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Physician Advocacy in a "Culture of Disbelief": A Critical-Interpretive Study of Asylum Medicine

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Refugee studies scholarship has established that intense suspicion undergirds the process of refugee status determination, calling it, "a culture of disbelief." Meanwhile, literature in medical anthropology has found that medical practitioners play a key role in the control and management of asylum seekers when they act as forensic evaluators. This study focuses on a group of physician advocates involved in a medical advocacy movement called Asylum Medicine (AM): an expert witness project that sits uncomfortably at the intersection of forensics and human rights. This article contributes to scholarship by revealing that the "culture of disbelief" extends onto medical authorities. Taking a critical-interpretive approach to health communication, I discuss how AM practitioners deploy a range of tactics including following legal scripts for objective behavior; anticipating opposition for their advocacy outside of expert-witness situations; and using the language of trauma and post-traumatic stress disorder as shorthand to expeditiously respond to legal scrutiny. In a culture of disbelief that places medical objectivity in opposition to political advocacy, such tactics help AM practitioners execute an ethical stance where medical objectivity *is* political advocacy.

Keywords: physician advocacy, Asylum Medicine, forensic evaluations, refugee status determination

Refugee studies scholarship has established that a phenomenon known as the "culture of disbelief" (Anderson, Hollaus, & Williamson, 2014; Gibson, 2013; Jubany, 2017; Käkelä, 2022; Souter, 2011) undergirds refugee status determination (RSD) in wealthy states. In the past two decades, a pervasive anti-migrant culture has manifested through increased immigration restrictions, heightened policing and surveillance of migrant communities, and new forms of border militarization (De Genova & Peutz, 2010; Espiritu et al., 2022; Menjívar & Abrego, 2012; Menjívar, Ruiz, & Ness, 2019). Within current immigration policies, more asylum seekers are denied refuge than are accepted (Kerwin, 2012; Lawrence & Ruffer, 2014). The continued denial of refugee status for so many is only one symptom of what constitutes *a culture of disbelief.* Within an adversarial immigration process, asylum seekers' testimonies are treated as *false first*. In other words, although seeking asylum is a protected human right (Kerwin, 2012; Lawrence & Ruffer, 2014), asylum seekers in wealthy states are criminalized or treated as guilty until proven innocent.

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A culture of disbelief impacts the health of refugees, asylum seekers, and displaced migrants, whose well-being hinges on access to medical care via legal status and protection (Bäärnhielm, Laban, Schouler-Ocak, Rousseau, & Kirmayer 2017; Castañeda et al., 2015; Dawes & Williams, 2020; Khullar & Chokshi, 2019). Such protection is granted through RSD. Within the culture of disbelief, the testimony of medical professionals has emerged as a critical factor in shaping the outcomes of asylum seekers' claims for refugee status (Ferdowsian, McKenzie, & Zeidan, 2019; Lawrence & Ruffer, 2014). In the United States, where medical evaluations and medical care are not available to asylum seekers, immigration lawyers solicit the input of medical professionals to provide expert testimony for asylum claims (Ferdowsian et al., 2019; Lawrence & Ruffer, 2014). Medical practitioners are considered authoritative in legal settings not only because of clinical knowledge but also because of their reputation as "objective" professionals (Ferdowsian et al., 2019; Good, 2007). Specifically, medical professionals are sought out because medical evidence and diagnoses of physical and psychological injuries can qualify as "forensic evidence," suggestive of the "proof of persecution" required in an asylum claim. Consequently, there has been an increasing demand for medical expert witnesses to conduct forensic evaluations in the refugee determination processes.

This study delves into the communication strategies and negotiations employed by an emergent and porous medical social movement called Asylum Medicine (AM). At its broadest, I understand AM as involving the work of physicians who advocate for migrant health equity and engage in different kinds of witnessing projects across multiple contexts. Varied AM interventions can include providing written and/ or verbal expert testimony for RSD cases; writing public op-ed pieces that critique immigration restrictions; publishing academic research on AM data and outcomes; training and mentoring other medical professionals on how to advocate for migrants' rights; conducting forensic exams of asylum seekers; hosting AM trainings using institutional spaces and resources; or conducting forensic exams over Zoom or Skype when using institutional resources are forbidden for such purposes. This study focuses on one of these endeavors: AM's "expert witness project."

The expert witness project sets out to train physicians on how to conduct and report forensic evaluations of asylum seekers. Despite a defined set of best practices and delineation of roles, the expert witness project sits uncomfortably at the intersection of forensics and human rights. The emergent and porous nature of the AM movement means that seemingly distinct roles like those of medical practitioners, physician advocates, and forensic evaluators bleed into or influence each other. While formal AM discourses found in training materials follow legal scripts in their attempt to distinguish among these roles (medical practitioner, physician advocate, and forensic evaluator) this study unpacks the underlying motivations of the AM movement and the communicative challenges faced by AM practitioners. "AM practitioners" refers to physicians who have undergone specific AM trainings. The AM practitioners interviewed in this study range from those who are significantly invested (e.g., as AM trainers who conduct multiple evaluations a year and drive AM workshops) to those who are loosely connected to a network of AM practitioners (e.g., as medical students or physicians who sporadically conduct evaluations after having attended a training). As forensic evaluators, an AM practitioner's role is to assess the physical and psychological symptoms exhibited by asylum seekers. These evaluations play a critical role in RSD, offering evidence to corroborate the narratives of individuals fleeing persecution and seeking refuge in the United States (Ferdowsian et al., 2019). Outside of their role as forensic evaluators and expert witnesses, most AM practitioners self-identify as physician advocates (Fisher, 2018; Gusmano, 2019; Paul, 2019). They use their expertise and social authority to

advocate for migrants' rights through varied advocacy efforts like writing op-eds, training and educating other medical professionals on how to provide expert testimony, and/ or fighting for policy change to provide health care to migrants. The term "AM practitioner" aims to capture a hybrid professional identity where the seemingly distinct roles of forensic evaluator/ expert witness, physician advocate, and medical caregiver blend into each other. Discussing the AM practitioner as forensic evaluator-as-physician-advocate-as-medical-caregiver simultaneously highlights the dilemmas of physician advocates operating within a culture of disbelief and the maneuvers they use to affirm their stance that medicine is advocacy.

As suggested, the central communication challenge of AM is the unresolved question of whether the work undertaken by AM practitioners should be understood as "advocacy." While critics of physician advocacy argue that medicine and political advocacy do not and should not mix (Huddle, 2011), proponents contend that advocacy is an inherent part of practicing medicine (Fisher, 2018; Gusmano, 2019; Paul, 2019). Some physician advocates cite the Hippocratic oath taken by physicians, which compels them to abide by certain ethical standards, while others contend that central to an understanding of a person's health is their social and political context (Hubinette, Dobson, Scott, & Sherbino, 2017). This study animates this debate by discussing the nuances in the roles and responsibilities of AM practitioners whose work sits awkwardly at the intersection of forensics and social justice. As this article demonstrates, AM practitioners grapple with the ethical imperative to both demonstrate objectivity to legal audiences while advocating for the rights and well-being of asylum seekers.

Taking a critical interpretive approach to health communication (Dutta, 2010; Lupton, 1994; Zoller & Kline, 2008), I discuss the communication tactics of AM practitioners. I do this through a multifaceted research approach by conducting in-person and digital ethnographic observations of AM trainings and in-depth semi-structured interviews of 27 AM practitioners and by documenting the analysis of affidavit templates and an AM guidebook (McKenzie, 2022). Most of the practitioners interviewed in this study are leaders in AM. The sample size reflects various medical specialties such as psychiatry, pediatrics, internal medicine, and emergency medicine. This approach yields critical insights into the communication strategies of healthcare professionals who are scrutinized for their advocacy.

American RSD and an Emphasis on "Credibility"

In the summer of 2018, during the time of this research, two new asylum policies targeted Central American migrants. The first removed protections for migrants who were fleeing persecution from gang and domestic violence (Medel & Ramírez, 2020). The removal of these protections discriminated against gendered, brown bodies who are most likely to be victims of such violence (McKinnon, 2009). Second, the administration took a "zero-policy" stance toward undocumented migrants, continuing a long history of classifying Central American migrants as "criminals" (Medel & Ramírez, 2020). These policy changes drastically reduced asylum seekers' avenues for protection. At the same time, they prompted an outpouring of support and resistance efforts. One of the advocacy responses is the snowballing of AM.

Credibility and the REAL ID Act

A primary feature of the contemporary U.S. culture of disbelief of migrants includes an emphasis on credibility in RSD. To corroborate their claim, it is incumbent on the asylum seeker to provide evidence as "proof of persecution." Due to the erratic and unexpected conditions of migration, there is often limited "proof of persecution." As a result, immigration judges rely on determinations of credibility (Good, 2007; Lawrence & Ruffer, 2014) and have great discretionary powers to dismiss a claim based on "lack of credibility." While determinations made on credibility have helped make long and complex asylum cases more efficient (McKinnon, 2009), the consequence has been that asylum seekers must be able to demonstrate persecution in ways that are immediately and undeniably legible to immigration judges. The REAL ID Act, introduced in 2005, formalized the emphasis on credibility. According to Lawrence and Ruffer (2014), the REAL ID Act "even encourages immigration judges to find asylum seekers lacking credibility even if the discrepancies or miscomprehensions in their responses refer to matters ancillary to their particular claim" (pp. 8–9). The communicative dilemmas discussed in this project emerge from this tumultuous historical and legal background of introducing and repealing migrant rights. In the absence of documented proof of persecution, the asylum seeker's body is treated as the primary witness to their persecution (Fassin & D'Halluin, 2005; Pestre, 2012). This has resulted in the reliance on expert witnesses who have the authority to "corroborate" or "interpret" the asylum seeker's body and psyche through medical diagnoses. In other words, "correct" asylum claims are supported by medical professionals who document medical evidence. This does not point to an "innate" correctness but to a "demonstrated" correctness where communicative acts fulfill a persuasive role within a system that has limited ways of recognizing the value of human life.

A Critical Interpretive Approach to Health Communication

As laid out in the previous section, my approach to studying migrant health is grounded in the recognition that American immigration policy is not neutral. This calls for a critical examination and reorientation of traditional health communication frameworks that recognize the political and power dynamics undergirding the research context. Such an orientation falls under the objectives of *critical* health communication (Dutta, 2010; Hernández, 2019; Lupton, 1994; Sastry, Zoller, & Basu, 2021; Zoller & Kline, 2008). Critical health communication is invested in challenging existing power structures with the aim of fostering health equity and justice. Alternative methods of health communication that center on structural power and the politics of medical authority are essential, especially in addressing migrant health.

Frameworks within critical health communication theory, including critical-interpretive approaches and culture-centered approaches, offer nuanced perspectives to navigate the complexities of migrant health. These frameworks are adept at analyzing the effects of state violence on marginalized identities intersecting with class, race, gender, and sexuality. They align with social movements that critically engage with political violence and support scholarship that complements activism on the ground (Dutta, 2010; Hernández, 2019; Lupton, 1994; Sastry et al., 2021; Zoller & Kline, 2008).

Theoretical insights from critical health communication research provide a valuable lens to examine the communication tactics employed by AM practitioners. I focus on how these practitioners negotiate the terrain between legal expectations of medical objectivity and self-expectations of medical advocacy. There

is a need to engage with the interpersonal and professional practices and logics that structure migrant health to challenge the broader culture of disbelief.

Qualitative Methods

This study adopts a multi-method approach to unpack the complexities of AM's communication strategies. The entirety of the study, from data collection to analysis, took place during Donald Trump's 2016–2022 presidency. During this time, there were several erratic changes to immigration policy such as the "Muslim ban," halted refugee proceedings, the building of a wall along the Southern U.S.-Mexico border, the separation of migrant children from their families, and increased detention of asylum seekers in prison-like settings. These affronts to migrants' rights accelerated the expansion of AM movement and network.

In addition to traditional ethnographic methods, I used digital ethnography to capture the nuances of online interactions within the AM community and reveal shifts and developments within the movement amid the COVID-19 pandemic. Semi-structured interviews with practitioners provided invaluable insights into the decision-making processes and ethical dilemmas within AM. These interviews highlighted the competing demands and tensions inherent in navigating the role of a medical expert witness within a highly politicized context shaped by a broader culture of migrant disbelief. I used snowball sampling to interview 27 physicians. The semi-structured interviews focused on themes of what clinical objectivity meant to the physicians, what advocacy means, participation in AM, experiences of providing testimony, negotiation of political and objective roles, and best practices.

To complement the ethnographic data, I conducted a document analysis of *Asylum Medicine: A Clinician's Guide* (McKenzie, 2022) to gain insights into the norms and principles governing the movement's communication practices. I also analyzed more than 1,000 pages of documents, including training materials, academic publications, and media articles like opinion pieces written by leading AM practitioners. I conducted the data analysis using a thematic analysis approach, drawing from Berg and Lune (2012). The process involved several key steps. I began by listening to and transcribing the interviews and reading through the transcripts multiple times to gain a comprehensive understanding of the content and context of AM. Next, I systematically coded the data by identifying significant statements and assigning initial codes to segments of text that appeared relevant to my research questions (e.g., the professional and personal dilemmas that AM practitioners faced). The initial codes were then reviewed and grouped into potential themes. This involved looking for patterns and broader categories that could encapsulate the codes, for example, legal scripts and expectations of objectivity. I refined the themes by ensuring they accurately reflected the coded data and were distinct from each other. This step also included comparing themes across different data sets to ensure consistency. Finally, I defined and named each theme to capture the essence of the data succinctly. Each theme was accompanied by a detailed description and representative quotes from the data to illustrate its relevance.

In this analysis, I drew from the framework established by refugee studies scholarship, particularly the concept of a "culture of disbelief" that underpins RSD processes. This culture places intense suspicion on asylum seekers and I argue that this skepticism extends onto medical authorities involved in forensic evaluations.

I used a critical-interpretive approach to health communication to examine how AM practitioners navigate their roles at the intersection of forensic evaluation and migrant-rights-driven medical work. The analysis revealed that AM practitioners deploy various tactics to maintain their ethical stance that medical objectivity is inherently political advocacy. These tactics include following legal scripts for objective behavior, anticipating opposition for advocacy, and using the language of trauma and post-traumatic stress disorder (PTSD).

Through this thematic analysis, I uncovered the motivations underlying AM practice and the dilemmas faced by practitioners in demonstrating objectivity and trauma-informed practice. The findings contribute to understanding how the culture of disbelief extends to medical authorities working with asylum seekers and how these practitioners negotiate their dual roles as medical experts and advocates.

Results and Discussion

This qualitative health communication study reveals the pervasive influence of legal expectations to demonstrate physician objectivity on the communication practices of AM practitioners. Despite their widely accepted authority as "objective" experts, AM practitioners find themselves anticipating legal scrutiny if they are perceived to be "advocates." In response to this suspicious legal gaze, practitioners have adopted three key communication strategies. First, AM practitioners adopt legal scripts for medical objectivity. Second, they anticipate pushback specifically for their advocacy of migrants even when this advocacy falls outside of their role as expert witness. And third, AM practitioners, regardless of their specialization, rely on the legally legible language of trauma as shorthand to respond to legal suspicion. These strategies reveal how physician advocates exercise an ethical stance of *medical objectivity is political advocacy* in the face of legal suspicion.

Legal Scripts for Objectivity

Although AM practitioners derive their authority from being regarded as "objective," they are not immediately given the benefit of the doubt as expert witnesses in American RSD. Instead, in their role as expert witnesses, AM practitioners obey legal scripts on how to appear objective under the legal gaze. Their tactics for appearing objective include the following: emphasizing their medical credentials and authority more than they would in medical settings; verbalizing that they are limited in their role to determine the credibility of an asylum seeker's testimony even though it is an inherent part of their job when taking medical histories; and using the language of forensic evaluations instead of medical care, calling the asylum seekers "clients" instead of "patients" to manage legal expectations of objectivity.

Emphasizing Medical Credentials

AM training materials encourage prospective medical evaluators to demonstrate their objectivity by emphasizing their credentials. According to their trainings, this demonstrates the physician's credibility as an expert witness. The AM guidebook (McKenzie, 2022) also emphasizes that AM practitioners lead with medical credentials. A few of my interviewees shared their affidavit templates with me. These templates

consistently led with the physician's credentials as suggested in the trainings. The second page (which follows a title page) of an affidavit template is included below. Identifying information has been redacted.

> I, [redacted] hereby swear the following to be true and correct to the best of knowledge,
> Qualifications:
>
> 1. I am a citizen of the United States. I was born in [redacted]. I currently reside at [redacted]. I am a licensed physician in [redacted] and am board certified in the specialty of Internal Medicine. I graduated from Harvard Medical School and received my clinical training at the [redacted] in [redacted] in Internal Medicine.
> 2. During medical school, I spent a month working at [redacted] in [redacted] under the [redacted], learning to perform psychiatric evaluations of asylum applicants and document their histories. I have also undergone training through Physicians for Human Rights in the evaluation and documentation of the physical and psychological sequelae of torture. I have taught courses on the medical care and evaluation of survivors of torture throughout the United States, as a medical consultant for Doctors without Borders.
> 3. Currently, I am a member of the Section of General Internal Medicine at [redacted] and am an Assistant Professor at [redacted]. I currently serve as the Director of [redacted] at [redacted] My clinical practice focuses on care of asylum seekers, immigrants and refugees, many of whom have experienced torture. In that role, I see patients and teach residents about care for refugees, asylees and survivors of torture.
> 4. I am a member of the Forensic Medical Evaluation Group, a multidisciplinary group at [redacted] and [redacted] providing evaluation and documentation of physical and psychological evidence of torture and abuse. I have previously been qualified as an expert witness in the [redacted]

This template illustrates that physicians demonstrate credibility to the courts in the form of credentials. It is noteworthy that in this template, the physician lists three extra qualifications in addition to being a board-certified physician. On one hand, listing credentials is in line with the message reiterated across trainings and interviews. But listing *multiple* credentials and qualifications suggests that physicians need to prove their competency against skepticism. In response, physician advocates perform objectivity by listing not one but as many medical qualifications as possible. As an expert witness, physicians only need to be able to conduct medical exams and take medical histories; hence, a single line attesting to the fact that they are board-certified should be sufficient. The presence of lists, however, responds to a broader culture of suspicion where objectivity and credibility must be demonstrated.

Demonstrations of expert-witness credibility are one of the ways in which physician advocates manage legal expectations. A senior trainer underscores the importance of these lists, emphasizing that his credibility is not taken for granted:

> My intro is two pages of single-spaced stuff and I just throw everything at them, you know, every credential I can imagine to establish my own gravitas and credibility . . . And

> honestly, I think for a lot of judges, it's all they care about. Your credentials and the conclusion. That goes a long way.

The physician describes listing credentials as "throw[ing] everything at them . . . to establish my own gravitas and credibility." Such framing reveals the physician's awareness of the broader culture of skepticism, which requires objectivity as something that needs to be "proved." The awareness that he has to prove credibility for an audience is demonstrated in other parts of the quote where he says, "For a lot of judges, it's all they care about . . . it goes a long way." Across interviews, trainers expressed a similar strategy to demonstrate their own credibility in court. The culture of disbelief establishes norms of what credibility looks like and governs how medical practitioners present themselves and their evidence.

Perhaps the most explicit discussion of anticipating legal suspicion can be seen in the AM guidebook. In the chapter "Best Practices for Writing Affidavits and Preparing for Testimony," the authors (Gomez & Berthold, 2022) suggest that government attorneys will attempt to show bias by arguing that the physician "has only ever testified on behalf of asylum seekers (and never against their interests)" (p. 149). To challenge this, the chapter suggests that the AM practitioner can take the following approach:

> [The expert witness was] working at a nonprofit agency whose largest funder was the US government. The expert witness could further clarify that, in fact, their salary was primarily paid by the US government, and that the expert witness's agency was audited every year to ensure that it only served those who had experienced state-sponsored torture. (Gomez & Berthold, 2022, p. 149)

This argumentative move positions the physician as a government-funded agent making the physician legible to the court. The chapter (Gomez & Berthold, 2022) continues to offer other ways that an expert witness can perform objectivity by citing their "experience in training relevant federal personnel (such as training asylum officers or judges on the psychosocial effects of torture)" (p. 149). Again, the guidebook (McKenzie, 2022) suggests centering legal personnel like asylum officers and judges to highlight the importance of the physician's work when their credibility may be challenged.

Trainers also encourage prospective asylum evaluators to lean into the symbolic reputation of medical practitioners. In an interview, one psychiatrist argues that his medical training as an objective practitioner challenges the law's adversarial approach. He says, "What the patient tells you is happening, not necessarily what you're seeing, is going to be more important than what you see." Appealing to his medical training he says,

> In medical school, they say that the diagnosis comes ninety percent of the time from the history. And in psychiatry, it's like ninety-five or ninety-seven percent of the history . . . it's beneficial to be able to report on physical symptoms because people find that believable. But it's the standard of care in my practice to—when people come to me reporting symptoms in a way that's believable—to believe them, even without physical evidence of those symptoms.

This excerpt reveals that the evaluator is not only critical of the legal suspicion that asylum seekers face but also the suspicion that he may face as a psychiatrist. In the interview, he provides a glimpse of how he might respond if his credibility is questioned in the court. He emphasizes that his training in psychiatry approaches credibility very differently than the court. Unlike the legal default of suspicion, a psychiatrist is trained to believe patients. Like others discussed in this section, the psychiatrist demonstrates credibility by referring to and emphasizing his training and credentials.

Malingering as an Alternate Word for Credibility

In legal proceedings, only the judge has the authority to determine the credibility of the asylum seeker's claim. Consequently, immigration lawyers and AM trainers coach prospective expert witnesses to avoid using the language of credibility in their written and/or verbal testimonies. This could be problematic for physicians because, as many of them saw it, determining credibility is an inherent, almost intuitive, aspect of conducting a medical evaluation. The primary difference between AM practitioners and immigration judges is that most AM practitioners assume credibility until they find evidence against it, while immigration judges tend to exercise skepticism against credibility.

While physicians abide by the legal scripts and refrain from using the language of credibility, some of them mentioned that they used the language of "malingering" as an alternative way of addressing the claimant's credibility. Malingering is the medical term for feigning illness. Many of my interviewees find "malingering" to be an uncomfortable topic. This discomfort was also reflected in trainings and the AM guidebook (McKenzie, 2022). According to almost all the AM psychiatrists interviewed in this study, there are no robust tests for malingering. As a result, practitioners tend to take two different approaches to addressing malingering in their testimonials. Some do not address it in their written or verbal testimonies because they do not test for it, while others say they address it as a way of weighing in on claimant credibility without using the language of credibility. With regard to asylum seekers' credibility, most physicians say they rely on their own medical instincts—developed over years of training. They contend that their medical instincts are more reliable than unsubstantiated tests for malingering. The AM guidebook encourages prospective asylum evaluators to approach malingering in a similar manner: "Evaluators may weigh in on the believability of an asylum-seeker by explaining why their assessment does not support malingering" (Gomez & Berthold, 2022, p. 135). Malingering is discussed eight times throughout the guidebook. Seven of the eight times, it treats malingering as a signifier of credibility. Only once, in a chapter on conducting remote evaluations (Raker & Niyogi, 2022), does the guidebook offer a tool for testing malingering when the medical evaluator is not physically in the same room as the asylum claimant. The hesitant communication around malingering suggests that while evaluators do not test for malingering, they may use the language of malingering strategically in their legal testimonies if it can add credibility to an asylum seeker's claim.

"Clients" Instead of "Patients"

Finally, one of the common practices in AM is the adoption of forensic terminology to enhance legibility in courts. This shift both reduces friction in communicating with the judicial system and underscores the unique role of medical professionals in these contexts. One of the most prominent experts in the field,

Katherine C. McKenzie (2022), writes in the introduction of the AM guidebook, "Practices in the field include referring to asylum seekers as 'clients,' rather than 'patients,' in recognition of the non-caregiving role of medical forensic evaluators" (p. vi). This terminology reflects a critical understanding that the primary function of these evaluations is not therapeutic but rather to provide an objective, forensic analysis that can support legal proceedings. By adopting legal language, practitioners align their work more closely with the standards and expectations of the court. This practice ensures that the assessments are perceived as impartial and professional, which is crucial for the adjudication of asylum claims.

Anticipating Pushback for Advocacy Done Outside of Expert Witnessing

Another strategy that AM trainings espouse in the face of suspicion is preparing practitioners to be challenged on their advocacy activities beyond their role as an evaluator. AM's tenuous relationship with the objectivity–advocacy dichotomy is revealed in the guidebook's warning to clinicians. In their chapter ("Best Practices for Writing Affidavits and Preparing for Testimony") Gomez and Berthold (2022) assert,

> An evaluator's role in the litigation is to provide **objective evidence** about the asylum seeker's physical or mental state. Further, evaluations are generally submitted in the form of a sworn affidavit or declaration under penalty of perjury. Evaluators must only submit testimony that **they believe to be true**, or else risk committing perjury, and they must maintain an **objective tone** and purpose in their evaluations. **Showing clear bias in favor of the asylum seeker or reaching dubiously favorable findings and conclusions is not only ethically questionable, but it may also render the evaluation less reliable as evidence, defeating the purpose of the endeavor.** (p. 148; emphasis, my own)

The writers of this chapter (Gomez & Berthold, 2022) straddle a complicated and fine line. There are several ways in which they reveal their intended audience: A group of advocates, rather than a group of forensic evaluators. While they emphasize that the evaluator must be objective, they seem to recognize that objectivity is not assumed by legal audiences and that it must be demonstrated to the judge. Gomez and Berthold (2022) offer two ways in which evaluators can demonstrate this objectivity. The first is through evidence. The second is through tone. Anticipating the possibility that evidence can be falsified, the writers (Gomez & Berthold, 2022) warn that physicians are required by law to "submit testimony that they believe to be true" (p. 148). While this warning forecloses the possibility of fabricating evidence, it does not close off the possibility of multiple medical interpretations and the value of diverse medical opinions. This is a marked difference from traditional diagnostic practices, which make determinations of correct and incorrect ways of diagnosing. For legal purposes, what is required is that physicians *believe* their own testimony. Gomez and Berthold (2022) go on to say that "showing clear bias in favor of asylum seeker [can] . . . defeat the endeavor" (p. 146). They do not discourage physicians from sympathizing with asylum seekers but discourage *showing it*. This reveals the lightly veiled assumption that most people reading the guidebook are intent on helping asylum seekers. The guidebook (McKenzie, 2022) warns that an evaluator's good intentions of being "in favor of the asylum seeker" can "defeat the purpose of the endeavor" (Gomez & Berthold, 2022, p. 146). In other words, evaluators should exercise caution regarding how their good intentions are *presented*.

This sentiment is repeated in trainings where trainers make an additional point to connect well-intentioned individuals to the broader AM movement. At a comprehensive two-day online AM training, a trainer gently addresses "benevolent desires." His tone is calm and affirming:

> Out of really just benevolent kind of desires, you might want to step beyond what you're capable of doing [or realm of expertise]. And I think it's important to recognize those desires and understand where that they're coming from a good place . . . or maybe there's the desire to kind of cut a corner when coordinating with a legal representative—to maybe overstate a finding. There may be some short-term gains to that, but there could also be some longer-term consequences, **including slowly undermining the credibility of yourself or your partners or even the larger community of health care providers that do this work.**

Echoing the sentiment laid out in the guidebook, the physician seems to only note benevolent desires. No mention is made of possible negative biases or assumptions that evaluators may have. Fabricated evidence and overstated findings are framed within the context of "coming from a good place," which can endanger the broader community of healthcare providers. By connecting the individual with the collective, AM trainings teach and encourage trainees to look at the objectivity–advocacy binary from the perspective of the law rather than what many physician advocates hold to be true and intuitive: That objectivity *is* advocacy.

Evaluators from two medical specialties have an especially hard time with this legal distinction: Pediatricians are professionally obligated to be advocates of their patients, and psychiatrists who have undergone board training in forensic evaluations view their AM pro bono work as very different from being hired as a government forensic psychiatrist. In anticipation of legal scrutiny, interviewees from both these specializations leaned into their medical training to assert that they were professionally obligated to be advocates of the people they evaluated and diagnosed.

Physicians of internal medicine and emergency medicine, on the other hand, tended to frame their evaluations as distinct from their advocacy work. As one interviewee said, "I can be protesting on the streets for migrants' rights on Thursday and conduct a completely objective medical evaluation on a Friday. They are mutually exclusive." One interviewee went to great lengths to hide her advocacy from the public, "I don't have any social media accounts, I never post, or write op-eds because they can be used to undermine my credibility and against my clients. I am always thinking, how would the judge in Texas view this?" In this case, "the judge in Texas" refers to the fact that asylum seekers are more likely to be denied in politically conservative states like Texas and that immigration judges reflect the political biases of the state that they practice in. A few physicians discussed situations in which the immigration lawyer strongly suggested that they omit their advocacy work from their resumes and, occasionally, their online public profile. While some physicians were okay with complying with this, it caused confusing distress for others.

Language of Trauma and PTSD as Shorthand to Respond to a Suspicious Legal Gaze

AM practitioners use a third strategy to respond to the legal suspicion that they face because of their association with asylum seekers. The language of trauma and the diagnosis of PTSD is particularly helpful in explaining what the legal gaze may perceive as "dubious," including claimants' inability to apply by the one-year filing deadline. In the period that I conducted my interviews, physicians reported that the "one-year filing" deadline was one of the most common reasons that they were approached for affidavits. When physicians were approached to provide expert testimony, lawyers would ask them if there could be a medical reason why the claimant did not meet their deadline. A physician compares two scenarios concerning the one-year filing deadline:

> I've met with folks who were like, *oh, I just didn't know that there was a deadline and so I didn't do it.* And then that's not super useful. But then, I've met other folks who are like, well, *I guess I'm super depressed. And I had a really, really hard time just like getting anything done or my trauma symptoms are so bad. Every time I thought about it, I had a huge panic attack and never felt like that was relevant.* This addresses a rebuttal from the government.

While the physician does not provide opinions about the "one-year" filing deadline or comment on whether it should be redacted from a mental health perspective, the interviewee speaking from the perspective of a medical evaluator, describes certain kinds of language as "useful" for the asylum seeker's claim. This implies a position of strategizing *with* the claimant as opposed to against. This distinction is important in parsing the nuances and windows of opportunity for policy change. If AM practitioners document enough evidence to support the claim that the one-year filing deadline itself adversely affects a claimant's health, the movement may be well positioned to influence policy down the road.

AM practitioners also rely on the layman's understanding of a PTSD diagnosis and public discourses of trauma to strategically help a medically illiterate audience understand the effects of persecution on a person's psyche and capacities. As one psychiatrist explained, in cases where his medical diagnosis was too obscure or complex for a legal audience to understand, he would use the PTSD diagnosis to facilitate communication. In medical contexts, a PTSD diagnosis is generally only made by certified psychiatrists, however, in AM situations, physicians from other specialties undergo training specifically so they can diagnose and speak to the symptoms of PTSD. In addition to alluding to the high incidence of PTSD in asylum seekers, it also speaks to the persuasive power of PTSD to communicate the possibility of past persecution.

The AM guidebook describes three ways psychological evaluations can be crucial in addressing a culture of disbelief in asylum cases. First, a medical evaluator can "explain the effects of trauma and stress on memory" (Gomez & Berthold, 2022, p. 135). Second, they can comment on an asylum claimant's behavior and "demeanor." Third, as discussed in the previous section, while trainers advise against using the language of credibility, which is "a legal finding that only an adjudicator can make" (Gomez & Berthold, 2022, p. 135), they may choose to comment medically on "malingering." Dominant AM discourses train

mental health evaluators to comment on narrative inconsistencies in an asylum claim using the language of trauma and PTSD. The guidebook explains that

> Where an applicant may be unable to describe specific details, recount events sequentially, or recall events without variability, a psychological evaluation may help explain how these occurrences are consistent with having survived trauma and explain the effects of trauma and stress on memory. (Gomez & Berthold, 2022, p. 135)

Across all the chapters, the guidebook makes little to no effort to suggest that narrative inconsistencies may be a result of fabricated narratives. This suggests that AM shapes physicians to be migrant advocates while trying to help physicians navigate the suspicious gaze of RSD. In addition to narrative gaps or inconsistencies, trainings encourage psychological evaluators to comment on demeanor inconsistencies. For example, materials from one training explain that

> If an applicant's demeanor is flat, dissociative, or seemingly out of character with the tenor of the testimony, a psychological evaluation could identify these testimonial characteristics as consistent with conditions such as post-traumatic stress disorder, major depressive disorder, dissociative disorders, or other conditions that could result from surviving traumatic events. (Gomez & Berthold, 2022, p. 135)

Again, the guidebook helps prospective evaluators identify and intervene in incidents of misunderstanding and misrepresentation by the court. Furthermore, it guides prospective evaluators toward possible diagnoses and medical language to help them make the direct connection between their expertise and perceptions of disbelief harbored by the court.

AM evaluators are also involved in connecting the symptoms of an asylum seeker to the established clinical understanding of trauma and interpreting physical and psychological sequela for legal audiences. As the senior trainer says in the following excerpt, trauma can "explain behaviors that might otherwise be looked at dubiously" and went on to add,

> As an expert witness, I think your role is to testify about that individual and then about trauma broadly. You can say, based on your understanding of the literature and your clinical expertise, that someone's behavior and appearance in court and their historic symptoms are related to their trauma and ways in which that may manifest in court and **explain behaviors that might otherwise be looked at dubiously**, like when people report their trauma without breaking down crying or when they have trouble remembering very specific details of the trauma . . . Those are the roles of the expert witness in this regard.

This excerpt reveals how physicians use not only their authority but also their discretion to strategically challenge the culture of disbelief that expects particular performances from persecuted individuals. Legal expectations reinforce not only the notion that persecuted migrants will develop PTSD but also that PTSD results in particular kinds of affective presentations—like breaking down, crying, as this example suggests.

AM trainers emphasize that asylum evaluators can play a critical role in debunking this myth. In other words, physician advocates take part in curating believability specifically by using their expertise to address and challenge the suspicious gaze of the immigration system that treats nonconforming presentations as not credible. In so doing, they exploit the legal dichotomy of the objectivity–advocacy binary to challenge the culture of disbelief.

In a contrasting example, a psychiatrist describes how a psychiatric understanding of trauma can explain denial or avoidance of persecution in an asylum seeker. The psychiatrist describes it as a case of "lying in the other direction":

> [One man I evaluated had] experienced a lot of anti-Semitic discrimination, including assaults on his family and home, like flaming bricks . . . he was very buttoned up and culturally experienced a lot of shame around having any psychological sequela of the trauma . . . [his feelings of shame meant that] he was highly motivated to not report anything at all. So he was . . . **lying in the other direction** . . . [but] it was clear in the course of the interview that he was experiencing a ton of psychological symptoms . . . toward the end, after having relayed his experience in a monotone, but tightfisted kind of way, he just broke down crying. He couldn't talk anymore . . . [without my testimony] he would never be able to say, "I'm experiencing these symptoms" because he's so heavily avoidant. [In the courts] that can be taken as evidence that he didn't experience the trauma when in fact, his avoidance is so dense, he can't even report symptoms. I mean, **that was an important distinction for us to be able to make for the judge and important for us as psychiatrists to be able to weigh in, because it could have easily been missed if we didn't keep going**.

In this case, "lying in the other direction" means that the claimant is inclined to underreport or not report their symptoms. In this excerpt, the AM practitioner explains how he uses the language of trauma to challenge the suspicious legal assumption that asylum seekers will overreport their symptoms to gain asylum. Based on the framing used in this excerpt, it is not sufficient that the physician was able to document psychological sequelae. A medical diagnosis of trauma helps to explain seemingly contraindicative behavior. In this case, a claimant's denial of having psychological symptoms of trauma does not mean that he is not distressed or that he did not face persecution. According to the psychiatrist, PTSD can explain how the opposite is true: The claimant's avoidance of talking about his traumatic experiences or psychological distress is, in the medical perspective, evidence that he has had traumatic experiences and psychological distress. Using the phrase "lying in the other direction," the physician contextualizes an asylum seeker's medical symptoms within social practices of hiding shame to imply that the claimant had faced discrimination due to his religion. In this way, AM strategy involves using trauma to join the seemingly disparate elements of social, cultural, and political life together and helping make political persecution believable when an asylum seeker's behavior does not meet the legal expectations regarding a persecuted individual.

In addition to explaining counterintuitive behavior, AM strategy also involves explaining negative or uncooperative behaviors. The following excerpt from an interview discusses a range of other behaviors that the courts need to be educated on:

> [It] offers an explanatory model for the way that someone's psychological presentation occurs. So people with accumulated minor traumas—in addition to having symptoms of PTSD—also have other symptoms more often than [trauma caused by] a singular event. **They'll be more likely to have really tumultuous relationships and mistrust people [or they are] more likely to dissociate or remove themselves from their lived experience when things get really overwhelming. They may have what appears to be personality disorders: severe mood swings, sensitivity to insults, inability to trust, and feeling very empty, etc.**

To a physician who is not trained in how to be an expert witness, the range of symptoms may seem too broad for a single diagnosis. However, within AM practice and for efficiently communicating with a legal audience, both crying and not crying can be attributed to a traumatic event related to persecution. To make their case, physicians must work closely with lawyers to make connections between the medical evaluation and the political context such that a medical lens can make persecution visible to the law.

Conclusion

This article has examined the communicative dilemmas faced by physician advocates involved in the AM movement. Specifically, it described the nuanced strategies that AM practitioners take up as forensic evaluators in RSD. The study revealed that the "culture of disbelief" established in refugee studies scholarship also extends to medical expert witnesses. The exploration of AM strategy discusses how physician advocates exercise the ethical stance: medical objectivity is political advocacy in the face of legal scrutiny. By adopting a critical-interpretive approach to health communication, I have elucidated the tactics employed by AM practitioners to negotiate this fraught landscape. These tactics include adherence to legal scripts, anticipation of opposition to advocacy, and the strategic use of trauma language to navigate legal scrutiny efficiently. As this study demonstrates, the intersection of medical practice and asylum advocacy represents a site of resistance against the prevailing culture of disbelief. By illuminating the strategies employed by AM practitioners, this research contributes to a broader dialogue on the role of healthcare professionals in advancing social justice and human rights in the context of refugee protection.

References

Anderson, J., Hollaus, J., & Williamson, C. (2014). *The culture of disbelief.* Refugee Studies Center. Retrieved from https://www.rsc.ox.ac.uk/files/files-1/wp102-culture-of-disbelief-2014.pdf

Bäärnhielm, S., Laban, K., Schouler-Ocak, M., Rousseau, C., & Kirmayer, L. J. (2017). Mental health for refugees, asylum seekers and displaced persons: A call for a humanitarian agenda. *Transcultural Psychiatry, 54*(5–6), 565–574. doi:10.1177/1363461517747095

Berg, B. L., & Lune, H. (2012). *Qualitative research methods for the social sciences* (8th ed.). Upper Saddle River, NJ: Pearson.

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M.-E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health, 36*(1), 375–392. doi:10.1146/annurev-publhealth-032013-182419

Dawes, D. E., & Williams, D. R. (2020). *The political determinants of health*. Baltimore, MD: Johns Hopkins University Press.

De Genova, N., & Peutz, N. (Eds.). (2010). *The deportation regime: Sovereignty, space, and the freedom of movement*. Durham, NC: Duke University Press. doi:10.1215/9780822391340

Dutta, M. J. (2010). The critical cultural turn in *health communication*: Reflexivity, solidarity, and praxis. *Health Communication, 25*(6–7), 534–539. doi:10.1080/10410236.2010.497995

Espiritu, Y. L., Duong, L. P., Vang, M., Bascara, V., Um, K., Sharif, L., & Hatton, N. (2022). *Departures: An introduction to critical refugee studies*. Berkeley: University of California Press.

Fassin, D., & D'Halluin, E. (2005). The truth from the body: Medical certificates as ultimate evidence for asylum seekers. *American Anthropologist, 107*(4), 597–608. doi:10.1525/aa.2005.107.4.597

Ferdowsian, H., McKenzie, K., & Zeidan, A. (2019). Asylum medicine: Standard and best practices. *Health and Human Rights, 21*(1), 215–225.

Fisher, K. (2018). Physician advocacy: The importance of both organizational and individual doctor voices. *Academic Medicine, 93*(2), 152–153. doi:10.1097/ACM.0000000000002057

Gibson, S. (2013). Testimony in a culture of disbelief: Asylum hearings and the impossibility of bearing witness. *Journal for Cultural Research, 17*(1), 1–20. doi:10.1080/14797585.2011.613221

Gomez, V., & Berthold S. M. (2022). Best practices for writing affidavits and preparing for testimony. In K. C. McKenzie (Ed.), *Asylum medicine: A clinician's guide* (pp. 133–152). Cham, Switzerland: Springer.

Good, A. (2007). *Anthropology and expertise in the asylum courts*. Retrieved from https://doi-org.proxy.lib.uwaterloo.ca/10.4324/9780203945346

Gusmano, M. K. (2019). Physician advocacy for public health. *Journal of Health Politics, Policy and Law, 44*(1), 5–41. doi:10.1215/03616878-7206707

Hernández, L. H. (2019). Feminist approaches to border studies and gender violence: Family separation as reproductive injustice. *Women's Studies in Communication, 42*(2), 130–134. doi:10.1080/07491409.2019.1605213

Hubinette, M., Dobson, S., Scott, I., & Sherbino, J. (2017). Health advocacy. *Medical Teacher, 39*(2), 128–135. doi:10.1080/0142159X.2017.1245853

Huddle, T. S. (2011). Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Academic Medicine, 86*(3), 378–383. doi:10.1097/ACM.0b013e3182086efe

Jubany, O. (2017). *Screening asylum in a culture of disbelief*. Cham, Switzerland: Palgrave Macmillan. Retrieved from http://link.springer.com/10.1007/978-3-319-40748-7

Käkelä, E. (2022). Strategies of denial: Women's experiences of culture of disbelief and discreditation in the treatment of asylum claims on the grounds of female genital cutting (FGC). *Journal of Ethnic and Migration Studies, 48*(3), 560–577. doi:10.1080/1369183X.2021.1943337

Kerwin, D. (2012). The faltering US refugee protection system: Legal and policy responses to refugees, asylum-seekers, and others in need of protection. *Refugee Survey Quarterly, 31*(1), 1–33. doi:10.1093/rsq/hdr019

Khullar, D., & Chokshi, D. A. (2019). Challenges for immigrant health in the USA—the road to crisis. *The Lancet, 393*(10186), 2168–2174. doi:10.1016/S0140-6736(19)30035-2

Lawrence, B. N., & Ruffer, G. (2014). *Adjudicating refugee and asylum status: The role of witness, expertise, and testimony.* Cambridge, UK: Cambridge University Press. doi:10.1017/CBO9781107706460

Lupton, D. (1994). Toward the development of critical health communication praxis. *Health Communication, 6*(1), 55–67. doi:10.1207/s15327027hc0601_4

McKenzie, K. C. (Ed.). (2022). *Asylum medicine: A clinician's guide*. Cham, Switzerland: Springer.

McKinnon, S. L. (2009). Citizenship and the performance of credibility: Audiencing gender-based asylum seekers in U.S. immigration courts. *Text and Performance Quarterly, 29*(3), 205–221. doi:10.1080/10462930903017182

Medel, C., & Ramírez, Y. (2020). "When is a migrant a refugee?": Hierarchizing migrant life. In M. Franz & K. Silva (Eds.), *Migration, identity, and belonging* (pp. 67–80). New York, NY: Routledge.

Menjívar, C., & Abrego, L. J. (2012). Legal violence: Immigration law and the lives of Central American immigrants. *American Journal of Sociology, 117*(5), 1380–1421. doi:10.1086/663575

Menjívar, C., Ruiz, M., & Ness, I. (2019). Migration crises: Definitions, critiques, and global contexts. In C. Menjívar, M. Ruiz, & I. Ness (Eds.), *The Oxford handbook of migration crises* (pp. xxx–18). Oxford, UK: Oxford University Press. Retrieved from http://oxfordhandbooks.com/view/10.1093/oxfordhb/9780190856908.001.0001/oxfordhb-9780190856908-e-71

Paul, D. W. (2019). Medical training in the maelstrom: The call to physician advocacy and activism in turbulent times. *Academic Medicine, 94*(8), 1071–1073. doi:10.1097/ACM.0000000000002765

Pestre, É. (2012). Instrumentalizing the refugee's body through evidence. *Recherches en Psychanalyse, 14*(2), 147a. doi:10.3917/rep.014.0147a

Raker, E., & Niyogi, A. (2022). Performing remote asylum evaluations. In K. C. McKenzie (Ed.), *Asylum medicine: A clinician's guide* (pp. 123–132). Cham, Switzerland: Springer.

Sastry, S., Zoller, H. M., & Basu, A. (2021). Editorial: Doing critical health communication: A forum on methods. *Frontiers in Communication, 5*, 637579. doi:10.3389/fcomm.2020.637579

Souter, J. (2011). A culture of disbelief or denial? Critiquing refugee status determination in the United Kingdom. *Oxford Monitor of Forced Migration, 1*(1), 48–59.

Zoller, H. M., & Kline, K. N. (2008). Theoretical contributions of interpretive and critical research in health communication. *Annals of the International Communication Association, 32*(1), 89–135. doi:10.1080/23808985.2008.11679076