Asylum Medicine: Standard and Best Practices

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Abstract

Due to global events in recent years, applications for political asylum have increased, although the number of people granted asylum in the United States and elsewhere has declined. Physicians and other health care professionals can play a crucial role in the evaluation of individuals seeking asylum, since appropriately documented objective clinical evidence of torture and other forms of persecution can increase the likelihood that survivors of human rights abuses obtain asylum. Many clinicians have the requisite expertise and skills needed to conduct forensic asylum evaluations. However, despite growing interest in this area, the demand for medical and psychiatric forensic evaluations exceeds the number of clinicians who are prepared to conduct asylum evaluations. In an effort to increase the number of qualified clinicians interested and involved in medical and psychiatric evaluations of asylum seekers, this article offers a summary of standard and best practices in the area, including recommended qualifications and competencies relevant to the practice of forensic asylum evaluations, guidance on effective approaches to the medical and psychiatric evaluation of asylum seekers, and recommendations related to medicolegal documentation and testimony. We also highlight gaps in evidence regarding best practices.

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Competing interests: Hope Ferdowsian is a medical expert and volunteer for Physicians for Human Rights and HealthRight International. She has been compensated in the past as a lead trainer in asylum medicine training sessions. Her book, *Phoenix Zones: Where Strength Is Born and Resilience Lives*, addresses human rights abuses, including torture. Katherine McKenzie is a volunteer for Physicians for Human Rights and has been compensated in the past as a lead trainer in asylum training sessions. She volunteers for nonprofit organizations such as American Friends Service Committee, Connecticut Institute for Immigrants and Refugees, Integrated Refugee and Immigrant Services, New Haven Legal Assistance Association, and HealthRight International. When traveling to detention facilities, she is compensated for her travel expenses. She was paid to speak at Stony Brook University Grand Rounds on a subject relevant to asylum medicine. Amy Zeidan is a volunteer for Physicians for Human Rights. All three authors openly advocate for human rights.

Introduction

Worldwide, conflict, violence, and persecution have driven internal and external displacement to a higher level each year for five consecutive years. As a result, the global number of refugees and asylum seekers has increased significantly, fueling human rights and public health concerns. Individuals seeking asylum commonly assert a history or risk of violent persecution, as well as corresponding physical and mental health challenges. If forced to return to their country of origin, asylum seekers commonly face the risk of severe injury or death.

By the end of 2017, the number of people seeking asylum worldwide rose to more than three million, while the number of countries hosting large numbers of displaced persons has remained relatively small.[1] In the United States, applications for asylum have increased, although the number of people granted asylum has declined in recent years.[2]

Asylum law emerged from human rights treaties created after the Second World War, including the Universal Declaration of Human Rights, the United Nations Convention relating to the Status of Refugees, and the US Refugee Act.[3] In order to qualify for asylum, applicants need to show that they have suffered or will likely suffer persecution in their country of origin based on their political opinion, race, religion, nationality, or membership in a certain social group. Torture and other forms of abuse are considered protected forms of persecution under US law. Physicians therefore have an important role to play in the evaluation of individuals seeking asylum. Appropriately documented objective clinical evidence of torture or ill treatment can increase the likelihood that survivors of human rights abuses obtain asylum. One study showed that 89% of asylum seekers who had undergone a clinical evaluation were granted asylum, in contrast with a national average of 37.5% of asylum seekers at the time.[4]

Presently, the demand for forensic asylum evaluations in the United States exceeds the number of clinicians prepared to conduct them.[5] This may be particularly true in certain areas of the country, especially non-urban areas, and in cases requiring mental health assessments. Despite the growing need for qualified experts, there is limited professional, practical, and ethical guidance for interested medical professionals. Similarly, despite growing interest in and satisfaction with this area of medicine, there is a paucity of published best practices relevant to the evaluation of asylum seekers and the training of qualified medical professionals.[6] The Istanbul Protocol, published in 1999, was the first set of international standards for the documentation of torture and its consequences.[7] Since then, some nongovernmental organizations have provided a small number of reference materials to trainees, and scholars have published papers and books on the role of physicians and other health care professionals in asylum evaluations, the purpose of and basic approach to an asylum evaluation, and the health needs of asylum seekers.[8] Although all of these resources offer important information, they are perhaps too lengthy, impractical, and nonspecific for interested health care professionals with busy schedules and multiple clinical and nonclinical demands.

In an effort to increase the number of qualified clinicians interested and involved in asylum evaluations, we offer a brief summary of standard and best practices specific to the forensic evaluation of asylum seekers. Our recommendations are informed by published standards, where available, as well as legal and ethical considerations. Published standards for the forensic evaluation of asylum seekers generally reflect instruction provided by organizations such as Physicians for Human Rights and HealthRight International (formerly Doctors of the World-USA), as well as the 1999 Istanbul Protocol. However, other forms of forensic medicine instruction may also inform best practices. This article aims to provide a summary of the most widely published practices in forensic evaluations specific to asylum seekers and to encourage further discussion about basic standards and best practices in this area.

Sometimes referred to as "asylum medicine," the objective forensic evaluation of asylum seekers offers physicians and other clinicians an opportunity to use their knowledge and skills to serve a particularly vulnerable population. Although health care professionals can support asylum seek-

ers and refugees in myriad other ways, this article is limited to the role of physicians and other clinicians in the forensic evaluation of asylum seekers.

Recommended qualifications and competencies for forensic asylum evaluations

Qualifications and expectations

The purpose of an asylum evaluation is to obtain facts pertinent to the asylum seeker's history of torture, ill treatment, or persecution; perform a focused exam to document physical and psychological evidence of trauma; and establish the level of consistency between the person's history and exam findings. Physicians, mental health professionals, and other clinicians already possess many of the basic skills necessary to conduct asylum evaluations, including empathic medical interviewing skills, the physical and psychological assessment of trauma sequelae, and medical documentation. With further study, training, or mentorship, such knowledge and skills may be honed toward the forensic evaluation of asylum seekers. Many clinicians have the requisite capacities to develop experience and expertise in this area.

Clinicians who conduct asylum evaluations are not expected to provide treatment. Instead, they are expected to summarize their encounter with the asylum seeker and their findings in the form of a medicolegal report, which may then be used by the asylum seeker's attorney.[9] A medicolegal report typically requires the responsible clinician to present findings that support or refute a history of torture or ill treatment, as well as an assessment on the risks involved in returning the applicant to their country of origin and on other risks related to the asylum seeker's health conditions.[10]

Although there is no national licensure available or required for clinicians who perform asylum evaluations, some organizations provide certification of training.[11] No published studies have evaluated the merits of certification of training or prior experience in determining asylum outcomes, which are primarily distinguished by legal jurisdiction.[12] The Federal Rules of Evidence, a set of rules that govern the introduction of evidence in US federal trial courts, provide standards for the admission of expert evidence and refer to the "knowledge, skill, experience, training, or education" of the individual performing the evaluation. Knowledge, skill, experience, training, and education can be demonstrated by the inclusion of a curriculum vitae or a statement within the medicolegal report.[13]

General competencies

To be useful and effective as asylum evaluators, physicians and other qualified professionals may need to expand their traditional roles. At a minimum, clinicians who perform asylum evaluations should be able to demonstrate the following competencies.[14]

1. Familiarity with asylum law and the role of clinicians in evaluating asylum seekers
2. Knowledge of medical and mental health consequences of torture and ill treatment (Table 1)
3. An objective and professional approach that includes respect for privacy and confidentiality, informed consent, appropriate language interpretation services, and attention to trauma-informed care
4. Relevant history-taking and interview techniques and physical examination skills
5. Familiarity with standardized language for describing the diagnostic probability or consistency of medical and mental health findings, often guided by the Istanbul Protocol (Table 2)
6. Medicolegal documentation as it pertains to the clinical assessment of asylum seekers (Table 3)
7. Effective and responsive interpersonal and communication skills that extend to legal professionals and referring agencies
8. Ongoing personal and professional development, including continuing education and attention to the potential for vicarious trauma

More specific competencies may be required of those who perform specialized clinical assessments or who serve as mentors or trainers. Ideally, train-

ing programs should be conducted by experienced asylum evaluators who are attentive to key competencies and offer attendees the potential for ongoing mentorship and professional development.

Preparation for and performance of asylum evaluations

Preparation

Clinicians new to asylum evaluations can typically connect with asylum seekers in three different ways. First, some nonprofit organizations connect clinicians interested in performing asylum evaluations with legal professionals and their clients.[15] In addition, a number of asylum clinics organized by medical students connect clinicians with training opportunities, mentorship, and scheduled asylum evaluations (Table 4).[16] Finally, for those who practice where formal processes do not exist, opportunities may be identified through local resettlement and legal agencies that work with immigrants.

Communication with an asylum seeker's attorney in advance of the clinical evaluation is paramount. This discussion should include the purported legal rationale for asylum, the type of clinical evaluation indicated, and any concerns of the legal team. In advance of the visit, the clinician should review materials provided by the attorney, including the asylum seeker's statement and any relevant medical records. Clinicians can also consult the literature about findings related to specific types of torture or country conditions.

Finally, it is important to arrange for appropriate interpretation services, with attention to dialect as well as cultural, gender, and other individual considerations. Professional medical interpretation is preferred and can be arranged by the asylum seeker's attorney. Although in-person interpretation services are optimal, some situations may require the use of a professional telephone interpretation service.

TABLE 1. Common medical and psychiatric findings after torture or ill treatment

Organ system or discipline	Specific injuries or ailments	Description	Notes
Dermatologic*	Laceration	Tear in skin	• Typically results from blunt trauma • Shape may reflect the design and force of the instrument, including beating with a baton or similar object, whipping with a belt or similar object, a human bite, or a gunshot wound
	Incision	Precise tear in skin	• Typically produced from sharp objects • Causative instruments may include knives, razorblades, scalpels, or glass
	Abrasion	Superficial injury to skin	• Typically caused by friction • Careful examination may allow identification of the instrument and direction of force
	Burn	Injury caused by exposure to heat, electricity, or acid	• Typically caused by electrical, thermal, or chemical energy • Scars vary depending on the source and duration of burn, personal characteristics, and course of healing • Cigarette burns and branding commonly leave characteristic scars • Electrical burns are less likely to leave distinct scars
Neurologic	Traumatic brain injury	Disruption of the normal function of the brain	• May result from blunt trauma, a jolt, penetrating head injury, or suffocation, including near drowning (e.g., waterboarding) and strangulation • Neurological examination, including neurocognitive assessment, is essential; such assessment may include the use of screening tools such as the Montreal Cognitive Assessment test • Symptoms may overlap with those of mental disorders
	Post-concussion syndrome	Concussive symptoms after trauma	• Symptoms may include a history of headaches, sleep impairment, or impaired memory or concentration • Symptoms may overlap with those of mental disorders
	Peripheral neuropathy	Injury to the peripheral nerves	• May result from blunt trauma, suspension, or burns • Early sequelae may include diminished mobility, pain, or numbness • Later sequelae may include asymmetric weakness or paresthesias

Approach to the evaluation: Informed consent and interview considerations

As with all clinical interactions, it is essential to set expectations and obtain informed consent. Care should be taken to explain to the asylum seeker that the health care professional's role is as a forensic evaluator rather than as a treating clinician. Clinicians should articulate the limitations of confidentiality, including that relevant findings will be described in a report that may be viewed by individuals involved in the legal process. If there are components of the history or exam that the asylum seeker is uncom-

TABLE 1. *continued*

Organ system or discipline	Specific injuries or ailments	Description	Notes
Orthopedic	Arthralgias	Pain or discomfort involving the joints or spine	• May result from beatings, forced positioning, confinement, weight-bearing activities, or forced crawling • Neck and back pain are commonly reported
	Myalgias	Pain or discomfort involving the muscles	• May result from beatings, forced positioning, confinement, weight-bearing activities, or nutritional deprivation • History may reveal evidence of myoglobinuria
	Fractures	Interruption of normal bone tissue	• May be displaced or nondisplaced • Lack of access to medical treatment may result in abnormal healing and unusual physical exam findings
	Falanga	Beating of the soles of the feet	• Early symptoms may include bruising, swelling, or pain • Later symptoms may include pain and problems with ambulation • Examination findings may reveal an awkward gait or deformities of the feet
Otolaryngology	Dental	Trauma involving dentition	• May include intrusion, displacement, or fracture
	Telefono	Blunt trauma to the ears	• Early symptoms may include pain, bleeding, tinnitus, or hearing loss • Late symptoms may include rupture or scarring of the tympanic membrane, tinnitus, or hearing loss
Genitourinary and gynecological	Sexual violence	Any form of nonconsensual interaction with the sexual organs, including the urogenital region, anal region, and breast tissue; may include female genital mutilation/cutting	• Physical evidence of sexual violence is difficult to obtain, particularly as time elapses; psychological evidence is more common after sexual violence • Chronic sequelae of sexual violence varies and may include sexual dysfunction, sexually transmitted infections, urinary tract infections, chronic pain syndromes, pregnancy and potential complications of pregnancy, or psychiatric findings, as indicated below
Psychiatric	Mental illness	Mental health issues that may or may not meet diagnostic criteria for designated psychiatric disorders	• Individuals may meet diagnostic criteria for mental disorders, including posttraumatic stress disorder, major depression, generalized anxiety disorder, adjustment disorders, somatoform disorders, substance use disorders, obsessive-compulsive disorders, and eating disorders, among others • General symptoms are also possible, including fear; confusion; anxiety; anger; sadness; social withdrawal or dysfunction; problems with self-esteem; sleep disturbances; impairments in cognition, including deficits in memory, attention, language, and learning; chronic pain; sexual dysfunction, including dyspareunia and decreased sexual interest; and global dysfunction

*Scar appearance will depend on several factors, including force and velocity of trauma, the characteristics of the object and surface subject to trauma, skin plasticity and pigmentation, comorbid medical problems, and access to medical treatment before, during, and after torture or ill treatment.

Sources: Office of the United Nations High Commissioner for Human Rights, Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment, Professional Training Series No. 8/Rev. 1 (2004); Physicians for Human Rights, Examining asylum seekers: A clinician's guide to physical and psychological evaluations of torture and ill-treatment (Cambridge, MA: Physicians for Human Rights, 2012); HealthRight International, Training manual for physicians and mental health professionals (New York: HealthRight International, 2010); V. Iacopino, "Medical evaluations of asylum seekers," AMA Journal of Ethics, September 2004; D. Forrest, "Examination for the late physical after effects of torture," Journal of Clinical Forensic Medicine 6 (1999), pp. 4–13; A. Moreno and M. A. Grodin, "Torture and its neurological sequelae," Spinal Cord 40 (2002), pp. 213–223; L. Danielsen and O. V. Rasmussen, "Dermatological findings after alleged torture," Torture 16 (2006), pp. 108–127.

TABLE 2. Degrees of consistency

Not consistent	The lesion could not have been caused by the trauma described
Consistent with	The lesion could have been caused by the trauma described, but it is nonspecific and there are many other possible causes
Highly consistent	The lesion could have been caused by the trauma described, and there are few other possible causes
Typical of	This is an appearance that is usually found with this type of trauma, but there are other possible causes
Diagnostic of	This appearance could not have been caused in any way other than that described

Source: Reprinted with permission from K. C. McKenzie, J. Bauer, and P. P. Reynolds, "Asylum seekers in a time of record forced global displacement: The role of physicians," Journal of General Internal Medicine 34 (2019), pp. 137–143. Adapted from Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment, UNHCR Professional Training Series No. 8/Rev. 1 (2004).

TABLE 3. Medicolegal documentation: General guidance*

General segment	Examples of details for inclusion
Evaluator's professional background and qualifications	• Professional affiliation(s) • Education and training history • Any other relevant experience, training, or expertise
Description of evaluation	• Referral information regarding the asylum seeker • Informed consent documentation • Individual's name, date of birth, age, location of birth, gender, and any other identifying characteristics relevant to the evaluation • Date, location, and duration of evaluation • Use and description of interpretation services, if applicable • Names and brief descriptors of any others present for the evaluation • Materials or resources reviewed prior to the evaluation
Relevant history of asylum seeker	• Relevant past medical or surgical history, family and social history, or prior trauma, as well as any relevant treatment
Reported account of torture, ill treatment, or other form(s) of persecution	• Circumstances of arrest, detention, torture, or ill treatment • Physical or mental symptoms • Access to medical or psychiatric care and details of care, if relevant
Physical examination, if indicated	• General appearance • Itemized findings related to torture or ill treatment • Any significant findings unrelated to torture or ill treatment • Inclusion of cognitive assessment or other screening or diagnostic tests, if indicated • Relevant behavioral observations during the evaluation
Psychological or psychiatric examination, if indicated	• Methods of assessment (e.g., screening or diagnostic tools) • Findings and consistency with diagnostic criteria, if indicated
Any other findings, if indicated	• Laboratory or other diagnostic results**
Summary and interpretation of findings and recommendations	• Assessment and summary of the degree of consistency between history, exam findings, and other available information • Assessment and summary of the degree of consistency between comprehensive findings, history of torture or ill treatment, and anticipated clinical sequelae • Any recommendations for further assessment, treatment, or care

* The report format can vary depending on the evaluator's preferences, type of evaluation performed, and other factors.
** Often, resources are limited, and laboratory and radiological examination are unnecessary.
Sources: Office of the United Nations High Commissioner for Human Rights, Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment, Professional Training Series No. 8/Rev. 1 (2004); Physicians for Human Rights, Examining asylum seekers: A clinician's guide to physical and psychological evaluations of torture and ill-treatment (Cambridge, MA: Physicians for Human Rights, 2012); HealthRight International, Training manual for physicians and mental health professionals (New York: HealthRight International, 2010); E. Scruggs, T. C. Guetterman, A. C. Meyer, et al., "An absolutely necessary piece: A qualitative study of legal perspectives on medical affidavits in the asylum process," Journal of Forensic and Legal Medicine 44 (2016), pp. 72–78; A. Pitman, "Medicolegal reports in asylum applications: A framework for addressing the practical and ethical challenges," Journal of the Royal Society of Medicine 103 (2010), pp. 93–97; M. Peel and V. Iacopino, The medical documentation of torture (San Francisco: Greenwich Medical Media, 2002).

fortable exposing in a written report, these items should be clarified during the interview.

An asylum evaluation can be lengthy and invasive for individuals as they relive traumatic experiences from their past. A number of interview techniques can create a safe environment, including nonthreatening questions, active listening, and attention to body language.[17] The interview should be guided by the principles of objectivity and trauma-informed care. Open-ended questions are preferred, with the use of more specific questioning to clarify details.

Physical evaluation

Asylum seekers with physical evidence of torture or ill treatment may display scars, injuries, or ongoing physical ailments (Table 1). Responses to torture and ill treatment vary depending on one's personal characteristics, medical history, the type and severity of torture employed, methods of restraint, access to treatment, and other factors.[18] A comprehensive exam from head to toe, with a focused assessment of skin, is useful to avoid missing evidence of trauma.[19] Clinicians should also note significant findings unrelated to torture or ill treatment.

Several resources are integral to a physical evaluation, including a ruler, camera, anatomical diagrams, and diagnostic materials required for systems-based examination. When reporting exam findings, clinicians should document the relationship between observed physical characteristics and the mechanism of trauma described, as well as a clinical assessment regarding the level of consistency or diagnostic probability of the trauma described (Table 2).[20] Clinicians should attempt to obtain explanations for each scar, which they should measure, describe, and record in text and a diagram, if possible. The site, size, shape, color, borders, and surrounding area of each injury should also be documented.[21]

Some asylum seekers may be hesitant to disclose injuries or scars, or they may have significant memory deficits that make exact mechanisms of injury difficult to recall. Explanations for recall deficits include loss of consciousness during torture, significant emotional disturbances, and traumatic brain injury.[22] Additionally, the frequency and severity of injury may be so extreme that it becomes difficult to differentiate each scar by an exact etiology. In these instances, it is important to document as many pertinent findings from the history and exam as possible.

Psychological or psychiatric evaluation

Psychological findings constitute some of the most common chronic sequelae of torture. Most individuals who experience traumatic events suffer posttraumatic psychiatric symptoms and are at higher risk of developing mental illness (Table 1).[23] Therefore, a psychological evaluation of an asylum seeker should consist of a mental health history, past and present psychiatric symptoms, an assessment of global functioning, and screening for and diagnosis of mental illness if indicated. Due to the increasing demand for psychological evaluations, many non-psychiatrists commonly perform psychological evaluations of asylum seekers as they would of patients in their normal practice.[24] Nonetheless, as with any clinical mental health evaluation, the approach differs from that of a physical evaluation and commonly involves an extended interview supported by specific techniques and tools.

There are several useful screening and diagnostic tools that can be utilized during the course of a mental health evaluation. Although not specifically designed for asylum seekers, screening tools that can assist with psychological evaluations include the Primary Care Posttraumatic Stress Disorder 5, the Patient Health Questionnaire 9 (for depression), and the Posttraumatic Stress Disorder Symptom Scale 5.[25] These tools can be used to screen for mental disorders, whereas the Diagnostic and Statistical Manual of Mental Disorders can be used for diagnostic purposes.[26] Additionally, screening tools for assessing cognitive impairment, such as the Montreal Cognitive Assessment test, may be useful for identifying potential contributors to abnormal mood or cognition.[27]

Additionally, within the fields of forensic psychiatry and forensic psychology, there are specific tools and best practices that appropriately trained

professionals can reference and use. However, no published studies have compared different methods of psychiatric or psychological evaluation in determining asylum outcomes.

Regardless of the methods or tools used by evaluators, it is important to remember that an individual's response to torture and other forms of trauma may be influenced by their cultural background and individual characteristics. Factors that promote resilience and healing, including individual and environmental contributors, may also influence how asylum seekers reflect a history of trauma.[28] Access to treatment can also affect healing and resilience and should be taken into account during any psychological evaluation. Further, language differences can confound how an asylum seeker interprets the clinician's screening and diagnostic questions, as well as how the clinician interprets the asylum applicant's responses.

Medicolegal documentation and testimony

Medicolegal documentation

Typically, three primary domains are covered in a medicolegal report: background information, examination findings and supplementary evidence, and conclusions (Table 3). Findings and conclusions are generally reported in a manner that is specific to the type of evaluation performed. For example, if an evaluation is limited to a physical examination,

TABLE 4. Nongovernmental organizations and academic medical centers offering asylum medicine training or services*

Albert Einstein College of Medicine
Brown Human Rights Asylum Clinic
Capital District Asylum Collaborative (Albany, NY)
Columbia Human Rights Initiative Asylum Clinic
CUNY/Sophie Davis
Dartmouth
Georgetown School of Medicine Asylum Program
Harvard Student Human Rights Collaborative
HealthRight International**
Human Rights Clinic of Miami
Human Rights Initiative at the University of Buffalo
Mount Sinai Human Rights Program
New York Medical College Center for Human Rights
Philadelphia Human Rights Clinic
Physicians for Human Rights**
Touro Harlem Health Clinic
UConn School of Medicine
University of Michigan Asylum Collaborative
USC-Keck Human Rights Clinic
UTMB Galveston
Weill Cornell Center for Human Rights
Yale Center for Asylum Medicine

* As of December 2018
** Nongovernmental organizations
Sources: K. C. McKenzie, J. Bauer, and P. P. Reynolds, "Asylum seekers in a time of record forced global displacement: The role of physicians," Journal of General Internal Medicine 34 (2019), pp. 137–143; Physicians for Human Rights, Focus areas: Persecution and asylum (2018). Available at https://phr.org/issues/asylum-and-persecution/#top; HealthRight International, Human Rights Clinic forensic evaluation services (2018). Available at https://healthright.org/forensic-evaluation-services.

the medicolegal report should focus on pertinent exam findings, describing the consistency of each finding and summary of findings, as highlighted in the Istanbul Protocol (Table 2).[29] Medicolegal reports of psychological or psychiatric evaluations typically focus on the type of screening or diagnostic methods used, pertinent psychological findings, and conclusions. Within any medicolegal report, it is important to avoid equivocal, contradictory, confusing, and ambiguous language, as well as overly detailed accounts or extraneous information, which can be detrimental to an asylum applicant's case.[30] Although medical terminology is not necessarily discouraged, it should be accompanied by language that can be easily interpreted by an asylum officer or immigration judge.

As with other forms of documentation, clinicians should carefully review medicolegal reports for content, grammatical, and other errors. For novices, an experienced mentor can review the document. Once complete, the report should be shared with the asylum applicant's attorney and revised and finalized as appropriate. Some attorneys may request changes to or notarization of the document. Clinicians are not obliged to make edits based on attorneys' recommendations. Rather, clinicians should maintain an objective evaluation and documentation.

Forensic photography

Photographs can be a powerful and useful part of a forensic evaluation, although the use of forensic photography has not necessarily been shown to influence judicial decisions.[31] The asylum applicant's consent for photography can be requested by the attorney prior to the evaluation, as well as at the time of the evaluation; careful attention should be paid to the potential for coercion or retraumatization. Although forensic reports are not anonymous, attempts should be made to maintain the individual's privacy, including by de-identifying the person in photographs. This can be done by avoiding photographs of the face or, if there are scars on the face, taking a partial photograph obscuring the person's eyes.

Photographs should be stored in a locked filing cabinet or on a computer that is password-protected and encrypted at the level used for the protection of patient information. Photographs do not need to be individually labeled with the person's name; instead, they can be stored in a file with the individual's identifying information. Photographs can become part of the medicolegal report and shared with the person's attorney in a secure manner.

Testimony

Typically, asylum evaluators are not asked to provide oral testimony in immigration court. If asked to do so, it is important to clarify with the attorney the reason for the testimony, whether it will be telephonic or in-court testimony, the date and time of the anticipated testimony, and whether a subpoena is involved. It may also be useful to discuss the case in further detail with the attorney and prepare for cross-examination.

Conclusion

Currently, despite critical need and interest, relatively few health care professionals are adequately prepared to perform forensic asylum evaluations. Additionally, resource constraints limit the availability of training opportunities. In this article, we have aimed to provide an overview of standard practices in the forensic evaluation of asylum seekers so that clinicians may feel better prepared to participate in asylum evaluations. Clearly, there is a need for more work in this area, including rigorous discussion and an evidence-based evaluation of standard practices. Presently, the most important and consistent factors affecting the final outcome of an asylum case are jurisdiction and whether an attorney represents the asylum seeker.[32]

As clinicians who perform forensic asylum evaluations continue to develop and refine best practices, others who are interested in performing such evaluations can pursue training and mentorship opportunities offered by nonprofit organizations such as Physicians for Human Rights and HealthRight International, as well as continuing medical education, fellowships, and certification in specific areas of forensic medicine, psychology, and psychiatry.

We have not addressed a number of issues that deserve greater consideration, including the evaluation of minors, the evaluation of asylum seekers at detention centers, and the need to promote vicarious resilience among asylum medicine evaluators to reduce the risk for compassion fatigue.[33] As studies have shown, many individuals who work with torture or other trauma survivors benefit from the work, although there are also a number of personal and professional challenges that require attention.[34] Additionally, more robust discussion is needed on how clinicians can maintain objectivity and how they can continue to advocate for human rights protections without disqualifying themselves as forensic experts.[35]

In order to sustain and expand the practice of forensic asylum evaluations, systemic issues also need greater consideration. Network building and peer support are critical, as is institutional support. Most clinicians who perform asylum evaluations are not compensated, and academic centers and other health care systems frequently do not provide protected time for performing asylum evaluations or for teaching students and residents how to perform them.[36] Since many asylum seekers and their families live in communities served by these academic centers and health care systems, this issue merits further exploration. At a time when more global citizens are at risk for displacement, torture, and persecution, it is incumbent on the medical community to respond in kind.

References

1. "Forced displacement above 68m in 2017, new global deal on refugees critical," *UNHCR USA Press Releases* (June 19, 2018). Available at http://www.unhcr.org/en-us/n ews/press/2018/6/5b27c2434/forced-displacement-above-68m-2017-new-global-deal-refugees-critical.html.

2. N. Mossaad and R. Baugh, *Refugees and asylees: 2016* (Washington, DC: Department of Homeland Security Office of Immigration Statistics, 2018). Available at https://www.dhs.gov/immigration-statistics/refugees-asylees.

3. Universal Declaration of Human Rights, G.A. Res. 217A (III) (1948), art. 14(1); Convention relating to the Status of Refugees, G.A. Res. 429(V) (1950), art. 33(1); *Refugee Act of 1980*, Public Law 96-212, *US Statutes at Large* 94, pp. 102–117 (1980).

4. S. L. Lustig, S. Kureshi, K. L. Delucchi, et al., "Asylum grant rates following medical evaluations of maltreatment among political asylum applicants in the United States," *Journal of Immigrant and Minority Health* 10 (2008), pp. 7–15.

5. K. C. McKenzie, J. Bauer, and P. P. Reynolds, "Asylum seekers in a time of record forced global displacement: The role of physicians," *Journal of General Internal Medicine* 34 (2019), pp. 137–143.

6. R. Mishori, A. Hannaford, I. Mujawar, et al., "'Their stories have changed my life': Clinicians' reflections on their experience with and their motivation to conduct asylum evaluations," *Journal of Immigrant and Minority Health* 18 (2016), pp. 210–218.

7. Office of the United Nations High Commissioner for Human Rights, *Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment*, Professional Training Series No. 8/Rev. 1 (2004). Available at https://www.ohchr.org/Documents/Publications/training8Rev1en.pdf.

8. McKenzie et al. (see note 5); Physicians for Human Rights, *Examining asylum seekers: A clinician's guide to physical and psychological evaluations of torture and ill-treatment* (Cambridge, MA: Physicians for Human Rights, 2012); HealthRight International, *Training manual for physicians and mental health professionals* (New York: HealthRight International, 2010); J. M. Peart, E. H. Tracey, and J. B. Lipoff, "The role of physicians in asylum evaluation: Documenting torture and trauma," *JAMA Internal Medicine* 176 (2016), p. 417; S. M. Meffert, K. Musalo, D. E. McNiel, et al., "The role of mental health professionals in political asylum processing," *Journal of the American Academy of Psychiatry and the Law* 38 (2010), pp. 479–489; V. Iacopino, "Medical evaluations of asylum seekers," *AMA Journal of Ethics*, September 2004; L. F. Goodman, G. W. Jensen, J. M. Galante, et al., "A cross-sectional investigation of the health needs of asylum seekers in a refugee clinic in Germany," *BMC Family Practice* 19 (2018), p. 64.

9. E. Scruggs, T. C. Guetterman, A. C. Meyer, et al., "An absolutely necessary piece: A qualitative study of legal perspectives on medical affidavits in the asylum process," *Journal of Forensic and Legal Medicine* 44 (2016), pp. 72–78; A. Pitman, "Medicolegal reports in asylum applications: A framework for addressing the practical and ethical challenges," *Journal of the Royal Society of Medicine* 103 (2010), pp. 93–97.

10. Pitman (see note 9).

11. McKenzie et al. (see note 5).

12. M. Rosenberg, R. Levinson, and R. McNeill, "Heavy odds," *Reuters Investigates* (October 17, 2017). Available at https://www.reuters.com/investigates/special-report/usa-immigration-asylum.

13. *Federal rules of evidence*, art. VII, rule 702. Available at https://www.rulesofevidence.org/article-vii/rule-702.

14. Office of the United Nations High Commissioner for Human Rights (see note 7); Physicians for Human Rights (2012, see note 8); HealthRight International (2010, see note 8); Iacopino (see note 8).

15. McKenzie et al. (see note 5); Physicians for Human Rights, *Focus areas: Persecution and asylum* (2018). Available at https://phr.org/issues/asylum-and-persecution/#top; HealthRight International, *Human Rights Clinic forensic evaluation services* (2018). Available at https://healthright.org/forensic-evaluation-services.

16. McKenzie et al. (see note 5); Physicians for Human Rights (2018, see note 15).

17. Iacopino (see note 8).

18. Office of the United Nations High Commissioner for Human Rights (see note 7).

19. Physicians for Human Rights (2012, see note 8); HealthRight International (2010, see note 8).

20. Office of the United Nations High Commissioner for Human Rights (see note 7).

21. Physicians for Human Rights (2012, see note 8); HealthRight International (2010, see note 8).

22. Meffert et al. (see note 8).

23. P. Sen, "The mental health needs of asylum seekers and refugees: Challenges and solutions," *BJPsych International* 13 (2016), pp. 30–32.

24. Meffert et al. (see note 8).

25. A. Prins, M. J. Bovin, D. J. Smolenski, et al., "The primary care PTSD screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample," *Journal of General Internal Medicine* 31 (2016), pp. 1206–1211; K. Kroenke, R. L. Spitzer, and J. B. W. Williams, "The PHQ-9: Validity of a brief depression severity measure," *Journal of General Internal Medicine* 16 (2001), pp. 606–613; E. B. Foa, C. P. McLean, Y. Zang, et al., "Psychometric properties of the Posttraumatic Stress Disorder Symptom Scale Interview for DSM-5 (PSSI-5)," *Psychological Assessment* 28 (2016), pp. 1159–1165.

26. American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, 5th ed. (Arlington: American Psychiatric Association, 2013).

27. Z. S. Nasreddine, N. A. Phillips, V. Bedirian, et al., "The Montreal Cognitive Assessment, MoCA: A brief screening tool for mild cognitive impairment," *Journal of the American Geriatrics Society* 53 (2005), pp. 695–699.

28. See, for example, M. Hutchinson and P. Dorsett, "What does the literature say about resilience in refugee people? Implications for practice," *Journal of Social Inclusion* 3 (2012), pp. 55–78.

29. Office of the United Nations High Commissioner for Human Rights (see note 7).

30. Physicians for Human Rights (2012, see note 8); HealthRight International (2010, see note 8); M. Peel and V. Iacopino, *The medical documentation of torture* (San Francisco: Greenwich Medical Media, 2002).

31. R. Park and J. Oomen, "Context, evidence and attitude: The case for photography in medical examinations of asylum seekers in the Netherlands," *Social Science and Medicine* 71 (2010), pp. 228–235.

32. H. Zonana, "Commentary: The role of forensic psychiatry in the asylum process," *Journal of the American Academy of Psychiatry and the Law* 38 (2010), pp. 499–501; J. Ramji-Nogales, A. Schoenholtz, and P. Schrag, "Refugee roulette: Disparities in asylum adjudication," *Stanford Law Review* 60 (2007), p. 95.

33. P. Hernández, D. Gangsel, and D. Engstrom, "Vicarious resilience: A new concept in work with those who survive trauma," *Family Process* 46 (2007), pp. 229–241.

34. Mishori et al. (see note 6); A. Joscelyne, S. Knuckney, M. L. Satterthwaite, et al., "Mental health functioning in the human rights field: Findings from an international internet-based study," *PLoS ONE* 10 (2015).

35. C. A. Morgan, "Psychiatric evaluations of asylum seekers: Is it ethical practice or advocacy?" *Psychiatry* 4 (2007), pp. 26–33; C. D. Chacko, "Regarding psychiatric evaluations of asylum seekers," *Psychiatry* 4 (2007), p. 17; S. L. Lustig, "Psychiatric evaluations of asylum seekers: It's both ethical practice and advocacy, and that's ok!" *Psychiatry* 4 (2007), pp. 17–18.

36. McKenzie et al. (see note 5).