Who We Miss

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A middle-aged male patient presents with survival of targeted violence persisting for 4 years and a credible fear of death if he returns to his country of origin. This clinical scenario, though unlikely to appear on a board exam, represents a pivotal moment of exposure to a "can't-miss" diagnosis in my training. The patient is the first client I met in my medical school's human rights clinic. In practice, many physicians will come across survivors of torture and other human rights abuses, often unwittingly, regardless of their deliberate engagement in human rights work. Over 400,000 survivors of torture are believed to live in the United States, but according to one study more than 77% of self-reported survivors of torture in a public New York emergency department had never been asked by a physician about torture.[1] For me as a student, and I hope even for the most senior providers, this forensic encounter will be a reminder that physicians' power to intervene in the recurrence of violence depends on our ability to evoke a patient's complete story.

Physicians underestimate their own capacity to respond to humanitarian challenges. Neutralizing the urgent threat to this person's life initially appears beyond the scope of our profession. Our scientific textbooks focus on molecular interactions and physiologic disturbances, while the mechanisms of this client's affliction hinge on intractable geopolitics and social upheaval. Nonetheless, physicians have an effective treatment in their toolkit: the patient's history. Medical training teaches us that a patient's history predominantly informs the acute diagnosis and therapeutic regimen. But statins or antibiotics do little to address human rights abuses. An exhaustive history that contextualizes and reveals medical evidence will uniquely gird a successful asylum case, the key to saving the client I met.

Permission to remain in the United States would prevent a daunting onslaught of likely sequelae in the client's country of origin that include systematic psychological trauma, physical torture, and, in the worst instances, violent death. Legal professionals maintain that a forensic evaluation and medicolegal affidavit strongly benefit the case of most asylum seekers.[2] In one study of a prominent nongovernmental organization's efforts, 89% of asylum seekers who received medical evaluations—which necessarily include a thorough personal history—obtained asylum, a grant rate significantly higher than the 37.5% national average at the time.[3] With no end in sight to numerous international crises, physicians intent on deploying their expertise to aid the most vulnerable among us will, unfortunately, have ample opportunity. In fiscal year 2015, the United States saw a 48% increase in affirmative asylum applications over the previous year, topping 84,000 received.[4]

In the evaluation at the human rights clinic, the client's calm exterior gave way to an apparent, if controlled, nervousness. The windowless hospital exam room may have conjured up memories of detention by police in transit nations and ultimately by American immigration enforcement. The conditions were far from ideal for requesting the most sensitive details of the client's trauma. Meanwhile, I felt energized, eager to contribute in some small way as a medical student to the cause of protecting the defenseless.

To be effective in assisting asylum seekers, we need to recognize our own biases about them. Eliciting an authentic picture of traumatic experience, especially under the contrived circumstances of the medical evaluation, demanded that I deliberately subdue my own assumptions of what immense suffering looks like. When we see only the vulnerability of survivors of torture, female genital mutilation, intimate partner violence, or gang violence, we will inevitably treat them accordingly. We may show empathy, but it will be empty of genuine respect, impeding our ability to deliver optimal care. Creating space for an individual's story required elevating his resilience above my deeply engrained notions of victimhood—expectations that I would meet a shattered person desperate for assistance. If history is the intervention, humility is the mode of delivery.

As I administered a screening for social service referrals early in the evaluation, intending to check boxes for support groups, English classes, and food pantries on a rigid

questionnaire, the client stopped me: "I was a successful businessman at home," he told me. "I want to bring my business here. Otherwise, I am not interested in help." Intent on filling out a form, I had inadvertently positioned myself as a provider and him as a recipient. In response, he closed an avenue of aid, although not for lack of need. And so I temporarily lost the opportunity to learn about the client's present well-being and the clues it held to his past.

The greatest service a forensic evaluator can provide to an individual asylum seeker is the pursuit of a complete narrative. Only whole responses can allow us to identify that scars are consistent with certain weapons and defensive positions, or to note that a wound has healed by secondary intention, in line with an incident too severe for the seeking of early medical care. A superficial exploration of a client's experience reveals identities of perpetrators and dates of assaults. But deeper listening is necessary to unearth the anxieties and heart-racing episodes that permeate a client's daily routine, providing evidence that persists even when the physical marks of abuse are all but invisible. A seemingly minor detail that a client initially withholds, not realizing its relevance, becomes the linchpin of a lifesaving case.

Despite a reluctant start, the client told a story of human suffering and resilience that unfolded across 2 hours of interview. He recounted beatings with bamboo rods and hockey sticks, attacks with machetes, intimidation of his employees, and threats involving the rape of his wife. Even when he became tearful, he did not seem to regret his relentless support of the home-country politics for which he has sacrificed his security, his psyche, and his livelihood. On paper, in his asylum application, he had named a litany of countries that constituted milestones on a tortuous 6-month road to the US border. In person, the list came alive with meaning. He described at length the vehicles and smugglers of midnight border crossings, weeks spent stalled in safe houses or detention, weary marches through jungles. Truly he captivated us all—faculty physicians, professional translator, and student shadow—with a will to thrive.

I refused to repeat my mistake. I listened and reflected. I tried to picture the client's best and worst days at home and en route to the United States, but could not begin to generate such extremes in my imagination. When the physician evaluator checked whether we had any further questions, I adjusted my body language and spoke directly to the client, not to the translator. With open ends, I asked plainly, "Would you mind telling us more about your dreams?" I paused, locking eyes with the client, indicating that his story would always be more important than my questions. A beat, then 2, then 3 followed. His voice masked under a layer of deep anguish or shame, he told of reliving his attacks in recurring nightmares. I thanked him in a whisper, reflecting my own relief that together we had generated new evidence of abuse, but also betraying my ambivalence that our success was grotesque, achieved through his enduring pain.

The aspiration to serve the vulnerable guided me into medicine. As a future physician, who will I miss? If I find them, I aspire to remain a student and intervene by having the humility to listen.

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