

**A NON-MEDICALIZED MEDICAL DEDUCTION?:
O'DONNABHAIN V. COMMISSIONER & THE I.R.S.'S
UNDERSTANDING OF TRANSGENDER
MEDICAL CARE**

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INTRODUCTION

On January 4, 2006, Rhiannon O'Donnabhain experienced what nearly every American taxpayer dreads—she was informed she was being audited by the Internal Revenue Service (“I.R.S.”). After a lengthy battle that affected much more than her tax liability, O'Donnabhain's struggle was vindi-

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cated: on November 21, 2011, the I.R.S. released a simple one page advisory stating that it will permit medical deductions for transgender¹ medical care.² In releasing this advisory, the I.R.S. adopted the reasoning and conclusions of the previous Tax Court decision.³

The issue before the court was in essence a medical question regarding the scope of the medical deduction, and the court followed the traditional course in transgender jurisprudence, relying on medical evidence and the diagnosis of a disease to permit O'Donnabhain's deduction for her sex reassignment treatment. However, there is much debate within the transgender community about reliance on the medical model. While the first prong of the Internal Revenue Code ("the Code") definition of medical care states that deductible medical care costs are any amount "for the diagnosis, cure, mitigation, treatment, or prevention of a disease," there was an alternative option. The second prong of the Code's definition of medical care permits deductions for amounts paid "for the purpose of affecting any structure or function of the body." As such, this second prong provided an avenue for the court to utilize a potentially more expansive rationale, which could have moved the law to recognize transgender rights beyond a medicalized conception of transgender identity. Though this strategy was not appropriate in this case, the opportunity remains available for future advocates attempting to pursue transgender rights based on the right to self-determination of one's body.

This Note will analyze the underlying Tax Court decision and raise questions about its implications. Part I will provide a brief history of O'Donnabhain, her condition, the treatment she sought, and her struggle to defend her rights. Part II will explore in further detail the definitions and case law that formed the basis of the Tax Court's decision. To conclude, Part III will explore how the Tax Court's choices in statutory interpretation impact the transgender community and broader advocacy efforts. It will also raise the possibility that a future taxpayer could rely on the second prong of

¹ As I am not myself transgender, I would like to defer to those within the community in an effort to utilize terminology that is as respectful and inclusive as possible. Following the model of transgender activist and attorney Franklin Romeo, I use the term "transgender" to refer to a broad spectrum of people whose identity or lived experience do not conform to the identity or experiences typically associated with the sex assigned to that person at birth. This includes, but is not limited to, people who identify or live some or all of the time as a gender other than that assigned to them at birth, people with intersex conditions, transsexuals, genderqueers, cross-dressers, masculine women, and feminine men. 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). As he notes, "each of these terms carries different connotations and limitations and . . . meanings may change over time. [However], in using them, the author seeks to be as inclusive as possible in terms used, and to respect the complexities and evolving nature of terms people use to self-identify." *Id.*

² I.R.S. Action on Decision I.R.B. 2011-47 (November 21, 2011).

³ O'Donnabhain v. Comm'r, 134 T.C. 34 (2010), *acq. in result*, 2011-47 I.R.B. 4.

the definition of medical care for a deduction, thus expanding the legal recognition of transgender rights.⁴

I. RHIANNON O'DONNABHAIN'S STORY⁵

Rhiannon O'Donnabhain was born on the South Shore of Boston and, in many ways, lived the typical American dream. She grew up in a close-knit Irish Catholic family, earned a degree in civil engineering, enlisted in the Coast Guard during the Vietnam War, held a steady job at an engineering firm, married, and had three children. However, throughout her life, O'Donnabhain struggled with the feeling that her gender identity did not align with the gender she was assigned at birth.

⁴ I make this suggestion with trepidation, and full acknowledgment that I am not transgender and therefore have an extremely limited understanding of the complexities involved for transgender individuals in pursuing, financing, and litigating around medical care. I take to heart the caution suggested by Julia Serano for non-transgender individuals writing about the transgender community:

If cissexual academics truly believe that transsexual and intersex people can add new perspectives to existing dialogues about gender, then they should stop reinterpreting our experiences and instead support transsexual and intersex intellectual endeavors. . . . And they should finally acknowledge the fact that they have no legitimate claim to use transsexual and intersex identities, struggles, and histories for their own purposes. . . . Non-intersex, cissexual artists and academics should put their pens down, open up their minds, and simply listen to what we have to say about our own lives.

JULIA SERANO, WHIPPING GIRL: A TRANSEXUAL WOMAN ON SEXISM AND THE SCAPEGOATING OF FEMININITY 212 (2007). Julia Serano defines cissexual individuals as "people who are not transsexual and who have only ever experienced their subconscious and physical sexes as being aligned." *Id.* at 12.

Further, in line with Jacob Hale's *Suggested Rules for Non-Transsexuals Writing About Transsexuals, Transsexuality, Transsexualism, or Trans ____*, I put forward this Note, not as a "meal ticket (retention, tenure, promotion)," but rather in the hope that it can be of use to those who are looking for ways to expand the legal discourse. In that spirit, I hope that those within the transgender community can find something useful for consideration, critique, or amendment. Jacob Hale, *Suggested Rules for Non-Transsexuals Writing About Transsexuals, Transsexuality, Transsexualism, or Trans ____*, SANDY STONE (NOV. 18, 2009), <http://sandystone.com/hale.rules.html>.

⁵ The facts about O'Donnabhain's personal and medical history were derived from the opinion of the Tax Court and her biography on the Gay & Lesbian Advocates & Defenders ("GLAD") website. See *Rhiannon O'Donnabhain*, GLAD, available at <http://www.glad.org/uploads/docs/cases/odonnabhain-bio.pdf> (last visited Apr. 3, 2012). The decision of how to present the facts of the case is often significant and meaningful to the client. As Sharon McGowan of the American Civil Liberties Union described in representing her transgender client in a seminal case at the D.C. Circuit, "[I]t became clearer to me over time that how we presented Ms. Schroer's life and identity to the court was more than just a strategic question. For her, it was also a highly personal matter implicating fundamental issues of identity and integrity." Sharon McGowan, *Working with Clients to Develop Compatible Visions of What it Means to "Win" a Case: Reflections on Schroer v. Billington*, 45 HARV. C.R.-C.L. L. REV. 205, 213 (2010). I have therefore attempted to present O'Donnabhain's story here as faithfully as possible to how it was presented by her advocates.

Although born genetically male, beginning in childhood and throughout adolescence and adulthood, O'Donnabhain "felt that she was a female trapped in a male body."⁶ In 1997, after several months of therapy, O'Donnabhain was diagnosed with Gender Identity Disorder ("GID"), a mental health condition where individuals experience dysphoria between their birth assigned gender and their gender identity, expression, or behaviors, often leading to depression, anxiety, and other psychological distress.⁷ In consultation with her physician, O'Donnabhain began the course of treatment developed by the World Professional Association for Transgender Health ("WPATH").⁸ The WPATH "Standards of Care," referred to as the "Benjamin standards," named after physician Harry Benjamin, who pioneered work in the study of transsexualism,⁹ recommend a carefully sequenced three stage course of treatment beginning with hormonal sex reassignment, followed by living full-time as a member of the opposite sex, and concluding with sex reassignment surgery.¹⁰ Under the supervision of her therapist and other consulted physicians, O'Donnabhain followed this treatment plan and underwent surgery on October 19, 2001.¹¹ In filing her 2001 taxes, O'Donnabhain claimed a medical deduction under § 213 of the Code for the cost of her hormone treatment, sex reassignment surgery, breast augmentation surgery, and the travel expenses related to her surgeries.¹² The I.R.S. disallowed these deductions with a notice of deficiency.¹³ In 2006, with the help of Gay & Lesbian Advocates & Defenders ("GLAD"), O'Donnabhain brought a suit in the Tax Court against the I.R.S., arguing that the treatment she received as part of her transition constituted medical care

⁶ *O'Donnabhain*, 134 T.C. at 35.

⁷ GID is recognized in the primary diagnostic tool for mental health practitioners, the Diagnostic and Statistical Manual of Mental Disorders ("the DSMIV-TR").

The DSMIV-TR states that a diagnosis of GID is indicated where an individual exhibits (1) a strong and persistent desire to be, or belief that he or she is, the other sex; (2) persistent discomfort with his or her anatomical sex, including a preoccupation with getting rid of primary or secondary sex characteristics; (3) an absence of any physical intersex (hermaphroditic) condition; and (4) clinically significant distress or impairment in social, occupational, or other important areas of functioning as a result of the discomfort arising from the perceived incongruence between anatomical sex and perceived gender identity.

O'Donnabhain, 134 T.C. at 36 (citing Diagnostic and Statistical Manual of Mental Disorders (4th ed. 2000 text revision) (DSM-IV-TR, published by the American Psychiatric Association, at 581)).

⁸ *O'Donnabhain*, 134 T.C. at 37.

⁹ The term "[transsexual] is frequently used to describe people who have undergone, or desire to undergo, gender-related medical care such as hormone therapy or gender-related surgeries." Romeo, *supra* note 1, at 713 n.1. Since I have for the most part used the term "transgender" as an umbrella term, which includes transsexuals, I distinguish the two and use "transsexual" primarily when it is an individual's term of choice or the term used by the court or scholar.

¹⁰ *O'Donnabhain v. Comm'r*, 134 T.C. 34, 38 (2010).

¹¹ *Id.* at 41.

¹² *Id.* at 41-42.

¹³ *Id.* at 42.

and was thus eligible for a deduction under § 213.¹⁴ On November 9, 2010, the Tax Court entered its final decision in favor of O'Donnabhain, and on February 7, 2011, the government conceded that it would not appeal the decision.¹⁵ O'Donnabhain's case concluded in November 2011 when the I.R.S. announced that it would follow the Tax Court's decision.¹⁶

II. THE TAX COURT PERMITS O'DONNABHAIN'S DEDUCTIONS TO TREAT HER DISEASE

O'Donnabhain's case before the Tax Court was one of first impression.¹⁷ While several Courts of Appeal have evaluated the necessity of providing medical care to transgender individuals under other statutory and constitutional schemes, this was the first time the question was addressed within the Code.¹⁸ The decision therefore relied heavily upon statutory interpretation and the Tax Court's understanding of the scope of the medical deduction according to Congressional intent.

This Part will briefly analyze the statutory language provided by the Code regarding medical deductions and will then analyze the opinion produced by the Tax Court that permitted O'Donnabhain to deduct her expenses for hormonal and surgical sex reassignment, but disallowed her deduction for breast augmentation.

A. *The Parties Debate the Meanings of "Disease" and "Treatment"*

The I.R.S. maintained that O'Donnabhain's sex reassignment treatment was elective and cosmetic and thus not eligible for a medical deduction.¹⁹ In order to demonstrate the impermissibility of the deduction, the I.R.S. argued that GID is not a disease under the statute, that O'Donnabhain did not suffer from GID, and that the expenses she attempted to deduct were not "treatment" for the disease. The I.R.S.'s primary source of authority was a medi-

¹⁴ Petition to United States Tax Court, *O'Donnabhain v. Comm'r*, 134 T.C. 34 (March 31, 2006) (No. 6402-06).

¹⁵ *Win in O'Donnabhain Tax Court Case: GID Qualifies as Medical Care*, GLAD, available at <http://www.glad.org/uploads/docs/publications/odonnabhain-win.pdf> (last visited April 5, 2012).

¹⁶ I.R.S. Action on Decision I.R.B. 2011-47 (November 21, 2011).

¹⁷ *O'Donnabhain*, 134 T.C. at 53. The I.R.S. had previously only addressed the issue of transgender medical treatment once, and this was prior to the addition of the cosmetic surgery exception. See I.R.S. Letter Rul. 8321042 (Feb. 18, 1983) (permitting a deduction for taxpayer's travel costs when he accompanied his son to obtain sex reassignment surgery). See also Susan L. Megaard, *Scope of the Medical Expense Deduction Clarified and Broadened by New Tax Court Decision*, 112 J. TAX'N. 353, 355 (2010).

¹⁸ See, e.g., *De'lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (finding that GID poses a serious medical need for Eighth Amendment purposes); *Allard v. Gomez*, 9 Fed. Appx. 793, 794 (9th Cir. 2001) (holding the same); *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (holding that state Medicaid plan may not deny reimbursement for sex reassignment surgery on grounds that it is cosmetic surgery).

¹⁹ *O'Donnabhain*, 134 T.C. at 52-53.

cal expert who suggested that because of the lack of pathology, “GID is a mental disorder . . . but not a disease or an illness.”²⁰

O’Donnabhain argued that GID is a serious medical condition that requires treatment, and that can be classified as a disease under I.R.C. § 213.²¹ Further, she claimed that the Benjamin standards provide the medically accepted treatment plan within the field, which thus constitutes beneficial and effective treatment for GID.²² O’Donnabhain also argued along the second prong of the medical care definition that her expenses were medical care with the purpose of affecting the structure or function of her body, rather than cosmetic procedures directed at improving her appearance.²³

B. The Court Considers the Meaning of Medical Care Under § 213

The Tax Court ultimately concluded that O’Donnabhain’s treatment constituted medical care under § 213 of the Code and thus was eligible for a medical deduction.²⁴ To arrive at this conclusion, the court analyzed the appropriateness of classifying GID as a disease and of considering hormonal and surgical sex reassignment as the appropriate treatment for that disease.²⁵ Additionally, the court assessed the legislative history of the Code as well as Congress’s intention to allow medical deductions for mental health conditions.²⁶

1. Statutory Definition and Standards

Section 213 of the Code provides a deduction for medical expenses of the taxpayer or his or her dependents. While the Code generally seeks to limit tax benefits to business or non-personal expenses,²⁷ this is one area of the Code where deductions relating to personal needs are allowed. Section 213 permits deductions for “expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer . . . to the extent that such expenses exceed 7.5 percent of adjusted gross in-

²⁰ *Id.* at 46. The I.R.S.’s expert, Dr. Dietz, maintained that “the designation of a condition as a mental disorder in the DSM-IV-TR does not indicate that the condition is a disease. To be a disease, a mental disorder must have a demonstrated organic or biological origin in the individual.” *Id.* at 47.

²¹ *Id.* at 53.

²² *Id.*

²³ Post-Trial Reply Brief of Petitioner Rhiannon G. O’Donnabhain at 26, O’Donnabhain v. Comm’r., 134 T.C. 34 (2010) (No. 6402-06). *See also* O’Donnabhain, 134 T.C. at 53 n.30.

²⁴ O’Donnabhain, 134 T.C. at 34.

²⁵ *Id.* at 55–63.

²⁶ *Id.* at 49–50.

²⁷ I.R.C. § 262(a) (“General Rule—Except as otherwise provided in this chapter, no deduction shall be allowed for personal, living, or family expenses.”). *See e.g.*, Smith v. Comm’r, 40 B.T.A. 1038 (1939), *aff’d per curiam*, 113 F.2d 114 (2d Cir. 1940) (holding that the cost of child care is inherently personal and thus not deductible, even if it is necessary for the taxpayer to work).

come.”²⁸ The Code provides a two pronged definition for medical care: “amounts paid—for the diagnosis, cure, mitigation, treatment, or prevention of disease, *or* [amounts paid] for the purpose of affecting any structure or function of the body”²⁹

While the regulations promulgated by the Treasury often provide guidance and clarification on the meaning and scope of Code provisions,³⁰ the regulations do not provide a definitive answer regarding what qualifies as a medical deduction. The regulations primarily echo the language of the statute and do not add much interpretive guidance, especially with regard to the second prong of the definition.³¹ However, the regulations do include some examples of procedures that qualify as medical care under the second prong of the medical care definition, “amounts paid for the purpose of affecting any structure or function of the body.”³² For example, “[a]mounts paid for operations or treatments affecting any portion of the body, including obstetrical expenses and expenses of therapy or X-ray treatments, are deemed to be for the purpose of affecting any structure or function of the body and are therefore paid for medical care.”³³ This clarification suggests that therapy procedures, for example, hormone therapy, as well as obstetrics, like abortion or sterilization, are eligible for the medical deduction.³⁴ In O’Donnabhain’s case, these examples could serve as potentially analogous procedures.

However, the regulations also state that “[d]eductions for expenditures for medical care allowable under section 213 will be confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness.”³⁵ At first, it appears that this section of the regulations limits the medical care definition and neuters the second prong of the

²⁸ I.R.C. § 213(a). There is a prospective amendment to change this amount to 10% for years beginning after December 31, 2012. Patient Protection and Affordable Care Act, § 9013(a), Pub. L. No. 111-148, 124 Stat. 868 (2010) (applicable to taxable years after December 31, 2012, as provided by § 9013(d) of the Act).

²⁹ I.R.C. § 213(d)(1)(A) (emphasis added).

³⁰ In situations where the regulations provide further clarification, the interpretation offered by the Treasury is considered authoritative. According to the U.S. Supreme Court in *Mayo Found. for Med. Education and Research v. United States*, I.R.S. regulations are deserving of *Chevron* deference and thus should be authoritative if reasonable. 131 S. Ct. 704, 713 (2011). “We see no reason why our review of tax regulations should not be guided by agency expertise pursuant to *Chevron* to the same extent as our review of other regulations.” *Id.*

³¹ Megaard, *supra* note 17, at 354 (“The same Regulation provides less guidance on the second part of the statutory definition.”).

³² I.R.C. § 213(d)(1)(A).

³³ 26 C.F.R. § 1.213-1(e)(1)(i) (1960).

³⁴ O’Donnabhain v. Comm’r, 134 T.C. 34, 98 (2010) (Holmes, J., concurring) (citing Rev. Rul. 73-201, 1973-1 C.B. 140); *see also* Megaard, *supra* note 17, at 364 (citing Rev. Rul. 73-201, 1973-1 C.B. 140; Rev. Rul. 73-603, 1973-2 C.B. 76) (“Applying this standard, the IRS has allowed deductions for voluntary procedures that affect a bodily structure or function such as a vasectomy, a legal abortion, birth control pills, and an operation to render a woman incapable of having children.”).

³⁵ 26 C.F.R. § 1.213-1(e)(1)(ii) (1960).

definition (“amounts for the purpose of affecting any structure or function of the body”) in the absence of a diagnosed defect or illness. Upon close reading, however, it is possible that this part of the regulation’s definition only applies to the first prong of the definition.³⁶ Further, it seems that this part of the regulation is intended to reiterate the Code’s emphasis on only permitting deductions for expenses which have a legitimate medical purpose and are not purely voluntary or “merely beneficial to . . . general health.”³⁷ This understanding is reasonable when taken in its context. The conclusion of the section of the regulations contrasts these permissible deductions with those that would be beyond the scope of the deduction: “an expenditure for a vacation [although likely good for general health and well-being], is not an expenditure for medical care.”³⁸ Further, tax scholar Susan Megaard has noted that different standards are applied to the two different prongs of the medical care definition.³⁹

The distinctions drawn by the Code and by the regulations reflect a value judgment about what is personal and voluntary and what is a legitimate expenditure. However, as Franklin H. Romeo has outlined, reproductive rights, although certainly not as robust as they could be, might provide a good example of rights whose necessity should be left to the individual to determine.⁴⁰ Although sterilization or abortion can be seen as purely personal or voluntary procedures, the I.R.S. has permitted deductions for these

³⁶ As Judge Holmes points out in his concurrence, “that sentence doesn’t apply to the second type of medical care—lest it be somehow read to overturn even the IRS’s settled opinion that procedures as diverse as abortion, vasectomies, and face lifts, qualify as ‘medical care’ because they affect a structure or function of the body.” *O’Donnabhain*, 134 T.C. at 98 (Holmes, J., concurring). Judge Holmes continues to explain that “[t]he sentence quoted by the majority is, in context, aimed at distinguishing expenses aimed directly, rather than remotely at preventing or alleviating illness. It is immediately followed by a list of expenses that are *per se* medical-care expenses, and which includes surgery and prescriptive drugs (like hormones) that O’Donnabhain received.” *Id.* at 98 n.13.

³⁷ 26 C.F.R. § 1.213-1(e)(1)(ii) (1960).

³⁸ *Id.* A similar concern has been addressed with taxpayers attempting to deduct the costs of installing a swimming pool or paying for prescribed exercise. *See, e.g.,* *Evanoff v. Comm’r*, 44 T.C.M. 1394 (1982) (holding that the expenditure was personal rather than medical if the taxpayer could have used a nearby community swimming pool but chose not to for religious reasons); *Altman v. Comm’r*, 53 T.C. 487 (1969) (denying a deduction for transportation to and from the golf course when taxpayer failed to prove why he had to golf instead of engaging in another exercise activity).

³⁹ Megaard, *supra* note 17, at 362 (“[T]he cases that have applied Section 213 demonstrate that different standards for determining deductibility have been used for expenses to treat a specific medical condition, costs that are wholly medical in nature, and expenses that affect a structure or function of the body.”). However Megaard does not clarify what the standards are.

⁴⁰ Romeo, *supra* note 1, at 744–46 (discussing *Roe v. Wade*, 410 U.S. 113 (1973), and *Skinner v. Oklahoma*, 316 U.S. 535 (1942), as two examples of cases in which “courts have recognized . . . constitutional grounds for respecting the rights of people to determine their own reproductive choices”).

procedures, finding them to be sufficiently medical and within an individual's rights to determine.⁴¹

The court also looked to prior case law to determine the standard for medical deductions permitted under the first prong of the medical care definition. This inquiry led to the framework established by *Jacobs v. Commissioner*.⁴² Under that model, the taxpayer “must show (1) ‘the present existence or imminent probability of a disease, defect or illness—mental or physical’ and (2) a payment ‘for goods or services directly or proximately related to the diagnosis, cure, mitigation, treatment, or prevention of the disease or illness.’”⁴³ Based on this standard, in order to permit a medical deduction, the court must find the existence of a disease and proof that the medical care at issue was directly or proximately related to treatment of the disease.

2. *The Majority Permits Most of O'Donnabhain's Deductions*⁴⁴

The Tax Court ruled in favor of O'Donnabhain, concluding that GID is a disease within the meaning of the statute, that O'Donnabhain suffered from GID, and that her expenses for hormone therapy and sex reassignment surgery went to treating her severe GID.⁴⁵ Although the I.R.S. attempted to utilize expert testimony to suggest that GID is not a disease within the meaning of the Code, the Tax Court firmly stated that “[t]he meaning of a statutory term is a pure question of law that is ‘exclusively the domain of the judge.’”⁴⁶ Regarding the I.R.S.'s interpretation, the court did not mince words in holding that “respondent's position is meritless . . . [and] flatly contradicted by nearly a half century of caselaw [sic].”⁴⁷ The court's decision to explicitly negate the I.R.S.'s expert witness, in the midst of a decision which was otherwise extremely deferential to medical professionals,⁴⁸ was

⁴¹ See, e.g., Rev. Rul. 73-201, 1973-1 C.B. 140; 140; Rev. Rul. 73-603, 1973-2 C.B. 76.

⁴² *O'Donnabhain v. Comm'r*, 134 T.C. 34, 50 (2010) (citing *Jacobs v. Comm'r*, 62 T.C. 813, 818 (1974)).

⁴³ *Id.*

⁴⁴ The decision of the Tax Court was heavily splintered. The majority opinion written by Judge Gale was joined by Judges Colvin, Cohen, Thornton, Marvel, Wherry, Paris, and Morrison. *O'Donnabhain*, 134 T.C. at 77. Judge Halpern and Judge Holmes wrote separate concurrences. *Id.* at 77, 85. Judge Goeke agreed with Judge Holmes and concurred with the result but offered his own analysis. *Id.* at 100. Judge Foley concurred in part and dissented in part. *Id.* at 104. Judge Gustafson concurred in part and dissented in part. *Id.* at 109.

⁴⁵ *O'Donnabhain*, 134 T.C. at 76. Despite the allowance for most of her expenses, the court held that O'Donnabhain's expenses for her breast augmentation surgery were cosmetic surgery excludable from the medical care deduction. *O'Donnabhain*, 134 T.C. at 72–73.

⁴⁶ *O'Donnabhain*, 134 T.C. at 56 (citation omitted).

⁴⁷ *Id.*

⁴⁸ The decision relied heavily on medical evidence, the authority of the DSM-IV-TR, and diagnoses made under it. This judicial medicalization of transgender identities has been a subject of much debate and criticism. See *infra* Section IV.

striking and emphasized the court's willingness to abide by similar judicial precedent and adopt the commonly recognized medical nature of GID. Although the normative judgment of this model has been debated, trans scholars and activists often agree that a medicalized understanding of transgender identity has been useful in securing rights for transgender individuals.⁴⁹

Because GID is considered a mental condition, the court considered how other mental conditions have been treated under the Code. The court relied on two key indicators that a mental condition constituted a disease under § 213: (1) the opinion of medical professionals⁵⁰ and (2) the characterization of the condition as a disease or disorder within diagnostic reference texts.⁵¹ Citing previous case law surrounding mental conditions, the court "found mental conditions to be 'diseases' where there was evidence that mental health professionals regarded the condition as creating a significant impairment to normal functioning and warranting treatment."⁵² Because medical experts, including the I.R.S.'s own experts, conceded that GID can create "significant impairment to normal functioning,"⁵³ the court found that GID met this criterion for a disease. Additionally, the court found it persuasive that the condition was listed as a disease in nearly every diagnostic reference text that mentioned it.⁵⁴

⁴⁹ See, e.g., Romeo, *supra* note 1, at 726

("The medical model of gender nonconformity has proven to be one of the few ways in which gender nonconforming people have been able to garner respect and recognition of rights in legal settings. While the biological model of gender has resulted in the blanket denial of legal protections to transgender litigants, courts have looked to the medical model as a way of legitimizing gender nonconformity. Increasingly, as the medical regulation of gender transition has become more uniform and visible, courts have been willing to grant at least rudimentary legal protections to transgender litigants who are able to provide documentation of a GID diagnosis and related medical treatment.");

see also Dean Spade, *Resisting Medicine, Remodeling Gender*, 18 BERKELEY WOMEN'S L.J. 15–28 (2003) ("Everywhere that trans people appear in the law, a heavy reliance on medical evidence to establish gender identity is noticeable. . . . In almost every trans-related case, . . . medical evidence will be the cornerstone of the determination of [the transgender individual's] rights.") (citations omitted); Carolyn Grose, *A Persistent Critique: Constructing Clients' Stories*, 12 CLINICAL L. REV. 329, 343–45 (2006) ("The legal system has for the most part adopted this official story, incorporating into case law both the DSM descriptions of the conditions, and the Harry Benjamin Standards of Care for their treatment." (citing *In re Heilig*, 816 A.2d 68 (Md. 2003) (punting the determination of gender to the medical and scientific communities, claiming this is "beyond its area of expertise.")) (citations omitted)); see also Jonathan Koenig, *Distributive Consequences of the Medical Model*, 46 HARV. C.R.-C.L. L. REV. 619, 625 (2011) ("This method of advocacy has become so common for advocates whose clients' own goals and identities can be met through the medical model . . . that this medical model rhetoric has taken over much judicial thinking about trans identity.").

⁵⁰ *O'Donnabhain v. Comm'r*, 134 T.C. 34, 57 (2010).

⁵¹ *Id.* at 58 (citing *Starrett v. Comm'r*, 41 T.C. 877, 878 & n.1, 880–82 (1964)).

⁵² *Id.* at 57; see also *id.* at 59 (citing *Fay v. Comm'r*, 76 T.C. 408 (1981)).

⁵³ *O'Donnabhain*, 134 at 57, 42.

⁵⁴ See *id.* at 60, 61. In line with the DSM-IV's warning that "it does not imply that the condition . . . meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability" the court provides a caveat that GID's

For further support of the proposition that mental conditions were intended to be covered under § 213's deduction for medical care, the court looked to the legislative history behind the Code. Citing the clear intention of the Senate Finance Committee to include treatment for mental illness, the court referenced a quote from the Committee report, which explicitly mentioned mental conditions.⁵⁵ This statement suggests that the Senate Finance Committee considered mental conditions to be as deserving of medical care deductions as physical conditions.

Concerning the appropriateness of the treatment, the court stated that the standard for exemptions is simply that the "circumstances 'justify a reasonable belief the . . . [treatment] would be efficacious.'"⁵⁶ Therefore the court was willing to tolerate some uncertainty within the medical community about the necessity and effectiveness of the treatment at issue. This generous standard was met, as the court found that "every psychiatric reference text that has been established as authoritative in this case endorses sex reassignment surgery as a treatment for GID in appropriate circumstances."⁵⁷ The medical experts who were consulted for the case established the necessity of the procedures by explaining that "it is also important to the mental health of a male with severe GID to be able to 'pass' convincingly in public as female—that is, to be perceived as female by members of the public. Failure to pass exacerbates the anxieties associated with GID."⁵⁸ Additionally, the Tax Court cited other courts that have recognized the Benjamin standards as the appropriate medical treatment for GID.⁵⁹

C. *Hormonal and Surgical Sex Reassignment are Not Cosmetic*

The court also addressed the cosmetic surgery exception in I.R.C. § 213(d)(9) and found that O'Donnabhain's hormones and sex reassignment surgery were not cosmetic surgery and were thus not exceptions to the medical deduction.⁶⁰ It is important to note that this was likely unnecessary in this case on account of the fact that procedures which meet the first prong of the medical care definition ("diagnosis, cure, mitigation, treatment, or prevention of disease") are arguably not subject to analysis under the cosmetic surgery exception.⁶¹ The exception states that "'medical care' does not in-

inclusion in the DSM-IV does not decide the diagnosis but "evidences widespread recognition of the condition by the psychiatric profession." *Id.* at 60 n.37.

⁵⁵ *Id.* at 49 ("It is not intended, however, that a deduction should be allowed for any expense that is not incurred primarily for the prevention or alleviation of a physical or mental defect or illness." (quoting S. Rep. No. 77-1631, at 95-96 (1942)) (emphasis added)).

⁵⁶ *Id.* at 69 (quoting *Havey v. Comm'r*, 12 T.C. 409, 412 (1949)).

⁵⁷ *Id.* at 65.

⁵⁸ *Id.* at 43.

⁵⁹ *Id.* at 66-67 (citing numerous cases).

⁶⁰ *Id.* at 51-70.

⁶¹ Telephone interview with Jennifer Levi, Transgender Rights Project Director, Gay & Lesbian Advocates & Defenders (Feb. 1, 2012) [hereinafter *Levi interview*]; *see also*

clude cosmetic surgery or other similar procedures, unless the surgery or procedure” meets one of three exceptions.⁶² The Code further defines “cosmetic surgery” as “any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.”⁶³

The court explained that Congress created the cosmetic surgery exception in § 213(d)(9) to alleviate the concern that the second prong of the medical care definition was too permissive.⁶⁴ The congressional history of this amendment confirms that Congress did not intend for the medical deduction to include “amounts paid for ‘an elective, purely cosmetic treatment.’”⁶⁵ Therefore, Congress did not approve of the I.R.S.’s decision to allow treatment that was considered to be purely cosmetic in nature. For instance, the I.R.S. had permitted medical deductions for facelifts, hair transplants, and hair removal through electrolysis.⁶⁶

In analyzing the exception with regard to O’Donnabhain’s procedures, the court stated that, to date, there was no precedential case interpreting the exception.⁶⁷ However, for the purposes of this analysis, the court cited other cases outside of the tax context that have held that “sex reassignment surgery and/or hormone therapy are not cosmetic procedures.”⁶⁸ Additionally, as Megaard points out, if a procedure meets the first prong of the medical care definition and is found to treat a disease, it is excluded from the cosmetic surgery exception, even if it does not promote a bodily structure or function.⁶⁹ Therefore, the court held that O’Donnabhain’s expenses, with the

Megaard, *supra* note 17, at 359–60 (arguing that expenses that “prevent or treat illness or disease” are not cosmetic surgery based on the definition of cosmetic surgery). *But see O’Donnabhain*, 134 T.C. at 105 (Foley, J., concurring in part and dissenting in part) (arguing that it was necessary to engage in the “cosmetic surgery” exception analysis because “[s]imply put, the fact that a procedure treats a disease is not sufficient to exclude the procedure from the definition of ‘cosmetic surgery.’”).

⁶² I.R.C. § 213(d)(9)(A). The three exceptions include whether the 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.” *Id.*

⁶³ *Id.* at § 213(d)(9)(B).

⁶⁴ *O’Donnabhain v. Comm’r*, 134 T.C. 34, 51 (2010).

⁶⁵ *Id.* at 51 (citing H.R. Rep. 101-964, at 1031 (1990)).

⁶⁶ *Id.* at 27 (citing Rev. Rul. 82-111, 1982-1 C.B. 48 (hair transplants and hair removal); Rev. Rul. 76-332, 1976-2 C.B. 81 (facelifts)).

⁶⁷ *Id.* at 52.

⁶⁸ *Id.* at 70–71 (citing *e.g.*, *Meriwether v. Faulkner*, 821 F.2d 408, 411–413 (7th Cir. 1987); *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980); *J.D. v. Lackner*, 145 Cal. Rptr. 570, 572 (Ct. App. 1978)). *See also* Liza Khan, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 *YALE J. HEALTH POL’Y, L. & ETHICS* 375, 394 (2011) (discussing the non-cosmetic nature of sexual reassignment surgery in the insurance context). *But see* *Smith v. Rasmussen*, 249 F.3d 755, 759–58 (8th Cir. 2001) (finding the denial of reimbursement for sex reassignment surgery proper where State Medicaid plan designated sex reassignment surgery as “plastic surgery” and alternate GID treatments were available).

⁶⁹ Megaard, *supra* note 17, at 359–60.

exception of the breast augmentation surgery, were not cosmetic and thus were not disqualified by the statutory exception.

The majority opinion decided that the cosmetic surgery exception was inapplicable because O'Donnabhain's procedures "prevent or treat an illness or disease."⁷⁰ However, in his concurrence, Judge Goeke also argued that O'Donnabhain's procedures were not cosmetic surgery based on the beginning of the term's definition: "any procedure which is directed at improving the patient's appearance."⁷¹ He relied on the medical purpose of the procedure and claimed that because "the transformation of petitioner's genitals was not directed at improving petitioner's appearance but rather was functional" it is excluded from cosmetic surgery and therefore should be a permissible deduction as medical care.⁷²

Scholars have made similar arguments that because sex reassignment procedures are not aimed at improving appearance, they are not cosmetic. One line of reasoning suggests that "[h]ormone therapy and sex reassignment surgery do not simply enhance ordinary biological features: they radically change the anatomy and biological function of patients' bodies."⁷³ Additionally, some scholars and activists have argued that because of both the medical and social risks and difficulties of undergoing transition related care, it is hard to argue that an individual would voluntarily pursue treatment simply to improve appearance.⁷⁴ Lastly, others have suggested that, for better or for worse, because the decision to undergo transition related treatment is not solely in the hands of the patient, doctors will have a role in regulating the provision of this medical care and will likely prevent patients from accessing it frivolously.⁷⁵

⁷⁰ *O'Donnabhain*, 134 T.C. at 54 ("Both the statutory definition of 'medical care' and the statute's exclusion of 'cosmetic surgery' from that definition depend in part upon whether an expenditure or procedure is for 'treatment' of 'disease.'").

⁷¹ *O'Donnabhain*, 134 T.C. at 101 (Goeke, J., concurring).

⁷² *Id.* Although one could make an argument that these procedures did affect the "function" of O'Donnabhain's body by facilitating the alignment of her physical body with her gender identity, some of the Judges on the Tax Court felt explicitly that these procedures did not "promote the proper function," but rather "drastically terminat[ed] a male patient's functioning sexuality." *O'Donnabhain*, 134 T.C. at 112 n.4 (Gustafson, J., concurring in part and dissenting in part).

⁷³ Khan, *supra* note 68, at 396. *But see* Megaard, *supra* note 17, at 359 (arguing that while these procedures definitely fit within the second prong of §213(d)(1)(A) as "affect[ing] the structure and function of the body" they most likely do not "promote any physical structure or function of the body," which she claims is required by §213(d)(9)(B)).

⁷⁴ Khan, *supra* note 68, at 396 ("[O]nce one considers the physical and social consequences of transition-related treatment, it is difficult to see it as cosmetic in nature. . . . Transitioning to a different gender, moreover, can put family relationships, friendships, and employment at risk. Few undergo this 'long and arduous' procedure just to improve their appearance or self-esteem.").

⁷⁵ *See id.* ("The decision to pursue gender-confirming care, moreover, is not exclusively at the discretion of the patient; doctors impose stringent requirements on transgender patients . . ."); Koenig, *supra* note 49, at 630 ("[M]edical providers within the United States will not perform the surgery if it is sought for purely aesthetic reasons.").

The cosmetic surgery exception is broad and applies to cosmetic surgery “or similar procedures.” This could raise the concern that even if sex reassignment is not found to be “cosmetic,” it would still be excluded as a “similar procedure.”⁷⁶ However, in his concurrence, Judge Goeke argued that O’Donnabhain’s surgery would also not qualify as a “similar procedure.”⁷⁷ He claimed that excluding O’Donnabhain’s surgery as a “similar procedure” would “negate the import of the definition of cosmetic surgery.”⁷⁸ Instead he suggested that “‘similar procedures’ in subparagraph (A) [of § 213 of the Code] refers to procedures directed at improving appearance that are not necessarily considered surgical.”⁷⁹ Therefore, under this logic, O’Donnabhain’s procedures should not be similarly excluded procedures either.

D. O’Donnabhain’s Breast Augmentation Surgery is Not Deductible

The majority decided that O’Donnabhain’s breast augmentation surgery did not go to treating her GID, and therefore, this deduction was not allowed.⁸⁰ The majority used O’Donnabhain’s doctor’s notes to claim that prior to surgery, as a result of her hormone treatments, her breasts were “a very nice shape” and “within a normal range of appearance.”⁸¹ Therefore the court concluded that the breast surgery did not go to treat GID, making the breast augmentation fit squarely within the definition of the cosmetic surgery exception.⁸² However, in his concurrence, Judge Halpern pointed out that the doctor’s note was taken out of context and that the doctor’s testimony explained that “the surgery was different from the surgery he would perform on a biological female: ‘[I]t was to give her a female looking breast, which is quite different from a male breast.’”⁸³ Further, Judge Halpern quoted the surgeon’s testimony that “the primary purpose of the breast surgery was not to improve petitioner’s appearance but ‘to assign her to the appropriate gender.’”⁸⁴ Relying on these facts and the logic of Judge Goeke, arguably O’Donnabhain’s breast augmentation should have also been deductible. As Judge Goeke stated, if the purpose of the procedure is not “to improve appearance” it should be a permissible medical deduction. Under the second

⁷⁶ See, e.g., *O’Donnabhain v. Comm’r*, 134 T.C. 34, 107–08 (2010) (Foley, J., concurring in part and dissenting in part).

⁷⁷ *O’Donnabhain*, 134 T.C. at 101 (Goeke, J., concurring).

⁷⁸ *Id.* at 102.

⁷⁹ *Id.* (suggesting that Botox, which is directed at improving appearance, but is not actually surgical, is what Congress had in mind as a “similar procedure”).

⁸⁰ *O’Donnabhain*, 134 T.C. at 72–73.

⁸¹ *Id.*

⁸² *Id.* at 73.

⁸³ *Id.* at 78 (Halpern, J., concurring).

⁸⁴ *Id.* Although Judge Halpern clarified the record to show that the procedure was not “to improve appearance,” he still found the breast augmentation not deductible because it was not “within the treatment protocols of the Benjamin standards.” *Id.* (Halpern, J., concurring).

prong of the medical care definition, O'Donnabhain would also not have to prove that the breast surgery went to treat her disease. Therefore, if O'Donnabhain could prove that the procedure affected the function and structure of her body, but did not go to improving her appearance, it should be deductible.

III. ANALYSIS AND IMPLICATIONS OF THE COURT'S RELIANCE ON THE FIRST PRONG OF THE MEDICAL CARE DEFINITION

The Tax Court's decision and its choice to permit O'Donnabhain's deduction based on a medicalized understanding of her transgender identity are significant. First, the Tax Court's decision served as the basis for the I.R.S. advisory,⁸⁵ and therefore provided the rationale undergirding the I.R.S.'s decision to permit deductions for similar procedures in the future. Furthermore, as the first and only case thus far that interprets the issue of transgender medical care in the Code, it will likely influence future jurisprudence as well.⁸⁶ The holding centered on the appropriate statutory definition of "disease" and whether GID could be considered a disease for medical deduction purposes.⁸⁷ However, the definition of "medical care" in the statute also has a second prong including "amounts paid . . . for the purpose of affecting any structure or function of the body."⁸⁸ Although it would appear that this prong of the definition is a natural and potentially more neutral fit for the procedures O'Donnabhain was deducting, it was not addressed by the court.⁸⁹

At first glance, it is surprising that the court relied on the first prong of the definition without even addressing the second. The court explained that the second prong of the definition was deemed too "liberal" by Congress

⁸⁵ I.R.S. Action on Decision I.R.B. 2011-47 (November 21, 2011) ("The Tax Court rejected the IRS administrative position reflected in CCA 200603025. The Service will follow the *O'Donnabhain* decision.")

⁸⁶ It is important to note that the Tax Court decision itself is only persuasive and does not have precedential value. 26 U.S.C. § 7463(b) ("A decision entered in any case in which the proceedings are conducted under this section shall . . . not be treated as a precedent for any other case."). Further, although the I.R.S. decided not to appeal the case, Tax Court decisions can be appealed to the U.S. Courts of Appeals. 26 U.S.C. § 7482(a)(1) ("The United States Courts of Appeals (other than the United States Court of Appeals for the Federal Circuit) shall have exclusive jurisdiction to review the decisions of the Tax Court, . . . in the same manner and to the same extent as decisions of the district courts in civil actions tried without a jury; and the judgment of any such court shall be final, except that it shall be subject to review by the Supreme Court of the United States").

⁸⁷ *O'Donnabhain v. Comm'r*, 134 T.C. 34, 66-67 (2010).

⁸⁸ I.R.C. § 213(d)(1)(A).

⁸⁹ *O'Donnabhain*, 134 T.C. at 53 n.30. The court explicitly mentioned that because the expenditures were deductible under the first prong, with GID qualifying as a "disease" for the purposes of the statute, it was unnecessary to resolve the issue with regard to the second prong of the medical care definition. *Id.*

and was thus amended in 1990.⁹⁰ However, the Court explained that in 1990 Congress added the cosmetic surgery exception to alleviate this problem.⁹¹ Therefore it seems that a procedure which has “the purpose of affecting any structure or function of the body”⁹² but which does not constitute “cosmetic surgery” would still be appropriately deductible under the second prong of the medical care definition in § 213(d)(1). Further, because the Commissioner stipulated that all three procedures that O’Donnabhain underwent fit within the second prong,⁹³ and there was clear precedent outside of the tax context stating that the procedures at issue for O’Donnabhain were not cosmetic procedures,⁹⁴ it is unclear why the court would not have chosen to follow the second prong of the definition. This would have enabled the Court to provide relief for O’Donnabhain without positioning GID as a disease.⁹⁵

However, speaking with one of O’Donnabhain’s attorneys, Jennifer Levi, who is a well-known transgender rights advocate, I was able to learn more about the strategy of this case and the considerations animating the lawyers’ decisions. According to Levi, the goals of the case included creating broader recognition for the medical legitimacy of gender transition and establishing the appropriateness of hormonal and surgical sex reassignment as medical care.⁹⁶ The tax context provides a slightly different standard for evaluating medical care because the Code only requires that the expenses be medical care, not that they be medically necessary.⁹⁷

⁹⁰ *Id.* at 51.

⁹¹ *Id.*

⁹² I.R.C. § 213(d)(1)(A).

⁹³ *O’Donnabhain*, 134 T.C. at 98 (Holmes, J., concurring) (quoting the Commissioner as having said, “‘Petitioner’s sex reassignment surgery affected structures or functions of petitioner’s body;’ ‘Petitioner’s prescription hormone therapy affected structures or functions of petitioner’s body;’ and ‘Petitioner’s breast augmentation surgery affected structures or functions of petitioner’s body.’”). *Id.* at 98 n.12.

⁹⁴ *O’Donnabhain v. Comm’r*, 134 T.C. 34, 70–71 (2010) (citing *Meriwether v. Faulkner*, 821 F.2d 408, 411–3 (7th Cir. 1987); *Pinneke v. Preisser*, 623 F.2d 546, 548 (8th Cir. 1980)).

⁹⁵ I recognize that for some within the transgender community, judicial recognition of GID was a desirable goal. Levi interview. However, at the very least the court could have addressed both claims, thereby expanding the bases for future claims. Recognizing the contentiousness of these issues, Judge Holmes discusses his dismay at the majority’s decision to enter into the “culture wars in which tax lawyers have heretofore claimed noncombatant status.” *O’Donnabhain*, 134 T.C. at 85 (Holmes, J., concurring).

⁹⁶ Levi interview.

⁹⁷ See Megaard, *supra* note 17, at 362 (“Medical necessity generally is not a requirement for deductibility.”). In other realms, like insurance for instance, a plaintiff would need to prove that her treatment was medically necessary in order to get coverage. See e.g., Khan, *supra* note 68, at 399 (“Both public and private insurers attempt to control healthcare costs by refusing coverage for procedures they believe are not ‘medically necessary.’”). In the majority opinion, Judge Gale addressed the medical necessity of O’Donnabhain’s treatment, even though it was not necessary under the Code. *O’Donnabhain*, 134 T.C. at 74–76. Judge Holmes criticized the majority for engaging in a discussion of medical necessity, which he believed was unnecessary to the holding. *O’Donnabhain*, 134 T.C. at 85 (Holmes, J., concurring). Despite this, even the majority opinion, which decided that O’Donnabhain’s treatment was medically necessary, stipu-

Levi explained that O'Donnabhain did suffer from GID, and did experience her condition as a disease requiring medical attention.⁹⁸ Therefore, relying on the medical care definition was not only the strongest legal strategy, but also reflected the plaintiff's experience.

In this Part, I will assess some of the benefits and limitations of the court's choice in statutory interpretation, as well as analyze the opportunities still available in the Code for future transgender taxpayers.

A. *Practical Implications*

The Tax Court decision and the subsequent advisory from the I.R.S. were hailed as victories for the transgender community.⁹⁹ Most immediately, the decisions allowed O'Donnabhain to receive tax relief for her medical care and saved her about \$5,000.¹⁰⁰ Considering the tremendous costs involved in medically transitioning genders, this is clearly significant. The I.R.S.'s decision to abide by the ruling of the Tax Court additionally means that future taxpayers considering a medical transition can anticipate receiving some relief for the costs of these procedures.¹⁰¹ Particularly because the

lated that this is not a requirement in the Code. *O'Donnabhain*, 134 T.C. at 74 (acknowledging a lack of statutory reference to medical necessity in the Code).

⁹⁸ Levi interview.

⁹⁹ See *GLAD Wins Case vs. IRS on Sex Reassignment Deductions*, U.S. Tax Court Sets Precedent, Says Treatment is Medical Care, GLAD (Feb. 2, 2010), available at <http://www.glad.org/current/press-release/glad-wins-case-vs-irs-on-sex-reassignment-deductions/>; see also Max Camp, *O'Donnabhain v. Commissioner: Treatment Costs for Gender Identity Disorder are Tax-Deductible Medical Expenses*, 20 L. & SEXUALITY 133, 141 (2011) ("Clearly on its face, this ruling by the Tax Court is a victory for people suffering from GID who undergo hormone therapy and sex-reassignment surgery."); Megaard, *supra* note 17, at 354 ("The Tax Court's *O'Donnabhain* decision brings tax policy into line with current health policy and business practice".).

¹⁰⁰ See *GLAD Wins Case vs. IRS on Sex Reassignment Deductions*, U.S. Tax Court Sets Precedent, Says Treatment is Medical Care, GLAD (Feb. 2, 2010), available at <http://www.glad.org/current/press-release/glad-wins-case-vs-irs-on-sex-reassignment-deductions/>. O'Donnabhain's total costs for her medical procedures were around \$25,000. *Id.*

¹⁰¹ While taxpayers should be able to deduct costs for treating GID under this decision, the GLAD website is very careful to warn that the *O'Donnabhain* decision does not automatically guarantee that gender-confirming treatment will be *per se* deductible under § 213. Claimed deductions might still be audited by the I.R.S., and thus even with the precedent, taxpayers might have to defend their treatment decisions. *Win in O'Donnabhain Tax Court Case: GID Qualifies as Medical Care*, GLAD, (January 2012), available at <http://www.glad.org/uploads/docs/publications/odonnabhain-win.pdf>:

[O]ur win does not guarantee that every medical deduction for the treatment of GID will be allowed by the IRS. Medical deductions can always be audited and require that you have strong documentation from your care providers that the treatment is medically appropriate. In the *O'Donnabhain* decision, the judges relied heavily on the *WPATH Standards of Care* in determining whether specific treatments were appropriate. . . . The bottom line is to make sure that you have the strongest medical documentation possible for each part of the treatment for which you are claiming a medical deduction.

cost of hormonal and surgical sex reassignment is not always permitted under health insurance plans,¹⁰² receiving tax benefits is impactful.

Advocates are hopeful that establishing through a Tax Court opinion that these procedures are legitimate medical care will influence the determinations of other legal questions that hinge on the seriousness and medical necessity of gender confirming care as not cosmetic and not a choice.¹⁰³ Because legal rights are often conditioned on medical evidence of transition, the accessibility of medical care has far reaching effects.¹⁰⁴ The question of legitimating gender based on medical evidence arises around issuing appropriate identity documents,¹⁰⁵ gaining restroom access,¹⁰⁶ obtaining insurance coverage,¹⁰⁷ securing protection from employment discrimination,¹⁰⁸ and permitting children to present at school in their lived gender, rather than their birth assigned one.¹⁰⁹ Additionally because gender plays such a central role in our society, the social ramifications of not being able to fully inhabit one's lived gender can be great.¹¹⁰ The vast majority of cases regarding transgender medical care have been litigated within the prison context and thus seems to implicate specific legal questions, which might be less generally applicable for other areas of transgender rights.¹¹¹ Therefore, a strong decision like the one the Tax Court issued in the *O'Donnabhain* case creates an

¹⁰² See generally Khan, *supra* note 68 (discussing insurance companies' coverage of transgender related medical care).

¹⁰³ Levi interview; see also Koenig, *supra* note 49, at 634 ("For those who conform to the medical model, the recognition of the medical necessity of care can have positive spillover effects by increasing the recognition of the medical model in other areas of law.").

¹⁰⁴ See Khan, *supra* note 68, at 382 (citing the need for medical evidence in order to change the sex designation on "birth certificates, driver's licenses, and social security cards," as well as to legitimize marriage and determine child custody).

¹⁰⁵ See, e.g., *In re Heilig*, 816 A.2d 68, 86–87 (Md. 2003).

¹⁰⁶ See, e.g., *Goins v. West Group*, 635 N.W.2d 717, 723 (Minn. 2001) (holding that "absent more express guidance from the legislature, . . . an employer's designation of employee restroom based on biological gender is not . . . discrimination . . .").

¹⁰⁷ See, e.g., *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

¹⁰⁸ See, e.g., *Smith v. City of Salem*, 378 F.3d 566, 568 (6th Cir. 2004) (discussing Smith's GID diagnosis).

¹⁰⁹ See, e.g., *Doe v. Yunits*, No. 001060A, 2000 WL 33162199 (Mass. Oct. 11, 2000) (holding that the school discriminated against the fifteen year old MTF student by telling her she could not return to school unless she wore male attire).

¹¹⁰ See Khan, *supra* note 68, at 388 ("Gender plays a significant, though often overlooked, role in our daily lives, and an inability to fully assume a certain gender can have dire consequences for an individual's mental health, personal safety, and employment opportunities.").

¹¹¹ See, e.g., *De'lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (holding that "an inmate's need for protection against continued self-mutilation was a serious medical need to which prison officials could not be deliberately indifferent"); *Allard v. Gomez*, 9 F. App'x 793, 795 (9th Cir. 2001) (reversing a grant of summary judgment from the lower court to determine whether the hormone therapy was denied [to a prisoner] on the basis of an individualized medical evaluation or as a result of a blanket rule denying such treatment, which could suggest deliberate indifference).

important model for the future determination of claims in many different realms relying on the question of the appropriateness of medical transition.¹¹²

There is some debate over whether a decision like *O'Donnabhain* will actually reach the poorest individuals who are most in need of the relief it could provide. The § 213 deduction only applies to individuals who choose to itemize their deductions rather than take the standard deduction offered by the government.¹¹³ Those who itemize are principally individuals of greater means.¹¹⁴ Additionally, as the Code states, the deduction is reserved for individuals whose medical expenses “exceed 7.5 percent of adjusted gross income.”¹¹⁵ The upfront outlay of costs required to even reach the deduction threshold is therefore prohibitive to many individuals desiring hormonal or surgical sex reassignment treatment but who cannot afford to give up such a large percentage of their income. That said, according to Levi, the decision is financially extremely significant.¹¹⁶ Many individuals who have called the GLAD office to inquire about similar tax issues are precisely people with lower incomes for whom this is such a big issue.¹¹⁷ Levi explained that many individuals save for years in order to be able to afford medical transition procedures, and that the I.R.S. has in the past audited some individuals’ tax returns presumably upon seeing that the expenses which were deducted were quite high relative to the income they were earning.¹¹⁸ Thus, those in the lower income bracket who had been able to afford the procedures were in greater need of a definitive decision granting them a tax deduction.¹¹⁹

One inherent limit of the tax court’s holding is that it will not reach those in the transgender community who either do not identify as having GID or who cannot access a diagnosis of GID.¹²⁰ As was mentioned, this

¹¹² Levi interview.

¹¹³ *Tax Topics: Should I Itemize?*, INTERNAL REVENUE SERVICE, <http://www.irs.gov/taxtopics/tc501.html> (Dec. 22, 2011).

¹¹⁴ See, e.g., Alesdair Ittelson, *Trapped in the Wrong Phraseology: O'Donnabhain v. Commissioner—Consequences for Federal Tax Policy and the Transgender Community*, 26 BERKELEY J. GENDER L. & JUST. 356, 361 n.25 (2011) (citing STAFF OF JOINT COMM. ON TAX’N, 111TH CONG., ESTIMATES OF FED. TAX EXPENDITURES FOR FISCAL YEARS 2009-2013 41 (Comm. Print 2010)). But see Megaard, *supra* note 17, at 364 (“[T]ax deductions in such cases will primarily be confined to lower-income and uninsured taxpayers who can itemize. . . . [M]ost middle- and upper-income taxpayers will be unable to deduct any medical expenses either because they cannot itemize or because their unreimbursed medical expenses do not exceed their applicable . . . floor.”).

¹¹⁵ I.R.C. § 213(a). However the prospective amendment will change this amount to 10% for years beginning after December 31, 2012. Patient Protection and Affordable Care Act, § 9013(a), Pub. L. No. 111-148, 124 Stat. 868 (2010) (applicable to taxable years after December 31, 2012, as provided by § 9013(d) of the Act).

¹¹⁶ Levi interview.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ See, e.g., Romeo, *supra* note 1, at 731 (“Because the experiences of many gender nonconforming people do not match the diagnostic criteria of GID, and because, for all except the most privileged few, accessing trans-friendly health care is extraordinarily difficult, the medical model of gender does not serve the vast majority of gender nonconforming people.”); Koenig, *supra* note 49, at 634 (“[F]or trans people who do not

decision gives doctors significant power to choose whose identities to recognize, who to diagnose, and who to provide with gender-confirming care.¹²¹ It is important to note that diagnoses, such as GID, upon which O'Donnabhain's decision was based, are not accessible to all transgender individuals, especially those with fewer resources and lack of access to medical care and trans-friendly medical care in particular.¹²² If these individuals desire certain medical procedures, either to allow them to fully embody their lived gender, or to facilitate their access to other rights and privileges,¹²³ conditioning a tax deduction (and thus greater affordability) on a diagnosis creates an additional hurdle to overcome.

B. Symbolic Implications

Symbolically, the I.R.S. decision is both affirming of transgender rights and also potentially limiting. On the one hand, there are those within the transgender community who would argue that conditioning O'Donnabhain's deduction on the diagnosis of GID limits the availability of this right to a segment of the transgender community and further entrenches notions around the stigma of transgenderism and the essentialism of a gender binary. At the same time, it can be seen as a positive development that O'Donnabhain was permitted to deduct the expenses from her medical treatment on her tax return. This conveys the idea that her medical needs are equal to the needs of all other American taxpayers and are deserving of the same treatment.¹²⁴ I will address each argument in turn.

The reliance and predominance of the medical model within transgender litigation has produced much controversy and criticism within the community. The criticisms generally fall under four main categories.¹²⁵ The

have a GID diagnosis, either because they are opposed to the pathologization of their identity or because they do not meet the 'criteria,' these cases do not produce gains.”)

¹²¹ Romeo, *supra* note 1, at 730:

The result of courts' reliance upon the medical model has been twofold. On one hand, use of the medical model has opened up a viable option for claims for transgender people whose experiences comport with the diagnostic criteria of GID. On the other hand, it sets up the medical establishment as a gatekeeping institution that regulates gender nonconformity and predicates legal rights on access to health care.

¹²² Spade, *supra* note 49, at 35.

¹²³ See *supra* notes 104–110.

¹²⁴ According to the GLAD website, “What she wants, she says, is fair and equal treatment—to not be discriminated against simply because she is transgender. ‘I’m not asking for any more than any other person is entitled to,’ [O’Donnabhain] says.” *Rhianon O’Donnabhain*, GLAD, available at <http://www.glad.org/uploads/docs/cases/odonnabhain-bio.pdf> (last visited April 5, 2012).

¹²⁵ Alvin Lee, *Trans Models in Prison: The Medicalization of Gender Identity and the Eighth Amendment Right to Sex Reassignment Therapy*, 31 HARV. J. L. & GENDER 447, 457 (2008); see also Jennifer Levi, *Clothes Don’t Make the Man (Or Woman), But Gender Identity Might*, 15 COLUM. J. GENDER & L. 90, 104–05 (2006) (summarizing the critiques of the medical model within the disability context).

first argument is that utilizing the medical model pathologizes and stigmatizes those within the transgender community and therefore the marginal gains accrued from the legal victories are undercut by the sociological harms.¹²⁶ The holding of the Tax Court means that in order to get relief, plaintiffs will likely need to frame their condition as a disease.¹²⁷ This sort of language further entrenches the medicalization of transgender identity and can be seen as perpetuating negative ideas about transgender individuals that have fueled much fear, ignorance, and discrimination.¹²⁸ Such a negative perception of transgender individuals was epitomized in Judge Gustafson's opinion when he stated,

When a patient presents with a healthy male body and a professed subjective sense of being female, the medical profession does not treat his body as an anomaly, as if it were infected by the disease of an alien maleness. Rather his male body is taken as a given, and the patient becomes a *psychiatric* patient because of his disordered feeling that he is female.¹²⁹

For some in the transgender community, this is not how they experience their identity but feel forced to adopt this perspective in order to access the care they require. In order to access resources, these individuals must frame their claims according to the terms of mainstream institutions, even if those terms don't reflect their lived reality. As one activist wrote, "While I accepted the label of 'transsexual' in order to obtain access to the hormones and chest surgery necessary to manifest my spirit in the material world, I have always had a profound disagreement with the definition of trans-sexualism as a psychiatric condition and transsexuals as disordered people."¹³⁰

The second argument suggests that the medical model is inaccessible to low-income trans people who are unable to procure medical diagnosis and

¹²⁶ See, e.g., Judith Butler, UNDOING GENDER 76 (2004) ("[T]o be diagnosed with . . . [GID] is to be found, in some way to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being given at all.").

¹²⁷ It is important to note that O'Donnabhain's briefs focused on this approach and that the court did not reach a decision regarding the second prong of the definition. O'Donnabhain v. Comm'r, 134 T.C. 34, 53 n.30 (2010). Therefore it is possible that a different plaintiff could achieve a successful outcome under the rationale of the second prong.

¹²⁸ See, e.g., Khan, *supra* note 68, at 386 ("Many transgender advocates resist the medicalization of gender variance, arguing that the description of transgender people in medical terms leads to an understanding of non-normative gender identity as diseased or disordered."); Anne C. DeCleene, *The Reality of Gender Ambiguity: A Road Toward Transgender Health Care Inclusion*, 16 L. & SEXUALITY 123, 136 (2007) ("Medical diagnosis proves to be pathologizing; it enhances the stigma that transgender people's condition is unhealthy and should be cured.").

¹²⁹ O'Donnabhain, 134 T.C. at 121–22 (Gustafson, J., concurring in part and dissenting in part). This opinion was joined by Judges Wells, Foley, Vasquez, and Kroupa, suggesting that even within the court, prejudice against transgender individuals is quite pervasive. *Id.* at 122.

¹³⁰ Spade, *supra* note 49, at 23 (citing LESLIE FEINBERG, TRANS LIBERATION: BEYOND PINK OR BLUE 63 (1998)).

gender confirming medical care.¹³¹ As this argument refers more to the distributive effects of who can access rights on the basis of the medical model, it is primarily addressed in Part IV.A.

The third critique is that the medical model is underinclusive and does not reach many who would identify as transgender or gender nonconforming.¹³² According to the most recent and most comprehensive study to date on the transgender community, “[t]wenty-seven percent (27%) said they were not living full-time in their desired gender yet but wanted to someday,” and “[e]ighteen percent (18%) said they did not want to live full time in a gender other than that assigned at birth.”¹³³ These individuals would potentially not want to pursue gender-confirming care, or would choose to pursue some treatments, such as hormones or top surgery, but not others. For those who do not see their transgender identity as a disease and therefore do not seek diagnosis, or for those who don’t want to follow the full range of medical treatment outlined for “proper” transition, the Tax Court decision can be alienating, defining what it means to be transgender, and what constitutes necessary medical care.

The fourth critique is that relying on the medical model further entrenches the gender binary.¹³⁴ Some within the community feel that the medical establishment works against the norms of the community, using GID to “promote a regime of coercive binary gender; and . . . [is] misused by some mental health practitioners as a basis for involuntary psychiatric treatment for gender transgressive people.”¹³⁵ In this vein, privileging and encouraging medical diagnoses and medical transition ensures that gender non-conforming individuals will “choose” a gender and stick with it, rather than challenging the rigid model and living in a gender outside of the normative binary.

To frame medical transition as the appropriate and legitimate treatment for transgender individuals suggests to some that this is *the* way to be transgender making the steps involved in medical transition necessary to live as a “real” transgender person.¹³⁶ As the statistics show, this is not the case for everyone and thus can negate the experiences of those for whom medical transition is either undesirable or inaccessible. A decision like *O’Donnabhain* does further entrench the legal legitimation of the medical-

¹³¹ Lee, *supra* note 125, at 458.

¹³² Lee, *supra* note 125, at 457.

¹³³ JAIME M. GRANT, ET AL., NAT’L CTR. FOR TRANSGENDER EQUAL. AND NAT’L GAY AND LESBIAN TASK FORCE, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 26 (2011).

¹³⁴ Lee, *supra* note 125, at 459.

¹³⁵ Spade, *supra* note 49, at 35.

¹³⁶ See, e.g., Koenig, *supra* note 49, at 624 (“[T]he notion that ‘true’ trans persons desire gender-confirming surgery remains common in law.”). Scholars have traced this notion back to Harry Benjamin who “distinguished nonsurgical transsexuals, who did not request surgery, from moderate and high intensity ‘true’ transsexuals, who did request surgery.” Lee, *supra* note 125, at 452.

ized model as it suggests that the clearest and easiest way for a transgender taxpayer to benefit from the precedent it created is if she considers her gender dysphoria to be a disease and any gender-confirming care she receives to be treatment for this disease.

There is also a camp within the transgender community who believe that the medical model provides the best course for litigation, especially in certain cases where a medical diagnosis is accurate and appropriate. Some transgender advocates and activists argue that the medical model provides practical and strategic advantages and thus should be continuously strengthened and pursued.¹³⁷ Practically speaking, the “use of the medical model has opened up a viable option for claims for transgender people whose experiences comport with the diagnostic criteria of GID.”¹³⁸ Further, in some ways, within the medical deduction context of the Code, it is not possible to totally abandon a medicalized notion of transgenderism because the deduction is explicitly for medical treatment.¹³⁹

While not every transgender client looking to defend deductions for gender-confirming care may share O’Donnabhain’s experience, the decision of the court does not claim that this is the only way to be transgender.¹⁴⁰ For those individuals who experience GID as a disease and see medical transition as the appropriate treatment, the Court’s decision provides not only practical relief but also an affirmation of their lived experience.¹⁴¹

¹³⁷ See, e.g., Koenig, *supra* note 49, at 626–27:

First, when a person does experience trans identity as a psychological or medical condition, relying upon the medical model legitimizes the identity. Second, because these medical arguments are effective, attorneys must sometimes make them to fulfill the ethical obligation to act in the best interests of their clients, despite opposition from the broader trans movement. Third, because advocates have relied heavily on the medical model in the past, it is necessary to cite the model when making legal arguments based on precedent. Fourth, the medical model provides a basis for arguing that gender identity is part of a person’s biological sex.

¹³⁸ Romeo, *supra* note 1, at 730.

¹³⁹ See, e.g., Lee, *supra* note 125, at 468–69 (arguing a similar point within the prison right-to-care context).

¹⁴⁰ See Levi, *supra* note 125, at 106:

Acknowledging [that this identity or condition can be seriously limiting for some without treatment] does not, however, universalize the experience or suggest that to be the case for everyone who identifies as transgender. Nor does acknowledging that fact require that every transgender individual follow any particular course of care or treatment for the condition.

See also Ittelson, *supra* note 114, at 382 (“[T]hose seeking to prohibit the recognition of transgender medical care will employ the diversity of the transgender community to invalidate the claim that medical treatment is a necessary part of GID. . . . [However,] courts must not deny recognition of transgender medical care due to the diversity of approaches to medical care within the transgender community.”)

¹⁴¹ See, e.g., Lee, *supra* note 125, at 468 (“[R]egardless of the medical model’s origins or its effect in the abstract, there are trans people who believe that it accurately describes their experiences. There are undoubtedly members of the trans community for whom the medical model is inaccurate or inadequate, but dismissing the medical model

Additionally, as articulated by Levi, a goal of the broader litigation strategy that she and her colleagues pursue through the Transgender Rights Project at GLAD is to de-stigmatize the entire experience of medical conditions, particularly those that are framed as mental health conditions.¹⁴² In this way, the tax court's decision to recognize O'Donnabhain's condition, and to grant her a deduction for the legitimate medical expenses she incurred to treat it, makes significant progress toward removing the stigma associated with the medical care around gender-confirming care and gender transition.

In response to the criticism that it is problematic to frame GID as a disease, Levi felt that it actually exacerbates the stigma involved to reframe medical care as nonmedical and to shy away from medical language as if medical care is something to be avoided.¹⁴³ This approach, criticizing the medicalization of treatment, is alienating for those who have experienced GID as a disease and are looking for relief within the medical establishment. Under such a framework, advocates that push for the de-medicalization further stigmatize people like O'Donnabhain, who experience GID as a disease, and push them further into the margins of the transgender community.

In this case in particular, the use of the medical model seems to have been strategically wise. First O'Donnabhain did identify her gender dysphoria as a disease. Second, she was seeking a medical deduction for what she considered to be medical treatment. Lastly, the standard didn't even suggest that the treatment needed to be medically necessary (creating a precedent that the "correct" way to be transgender is to medically transition). She only needed to prove that the procedures she received were medical care. Therefore, for plaintiffs like O'Donnabhain, the Tax Court decision and the subsequent I.R.S. advisory opinions are important symbolic victories legitimizing their experience of disease and realizing their equal right to deduct these valid medical costs.

simply because it stems from or bolsters a fictional gender binary disserves those trans people who believe that the gender-related discomfort they have felt throughout their lives is best described in medicalized terms.”).

¹⁴² Levi interview; *see also* McGowan, *supra* note 5, at 220 n.52 (“I find troubling the way in which [the critique of the medical model] seems to accept that stigma is a natural corollary of mental health diagnoses. For those who are comfortable with the notion that gender dysphoria is experienced by some, but not all, transgender people, there would seem to be a natural alliance with the broader network of health advocates working to reduce the stigma associated with mental health issues more generally.”). Citing Levi's work on utilizing disability law to litigate transgender claims, McGowan also suggests that “the goal . . . is not to pathologize the individual with a particular health condition or need, but rather to recognize that society has an obligation to accommodate the needs of individuals with unique health conditions in order to maximize their ability to participate in society.” *Id.* at 221 (citing Jennifer Levi & Ben Klein, *Pursuing Protection for Transgender People Through Disability Laws*, in *TRANSGENDER RIGHTS* 74, 80–83 (Paisley Currah et al. eds., 2006)); *see also* Lee, *supra* note 125, at 46 (“This criticism, however, is largely the product of ableist attitudes that have been adopted from society's unjust biases against disabilities in general.”).

¹⁴³ Levi interview.

C. *An Alternative Rationale for Gender-Confirming Care Deductions*

In a discipline that relies so heavily on precedent, it is no surprise that certain frameworks and discourses become dominant and establish the models to be followed. This is no different within the area of transgender jurisprudence than in any other area of the law. Carolyn Grose, a clinical professor who has done much work representing transgender clients, has described her experiences navigating the “official” legal stories within the transgender community:

[T]he official stories hold. They are, first, that gender is binary—that is, everyone is either a man or a woman—second, that gender is determinable using specific criteria, and third, that gender can be changed only under very rare and clearly identified and identifiable conditions. Underlying these stories are two non-legal official stories: the medical and scientific community’s definition of “transsexual” and “gender identity disorder,” and the standards of care for treating these conditions.¹⁴⁴

The decision that came out of the *O’Donnabhain* case seems to fit exactly within this traditional model. As Grose describes, for those within the hegemonic system, it can be challenging to hear stories that do not fit the mold and therefore it is often strategic for advocates to work within the established framework.¹⁴⁵ However, Grose also suggests that because this area of the law is still developing, there is an opening for lawyers to work with their clients and create arguments and subsequently precedent that reflect their diverse and often “outsider” experiences.¹⁴⁶

Attorneys for transgender clients have the difficult task of explaining to a traditional and at times unsympathetic audience their clients’ stories, which often challenge the adjudicator’s understandings of the world. In this way, “[l]awyers tell stories in their role as ‘representors’ of their clients and, in that role, they must tell stories that can be heard and believed by legal decisionmakers.”¹⁴⁷ On account of this dynamic, lawyers make choices in how they present clients—how they frame their stories, which facts to highlight, what evidence to provide, and which claims to privilege. Additionally, lawyers make choices in which clients they choose to represent.¹⁴⁸ Current precedent weighs in favor of taking a client who fits in with the medical model

¹⁴⁴ Grose, *supra* note 49, at 337.

¹⁴⁵ *Id.* at 336 (“When an outsider tells a story that doesn’t fit in to the insider’s understanding of the world, the insider tends either not to believe the outsider, or to recast the outsider’s story into language and context that makes sense to the insider.”).

¹⁴⁶ *Id.* at 364 (“The absence of a solid legal foundation provides creative and critical lawyers valuable opportunities to step in and give the court an independent basis for adjudicating the particular dispute before it, rather than punting to one of the two official stories prior courts have relied on.”).

¹⁴⁷ *Id.* at 330.

¹⁴⁸ Koenig, *supra* note 49, at 644

and perhaps wishes to be a part of the gender binary. This too influences the decisions which are made and the precedent that is established for certain types of claims.

A close reading of the *O'Donnabhain* decision leads me to believe that although it would be non-traditional, and certainly would stray from the traditional stories which have been upheld by transgender jurisprudence, a claim for a medical deduction based on the second prong of the medical care definition (amounts paid for procedures which have the “purpose of affecting any structure or function of the body”) could be successful. Dean Spade, a well-known legal scholar and transgender advocate, has suggested that “[t]he mostly unexplored territory remains in the realm of de-medicalization, where trans rights are recognized but will not hinge upon surgical status or medical evidence.”¹⁴⁹ Because of the language available in the Code, I believe that this is one area of the law where it could be explored.

Several factors weigh in favor of introducing a non-traditional story into this context. The first is that there is some recent precedent for a judicial determination that did not rely on a medicalized notion of transgenderism in the D.C. Circuit’s decision in *Schroer v. Billington*.¹⁵⁰ The case was a Title VII discrimination case in which Diane Schroer was denied a job because of her decision to present in her new job as a woman.¹⁵¹ The court held that it did not matter for Title VII liability “whether the library withdrew its offer of employment because it perceived Schroer to be an insufficiently masculine man, an insufficiently feminine woman, or an inherently gender-nonconforming transsexual.”¹⁵² “Advocates in *Schroer* were prepared to use the medical model as a core component of their argument, but the court conferred a legal benefit on the plaintiff without adhering to the strict confines of the medical model or demanding a showing of trans-related surgery.”¹⁵³ While this is only one decision, it opens up the possibility that “successful arguments need not be based on the medical model.”¹⁵⁴

Second, Romeo offers a compelling theoretical argument for how transgender rights, and more specifically the right to determine one’s own gender identity and expression, can be analogized to the reproductive rights context,

(“A softer distributive effect is driven by the selection of plaintiffs that conform to the medical model when advancing these cases in impact litigation. The medical model produces trans identity as immutable and does not challenge gender norms, thus making these plaintiffs more palatable to courts. At the same time, many trans people do not view their identity as immutable and explicitly seek to challenge gender norms. So while impact litigation serves the role of advancing novel legal arguments, the decision not to advance arguments that are more encompassing of diverse trans identities is telling, as it has profound effects for framing the identity in the law.”).

¹⁴⁹ Spade, *supra* note 49, at 30.

¹⁵⁰ 577 F. Supp. 2d 293 (D.D.C. 2008).

¹⁵¹ *Id.* at 305.

¹⁵² *Id.*

¹⁵³ Koenig, *supra* note 49, at 642.

¹⁵⁴ *Id.*

which has been mostly framed around the due process rights of privacy and bodily integrity.¹⁵⁵ This argument is even more compelling in light of the fact that previous procedures that have fallen under the “for the purpose of affecting any structure or function of the body” prong of the medical care definition, and do not treat a disease, are primarily within the reproductive health context.¹⁵⁶

Lastly, and perhaps most importantly, the plain language of the statute suggests that a deduction should be permitted for procedures which have the “purpose of affecting any structure or function of the body”¹⁵⁷ and which are not “cosmetic surgery.”¹⁵⁸ Though it certainly did not win a majority of the votes on the Tax Court, Judge Halpern’s opinion discusses in much detail the formal logic of the statute and concludes that “[a] procedure is cosmetic surgery . . . only if the procedure *neither* meaningfully promotes the proper function of the body *nor* prevents or treats illness or disease. If one of the alternatives is true, however, then the expression is false and the test is flunked”¹⁵⁹ This logic suggests that a strong case could be made that gender-confirming care, even if not framed as the appropriate treatment of a disease, could be deductible as non-cosmetic medical care, “affecting [the] structure or function of the body.”

It is necessary to warn that, as with any approach, there will be benefits and limitations of this strategy as well. Before any advocate were to take on a claim like this, it would be necessary to carefully assess the potential impact for the particular client, as well as the broader transgender community. One scholar has already warned that one potential drawback to utilizing “arguments for medical necessity without a GID diagnosis [is that it] could undermine current recognition of the medical necessity by exposing a lack of consensus in the scientific community regarding the basis for providing such care.”¹⁶⁰ It is possible that as much as critics feel that the medical model precludes access for those who do not desire or cannot access a GID diagnosis, a non-medical model could be problematic for those that do.

¹⁵⁵ Romeo, *supra* note 1, at 745–47.

(“A reproductive rights analogy could provide a useful framework through which courts could conceive of gender in a way that does not pathologize gender non-conformity, but acknowledges that gender—like pregnancy—is a healthy aspect of life that presents fundamental issues of bodily integrity and personal choice, which every person has an inherent interest in self-determining.”).

¹⁵⁶ See, e.g., Rev. Rul. 73-201, 1973-1 C.B. 140; Rev. Rul. 73-603, 1973-2 C.B. 76.

¹⁵⁷ I.R.C. § 213(d)(1)(A).

¹⁵⁸ I.R.C. § 213(d)(9).

¹⁵⁹ *O’Donabhain*, 134 T.C. at 84 (Halpern, J., concurring). However, Judge Foley relies on congressional intent to claim that avoiding a classification of cosmetic surgery requires a showing that the procedure meets both requirements: it “meaningfully promote[s] the proper function of the body” and “prevent[s] or treat[s] illness or disease.” *O’Donabhain*, 134 T.C. at 105 (Foley, J., concurring in part and dissenting in part).

¹⁶⁰ Koenig, *supra* note 49, at 634.

CONCLUSION

There is tension within cause lawyering between representing one's client and representing the movement.¹⁶¹ Sometimes the means needed to accomplish the client's goals do not support the ends desired by all within the community. Because most movements, including the transgender movement, are diverse and do not have a unitary experience or a unitary goal, working for change can pose a challenge. As Spade warns, "[s]ometimes it is possible to use victories for single plaintiffs to expand rights for a broad group, but it is always important to be careful that the fight for a single plaintiff's rights does not curtail rights for a broader group."¹⁶²

In this case, with respect to O'Donnabhain's medical care deduction, framing GID as a disease requiring treatment was the best fit for the plaintiff who presented. O'Donnabhain's attorneys strategically employed all of the strongest legal arguments at their disposal to convince the Tax Court to permit her medical deduction. There may be another case out there to argue for a medical deduction for hormonal and surgical transition procedures under the "structure and function" prong of the medical care definition, but this was not the case. I would urge other transgender taxpayers considering a deduction and their advocates to keep this in mind and carefully consider whether the Tax Code and the medical deduction could provide a forum for the further expansion of transgender rights.

¹⁶¹ See, e.g., McGowan, *supra* note 5, at 205–6 (reflecting on the challenges of whether "the lawyer and the client have compatible visions of what it means to 'win' the case, and . . . [w]hen should an advocate bring a claim that has a high risk of producing bad law not only in her own case but also for future litigants based on her belief that, even in losing the claim, benefits might accrue to her client"); Ittelson, *supra* note 114, at 382 ("Conflicts arise for representatives of individual transgender plaintiffs. These representatives, frequently LGBTQ non-profits primarily devoted to impact litigation, must balance articulating the reality of a more fluid gender spectrum with the interests of their individual clients."). McGowan states that her goal is to support lawyers to "not only advance the cause of civil rights but also promote the dignity and humanity of their clients." McGowan, *supra* note 5, at 208.

¹⁶² Spade, *supra* note 49, at 36.