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Establishing (Un)Certainty: Language and Reproducing Suspicion in Forensic Medical Evaluations

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ABSTRACT

While forensic medical evaluations (FMEs) have been shown to bolster rates of asylum approval in the United States, a discourse analysis of deidentified FMEs reveals a more nuanced function. In the suspicious and disbelieving culture of asylum adjudication, the rhetorical strategies and devices along with mandated neutral language in FMEs can inadvertently marginalize, reproduce suspicion of, and introduce (un)certainty about applicant testimony. Thus, FMEs can be co-opted to become a technology of state control over asylum seeker's lives by allowing adjudicators to utilize them as flexible justification to support arbitrary asylum decisions under the guise of medical evidence.

KEYWORDS

forensic medical evaluations; rhetoric; asylum; adjudication

RÉSUMÉ

Bien qu'il ait été démontré que les évaluations médico-légales contribuent à augmenter les taux d'acceptation des demandes d'asile aux États-Unis, une analyse discursive d'évaluations médico-légales anonymisées révèle une fonction davantage nuancée. Dans la culture méfiante et incrédule qui caractérise les décisions en matière d'asile, les stratégies et figures de réthorique ainsi que l'usage du langage neutre imposé dans les évaluations médico-légales peuvent, par inadvertance, marginaliser, reproduire la méfiance de et introduire l'incertitude en ce qui concerne le témoignage du demandeur ou de la demandeuse. Les évaluations médico-légales peuvent donc être exploitées pour devenir un outil de contrôle étatique sur la vie des personnes qui demandent l'asile en permettant aux juges de l'utiliser comme justification flexible pour appuyer des décisions arbitraires en matière d'asile sous prétexte de preuves médicales.

INTRODUCTION

In the United States, asylum is a discretionary protection status conferred to foreign nationals who meet the threshold of having a "well-founded fear" of persecution based on certain grounds (UNHCR, 1951, p. 3). Asylum seekers demonstrate they meet the criteria for asylum by providing credible testimony and corroborating evidence, if possible. Usually done in accordance with the **Istanbul Protocol**, an international guideline outlining how to investigate and document torture and ill-treatment, forensic medical evaluations (FMEs) consist of physician qualifications, history of the applicant's narrative, documentation of observations, and assessment of credibility from a medical perspective (Ferdowsian et al., 2019; Hampton & Mishori, 2023; Zeidan & Ferdowsian, 2022). FMEs have emerged as a critical form of evidence for refugee status determination (RSD) (Peart et al., 2016). Usually sought by the applicant's legal counsel or advocacy organizations, FMEs can bolster claims of past persecution, eligibility for humanitarian

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asylum via lasting effects, or torture under the **Convention Against Torture** (Bauer, 2022; Ferdowsian et al., 2019).

The persuasiveness of FMEs used in RSD decisions is reflected in statistics: 89% of asylum cases with an FME were granted approval between 2000 and 2004, compared with the United States' national average of 37.5% over that same period (Lustig et al., 2007). A more contemporary study between 2008 and 2018 found that 81.6% of asylum cases with medical evaluations were approved compared with the national average of 42.4% (Atkinson et al., 2021). While FMEs seem incredibly persuasive given higher asylum approval rates for those with an FME, this correlation invites scrutiny. Atkinson et al.'s (2021) cases were pre-screened by Physicians for Human Rights (PHR) for severe symptoms and had legal representation, with most adjudicated in courts that historically favoured immigrants. Confoundingly, both legal representation and geographic region are major determinants of asylum outcomes (Miller et al., 2015; Ramji-Nogales et al., 2007; Rosenberg et al., 2017). Thus, careful attention to the specific context and content of FMEs is vital to understanding how FMEs act within the discretionary field of RSD decisions—particularly since asylum literature highlights an intensified culture of suspicion and cases where the FME actually acts as a way for an adjudicator to question the veracity of an asylum seeker's testimony (Beneduce, 2015; Shuman & Bohmer, 2010; Sorgoni, 2019). Crucially, Atkinson et al. (2021) have pointed out this key tension in their data: Despite careful screening by PHR, legal representation, and an FME, some applicants were not granted approval.

This article examines the rhetoric of FMEs in US asylum cases and training materials to highlight how larger trends in asylum can be sourced from the language and rhetorical devices present in FMEs and how FMEs can be mobilized as a technology of suspicion. I begin by analyzing how the ethos of science and medicine establishes physicians as interpreters of bodily trauma, unintentionally degrading the asylum seeker's authority over their testimony. This allows physicians to utilize the medical gaze, acting as gatekeepers of bodily expertise and "truth." I then focus on the neutral, probabilistic language of FMEs introduced partly by the medical gaze as well as objective standards of science and medicine, showing how it decontextualizes body from narrative, allowing the state to take advantage of the ambiguity created in the process. Consequently, I argue that FMEs actually reproduce the overall ethos of suspicion characteristic to asylum. But even physician authority is constrained by the state, co-opting both legal limitations and (un)certainty to rationalize decisions. In response, I analyze possible rhetorical workarounds that attempt to circumvent this constraint but highlight that these too can reinforce suspicion. Ultimately, the state can co-opt the FME to, as Foucault (1978) puts it, maintain its exceptional sovereign power by "deciding life and death" (p. 135). Through this analysis and focus on the role and content of the FME in the context of a "state of suspicion" (Borrelli et al., 2022, p. 1028), I show how the FME contributes to larger patterns regarding the discretionary nature of RSD decisions, unveiling how it can act as a technology of suspicion by establishing (un)certainty—where it intertwines with larger bordering processes to classify peoples into deserving and undeserving, credible and incredible.

BACKGROUND AND THEORETICAL FRAMEWORK

Significant disparities in asylum approval rates differ not only on a large geographic

level but even between different adjudicators within the same city, demonstrating the profound impact of adjudicator subjectivity on case outcomes (Ramji-Nogales et al., 2007). For example, two Honduran women with nearly identical immigration narratives had different case outcomes because they were adjudicated by different judges—one in San Francisco, California, and the other in Charlotte, North Carolina (Rosenberg et al., 2017). Notably, the judge in Charlotte cited that the applicant's credibility was undermined by her "flat affect," "little emotion," and "poor demeanour" (Rosenberg et al., 2017, "Day in Court"). Even though the United States has different asylum laws and procedures, insights from international asylum literature help illuminate broader patterns about how the discretionary nature of RSD is created. For example, the Charlotte judge's subjective interpretation of applicant behaviour in deciding whether a claim has merit is evidence of what Kobelinsky (2019) called the "intime conviction" of French asylum judges (p. 53), showing how credibility is derived from not only standard parts of an asylum application but also affective and emotional components that are subjective and differ from judge to judge. When the affective component is introduced, "it is no longer facts but people that are subject to judgment" (Kobelinsky, 2019, p. 62), highlighting the unpredictability of asylum appeals. Comparably, Feneberg et al. (2022) have demonstrated that even "objective" country of origin information (COI) is highly malleable, finding that Germany's higher administrative courts use similar content in COI to justify opposing decisions. The worry here is that COI is used not to inform a decision but to justify an adopted position (Kelly, 2012). Similarly, Haas (2023) examined supporting documents in the US context, exposing how they are "imbued with paradoxes and gray areas" (p. 148) as they can strengthen but also draw suspicion to testimony. Thus, both subjective and objective components figure into the arbitrariness of RSD decisions.

In conversation with this understanding of the discretionary aspect of RSD, I wish to turn attention to the FME—another "objective" component of an asylum seeker's case. The FME is a separate form of supportive evidence; it is a way for the asylum seeker to corroborate their narrative through an authoritative medical interpretation of physical and psychological sequelae. Analyses of medical evaluations in other countries have shown that medical certificates often function as an "open sesame" (Fassin & D'Halluin, 2005, p. 600) since they are one of the only ways that can attest to the veracity of psychological and, especially, physical trauma, which is often seen as being more persuasive when seeking asylum (Aarts et al., 2019). This correlation between presence of a FME and asylum approval has been demonstrated as well in the US context but needs to be carefully interpreted given multiple confounding factors (Atkinson et al., 2021; Lustig et al., 2007; Miller et al., 2015; Ramji-Nogales et al., 2007).

The asylum apparatus hinges heavily on an asylum seeker's ethos, usually characterized as "character" or "credibility." As Kagan (2015) pointed out, it is "a practical necessity for asylum-seekers to be believed, as they usually cannot prove their cases except through their own testimony" (p. 124). Yet the credibility of an asylum seeker is not inherent—it is dependent on, created by, and moulded through interactions with media discourse surrounding immigration, judges' imported preconceptions and implicit biases, and even the image of the "ideal" refugee. Kagan's dynamic understanding of credibility appropriately necessitates an analysis of the documents that figure into RSD decisions,

for credibility is negotiated in no small part through these documents.

Fittingly, the negotiable aspect of credibility matches the rhetorical concept of ethos. Miller's (1974) understanding of the etymological roots of **ethos** in "manners, customs"; "the abodes of men," referring to a place, "haun[t,] or abod[e]"; and "moral character" or "the delineation of character" (p. 310) reveals that ethos is developed and negotiated relationally and communally, destabilizing the conventional conception of ethos as "essentialized reputation, 'voice,' or inborn trait" (Ryan et al., 2016, p. 6). It is this relational and negotiable aspect of ethos that is most salient in asylum because at its core, asylum is about a "well-founded"—or **credible**—"fear of being persecuted," making it an appropriately rhetorical problem (UNHCR, 1951, p. 14).

The problem of asylum is also dialectical: Through the defensive aspect of asylum, where an application for asylum is filed by somebody who is already in removal proceedings from the United States, the state's adversarial and negative framing inherently communicates suspicion, a belief that migrants are fraudulently staying within or entering the United States (Gilman, 2023; UNHCR, n.d.). Meanwhile, the asylum seeker sees one's claim to enter or stay within the United States as fully legitimate, evidenced by the literal claim to asylum and one's grounding in lived experience (Haas, 2023). Thus, asylum seekers need to—drawing on Miller's argument about ethos—renegotiate their credibility with the state to convince the state that their reasons for being granted asylum are credible and therefore "deserve" to be granted asylum.

However, migrants' credibility is already damaged as a "culture of disbelief" characterizes contemporary asylum courts (Souter, 2011, p. 48). Migrants are often perceived as duplicitous, as people "trying to take advantage of the country's hospitality" (Fassin & D'Halluin, 2005, p. 600). In fact, Jubany (2017) has pointed out that immigration officers are "trained to disbelieve" (p. 81). This culture of disbelief leads to a hermeneutics of suspicion (Lawrance, 2018), where every part of the asylum seeker's case is subject to the suspicious gaze of the judge, who acts as proxy for the state (Gillespie, 2024). Borrelli et al.'s (2022) concept of the "state of suspicion" is particularly helpful here as it refers to a suspicious "state of mind" (p. 1028) that justifies the expansion of state power through border control and regimes; legally codified suspicion, the legal practices that result from the view that migrants are "a priori suspicious and illegal" (p. 1030); and the materialization of suspicion through various technologies, such as biometric systems, COI, and, as I propose, FMEs.

METHODS

I conducted a discourse analysis of six FMEs (see summary in Table 1) using a rhetorical framework. Five are available publicly through the Society for Asylum Medicine, with one of them made available courtesy of PHR; through PHR's (2012) training manual; and through the Weill Cornell Center for Human Rights [WCCHR] (2015)'s **Asylum Evaluation Training Manual**. The sixth is not a copy of an FME but rather a publicly available court decision written by an immigration judge, Philip Verrillo, that summarizes the FME and other testimony. All evaluations were done and written by one or more licensed medical doctor(s). Identifying information about the applicant and physician for each evaluation had already been redacted or replaced with pseudonyms. Four of the evaluations, however, have identifying information about the physician(s) who wrote them.

Table 1

Summary of the Six Forensic Medical Evaluations

Date	Country of origin	Brief background
10/2/13	Redacted	LM is seeking asylum based on his political beliefs. He was a member of the Union for Democracy and Social Progress. LM has multiple scars, which were examined for consistency (Society of Asylum Medicine, 2013).
3/2/17	Honduras	Ms. XXX is seeking asylum having endured abuse by her male partner. Ms. XXX has two scars that were examined (Society of Asylum Medicine, 2017).
10/1/13	Syria	Mr._ is seeking asylum after being detained by Syrian military intelligence. He underwent a physical and mental status examination (Patel & Iacopino, 2013).
n.d.	Redacted	Ms. A is seeking asylum for fears relating to her gender identity. She is male-to-female transgender. She has multiple scars from past injuries, which were examined (WCCHR, 2015).
9/30/99	Bosnia	Mr. Z is seeking asylum after being tortured and persecuted for being Muslim in Bosnia. He has multiple scars, dental trauma, and corroborative evidence in the form of radiologic images of his chest and face, where he states he was beaten (PHR, 2012).
1/14/15	Guatemala	Respondent is seeking asylum after being persecuted and tortured by the Mara-18 gang. He has a facial scar along with corroborative medical records. This summarized FME is contained within the written decision and order of immigration judge Philip Verrillo granting asylum (Bauer, 2015).

Discourse analysis involves examining how the rhetorical features of patterned texts act within a socio-political context to illuminate how language shapes the larger discourse, with particular attention given to the production of power, knowledge, and truth (Khan & MacEachen, 2021; Lupton, 1992). Since the ultimate purpose of the FME is to help persuade the court of an asylum seeker's credibility (Hampton & Mishori, 2023), I focused on key parts of Aristotle's rhetorical theory—particularly ethos, logos, and enthymemes (Rapp, 2002). I also analyzed the effects of specific word choice on rhetorical value within the politicized context of asylum adjudication.

By examining how FMEs mobilize expertise, construct bodies, constrain the authority of both asylum seeker and physician, and are limited by legal and scientific standards, I traced how these documents function as technologies of suspicion within the US asylum regime. This approach allowed me to examine the FME not just as a solely supportive document but as a contested artifact that attempts to bring a measure of objectivity into a space characterized by disbelief, suspicion, and discretion.

While much has been written on the impact of having FMEs as part of an asylum case (Arastu, 2022; Atkinson et al., 2021; Lustig et al., 2007), little work has been done in evaluating their rhetorical form, identifying how these documents are or are not persuasive. By situating FMEs as appropriately rhetorical pieces situated in

the suspicious culture of asylum, I aim to better understand how "objective" evidence is interpreted and repurposed to reproduce and serve state power.

RESULTS

Mobilizing the Ethos of Science and Medicine

Analyzing deidentified FMEs makes apparent that the ethos of science and medicine is mobilized by demonstrating how the physician holds intimate knowledge of the body that even the applicant is unaware of. Patel and Iacopino (2013) wrote that "[a] Baker's cyst can develop after knee trauma. The fact that Mr. X was unaware of this persistent cyst is not surprising; it is not visible to him and requires a trained medical examiner to detect such abnormalities" (p. 11). They mobilized their physician status to provide expertise and credence on behalf of the asylum seeker.

As Segal and Richardson (2003) have posited, scientific ethos comes in part from the scientist's ability to demonstrate that they are, in fact, a scientist. Their ethos is linked to membership to a specific group with norms and conventions that cultivate their reputation for being able to translate, understand, and study natural phenomena. Similarly, a physician's ethos comes in part from a demonstration of their membership in the medical community—in this case, through the use of medical jargon followed by layperson's definitions: "A circular area of superficial varicosities (varicose veins) on the lateral (outside) surface of the right knee, 4 cm above the fold of the knee, 4 cm in diameter" (Society of Asylum Medicine, 2017, p. 2). Here the physician demonstrates their authoritative membership in the medical community by speaking about the body in purely medical terms. This imbues the medical evaluation with the authority of medical expertise.

Medical expertise is also supplied by the "qualifications" section included in most medical evaluations. Unlike the rest of the evaluation, the focus here is on the physician. This section fully establishes the physician as a member of the medical community as they state their education, training, and qualifications, mobilizing the vast amount of expertise they have to assert the legitimacy of the clinical encounter. For example, Dr. McKenzie explicitly states her education and additional "training in evaluating asylum seekers from two advocacy organizations" (Bauer, 2015, p. 7) along with her extended medical experience of 20 years, positioning her as an expert and qualifying her to perform these evaluations and offer her opinions.

By emphasizing the difference between the layperson's knowledge of medicine and the physician's extensive training, education, and experience, physicians can claim "special authority" to speak about the body as their claim to the body comes from the very lack of understanding the layperson has in comparison (Hartelius, 2010, p. 125). Thus, when the physician voices their observations of the body, the purpose of the translation into everyday terminology is twofold: to enable the court to understand what is being described and to remind the court of the epistemic authority of medicine.

The Physician as Gatekeeper

However, aspects of the evaluation can imply that the physician holds even more intimate knowledge of the applicant's body than the applicant themself by suggesting that detecting what has been found "requires a trained medical examiner" (Patel & Iacopino, 2013, p. 11): Physicians position themselves as not only translators but **gatekeepers** of the legitimate body, capitalizing on their professional ethos to sanction scars and

trauma. The emphasis on "trained medical examiner" again highlights the gulf between the layperson's knowledge of medicine and anatomy and that of the physician. In a different evaluation, Dr. Iacopino finds a "3 cm × 1 cm raised mass on the back of his [the applicant's] head" that the applicant was "unaware of … until [his] examination," probably due to its location or the applicant's loss of consciousness (PHR, 2012, p. 109). Drawing attention to the fact that even the applicant was "unaware" of this remnant of torture, the physician depicts the truthfulness of the body and objectivity of the evaluation. Critically, as Smith et al. (2015) pointed out, physicians lose their authoritative power when they seem to act as advocates rather than objective evaluators. Hence, by stressing the asylum seeker's own lack of awareness, Patel and Iacopino remind the state about the body's veracity and the necessity of a physician to interpret it. Physicians do not simply translate but instead gatekeep certain aspects of the body and narrative as they unearth physical remnants of trauma that even the asylum seeker has no knowledge of.

This theme of physician as gatekeeper and interpreter of the body is continued in the interpretation of the history combined with physical examination:

> The historical information presented in Mr. X's testimony is entirely consistent with what I would expect given the methods of torture alleged including his description of the nature and duration of healing of injuries. It is worth noting that without medical knowledge of human anatomy and pathophysiology, most individuals would not be able to provide such accurate historical information.
>
> (Patel & Iacopino, 2013, p. 12)

This hierarchy of knowledge about the body is reminiscent of Foucault's medical gaze—the way in which biomedicine transforms illness into disease by filtering out and minimizing the patient's subjective experience in favour of physical symptoms and findings. A key part of the medical gaze, "which c[an] penetrate illusion and see … the hidden truth of the body that could only be understood by the medical expert" (Hancock, 2018, p. 443), is that the patient becomes objectified in service of producing a more legitimate knowledge. In this context, the archaeological revelation of "truth" derived from the medical gaze may be seen as more authoritative because it positions itself as objective by denying subjectivity (Nussbaum, 1995); this disregard for subjectivity mirrors the role of evidence in asylum: Credibility is determined in large part not by the asylum seeker's own account but by external, objective signs that appear to confirm or deny it (Arastu, 2022; Ardalan, 2015; Lawrance, 2019), rendering the clinical gaze uniquely persuasive in a system characterized by disbelief of personal testimony. What is relevant here is just how prominently the medical gaze is made apparent in this encounter—for the doctor positions themself as having private and specialized insight into the asylum seeker's body as a rhetorical strategy to foreground medical authority over the applicant's already suspicious testimony.

However, this rhetorical strategy can unintentionally supplant the narrative of the asylum seeker: As the physician positions themself as omniscient translator of the body's story, the applicant's testimony is meanwhile implicitly repositioned as secondary. Ardalan (2015) recognizes that immigration judges may "privilege 'objective' documentary evidence of harm suffered … over testimonial evidence" and even over the "most difficult evidence to assess—the testimony of the applicant" (p. 154). Similarly, Lawrance (2019) finds that COI can "erase the lived experiences of refugees" (p. 145). There are also echoes of Hartelius's (2010) analysis of the rhetoric of expertise here as well: Just

as the physician can claim "special authority" (p. 125) over the body precisely due to the other's lack of understanding about the body, the asylum seeker can similarly also claim a certain expertise about their own lived experience. However, unlike the physician's "special authority," the lived expertise of the asylum seeker is under scrutiny: As the asylum seeker is the only one to have known and lived through the experience that they relate through testimony, the very isolation of their experience—from which one could theoretically claim full knowledge and authority over—is the simultaneous font of suspicion. Indeed, even when an asylum seeker seems credible, the state may come to an adverse credibility decision based on the fact that an asylum seeker was unable to produce corroborative evidence in the form of a medical evaluation (Arastu, 2022).

Thus, expertise is a two-way street: Physicians speaking to the legitimacy of the body by rhetorically mobilizing the medical gaze can detract from the credibility of the asylum seeker's narrative. And as the evaluation is made persuasive through the epistemic authority of medicine, the translation of the body, and the medical gaze, the narrative testimony of the asylum seeker is simultaneously cross-examined with respect to the physician's evaluation and can be made even more suspect.

Objectivity, Neutrality, and the Decontextualization of Narrative

While subjecting oneself to the medical gaze via forensic evaluation can be an agentic move in trying to receive refugee status for asylum seekers, the medical gaze also has the effect of decontextualizing the body from narrative: The asylum seeker's narrative is reconfigured in bodily, rather than spoken, terms. This reconfiguration, however, may constrain the asylum seeker's agency as they lose authority and control over their narrative.

Structural guidelines provide insight into how these evaluations are meant to function as rhetoric. According to the **Istanbul Protocol**, the physician must "remai[n] objective in their clinical assessment" (Office of the High Commissioner for Human Rights [OHCHR], 2022, p. 74). As part of this objectivity, the **Istanbul Protocol** neutralizes the interpretation of physical findings by specifically defining certain terms (Wallace & Wylie, 2013). For example, the protocol defines **consistent with** to mean "the finding could have been caused by the alleged torture or ill-treatment, but it is non-specific and there are many other possible causes" (OHCHR, 2022, p. 89). The other terms—**not consistent**, **highly consistent**, **typical of**, and **diagnostic of**—form a full spectrum of probabilities where the two extremes actually preclude other possible causes (OHCHR, 2022, p. 90). In practice, however, those extreme terms are hardly—if ever—used (Bauer, 2015; Kelly, 2012).

In the WCCHR handbook (2015), Dr. Sirotin recounts both Ms. A's narrative of how various scars were produced and her own assessment of consistency: Ms. A was rejected by her family for being effeminate and was pushed into a river, where her right leg became caught in tangled barbed wire. Ultimately, Dr. Sirotin ascertains, "These scars are highly consistent with injury from cuts from a cluster of sharp, thin metal objects, such as barbed wire" (p. 18). Bodily trauma is reinterpreted through this lens of "neutrality": Stripped of assigned narrative meaning, scars become the subjects of probabilities and possibilities. Lifted from the body, they are examined in isolation, where multiple meanings can explain physical sequelae.

The neutral and cautious terms indicating consistency can only suggest so much

about the injury with which the scar is associated. For all the intimate knowledge of the body that the physician purports to know through the medical gaze, to someone unfamiliar with the conventions of science and medicine, the fact that the physician can at most comment that scars and reports of pain are only "consistent with" the historical trauma supplied by the asylum seeker is not very convincing. Indeed, the state often takes advantage of this neutralization for—when examined under this lens of neutrality and objectivity—scars and bodily trauma can now be associated with the cause the asylum seeker assigns **or** unrelated causes. While Dr. Sirotin determines the collection of scars found on Ms. A's body "highly consistent" with the supplied narrative, what the doctor is careful not to comment on is **why** Ms. A's scar was produced in this way (WCCHR, 2015). Was Ms. A really pushed by her cousins for being effeminate? Or did she trip and fall? This epistemic gap has been remarked upon by Beneduce (2015), who noted the impossibility of "'establis[hing]' whether a burn results from torture or from other circumstances" (p. 559). FMEs sometimes even suggest alternative explanations for scars and bodily sequelae characterized as "consistent" (Kelly, 2012). Dr. McKenzie's FME exemplifies Kelly's findings as she writes that "various other unknown circumstances and/or weapons could have caused Respondent's injuries" (Bauer, 2015, p. 7). And judges do engage in this suspicious frame of thinking: Fassin (2013) observed how a judge questioned photographic evidence of a Bangladeshi asylum seeker lying in the hospital bed after being beaten and seeing his close relatives murdered, asserting that the claimant could have just fallen off a bicycle.

However, these linguistic constraints reflect inherent scientific and legal boundaries. As Foucault notes, "the restraint of clinical discourse … reflects the non-verbal conditions on the basis of which it can speak" (1963/2002, p. xix). Medical knowledge is produced by decoding measurable, observable signs in isolation from social or narrative meaning to establish generalizable, "objective" truths about the body. Therefore, divorced from narrative origin, physical scars cannot prove causation because the physician was not there to witness the act personally (Good, 2004; Kelly, 2012). Thus, the **Istanbul Protocol**'s specific language of using varying levels of "consistency" emerges from unavoidable epistemological limitations.

Nonetheless, the appropriate language dictated by the **Istanbul Protocol** that only comments on the consistency of scars and their production gives the state flexibility to use the evaluation as a technology of suspicion—one that can cast doubt on or affirm a narrative, despite the fact that scars can be considered "highly consistent." The multiplicity of interpretations is evidence that under the decontextualization of the medical gaze, the asylum seeker loses authority over their narrative and body: The narrative context of each scar given by the asylum seeker is no longer the authoritative one and must compete with an infinity of possible causes introduced by the lens of neutrality that uses the medical gaze. And, ironically, it is precisely this loss of narrative control that makes the FME compelling—the subjective becomes objective, satisfying adjudicators' need for outside evidence (Bohmer & Shuman, 2018). This decontextualization and neutrality become instrumental to the state's hermeneutics of suspicion: Judges can exploit the inherent ambiguity of medical language—such as "consistent with"—to disbelieve applicant testimony—citing alternative possibilities—thus leveraging clinical uncertainty to assert epistemic control (Beneduce, 2015; Fassin, 2013; Tay et al., 2013).

Whereas Gillespie (2024) posits that medical knowledge is co-opted by the state in service of the border regime as FMEs establish truths about the body, I propose that the state's co-option of the medical evaluation is slightly different: Medicine does not establish "truth" but contributes (un)certainty. As a physician cannot determine causality, the connection between the bodily narrative and the spoken testimony is reconfigured in a way such that the state is able to effectively choose whether it is to use "objective" evidence to justify decisions partly by citing the "truth" unearthed by medicine or the uncertainty of causation.

Reproducing the Ethos of Suspicion

Critically, this decontextualization the **Istanbul Protocol** calls "neutral" can be mobilized to become a manifestation of the larger ethos of suspicion surrounding asylum. **Neutralizing** implies that the applicant is motivated or biased, which is not inaccurate, but when the neutral is persuasive precisely because it is neutral, it starkly showcases how precisely unneutral asylum seekers are (Haas, 2023): For the asylum seeker, the stake of asylum is their **life**, both bare and political (Agamben, 1998). Thus, asylum seekers' only chance at "living well"—regaining their "political life"—is through gaining asylum (Kagan, 2015). By juxtaposition of the neutral authority of the physician, however, their motivations are amplified and made implicitly suspicious regardless of whether or not the evaluation supports or negates the applicant's testimony: The very act of needing to use an outside source to offer their ethos is evidence of disbelief and suspicion in their narrative. Even the term **forensic** in **forensic medical evaluation** is associated with the investigation of a crime, at deciding the "just/unjust" (Rapp, 2002, "1. Aristotle's Works on Rhetoric"). Taken together, the FME seems to be an investigation of what is firstly deemed suspicious and unearthing truth—if any—by scrutinizing the body. Thus, the very act of relying on an outside—"neutral"—source can imply that the applicant's testimony is inherently unreliable (Bohmer & Shuman, 2018; Gilman, 2023; Haas, 2023).

Importantly, because the asylum seeker is further cast as suspicious, even more credence is given to the "neutral" medical evaluation. This dynamic of the FME's increased authority via reproducing suspicion of asylum seekers is reflected in the disparity between denial and approval rates for African asylum seekers with an FME. In the United States, there is a pattern of institutional suspicion regarding asylum claims specifically from African asylum seekers, which results in lower rates of approval (Terretta, 2015). However, Atkinson et al.'s (2021) study of asylum claims from 2008 to 2018 found that the highest approval rates (90.6%) were from African asylum seekers with an FME. Arastu (2022) interprets this disparity to mean that only when there is an FME do "Black immigrants … become 'believable' to adjudicators" (pp. 105–106). Thus, the rhetoric of neutrality cyclically empowers itself while degrading the rhetorical power of an applicant's testimony. While the medical evaluation tries to speak to the legitimacy of the narrative through the expertise of medicine, it may inadvertently overshadow the asylum seeker's authority over their own experiences, further highlighting its singularity as a source of suspicion (Haas, 2023) rather than truth, reproducing the overall ethos of suspicion surrounding asylum.

Neutrality Delimits the Physician's Authority

Even while the physician's authority is privileged over the asylum seeker's through the

medical evaluation, the physician's ethos is also limited. Physicians, and other expert witnesses, cannot determine or affirm causality: They are legally barred from giving their opinion on the core issue of whether persecution occurred as this determination is reserved for adjudicators (Arastu, 2022; Hampton & Mishori, 2023; Kelly, 2012; Smith et al., 2015). As explored earlier, the physician's purview is restricted to observations of the body and their clinical judgements of compatibility and consistency for necessary legal and ethical reasons. What physicians are expected to offer is an assessment of whether the physical findings align with an asylum seeker's narrative of how the scars are produced as outlined by the **Istanbul Protocol** (OHCHR, 2022, p. 90). However, discursive openings are produced when the physician appropriately remains within their legal bounds as an expert witness, and the state can take advantage of this gap, gaining the flexibility to weaponize this objective assessment against the applicant.

State control over the interpretive value of medical evidence is starkly revealed in judicial treatment of FMEs. The FME's weight is "highly circumscribed" (Kelly, 2012, p. 760). Even when a scar was highly consistent with testimony, a judge found the report "unhelpful" (p. 760) because they found the applicant's claims to be "easy to manufacture" (p. 759). The ease with which judges seem able to disregard or include medical evidence highlights not that physicians need to stay within their legal role but that the authority of physicians is restricted by the state based on how the judge wants to use the evidence. Good (2004) cites opposing cases that demonstrate this tension: In one, medical evidence was rejected because the judge thought the physician's final opinion of the likelihood of credibility crossed into legal judgement; in the other, the judge accepted the medical evidence, noting they were not "bound by the doctor's conclusion" (p. 122) and that it would be wrong to disregard uncontested expert evidence. Similarly, an FME's conclusion of "compatible with a history of torture" (Wallace & Wylie, 2013, p. 764) stepped into legal territory—according to the judge—despite not even mentioning "credibility."

Faced with this judicial capriciousness, physicians attempt to modulate their language when assessing the alignment between physical evidence and applicant testimony. These sample FMEs reveal a spectrum of rhetorical approaches that negotiate the precarious boundary between medical credibility opinions and legal conclusions. Some physicians rely on the **Istanbul Protocol**'s sanctioned lexicon of neutrality and uncertainty to signal medical credibility, opining that "allegations of torture" are "highly consistent" with their findings (Patel & Iacopino, 2013, p. 13; PHR, 2012, p. 109). While this defensive framing anticipates judicial scrutiny, it risks being easily dismissed (Kelly, 2012). On the most assertive end, "Declaration of YYY, M.D. Concerning LM" (Society of Asylum Medicine, 2013) concludes that "LM lived for years in the DRC [Democratic Republic of the Congo] and was harassed and ultimately detained and tortured for his political beliefs" (p. 4). The omission of the wording "LM states" (pp. 2–4)—judiciously used elsewhere in the FME to indicate what LM told the physician—suggests that this statement is the doctor's opinion given the physical findings. This syntax explicitly links the physical findings to torture and persecution, which may step into the realm of legal credibility but notably leaves no room for interpretive nuance by the state about the physician's opinion. Finally, Dr. McKenzie concludes with a percentage, utilizing statistics to assert credibility without declaring it (Bauer, 2015,

p. 7). Yet even this rhetorical method risks dismissal if the adjudicator deems it an overall credibility assessment, as shown by Good (2004).

In emphasizing neutrality and legal boundaries, the state delimits the authority of the physician: It is outside the physician's scope of medical knowledge to determine credibility because the body can only be interpreted objectively and literally via the medical gaze. While this is a legal boundary of being an expert witness, it is also at odds with how physicians are trained and approach an FME: Doctors are trained to filter what patients say through their own expertise and experience to understand what is happening clinically (Forrest, 2000; Misra-Latty, 2025); essentially, they are not as "easily hoodwinked by claimants" as adjudicators argue (Kelly, 2012, p. 760).

This judicial emphasis on physician restraint highlights the physician's double bind and the state's ultimate control. Beneduce (2015) provided an example of an applicant who had a diagnosis of post-traumatic stress disorder and a medical certificate, but the judge believed "there [was] no proof that such injuries could be traced to the episodes of torture and violence" (p. 558), evidently wanting a more causal connection than the physician can legally make. However, when that causal connection is even hinted at, some adjudicators assert that the physician is not entitled to make such a statement (Good, 2004; Wallace & Wylie, 2013). Strikingly, this judicial hegemony presides over other forms of expertise. Courts are ready to dismiss expert evidence attesting to country conditions if they are seen to "over-ste[p] their mark" as was the case where two experts wrote that it would be "unduly harsh" (Good, 2004, pp. 125–126) to return someone to their country of origin.

Ultimately, while the restriction of physician authority is a legal and ethical limit, within the politicized and suspicious context of US asylum court, it is subordinated to become a mechanism to reproduce the border regime and maintain state control. By capitalizing on this legal prohibition, the state maintains medical uncertainty: Judges can weaponize neutral terms as grounds for dismissal of evidence or reject expert opinions as "overstepping" (Good, 2004; Wallace & Wylie, 2013), obscuring institutional biases under the guise of evidential neutrality. Physicians modulate their authority through language not just to navigate legal boundaries but to negotiate survival within a system that grants their expertise weight only when it aligns with state objectives. The result is a self-reinforcing hermeneutic of suspicion: Limited physician authority is not a flaw but a feature of its co-option to rationalize (dis)belief in service of sustaining the state's absolute power to create "truth."

Rhetorical Workarounds: Elimination and Enthymemes in Forensic Medical Evaluations

In the sample FMEs, physicians deployed two rhetorical workarounds—enthymemes and elimination—to imply causality without overstepping the legal bounds of an expert witness.

Physicians use **enthymemes**—syllogistic arguments that connect two statements through an unstated premise—to connect an asylum seeker's narrative and physical evidence of trauma. In "Declaration of YYY, MD Regarding XXX" (Society of Asylum Medicine, 2017), the physician described a finding as

> [a] circular area of superficial varicosities (varicose veins) on the lateral (outside) surface of the right knee. … Ms. XXX describes that the areas are painful, and that they developed after YYY kicked her with his metal tipped boot in this area.

> Superficial varicosities can develop in areas of previous blunt trauma. (p. 2)

The unstated premise is that the blunt trauma kick from the metal-tipped boot of YYY caused the development of superficial varicosities. However, the physician cannot explicitly state this premise because their authority to do so has been limited as dictated by the **Istanbul Protocol**.

Supposedly, the enthymeme is persuasive because the audience supplies the suppressed premise themself (Prenosil, 2012, p. 284). But in practice, the enthymeme is only useful when the conclusion has already been stated since supplication of the correct premise is difficult because there are numerous cultural assumptions available (Fredal, 2018, p. 32). Especially in the adversarial context of asylum, enthymemes fail because adjudicators—operating within a "state of suspicion" (Borrelli et al., 2022, p. 1028)—more likely supply **competing** premises, making the enthymeme a rather weak rhetorical device as the physician cannot speak to causality.

Given the limitations of the enthymeme, some physicians use **expeditio**, a rhetorical strategy that appeals to an audience's logos by pre-emptively offering alternative explanations and eliminating them. Dr. McKenzie's utilizes expeditio, or elimination, in her FME as she eliminates the potential connection between a car crash also listed in Respondent's records and the orbital injury: "[S]he has not seen specific, localized injuries like Respondent's result from a motor vehicle accident" (Bauer, 2015, pp. 7–8). The enthymeme that the respondent's injuries were caused by a machete strike is strengthened by the doctor utilizing her ethos as a medical professional with "20 years of medical experience" to eliminate other possible causes (Bauer, 2015, p. 8). By explicitly stating the implausibility of this other documented cause, Dr. McKenzie eliminates the potential premise that the vehicle accident could have caused this injury, which could negatively affect the applicant's credibility.

Notably, not only is Dr. McKenzie's expeditio persuasive on its own, but the FME acts in concert with other evidence to bolster a case. The respondent also provided historical medical records detailing treatment sought after the attack, which the judge cited as corroborating Dr. McKenzie's assessment and a COI report (Bauer, 2015). Indeed, while my focus has been on the ways FMEs introduce uncertainty, it is important to account for the supportive effect of FMEs in corroborating narrative—introducing certainty. Dr. Mckenzie concludes that the likelihood of a fracture occurring in the manner the respondent describes is "approximately 85 percent" (p. 7). Evidently, this adjudicator—unlike the one presented in Good (2004)—found this language persuasive alongside other evidence. While the FME remains susceptible to multiple interpretations, when aligned with other evidence, it often reinforces the applicant's narrative.

Nonetheless, the enthymeme can also be deleterious to an asylum case for it acts in synergy with the **Istanbul Protocol**'s definition of **consistency**. The enthymeme relies on a specific cultural assumption in order to be persuasive. In "Declaration of YYY, MD regarding XXX" (Society of Asylum Medicine, 2017), the major conclusion—suppressed premise—necessary for the applicant's argument is that YYY's kick with a metal-tipped boot is the form of blunt trauma that resulted in the clinical findings of superficial varicosities. However, this conclusion is not so easily supplied when we realize that the **Istanbul Protocol**'s definition of **consistent with** brings with it all the possible blunt traumas that can cause superficial varicosities to develop. This leaves the audience even more

aware of all the actions that can cause "blunt trauma" beside the kick of a "metal-tipped boot"—perhaps a bad fall or sporting injury. Thus, enthymemes can have the unintended effect of further degrading the ethos of the asylum seeker by bringing their narrative in relief with the infinity of other possible scenarios previously supplied by the phrase **consistent with**. This ethos-degrading effect is even more pronounced when the medical evaluation has already privileged itself to the applicant's narrative via the medical gaze. Thus, the indeterminacy of the language, which is explicitly intertwined with the authority of the physician in asylum—what they can and cannot say about the cause of scars and trauma—can be co-opted by the state as medicine contributes to establishing (un)certainties.

CONCLUSION

Ironically, as Bohmer and Shuman (2018) have pointed out, the move toward using medicine to provide more "objective" evidence to confirm legitimate cases of asylum has only further intensified the overall culture of suspicion in asylum. A discourse analysis of the language and rhetorical conventions of the FME unveils the cyclical and self-sustaining interaction between the hermeneutics of suspicion and the larger culture of disbelief surrounding RSD: While the culture of disbelief can lead to a skeptical reading of FMEs, the restricted language and conclusions of the evaluation can also lead to further intensification of this ethos of suspicion. Thus, hidden within the FME are mechanisms that allow it to be used as a technology of suspicion.

Furthermore, the rhetorical conventions of the **Istanbul Protocol** play a critical role in asylum cases: While upholding the standards of scientific and medical writing—from which physician expertise derives its persuasiveness by positioning itself as "objective"—they may also unintentionally allow the state ultimate power over the decision of asylum by delimiting the authority of the physician. The vagueness of an FME's language may function as a tool of bordering as the state enforces and creates the border by subordinating the delimited expertise of medicine to establish its own version of truth and credibility, which may have little to do with an asylum seeker's presented case and more to do with "gut feelings" (Kelly, 2012, p. 763). Indeed, judges may even "make a decision first and then write the decision to justify why [they] have come to that decision" (p. 762). Taking advantage of the indeterminate language of the FME, the state can defend either decision, supporting the incredibly high levels of discretion and apparent arbitrariness in asylum (Miller et al., 2015; Ramji-Nogales et al., 2007). This critical reflection on how the structure and syntax of the FME introduce (un)certainty to justify opposite conclusions about asylum cases not only parallels the instability of other "objective" evidence but also supports what Fassin (2013) observes about the asylum process: "Truth is what institutions decide to be true" (p. 59).

It is important to also note the role this instability of "objective" information plays in the unpredictability of the state's decisions. The "aura of objectivity" (Magalhães, 2016, p. 133) imbued by these technologies is meant to both give credence to the state's decision while also obfuscating unprecedented levels of "arbitrariness, unpredictability, and inconsistency" (Borrelli et al., 2022, p. 1030) present in asylum courts. And the opacity and discretionary nature of these decisions functions as a way for the state to maintain covert power over life and death, exemplary of Agamben's (1998) "state of exception," highlighting how it uses "objec-

tive" evidence not only to establish truth and credibility but also to highlight uncertainty and suspicion. Another possible explanation for the observed patterns of discretion is judges' lack of familiarity with the guidelines, specifically the **Istanbul Protocol**, surrounding how FMEs are conducted and written. Both asylum adjudicators' and immigration judges' training materials fail to mention the **Istanbul Protocol**, never mind educating adjudicators and judges on the idiosyncrasies of the language of the FME as outlined by the protocol (Arastu, 2022; Hampton & Mishori, 2023). At the very least, a baseline understanding of the language used in the evaluation would prevent a "suspicious" reading of the document by adjudicators and judges (Arastu, 2022) as outlined in the analyses above. Nonetheless, for many asylum seekers, an FME is the only form of corroboration they can receive to their testimony, playing a crucial role in gaining asylum (Arastu, 2022; Atkinson et al., 2021; Lustig et al., 2007; Shuman & Bohmer, 2004). However, this reliance upon corroborating evidence highlights the profound power of the state to co-opt medicine as "objective" evidence—not to discover truth but to legitimize its own political work in creating the border and recognizing "legitimate" refugees.

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