Recent Developments
Trapped in the Wrong Phraseology:
O’Donnabhain v. Commissioner—
Consequences for Federal Tax Policy and the
Transgender Community

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ABSTRACT
The U.S. Tax Court’s 2010 decision in O’Donnabhain v. Commissioner reinterprets the scope of the medical expense deduction by authorizing the deduction of surgical treatment for Gender Identity Disorder (GID). After explaining the tax framework upon which the O’Donnabhain decision rests, this Recent Developments piece describes the decision and examines its consequences for the U.S. federal budget and the medicalization of the transgender community. The author concludes that O’Donnabhain will not significantly widen the pool of deductible medical care outside of sexual reassignment surgery and hormone therapy. The author applauds O’Donnabhain as a victory for those seeking to deduct expenses incurred in the treatment of GID but cautions that the decision may enforce a homogenous, medicalized model of the “ideal” transgender body.

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INTRODUCTION

The United States entered the 21st century on the heels of three years of federal budget surplus for the first time since 1970.1 Yet an examination of our current fissuring national budget suggests the national deficit may exceed $1 trillion annually for at least the next 10 years.2 In 2009 alone, the U.S. federal deficit was larger than the GDP of all but six other countries in the world.3 Much of President Obama’s tax overhaul focuses on reducing tax expenditures in the form of itemized deductions, an element of the U.S. Tax Code which allows individuals and businesses to reduce their tax liability by claiming certain expenses as exempt from taxation.4 The medical expense deduction, which allows an individual to deduct certain types of medical expenses as authorized under 26 U.S.C. § 213, resulted in a tax expenditure of $8.76 billion in 2009.5

The U.S. Tax Court’s 2010 decision in O'Donnabhain v. Commissioner reinterpret the scope of the medical deduction.6 The O'Donnabhain decision, which authorized the deduction of a surgical treatment for Gender Identity Dis-

2. Id.
3. Id.
5. STAFF OF J., supra note 4.
order (GID), raises two important questions. First, the decision may affect the economic utility of the medical expense deduction if it is read to significantly broaden the current boundaries of what is considered deductible care. This Note will examine whether the decision itself broadens the scope of the medical deduction to the extent that there will ultimately be a detrimental effect on tax revenue or whether it merely opens the door for future decisions to do so. Second, this note will consider whether the O'Donnabhain decision will further encourage the divide between wealthy, "real" transsexuals and individuals of a lower socioeconomic class who cannot, for economic reasons, attain an "ideal" surgical transition. The decision may provide a tax incentive for taxpayers who already have the preexisting funds to purchase transgender-related surgeries.

At its core, the decision brings Internal Revenue Service policy into alignment with the current medical consensus: GID is a legitimate condition, the treatment of which may in certain cases medically necessitate sexual reassignment surgery and hormone therapy. Issues remain, however, with the disproportionate use of the itemized deduction by individuals in higher tax brackets. This raises questions as to whether this deduction will reinforce, rather than remove, the current economic barriers which may prevent lower-income, gender non-conforming people from accessing the normative medical model of transgenderism.

Part One of this paper will explain the tax framework upon which the O'Donnabhain decision rests. Part Two describes the decision itself, the lead opinion, and the nine additional opinions. Part Three examines the consequences for both the U.S. federal budget and the medicalization of the transgender community.

I. BACKGROUND OF THE CASE AND THE U.S. TAX FRAMEWORK

A. Rhiannon O'Donnabhain

In 2001, Rhiannon O'Donnabhain, an engineer from South Boston who once served in the U.S. Coast Guard, underwent sexual reassignment surgery and breast augmentation as part of her transition to living full-time as a woman.7 She later deducted the amount of her sexual reassignment surgery and breast augmentation, in addition to the cost of her hormone treatments for the year, on her 1040 income tax form.8

The IRS then challenged the deductibility of all three components of her transition under 26 U.S.C § 213.9 O'Donnabhain appealed the decision to the U.S. Tax Court, and in a heavily splintered opinion, the court authorized her de-

8. Id.
9. O'Donnabhain, 134 T.C. at 35. 26 U.S.C § 213 governs allowable medical deductions for individuals choosing to itemize their tax returns.
ductions for sexual reassignment surgery and hormone therapy but disallowed the deduction for her breast augmentation, deeming the breast augmentation cosmetic and, thus, excluded by 26 U.S.C. § 213(d)(9).

B. The Itemized Deduction

Under the current tax scheme, individuals filing tax returns may choose either to itemize their deductions or to take a standard deduction. A standard deduction is a flat amount, typically increased for inflation each year, which taxpayers can deduct instead of itemizing their deductions. The standard deduction offers a benefit to taxpayers whose itemized deductions add up to less than the amount offered by the standard deduction in the given fiscal year. In the year 2008 (the most recent year for which the IRS provides statistics), out of 142,450,569 total tax returns, 48,167,223 returns employed the itemized deduction, while 91,780,792 returns utilized the standard deduction. As the amount offered for the standard deduction remains relatively small, $5,700 for a single individual or $11,400 for two individuals filing jointly, the number of individuals itemizing their deductions correlates with income. The number of individuals using the standard deduction is highest at the two lowest income brackets and reduces as income increases. As this data suggests, the standard deduction "functions to exempt from tax a certain amount of income for those taxpayers, particularly in low brackets, who do not have" significant expenses that could be itemized.

Problems with itemization exist on the policy level. Commentators have noted that the particularities of what constitute an allowable deduction, such as the AGI threshold requirement, improperly incentivize certain types of spending. The deduction, meant to achieve a public good, may in fact create a coun-
For example, the determination of long-term care insurance as deductible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), passed with the purpose of reducing Medicare expenditures, led to a decrease in overall tax revenue even when weighed against the potential benefits.

The itemized deduction is criticized for disproportionately benefitting wealthy taxpayers. Economists have demonstrated that higher income earners are more able to adjust their taxable income through the use of flexible tax adjustments like deductions. Recent federal budgets have proposed capping the value of itemized deductions for individuals in the highest tax brackets, brackets in which deductions generally create higher outlay ratios. The Obama administration estimates that a 28% cap on the deduction for charitable giving alone would save approximately $275 billion in revenue over the next ten years.

Though this Note will not directly address the efficacy or fairness of the itemized deduction, it is necessary to recognize potential criticisms because the medical deduction operates as a function of the itemized deduction scheme.

18. See Charles Courtemanche & Daifeng He, Tax Incentives and the Decision to Purchase Long Term Care Insurance, 93 J. OF PUB. ECON. 296, 296-310 (2009) (noting "the foregone tax revenue exceeds the savings for Medicaid, suggesting that it may not be fiscally wise to use tax subsidies to expand the private LTC insurance market").

19. Id.

20. THOMAS HUNGERFORD, CONG. RESEARCH SERV., RL 33641, TAX EXPENDITURES: TRENDS AND CRITIQUES 22 (2006), available at http://assets.openers.com/pts/RL33641_20060913.pdf ("The benefits of much of the tax expenditures go to taxpayers in the upper part of the income distribution, and they often subsidize an activity for which the taxpayer receives a benefit."). Note that for taxpayers with a certain income (above $160,800 in 2009), the total amount itemized is reduced by 3% of the excess of adjusted gross income over $166,800; or 60% of the total itemized deductions otherwise allowable. Id.


23. STAFF OF J., supra note 4.

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The dynamics that influence taxpayers to take advantage of the itemized deduction shape the discourse concerning the medical deduction. For instance, the itemized deduction remains a tax benefit primarily utilized by the wealthy.25 O'Donnabhain, a case authorizing a medical deduction which can only be utilized if the individual itemizes rather than taking the standard deduction, must be understood in the greater context of the economic realities facing transgender individuals: higher rates of unemployment,26 underemployment,27 and a lack of workplace anti-discrimination statutes both at the federal level and, in most cases, locally.28

C. The Medical Expense Deduction

A plethora of expenses can be itemized for deduction under the current tax code. Examples include charitable contributions,29 the purchase of a clean-air vehicle,30 alimony payments,31 tuition expenses,32 and of particular interest here, medical expenses.33 Itemized deductions allow the federal government to "ease the burden of catastrophic expenditures that affect a taxpaying unit's ability to pay tax and to encourage certain types of activities such as home ownership and charitable contributions."34 For these reasons, individuals may currently only deduct medical expenses if their combined expenditures exceed 7.5% of their adjusted gross income (AGI).35 Thus, the medical deduction is designed not to allow a deduction for all out-of-pocket medical costs incurred in a given tax year, but only to cover amounts in excess of the fixed percentage the IRS has determined would constitute a hardship.36 For example, if Sue has an AGI of $50,000,
7.5% would equal $3,750. Sue will only be able to deduct the medical expenses she has incurred above this amount. However, under H.R. 4872, the recently passed Health Care and Education Reconciliation Act, the previous threshold of 7.5% will be raised to 10% of AGI in 2012. Following 2012, therefore, Sue will only be able to deduct medical expenditures in excess of $5,000.

The statutory language of what constitutes an allowable medical deduction is remarkably broad. Section 213 of the United States Tax Code states that individuals may deduct “expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent.” Medical care available for deduction is statutorily defined as “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,” transportation to and from the aforementioned medical care, qualified long-term care, and insurance covering qualified medical care.

The medical deduction was introduced in 1942 as an amendment to the 1939 Tax Code. At the time, medical care under the statute was defined as “amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance).” The statute itself has been updated over time through various legislative additions. In addition, the U.S. Tax Court and federal courts regularly issue rulings on questions of tax code interpretation, and opinions regularly include decisions that define the boundaries of the medical expense deduction. The Tax Court and federal courts have jurisdiction to hear cases brought by taxpayers who argue that the IRS has wrongly ascertained a tax deficiency in the taxpayer’s return.

D. The Appeals Process

If the IRS identifies a deficiency in the taxpayer’s return, the Service sends
written notice outlining the alleged miscalculation. The taxpayer is generally given a deadline of sixty days to raise a challenge to the notice or else the right of appeal is waived. The taxpayer may do one of three things at receipt of the notice: respond to the notice by paying in full, ignore the notice which begins the IRS collection process, or send the IRS documentation supporting the calculation at issue. The IRS then reexamines the documentation and issues a decision. If the IRS does not accept the taxpayer’s calculation, the individual is given a deadline by which to appeal the determination. The taxpayer may then issue a Formal Appeal or a Small Case Request, the latter reserved for disputes under $25,000. Both appeals trigger either a telephone or in-person conference with an appeals representative, for which a taxpayer may hire a representative, most commonly an attorney or an accountant.

Following the appeals conference, the IRS issues a formal Notice of Deficiency or Notice of Determination at which point the taxpayer may appeal the case to the U.S. Tax Court. The Tax Court, created under the Revenue Act of 1924, was initially part of the executive branch, but was incorporated into the judiciary under the Tax Reform Act of 1969. While taxpayers may also file suit directly in federal district courts, the Tax Court is the only avenue through which to do so without first paying the disputed amount in full. In addition, a taxpayer may pay a proportion of the disputed amount in order to avoid accruing interest during the proceedings.

II. O’DONNABHAIN v. COMMISSIONER

A. Background of the Case

Rhiannon O’Donnabhain, a transgender woman, was diagnosed in 1996 with GID. GID can be described as a disparity between an individual’s assigned sex at birth and the gender that individual feels the most comfortable presenting to the world. O’Donnabhain deducted the expenses she incurred (above the 7.5% AGI floor) in the treatment of her GID during the 2001 fiscal year.

45. Id.
46. Id.
47. Id.
48. Id.
49. Id.
50. Id.
The IRS Office of Chief Counsel issued a legal memorandum to O'Donnabhain at the time of the determination rejecting the itemized deduction of $5,679 for her GID-related medical expenses, because she had allegedly provided "nothing to substantiate that these expenses were incurred to promote the proper function of the [her] body and only incidentally affect [her] appearance." In finding the medical expenses nondeductible under the definition of "medical care" within § 213(d)(1), the General Counsel argued that "whether gender reassignment surgery is a treatment for an illness or disease is controversial."

O'Donnabhain appealed the Notice of Deficiency to the United States Tax Court. At trial, the IRS echoed the arguments from its memorandum, arguing that the care was not deductible under § 213 and that O'Donnabhain's GID-related expenses fell under the statutory exception for "cosmetic surgery or other similar procedures" under § 213(d)(9). O'Donnabhain argued that the expenses she incurred for hormone therapy, sex reassignment surgery, and breast augmentation all constituted deductible medical expenses for the purposes of § 213.

Central issues in the litigation included whether GID fell into the category of "disease," whether GID would warrant "legitimate medical treatment," and whether the procedures O'Donnabhain underwent were "necessary in the treatment of her condition."

The decision was heavily splintered, with no majority opinion, and the opinions displayed fervor unusual in Tax Court decisions. As the impenetrable combination of judicial opinions demonstrates, the deductibility of Ms. O'Donnabhain's GID-related medical expenses under § 213 caused a stir among the judges of the Tax Court. Of the sixteen judges who heard the case, seven agreed with Judge Gale's lead opinion which authorized deduction of medical expenses related to the sexual reassignment surgery and hormone replacement, but not breast augmentation.

Judge Halpern wrote a concurrence to find fault with the lead opinion's determination that the breast augmentation was not deductible, though he agreed with the ultimate result, and to comment on the other opinions. Holmes, who joined the Halpern concurrence, wrote a separate concurrence, with which Judge Goeke concurred, to state that while he agreed with the lead decision regarding O'Donnabhain, he took issue with the opinion that sex reassignment surgery was always the "proper treatment" for GID. Judge Goeke also wrote a separate opi-
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nion, with which Judge Holmes agreed in the result only, to concur with the lead result but to disagree with the analysis of § 213. Judge Foley wrote separately to concur in part and dissent in part, and argued that while the lead opinion reached the correct result, it wholly misinterpreted the plain language of the cosmetic surgery exception under § 213(d)(9). Finally, Judge Gustafson concurred with the lead opinion’s disallowal of the breast augmentation and dissented in regard to the authorization of O’Donnabhain’s genital sex reassignment surgery and hormone replacement.

The wide variety of positions in a case that has ultimately been seen as a victory for transgender individuals is notable not only because it demonstrates the considerable range of attitudes held by the judges towards transgender plaintiffs but also because the analyses center on the policy of the medical deduction as it relates to a group whose status in society is uniquely correlated to a normative medical model. The “typical” transgender individual, here Ms. O’Donnabhain, is unambiguously constructed and identified within society in relation to a series of expensive and, in some cases, reductionist medical narratives. The six different opinions in this case and the economic conclusions they explicitly or implicitly draw offer a unique opportunity to examine current legal attitudes toward the transgender community. The decision is not only engaging because of the differing analytic approaches but also because the court, officially charged with hard line statutory analysis of the Tax Code, ultimately represents a policy-making body insofar as its interpretation can legitimize or delegitimize an individual’s gender identity.

Because the opinions each individually implicate different tax policy considerations and differ wildly in their analysis of the Code, I will examine and explain the opinions’ various rationales. This will provide background to the more nuanced conclusions I offer in the final sections of this article.

B. The Lead Opinion

Judge Gale’s opinion ultimately determined that O’Donnabhain’s deductions for hormone replacement therapy and sexual-reassignment surgery were justified under § 213. Her breast augmentation, however, was excluded under the cosmetic surgery exclusion of § 213(d)(9). The opinion consists of two parts: the Findings of Fact, in which the court outlines O’Donnabhain’s history

64. Judge Wells, Judge Vasquez, Judge Kroupa, and Judge Gustafson joined in this opinion.
65. Judge Wells, Judge Foley, Judge Vasquez, and Judge Kroupa joined in this opinion.
67. Note that this highlights a deeper problem with the medical deduction scheme—that qualifying expenses are difficult to identify. 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 (2009).
68. O’Donnabhain v. Comm’r. 134 T.C. at 70.
69. Id. at 85.
and the findings of the experts provided by both O'Donnabhain and the IRS; and
the Opinion itself, in which the court attempts to define the current boundaries of
medical care under § 213. In the Opinion section, the court analyzed whether
GID is a "disease" that would necessitate medical care of the sort articulated
within the statute, whether O'Donnabhain actually had GID, and whether the
sexual reassignment surgery, hormone replacement therapy, and breast augmen-
tation qualify as "necessary treatment."

1. Findings of Fact

The IRS disallowed O'Donnabhain's deduction for the cost of care she re-
ceived in 2001, which included the costs associated with her hormone treatment,
genital surgery, and breast augmentation. Her tax return was met with a "notice
of deficiency," which alerts the taxpayer to the deficiency in their tax return and
alerts them to the possibility for appeal to the Tax Court.\footnote{Id. at 42.}

The lead opinion explained that O'Donnabhain underwent psychotherapy
and after approximately twenty sessions was diagnosed as a transsexual with
"severe gender identity disorder."\footnote{Id. at 36.} The opinion introduced the Benjamin Stan-
dards of Care, a treatment model for GID promulgated by the World Profession-
prescribe "hormonal sex reassignment . . . living full time in society as a member
of the opposite sex . . . [and] genital sex reassignment and/or nongenital sex
reassignment."\footnote{O'Donnabhain. 134 T.C. at 38.} O'Donnabhain's psychotherapist "administered a course of
treatment" along these guidelines,\footnote{Id at 39.} and O'Donnabhain underwent hormone
therapy, presented a feminine appearance,\footnote{Note that obviously subjective standards are presented as normatively established.} and had genital, breast, and facial
surgery to surgically alter her body to appear more female.\footnote{O'Donnabhain, 134 T.C. at 35.}

The opinion then considered the expert testimony presented by
O'Donnabhain's medical expert, Dr. George Brown, and the IRS medical ex-
erts, Dr. Chester Schmidt and Dr. Park Dietz. Dr. Brown advocated "one or
more of the triadic therapies in the Benjamin Standards" and rejected the idea
that sex reassignment surgery fell under the cosmetic surgery exclusion. The
opinion stated that Dr. Brown "observe[d] that normal genetic males generally
do not desire to have their penis and testicles removed."\footnote{Id. at 43.} The opinion explicitly
situates O'Donnabhain as outside the realm of "normal" in order to justify her
surgery as non-cosmetic. This problematic representation will be explored in the
later section of this Note in which the consequences of the case are discussed.

The IRS expert in the medical treatment of GID, Dr. Schmidt, was individually "undecided" about the validity of the standard GID diagnosis and was "uncertain that GID is a mental disorder in light of the heterogeneity of GID patients."78 Thus, as a direct result of the wide spectrum of manifestations of what constitutes GID, Dr. Schmidt cast doubt on the validity of deeming the condition a mental disorder. Dr. Schmidt "agreed that GID requires treatment" because "you can't wait around day after day being ambiguous about your gender identity. It will tear you apart psychologically."79 However, Dr. Schmidt concluded that the Benjamin Standards lacked the requisite scientific demonstration of efficacy to require their prescription in the treatment of GID, thus determining that the procedures were elective.80

The IRS psychiatric expert, Dr. Dietz, opined that GID was a mental disorder but not a "disease" because it was not sufficiently proven to result from a "pathological process within the body."81 Though the court noted that other medical commentators have argued for discomfort, dysfunction, or pathology to determine the presence of a disease, in Dr. Dietz's opinion only pathology could warrant the diagnosis.82

2. Opinion Section

Pleading multiple theories, the IRS argued that GID was not a disease for the purposes of § 213 because it did not "arise from an organic pathology within the human body," that if GID were to be deemed a disease the procedures O'Donnabhain deducted did not treat it, and, barring those two arguments, that O'Donnabhain was incorrectly diagnosed, ultimately barring a deduction.83 As discussed earlier, O'Donnabhain posited that GID was a legitimate medical condition accepted within the medical community as requiring surgery, that the surgical procedures she underwent as a result of her GID fell squarely within accepted medical guidelines for treatment, and that the procedures were not barred by the cosmetic exclusion.

The court followed the precedent set in Jacobs v. Commissioner, a seminal case which "reviewed the legislative history of § 213 and synthesized the case law to arrive at a framework for analysis of disputes concerning medical expense deductions."84 In Jacobs, the court determined that in order to show a deduction that fell under § 213, the taxpayer must demonstrate the present existence of disease, defect, or illness, and "payment for goods or services directly or proximate-

78. Id. at 45.
79. Id.
80. Id. at 46.
81. Id.
82. Id.
83. Id. at 53.
84. Id. at 50.
ly related to the diagnosis, cure, mitigation, treatment, or prevention of the disease or illness.”

Under Jacobs, when an expense may be considered “not wholly medical in nature,” it must be shown that the expense would not have been incurred but for the disease or condition at issue.

In determining whether GID was a disease, the court explained that the use of expert testimony to define statutory terms is “generally improper” and that the court would instead rely on the plain language of the statute, the IRS regulations, the legislative history, and case law. The court dismissed the IRS position that mental disorders do not constitute a disease under § 213 because is “flatly contradicted by nearly half a century of case law.”

The court cited a number of cases finding mental conditions to be deductible where “there was evidence that mental health professional regarded the condition as creating a significant impairment to normal function and warranting treatment.”

Again, one sees the unexamined implicit assertion that “significant impairment” is a bar to being deemed a “normal” individual. Regardless, the court concluded that “a more colloquial sense of the term ‘disease’ was intended [rather] than the narrower (and more rigorous) interpretation” that the IRS presented.

The court accepted that a diagnosis of GID, in the case of an individual like O’Donnabhain, was “widely recognized” and the “prevailing view” in the medical community. Rejecting the notion that the condition was “socially constructed” and noting various appellate court rulings recognizing GID, the court concluded:

The severity of petitioner’s impairment, coupled with the near universal recognition of GID in diagnostic and other medical reference texts, bring petitioner’s condition in line with the circumstances where a mental condition has been deemed a “disease” in the caselaw under section 213.

Thus, the court dismissed the first prong of the IRS’s argument. The court then turned to the question of whether O’Donnabhain herself had GID and swiftly concluded that the evidence introduced into the record proved she did.

The opinion then analyzed whether the surgical procedures O’Donnabhain deducted served to treat the “disease” of GID. The court presumed to interpret

85. Id. (citing Jacobs v. Commissioner, 62 T.C. 813, 818 (1974)).
86. Id.
87. Id. at 56.
88. Id.
89. Id. at 57.
90. Id. at 58.
91. Id. at 60.
92. Id. at 62 (noting that “seven of the U.S. Courts of Appeals that have considered the question have concluded that severe GID or transsexualism constitutes a ‘serious medical need’ for purpose of the Eighth Amendment.”).
93. Id. at 61.
94. Id. at 64.
“treatment” or “treat” “in their ordinary, everyday sense” and quoted a number of dictionary definitions.\textsuperscript{95} The court cited an early case in the determination of the range of the medical deduction that required that the treatment “bear a direct and therapeutic relation” to the disease\textsuperscript{96} and rejected at length the assertion of Dr. Schmidt, the IRS expert, that the Benjamin Standards are not widely accepted medical standards for the treatment of GID.\textsuperscript{97} The court also adopted a flexible standard of what constitutes treatment, with regard to acceptance within the medical community. The court placed ultimate importance on whether the treatment would reasonably be considered effective and left a significant amount of room for interpretation with regard to GID treatment.\textsuperscript{98}

For all the reasons above, the court determined that O'Donnabhain's hormonal treatment and genital surgery was covered under § 213 as medically necessary treatment.\textsuperscript{99} However, the court parted from O'Donnabhain's position in relation to the deduction for her breast augmentation and stated that “petitioner has not argued, or adduced evidence, that the breast augmentation surgery ameliorated a deformity,”\textsuperscript{100} the language used in the cosmetic surgery exclusion to define which cosmetic surgery is covered.\textsuperscript{101} The court noted that the Benjamin Standards authorize breast augmentation surgery if the desired breast shape is not produced at the conclusion of eighteen months of hormone treatment.\textsuperscript{102} The court pointed to the cosmetic nature of the surgery, primarily relying on the report of an examination by the doctor who performed the surgery, who noted that she had developed B cup breasts “of a very nice shape” as a result of undergoing hormone treatment.\textsuperscript{103} The court concluded that O'Donnabhain's chest at the time of surgery was “within a normal range of appearance, and there is no documentation concerning petitioner’s comfort level with her breasts.”\textsuperscript{104} Thus, the court concluded that the breasts’ “apparent normalcy” coupled with the fact that there was insufficient documentation of O'Donnabhain's particular need for the surgery as treatment for GID indicated the breast augmentation was cosmetic.\textsuperscript{105}

Turning lastly to the IRS argument that O'Donnabhain's genital surgery was not medically necessary, the court rejected the contention that § 213(d)(9) imposes a requirement of medical necessity on the deduction of procedures affecting appearance and instead found that sexual reassignment surgery falls under § 213(d)(1)(a) as medical care.\textsuperscript{106}

\begin{footnotes}
\item[95. ] \textit{Id.}
\item[96. ] \textit{Id. at 65.}
\item[97. ] \textit{Id. at 69.}
\item[98. ] \textit{Id. at 76.}
\item[99. ] \textit{Id. at 77.}
\item[100. ] \textit{Id. at 72.}
\item[101. ] \textit{26 U.S.C. § 213(d)(9)(A).}
\item[102. ] \textit{O'Donnabhain, 134 T.C. at 72.}
\item[103. ] \textit{Id. at 72-73.}
\item[104. ] \textit{Id.}
\item[105. ] \textit{Id.}
\item[106. ] \textit{Id. at 74.}
\end{footnotes}
C. Judge Halpern’s Concurrence

Judge Halpern concurred with the decision to authorize deduction of sexual reassignment surgery and hormones but not O’Donnabhain’s breast augmentation. Judge Halpern, in assessing whether the procedure treated GID, stated that it was incorrect to rely on surgical notes written prior to the breast augmentation procedure because the surgeon explicitly testified that the procedure was to transform O’Donnabhain’s chest from male-appearing to female-appearing, demonstrably rendering the procedure more than merely cosmetic. However, he agreed with the disallowal of deduction because he found that the augmentation was not necessitated by the Benjamin Standards.

D. Judge Holmes’s Concurrence

Judge Holmes concurred with the outcome of the lead opinion but wrote separately to differentiate between O’Donnabhain specifically and whether sexual reassignment was “the proper treatment” for GID in all cases. Judge Holmes outlined three approaches that he argued offered an alternative viewpoint to the lead opinion’s holding that GID was a disease: that feelings of gender dysphoria are “a form of delusion,” that transsexualism is itself a social construct that need not require surgery if the individual is counseled to “relate to their own sex in their native bodies,” and third, that the condition is adopted as a result of a sexual fetish. Judge Holmes also asserted that the lead opinion’s finding that sexual reassignment surgery was medically necessary in all cases of GID “was not essential to the holding and derails our Court into culture wars in which tax lawyers have heretofore claimed noncombatant status.”

In attempting to offer a more nuanced perspective on the current state of attitudes towards GID, Judge Holmes instead demonstrated a common misunderstanding of gender non-conforming individuals. He stated that O’Donnabhain argued, and that the lead opinion accepted, that “the reason a transsexual person seeks [sexual reassignment surgery] is to correct a particular type of birth defect.” Nowhere in the lead opinion, however, does this argument appear. Regardless of whether O’Donnabhain personally believes that her GID is a birth defect, Judge Holmes proffered that the position that GID is a legitimate medical condition, along with positions arguing that GID is a delusion, a fetish, or in fact wholly socially constructed, “are all intensely contested.” Yet, the source cited for the proposition that GID is a delusion is a single article published in The

107. Id. at 78.
108. Id.
109. Id.
110. Id. at 85.
111. Id. at 86-88.
112. Id. at 86.
113. Id. at 88.
114. Id. at 87.
American Scholar, which, in the words of its website, is "the venerable but lively quarterly magazine of public affairs, literature, science, history, and culture published by the Phi Beta Kappa Society." The source cited for the proposition that GID is wholly a social construct was written fifteen years ago. In regard to the argument that GID arises out of a particular sexual fetish, Judge Holmes cited sources which themselves explicitly do not purport to refer to the entire community of individuals who seek out sexual reassignment surgery, and the articles cited do not offer any reason why this type of erotic attachment invalidates the GID diagnosis if it has met the Benjamin Standards.

His concurrence continued by questioning the necessity of surgical intervention, noting that the medical textbooks upon which the lead opinion relied offered sexual reassignment as a permissive option and not as obligatory treatment in all cases. While he ultimately agreed with the lead opinion that GID is a disease, Judge Holmes took issue with the lead opinion’s characterization of sexual reassignment surgery as always “medically necessary” because, he argued, “the picture of scientific consensus that the majority presents is not quite right.” Nonetheless, he also agreed that § 213(d)(1)(A) covered O’Donnabhain’s sexual reassignment surgery and hormone therapy and that the cosmetic surgery exception in § 213(d)(9)(B) did not represent a barrier because “O’Donnabhain’s hormone treatment and [sexual reassignment surgery] established a biological baseline of a sexual appearance for her.” However, he found her breast augmentation was “focused on changing what she already had” and was thus cosmetic.

E. Judge Goeke’s Opinion

Judge Goeke argued that the definition of “cosmetic surgery” under § 213(d)(9)(B) inherently included sexual reassignment surgery, because the definition excludes surgeries that do not “meaningfully promote the proper function of the body or prevent or treat illness or disease.” Because the record, ac-

118. O’Donnabhain, 134 T.C. at 87 (citing Ray Blanchard, Typology of Male-to-Female Transsexualism, 14 ARCHIVES SEXUAL BEHAV. 247 (1985); Peggy Cohen-Kettenis & Louis Goo- ren, Transsexualism: A Review of Etiology, Diagnosis and Treatment, 46 J. PSYCHOSOMATIC RES. 315, 321-22 (1999); Anne Lawrence, Clinical and Theoretical Parallels Between De- sire for Limb Amputation and Gender Identity Disorder, 35 ARCHIVES SEXUAL BEHAV. 263 (2006)).
120. Id. at 94.
121. Id. at 99.
122. Id.
123. Id. at 101.
ccording to Judge Goeke, sufficiently proved GID to be a disease, sexual reassignment surgery and hormone treatment were not cosmetic, and could not not fall within the exceptions for cosmetic procedures relating to disease under § 213(d)(9)(B). Judge Goeke proffered that the phrase “cosmetic surgery or other similar procedures” in § 213(d)(9)(A) referred to cosmetic surgery and similar cosmetic procedures. Thus, because O’Donnabhain’s procedure, argued Goeke, “was not directed at improving petitioner’s appearance but rather was functional,” a consideration of whether either treatment fit under the § 213(d)(9)(B) exclusion was unnecessary.

Judge Goeke stressed the importance of construing the lead opinion narrowly because defining a surgical procedure performed as a result of a mental condition as cosmetic, but deductible under § 213(d)(9)(B), might allow taxpayers to deduct “expenses for surgery directed solely at altering physical appearance ... if it is intended to alleviate mental pain and suffering.” Judge Goeke interpreted § 213(d)(9)(B) to always exclude physical treatment to alleviate mental pain and pointed to legislative history that employed examples such as malignancy to determine when cosmetic surgery is deductible. While Judge Goeke found that the other two procedures at issue fell squarely within § 213(a) and not within § 213(d)(9)(B), he found the breast augmentation not deductible because “the nuances of feminine appearance 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.”

F. Judge Foley’s Opinion

Judge Foley, in a particularly colorful opinion in which he continually used male pronouns to refer to Ms. O’Donnabhain, challenged the lead opinion’s reading of the plain language of § 213, concurred with the denial of the breast augmentation, but dissented from the authorization of a deduction for the sexual reassignment surgery. He did not offer an opinion on hormone therapy. He asserted that § 213(d)(9)(B) was a disjunctive test, in which a cosmetic procedure is not deductible if it does not “meaningfully promote the proper function of

124. Id.
125. Id. at 102.
126. Id. at 101.
127. Id. at 102.
128. Id. at 102-03.
129. Id. at 103.
130. Id. at 104 (“In allowing deductions relating to petitioner’s expenses, the majority has performed, on congressional intent, interpretive surgery even more extensive than the surgical procedures at issue—and respondent has dutifully assisted. This judicial transformation of section 213(d)(9) is more than cosmetic.”).
131. Id. at 104.
132. Id.
the body” or “prevent or treat illness or disease.” Thus, a procedure would fall under the cosmetic exclusion if it were directed at improving the patient’s appearance and neither one of the preceding phrases applied.

Judge Foley addressed the contention in Judge Halpern’s concurrence that such a reading of the statute is grammatically incorrect. However, after a discussion including a lengthy footnote on the superior value of congressional intent when placed in clear opposition to the true grammatical meaning of a statute, Judge Foley maintained that § 213(d)(9)(B) must be interpreted broadly in order to limit deductions for cosmetic procedures.

Judge Foley’s opinion then continued by arguing that the procedures should not be covered because they fall under the “similar procedures” phraseology of § 213(d)(9), which specifically excludes cosmetic procedures. This differed from the opinion of Judge Goeke, who held that the procedures were wholly excluded from § 231(d)(9)(A), because they were not cosmetic at all. Judge Foley argued that the congressional history was clear on the matter and that the lead opinion incorrectly ignored such congressional intent. He noted that the IRS “inexplicably conceded” that similar procedures could in fact refer to sexual reassignment surgery. He argued that the lack of statutory or regulatory authority left the option open to disallow. Finally, the Judge faulted the IRS’s “laxity” and explicitly encouraged an appeal: “if respondent is comfortable, however, with his current interpretation of the statute and the accompanying litigation position, I offer a word of advice – ‘Katy, bar the door!’”

G. Judge Gustafson’s Opinion

Judge Gustafson concurred with the disallowal of the breast augmentation but dissented from the deduction of the sexual reassignment surgery, and elected not to address the question of the hormone therapy because it represented a “de
minimis deduction" of only $382.143. Judge Gustafson, along with Judge Foley, used the male pronouns "he" and "his" throughout the entire opinion and referred to the surgeries O'Donnabhain underwent as "startling . . . self-mutilation." However, he then stated 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," referencing the fact that a legal abortion may be deductible under § 213.145

Although Judge Gustafson accepted that O'Donnabhain had GID and that "medical consensus favors [sexual reassignment surgery] for a GID patient like petitioner," he wrote that the lead opinion incorrectly applied § 213(d)(9) and that the decision went against clear congressional intent. In his analysis of § 213(d), Judge Gustafson focused on "proper function of the body" and noted that sexual reassignment surgery "drastically terminates a male patient's functioning sexuality." Judge Gustafson argued that the sexual reassignment surgery fell under the "similar procedures" language of the § 213(d)(9)(A) exclusion. In order to find that the sexual reassignment surgery was not covered under § 213(d)(9)(B), Judge Gustafson had to consider whether the procedure could "meaningfully promote the proper function of the body or prevent or treat illness or disease." Because he had already dismissed whether it "promote[d] the proper function of the body," he moved to whether it would "prevent or treat illness or disease." Judge Gustafson disputed that the procedures served to treat the disease of GID, finding instead that they treated the symptom, which he argued was too broad a reading of the statute. He then turned to whether sexual reassignment surgery even constituted a treatment for GID and concluded that because GID was characterized as a mental disease and the treatment prescribed was physical, the surgery had not treated the mental disease and was therefore not deductible.

III. O'DONNABHAIN'S CONSEQUENCES

A. Implications for Tax Policy

O'Donnabhain will have concrete effects on transgender taxpayers, and it will affect these individuals regardless of whether they are seeking surgery or hormone therapy as treatment for their GID. Additionally, O'Donnabhain may

144. Id. at 109-10.
145. Id.
146. Id.
147. Id. at 112.
148. Id. at 111.
149. Id. at 112.
150. Id. at 122.
151. Id.
have broad implications for tax policy when considered in the context of the itemized deductions' impact on tax revenue. The decision authorizes the deduction of a physical treatment for a condition that is currently considered a mental "disease," the cause of which is presently unsettled within the medical community. As a number of the opinions articulate, there is the potential for the lead opinion to be read broadly in such a way as to authorize physical treatments for mental conditions if such treatments would survive the same analysis offered by the lead opinion. Depending on the number of individuals who attempt to deduct physical treatments for mental diseases and the cost of such treatments, *O'Donnabhain* could have serious consequences for the utility and function of the medical deduction.

The medical deduction is not the greatest of the itemized deductions in terms of lost tax revenue. 152 Much larger is the exclusion for employer contributions to health care, but this deduction is unlikely to be altered in the near future. 153 Under the Joint Committee on Taxation's report, Estimates of Federal Tax Expenditures For Fiscal Years of 2009-2013, the medical deduction represents an expenditure of $76.7 billion. 154 Note that the expenditure for the years 2009-2013 for exclusion of employer contributions for health care is projected at $568.3 billion. 155 With the budget deficit projected to average more than $1 trillion per year until 2019, 156 every bit of revenue counts. According to the Congressional Budget Office, President Obama's limits on itemized deductions, coupled with other minor tax adjustments, will reduce the deficit by $2 billion in 2010, $11 billion in 2011, $29 billion in 2012 and by increasing amounts in the following years. 157

In order to better understand the true cost of the medical deduction, it is helpful to consider the deduction in relation to its outlay equivalent. 158 For ex-

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152. See Auerbach & Gale, supra note 1, at 121 ("[I]n proposing to finance new healthcare spending with income tax increases on high-income households and improved tax compliance, rather than by curtailing or transforming the employer deduction for health insurance premiums, the administration has promised away billions of potential revenue gains that could otherwise have been used for deficit reduction, leaving fewer options for deficit reduction on the table.").

153. Id.

154. A tax expenditure analysis is not precisely the same as a revenue analysis, as "tax expenditure calculations do not incorporate the effects of the behavioral changes that are anticipated to occur in response to the repeal of a tax expenditure provision. Second, tax expenditure calculations are concerned with changes in the reported tax liabilities of taxpayers." See STAFF OF J., supra note 4. In addition, tax expenditures may underestimate "the cost of a direct spending program alternative because they do not account for the fact that an equivalent spending program would frequently produce income that would itself be subject to tax." See Burman et al, supra note 4.

155. See STAFF OF J, supra note 4

156. See Auerbach & Gale, supra note 1.


158. An outlay equivalent refers to the cost of achieving the same policy goal were the govern-
ample, in 2004, the revenue loss of the medical deduction was $6.34 billion, but analysts have estimated an outlay equivalent of $6.91 billion, and thus the ratio of outlay equivalent to revenue loss was only 1.09, a ratio lower than that for charitable contributions (1.42), the child credit (1.33), and the pension contribution and earnings deduction (1.19). Thus, the medical deduction may, at least according to some standards, be relatively cost-effective.

1. Does O'Donnabhain Expand the Medical Deduction, and If So, How Much?

Under its narrowest interpretation, O'Donnabhain authorizes the deduction of sexual reassignment surgery and hormone replacement therapy for taxpayers diagnosed with GID for whom such treatment would be appropriate. Hormone therapies for transgender individuals generally do not exceed $1,000 annually and are more frequently less than half that amount. Sexual reassignment surgery, however, can range from $5,000 to over $100,000, depending on the type of surgery. What constitutes sexual reassignment surgery can vary depending on the needs of the individual. Many individuals, however, are precluded from seeking any type of medical transition because of the prohibitive social or economic costs. Of course, only an individual who undergoes surgery will be able to claim it as a medical deduction.

According to the IRS figures from fiscal year 2008, 48,167,223 people itemized their deductions in 2009. There have been few large-scale studies of the incidence of transgenderism in general populations. However, for the purpose of argument let us estimate that roughly one per 30,000 adult males and one per 100,000 adult females seek sex reassignment surgery, the findings of a study of the incidence of transgender individuals in the Netherlands. Generously estimating to finance the practice through direct outlays.

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Id.


See Dean Spade, Resisting Medicine, Re/modeling Gender, 18 BERKELEY WOMEN’S L.J. 15, 18 (2003) ("In a context in which medical care remains inaccessible to most - and particularly to low-income--gender transgressive people, where medical care associated with sex reassignment is still doled out through gender-regulating processes that reinforce oppressive and sexist gender binaries, and where, because of these circumstances and others, many gender transgressive people will choose not to or be unable to access medical care associated with their gender identity."); see also Jerry L. Dasti, supra note 157, at 1758 ("While sex-reassignment surgery is almost always a prerequisite to a legal recognition of one’s chosen sex and gender, the high cost of this treatment makes it inaccessible to many lower- and middle-class transsexuals.").

AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
mating the overall incidence at one in 50,000 people results in approximately 963 current itemizers taking the medical deduction. Multiplying the amount of O'Donnabhain’s deduction ($5,679) by the above approximate estimate of the population of itemizers who may transition, we reach a total deduction of $5,470,833. Ultimately, this is a negligible cost to bring IRS policy in line with the medical consensus. Further, it is important to note when considering these figures that some individuals who are able to itemize and can afford surgery may choose not to for personal or political reasons.

The possibility of greater revenue loss lies in the potential expansion of deductibility to other conditions that occur more frequently than GID, conditions which may necessitate a type of surgical intervention that is equally or more expensive. The O'Donnabhain lead opinion authorizes a deduction for a surgery that arises out of what the court determines to be a mental condition, deeming O'Donnabhain’s surgery medically necessary even though it altered tissue that was functioning “normally.” This raises the issue of the slippery slope, insomuch as determining that the surgery is not cosmetic under § 213(d)(9)(B) could open the door to a wide variety of previously foreclosed surgical interventions. However, the court does not allow O'Donnabhain’s deduction for her breast augmentation. O'Donnabhain only authorizes sexual reassignment surgery and hormone replacement. As may be obvious, taxpayers who do not identify as transgender will not immediately seek sexual reassignment surgery or hormone treatment as a result of this decision. However, it is important to consider the wider implications of the decision as it authorizes care for a condition with unknown etiology.

It is unlikely O'Donnabhain will serve as precedent to authorize medical deductions that are not already covered, aside from specifically transgender care. Though commentators have stated that the decision may open the door for mental conditions with unknown causes, in reality the IRS already allows deductions for treatment of a variety of mental conditions, the exact causes or sources of which are in large part undetermined or at least at question within the medical community. Taking Attention Deficit Hyperactivity Disorder as an example, it is highly likely that the IRS would not appeal the deduction of this care if it were prescribed by a physician and accepted as medically necessary with the level of consensus that currently applies to GID diagnosis and treatment.

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DSM IV-TR 579 (4th ed. 2000) (“There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.”).

165. Note that this discounts what may be significant statistical differences as a result of age, background, culture, and the differences in cost of female-to-male procedures.


The current tax scheme already allows deductions for surgical treatment for conditions that have an element of mental health in play. Take, for example, the deduction for physician-recommended surgical intervention for obesity. The difference in that case is that while obesity may be seen as an inherently unhealthy physical condition that requires medical intervention regardless of the cause, GID is still considered by many individuals (including, as the opinions demonstrate, a number of judges on the Tax Court) to be a "delusion"—a psychological problem which can only be treated by altering brain chemistry somehow, as Judge Gustafason argues in his opinion.168

Regardless of individual opinions about GID or the unknown origins of the condition, the record in O'Donnabhain and greater scientific literature on the whole demonstrate that GID can have deleterious effects if untreated.169 But once the Tax Court has authorized deduction for a surgical treatment for a condition with unknown origins, where will the line be drawn? Could an individual suffering from low self-esteem due to their short stature or unattractive features claim the same type of medical necessity?

The difference between these two scenarios lies in what constitutes health, medical care, and disability. Take an individual with a short stature, for example. If someone with an otherwise "normal" body suffers from a condition which has deformed the bottom half of their legs, a physician may prescribe a type of surgery which could have the effect of increasing the patient's height. Note that this would explicitly not constitute a "deformity" under the language in § 213(b)(9)(A) and therefore not be deductible. Nonetheless, it is conceivable that an individual who is 5'2" may suffer extreme mental anguish and distress at not being four or five inches taller. If this individual exhibits symptoms of body dysphoria, does O'Donnabhain open the door to deducting a heightening procedure?

The answer is no, at least not in the foreseeable future under the current tax code. First, it is likely that courts will stick to the medical care language and shy away from the cosmetic exclusion problem. Thus, in order for care to be deductible, it must be primarily medical care rather than cosmetic treatment that has a medical benefit. Secondly, though GID's exact etiology is uncertain, it is confined to a distinct group of individuals. It is highly unlikely that an individual who does not suffer from GID will derive potential benefit from undergoing treatments advocated by the Benjamin Standards. The Tax Court will be extremely hesitant to read into O'Donnabhain deductions for treatments that are not confined to a particular and small minority of individuals.

Thus, the next question is whether the deduction for sexual reassignment surgery is somehow different because it alters otherwise healthy tissue. In reality, the IRS already authorizes deductions for sterilization, which undoubtedly is the cutting of otherwise healthy tissue, for which the taxpayer need not demon-
strate the existence of any particular disease or mental condition. The door has already been opened to the deduction of procedures that alter the “normative” function of the human body, and to draw a bright line around a condition that has consensus as legitimate within the medical community solely as a result of transphobia has no merit.

While the economics relating to the transgender population are quantifiable, the wider effects of *O'Donnabhain* remain to be seen, though they point in the direction of a negligible economic burden. An inquiry into the purpose of the medical deduction may be helpful, but as the differing interpretations of the judges illustrate, purpose is not so easily ascertained. As evidenced by the multiple opinions in *O'Donnabhain*, the legislative history can be viewed in a variety of different ways, and the evolution of case law is not dispositive. Though the legislative history states that “[t]he primary rationale for allowing an itemized deduction for medical expenses is that ‘extraordinary’ medical costs—those over a floor designed to exclude predictable, recurring expenses—reflect an economic hardship, beyond the individual’s control, which reduces the ability to pay Federal income tax,” should this apply proportionally across all income brackets? Is the itemized deduction for medical expenses still serving its purpose if it is more regularly employed by wealthy people? Issues of horizontal and vertical equity arise.

The deduction generally benefits the poor (when they have catastrophic medical expenses) and the wealthy, with decreasing utility for those in the middle tax brackets. The 2008 IRS numbers demonstrate that a deduction for physical treatment of mental conditions will reflect the economic limitations of the itemized deduction. Given the recent decision, the effect on the general tax base remains to be seen. In the next section I will discuss potential effects on the population at whom the decision is most directly targeted: transgender (or, to use a more inclusive term, gender non-conforming) individuals.

**B. Implications for Transgender Individuals**

1. **Recognition in the Law, But at a Cost**

*O'Donnabhain* demonstrates the language that courts regularly employ to deconstruct the gender identity of transgender plaintiffs. The Findings of Fact section contains a great deal of detail concerning petitioner’s history and expe-
rience with GID and notes that she “was born a genetic male with unambiguous male genitalia” and “first wore women’s clothing secretly around age 10.”

While O’Donnabhain “earned a degree in civil engineering, served on active duty with the U.S. Coast Guard, found employment at an engineering firm, married, and fathered three children . . . her discomfort with her gender persisted.”

The language of the court mirrors that of the publicity promulgated by Gay and Lesbian Advocates and Defenders (GLAD), the non-profit legal organization representing O’Donnabhain in the case. By the time O’Donnabhain finally decided to begin the formal process of transitioning to living as a woman, she “was focused all the time on the strong feeling that she was in the wrong body. Her suffering made forming social relationships difficult, affected interactions with her family, and occupied her constantly.”

The court cites the oft-repeated trope that O’Donnabhain was “trapped in the wrong body,” language put forward by O’Donnabhain’s own advocates and likely strategically chosen for its accessibility for the non-trans population.

This type of language has been criticized by commentators as enforcing a binary concept of gender in which an individual cannot be considered truly “transgender” unless they conform to a strict definition of what constitutes female or male. This critique stems from the treatment of transsexuals in the 1960s and 1970s, when individuals were not considered appropriate “candidates” for surgical transition unless they would be both conventionally attractive and heterosexual in the gender to which they were transitioning. As the Holmes dissent notes, some second wave feminists even argued that transgenderism itself was a social construct that reinforced patriarchy.

Unlike the earlier commentators quoted by Judge Holmes, more current critical gender theorists note that the recognition of such a construction on an individual level does not inherently enforce it, what enforces static gender norms is the assumption on the part of larger social forces that there is only one way to be appropriately transgender. Thus, scholars argue, it is the freedom to define transgenderism on an individual level that represents a true step forward.
Presenting O'Donnabhain as not truly "female" unless she possesses a vagina and other particular physical characteristics not only erases the existence of intersex individuals (estimated between one in 100 and one in 2000 infants),\(^{183}\) but also those who choose to, or must as a result of economic or medical factors, live outside of the framework that determines gender as a result of genital configuration. Critics may argue that all judicial inquiries into medical necessity require deconstructing the body of the plaintiff in order to determine whether the medical care sought is truly necessary. Yet the contemptuous nature of the opinions calls into question whether the decision falls on the side of supporting transgender plaintiffs or ridiculing their transformations.

2. Economic Realities: The Medical Model of Transition is Prohibitively Expensive

A wide variety of reasons may impact whether or not an individual medically transitions. From a social perspective, there is a parallel to behavioral expressions of sexuality.\(^{184}\) Expression of sexuality and gender identity are dependent on a wide variety of factors such as religion, culture, family structure, geographic location, etc. As the WPATH Benjamin Standards of Care note:

Access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion, there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized.\(^{185}\)

Some transgender individuals have the opportunity to medically transition "fully" under the medical model and others, for whatever reasons, cannot even entertain the possibility that transgender people exist. While examinations of the forces affecting these personal decisions have filled countless volumes, incredible pressure exists from the outside world to conform in both appearance and physical structure to the cultural norms of either "male" or "female." Transgender people may be the subject of aggression and violence as a result of their non-conforming identities.\(^{186}\)


\(^{185}\) Meyer III et al., *supra* note 72.

For individuals whose gender does not correlate to their assigned sex at birth and who have access to the medical establishment, there exists a developing model, referenced at length in the opinion, to address the "discord" between gender identity and biological sex. The medical profession has legitimized GID by recognizing it in the Diagnostic and Statistical Manual of Mental Disorders (the manual through which the American Medical Association catalogs mental conditions), and there is a relatively widely accepted treatment plan. It appears that the best legal strategy for litigants may be to ignore the diverse array of combinations of gender identity and biological sex that exist within the umbrella category of transgender. As demonstrated by the concurrences in O'Donnabhain, those 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. Yet, courts should not invalidate the medical reality of severe depression because certain individuals can exercise and temporarily suppress their symptoms, just as they must not dismiss medical treatments of schizophrenia when certain patients respond well to homeopathic medicines. In the same way, courts must not deny recognition of transgender medical care due to the diversity of approaches to medical care within the transgender community.

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. In this case, as in many others involving the legal rights of non-conforming individuals, it is the job of the legal advocate to convince a panel likely comprised of highly privileged, Caucasian, heterosexual, gender-conforming men that their client is deserving of recognition. Title VII has made some headway in protecting gender non-conforming behavior, but the Supreme Court has only implicitly addressed how gender identity may fall into Title VII's protections. Does it pay to engage the courts in a dialog which offers the possibility that gender is not inextricably tied to birth sex? It is unlikely to be successful at the current stage in the law, and it certainly would not have been in the case at hand.

Finally, O'Donnabhain may further aggravate the specific effects of wealth

187. Note that many of these nonprofits "have traditionally focused on concerns central to the lives of nonpoor lesbian and gay people and have ignored the most pressing issues in the lives of poor people, people of color, and transgender people." Dean Spade, Compliance is Gendered, in TRANSGENDER RIGHTS, supra note 178.

188. See Frontiero v. Richardson, 411 U.S. 677, 684 (1973) (noting that explicit discrimination against women in legal opinions "was rationalized by an attitude of 'romantic paternalism' . . . As a result of notions such as these, our statute books gradually became laden with gross, stereotyped distinctions between the sexes.").

189. See Price Waterhouse v. Hopkins, 490 U.S. 228, 251 (1989) ("An employer who objects to aggressiveness in women but whose positions require this trait places women in an intolerable and impermissible catch 22: out of a job if they behave aggressively and out of a job if they do not. Title VII lifts women out of this bind.").
disparities within transgender communities, where access to surgical transition is seen (and experienced by many) to be not only medically necessary but also the mark of social acceptance into the target gender. The economic dynamics of itemized deductions may thus reinforce a correlation between wealth and "true" transsexuality. In addition to the complaint that the itemized deduction may unfairly benefit the wealthy, there may be an inherent disincentive to itemize because of the difficulty of itemization. Determining what can and what cannot be itemized can be a complicated process for individuals unfamiliar with the tax code.

This decision may provide a tax incentive for individuals who can already afford to purchase surgeries, further encouraging the divide between wealthy, "real" transsexuals and individuals of a lower socioeconomic class who cannot, for economic reasons, attain an ideal surgical transition.

**CONCLUSION**

If *O'Donnabhain* is interpreted to significantly broaden the current boundaries of the medical expense deduction by allowing the deduction of medical care for mental conditions currently not covered by the medical expense deduction, the effects on tax revenue may be significant. However, I argue that *O'Donnabhain* will not significantly widen the pool of deductible medical care outside of sexual reassignment surgery and hormone therapy.

For individuals seeking those treatments and for the transgender community as a whole, *O'Donnabhain* represents an important step forward in the legal recognition of the transgender experience. Though the long-term effects of *O'Donnabhain* remain to be seen, the decision brings IRS policy into alignment with the current medical consensus: GID is a legitimate condition, the treatment of which may in certain cases medically necessitate sexual reassignment surgery and hormone therapy. Though the economic disparities in access to medical care and the disproportionate use of the itemized deduction will narrow the population of individuals who may take advantage of the deductibility (and may consequently enforce a homogeneous, medicalized model of the "ideal" transgender body), the case remains an important victory for those seeking to deduct expenses incurred in the treatment of GID.

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190. The term "transsexual" generally refers to individuals who have undergone both hormone treatment and sexual reassignment surgery. This is in contrast to the term "transgender," an umbrella term that includes gender non-conforming individuals along an array of medical intervention plans. See Dallas Denny, *Transgender Communities of the United States in the Late Twentieth Century*, in TRANSGENDER RIGHTS, supra note 178.