

“I Do Not Suffer from Gender Dysphoria. I Suffer from Bureaucratic Dysphoria”:¹

An Analysis of the Tax Treatment of Gender Affirmation Procedures Under the Medical Expense Deduction

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INTRODUCTION

On March 24, 2018, the Trump Administration announced a policy banning

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1. Paisley Currah, “The Transgender Rights Imaginary,” 4 *Georgetown Journal of Gender and the Law* 705, 717 (2003) (quoting testimony from *City Council of New York, Transcript of the Minutes of the Committee on General Welfare*, 195 (4 May 2001)).

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some transgender people from serving in the military. Rather than issuing a blanket ban, the Department of Defense (DOD) recommended banning “[t]ransgender persons with a history or diagnosis of gender dysphoria . . . [and those] who require or have undergone gender transition.”² DOD used “gender dysphoria,”³ a psychological diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), to justify banning transgender people from the military in a way that is not overtly transphobic, as the disqualification “is consistent with the Department’s handling of other mental conditions that require treatment.”⁴

DOD’s policy is one example of the negative effects inherent in pathologizing gender-affirming medical procedures for transgender people. While pathologization starts with the DSM-V and the American Psychological Association, it is reinforced and legitimized by the U.S. tax system. Tax law is generally thought of as a neutral body of law serving to make objective decisions about government revenue sources.⁵ However, tax law is not insulated from normative, value-based decision making. While tax judges and tax attorneys are required to be specialists, they must thoughtfully consider the full range of social implications of their decisions and arguments. In addition, “[t]he growing critical tax literature highlights the many ways in which the tax laws are used to reinforce majoritarian norms and form an integral part of the complex web of subordination in American society along lines of race, ethnicity, gender, sexual orientation, marital status, and disability.”⁶

The United States Tax Court’s decision in *O’Donnabhain v. Commissioner* serves as a prime example of this phenomenon.⁷ In *O’Donnabhain*, the court granted a medical expense deduction for O’Donnabhain’s vaginoplasty and hormone therapy based on her diagnosis of Gender Identity Disorder (GID) and the court’s own normative evaluation of what a female-sexed body should look like.⁸ Thus, in order to circumvent a discussion of whether tax law recognizes medical care costs if they are informed by personal choice, the court legitimized the pathologization of transgender persons.

However, this Article argues that medical expenses associated with transition should be deductible regardless of psychological diagnosis or normative ideals of sexed bodies. The reliance on diagnosis and subjective ideas of sexed

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2. Jim Mattis, “Military Service by Transgender Individuals,” *Memorandum from the Secretary of Defense to the President*, 2 (22 Feb. 2018), <https://perma.cc/U58C-LR93>.
 3. The DSM-V’s first diagnostic criteria for gender dysphoria in adults is “[a] marked incongruence between one’s experienced/expressed gender and assigned gender,” of at least six months’ duration. “What is Gender Dysphoria?” *American Psychological Association*, <https://perma.cc/Q3W5-BC6C>.
 4. “Military Service by Transgender Individuals,” note 2, at 5.
 5. Anthony Infanti, “LGBT Taxpayers: A Collision of Others,” 13 *Georgetown Journal of Gender and the Law* 1, 15 (2012) (noting that “many see tax as an exceptional area of the law that should be above the fray of the so-called culture wars”).
 6. *Id.* at 36-37.
 7. *O’Donnabhain v. Commissioner*, 134 T.C. 34 (2010).
 8. *Id.*

bodies reinforces the pathologization of transgender people while also reinforcing and policing the gender binary. Part I lays out the current state of the law regarding medical expense deductions. Then, Part II explains the medical model of transgender identity, wherein transgender individuals are diagnosed with GID in order to access gender confirming medical care. Part III, using *O'Donnabhain v. Commissioner* as an example, details the tax court's application of the medical expense deduction to gender confirmation procedures, as well as its treatment of transgender taxpayers. Part IV argues that the current application of the medical expense deduction to transgender taxpayers furthers the stereotype that transgender people are abnormal and suffer from a medical condition that must be corrected. Lastly, Part V questions the disparate treatment of transgender taxpayers, who are required to validate their gender identity in order to access the medical expense deduction, unlike cisgender taxpayers. The Article concludes by finding that pathologization of transgender taxpayers will only end when the Tax Court employs a new line of reasoning in granting medical expense deductions—one that does not rely upon the medicalization of transgender identities.

I. THE STATE OF THE LAW

The medical expense deduction is codified under Section 213 of the Internal Revenue Code (“the tax code”) and is a form of itemized deduction.⁹ Taxpayers can deduct “the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent.”¹⁰ Section 213 defines “medical care” 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.”¹¹

Taxpayers can only deduct expenses that exceed 7.5 percent of their gross income.¹² Itemized deductions are predominantly used by taxpayers of higher incomes.¹³ In 2013, 29.6 percent of individual returns took itemized deductions.¹⁴ The Joint Committee on Taxation estimates that in 2017 approximately 62 percent of taxpayers making between \$100,000 and \$200,000 itemized their deductions and approximately 13 percent took a medical deduction.¹⁵ Of the 9,942,000

9. I.R.C. § 213(a) (2017).

10. *Id.*

11. I.R.C. § 213(d)(1)(A).

12. I.R.C. § 213(f)(2).

13. Chenxi Lu, “Itemized Deductions,” *Tax Policy Center* (27 Jan. 2017), <https://perma.cc/Y6GX-VRPJ> (“In 2014, more than 90 percent of households reporting adjusted gross income (AGI) over \$500,000 chose to itemize, compared to fewer than half of those with AGI between \$50,000 and \$100,00 and only 7 percent with AGI under \$30,000.”). Lu also notes that “[m]ost taxpayers choose the standard deduction because it is larger than the deductions they can itemize.” *Id.*

14. “SOI Tax Stats – Tax Stats at a Glance,” *Internal Revenue Service* (18 May 2018), <https://perma.cc/FGV5-9YNT>.

15. “Estimates of Federal Tax Expenditures for Fiscal Years 2016-2020,” *Joint Committee on Taxation*, 44-45 (30 Jan. 2017) (noting that of the 28,584,000 taxpayers with an income between \$100,000 and \$200,000, 17,844,000 itemized their deductions, 2,308,000 of which

taxpayers making over \$200,000, approximately 90 percent itemized their deductions and approximately 3 percent took a medical deduction.¹⁶ Under the Trump Administration’s “Tax Cuts and Jobs Act of 2017,” the number of taxpayers taking itemized deductions is likely to decrease because the Act increases the standard deduction to \$12,000 for individuals.¹⁷ Meaning, the number of medical expense deductions is also likely to decrease.

Section 213(d)(1)(A) provides two prongs of expenditures that are deductible as “medical care”: (1) medical expenses that are medically necessary or (2) expenses that more generally affect the body. Section 213(d)(9) then excludes cosmetic surgery from health care expenses deductible as medical care. The tax code 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.”¹⁸ But deductions for cosmetic surgery are permitted if “the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury arising from an accident or trauma, or disfiguring disease.”¹⁹

Put together, these provisions mean that the tax code allows deduction of expenses for (1) care that is medically necessary, including medically necessary cosmetic surgery but excluding purely cosmetic procedures, and (2) care that affects any structure or function of the body, but again excluding purely cosmetic surgery. In order to claim a medical expense deduction, the taxpayer must prove that their procedure satisfies the definitional requirements of at least one of these two prongs.

To seek a deduction under the first prong—that is, to show that expenses are medically necessary—a taxpayer must prove: (1) “the present existence or imminent probability of a disease, defect or illness” and (2) “a payment for goods or services directly or proximately related to the diagnosis, cure, mitigation, treatment, or prevention of the disease.”²⁰ This test emphasizes the need for a medical diagnosis of a disease. Under its logic, even though the taxpayer may choose not to undergo treatment, the expense is deductible when the choice—unlike the choice to have a purely cosmetic surgery—hinges on a medical diagnosis of a condition *requiring* medical attention. The code’s definition of

took a medical deduction).

16. *Id.* (noting that of the 9,942,000 taxpayers with an income over \$200,000, 8,974,000 itemized their deductions, 296,000 of which took a medical deduction).
17. See “Trump Tax Plan: The Key Points from the Final Bill,” *The Guardian* (19 Dec. 2017), <https://perma.cc/KKJ2-N85P>. For a taxpayer to itemize their deductions rather than take the standard deduction, their total itemized deductions must be more than the standard deduction. “Topic Number 501: Should I Itemize?” *Internal Revenue Service* (31 Jan. 2018), <https://perma.cc/6R5B-4FQB> (recommending that taxpayers “itemize deductions if [the] allowable itemized deductions are greater than [the] standard deduction”).
18. I.R.C. § 213(d)(9)(B).
19. I.R.C. § 213(d)(9)(A).
20. *O’Donnabhain*, 134 T.C. at 50 (quoting *Jacobs v. Commissioner*, 62 T.C. 813 (1974)) (internal quotations omitted).

“disease” also extends to mental conditions.²¹ A mental health condition is a “disease” if there is: (1) a determination by a mental health professional that the condition created a significant impairment to normal functioning, warranting treatment, or (2) the condition is listed in a medical reference text.²²

The second prong of deductible medical expenses includes those relating to procedures or surgeries “for the purpose of affecting any structure or function of the body.”²³ Under this category, “the taxpayer must ‘prove *both* that the expenditures were an essential element of the treatment *and* that they would not have otherwise been incurred for nonmedical reasons.’”²⁴ The requirement that the taxpayer show the expenses would not have been incurred for nonmedical reasons makes this category of deductible expenses a hybrid of voluntary (non-deductible) “cosmetic surgery”, and the “medically necessary” prong, which concerns expenses the code frames as involving little to no choice. The “structure or function” prong falls somewhere between those two poles because no bright line rule exists for how much a taxpayer’s personal choice can play into a surgery or procedure before the expenses from it are no longer deductible. The clearest example of the hybrid nature of this medical expense category is the IRS’s allowance of deductions for procedures regarding the sexed body and reproduction,²⁵ including contraception, abortion, and vasectomies.²⁶

21. Id. (noting that “it has also long been settled that ‘disease’ as used in section 213 can extend to mental disorders”).

22. Id. at 59.

23. I.R.C. § 213(d)(1)(A).

24. *O’Donnabhain*, 134 T.C. at 50 (quoting *Jacobs v. Commissioner*, 62 T.C. 813 (1974)).

25. Additionally, “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.” Lauren Herman, “A Non-Medicalized Medical Deduction?: *O’Donnabhain v. Commissioner* & the I.R.S.’s Understanding of Transgender Medical Care,” 35 *Harvard Journal of Law & Gender* 487, 513 (2012).

26. Revenue Ruling 73-603, 1973-2 C.B. 76 (1973) (holding that expenses for legal vasectomies, abortions, and tubal ligations “at the taxpayers’ own request” are “for the purposes of affecting a structure or function of the body” and are therefore deductible); Revenue Ruling 73-200, 1973-1 C.B. 140 (1973) (holding that “the cost of birth control pills prescribed by a physician qualifies as a medical expense”).

For example, in *Kozlowski v. Commissioner*, the court rejected a married couple's attempt to deduct the cost of their son's adoption as a medical expense under Section 213, distinguishing adoption costs from the expense of elective abortion.²⁷ The court reasoned that "childbirth, abortion, and contraception medical expenses" are deductible as a logical consequence of allowing deductions of most medical expenses because "[s]uch expenses involve the physical welfare of the woman and deduction of attendant medical expenses advances the Congressional effort to enhance public health and morale."²⁸ Childbirth, abortion, and contraception, like adoption, inherently involve personal choices as to if, when, and how a taxpayer decides to reproduce. But, unlike adoption, these choices are made in a medical context. The court evaded the question of whether expenses are deductible when a taxpayer's personal choices alone necessitate medical care by focusing its reasoning on a person's physical welfare. In short, the tax court was comfortable allowing deductions for abortions without addressing what degree of personal choice invalidates the medical necessity of a procedure for Section 213 purposes by emphasizing that abortions concern a person's physical health.²⁹

The IRS also addressed the issue of elective abortion in IRS Revenue Ruling 73-201. The IRS found that an elective abortion is deductible under Section 213 because "the operation . . . is deemed to be for the purpose of affecting a structure or function of the body."³⁰ In the same revenue ruling, the IRS explained that the medical expense deduction is "confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness."³¹ Rather than requiring a taxpayer to prove that an abortion is "medically necessary," the IRS avoided a controversial topic by focusing on the second prong of deductible medical expenses.

II. THE MEDICAL MODEL OF TRANSGENDER IDENTITY

The American Psychiatric Association updated the Diagnostic and Statistical Manual (DSM) in 2013 by publishing the DSM-V, which replaced the previous condition of "Gender Identity Disorder" (GID) with "Gender Dysphoria."³² Gender dysphoria and the DSM exist within a medical model that frames "gender nonconformity . . . as a psychological condition most appropriately treated through medical services."³³ Further, this model "relies upon medical evidence—both in the form of psychological diagnoses and physical treatments such as hormone

27. *Kozlowski v. Commissioner*, T.C. Memo. 1979-176 (U.S. Tax Court 1979).

28. *Id.*

29. *Id.*

30. Revenue Ruling 73-201, 1973-1 C.B. 140 (1973).

31. *Id.*

32. "From Planning to Publication: Developing DSM-5," *American Psychiatric Association* (8 Nov. 2018), <https://perma.cc/8A9P-6LKD>.

33. Franklin Romeo, "Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law," 36 *Columbia Human Rights Law Review* 713, 718 (2005).

therapy and gender-related surgeries—in order to establish gender transgressions as legitimate and therefore worthy of recognition and protection under the law.”³⁴

Harry Benjamin is credited with founding the modern medical model in 1966 with his psychological definition of “transsexualism.”³⁵ In 1979, the Harry Benjamin International Gender Dysphoria Association developed the prevalent “Benjamin standards” based on his work.³⁶ The standards “are widely accepted in the psychiatric profession, as evidenced by the recognition of the standards’ triadic therapy sequence as the appropriate treatment for GID.”³⁷ The triadic therapy sequence involves psychotherapy, hormone therapy, and then what is traditionally termed “sex reassignment surgery.” The standards are “noteworthy because [they] first introduced the still prevalent notion that demand for gender-related surgery is a central signifier of transsexualism.”³⁸ The triadic therapy sequence and the reliance on the demand for gender-related surgery fit into Benjamin’s conclusion that “in general, psychotherapy was often sufficient for milder cases of transsexuality, whereas surgical and hormonal interventions were necessary for more severe cases.”³⁹

Today, the Harry Benjamin International Gender Dysphoria Association is called the World Professional Association for Transgender Health and the organization continues to develop and publish medical standards of care for the health of transsexual, transgender, and gender-nonconforming people.⁴⁰ The standards “set forth the eligibility criteria that patients must meet in order to obtain certain kinds of treatment.”⁴¹ These eligibility criteria center on ensuring the authenticity of the patient’s transgender identity. For instance, before undergoing genital surgery, the standards require that the patient have “12 continuous months of living in a gender role that is congruent with their gender identity.”⁴² In order to access gender-affirming medical procedures, a transgender person must obtain certification from a mental-health provider, which is generally predicated upon these guidelines.⁴³

The prevalence of the medical model means that the ability of transgender

34. *Id.* at 724.

35. See Alvin Lee, “Trans Models in Prison: The Medicalization of Gender Identity and the Eighth Amendment Right to Sex Reassignment Therapy,” 31 *Harvard Journal of Law & Gender* 447, 452 (2008) (“The medical model of trans identity as it is understood today was largely originated by Harry Benjamin, an American endocrinologist who first defined transsexualism as a mental syndrome in 1966.”).

36. See “History of the Association,” *World Professional Association for Transgender Health* (28 Oct. 2018), <https://perma.cc/387L-FN3P>; “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7,” *World Professional Association for Transgender Health* (28 Oct. 2018), <https://perma.cc/Q4F6-VVE2>.

37. *O’Donnabhain*, 134 T.C. at 65.

38. Lee, note 35, at 452.

39. *Id.* at 452-53.

40. “History of the Association,” *WPATH* (28 Oct. 2018), <https://perma.cc/387L-FN3P>.

41. Lee, note 35, at 454.

42. “Standards of Care,” note 36.

43. See Jonathan Koenig, “Distributive Consequences of the Medical Model,” 46 *Harvard Civil Rights-Civil Liberties Law Review* 619, 624-25 (2011).

people to access gender-affirming procedures is dependent on a diagnosis of GID or gender dysphoria. The focus on gender dysphoria and medicalization requires that a transgender taxpayer experience cross-gender discomfort.⁴⁴ That occurs when, for example, a person assigned female at birth experiences dysphoria due to his male gender identity.

Of course, transgender people themselves play into this normative narrative if and when they seek out a gender dysphoria diagnosis to access medical care. This is due to the fact that the medical model is the prevalent discourse for providing transgender people with access to medical interventions.⁴⁵ At some level there is a contradiction inherent in the way transgender people interact with the dysphoria narrative in order to access medical care. As the transgender activist Chase Strangio has written, “[i]ndividual trans people and advocacy movements have utilized those narratives but have, at the same time, critiqued the ways transgender identity and experience have been medicalized and how the processes for accessing health care force us as trans patients and advocates to reproduce the very pathologizing discourses of trans experience that we critique.”⁴⁶ The tax court’s focus on the medicalization of GID is not entirely a function of its views; it is also a consequence of the narrative used by trans-rights advocates.

III. TREATMENT OF TRANSGENDER TAXPAYERS

The tax court confronted the question of the deductibility of gender affirmation procedures as medical expenses in *O’Donnabhain v. Commissioner*. The resulting decision reifies the gender binary and undermines the complexity and fluidity of trans narratives. The court centered its analysis on whether Ms. O’Donnabhain’s gender affirmation procedures qualified as medically necessary or as unnecessary cosmetic surgery. While the court found that some of her gender affirmation procedures were non-cosmetic and medically necessary, the reasoning behind the decision reinforced normative ideals of gender performance and the gender binary, in addition to situating transgender people as not normal.⁴⁷

The plaintiff in *O’Donnabhain*, Rhiannon O’Donnabhain, was a transgender

44. Dean Spade, “Resisting Medicine, Re/Modeling Gender,” 18 *Berkeley Women’s Law Journal* 15, 28-29 (2003) (“The medical approach to our gender identities forces us to rigidly conform ourselves to medical providers’ opinions about what ‘real masculinity’ and ‘real femininity’ mean, and to produce narratives of struggle around those identities that mirror the diagnostic criteria of GID.”).

45. Romeo, note 33, 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. . . . [C]ourts have looked to the medical model as a way of legitimizing certain gender nonconformity.”).

46. Chase Strangio, “Can Reproductive Trans Bodies Exist?” 19 *City University of New York Law Review* 223, 225-26 (2016).

47. See Alesdair H. Ittelson, “Trapped in the Wrong Phraseology: *O’Donnabhain v. Commissioner*—Consequences for Federal Tax Policy and the Transgender Community,” 26 *Berkeley Journal of Gender, Law & Justice* 356, 366 (2011) (“The opinion explicitly situates O’Donnabhain as outside the realm of ‘normal’ in order to justify her surgery as non-cosmetic.”).

woman diagnosed with Gender Identity Disorder (GID) by her therapist in 1996.⁴⁸ In 2001, O’Donnabhain filed her taxes and claimed a \$21,741 medical expense deduction for expenses related to therapy, vaginoplasty, breast augmentation, and hormone therapy, as well as travel and lodging related to her surgeries.⁴⁹ The IRS disallowed her deduction in a notice of deficiency because it found her procedures to be elective and cosmetic, leading O’Donnabhain to petition the IRS decision to the tax court.⁵⁰

The tax court’s decision focused on determining if O’Donnabhain’s gender-affirming procedures met the definition of “medical care” under Section 213(d)(1)(A). The majority opinion recognized that a medical expense is deductible if it meets either of two definitional prongs, the first covering costs for “diagnosis, cure, mitigation, treatment, or prevention of disease,” and the second covering costs “for the purpose of affecting any structure or function of the body.”⁵¹ However, the court only focused on the “disease” requirement under the first prong, holding that a deduction can only be applied to expenses incurred for “the prevention or alleviation of a *physical or mental defect or illness*.”⁵² Relying on *Jacobs v. Commissioner*,⁵³ the court required O’Donnabhain to show that she had a physical or mental disease and that the expenses she sought to deduct were “related to the diagnosis, cure, mitigation, treatment, or prevention of the disease or illness.”⁵⁴ In addition, O’Donnabhain had to pass a “but-for” causation test in which she had to prove that the costs were for necessary treatment and would not have been incurred but-for the disease.⁵⁵ She also had to prove that her gender-affirming procedures did not qualify as “cosmetic surgery” under Section 213(d)(9)(B).⁵⁶

The tax court found GID to be a disease, reasoning that it is “a widely recognized and accepted diagnosis in the field of psychiatry[,] . . . a serious, psychologically debilitating condition”⁵⁷ and that seven U.S. Courts of Appeals “have concluded that severe GID . . . constitutes a ‘serious medical need’ for

48. *O’Donnabhain*, 134 T.C. at 35-36.

49. *Id.* at 41-42 (“During 2001 petitioner incurred and paid the following expenses (totaling \$21,741) in connection with her hormone therapy, sex reassignment surgery, and breast augmentation surgery”).

50. See Petition to United States Tax Court, *O’Donnabhain v. Commissioner of Internal Revenue*, (U.S. Tax Court 2006).

51. *O’Donnabhain*, 134 T.C. at 49 (referring to the Senate Committee on Finance’s comments on the new deduction for medical expenses).

52. *Id.* (emphasis in original) (quoting § 1.213-1(e)(1) of the Income Tax Regulations).

53. 62 T.C. 813 (1974) (holding that costs related to petitioner’s divorce from his wife were not deductible under § 213 even though the divorce was recommended by petitioner’s psychiatrist to treat petitioner’s mental illness).

54. *O’Donnabhain*, 134 T.C. at 50.

55. *Id.*

56. 26 U.S.C. § 213(d)(9)(B) (“[C]osmetic surgery’ means 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.”).

57. *O’Donnabhain*, 134 T.C. at 61.

purposes of the Eighth Amendment.”⁵⁸ Additionally, relying on Benjamin standards of care,⁵⁹ the court held that “[h]ormone therapy, sex reassignment surgery and, under certain conditions, breast augmentation surgery are prescribed therapeutic interventions . . . for GID”⁶⁰ and as such are medically necessary treatments for GID.⁶¹ The court found that O’Donnabhain’s vaginoplasty and hormone therapy were deductible under the medical expense provision. However, while recognizing that breast augmentation is recommended by the Benjamin standards, the court found that O’Donnabhain’s breast augmentation was cosmetic surgery.⁶² The court reasoned that since two of O’Donnabhain’s doctors had determined she had developed “normal” breasts⁶³ from her hormone therapy, her breast augmentation was not medically necessary as a treatment for GID.⁶⁴

A. Gender Performance and *O’Donnabhain*

Seeking to avoid a decision based on O’Donnabhain’s personal choice, the tax court in *O’Donnabhain* relied on the medicalization of transgender identities. This medicalization reinforces the gender binary by policing proper gender performance: when a person’s actions and physical appearance indicate to others that they are male or female. For transgender people, in order to properly perform gender they need to pass as cisgender.⁶⁵ In a larger critique of the diagnosis of GID and gender dysphoria, Judith Butler explains that “[t]he diagnosis . . . wants to establish that gender is a relatively permanent phenomenon,” meaning that GID and gender dysphoria diagnoses require gender identity to be static and permanent.⁶⁶ A transgender person must prove to their therapist that they have always wanted to live as another gender and that they have a plan as to how they will do so. It is an either/or situation. The transgender person is either a man or a woman and has always been such even if they were “born in the wrong body.” Butler goes on to critique that to be diagnosed with GID or gender dysphoria, the

58. *Id.* at 62.

59. *Id.* at 66 (“The Benjamin standards are widely accepted in the psychiatric profession, as evidenced by the recognition of the standards’ triadic therapy sequence as the appropriate treatment for GID”); see also Herman, note 25, at 490 (describing the Benjamin standards as “recommend[ing] 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”).

60. *O’Donnabhain*, 134 T.C. at 65.

61. *Id.* at 70 (finding that only O’Donnabhain’s hormone therapy and vaginoplasty were not cosmetic).

62. *Id.* at 72.

63. *Id.* at 73; see also *id.* at 72 (the court quotes O’Donnabhain’s plastic surgeon’s presurgical notes, recording that she had “approximately B cup breasts with a very nice shape.”).

64. *Id.* at 73.

65. Spade, note 44, at 26 (“I have gathered that the favored indication of such ‘success’ seems to be the intelligibility of one’s new gender in the eyes of non-trans people. Because the ability to be perceived by non-trans people as a non-trans person is valorized, normative expressions of gender within a singular category are mandated.”).

66. Judith Butler, “Undiagnosing Gender,” in *Trans Rights*, 274, 279 (The University of Minnesota Press, 2006).

transgender person’s narrative cannot be centered around cultural acceptance:

[The transgender person’s narrative cannot be based on their belief] that the norms that govern what is a recognizable and livable life are changeable, and that within [their] lifetime, new cultural efforts [are] made to broaden those norms, so that people like [themselves] might well live within supportive communities as a transsexual, and that it [is] precisely this shift in the public norms, and the presence of a supportive community, that allowed [them] to feel that transitioning has become for [them] possible and desirable.⁶⁷

To be diagnosed, which is necessary to gain access to gender-affirming procedures and then to access the medical expense deduction, a transgender person cannot say that their gender identity evolved after taking a gender studies course in college and realizing that gender is a social construct based on performance.⁶⁸ To access the medical care they desire, they must create a narrative of being born transgender due to a sense of gender dysphoria—meaning a discomfort and anguish based on the incongruity between their sexed body and their internal sense of gender.⁶⁹

Requiring a dysphoria narrative also relies on the gender binary because it assumes that for a transgender person to feel comfortable in their body, they must necessarily want to undergo complete medical transition and present as either completely masculine or feminine. Further, “privileging and encouraging medical diagnosis 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.”⁷⁰ While cisgender people are able to perform gender in ways that challenge gender norms (for example women shaving their heads and wearing masculine clothing or men wearing make-up), transgender people are told by the medical model, and the tax system that reinforces it, that they are to perform gender in alignment with the normative binary. To exist outside the gender binary is to be seen as making a choice about gender identity and therefore not worthy of a medical expense deduction.

The *O’Donnabhain* court adhered to these binary gender norms in its discussion of the aesthetic qualities of O’Donnabhain’s breasts. The court examined medical notes discussing O’Donnabhain’s pre-surgery breasts and found that her surgeon described her breasts as “approximately B cup breasts with

67. Id.

68. See e.g. Spade, note 44, at 19 (noting that his experience “to obtain the medical intervention [he sought], [he] need[ed] to prove [his] membership in the category ‘transsexual’ to prove to the proper authorities that [he had] Gender Identity Disorder”).

69. *G.G. v. Gloucester County School Board*, 822 F.3d 709 (4th Cir. 2016), Brief of Amici Curiae the World Professional Association for Transgender Health, et al. in Support of Appellant, at 15 (“The distress can be exacerbated by external influences such as discrimination, stereotyping, and societal expectations, but it is the incongruence between one’s physical body and internal gender identity that drives gender dysphoria.”).

70. Herman, note 25, at 508.

a very nice shape.”⁷¹ Judge Halpern’s concurrence specifically called out the majority opinion’s discussion of O’Donnabhain’s presurgical breasts as “superfluous and potentially misleading.”⁷² He noted that the opinion takes O’Donnabhain’s surgeon’s statements out of context, and that “the primary purpose of the breast surgery was not to improve petitioner’s appearance but to assign her to the appropriate gender.”⁷³ The majority opinion did not need to discuss the aesthetic qualities of O’Donnabhain’s presurgical breasts. But in doing so, the court perpetuated norms about how a female-sexed body should look, finding that B cup breasts fit within those norms.

B. The Tax Court’s Disbelief of O’Donnabhain’s Transgender Identity

The tax court’s decision in *O’Donnabhain* demands a static existence for transgender taxpayers. Rather than justifying gender affirming procedures as a personal choice, transgender individuals must rely upon a psychological diagnosis that they cannot choose. In turn, the diagnosis requires those individuals to conform to the mainstream, medicalized trans narrative. As such, the court perpetuates and judicially legitimizes a narrative wherein being transgender is something that happens *to* a person rather than *is* that person’s identity. As Butler points out, a gender dysphoria diagnosis “requires that a life takes on a more or less definite shape over time; a life can only be diagnosed if it meets the test of time” because it requires one “to show that one has wanted for a long time to live life as the other gender.”⁷⁴ The medical diagnosis relied upon by the *O’Donnabhain* court feeds into this narrative by fueling the court’s suspicion of whether transgender taxpayers were in fact “born this way,” requiring probing questions into medical histories.⁷⁵

In *O’Donnabhain*, the court focused its opinion on O’Donnabhain’s medical history and her doctors’ notes. The decision does not fully account for O’Donnabhain as a person or her lived experience as a transgender woman. This is most apparent in the court’s analysis of O’Donnabhain’s breast augmentation, which is discussed in Part III.A. To begin, the court noted that “[t]he Benjamin standards provide that breast augmentation surgery for a male-to-female patient ‘may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.’”⁷⁶ The court then,

71. *O’Donnabhain*, 134 T.C. at 72.

72. *Id.* at 78.

73. *Id.* (quotations omitted).

74. Butler, note 66, at 279.

75. See e.g. Spade, note 44, at 21 (positing about his experience seeking chest masculinization: “Are women who seek breast enhancement required to answer these questions? Am I supposed to be able to separate my political convictions about gender and my knowledge of the violence of gender rigidity . . . from my real ‘feelings’ about what it means to occupy my gendered body?”).

76. *O’Donnabhain*, 134 T.C. at 72.

without relying on any documentation from O’Donnabhain, determined that her breasts were sufficient for her gender role. The court reached this decision despite the fact that O’Donnabhain chose to undergo breast augmentation, indicating she felt her breast development was insufficient for her to feel comfortable as a woman.

Indeed, much of the majority’s analysis regarding the medical necessity of hormone therapy and vaginoplasty was likely unnecessary.⁷⁷ However, this focus is characteristic of a larger societal expectation of knowing the details of a transgender person’s surgical history, as is the medical model.⁷⁸ And “[t]he belief that people have a ‘right to know’ the intimate details of a trans person’s medical history is reflected in the courtroom, where judges persist in asking questions about and documenting trans people’s medical histories and the physical state of their genitals in exhaustive detail.”⁷⁹ But not all transgender people experience gender dysphoria let alone see their identity as a disease. For such people “the Tax Court decision can be alienating, defining what it means to be transgender, and what constitutes necessary medical care.”⁸⁰ Ironically, the court’s avoidance of personal choice actually forces transgender people to choose how they will receive the procedures they desire. Those who do not think of their transgender experience from a medical perspective must choose whether to seek diagnosis nonetheless in order to access the medical expense deduction or whether to forego the deduction and to access the procedures they desire through other means.⁸¹ In seeking to avoid the role of personal choice in medical deductions for gender confirmation surgery, the court actually forces some taxpayers to make a personal choice.

IV. TRANSGENDER AS ABNORMAL

Perhaps the most dangerous reasoning in the *O’Donnabhain* opinion is that it bases its decision that the medical expense deduction is allowed on the premise that transgender taxpayers experience a mental illness that needs treatment, thereby suggesting that they are not normal. This reasoning is layered with stigma

77. See *id.* at 91 (noting that once courts determine that a condition is a “disease,” they “need not go further into a discussion of the proper standards of care or opine on their effectiveness” and that it “is essentially a test looking to the good-faith, subjective motivation of the taxpayer”).

78. See e.g. Katie McDonough, “Laverne Cox Flawlessly Shuts Down Katie Couric’s Invasive Questions about Transgender People,” *Salon* (7 Jan. 2014), <https://perma.cc/9YHG-JJSA> (quoting Cox: “The preoccupation with transition and surgery objectifies trans people. And then we don’t get to really deal with the real lived experiences.”).

79. Kae Greenberg, “Still Hidden in the Closet: Trans Women and Domestic Violence,” 27 *Berkeley Journal of Gender, Law & Justice* 198, 213 (2012).

80. Herman, note 25, at 508.

81. See e.g. Butler, note 66, at 287 (“In a sense, the regulatory discourse surrounding the diagnosis takes on a life of its own: it may not actually describe the patient who uses the language to get what he or she wants; it may not reflect the beliefs of the therapist who nevertheless signs her name to the diagnosis and passes it along.”); Spade, note 46, at 23 (“No one at these [trans support] groups seems to see therapy as the place where they voice their doubts about their transitions . . . [n]o one trusts the doctors as the place to work things out. . . . [P]eople suggest different ways to get around the requirements.”).

surrounding transgender people, as well as people with mental health problems.⁸² Indeed, “to be diagnosed with gender identity disorder 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.”⁸³ By legitimizing gender-affirming procedures as medically necessary treatment, the court perpetuates the notion that taxpayers who want to change their sex characteristics are sick.

Further, in order for taxpayers to be treated, their treatment must allow them to “blend into mainstream society” by physically assimilating into the gender binary.⁸⁴ Within the medical diagnosis paradigm, and in this case the tax system, transgender people can never be “normal,” but medical procedures—which articulate criteria adhering to “a rigid version of gender norms”—can at least help transgender people better assimilate.⁸⁵ Taxpayers’ ability to conform to “normality” vis-a-vis gender-affirming procedures then proves that the medical care was necessary and thus recognized as a deductible expense. “It should be terrifying to think of our genders being subjected to judicial fact-finding whereby our medical and survival needs might turn on whether a fact finder believes our breasts or other sexed body parts are ‘normal.’”⁸⁶

In addition, transgender taxpayers who seek to deduct the cost of their gender affirmation procedures are uniquely subjected to judicial scrutiny. Their decisions to undergo certain procedures and their gender identity are doubted and questioned—not because the status of transgender people is considered controversial, but because courts perpetuate transgender as abnormal.

Take for example the IRS’s different treatment of abortion versus gender affirming procedures. In *O’Donnabhain*, the tax court briefly compares gender affirmation procedures to abortion by recognizing that, at least in the abortion context, “the [IRS] has not heretofore sought to deny the deduction for a medical procedure because it was considered unethical by some.”⁸⁷ The primary difference between abortion and gender-affirming procedures, as relevant to the scope of this Article, is that elective abortion is extremely difficult to analogize to cosmetic surgery. Of course, it can and has been argued that elective abortion does not “meaningfully promote the proper function of the body or prevent or treat illness or disease,” but abortion’s longstanding classification as an inherently medicalized procedure (as opposed to “cosmetic surgery”) likely prevents that argument from taking any real hold.⁸⁸ Additionally, taxpayers seeking deductions for abortions

82. A discussion of the stigma surrounding people with mental health problems is beyond the scope of this paper. However, I would be remiss to not acknowledge the crossover that occurs when every transgender person is forced to have a mental illness in order to access physical treatment, which then adds the stigma of being mentally ill to the stigma of being transgender.

83. Butler, note 66, at 275.

84. Shannon Price Minter, “Do Transsexuals Dream of Gay Rights?,” in *Trans Rights*, 141, 152 (University of Minnesota Press, 2006).

85. Butler, note 66, at 292.

86. Strangio, note 46, at 239.

87. *O’Donnabhain*, 134 T.C. at 70.

88. See generally Frederick R. Parker, “Federal Income Tax Policy and Abortion in the United

likely do not have to advocate against a “cosmetic surgery” designation because “the IRS traditionally has accorded great deference to the opinion of physicians in the context of abortions” while seeking to avoid probing women’s rationale for an intensely intimate decision.⁸⁹

However, physicians do not receive the same deference in the case of gender-affirming procedures. While the IRS concedes that the personal choice surrounding an elective abortion is one that carries serious consequences for the taxpayer’s physical and mental health and, therefore, should not be examined for traces of personal choice as it would be if analyzed under the “medical necessity” category, the court is unable to extend that line of reasoning to an individual’s choice to undergo gender-affirming procedures. In fact, it appears as though the IRS recognizes that abortion treats a medical condition (pregnancy), but views gender-affirming procedures simply as an extreme form of body modification. As such, O’Donnabhain had to prove to the tax court that her procedures were medical, and the only way to do so was to pathologize herself and her gender.

The tax court’s understanding of the transgender experience, or lack thereof, implicates reproductive consequences for transgender people. The tax treatment of gender-affirming procedures, via the adoption of a pathologizing medical model, assumes that for gender identity and the sexed body to align, the sexed body must be sterile. This creates an open question as to the tax treatment for the reproductive trans body. As discussed above, the reliance on a medical model of GID to grant medical expense deductions reinforces the gender binary. Within this model, it is assumed that part of gender-affirming procedures would be sterilization as part of bottom surgery. A person assigned male at birth would have their penis and testicles removed and that a person assigned female at birth would have their uterus, fallopian tubes, and ovaries removed, as well as their vagina. The basic assumption is that a trans person will have genital surgery, an assumption that is reinforced by the tax court’s easy acceptance of O’Donnabhain’s vaginoplasty for the medical expense deduction.⁹⁰

However, not all trans people want to be sterile.⁹¹ “[T]he medical necessity standard constrains us to a narrative about sexed embodiment wherein to be a woman, one must attain womanly embodiment with all of its attending physicality and meaning.”⁹² The tax court determined that bottom surgery is medically necessary to treat or cure GID. So, if a trans man or non-binary person capable of becoming pregnant were to seek a medical deduction not only for gender-affirming procedures (such as a chest masculinization or hormone therapy) but also

States,” 13 *MSU Journal of Medicine and Law* 335 (2009).

89. *Id.* at 352.

90. *O’Donnabhain*, 134 T.C. at 70 (“The evidence demonstrates that hormone therapy and sex reassignment surgery to alter appearance (and, to some degree, function) are undertaken by GID sufferers in an effort to alleviate the distress and suffering occasioned by GID, and that the procedures have positive results in this regard in the opinion of many in the psychiatric profession.”).

91. Strangio, note 46, at 238 (discussing this phenomenon in length).

92. *Id.*

for an elective abortion, would the IRS or the tax court grant either deduction? Would the transgender taxpayer's request for a medical expense deduction for an elective abortion throw their GID diagnosis and validity of their transgender identity into question? Would it be so questionable that the IRS would find the diagnosis faulty and refuse to grant a deduction? Or would the transgender taxpayer be forced to reinforce a narrative they do not agree with—that there is a binary sexed body—in order to receive both deductions?

The lack of recognition of transgender people's reproductive capacity by the tax court further reinforces the notion that transgender identities are abnormal. Unlike cisgender people, there is a societal assumption that transgender people do not need to access reproductive care, that they only access health care in relation to transition, and that they do not want biological children.⁹³ The narrative of GID adopted by the tax court furthers the invisibility of transgender people in the context of reproductive care. Transgender people:

[S]imply do not exist in so many spaces. [They] are the men who become pregnant, need gynecological care, want abortions; the women who need prostate care, produce sperm, can get their partners pregnant; the men, women, and non-binary people who may need care that defies every expectation of how bodies look, perform, and have sex.⁹⁴

By examining gender affirmation procedures and thus transgender identities according to the gender binary, the tax court implicitly denies the existence of the reproductive trans body.

V. COMPARING SIMILARLY SITUATED CISGENDER TAXPAYERS TO TRANS TAXPAYERS

Professor Katherine Pratt argues that “the IRS should follow its Mission Statement, the Taxpayer Bill of Rights, and the IRS's nondiscrimination policy, by promoting fairness in tax administration towards all taxpayers—regardless of sex, gender, or gender identity and expression.”⁹⁵ However, there is no fair, or at least equitable, tax administration between similarly situated cisgender taxpayers and transgender taxpayers.

To access the medical expense deduction, transgender taxpayers must conform to a medical model that requires proof of their gender identity and psychiatric history—proof that is not required of cis taxpayers. Thus, a transgender person must “convince a medical provider that they have a mental illness in order to obtain their desired medical treatment.”⁹⁶ The “treatment” for GID is unique

93. *Id.* at 224.

94. *Id.*

95. Katherine Pratt, “The Tax Definition of ‘Medical Care’: A Critique of the Startling IRS Arguments in *O'Donnabhain V. Commissioner*,” 23 *Michigan Journal of Gender and Law* 313, 389 (2016).

96. Greenberg, note 79, at 210.

among treatment for mental illness in that it does not predominately affect brain chemistry or psychological health (like antidepressants and substance abuse rehabilitation), but rather relies on surgical intervention.

Additionally, designation of a transgender taxpayer as mentally ill based on their gender identity perpetuates a social-level inequity between cis and trans taxpayers. This inequity is based on the government’s lack of recognition of transgender people’s gender identities. “Gender is as salient an aspect of identity for most transgender people as for most non-trans people. But transgender people are much less likely to have their gender acknowledged by the state and affirmed by the ideological apparatuses that reproduce hegemonic gender arrangements.”⁹⁷ All taxpayers have a gender identity; the only difference is that the tax system interrogates the gender identity of transgender taxpayers seeking medical expense deductions. This creates administrative inequity amongst similarly situated taxpayers, as well as increasing administrative complexity for one class of taxpayers.

Tying the medical expense deduction to normative beliefs about gender reinforces ideals concerning gender performance, as discussed above, as well as the notion that those who do not conform are illegitimate or must prove their legitimacy. A cisgender person does not need to convince a doctor or the tax system that they have a mental illness in order to alter their body to align with their gender identity and performance. While a cisgender woman will not get a medical expense deduction for breast augmentation, she does not have to convince a plastic surgeon that she has a mental health problem before being operated on, but a transgender woman likely will. By finding that surgery affecting physical appearance is necessary to align an individual with their desired gender identity, the tax court exacerbated the gendered othering of transgender individuals.

This is not to argue that gender-affirming surgery should not be deductible. Rather, it is meant to question why medical procedures related to gender fulfillment—regardless of transgender status or medical diagnosis—are assumed to be cosmetic. “[G]ender 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.”⁹⁸ Why should a medical expense deduction for a cisgender woman’s breast augmentation be disallowed?

VI. AWAY FROM MEDICAL NECESSITY

Rather than grant medical expense deductions for gender-affirming procedures based on medical necessity, the IRS or tax court could grant them based on the second prong of Section 213.⁹⁹ That prong, requiring medical care to

97. Currah, note 1, at 715.

98. Herman, note 25, at 504.

99. In fact, O’Donnabhain did argue that “the expenditures for the procedures at issue are deductible because they affected a structure or function of the body (within the meaning of sec. 213(d)(1)(A)) and were not ‘cosmetic surgery’ under sec. 213(d)(9) because they were

affect the structure or function of the body, was not fully explored in *O'Donnabhain*. Meaning, “[t]axpayers incurring costs for medical transition still could argue that medical transition changes the structure or function of the body and is not cosmetic surgery because transition is functional, i.e., it promotes psychological and social functioning.”¹⁰⁰ This avenue would bring the medical expense deduction for medical transition in line with that for elective abortion.

There is the possibility that since the cosmetic surgery exception is so broad the tax court or IRS could find that gender-affirming procedures are cosmetic.¹⁰¹ Part V questioned why the tax code disallows a medical expense deduction for cosmetic breast augmentation when such augmentation does indeed affect the function of the body—it affects social and psychological functions. Societally, there is a tendency to brush off concerns of “self-esteem,” but is the psychological ramification of poor self-esteem anything less a mental-health concern? Limiting cosmetic surgery is a value judgement made by Congress in an attempt to avoid subsidizing personal choice.

The tax code allows deductions for contraception, abortions, and vasectomies because they are procedures affecting the body. These allowances are directly related to the reproductive function of the sexed body, whereas cosmetic surgeries, like breast augmentation, and gender-affirming surgery begin with a presumption against deductibility and then must be proved to be deductible medical care. Cosmetic surgeries and gender-affirming procedures are also related to the sexed body, just not reproductively. So perhaps the real reason for the requirement for medical necessity is that the IRS and tax court see procedures directly affecting the sexed body, but not relating to procreation, as inherently personal choices, whereas they consider reproductive procedures to be medical and less personal.

CONCLUSION

The tax system purports to be neutral regarding personal decisions, aside from those provisions Congress purposefully included to either incentivize or disincentivize behavior. But is the tax code actually neutral when it comes to questions of personal choice? Consider Butler’s argument regarding the case of gender identity:

If GID insists that the desire to be another sex or the insistence that one is the other sex has to be evaluated without reference to cultural advantage, it may be

not ‘directed at improving the patient’s appearance’ and because they ‘meaningfully [promoted] the proper function of the body.’” *O’Donnabhain*, 134 T.C. at 53 footnote 30. The Tax Court did not analyze *O’Donnabhain*’s case under the second prong definition of “medical care,” and therefore it remains an open question.

100. Pratt, note 95, at 387.

101. See Herman, note 25, at 500 (“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.’”).

that GID misunderstands some of the cultural forces that go into making and sustaining certain desires of this sort. And then GID would also have to respond to the epistemological question of whether sex can be perceived *at all* outside the cultural matrix of power relations in which relative advantage and disadvantage would be part of that matrix.¹⁰²

The medical model’s categorization of transgender identities through GID or gender dysphoria perpetuates the normative idea that gender and sex are static and that their development takes place in a vacuum. The tax court in *O’Donnabhain* relied upon a GID diagnosis that in turn relied upon a particular notion of gender and sex, one that is largely normative and inherently static. The tax court’s reliance on the medical model denied the legitimacy of gender identity narratives that exist outside that model. This denial reinforces the status of transgender people as abnormal. “If we establish in law and social discourse that bodies must be coherently sexed to be legitimate, we make spaces for the harassment and violence levied upon those whose bodies transgress those expectations.”¹⁰³ The tax court’s reliance on the medicalization of transgender identities entrenched harmful, transphobic ideals of normative sexed bodies and gender identities, which perpetuate and loan credence to policies like the DOD’s ban on transgender people in the military.

102. Butler, note 66, at 291.

103. Strangio, note 46, at 243.

