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International medical graduates as untapped resource for community health and wellness

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ABSTRACT

Objectives: This study examines the potential of International Medical Graduates (IMG) in contributing to the health and wellness of a community, particularly through transdisciplinary knowledge engagement or mobilization in diverse settings. We aimed to gather IMGs' perspectives on potential non-physician roles to enhance community health and wellness using a qualitative descriptive approach.

Methods: Eight focus groups were conducted among IMGs in Canada between June and August 2020 (n = 42), followed by a thematic analysis of the verbatim transcripts. Two independent reviewers carried out inductive coding of the data. Emergent themes and sub-themes were identified. Through an iterative process incorporating insights from community partners, themes were refined to capture the lived experiences of IMGs in this context.

Results: We sought to engage this population in discussions to capture their perspectives on contributions to health and wellness. Participants suggested various alternative contribution pathways such as knowledge mobilization, research generation, and supportive community roles. They also identified individual and systemic challenges. Finally, strategies for change were proposed on personal, professional, and organizational levels.

Conclusion: The IMGs put forward various ideas and insights regarding their potential contributions to community health and wellness. They can be valuable assets in promoting health and improving health literacy. It is important to recognize that IMGs are eager to take on significant roles in the community and that they are currently an underused resource for enhancing community health and wellness.

1. Introduction

Preventative healthcare has emerged over the years as a crucial discipline of medicine, and incorporation into practice has never been more important (AbdulRaheem, 2023). Prevention can include identifying prevalent diseases in a population and addressing the associated factors (Yarnell, 2013). It can also involve implementing measures at individual, community, and systemic levels, to reduce the burden of diseases and minimize their impact on quality of life (Yarnell, 2013). Major instruments for disease prevention include health education, promotion, and advocacy (Whitehead, 2004; Galer-Unti et al., 2004). Health education generally refers to providing health information to populations, however; health promotion also aims at changing behaviours and attitudes to health of entire populations (Whitehead, 2004). Health advocacy includes informing policy to adapt to the need of the population (Galer-Unti et al., 2004). Appropriate utilization of these instruments can empower individuals to take control of their health, make informed decisions regarding their lifestyle, and management of any existing conditions (World Health Organization, 2015). However, health promotion delivery and organization must be tailored to populations, and extra care should be taken to ensure that the needs of marginalized populations are addressed.

The fabric of Canadian society is becoming increasingly diverse as the country continues to welcome migrants from different sociocultural backgrounds. Since 2021, immigrants have made up almost 23 % of Canada's population, and this could increase to 34 % by 2041 (Government of Canada Statistics Canada, 2022). Studies point to an underutilization of health services among immigrants (Wang, 2014), with barriers to access such as language, lack of navigational information, and cultural differences (Chowdhury et al., 2021). Many arriving in

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Canada are skilled migrants, and thus are educated and 'presumably' health literate. However, health literacy is a product of an individual's education, beliefs and cultural practices around health, and general knowledge about diseases, the healthcare system, and language including medical jargon (Turin and Chowdhury, 2022). As such, health literacy in the Canadian context may be low for immigrants and is often associated with unequal health outcomes among them (Turin et al., 2023). This underscores the growing concern that existing services may not sufficiently meet the needs of diverse immigrants. This contributes to the observation that while immigrants generally arrive in Canada in a relatively better health condition than their Canadian-born counterparts, their health tends to rapidly deteriorate as they attempt to adapt to the host country, including navigating a new and often very different healthcare system (Subedi and Rosenberg, 2014; Zghal et al., 2021). Therefore, approaches must be updated and expanded to meet the diverse needs of the immigrant communities. Potential measures include improving the cultural competence of health system, provision of culturally sensitive health services, and reformulating health promotion and education practices to align with community personae (Turin et al., 2023; Khalid et al., 2022).

International Medical Graduates (IMGs) in Canada are individuals who have graduated from a medical school outside Canada and the US (Turin et al., 2021a, 2021). It often takes years for IMGs to become licensed to independently practice medicine in Canada. Unfortunately, because of limited opportunities, the majority of IMGs cannot get licensed at all and remain un/under-utilized as physicians. Many IMGs, therefore, seek alternate ways to employ their skills for getting jobs (Lofters et al., 2014; Neiterman et al., 2017; Turin et al., 2021a, 2021). IMGs' experience as care providers and knowledge about the cultural beliefs and practices of immigrants qualify them as unique candidates to take the lead in health promotion, education, and advocacy roles (Harun and Walton-Roberts, 2022; Shaw-Taylor and Benesch, 1998). Particularly, as the provision of primary care in Canada becomes increasingly challenging due to an aging and diversifying population, a growing burden of chronic diseases, and a shortage of healthcare professionals, (Duong, 2022; Glazier, 2023) IMGs could potentially contribute to addressing these issues.

The objective of this research was to capture the perspectives of IMGs in alternative careers on how they envision contributing to improving community health and wellness, guided by the concepts of 'roles,' 'challenges,' and 'strategies.'

2. Methods

2.1. Study design

We undertook a qualitative descriptive approach in this study, which derives its focus from naturalistic perspectives (Ann Cutler et al., 2021). A qualitative descriptive approach is not preoccupied with theory development or interpretation, but rather on providing nuance and understanding to a phenomenon (Kim et al., 2017). In keeping with this paradigm, we intended to learn from the lived experiences of IMGs who attempted to utilize their health-related knowledge and skills in non-physician roles, and the surrounding conditions of that utilization. We deemed that focus group discussions would be a useful tool to collect data in this study as the nature of this study was to explore different perspectives and opportunities and identify barriers and facilitators for IMGs to contribute to the community. The focus group discussions were held over Zoom; an online conferencing platform (Zoom Video Communications, Inc.), using a secured account issued by the University of Calgary, due to COVID-19 restrictions in effect at the time of data collection. As a perk of using Zoom, we were also able to recruit IMGs from across Canada.

2.2. Recruitment and data collection

Ethics approval was given by the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary. The study was advertised through posters shared on social media groups dedicated to IMGs in Canada and with the community partner of the study, the Alberta International Medical Graduates Association (AIMGA). Given our intention to gather rich data from the lived experiences of IMGs who contributed to community health in non-physician roles in Canada, the proposed sample was guided by the study inclusion criteria: individuals who were internationally educated physicians residing in Canada and employed in alternative careers or had an invested interest in pursuing one. Recruitment, sampling, and data collection took place exclusively online. We used a purposive sampling method to recruit participants, however still ensured any interested participants fulfilled our inclusion criteria. After finding a suitable schedule for 4–7 IMGs per focus group, eight focus groups were then conducted ($n = 42$). The focus groups were conducted between June 2020 to August 2020. The consent form was sent electronically beforehand for review by participants and was again explained briefly by the moderator at the beginning of each focus group, followed by explicit oral consent from the participants. A note-taker accompanied the moderator. We followed a semi-structured interview guide. Each session lasted about 1–1.5 h and was conducted in English. We did not receive any request for translators. The discussion was recorded using Zoom's audio recording tool and was transcribed verbatim.

2.3. Data analysis

Following familiarization with the transcripts, we used an inductive thematic analysis as outlined by Braun and Clarke (Braun and Clarke, 2006). This method of data analysis is congruent with a qualitative descriptive approach, since our guiding questions were formed to test and understand specific topics within the IMG experience (contributions to health and wellness), and to develop a sense of direction in data collection and analysis (Willis et al., 2016). We first conducted a preliminary analysis of the first three focus groups to see if we would be able to get rich and relevant data or would need to modify our discussion approach. This also provided us with some insight into the topic, and we were able to explore deeper concepts in the following discussions. After the completion of all focus groups, we performed the analysis through initial coding followed by creating themes and sub-themes. The themes and sub-themes were reviewed and finalized following a discussion and revision with a community partner and IMG members. NVivo (version March 2020) was employed for analysis.

To promote the rigour of our study, we employed several procedures. Member-checking with two participants was conducted to verify transcript accuracy and ensure our interpretations accurately captured the perspectives of IMGs. An audit trail of analytical memos and decisions was maintained. Regular peer-debriefing sessions were held among our transdisciplinary research team to discuss coding, interpretations, analytic perspectives, and researcher biases/assumptions. Our diverse research team comprising IMGs and non-IMGs promoted reflexivity throughout the design, data collection, analysis, and reporting phases. Thick descriptions of participants and contexts are provided to allow judgments about transferability. These rigor-enhancing strategies ensured aspects of trustworthiness, including credibility, transferability, dependability, and confirmability, of our study results (Lincoln and Guba, 1985).

3. Results

Our aim was to engage the IMG community in meaningful discussions to explore their perspectives on how they can contributions to community health and wellness. The study was organized around three primary question categories: 1) potential roles for IMGs, 2) the

challenges they face in fulfilling these roles, and 3) strategies to foster IMGs in these roles. Throughout these discussions, participants presented a diverse array of pathways for contributing to health and wellness, extending beyond traditional medical practice. They also identified various challenges and barriers associated with these roles and proposed possible ways to foster and facilitate their active participation to enrich community health and wellness. Below are themes and subcodes based on participant responses to each guiding question. Participant identification codes are referenced after quotes and are organized by the number of focus group discussion (denoted as FGD) and participant number (denoted as P), for example the fictional patient FGD9P1 is participant 1 in the ninth focus group discussion held.

3.1. Potential roles for IMG to contribute to community health and wellness

Participants spoke about several roles they can play to provide the community with recourses and information surrounding health and wellness (Fig. 1). The suggested roles covered areas such as supportive roles for community individuals, knowledge mobilization, and research. Working one on one with community individuals was brought up, in the context of navigators, peer supporters, and volunteers, with many participants highlighting the additional support needed for our aging population.

> "I know in my family [the] elderly go to their doctors and they, when they come, they have absolutely no idea. What was the visit all about? And it is not just true about people who speak different languages." (FGD4P2)

Many participants highlighted the capacity of IMGs' strong communication with their respective communities, particularly being proficient in multiple languages as well as being seen as experts in their communities. This relates to the capacity of IMGs in the realm of knowledge mobilization, and health education, promotion, delivery. Comments were made on the potential for IMGs to support preventative wellness measures through their communication skills, and promote healthy lifestyles and rehabilitation, which can cross into many sectors and workforce industries.

> "-you know, linking the bridge between…a health protocol to a particular cultural people so that the program will be more efficient and more effective." (FGD1P2)

> "I will always ask about people around myself to be concerned about them. 'You shouldn't do this'. 'This is not good for health'. This is not like I'm talking in a nonphysician way. So health literacy component, right? … If I can, I can practice this for myself and ask … the people around myself, that would be pretty good thing." (FGD7P2)

Lastly, there were one especially insightful perspective shared on the importance of research, and the power of prevention that emerges from IMG participation in community and academia.

> "IMGs can be involved in research that way we can do like maybe systematic reviews, meta analysis, and all that and eying that, what information is out there… inform the various programs that are being implemented. If we're doing a wellness program we want to do based on evidence. And so, the first step is to see what works from studies that have been done elsewhere or in Canada, and integrate it into your wellness program that can help… people lead better lives… I think generally what I'm getting at is since we can't do the main, like diagnosis treatments and like direct patient contact…then what we can do is to see how we can prevent them from getting [sick] in the first place." (FGD5P1)

3.2. Challenges to IMGs' contribution to community health and wellness

Participants mentioned several challenges and barriers to community health and wellness contribution, which included challenges on an individual level, and challenges on a systemic larger scale level (Fig. 2). For instance, there was mention of expectations that IMGs were not able to meet, acting as barriers for newcomers to contribute to community health.

> "I know that even for volunteering opportunities, this is like applying to jobs… it's so competitive that, and you know, sometimes… I don't understand it. I want to volunteer and then you're not even giving me the opportunity to volunteer… those kinds of hurdles. If organizations could also see IMGS differently, um, that would also help in integrating IMGS faster." (FGD6P2)

IMG participants also made mention of the financial instability they experience as newcomers, and the other important priorities that must be addressed alongside their commitment to community contribution, such as financial concerns and family needs.

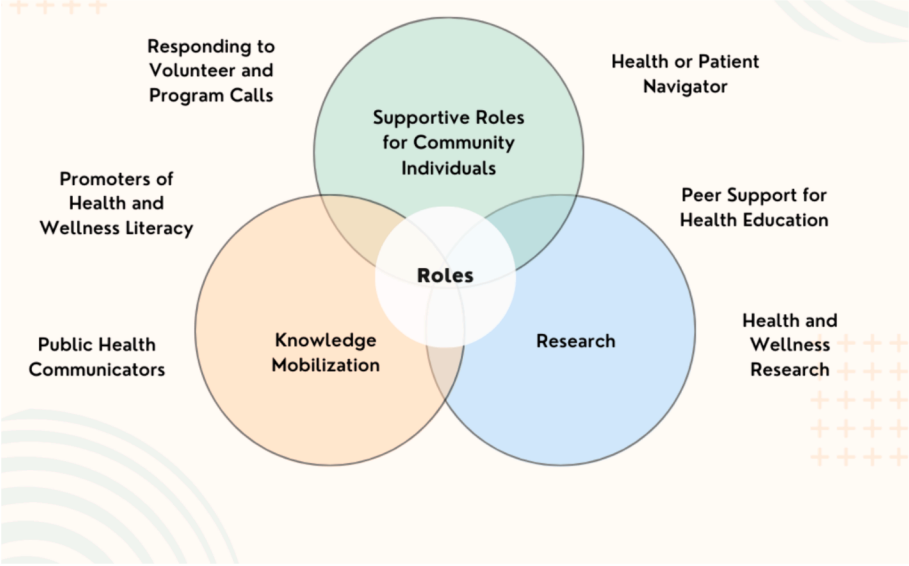

Fig. 1. Potential Roles for IMG.

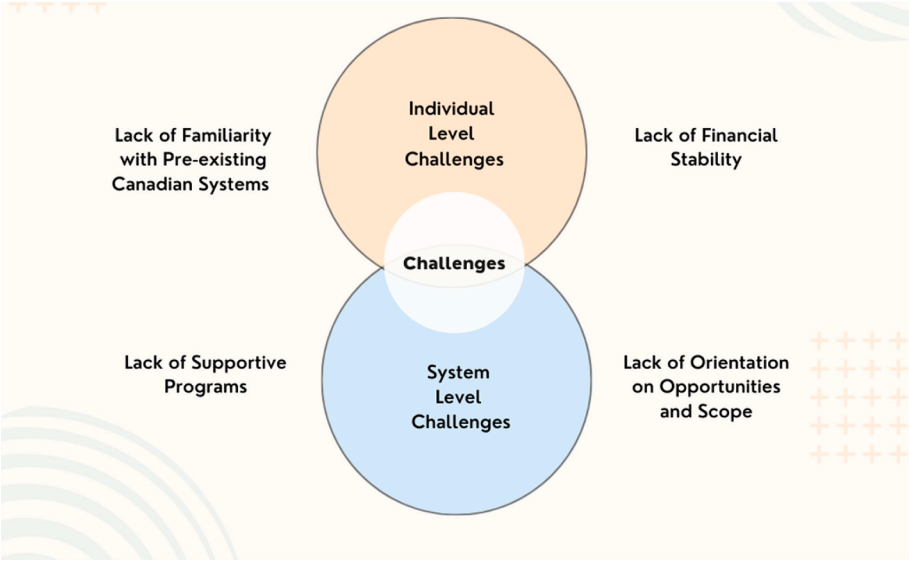

Fig. 2. Challenges to IMGs' contribution to community health and wellness.

"Even if I have these great ideas and IMG to contribute to the society, to go and volunteer and all that, I have to feed my family. I have to pay my bills. So there's no way I'm going to do all that whole haphazardly." (FGD5P1)

Lastly, many IMGs brought up the lack of orientation on opportunities available for them and the little support when it comes to retraining requirements and support programs. Critical systemic support and organizational backing were suggested, to make IMGs transition into health and wellness contributions faster and better.

"I think the very first thing to do is to have some sort of orientation program or certification program where people who are interested in these aspects of community health and alternative career get some form of training, hands on training, get to know the community, see aspects where they can contribute…" (FGD3P1)

3.3. *Strategies to foster IMGs in community health and wellness roles*

Participants went into further detail about the pathways to community health and wellness contributions and offered ideas on different ways to facilitate IMG contributions (Fig. 3). A common theme of these proposed changes was reliance on personal resources and self-sufficiency to facilitate health and wellness within community.

"I guess I'm also involved in my community with my church and I also, they know that I'm, I an IMG, they ask me questions, but I'm always really careful to say like, okay, this is not medical advice." (FGD2P1)

There is also mention of much larger resources and structures provided by organizations, that would facilitate large scale support, and would validate the authenticity of IMGs to provide tools to community.

"Otherwise, it has to be done with a backup from an organization, which kind of supports us to be introduced to the system… you know, because this is the organization that is supporting us, knowing our skills, knowing our value, knowing what we can provide and advocating for us in different things." (FGD3P2)

"This type of resources, persons can be important, uh, for the organizations or government they can be used or utilized to provide

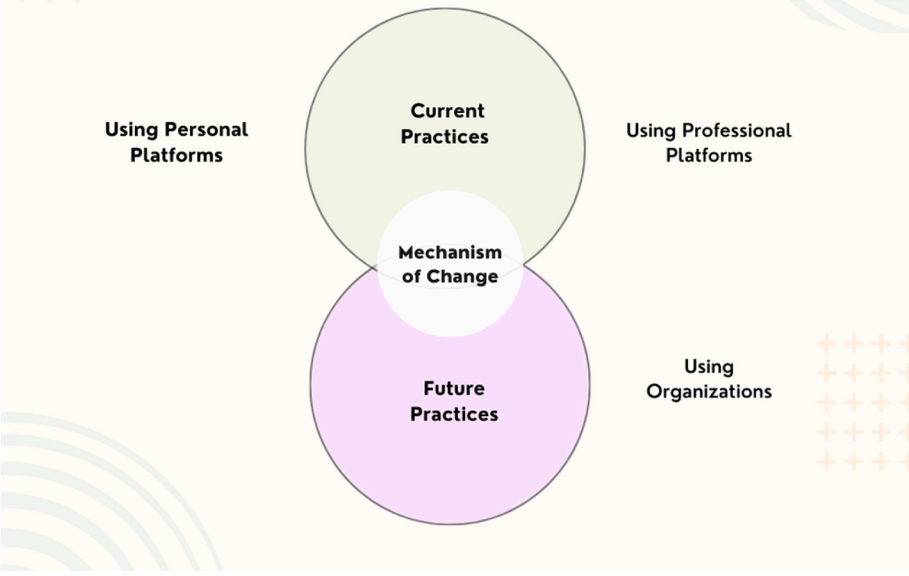

Fig. 3. Fostering IMGs' Health and Wellness Contributions.

health communication, health care communication, prevention communication. So, all these messages can be conveyed." (FGD1P3)

4. Discussion

The findings of this study offer a nuanced view of the IMGs' potential in contributing to community health and wellness through non-physician roles. Three main areas of focus formed the discussion, namely (1) potential roles for IMGs, (2) the challenges they face in fulfilling these roles, and (3) strategies to foster IMGs in these roles. IMGs demonstrated interest and confidence of taking on various roles to support their community beyond that of a practicing physician. They emphasized the importance of supportive roles like navigators, peer supporters, and volunteers, particularly to address the needs of aging and culturally diverse populations and those who face language barriers. This notion of varied roles underscores the unique communication skills IMGs bring to their communities, as many are multilingual and culturally sensitive.

Previous study also reported that IMGs find it particularly rewarding to be able to learn and help diverse communities (Torti et al., 2023). Nevertheless, despite their willingness and capability, IMGs face numerous challenges such as financial instability, particularly as newcomers (also reflected elsewhere), and the lack of opportunities, systemic negligence, and discrimination limit the extent and reach of their support (Moneypenny, 2018). The participants, however, suggested actionable mechanisms to overcome these challenges, ranging from personal initiatives to institutional supports. IMGs in our study called for more organized training and support to facilitate their contributions to community health. This warrants system level initiatives to enable this underutilized health human resources to better serve Canada's increasingly diverse population.

Career development theorists have often stressed that career development is more like a process than a destination, which is unique to each individual depending on the opportunities they come by, their geographical location, and their family responsibilities among other factors (Kosine and Lewis, 2008). From the three questions we asked revolving around the lived experience of IMGs in community, a variety of unique answers were provided. This highlights that perspective is created from an individual's life experiences rather than objective views of the world, which is in line with this study's constructivist paradigm, and supports our findings that contributions to community health and wellness are unique to each individual, based on their values, interests, and personal experiences (Dennick, 2016).

The responses collected also offer insight into the vastness and relevancy of IMGs' roles in health and wellness. The responses collected from participants told a story of varied positions, careers, fields, and roles, which align with literature findings. Using these responses, we can find innovative and effective solutions to support our Canadian healthcare. It is especially important to note that many health and wellness roles in a community do not necessarily require a licensure but can be elevated by IMGs' medical backgrounds in various capacities. This includes health program managers, researchers, or policy advocates, which create intersections to address unique gaps. For instance, in 2016 Statistics Canada reported that immigrants working in the occupations of nursing aide, orderly, and patient services were twice as likely as non-immigrants to have earned their university degrees in a health-related field (Government of Canada Statistics Canada, 2020). These care aides often provide 75–80 % of direct care to Canadians in long-term care facilities; to an increasing and aging population with complex health needs (Estabrooks et al., 2015). Whether it's in direct care, health program management, research, or policy, the depth of knowledge accessible to IMGs in these varied roles could be critical in addressing health challenges.

Challenges to community health and wellness contributions vary, including loss of professional identity, which stems from governments failing to officially recognize the credentials and educational history of IMGs. The failure of recognizing the credentials of migrant health workers, and not utilizing their skills and knowledge to their full potential can contribute to the unsustainability of health systems in destination countries (Ungureanu et al., 2019). When new immigrants are pressured to address more primary needs (such as financially supporting family and housing), community participation is affected, as the process of settling down and finding immediate employment are among more important factors that affect immigrants (Suarez-Balcazar et al., 2020). This was common notion in this study, as participants mentioned needing to address pressing personal circumstances prior to achieving professional stability. A difficult roadblock reported was the lack of services provided to support settlement and enhance immigrants' scope of awareness, leaving IMGs with feelings of distrust and unfamiliarity in their new settings, and reducing social trust between members of society during their interactions (Nooteboom, 2007).

Lastly, the versatility of IMGs, as demonstrated in the discussion, allows them to offer adaptable solutions that can effectively respond to the dynamic health needs of communities across the country. As these needs change and expand over time, IMGs are well-positioned to provide flexible support and fill critical roles within the healthcare system. This was seen during the COVID-19 pandemic that opened up many new employment opportunities in the sectors of pharmaceuticals, testing and vaccination (Bachmann et al., 2022). Pandemic healthcare roles aside, community-based roles also require certain levels of community credibility and liaising to be impactful, which are skills that IMGs can and do possess (Feroz et al., 2021). Additionally, it is very important to consider that social ecological model highlights the vast spheres of influences that people live and work in, and how individuals can interact with their community and neighbourhood (mesosystem) in bidirectional ways unique to the resources they have and social roles (Kilanowski, 2017). As such many IMGs have well connected relations to help reach their outcomes, which includes both their personal and professional activities, such as volunteering and career positions.

5. Strengths and limitations

Since this study focused on the experiences of IMGs within a Canadian context, our sample was limited to IMGs residing in Canada only. This study was conducted only in English and, as such, may have excluded the experiences of French-speaking only IMGs. We used purposive sampling in this study as we required certain IMG members who are actively pursuing alternate careers as we needed to recruit specific cases. There was also an overrepresentation of participants from Alberta considering the research team members of the study were based in Alberta. Our study used online focus groups to promote discussion and communication among participants. This allowed for many shared experiences to be discussed, as well as similar or differing attitudes and behaviours to be confirmed or denied, which was a strength of this study. Since the interview moderators had similar experiences being IMGs as participants, they were able to ask relevant probing questions, and collect valuable interview memo and notes for analysis – another strength of this study.

6. Conclusion

To effectively leverage the diverse skills and experiences of IMGs in enhancing community health, a multi-faceted approach is needed. Firstly, comprehensive pre-immigration support should be arranged through seminars, orientation programs, and guidance on practical aspects of settling in Canada. Upon arrival, targeted induction and training programs tailored to individual needs, focusing on communication, cultural competence, and organizational skills, are crucial. Health organizations must foster a welcoming environment by promoting cultural awareness, peer support networks, and training for supervisors and colleagues. Fair and transparent processes should be established to

recognize IMGs' prior education and experience, facilitating their contribution to community health in roles beyond that of physicians. Engaging IMGs in community outreach, health promotion activities, and decision-making processes can leverage their linguistic and cultural diversity to better serve diverse communities. Finally, ongoing support through professional development opportunities, job market integration assistance, and collaboration with associations supporting IMGs is essential for their successful integration and long-term contribution to community health and wellness.

7. Contributions to knowledge

7.1. What does this add to existing knowledge?

This study adds and expands to existing knowledge on alternate career pathways for International Medical Graduates in Canada, which was very limited to begin with. It highlights IMGs as an underutilized resource in community health and wellness, and it can serve as a starting point for policy analysis and public health interventions.

7.2. What are the key implications for public health interventions, practice, or policy?

IMGs pursuing careers in non-physician roles can be a valuable resource for promoting equitable health among newcomers, immigrants, and refugees in Canada. Involving IMGs in public health initiatives such as health promotional, health literacy, and educational activities can lead to more effective and culturally sensitive interventions.

8. Consent to participate

Informed consent was obtained from the study participants.

9. Patient contribution

This paper has involvement of community members with livid experience who are IMG immigrants to Canada and are working in the community health domain.

10. Authors' contributions

TCT and DL conceived of the paper. NC and TCT collected the data. MA, NC, and TCT conducted the analysis and drafted the paper. All authors provided critical input to multiple drafts.

Ethics approval

Ethics approval was obtained from the Conjoin Health Research Ethics Board of University of Calgary.

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CRediT authorship contribution statement

Meriem Aroua: Writing – original draft, Visualization, Methodology, Formal analysis. **Nashit Chowdhury:** Writing – review & editing, Supervision, Methodology, Formal analysis, Data curation. **Deidre Lake:** Writing – review & editing, Validation, Supervision, Methodology, Funding acquisition, Conceptualization. **Tanvir C. Turin:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The authors do not have permission to share data.

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