WHEN MEDICINE MEETS THE LAW

Inside WashU's Asylum Support Initiative

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INTRODUCTION TO ASYLUM

Wars and conflicts of our time have led to widespread displacement. Around the globe, millions of people have been forced to leave their homes to escape threats to their lives or freedoms, often with nowhere to return, no rights guaranteed, and no futures secured. In the long and difficult process of seeking international protection, they become asylum-seekers. Asylum is, in principle, a straightforward promise: that people who have fled persecution will not be sent back to face it. In practice, it is one of the most legally demanding forms of protection in the American immigration system, and one of the most consequential.

ASYLUM IN THE UNITED STATES

Asylum is a form of refugee protection sought by people who have fled to a host country from homelands where they have a well-founded fear of persecution, based on their race, religion, nationality, political opinion, or membership in a particular social group. In the United States, asylum is rooted in both domestic law and international obligations, most notably the 1951 Refugee Convention and its 1967 Optional Protocol, which established that countries have a responsibility to not return people to places where they face serious harm. When granted, asylum allows a person, along with certain family members, to remain in the U.S., work legally, and eventually apply for permanent residence.

The path to protection, however, is rarely straightforward, and asylum cases are rarely decided on the facts alone. Under U.S. law, an asylum-seeker must satisfy six distinct legal elements to be granted protection: they must be physically present in the U.S. or at a port of entry; they must have suffered persecution or have a well-founded fear of persecution; that persecution must be on account of the protected grounds listed above; it must be carried out by the government or by individuals the government cannot or will not control; the applicant must not have been firmly resettled in a safe third country; and they must not be ineligible for asylum for reasons including past criminal convictions or applying beyond the one-year filing deadline.

Even then, the outcome rests in the hands of a single adjudicator exercising wide personal discretion. An applicant may have experienced genuine, well-documented persecution and still walk out of a hearing without relief, because the word they used in testimony didn't precisely match their written affidavit, or because years of trauma have reshaped the way their memory holds detail. **"You can put together, objectively, the strongest asylum case,"** says Katie Meyer, Professor of Practice at the WashU School of Law, Director of the WashU Immigration Law Clinic, and a lead partner in the Asylum Support Initiative, **"and yet you could take that case before the adjudicator, present it perfectly, and they could deny it."** This is the reality that the Asylum Support Initiative was built to challenge.

Filling a Critical Gap: The Asylum Support Initiative

The Asylum Support Initiative (ASI), a collaboration between **WashU's Center for Human Rights, Gender & Migration** (CHRGM*), the **Immigration Law Clinic** (ILC), **WashU Medicine**, and the **MICA Project**, provides forensic medical evaluations for asylum-seekers in the St. Louis area. Forensic medical evaluations are formal assessments conducted by trained clinicians that document physical and psychological evidence consistent with a client's reported experiences of persecution, torture, or violence. These evaluations become expert declarations in asylum cases, offering adjudicators an objective, medically grounded corroboration of the asylum-seeker's testimony.

The need for such evidence has only grown more acute. Over the past decade, Meyer notes, skepticism toward asylum-seekers' claims has intensified across the immigration system, and adjudicators have increasingly demanded external proof before crediting an applicant's account of what they fear.

Before ASI formalized this work, forensic evaluations were provided on a more ad hoc basis in St. Louis, through the efforts of Dr. Rupa Patel, former faculty at WashU's School of Medicine. Kim Thuy Seelinger, Professor of Practice at the School of Public Health and Director of the CHRGM, represented low-income immigrants in New York City and San Francisco for years before coming to WashU from UC Berkeley in 2019. Arriving in St. Louis, she recognized the need to build out Dr. Patel's work and create a more systemic, sustainable process of providing pro bono forensic evaluations to local asylum-seekers.

According to Seelinger, **"It doesn't matter what jurisdiction you're in, asylum-seekers struggle to satisfy adjudicators' demands for 'documentation'. Unfortunately, it can be difficult to produce paper evidence of persecution or explanation of why one has trauma-related memory gaps. Several of us came to St. Louis from other cities where we had helped establish a pipeline of healthcare experts providing pro bono forensic evaluations to legal teams representing asylum-seekers. The need in St. Louis was clear, too, so we wanted to find a way to provide the same support to local asylum-seekers and the organizations that serve them."** Startup funds from WashU's Here & Next grant program helped turn this idea into a formal program.

**The CHRGM is in the process of transitioning into the Center for Health and Human Rights. This report reflects the Center's name at the time of writing.*

How the Asylum Support Initiative Works

Behind every evaluation is a structured system that the ASI has built to produce rigorous evaluations while sustaining the volunteer network that makes them possible. That system involves several deliberate steps: recruiting and training qualified volunteers, matching them to cases through partner organizations, conducting careful in-person or virtual sessions with clients, and drafting an evaluation that can withstand legal scrutiny. Below is how that process unfolds, from volunteer recruitment to case submission.

Recruitment

Eligible volunteers can be WashU physicians, psychologists, or licensed clinical social workers, or must be active WashU medical or social work students in good academic standing.

Training & Rostering

Volunteers are required to submit a CV, short writing sample, unofficial school transcripts (if a student), and licensures (as applicable) and to complete the first five core modules of the Asylum Medicine Training Initiative program. Completed applications are reviewed by WashU ASI leadership.

Referral & Dialogue

Attorneys at the MICA Project and the WashU School of Law ILC, alongside practitioners/students from the WashU Medical School/Brown School, work together to discuss client intake needs. WashU ASI leadership assigns ready-to-go forensic teams to complete evaluation meetings.

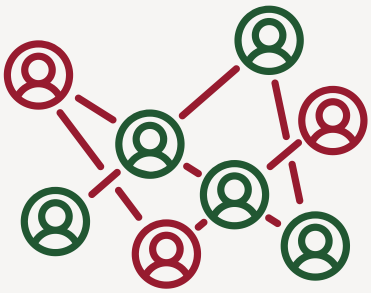
Forensic Evaluation Meetings with Client

Interpreter services are set up, as needed.
Meetings are held in-person or over HIPAA-encrypted Zoom.
On average, there are 2 sessions with the client and forensic team, and each session lasts approximately 1.5 to 2 hours.

Drafting & Submission of Forensic Evaluation

Initial draft is developed by the WashU forensic team and submitted to the lead attorney at the MICA Project or WashU School of Law ILC (depending on who the client's representative is for the case). An additional round of edits (time-dependent) between the WashU forensic team and the attorney concludes the final review, which is then signed off by the WashU forensic team lead.

The Asylum Support Initiative as a Connector



The organizational design that emerged is deliberately modest about its own role. While the CHRGM serves as a coordinating hub, maintaining case files, building training programs, and expanding a roster of qualified providers, it is the legal organizations, primarily the Immigration Law Clinic and the MICA Project, that bring in cases and explain what clients need.

"The connection is the whole thing," explains Julia D. López, Assistant Professor at WashU's School of Medicine, Assistant Professor at WashU's School of Public Health, and Associate Director of the CHRGM. ***"Law clinics have clients who need an evaluation and clinicians who want to provide one; without something in the middle, it can be hard to bring them together. The ASI is that middle. It makes the match, it gets students trained, and it keeps the community relationship going between cases so the network doesn't fall apart when things get quiet."***

For staff at the legal organizations working directly with clients, the value of this collaboration is tangible. **"As a MICA case manager and interpreter, I've seen how powerful forensic evaluations can be in helping clients tell their stories and support their asylum claims,"** says Carolina Ball, Bilingual Case Manager at the MICA Project. **"The ASI team approaches every evaluation with compassion and a trauma-informed lens, ensuring clients feel heard, respected, and supported throughout the process. Providing these evaluations free of charge makes an enormous difference for the individuals and families we serve."**

On the other side of the equation are medical students and clinicians from WashU Medicine and the Brown School of Social Work: people who are not only willing to provide the service, but genuinely eager to develop skills they can carry into their careers. The CHRGM's role, as Meyer puts it, is to function like a matchmaker, connecting need with capacity, and keeping both sides engaged.

That sense of ongoing connection has turned out to be one of the program's most important design features. When referrals slow down and clinicians aren't actively working a case, regular trainings on topics like trauma-informed interviewing and documenting physical findings of abuse keep participants both connected and prepared for new cases. **"Coming together, providing trainings, keeping people interested,"** Meyer says, is part of what sustains the program.

When Medicine Meets Testimony

Dr. Arwa Mohammad, an internal medicine resident at WashU, has been involved with the ASI since before its inception. As a first-year medical student seven years ago, she attended a forensic asylum training hosted by Dr. Rupa Patel and members of the MICA Project, walked up afterward, and asked how to get involved. The network she joined after that conversation was one of the foundations of what would become the ASI.

She was drawn to the work by a conviction she holds strongly: that global health doesn't require a plane ticket. **"Global health is part of our community health,"** she says. Mohammad asserts that the people described in news stories of displacement and persecution are not distant strangers; rather, they are members of our communities: patients, colleagues, and familiar faces in our neighborhoods. **"These are our neighbors,"** she notes, **"and we have to be aware. When you're walking around, you never really know what someone's been through. You never really know how that's impacted them and how that continues to impact them."**

Mohamed Ali Jama, a medical student who joined ASI in his first year after receiving an outreach email from Mohammad herself, came to the initiative through a different door. Born in Ethiopia to a Somali family displaced by civil war, he grew up watching his parents navigate the immigration system in Minnesota. **"It's been near and dear to my heart,"** he says, **"and I really jumped at the opportunity to try and help the best that I can."**

For both, the practice of sitting across from an asylum-seeker, listening carefully, and translating what they hear into a medically documented record has reshaped how they think about their profession.

Mohammad describes becoming more attuned to how significantly mental health can affect someone's daily functioning and more committed to patient-centered care. **"Whatever they need is what I'm there to provide,"** she says. **"Even if someone's not the 'perfect patient', that's just who they are, and you have to meet them there."**

For Jama, who is heading into a surgical specialty, the surprise has been discovering how much the work has helped him sharpen the foundational skill of clinical interviewing. **"The affidavit work has reminded me that history-taking is oftentimes the intervention,"** he says, **"and it doesn't necessarily go away just because you're a proceduralist."** He's also come to think differently about the value of clinical documentation for the person on the other side of the encounter. **"Every piece of documentation carries weight,"** he says. **"Someone else will read it. […] And sometimes, I think that may weigh on the people that come to see us clinically. […] It's made me a lot more cognizant of documentation from an ethical point of view."** That awareness is especially acute for patients who may fear that the written records could be used against them in a legal venue, or simply by a future provider who reads a chart and makes assumptions about them.

Being Believed Is Its Own Form of Care

One of the most striking things that emerges from talking with ASI's clinicians has nothing to do with legal strategy. It's what it means to be believed.

Asylum-seekers frequently arrive carrying years of silence about what happened to them and what they're continuing to experience as well as fear about whether anyone in a position of institutional authority could ever be trusted enough to hear it. The clinical team works deliberately to counter that fear and establish trust. Some of the ways they try to accomplish that include being explicit, as Jama describes it, about **"who we are and who we are not. We're not part of the legal team, we're not the judge,"** starting with non-traumatic biographical questions, and taking cues from body language and pacing rather than driving directly toward the difficult material. Often, he notes, later sessions are the most productive **"because we've established some rapport."**

"Being believed is itself therapeutic, separate from the legal outcome."

Jama describes the impact this can have on asylum-seekers: **"Being believed is itself therapeutic, separate from the legal outcome."** He references a body of literature on testimony as part of trauma recovery and on what it means for survivors of state violence to have their account formally received and affirmed. He's watched it happen in the room, **"Participants definitely open up and warm up as the interviews go on, as they get more comfortable with us, despite the fact that the material itself gets heavier."**

Clients often arrive not fully understanding the connection between the persecution they endured and the symptoms they're living with now. The clinical team's questions help them make that link, sometimes for the first time. **"I've had people tell me: 'I never thought that was related,'"** Mohammad recalls. **"'I thought I was crazy.' And they are genuinely thankful to finally have an explanation."** She's careful to note that the team isn't there to diagnose or treat, but that in asking the right questions, they make connections that clients have often never had the opportunity to make for themselves.

The team also acknowledges the cost the evaluation itself can carry. Asking someone to recall experiences of persecution in a clinical setting can be very difficult, even when the purpose is to help. **"You're retraumatizing these people, unfortunately, just by having them retell their story,"** Mohammad says. The team is aware of the harm, which shapes how they move: slowly, with the client setting the pace, and with deliberate structure on the clinical side to help carry the weight.

This work is not easy on the clinicians either. Listening to detailed accounts of persecution and torture takes a real toll. Mohammad describes blocking out the rest of the evening after interviews, giving herself time to decompress. What keeps her going, she says, is refusing to lose sight of the purpose: **"even whatever small thing I can contribute, at least I feel like I'm doing something about it."** When a case goes well, she says, **"the little positives outweigh the negatives."**

Meyer has come to reframe what she considers a "win" in this work. Even in cases where asylum is ultimately not granted, a strong forensic evaluation can lead a prosecutor to exercise discretion, a judge to weigh a case differently, or a client to feel that their suffering was real and recognized, not just in their own memory, but on the record.

Working in Uncertain Times

The current political moment has made everything more challenging.

The legal landscape for asylum in the United States is constantly shifting. Cases that were scheduled for trial in 2026 are being pushed to 2029; others that were years away are suddenly scheduled for hearings in two weeks, with little to no notice. Procedural mechanisms designed to allow adjudicators to dismiss cases without a hearing are being more widely applied. The result is a widespread uncertainty that makes it difficult to plan which cases are ready for a forensic evaluation and which aren't.

ASI has responded not by stepping back, but by experimenting. The program is piloting its first forensic evaluation over Zoom for a client currently in detention, testing whether a thorough, rigorous process can be compressed into an eight-to-ten-day window without sacrificing quality. It's a direct response to the new reality: cases that once would have had months of lead time now may have days.

"We are trying to figure out how we can meet the moment," Meyer says, **"hopefully not giving up on the really rigorous process that the medical providers have been doing, but adapting it slightly to also meet this expedited timeline."**

An Invitation to Get Involved

ASI is actively growing its roster of medical students, residents, and clinicians. Participants receive structured training and work alongside experienced preceptors and legal experts. No one enters the room alone, not literally, and not metaphorically.

"You don't necessarily need to feel ready," Jama says. **"Most people would be good at this. You learn on the job, and you won't necessarily ever feel ready until you take that role."** The time commitment is real, but he's clear about what participants take away: **"It will make you measurably better as an interviewer in any clinical context, period."**

"It will make you measurably better as an interviewer in any clinical context, period."

Mohammad offers a similar invitation, grounded in seven years of doing this work across medical school and residency. **"I think you really do learn a lot, and it makes you a stronger clinician and a stronger person,"** she says. Trauma-informed care is a phrase that gets thrown around a lot in medicine, she notes, but ASI is **"kind of like the peak of what it can actually mean, and it really teaches you, very quickly, what that actually looks like."** A lot of what you practice in the evaluation room, she adds, translates directly to everyday clinical work, whether you're on the wards, in a clinic, or in a procedure suite.

And Meyer speaks directly to students across medicine, law, social work, and public health: **"Getting involved with the ASI is a great opportunity in any field to grow some really essential skills. For those concerned about what's happening in this moment, it's one small but really important thing someone can do."**

Interested in volunteering with the Asylum Support Initiative? Learn more at the Center for Human Rights, Gender & Migration or visit the ASI program page to find out how to get involved.