-improving surgery that is not cosmetic surgery—notwithstanding the widespread insurance company classification of such surgeries as not “medically necessary”—because breast reconstruction promotes more normal functioning.

The arguments made by the IRS in *O'Donnabhain* are surprisingly weak and flatly inconsistent with decades of cases and administrative pronouncements, as Judge Gale's majority opinion notes.<sup>357</sup> A plausible explanation for the puzzling IRS argument is that the IRS denied O'Donnabhain's deduction based on bias against transgender persons<sup>358</sup> and agreement with Dr. McHugh's anti-GCS arguments, including his argument that GCS is immoral.<sup>359</sup> The IRS could not win the case by making overt religious, moral, or ethical objections; IRS counsel instead used the pretext of interpreting § 213 in farfetched, unprecedented ways.

#### D. IRS Arguments Taken as a Whole

Taken as a whole, the arguments made by the IRS are implausible. If the IRS arguments had prevailed in the *O'Donnabhain* case, the decision

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355. See, e.g., Linda A. Bergthold, *Medical Necessity: Do We Need It?*, 14 HEALTH AFFAIRS 180 (1995) (noting that the term “medical necessity” is ambiguous, “undefined” and “open to interpretation,” and that insurance plans use it “as a place holder to define the limits of their benefit coverage, despite widespread disagreement about its meaning”).

356. See *id.* at 181 (“medical necessity,” “a rationing tool largely under the control of insurance plan administrators,” is used by insurance companies to contain health care costs, through denial of coverage for expensive treatments).

357. *O'Donnabhain*, 134 T.C. at 56 (“[R]espondent's interpretation [of disease] is flatly contradicted by nearly a half century of caselaw.”).

358. Critical tax scholars also have noted an implicit bias towards “heteronormativity” in the tax law. See, e.g., Nancy J. Knauer, *Heteronormativity and Federal Tax Policy*, 101 W. VA. L. REV. 129 (1998).

359. See *Psychiatric Misadventures*, *supra* note 94, at 502.

would have reversed settled law regarding the deductibility of many, many types of medical expenses. The approach asserted by the IRS would: radically curtail the medical expense deduction in arbitrary ways; create massive confusion and uncertainty about the deductibility of medical expenses in specific cases; increase disputes and litigation regarding the definition of medical care; render § 213 very difficult for the IRS to administer; and deny a deduction for expenses that fit within the dominant rationales for § 213.

Under the IRS arguments asserted in *O'Donnabhain*, a taxpayer would be able to deduct expenses for an *inherently medical procedure* (*i.e.*, a procedure performed by health care professionals in a health care setting—not golf outings or resort vacations) only if the taxpayer could prove: (1) a *known internal biological* (*i.e.*, pathological) disease etiology for the “disease” for which they received care; (2) that the procedure was not undertaken to alter the taxpayer’s appearance (and if the procedure altered the taxpayer’s appearance, it is presumed that the primary purpose of the procedure was to alter appearance);<sup>360</sup> (3) that the taxpayer’s illness, condition, or disorder is not attributable to the taxpayer’s “behavior” or “choices”; (4) that the medical procedure in fact effected a “cure” or “treatment,” *i.e.*, that it was “efficacious”; (5) that there is no “controversy” within the medical community about the procedure; and (6) that the procedure was “medically necessary.”<sup>361</sup>

Under this test, taxpayers could not deduct the costs of many types of medical procedures. The etiology of many diseases, including most types of mental illness, is unknown, and the efficacy of many standard types of medical care for common diseases is indeterminate even to medical experts, much less ordinary taxpayers who are claiming deductions for expenses they incurred in good faith on the advice of their health care professionals.<sup>362</sup> Scientific ignorance about the causes of diseases should not prevent taxpayers who are following standard treatment protocols from deducting the costs of medical care ordered by health care professionals to restore or simulate normal functioning. In addition, the notion that a taxpayer can deduct the cost of a procedure only if it cures the patient is unprecedented and inconsistent with § 213.

Also, the classification of many types of medical procedures would be uncertain under the test proposed by the IRS in the *O'Donnabhain* case. This became evident during the trial, when Dr. Dietz could not classify as

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360. The § 213(d)(9) term “cosmetic surgery” is defined narrowly to exclude from the definition of medical care “only expenses ‘directed at improving the patient’s appearance.’” Post-Trial Brief of Petitioner, *supra* note 72, at 41 (emphasis in original).

361. See *supra* Part II.D.1.b. (IRS’s arguments in the *O'Donnabhain* case).

362. See *supra* text accompanying notes 264–.

diseases or non-diseases many common disorders or conditions about which he was questioned.<sup>363</sup> He further conceded that there is no medical reference text that could provide such classifications.<sup>364</sup> If a medical expert on disease classification is unable to classify common health disorders as diseases or non-diseases, using the narrow IRS test, the IRS and taxpayers also would be clueless about how to classify common disorders. The arbitrary nature of some elements of the IRS test (*e.g.*, whether there is proof of known internal disease etiology for a particular disorder) defy simple classification rules. The new test asserted by the IRS thus is not administrable.

In addition, taxpayers and the IRS likely would disagree on the classification of various medical procedures under the new hyper-technical IRS test, which would increase tax controversies and litigation to apply the test. Many new issues would have to be resolved under the narrow IRS test. For example, how would the IRS and taxpayers know whether a medical condition is a congenital defect? Would the costs of prescription growth hormone to treat a child with idiopathic short stature ("ISS") be deductible as medical expenses?<sup>365</sup> Growing taller improves appearance and ISS is defined as extreme shortness with no identifiable pathology.<sup>366</sup> Growth hormone thus would be "cosmetic" under the test the IRS asserted in *O'Donnabhain*, unless the IRS treated ISS as a congenital defect. A quick review of the various types of medical expenses listed in Taxpayer Publication 502 provides the following examples of costs that the IRS has classified as deductible but might no longer be deductible under the arguments that the IRS made in

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363. Trial Transcript, *supra* note 81, at 829–94. Dr. Dietz was questioned about classifying mental disorders that are listed in the DSM. Physical conditions, injuries, and congenital defects also might be difficult to classify under the narrow IRS test for medical expenses. Consider for example, the classification of the costs of Lasik eye surgery. Myopia is a condition affecting the visual system, but myopia does not have a disease pathology or etiology, and the eye surgery alters a patient's appearance because the patient no longer needs to wear glasses after the surgery. The IRS nonetheless ruled, in Revenue Ruling 2003-57 (after the 1990 enactment of the § 213(d)(9) cosmetic surgery limitation), that the taxpayer could deduct the cost of the eye surgery because it affected the functioning of the taxpayer's vision. Rev. Rul. 2003-57, 2003-1 CB 959 (2003). The ruling seems inconsistent with the arguments that the IRS made in the *O'Donnabhain* case.

364. Trial Transcript, *supra* note 81, at 892–93 (Dietz testimony). O'Donnabhain's lawyer asked Dr. Dietz whether there is "any publicly available source or text that indicates, for each individual [DSM] classification, whether that particular classification meets the definition of disease." *Id.* at 893. Dr. Dietz conceded that there is not. *Id.*

365. See, *e.g.*, Stefania Pedicelli et al., *Controversies in the Definition and Treatment of Idiopathic Short Stature* (ISS), 1(3) J. CLINICAL RES. PEDIATRIC ENDOCRINOLOGY 105 (Feb. 2009).

366. See, *e.g.*, *id.* at 108 ("[S]hort stature is defined on the basis of a statistical cut-off point [two Standard Deviations below mean height for the reference group] which does not automatically imply the presence of an underlying pathology").

the *O'Donnabhain* case:<sup>367</sup> inpatient treatment for drug addiction, inpatient treatment for alcohol addiction, weight-loss program, stop-smoking program, Christian Science practitioner, orthodontia, artificial teeth, artificial limbs, pregnancy test kit, legal vasectomy, sterilization, birth control pills, legal abortion, and fertility enhancement procedures.

As noted earlier, the IRS might deny deductions for expenses incurred to treat diseases with low survival rates or progressive debilitating diseases, and expenses incurred in clinical trials or for experimental medical treatment, on the grounds that the treatment is not “efficacious.” The denial of medical expense deductions in such cases is so antithetical to the rationales for § 213 that the IRS approach seems absurd.

To summarize, the arguments made by the IRS in the *O'Donnabhain* case are inexplicable as a matter of longstanding tax law. The IRS arguments can be explained, however, as an attempt to deny the taxpayer’s deduction for reasons having nothing to do with tax law—namely animus towards transgender persons and moral outrage regarding GCS.

#### *E. Treatment of Transgender Persons*

The IRS has a continuing obligation to treat taxpayers fairly.<sup>368</sup> Taxpayers have a right to “quality service” from the IRS, which includes “courteous [ ] and professional assistance.”<sup>369</sup> Taxpayers also have a right to “a fair and just tax system.”<sup>370</sup> In addition, the IRS has a policy of not discriminating “based on race, color, national origin, reprisal, disability, age, sex (including sexual orientation . . .), religion, or parental status.”<sup>371</sup> The extreme nature of some of the arguments the Office of Chief Counsel made in the *O'Donnabhain* case raises concerns about discrimination against transgender

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367. Pub. 502, *supra* note 45, at 5–8, 13–15.

368. IRS Mission Statement 2016, I.R.B. 2016-1 (Jan. 4, 2016) (“The IRS Mission: Provide America’s taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.”).

369. I.R.S. News Release FS-2015-5 (2015):

In addition to the Taxpayer Bill of Rights, the IRS is committed to ensuring that your civil rights are also protected. Taxpayers are not subjected to discrimination based on race, color, national origin, reprisal, disability, age, sex (including sexual orientation and pregnancy discrimination), religion, or parental status in programs or services conducted by the IRS or on its behalf. If a taxpayer believes he or she has been discriminated against, a written complaint can be emailed to [edi.civil.rights.division@irs.gov](mailto:edi.civil.rights.division@irs.gov) or mailed to the IRS Civil Rights Division.

*Id.*

370. I.R.S. Pub. 1 (2014) (Taxpayer Bill of Rights includes “The Right to a Fair and Just Tax System”).

371. *Supra* note 369.

persons, as well as concerns about the IRS making similar hyper-technical tax arguments to covertly advance a moral agenda that the IRS cannot achieve overtly.

Unlike some federal statutes, the Internal Revenue Code does not contain any explicit statutory expression of the views that GID and transsexualism are deviant sexual behavior and unethical.<sup>372</sup> The IRS arguments in the *O'Donnabhain* case nonetheless assert these views covertly, by making hyper-technical tax arguments about "disease" and "cosmetic surgery" in an attempt to deny O'Donnabhain a tax deduction for hormone treatment and GCS.

During the O'Donnabhain tax controversy and litigation, the IRS and Office of Chief Counsel showed disrespect for transgender persons, including O'Donnabhain. The IRS briefs and arguments, for example, include various instances of transgender stereotyping. The IRS and its expert witness, Dr. Dietz, treated O'Donnabhain like a criminal paraphiliac, lumping

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372. Some conservative interest groups openly express views that echo Dr. McHugh's views and have successfully enlisted like-minded legislators to express some of their views in legislation. For example, such groups and their allies in Congress strongly opposed enactment of the Americans with Disabilities Act, on homophobic grounds, and the proposed classification of GID and transsexualism as disabilities, on transphobic grounds. See Ruth Colker, *Homophobia, AIDS Hysteria, and the Americans with Disabilities Act*, 8 J. GENDER RACE & JUST. 33 (2004). One purpose of the ADA was to classify HIV/AIDS as a disability (such that accommodation for the disability would be required), leading conservative legislators to oppose the bill. *Id.* at 40. Representative Dan Burton argued: "The ADA is a last ditch attempt of the remorseless sodomy lobby to achieve its national agenda before the impending decimation of AIDS destroys its political clout. Their Bill simply must be stopped. There will be no second chance for normal America if the ADA is passed." *Id.* at 33. Although these groups lost the overall ADA battle, they won the GID/transgender battle by adding to the ADA a provision stating that the term "disability" does not include: "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, GID not resulting from physical impairments, or other sexual behavior disorders." *Id.* at 35. This characterization of GID and transsexualism as deviant sexual behavior is consistent with the views articulated by Dr. McHugh and Dr. Dietz. The statutory grouping of GID and transsexualism with the sex crimes of pedophilia, exhibitionism, and voyeurism conveys moral opprobrium against GID and transsexualism. *Id.* at 50 (noting that ADA transsexual exclusion language, which groups transsexual persons with persons with "sexual behavior disorders," is "extremely derogatory" towards transsexual persons). In addition, commentators argue that the exclusion of GID and transsexualism from the ADA definition of "disability" is unconstitutional. Kevin M. Barry, Brian Farrell, Jennifer L. Levi, and Neelima Vanguri, *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. REV. 507 (2016), <http://lawdigitalcommons.bc.edu/bclr/vol57/iss2/4> (asserting that "the ADA's transgender exclusions are unconstitutional no matter what level of scrutiny applies because moral animus against transgender people is not a legitimate basis for lawmaking").



together GID and criminal forms of sexual deviance.<sup>373</sup> Dr. Dietz's open hostility towards classifying GID as a disease was grounded in his extensive experience in criminal trials,<sup>374</sup> where his testimony that criminal defendants do not suffer from "disease" prevents them from escaping criminal responsibility for their actions. Dr. Dietz explained his reluctance to treat a mental disorder, such as GID, as a disease:

[T]o avoid certain kinds of mischief, it's necessary to clearly distinguish which disorders in the DSM are, in fact, diseases, [and] which ones are not. . . .

[M]ost often, . . . the distinction that I am asked to address is in reference to the predicate mental disease question for competence issues or sanity issues.

And there, the point is to have some reference point for ensuring that only people who have biological, pathological process get the special consideration of freedom from responsibility.

Because otherwise, if we allow the word disease to expand endlessly to everything in the DSM, all criminals could be said to suffer from the predicate mental disease. . . . And we would lose all accountability for individual human behavior.<sup>375</sup>

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373. During *voir dire*, Judge Gale asked Dr. Dietz: "Is it fair to say that the primary thrust of your work in the area of sexuality and gender has to do with the criminal environment and criminal culpability?" Trial Transcript, *supra* note 81, at 819–20. Dr. Dietz answered:

[F]ar more of my experience concerns the conditions known as paraphilias that often come in conflict with the law.

And more of my experience is among those who already have come in conflict with the law than those who have the same condition, but haven't offended or haven't been caught for offending.

Then to a lesser degree, . . . I have experience with the other range of human sexual problems, including sexual dysfunctions and gender identity problems and sexual orientation issues.

*Id.* at 820. At least half of Dr. Dietz's work as a forensic psychiatrist pertained to cases involving "violent behavior." *Id.* at 803. Dr. Dietz had no experience evaluating or treating patients with GID. *Id.* at 818–19.

374. At the time Dr. Dietz testified in the O'Donnabhain case, his professional experience included forensic psychiatric work in criminal cases involving the following high-profile defendants: "John Hinckley, Jeffrey Dahmer, the Menendez brothers, a number of the mothers who have killed their children . . . quite a few serial killers . . . the Unibomber case, the DC snipers, the serial shooters in Phoenix, Arizona, the shotgun stalker in Washington, DC." *Id.* at 798.

375. Trial Transcript, *supra* note 81, at 922–24 (Dietz testimony)

This criminal "accountability" framing by the IRS and Dr. Dietz was wholly inappropriate in the civil context of the *O'Donnabhain* case, where the issue was the income tax definition of "medical care."

Throughout the litigation, the IRS adopted a hostile "us-versus-them" and "ingroup-versus-outgroup" stance. Accordingly, the IRS relegated O'Donnabhain's therapists, doctors, and GID experts to the "them" (*i.e.*, the "homo-trans" "other") outgroup to try to impugn their credibility.<sup>376</sup> The IRS not only doubted O'Donnabhain's legal arguments regarding the proper interpretation of § 213(d) but also aggressively disputed the factual assertions made by O'Donnabhain, her therapists, her doctors, and Dr. Brown.

The IRS characterized O'Donnabhain as deceitful, deluded, or pathetic.<sup>377</sup> In effect, the IRS asserted the anti-trans version of the "masquerade hypothesis," which posits that "the trans person who transitions from one sex/gender to another is merely donning a mask or engaging in a pretense that effectively hides what they always really were (the "true person")."<sup>378</sup> This is at the heart of the IRS argument that the feminizing hormones and GCS changed O'Donnabhain's "appearance" only; the IRS assumption was that O'Donnabhain could never change from a biological man into a "true" woman. Under this view, O'Donnabhain living as a

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376. See, e.g., *The Psychology of Prejudice: An Overview*, UNDERSTANDING PREJUDICE, <http://www.understandingprejudice.org/apa/english/page9.htm> (last visited Aug. 13, 2016) (observing that "prejudice is also closely connected to the way that ingroup and outgroup members explain each other's behavior."). "[P]eople often make uncharitable attributions for the behavior of outgroup members." *Id.* "[C]ausal attributions implicitly follow a 'just world' ideology that assumes people get what they deserve and deserve what they get," denying the role of situational factors and "the problem of social injustice." *Id.* Also, people often "attribute behavior to dispositional causes [e]ven when behaviors are undeniably caused by situational factors." *Id.* In addition, people often segment the world into ingroups and outgroups and "(1) attribute negative outgroup behavior to dispositional causes (more than they would for identical ingroup behavior), and (2) attribute positive outgroup behavior to one or more of the following causes: (a) a fluke or exceptional case, (b) luck or special advantage, (c) high motivation and effort, and (d) situational factors." *Id.* This worldview perpetuates prejudice against outgroups, "because their positive actions are explained away while their failures and shortcomings are used against them." *Id.*
377. Trans people are stereotypically depicted by the media as "sexually predatory deceivers," deluded, or "pathetic, laughable fakes." See Bettcher, *supra* note 119, at 52–53, 64–68 ("[T]rans people are inevitably constructed as frauds or fakes" and their "trans self-identities are invalidated").
378. *Id.* at 52–55 (describing two versions of the masquerade hypothesis, both of which assume that medical transition does not change a trans person's "true" sex/gender).

woman is either deceitful or deluded.<sup>379</sup> O'Donnabhain argued the inverse version of the masquerade hypothesis: that she was always a woman on the inside, wearing the false mask of a man, until her medical transition allowed her to remove the mask and reveal her true self.<sup>380</sup>

The *O'Donnabhain* case illustrates various listening stances that can be taken toward a taxpayer-patient's story. A listener's listening stance can be represented on a spectrum, ranging from pure belief to pure doubt.<sup>381</sup> The clinicians (GID experts) who treated O'Donnabhain adopted a sympathetic "believing" stance that validated her story of lifelong psychological distress and suffering. The IRS, which adopted a "doubting" stance, was deeply skeptical (one might go so far as to say openly contemptuous) of (1) O'Donnabhain's story of lifelong distress and suffering from GID; (2) the medical clinicians who approved O'Donnabhain for GCS; (3) O'Donnabhain's expert witness; and (4) the medical experts who drafted the GID section of DSM-IV-TR and the Benjamin standards of care.<sup>382</sup> In addition, the IRS attacked the credibility of O'Donnabhain's therapist and doctors because they did not adopt a doubting stance towards their patient; the IRS argued that they should have spoken to third parties to independently corroborate her assertions, which the IRS disputed, about the emotional distress she felt. This attack on medical professionals who are sympathetic to the stories of transgender persons is extreme. It is difficult to imagine that the IRS would criticize medical professionals for believing their patients' claims of emotional distress in other medical contexts. The IRS

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379. *Id.* at 52–53 (“trans person who transitions from one sex/gender to another is [assumed to be] merely donning a mask or engaging in a pretense that effectively hides what they always really were . . . [and] is represented as either deceptive or deluded”).

380. *Id.* at 53 (“trans person who transitions is merely becoming what they always already were, through pulling off a kind of bodily mask which fails to express what that are ‘on the inside’ . . .”).

381. *See, e.g.*, JEAN KOH PETERS & MARK WEISBERG, *A TEACHER'S REFLECTION BOOK: EXERCISES, STORIES, INVITATIONS* 70–74 (2011) (distinguishing between listening with a “believing” stance and listening with a “doubting” stance, and exploring the psychological and emotional effects of such listening stances on speakers). *See also* MARY ROSE O'REILLY, *RADICAL PRESENCE: TEACHING AS CONTEMPLATIVE PRACTICE* 22–29 (1998) (adding a third, “neutral” listening stance, which she dubs “listening like a cow,” and exploring the psychological and emotional effect of this neutral listening stance on a speaker).

382. Judge Gale, the trial court judge and majority opinion author, adopted a neutral listening stance. He was willing to defer to medical experts, especially GID specialists. The Tax Court dissenters adopted a “doubting” listening stance, were not willing to defer to medical experts, and concluded that GCS affects the body but does not treat the mental condition of GID. They observed that GCS is regarded by many as unethical, but noted that medical expenses, such as abortion expenses, are classified as medical expenses notwithstanding the fact that many people believe that abortions are unethical.

also impugned Coleman’s medical assessment of O’Donnabain specifically because Coleman is a trans man.

The IRS also was dismissive of the narratives of transgender persons and reduced their stories to a desire for sexual gratification. The IRS argued that GID is not a disease because it was added to the DSM based on “narrative histories given by patients” rather than scientific basis.<sup>383</sup> To the contrary, Jay Prosser argues that narratives are “central” to transsexuals’ experiences and “involve the notion of home and belonging.”<sup>384</sup> “Transsexual narratives are driven by a sense of feeling not at home in one’s body, through a journey of surgical change, ultimately coming home to oneself (and one’s body).”<sup>385</sup> The IRS also argued that trans women, including O’Donnabain, may be motivated solely by erotic desire and have transvestic fetishism or autogynophilia rather than GID.<sup>386</sup> This argument is consistent with a stereotypic “long standing tendency to construe transsexuality in terms of sexual desire, to reduce cross-gender identification to a kind of sexual fetish.”<sup>387</sup> Taking another cue from Dr. McHugh’s writings, which pair GCS and limb amputations for sexual gratification, the IRS questioned Dr. Brown about the similarities between GID and apotemnophilia (body integrity identity disorder), a disorder characterized by sexual arousal from amputations and the desire to have one’s limbs amputated.<sup>388</sup>

Moral outrage towards transsexualism and GCS also are evident in the IRS and Chief Counsel documents in the *O’Donnabain* case, beginning with the CCA memo and continuing throughout the case in the Tax Court. For example, the IRS argued that GID is deviant sexual behavior, not a “disease.”<sup>389</sup> Additionally, the IRS argued that GCS does not treat GID, which is consistent with Dr. McHugh’s moral view that the “natural” human body (and “healthy” tissue) should not be surgically mutilated and that GCS is an “abomination.”<sup>390</sup> As commentators have noted, however,

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383. Respondent’s Opening Brief, *supra* note 14, at 169–70.

384. *E.g.*, Bettcher, *supra* note 119, at 42–43 (summarizing Jay Prosser’s view that retrospective “autobiographical narrative[s] [are] essential to understanding transsexual subjectivity” and “such narratives involve the notion of home and belonging”).

385. *Id.*

386. Respondent’s Opening Brief, *supra* note 14, at 27–28 (arguing that “[r]ather than GID, petitioner may have suffered from transvestic fetishism” and autogynophilia, which is “a biological man’s tendency to be sexually aroused by the thought or image of himself as a woman,” and which “may link transvestic fetishism with non-homosexual forms of GID”).

387. Bettcher, *supra* note 119, at 57 (citation omitted).

388. See Trial Transcript, *supra* note 81, at 409–11 (cross examination of Dr. Brown).

389. See *supra* note 248.

390. See McHugh, *Surgical Sex*, *supra* note 11, at 7–9. Dr. McHugh vehemently disagrees with those who persist in approving of GCS and criticizes what he claims is their “deep prejudice in favor of the idea that nature is totally malleable.” *Id.* at 8. He also

there is no purely “natural” body because bodies express cultural and religious norms.<sup>391</sup> For example, in our time and culture, the removal of a breast cancer patient’s healthy breast to construct a pair of symmetrical post-mastectomy breasts is treated as “normal,” and insurers’ attempted classification of such procedures as “cosmetic surgery” is treated as outrageous.<sup>392</sup> Yet at the same time, anti-GCS groups and their allies characterize GCS as unnatural self-mutilation and rhetorically pair it with amputation of limbs for sexual gratification.

Compare the costs of GCS for a taxpayer diagnosed with GID and the costs of breast reconstruction surgery following mastectomy. Agencies, legislators, and courts take a strong believing stance regarding the sad stories of breast cancer patients and their need for medical intervention to reconstruct their bodies.<sup>393</sup> With respect to GID and GCS, however, agencies, legislators, and courts are more likely to take a doubting stance.<sup>394</sup> How do we distinguish between these types of medical procedures? Both types of patients experience the internal psychological need to be whole and to be integrated psychologically. Both types of patients feel the need to fully function in public spaces and in private.

The dominant policy rationale for § 213 assumes that all medical care is involuntary<sup>395</sup> (regardless of whether the procedure is elective<sup>396</sup>). Taxpayers who incur catastrophic medical expenses are sympathetic, and sad narratives elicit even more sympathy towards those who have suffered. George Loewenstein, Deborah Small, and Jeff Strnad argue that, as a normative

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lements that “[w]ithout any fixed position on what is given in human nature, any manipulation of it can be defended as legitimate” by those who want GCS and think that they should get whatever they want. *Id.* See also Kass-McHugh Letters, *supra* note 106 (discussing the medicalization of mental disorders and the ethical issues that arise from such medicalization).

391. ORBACH, *supra* note 177, at 9.

[B]odies have always been an expression of a specific period, geography, sexual, religious, and cultural place . . . [O]ur taken-for-granted body is neither natural nor pure but a body that is inscribed and formed by the accretion of myriad small specific cultural practices. . . . [T]here never has been an altogether simple, “natural” body. There has only been a body that is shaped by its social and cultural designation.

*Id.* at 8–9.

392. See, e.g., 144 CONG. REC. S12825 (daily ed. Oct. 21, 1998) (statement of Sen. D’Amato) (describing as “absolutely unacceptable,” “wrong” and “outrageous” an insurer’s denial of coverage for breast reconstruction surgery on the grounds that the procedure was “cosmetic surgery” and not “medically necessary”).

393. See *supra* notes 55–62.

394. See, e.g., *supra* note 381.

395. See Kelman, *supra* note 24, at 865.

396. Pratt, *Magdalin*, *supra* note 26, at 1293–94.

matter, we tend to under-respond to impersonal information about human suffering; our outsized emotional reactions to the suffering of identifiable victims may “restore our ‘true’ morality, as it would function in small group, face-to-face settings.”<sup>397</sup> This may explain why many of the breast reconstruction statutes are named for identifiable victims, *i.e.*, for specific women who desperately wanted such breast reconstruction surgery, but were denied insurance coverage for the procedure.<sup>398</sup> Most religious leaders, legislators, and lay persons know women who have battled breast cancer, making it easy for them to imagine the plight of a woman for whom breast reconstruction feels necessary. However, most do not know transgender persons, making it difficult for them to imagine the plight of a transgender person for whom medical transition feels equally necessary.<sup>399</sup>

A broader rationale for § 213 is that tax law should promote well-being.<sup>400</sup> Being heard and treated with dignity are central to well-being. Does the *O’Donnabhain* decision promote or undermine the dignity of transgender persons? The result in the case supports access to medical care and deductibility of the medical costs of transition.<sup>401</sup> Medical transition makes it more likely that a patient presenting in the perceived gender can function normally in life without being dehumanized or attacked. “Passing” in the perceived gender, which reduces the risk of becoming a victim of transphobic violence, generally is one of the goals of medical transition.”<sup>402</sup>

Having a goal of “passing” is controversial, however. Race, feminist, and transgender scholars debate whether transgender “passing” should be condemned in the same way that transracial passing historically has been

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397. *Identifiable Victims*, *supra* note 27 (summarizing and commenting on research that demonstrates the identifiable victim effect).

398. *See, e.g.*, Women’s Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b (2015), 42 U.S.C. § 300gg-52 (2015) (“Janet’s Law”); ALA. CODE § 22-6-10 (2016) (“Vanessa’s Law”).

399. *See, e.g.*, GLAAD’s Transgender Media Program, GLAAD, <http://www.glaad.org/transgender> (last visited July 14, 2016) (according to a recent poll, only 16% of Americans personally know someone who is transgender); One-in-Four Have Lost Someone To Breast Cancer, RASMUSSEN REPORTS (Oct. 21, 2015), [http://www.rasmussenreports.com/public\\_content/lifestyle/general\\_lifestyle/october\\_2015/one\\_in\\_four\\_have\\_lost\\_someone\\_to\\_breast\\_cancer](http://www.rasmussenreports.com/public_content/lifestyle/general_lifestyle/october_2015/one_in_four_have_lost_someone_to_breast_cancer).

400. *See, e.g.*, Thomas D. Griffith, *Should “Tax Norms” Be Abandoned? Rethinking Tax Policy Analysis and the Taxation of Personal Injury Recoveries*, 1993 WISC. L. REV. 1115, 1118, 1121-22 (1993) (arguing that tax law should adopt normative criteria that (1) consider the consequences of specific tax policies and (2) attempt to maximize either (a) overall societal well-being, under a utilitarian ethic, or (b) the well-being of the least well-off persons in society, under a Rawlsian leximin ethic).

401. *See O’Donnabhain*, 134 T.C. 34.

402. Bettcher, *supra* note 119, at 50–52 (discussing conflicting views of various scholars).

condemned.<sup>403</sup> Some writers oppose GCS on the grounds that transgender persons should not alter their bodies to conform to rigid societal gender roles. Nuridden Knight compares a woman who wants to become a man to Pecola, a character in a Toni Morrison novel, who is black but wants blue eyes so desperately that she loses her mind.<sup>404</sup> Knight argues that freedom to alter the body creates its own form of slavery and wanting to change our physical bodies is an act of self-hatred.<sup>405</sup>

Paradoxically, the more our society tries to free itself from gender stereotypes, the more it becomes enslaved to them. By saying that people can be born in a body of the wrong gender, transgender activists are saying there is a set of feelings that are only allocated to women and another set for men. Therefore, they believe, those who feel things that do not conform to their sex's acceptable set of feelings must outwardly change their gender to match their mind.

Why are we colluding with narrow ideas of femininity or masculinity? What does it mean to "feel" like a woman? Should we question that idea as much as we have questioned ideas of a

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403. *See id.* In the racial context, "passing" has a negative connotation and is viewed by some as a form of "racial betrayal." Janice Raymond famously asked whether a black person should be diagnosed with the disease of being "transracial" if she wants to be white. She observed that blacks do not seek racial transition because they are aware that the problem of racism is societal, and she condemned transsexual medical transition as surgical sex-role oppression. *Id.* Numerous scholars have responded to Raymond's transracial rhetorical argument. Talia Bettcher notes that "transsexualism" is not generally viewed as an act of betrayal. *Id.* She observes that race is a designation of heredity and group identity, whereas sex is a designation of individual identity; this difference may explain the greater acceptance of transgender passing. She also disputes Raymond's claim that blacks do not seek racial transition. Purveyors of cosmetic procedures that make persons of color appear white deflect negative racial overtones, however, "by emphasizing individual self-expression and aesthetics." *Id.* at 52. Procedures that alter racial features, such as hair straightening and nose jobs, thus are characterized as promoting aesthetic values, instead of passing. *Id.* Christine Overall inverts Raymond's argument and argues that "those who accept the morality of transsexuality ought to accept the morality of 'transracialism.'" *Id.* at 51 (placing Overall's arguments within the broader context of the development of feminist theories about transsexuality). Cressida Heyes notes similarities and dissimilarities between racial passing and transgender passing and argues that "changing sex is exceptional." *See, e.g.,* Cressida J. Heyes, *Changing Race, Changing Sex: The Ethics of Self-Transformation*, in "YOU'VE CHANGED:" SEX REASSIGNMENT AND PERSONAL IDENTITY 135, 136 (Laurie J. Shrage ed., 2009) (emphasis in original).

404. Nuridden Knight, *An African-American Woman Reflects on the Transgender Movement*, PUB. DISCOURSE, June 4, 2015, <http://www.thepublicdiscourse.com/2015/06/15108/> (referring to Toni Morrison's book *THE BLUEST EYE*).

405. *Id.*

“woman’s place” or a “man’s role”? When did we come to accept the idea of “gendered thoughts” or “gendered feelings”? . . .

I hope we can one day find a more holistic, less invasive means to treat this disorder.<sup>406</sup>

By treating GID as pathological, transgender persons gain access to medical transition. Some transgender activists argue that completely eliminating the DSM code for GID (or Gender Dysphoria, the diagnosis that recently replaced GID in the DSM-5<sup>407</sup>) would better promote the dignity and autonomy of transgender persons.<sup>408</sup> In their view, the medicalization of transsexuality perpetuates binary patriarchal gender.<sup>409</sup> Although some transgender persons feel at home in one of the two binary genders, some transgender persons feel more at home in the “in-between space between man and woman.”<sup>410</sup>

Judith Butler observes that those who want to keep the medical diagnosis and those who want to eliminate it have different conceptions of autonomy:

Those who want to keep the diagnosis want to do so because it helps them achieve their aims and, in that sense, realize their autonomies. And those who want to do away with the diagnosis want to do so because it might make for a world in which they might be regarded and treated in nonpathological ways, therefore enhancing their autonomies in important ways.<sup>411</sup>

406. *Id.*

407. DSM-5 FACT SHEET, *supra* note 80.

408. *See, e.g.*, Judith Butler, *Undiagnosing Gender*, in *TRANSGENER RIGHTS* 274, 275 (Paisley Currah, Richard M. Juang, & Shannon Price Minter eds., 2006) (“[S]ome activist psychiatrists and transgender people have argued that the [GID] diagnosis should be eliminated altogether, that transsexuality is not a disorder, and ought not to be conceived of as one, and that trans people ought to be understood as engaged in a practice of self-determination, an exercise of autonomy.”) [hereinafter *Undiagnosing Gender*].

409. Bettcher, *supra* note 119, at 59 (noting that Emi Koyama recognizes that trans women may want to “pass” as non-trans women to reduce the risk of becoming a victim of “transphobic violence”). Having a goal of “passing” can be controversial, however. *Id.*

410. *Id.* at 43 (describing Jay Prosser’s argument that transgender “narrative involves making a home of the in-between space between man and woman”). Bettcher counters that “beyond-the-binary” transgender theory “tend[s] to marginalize trans people who situate themselves within the binary, and therefore fails as a complete account of trans oppression and resistance. *Id.* at 63. She frames trans oppression as transphobia, in the form of “reality enforcement” and “identity invalidation.” *Id.* at 64.

411. *Undiagnosing Gender*, *supra* note 408, at 276.



Both groups seek to promote the dignity and autonomy of transgender persons, but they differ in their views about how to promote them.

#### IV. IMPLICATIONS FOR THE TAX CLASSIFICATION OF SERVICES AND GOODS AS MEDICAL CARE

##### *A. Interpretation of the § 213(d) Definition of Medical Care*

Section A of this section summarizes various points discussed throughout this Article regarding the interpretation of the § 213(d) definition of “medical care.” Decades of cases and administrative practice distinguish between expenses incurred (1) for inherently medical services or goods and (2) for goods or services that are not inherently medical. Inherently medical services or goods include hospital services, doctors’ services, diagnostic procedures, surgical procedures, anesthesia, and prescription drugs. Services or goods that are not inherently medical are typically purchased for personal consumption reasons and include items such as vacations, travel to warmer or drier climates, swimming pools, gym memberships, golf, and lawn care.

The costs of inherently medical services or goods are “medical care” unless the “cosmetic surgery” exception applies. If the services or goods improve the taxpayer-patient’s appearance, the IRS and courts must determine whether the services or goods are “purely” cosmetic or were undertaken for the purpose of improving *dysfunction*. Judge Halpern’s concurring opinion in *O’Donnabhain* correctly interprets § 213(d)(9) to classify a medical procedure as “cosmetic” only if it (1) “is directed at improving appearance,” (2) “does not prevent or treat illness or disease,” and (3) “does not meaningfully promote the proper function of the body.”<sup>412</sup> The focus of the inquiry is on restoring or approximating “normal” functioning, which includes internal biological functioning, sexual functioning, psychological functioning, and social functioning. Medical services or goods that reduce dysfunction are “necessary” (not purely cosmetic), but § 213 does not require a taxpayer to establish that the services or goods are a “medical necessity,” as that term of art is defined in insurance contracts in the context of determining insurance coverage.<sup>413</sup> Based on the majority’s factual conclusion that *O’Donnabhain* established the medical necessity of GCS in the case, Judge Gale’s majority opinion in *O’Donnabhain* deflected the question of whether “medical neces-

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412. *O’Donnabhain*, 134 T.C. 34, 83–84 (2010) (Halpern, J., concurring).

413. See, e.g., Bergthold, *supra* note 355, at 183 (providing as an example the definition of “medical necessity” in 1995 Blue Cross insurance contracts, which Blue Cross used to determine which services were excluded from coverage). Bergthold notes that “[p]rivate plans defined coverage mainly by long lists of specific exclusions, some of which were longer than the list of covered services.” *Id.*

sity” is a requirement under § 213.<sup>414</sup> The question of whether a medical procedure is “necessary” was relevant in *O’Donnabhain* only for the purpose of interpreting the § 213(d)(9) cosmetic surgery rule and distinguishing between (1) “purely” cosmetic procedures, which improve appearance and do not improve dysfunction, and (2) “necessary” cosmetic procedures, which improve appearance and *improve dysfunction*.<sup>415</sup> The legislative history of the 1990 cosmetic surgery amendment illustrates this distinction with the example of post-mastectomy breast reconstruction, which is “necessary” notwithstanding that (1) it improves the patient’s appearance and (2) insurance companies denied insurance coverage of breast reconstruction as not “medically necessary.”

The costs of services or goods that are not “inherently medical” are “medical care” only if the taxpayer can establish that the expenses satisfy the test articulated in the *Havey* case.<sup>416</sup> The point of the inquiry is to distinguish between nondeductible personal consumption expenses and deductible expenses that are incurred primarily for medical reasons. As the *Havey* court noted, the inquiry might include the following questions about the “origin” of a disputed expense, to discern a taxpayer’s *ex ante* motivation in incurring the expense:<sup>417</sup>

- [1] Was it incurred at the direction or suggestion of a physician;
- [2] did the treatment bear directly on the physical condition in question;
- [3] did the treatment bear such a direct or proximate therapeutic relation to the bodily condition as to justify a reasonable belief the same would be efficacious;
- [4] was the treatment so proximate in time to the onset or recurrence of the disease or condition as to make one the true occasion of the other, thus eliminating expense incurred for general, as contrasted with some specific, physical improvement?<sup>418</sup>

Although a taxpayer must establish that the taxpayer incurred the expense, *ex ante*, primarily for a medical purpose, taxpayers do not have to establish, *ex post*, the “efficacy” of the services or goods. The taxpayer does *not* have to prove: (1) the services or goods in fact cured the taxpayer in the

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414. *O’Donnabhain*, 134 T.C. at 74–76 (deferring to the WPATH standards of care regarding GCS). Judge Holmes criticized the majority’s factual finding of “medical necessity” in *O’Donnabhain*, based on his concern that the majority’s finding may have far-reaching implications beyond the tax law. *Id.* at 92–96.

415. *See O’Donnabhain*, 134 T.C. 34.

416. *See Havey*, 12 T.C. 409.

417. *Havey*, 12 T.C. at 412.

418. *Havey*, 12 T.C. at 412.

particular case; (2) the services or goods are not “controversial”; or (3) the medical diagnosis was correct. Furthermore, a deduction for medical care that is legal cannot be denied based on ethical objections to the care.<sup>419</sup>

### *B. Implications for Classifying the Costs of Medical Transition*

If a taxpayer follows the Benjamin standards of care and has been diagnosed with GID (or Gender Dysphoria, the diagnosis that recently replaced GID in the DSM-5<sup>420</sup>), the taxpayer’s costs of hormone therapy and genital surgery are “medical care,” under the majority decision in the *O’Donnabhain* case. The classification of “top surgeries,” including breast augmentation for male-to-female transsexuals and double mastectomy for female-to-male transsexuals, is unclear and may depend on the facts of the case. Although the Tax Court held that O’Donnabhain’s breast augmentation surgery was not medical care, its conclusion was based in part on the fact that O’Donnabhain had developed “B” cup breasts from the hormone therapy, prior to the breast surgery. A taxpayer who is transitioning from male to female and does not develop breasts from hormone therapy might be able to argue that the breast surgery is an integral part of the medical transition.<sup>421</sup> Even if the taxpayer’s breast development is adequate, a taxpayer may be able to argue that chest/breast surgery is necessary to make the taxpayer’s chest appear more female, depending on the medical record in the case.<sup>422</sup>

For taxpayers who are medically transitioning from female to male, double mastectomy is more common than genital surgery.<sup>423</sup> The Tax

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419. As Judge Gustafson correctly stated in his *O’Donnabhain* opinion, “neither the tax collector nor the Tax Court passes judgment on the ethics of legal medical procedures, since otherwise deductible medical expenses are not rendered non-deductible on ethical grounds.” 134 T.C. at 110 (citation omitted) (noting, as an example, that the cost of a legal abortion is deductible).

420. DSM-5 FACT SHEET, *supra* note 80.

421. Judge Gale notes that the WPATH standards of care provide for breast augmentation surgery where there is medical documentation that breast development after 18 months of hormone treatment “is not sufficient for comfort in the social gender role.” *O’Donnabhain*, 134 T.C. at 72.

422. Dr. Meltzer, O’Donnabhain’s surgeon, testified that the bilateral breast surgery not only increased the size of O’Donnabhain’s breasts, but also made her “male appearing chest with a small amount of breast tissue on it” look more like a woman’s chest and breasts. Trial Transcript, *supra* note 81, at 622–24. The majority opinion discounted this testimony, however, because Dr. Meltzer’s presurgical notes stated that O’Donnabhain’s pre-surgical B-cup breasts had a “very nice shape.” *O’Donnabhain*, 134 T.C. at 72–73.

423. Bettcher, *supra* note 119, at 45 (although discussion of GCS tends to focus on genital surgery and male-to-female transition, top surgery “often figures more prominently in ftm contexts”).

Court's distinction between top surgery and genital surgery in the *O'Donnabhain* case probably would not preclude classification of the costs of such mastectomies as medical care, in the case of FTM transsexual taxpayers. Judge Gale's opinion indicates that transsexual taxpayers can deduct the costs of surgeries that serve a therapeutic purpose and are consistent with the WPATH standards of care.<sup>424</sup> Such surgeries, which are not limited to genital surgeries, include "top" surgeries and facial feminization surgeries. In dictum, Judge Gale states that the costs of facial feminization surgery could be deductible under this test.<sup>425</sup> The same would be true for therapeutic "top" surgeries.

The Benjamin standards of care require a medical diagnosis (GID in DSM-IV and DSM-IV-TR or Gender Dysphoria in DSM-5) to authorize hormones and surgical transition.<sup>426</sup> If the Gender Dysphoria diagnosis and the DSM code for it were eliminated in the future, would a taxpayer's costs for hormone therapy, genital surgery, and other medical transition procedures constitute "medical care"? Gender Dysphoria would no longer be classified as a disease. Taxpayers incurring costs for medical transition still could argue that medical transition changes the structure or function of the body and is not cosmetic surgery because transition is functional, *i.e.*, it promotes psychological and social functioning. The argument would be that medical transition is as critical for some transsexual persons as breast reconstruction surgery is for some breast cancer patients.<sup>427</sup>

### C. Implications for Classifying Other Medical Procedures

In the future, the IRS could try to use technical tax arguments like the "medical care" arguments it made in *O'Donnabhain* to further a moral

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424. *O'Donnabhain*, 134 T.C. at n. 52.

425. *O'Donnabhain*, 134 T.C. at n. 52.

426. DSM-5 FACT SHEET, *supra* note 80. The DSM-5 substitution of Gender Dysphoria for GID represented a compromise between transgender activists who advocated for eliminating the GID diagnosis and transgender activists who favored keeping it. *See, e.g.*, Bettcher, *supra* note 119, at 34 (discussing tension between activists who oppose the GID diagnosis and activists who favor it). Those who advocate for keeping the GID diagnosis justified it as a means of providing access to medical technology and funding for medical transition. Those who oppose the GID diagnosis argued that it is "pathologizing and paternalistic." *Id.* The new Gender Dysphoria diagnosis was thought to reduce stigma associated with the GID diagnosis. DSM-5 FACT SHEET, *supra* note 80.

427. Bettcher, *supra* note 119 (describing views of Christine Overall, who favors the view that medical transition is similar to "other life-changing and life-enhancing aspirations for personal transformation and self-realization"). Overall rejects both versions of the masquerade hypothesis, which assumes that gender is fixed and medical transition does not change it. *Id.*

agenda that it cannot assert overtly. The medical context in which this seems most likely to occur is reproductive care. Many of the arguments that the IRS made in *O'Donnabhain* could be redeployed to oppose medical expense deductions for the costs of legal fertility treatment or legal abortions. For example, the IRS might argue that fertility treatment costs are not medical care because the procedures may increase the risk of cancer<sup>428</sup> and thus are controversial in the medical community. As explained earlier, controversy does not make otherwise deductible medical expenses non-deductible, but that did not prevent the Office of Chief Counsel from trying to stop *O'Donnabhain* from deducting the costs of medical transition.

### CONCLUSION

Case law and Treasury regulations indicate that normal *functioning* is the baseline for determining whether medical expenses are for tax-favored “medical care.”<sup>429</sup> Functioning includes internal biological functioning, psychological functioning, and social functioning—and is based in part on the social and legal environment in which the individual lives.

The arguments made by the IRS in the *O'Donnabhain* case are puzzling from a tax perspective. Viewed through the lens of Dr. McHugh's characterizations of patients with GID (as delusional and choosing deviant sexual behavior) and his moral objections to GCS (as an “abomination”), they make perfect sense, however. The tax law arguments thus were “a mask for the politics of disgust.”<sup>430</sup> A majority of the Tax Court saw the “tax” arguments for what they were and rightly rejected them.

The question is: why did the IRS persist in such a weak case? Perhaps the motivation was moral outrage, which is immune to reason. Additionally, opponents of GCS perhaps saw the *O'Donnabhain* case as a skirmish in a larger war being waged by the “trans-homo movement” to obtain government funding for GCS. Dr. McHugh, his protégés, and his allies in the IRS and Office of Chief Counsel would not concede that battle, although they now seem to be losing the GCS funding war.<sup>431</sup>

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428. See, e.g., Pratt, *Inconceivable*, *supra* note 23, at 1182–84 (describing research on potential link between fertility treatment and increased risk of reproductive cancers).

429. See *supra*, Part II.D.2.

430. NUSSBAUM, *supra* note 19, at 26 (arguing that anti-LGBT arguments “are too flimsy to do much work without disgust as a backdrop, or are merely a mask for the politics of disgust”).

431. See, e.g., U.S. DEP'T OF HEALTH & HUMAN SERVS., DEPARTMENTAL APPEALS BOARD (DAB), APP. DIVISION, DOCKET NO. A-13-87, DECISION NO. 2576 (May 30, 2014) (invalidating NCD 140.3, which had denied Medicare coverage of GCS to treat GID), <http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf> (last visited March 20, 2016).

Going forward, the IRS should follow its Mission Statement,<sup>432</sup> the Taxpayer Bill of Rights,<sup>433</sup> and the IRS’s nondiscrimination policy,<sup>434</sup> by promoting fairness in tax administration towards all taxpayers—regardless of sex, gender, or gender identity and expression. In addition, Congress or the IRS should add “gender (including gender identity and expression)” to the IRS nondiscrimination policy to expressly prohibit discrimination against transgender taxpayers and other gender nonconforming taxpayers. More broadly, the IRS should resist making covert moral arguments in the guise of technical arguments that are untenable from a tax perspective.<sup>435</sup>

Furthermore, Congress and state legislatures should enact legislation to protect the civil rights of transgender persons and discourage discrimination and violence against transgender persons in housing, employment, and public accommodations. Changing gender identification on identity documents could be based on proof of the gender in which a person lives, without any legal requirement of genital surgery.<sup>436</sup> Medical transition should not be a requirement for a person to live within the law and avoid detention or arrest, and society should accept greater gender variation. In a more tolerant environment, the need to medically transition would focus more on relieving gender-related internal psychological distress and less on “passing” to avoid transphobic discrimination and violence. Ultimately, these changes would promote the dignity, autonomy, and functioning of all transgender persons, whether they medically transition or not. ✨

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432. IRS Mission Statement 2016, I.R.B. 2016-1, Jan. 4, 2016 (“The IRS Mission: Provide America’s taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.”).

433. I.R.S. Pub. 1 (2014) (Taxpayer Bill of Rights includes “The Right to a Fair and Just Tax System”).

434. See I.R.S. News Release FS-2015-5 (2015) (Taxpayer Bill of Rights includes “The Right to Quality Service”).

435. The contexts within which the IRS might make such covert moral arguments include cases involving tax deductions for: gender confirmation medical costs other than hormone therapy and GCS, such as breast augmentation surgery or mastectomy; and reproductive health care costs, such as the costs of contraceptives, vasectomy, tubal ligation, and legal abortion, as well as the costs of fertility treatment, including egg donor, IVF, and surrogacy.

436. See, e.g., Spade, *supra* note 301, at 802 (observing that a “proposal to reduce medical evidentiary requirements in gender reclassification policies in favor of self-identity and/or to create a standard policy nationally would do a great deal to eliminate some of the worst consequences of the incoherence of the current policy matrix,” but ultimately advocating for a more fundamental shift away from gender documentation).