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POSITION PAPER

International Medical Graduates in Psychiatry: Cultural Issues in Training and Continuing Professional Development

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Introduction

The term "International Medical Graduate" (IMG) refers to "a physician who has graduated from a medical school outside of the country in which he or she intends to practice."[1] In Canada, IMGs are physicians who received their medical training outside of Canada or the US, and who are pursuing or intend to pursue postgraduate residency training in Canada. A growing number of IMGs contribute to medical care around the world, and currently constitute 31% of the workforce in the UK, 25% in the US, 20% in Australia, and 23% in Canada.[2-5] The IMG experience in each country has unique features, based on local historical context and the changing intake criteria that reflect the fluctuating needs and policies of the receiving countries over time.[6,7] However, the IMG

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experience is often arduous, and the process of obtaining certification to practice is usually long and fraught with difficulties.[6-8]

Recent efforts have been made to address the emerging issues in training and certification for IMGs. This position paper addresses issues in IMG training and continuing professional development, with a focus on two key questions:

1. What are the specific training needs of IMGs in making the cultural transition from their place of original training to working effectively in the Canadian context?
2. In what ways can the cultural, linguistic, and other background knowledge and skills of IMGs be further developed during their clinical training and used in their subsequent work to enhance the delivery of mental health care to Canada's diverse population?

This paper will focus particularly on the culture-related issues in training, including those related to technical knowledge and competence, which are the concern of accreditation bodies and regulatory agencies.

Diversity Among IMGs

In North America, the Liaison Committee on Medical Education (LCME), which accredits medical schools in the US, cooperates with the Committee on Accreditation of Canadian Medical Schools (CACMS), to accredit medical schools in Canada.[9] Any physician who graduates from a non-LCME accredited medical school is considered an IMG. Medical graduates seeking postgraduate training (irrespective of their country of origin) need to apply for residency through the Canadian Resident Matching Service (CaRMS).[10] CaRMS classifies IMGs into two streams: 1) Immigrant IMG-CaRMS; and 2) Canadian/US-born IMG-CaRMS.[10]

In addition to CaRMS, points of entry into Canadian residency training include: 1) Visa IMG country-sponsored (visa IMG); and 2) immigrant IMGs entering Canada after completing a residency in their home country (immigrant IMGs). Visa IMGs have a point of entry into supernumerary residency training positions based on agreements between Canada and their home countries (commonly from the Middle East), and candidates are expected to return to their home countries upon their completion of training. Immigrant IMGs have completed postgraduate training in their home country and obtained equivalencies from provincial regulatory and national certifying bodies to practice psychiatry.[11,12]

This latter IMG contingent has historically included numerous physicians from former Commonwealth countries,[13] and these IMGs often have been tapped to meet the requirements of underserved areas in various regions of the country.[14-16] IMG psychiatrists have contributed greatly to Canadian psychiatry through key administrative, teaching, and research roles.

Although there is great heterogeneity within each broad IMG category, in terms of country of origin and expectations following training, there are many shared experiences.[17] Whereas Canadian- and US-born IMGs need to reintegrate into the Canadian educational and health care systems, immigrant IMGs may face additional cultural challenges related to their own acculturation.[8,18-20] Visa IMGs need to understand Canadian cultural contexts during their residency training and may also need to consider cultural issues when adapting what they have learned to health care contexts in their home countries when they return.

The origins of IMGs in Canada have shifted over the past decades. Early on, IMGs were often from Europe, whereas, later, they included physicians from Commonwealth countries,[13] and Canadian or US-born citizens trained at Caribbean medical schools.[21,22] More recently, IMGs entering the Canadian system reflect the overarching patterns of immigration and globalization.[7,23]

Distinctive Features of the IMG Experience

IMGs face distinctive issues related to their background, training experience, career trajectory, migration experience, and risk of exposure to discrimination. Compared with Canadian medical graduates (CMGs), IMGs are more likely to be male, older (mid-20's to late 40's), and to have previously practiced medicine for varying lengths of time.[24] Age, gender, ethnicity, previous training and work experience, immigration history, local immigration patterns, and physician recruitment preferences all influence the IMG experience.

Immigrant IMG trainees may experience greater difficulties compared with IMGs who have lived or trained in the country of their residency. A study of 108 IMGs from 70 different psychiatry residency and fellowship training programs in the US identified difficulties with acculturation, poor social support, and more junior status as predictors of compromised mental health during trainees' adaptation to residency.[25]

IMGs' experiences of postgraduate training differ from that of CMGs.[24,26-30] US, British, and Australian reports also note differences in experiences between IMGs and home-trained medical graduates.[31,32] Compared to CMGs, IMGs tend to experience greater uncertainty in obtaining training positions, follow a longer route to entering into postgraduate training, experience more social isolation and alienation, and may encounter prejudice from Canadian institutions and colleagues.[26,29] IMGs may also experience difficulties related to language, differences in medical education, length of time since graduation or last clinical experience, life stage and financial obligations, stress associated with being a migrant, cultural differences in communication styles, authority, gender roles, and the status of physicians.[26] IMGs able to overcome these challenges may experience less fatigue, greater self-esteem, and more personal growth.[33]

A qualitative study found that foreign-trained IMGs going through recertification in Canada pass through 3 phases of adjustment: 1) Loss, including loss of professional identity, status, and professional devaluation; 2) disorientation, with confusion in understanding the expected roles and responsibilities; and 3) adaptation.[18] An analysis of interviews of Canadian-born IMGs showed that the themes of loss, disorientation, and adaptation, while present, were less intense than among foreign-born IMGs.

Faced with issues of acculturation and discrimination in society, foreign-born IMGs may continue to feel like outsiders, particularly when they do not share the ethnicity of dominant social groups in their new home.[34] Although rates of discrimination related to being an IMG have approximated 30% in some studies,[35] data are limited. Studies from other areas of medical training suggests that discrimination towards IMGs may influence selection of trainees for residency[36] and can lead to a sense of isolation from peers.[37]

Residency Selection Process for IMGs

IMGs are significant contributors as health care providers in North America, often tasked with treating underprivileged and marginalized populations.[25] Although many IMGs choose psychiatry as their specialty,[38,39] there is evidence that IMGs face barriers in the selection process and, at times, must overcome major hurdles to gain a position in North American psychiatry residency programs. These barriers persist despite the shortage of psychiatrists in parts of the country, and the fact that some programs struggle to fill their residency positions.[40]

The literature documents 3 main problems in the residency selection process for IMGs that warrant further investigation: 1) Evidence of bias and discrimination toward IMGs in the residency selection process; 2) limitations of the IMG selection assessment; and 3) lack of agreement on guidelines used in choosing IMGs.[38]

Bias and Discrimination

Several studies have examined potential bias or discrimination in the IMG selection process.[41] An experimental study of US residency training programs in psychiatry found a higher response rate and more positive responses to requests for information from US medical graduates (USMGs) compared with IMGs.[40] Studies of residency programs in family practice[42] and surgery[36] have found similar potential discrimination in the IMG selection process. These studies point to the need to investigate whether systemic discrimination exists at the institutional level in Canadian residency programs.

Limitations of Existing Assessment Tools

Written examinations have limited reliability to assess clinical skills relevant to psychiatric training[38] and uncertain reliability when applied to candidates from very different cultures or contexts. One study using the multiple mini-interview (MMI)—a reliable and validated interview method to assess applicants for medical schools—in a sample of IMG residency candidates applying to family medicine residency in Alberta, suggests that skills that are difficult to quantify, such as professionalism, can be assessed in a standardized way; however, the impact on potential bias in the assessment process remains unknown.[43]

Since 2015, the National Assessment Collaboration (NAC) Objective Structured Clinical Examination (OSCE) has been a mandatory requirement for all IMGs applying to residency programs in all provinces, except Saskatchewan. According to the CaRMS website, the NAC OSCE (consisting of clinical stations presenting typical clinical scenarios) assesses the readiness of IMGs for entrance into postgraduate residency programs in Canada. This national, standardized examination tests knowledge, skills, and attitudes essential for postgraduate training in Canada.[44]

The use of a standardized IMG assessment tool across Canada could increase validity, transparency, and fairness in the assessment process. However, existing measures do

not assess the IMG's capacity to adapt to the stress of migration, acculturation, training, and practice.[25] These measures also do not capture the unique skills and clinical experiences IMGs may bring that can enhance Canadian psychiatry.

Need for Selection Guidelines

The literature suggests the need for national guidelines on the evaluation of IMGs beyond traditional written and clinical exams. Regulatory bodies have a role in ensuring that fair methods of assessment are employed and that discriminatory practices are identified and eliminated. Desbians and Vidaillet[41] call for medical organizations to take a stand similar to that of the American Psychiatric Association, which published a statement opposing discrimination against IMGs.[41] Providing postgraduate directors with clear guidelines and standardized methods for selecting IMG applicants may help prevent potential discrimination.

Postgraduate Training and Continuing Professional Development for IMGs

A survey of IMGs starting residency training in internal medicine and family medicine programs found that the most challenging areas for incoming IMGs were knowledge of the Canadian health care system, pharmaceuticals and hospital formularies, and the hospital system.[27] The only psychiatry-specific Canadian study examining IMG training needs found that IMGs had the most difficulty with their knowledge of the Canadian mental health care system, of evidence-based mental health, and of medical documentation.[30] Further, IMGs who did not speak English as a first language experienced significant difficulties coping with language barriers and social isolation during their transition into psychiatry residency programs.[30] Challenges regarding knowledge of the health care system and adjusting to psychotherapy training were greater for individuals who spent less than 1 year in their city of residency training.[30] For more senior trainees, challenges included difficulties understanding the local hospital system, medical documentation, and balancing personal and professional life.[35] These findings highlight the dual learning challenges faced by IMGs who must simultaneously master their roles as psychiatry residents and adapt to migration.[37]

Program directors and IMG supervisors have identified additional concerns about the communication skills of IMGs, specifically in the use of colloquial language, understanding linguistic idioms or slang, and communicating within interprofessional teams.[27,35,45] Some IMG supervisors expressed concerns with IMGs' clinical skills,[27,35] which may reflect the variability in training of IMGs before entering residency training programs.

A Framework for Cultural Curriculum for IMGs in Psychiatry

To facilitate the training of IMGs, we propose a framework for a competency-based IMG curriculum (Table 1). Clinical and personal transitional educational needs are both important and support each other. Clinical competencies can be divided into 3 parts: 1) Dyadic level competency, focusing on direct clinical interactions between IMGs and the diverse patient population in Canada; 2) system level competency, highlighting the interactions between IMGs and the Canadian health care system; and 3) integrated roles, looking at IMGs' capacity to perform the unique CanMEDS (framework delineating physician competency in various roles including medical expert, communicator, collaborator, leader/manager, health advocate, and scholar) roles, which may differ from typical psychiatrists' roles in the IMG's original training context. Personal transitional competencies include: "Acculturation and adaptation," which explicitly focuses on the need for IMGs to adapt culturally as immigrants; "learning styles and strategies," which specifies adaptations and strategies needed for effective learning during residency and beyond; and "examsmanship," which identifies competencies that facilitate the success of IMGs in residency programs, addressing potential cultural biases in evaluation and examination procedures. By framing these training needs in terms of explicit competencies, trainees and faculty can work together to ensure that the requisite knowledge, attitudes, and skills are developed through teaching, supervision, and evaluation.

Cultural Learning Objectives for IMGs

The outline for cultural formulation (OCF), first introduced in DSM IV,[46] and revised for DSM-5,[47] provides a systemic approach to exploring cultural differences relevant to clinical care.[48,49] We have adapted the 4 core areas of the OCF to identify cultural learning objectives for IMGs (Table 2):

1. Cultural identity of IMGs: The multiple or hybrid cultural identities of IMGs—both personal (e.g., culturally influenced gender and family roles, such as being a father) and professional (e.g., being a physician)—and their potential interactions (e.g., assessing family dysfunction clinically as a father and physician); different levels of language

Table 1. A Framework for Cultural Curriculum for International Medical Graduates (IMGs) in Psychiatry

Mapping IMG Needs and Curriculum Outline

IMG Needs	IMG Competency Based Curriculum Objectives
A. Clinical Training Needs	
1. Dyadic level competency (between psychiatrist and patient/family).	
i. Cultural awareness, safety, respect, and competence:	• Demonstrate cultural competence: Capacity to effectively provide care for the diverse Canadian communities including: ○ First Nations, Métis, and Inuit, ○ Immigration and refugees, ○ Ethnocultural and racialized communities. • Differential population needs based on gender and age including children and the elderly. • Observe "cultural safety:" Actions that recognize, respect and nurture the unique cultural identity of a person and safely meet their needs, expectations and rights.
ii. Communication:	• Use verbal and non-verbal communication skills with patients, families, and professional colleagues. • Demonstrate proficiency in comprehension and expression of language, including common local expression and slang. • Conduct cross-cultural communication effectively, including expression of emotions and empathy. • Work effectively with interpreters and culture brokers.
iii. Assessment, formulation, and treatment:	• Conduct comprehensive, patient-centred, culturally appropriate psychiatric assessment with patients of all ages. • Collaboratively develop a biopsychosociocultural treatment plan with the patient/family informed by the assessment. • Implement, monitor, and revise, as appropriate, a management plan. • Deliver evidence-based treatments, including psychotherapy.
2. Systemic level competency.	
Canadian health care system:	• Understand the Canadian health care system. • Become familiar with local jurisdiction, health services, and facilities. • Demonstrate adherence and enactment of relevant legislations and professional practice, including appropriate medical documentation.
3. Integrated roles as a specialist:	
CanMEDS framework:	• Describe, distinguish, and demonstrate the roles under the CanMEDS framework
B. Personal Transitional Training Needs	
1. Acculturation and adaptation:	• Reflect on own cultural identities, values, and experienced narratives. • Identify conflicts, deficits, and strengths related to cultural differences. • Identify, choose, and make use of acculturative strategies, resources, and opportunities to negotiate cultural differences and resolve acculturative challenges.
2. Learning styles and strategies:	• Reflect on personal and cultural learning styles and strategies. • Identify learning gaps and use available resources and deliberate strategies to overcome barriers in learning. • Facilitate broadening of learning styles and strategies personally and systemically through interactional dialogue with other learners and faculty.
3. Examsmanship:	• Identify potential barriers that contribute to inaccurate results in assessments. • Identify strategies, resources, and helpers that can facilitate a more accurate reflection of performance in assessments. • Advocate for systemic change for examinations that are inequitable.

CanMEDS (framework delineating physician competency in various roles including medical expert, communicator, collaborator, leader/manager, health advocate, and scholar); IMG, international medical graduate.

proficiency, depending on context (e.g., mastery of English in medical texts v. everyday idioms or dialects); and acculturation strategies that may be differentially employed in different personal to professional domains of life.

2. Cultural concepts of distress: Definitions of normality, expressions of distress, and explanations of symptoms and psychopathology vary with cultural and personal belief systems. This highlights the importance of IMGs becoming knowledgeable about culture and adept at addressing these differences, including those originating from their own cultural systems.
3. Psychosocial factors, as stressors and sources of strength: Psychosocial factors that affect IMGs include the stressors that immigrants face

Table 2. Outline for Cultural Enabling Learning Objectives for IMGs

Cultural Formulation[a]	Culturally Enabling Learning Objectives for IMGs
Cultural identities of IMG:	• Identify cultural identities of IMG at a personal and professional level. • Consider and enhance language proficiencies as needed. • Identify levels of acculturation, and employ various acculturative strategies in different personal and professional domains effectively.
Cultural conception of distress:	• Identify the similarities, differences, and interactions among the models of mental health, illness, and treatment based on: ○ IMG's mainstream medical system, ○ IMG's indigenous culture, ○ Canadian and local medical systems, ○ Patient's cultural beliefs. • Consider cultural differences in ontology, values, and ethics and their impact on concepts of health, illness, and treatment. • Adapt, bridge, or negotiate differences among competing models with patients, families, and other health care providers.
Psychosociocultural factors, including stressors and strengths:	• Identify sociocultural stressors as an IMG, and develop strategies and seek support to manage them. • Identify own cultural strengths and skills, and employ them in adaptation, learning, and care delivery. • Collaborate with communities and utilize systemic resources for personal coping and clinical work. • Identify systemic gaps and advocate for change.
Cultural features of the relationship between IMG and patients:	• Consider the interaction of gender/cultural differences, role expectations, and power differentials that affect the clinician and patient relationship for IMGs. • Reflect on and develop effective ways of working with transference and countertransference, considering social, cultural, and political factors. • Broaden, enhance, and refine the repertoire of skills as a clinician in the context of IMG treating the diverse Canadian populations.

IMG, international medical graduate.
[a]Adapted from DSM-5

compounded by the demands of professional training. IMGs also may draw upon specific strengths based on their cultural background, communities, and resources; and they may be in a unique position to advocate for systemic change based on their lived experience of migration.

4. Cultural features of the relationship between IMG and patients: The clinician–patient relationship may be shaped by patient perceptions, and the ways that they understand patients in relevant social contexts.[50] Accurate clinical assessment and treatment (particularly psychotherapy) depend on the quality of this relationship, informed by a shared fund of common experience and an empathic capacity to imagine another's situation and emotions. In addition to mastering verbal and nonverbal communication, IMGs need to become skilled in detecting and resolving problems in transference and countertransference, which may be influenced by cultural stereotypes, implicit norms and values (e.g., paternalistic v. autonomy-based approaches), and on biases, discrimination, historical-political factors, and power differences (e.g., based on gender, ethnicity, race, or social class).[51]

Postgraduate Training Considerations

Various strategies can be used to ensure integration of the IMG curriculum into the actual training experience of the IMGs (Table 3).

Given that IMGs are a select group of highly motivated learners who have overcome systemic barriers, it is important to engage their capacity for self-learning, including providing resources for clinical and personal transitional learning tasks. The Canadian Psychiatric Association launched its national IMG orientation resource in 2011, which serves as a resource for IMGs entering Canadian psychiatry residency programs.[10] This can be elaborated using the framework and outline presented in Tables 1 and 2. Expanding online resources to provide interactive courses may be an efficient way to disseminate standardized national modules to address IMG learning needs as well as to support more in-depth cultural learning and attitudinal change, which require reflective exercises and experiential activities.[52]

Most core learning needs to occur in the clinical setting. Observership programs before residency may assist with IMG transition.[53] Similarly, community-based clinical

Table 3. Pedagogical Methods for IMG Culturally Enabling Learning Objectives

Method	Aim
Guided Self-Learning Activities	
• Reference materials and resources, • Online courses and mobile apps, • Reflective activities (e.g., journaling, mindfulness activities, experiential activities, etc.).	Support individual reflection, independent learning, and cultural adaptation by providing methods, resources, and guidance.
Clinical Training	
• Observership, • Clinical supervision, • Community field-work.	Provide opportunities for integrated and contextually relevant clinical and cultural training through modeling, practice, and feedback.
One-on-One Learning and Support (with IMG or non-IMG)	
• Pairing with peer(s), • Pairing with mentor(s), • Individual counseling/psychotherapy.	Create a cultural safe space for learning and support longitudinally.
Group Learning and Support (with other IMGs and/or non-IMGs)	
• Formal educational programs (e.g., orientation day, seminars, film/media discussion groups, etc.), • Non-formal learning events (e.g., retreats, team-building exercises, among others), • Group support (e.g., peer support groups, group psychotherapy, among others).	Promote learning and support through collective interactions and experiences, which also increase openness to diversity; enhance collaborative skills; and strengthen social networks and supports.

work outside of regular academic placements may be especially helpful for IMGs to understand the diverse communities in Canada.

Although individual supervision can address many of the learning objectives and serve a supportive function for IMGs, it is helpful to provide other opportunities for one-on-one learning and support not associated with formal evaluation, such as through pairing with another IMG peer or mentor who has faced similar challenges. Where this is not feasible, pairing with a non-IMG peer or mentor may also be beneficial if they are culturally competent, can draw on their own cultural experiences of being different, and are sensitized to IMG issues. Personal psychotherapy, often recommended as part of psychotherapy training, may also serve as a useful support and resource for IMGs struggling with the acculturation process.[54]

Some of the IMG cultural learning objectives can also be addressed through trainee groups, which promote reflection through dialogue, enhance collaborative skills, and provide a sense of belonging and support. Psychiatry IMGs and faculty have supported the development of IMG orientation and transition to residency programs to address training gaps.[30,35,55] This can be delivered through front-ended orientation sessions and manuals, either for IMGs as a group or integrated into general orientation for all trainees. Supplementing group discussions with films, literature, and the arts can facilitate reflection on cultural issues, norms, and values.[56,57] Informal group learning activities, such as through retreats or team-building exercises, can help address the problems of isolation. Involvement of non-IMG residents in IMG-related activities is important not only to increase support for IMGs and improve their immediate learning environment, but also to provide an opportunity for all trainees to develop greater empathic understanding, collegiality, and cultural competence.

Faculty Development

To ensure successful implementation of the IMG curriculum, faculty development regarding IMG-specific supervision is needed. The Association for Faculties of Medicine in Canada has developed an online faculty development program toolkit to increase teachers' skill sets in educating IMGs.[58] Among other issues, interpretation of feedback by IMG trainees may vary based on cultural differences.[59] An adapted version of the "teaching, learning, and collaborating" model for feedback has been suggested as a way to provide effective feedback to IMGs.[60] Faculty development in cultural competence is especially important to deliver such a cultural curriculum with appropriate feedback, supervision, and support.[61]

Several frameworks have been described that may assist faculty in understanding and supporting IMG training needs.[35] Faculty should be familiar with frameworks on acculturation to appreciate the range of challenges and adaptive strategies of IMGs entering residency programs.[62]

Realizing the Potential of IMGs to Contribute to Culturally Safe and Responsive Mental Health Care Systems

IMGs present a potential resource for enhancing the Canadian health care system because of the range and depth of their cultural, linguistic, and international experience. Some IMGs have had experience providing medical services in large-scale conflicts, endured multiple migrations, or have had other experiences that may enhance their ability to understand and work with certain vulnerable populations. Addressing IMG cultural competence is important, as they may be called upon to work in underserved areas to fulfill return of service requirements as mandated in most provinces.

Enabling IMGs to make effective use of their unique cultures, additional knowledge, and skills to improve the accessibility and quality of mental health care requires specific training and structural changes in the health care system. This will ensure that IMGs are not exploited based on ethnocultural stereotypes, that they are trained in models and strategies for integrating their cultural knowledge into care, and that the health care system provides the essential resources needed to deliver culturally competent care in an equitable way.

Limitations of Ethnic Matching

Ethnolinguistic matching may facilitate the clinical encounter by improving communication, mutual understanding, and cultural safety, as well as address the underrepresentation of marginalized groups in the health care work force. However, ethnolinguistic matching often is imprecise, and inaccurate assumptions by patient or practitioner about shared identity and understanding can potentially lead to clinical misunderstandings and misalliance.[63]

Although ethnocultural minority clinicians (who may have been born, raised, and trained in Canada) may recognize the opportunity to provide specialized care for patients with similar backgrounds, many clinicians are concerned about being ethno-racially restricted in ways that devalue their broader competence and technical expertise.[64] Similar concerns may equally apply to IMG trainees.

Training to Facilitate Effective Use of Cultural Knowledge

Capitalizing on IMG diversity in mental health services requires turning implicit cultural knowledge and skills into conscious assets and expertise. The effective use of cultural knowledge also requires addressing the complexities of relationships between IMGs and their non-IMG colleagues, patients, and communities. Developing cultural competence requires openness to diversity and a willingness to address one's own identity and experiences regarding issues of marginalization and discrimination.[52,65]

Frameworks from cultural psychiatry can help IMGs negotiate training successfully and learn how to make effective use of their own breadth of cultural and linguistic knowledge to meet the needs of patients as well as help colleagues and institutions respond to the needs of Canada's increasingly diverse population. The guidelines for training in cultural psychiatry developed by the CPA are relevant to the training of IMGs.[61]

Institutional and Health Care System Change

Institutional settings can be made more welcoming and safe by allocating resources to ensure sufficient time and space to adequately explore and address cultural and linguistic differences.[66] "Safe spaces" are needed where IMGs, their colleagues, and faculty can reflect together on the relevance of cultural differences to mental health problems. This will require attention to institutional racism and discrimination that may exist in subtle forms.[67-69]

At the level of health systems, capitalizing on IMGs' cultural expertise may also require facilitating pathways that allow patients to find appropriate care, and creating opportunities for IMGs to consult with and train their colleagues to respond more appropriately. At both the institutional and health care system levels, addressing the legacy of colonization in Canada's relationship to indigenous peoples and the transgenerational effects of other historical events that have affected specific groups may raise awareness of such issues and facilitate discussion about similar forms of discrimination experienced by minority IMGs.[70-74]

Conclusion: Implications for Training and Continuing Professional Development

IMGs face multiple obstacles in pursuing psychiatric training, including bias in the residency selection process; challenges in their own migration and acculturation; and the need to learn about new health systems, modes of practice, and social contexts relevant to psychiatric assessment and treatment. Ethnocultural minority IMGs may face stereotyping and discrimination both within training programs and in practice settings. Regional and national regulatory bodies need to ensure that programs

do not engage in discriminatory practices in the IMG selection and training processes, and work together to address potential sources of bias. Trainees and practitioners need collegial support and strategies for dealing with this kind of prejudice. Discrimination reflects larger societal problems of institutionalized racism and intolerance. In addition to the focus on addressing inequity and promoting care of diverse patients, there needs to be a similar focus on the diversity of IMGs to facilitate cultural safety and competence in their training environment and in the health care system.

The diversity in IMG experience parallels the diversity in the multicultural patient population that enriches Canadian society. Capitalizing on this diversity by enabling IMGs to articulate and systematically apply their cultural knowledge will significantly improve the Canadian health care system. In recognizing the value of IMGs' unique knowledge and experience, training programs and health care institutions can create opportunities for IMGs to share their knowledge both by educating their colleagues and by supporting broader systemic initiatives to address diversity in health care. Finally, it is important to emphasize that IMG issues are dynamic and will require IMG input for solutions. Forums that bring together current and past IMGs at national, provincial, and individual program levels could allow IMGs to share their experiences and contribute to strategies to address the challenges and opportunities identified in this paper.

Glossary

CACMS	Committee on Accreditation of Canadian Medical Schools
CanMEDS	Framework delineating physician competency in various roles including medical expert, communicator, collaborator, leader/manager, health advocate, and scholar
CaRMS	Canadian Resident Matching Service
CMG	Canadian medical graduate
IMG	International medical graduate
LCME	Liaison Committee on Medical Education
MMI	Multiple mini-interview
NAC	National Assessment Collaboration
OCF	Outline for cultural formulation (DSM-5)
OSCE	Objective Structured Clinical Examination
USMG	US medical graduate

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