



World Psychiatric Association-Asian Journal of Psychiatry Commission on the Mental Health and Wellbeing of International Medical Graduates

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ABSTRACT

Historically, doctors have migrated for a range of personal, educational, economic, and political reasons. Likewise, medical students from many countries have moved abroad to complete their training and education and may or may not return to their country of origin. Within this context, globalisation has had a major impact on medical education and healthcare workforces, contributing to recent migration trends. Globalisation is a complex phenomenon with positive and negative outcomes. For example, lower-income countries are regularly losing doctors to higher-income areas, thereby exacerbating strains on existing services. Across various national healthcare settings, migrating International Medical Graduates (IMGs) can face socioenvironmental and psychosocial pressures, which can lead to lower mental wellbeing and undermine their contributions to clinical care. Rates of stress and burnout are generally increasing for doctors and medical students. For IMGs, stressors related to migration, acculturation, and adjustment are not dissimilar to other migrants but may carry with them specific nuances. Accordingly, this Commission will explore the history of IMG trends and the challenges faced by IMGs, proposing recommendations and solutions to support their mental health and wellbeing.

1. Introduction

In an increasingly interconnected world, it is not surprising that people migrate to different countries. Often there are political, educational, personal, or economic reasons that underpin these movements. Different push and pull factors can play a significant role and contingent on the group and regional setting, there may be distinct dynamics that affect migratory decisions, policies, and processes.

For doctors, the possibility of learning new and innovative techniques, improving personal and practical skills as a clinician or researcher, a lack of training opportunities in their home country, and

economic or professional advancement are just some of the key determinants. These can each influence the migratory decisions and heterogeneous experiences of a specific subgroup of doctors, namely: International Medical Graduates (IMGs) (i.e. an individual who has completed their primary medical qualification and degree overseas and has subsequently moved to another country). IMGs have an extensive representation and influence across global healthcare systems, particularly in high-income countries (HICs). Nevertheless, simultaneously, IMGs recurrently face profound challenges, with prominent issues arising related to acculturation, adaptation, adverse working conditions, and burnout.

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With this in mind, the World Psychiatric Association jointly with the Asian Journal of Psychiatry launched a Commission in October 2022 dedicated to the health and wellbeing of IMGs and hereafter presents its report.

Firstly, the Commission provides an overview of IMGs and wider trends in migration. Following this, the Commission explores the unique challenges faced by IMGs and how these can detrimentally affect mental health and professional opportunities. Finally, the Commission proposes several recommendations at a personal, institutional, legal, and political level to support the integration and wellbeing of IMGs within the international medical community.

1.1. Background and overview

Medicine can be a rewarding and fulfilling career. Yet, concomitantly, the pressures of contemporary patient care can carry associated personal harms for physicians, with studies identifying trends of burnout and deteriorating mental health due to occupational and psychosocial risk factors (e.g., (Devi, 2011)). Previously, psychiatric symptoms have been identified amongst doctors, including anxiety, depression, and substance use (Harvey et al., 2021). These may be prevalent amongst groups of medical residents and early career doctors (Levey, 2001; Volpe et al., 2014), who often experience demanding working environments. Similar adverse patterns have been noted in various medical contexts across Asia, with detrimental working conditions and exogenous factors connected to the COVID-19 pandemic exacerbating employment-related stress (e.g., Grover et al., 2019; Jia et al., 2022).

Although these concerns have been well-documented, the distinctive experiences and specific circumstances of IMG physician populations can entail additional psychological stressors and vulnerabilities (e.g., (Murillo Zepeda et al., 2022; Kalra et al., 2012)). Notably, globalisation and socioeconomic factors have resulted in graduates seeking to enter the medical profession or undertake medical education training across various regions (Organization for Economic Cooperation and Development, 2021). Such migratory movements can be underpinned by discrete macro, meso, and micro factors (Brennan et al., 2023), encompassing policy-level motivators, sociocultural aspects (e.g., a tradition of migration in certain countries), enhanced access to facilities and resources, and higher earning potential (e.g., Lofters et al., 2014; George and Rhodes, 2017; Robredo et al., 2022). In some cases, IMGs are compelled to migrate due to personal or geopolitical circumstances, such as international conflicts and refugee crises (e.g., Ha et al., 2019).

Furthermore, individuals who are citizens of one country may move to complete basic medical qualifications in another region and subsequently return to their country of origin. In higher-income areas, students are choosing to move abroad to obtain basic medical qualifications, as costs and admission requirements can be less onerous or competitive than in their country of birth or residence. In a dedicated report, the Organization for Economic Cooperation and Development (OECD) noted that the rates of medical graduates were increasing in these groups, as were migratory tendencies (Organization for Economic Cooperation and Development, 2021). Taking Ireland as an example, the OECD (Organization for Economic Cooperation and Development, 2021) indicated that burgeoning numbers of international medical students are from the USA, the UK, and Canada, and after graduation most choose to return to their home countries.

Thus, it is evident that there are different types of IMGs internationally and whilst certain IMGs may share common experiences and needs, heterogeneous characteristics are also apparent. To explore these intra-demographic aspects more granularly, this Commission demarcates between “internal” IMGs (IIMGs) and “external” IMGs (EIMGs). For the purposes of this report, IIMGs are those who temporarily leave their home country to study medicine abroad and return there to practise, owing to personal reasons or due to external issues like visa restrictions. Conversely, EIMGs will be used to denote those individuals who either graduate from a medical school overseas and

remain in this country of study or graduate in one country and move to another. Again, detailed consideration of these specific pathways is important, as they reflect individual motivations and may engender unique professional challenges and stressors (Pemberton et al., 2022).

Taken together, IIMGs and EIMGs can encounter sociocultural and professional challenges that contribute to psychosocial risk factors and negative health-related and work-related outcomes (Kalra et al., 2012). Applicable scenarios may include struggles with acculturation and integration, unfamiliarity with healthcare systems and cultures, limited career progression, and working within undesirable specialities or geographical locations; frequently, the latter are recurrently mandated by wider institutional or political policy priorities rather than through personal choice (e.g., Spike, 2006; Chen et al., 2011). Intersectional issues, including around gender, race, religion, and nationality can compound scenarios of disadvantage for IMGs (Lagunes-Cordoba et al., 2021). Separately, visa restrictions and inadequate integration schemes for arriving EIMGs and IIMGs often create difficulties related to language barriers, precarious working conditions, and disparities in medical training and healthcare norms (e.g., (Sciolla and Lu, 2016; Mannes et al., 2023)).

2. Global trends in IMG migration

Internationally, EIMGs and IIMGs make substantial contributions to healthcare systems and health delivery, especially in HICs and the Global North. Notably, the presence of IMG groups with mixed backgrounds, characteristics, and social identities can advance more culturally sensitive services and may be crucial in providing effective care for increasingly heterogeneous patient communities. This has been underlined in the psychiatric discipline (Levin, 2021), where it has been argued that IMGs strengthen the field by addressing unmet treatment needs, promoting care equity, and broadening cultural diversity.

Nonetheless, the emigration of IMGs can simultaneously result in a shortage of skilled healthcare professionals in the country of training, amplifying health inequities and expertise shortages, especially across low- and middle-income countries (LMICs) (Kollar and Buyx, 2013). This phenomena has been colloquially described as a medical “brain drain” (i.e., the migration of skilled IMGs abroad) (Majeed et al., 2017) or the “Great Brain Robbery” (Patel, 2003).

Within international frameworks, dichotomies have been noted between “importing” and “exporting” countries, of which HICs tend to fall into the former (Balon, 2016). In HICs, there can be a reliance on EIMGs in healthcare services, particularly in rural and socioeconomically disadvantaged areas or unpopular specialty domains where physician demand tends to be the greatest (e.g., Ahmed et al., 2018; Rao, 2018). For so-called “exporting” countries, IMG emigration may intensify healthcare gaps owing to the outflow of trained medical personnel. Alternatively, other “exporting” nations encourage doctor mobility systematically as part of larger geopolitical strategies. This is exemplified by initiatives like the so-called “doctors for oil” programme (Fein-silver, 2010), where Cuba has recurrently sent medical personnel overseas for economic and diplomatic gain.

2.1. North America, Europe, and Australia

Historically, there have been prominent trends in the migration of EIMGs and IIMGs to HICs and the Global North. Whilst geopolitical paradigms and the COVID-19 pandemic may have temporarily disrupted these movements in certain parts of the world (British Medical Journal, 2017; Elshazly et al., 2020), IMGs still represent a sizeable proportion of the overall physician workforce in HICs.

In the US, IMGs are estimated to make up 23% of total medical doctors (Nagarajan et al., 2020). Studies illustrate that IMGs from Canada, Egypt, India, Pakistan, Mexico, Iran, and Caribbean nations predominantly contribute to these figures (Ranasinghe, 2015). The proportion of IMGs in the physician workforce varies across

geographical areas and medical disciplines in the US. At a specialty level, IMGs account for 50% of physicians in geriatric medicine and 40% of critical care and internal medicine doctors (Frieden, 2022). Correspondingly, in 2022, researchers identified how 29% of psychiatrists across the US were IMGs (Duvivier et al., 2022). In Florida and New Jersey, IMGs constituted > 40% of the total number of psychiatrists in these states (Duvivier et al., 2022).

Moreover, in educational contexts, it has been established that 25% of individuals in US residency programmes were IMGs (Pinsky, 2017) and per data from 2022, there were approximately twelve thousand international applications annually for trainee positions (Hamnvik, 2022). Given these figures, the crucial role of EIMGs within US healthcare delivery has frequently been accentuated (e.g. Pinsky, 2017). As a prominent metric, researchers have found equal or even lower mortality rates amongst patients treated by IMGs in the US (e.g., Norcini et al., 2010; Tsugawa et al., 2017).

Similar trends to this are evident across different HICs, which often have a large proportion of EIMGs in the physician workforce and attract international students to trainee schemes. For instance, data from the General Medical Council in the UK indicates that ten thousand EIMGs joined the UK's medical register in 2021, accounting for 50% of new doctors in the country that year (General Medical Council, 2022). Significantly, these figures have grown disproportionately in comparison to local graduates (O'Dowd, 2019), despite possible constraints on migratory inflows owing to Brexit and the COVID-19 pandemic, with IMGs coming to the UK from South Asia, Africa, and the Middle East (General Medical Council, 2022).

Alongside economic benefits, personal ties to the UK and opportunities to train within the National Health Service (NHS) have been identified as "pull" factors. This is apparent for EIMGs migrating from the Indian subcontinent and countries across the wider British Commonwealth (George et al., 2007). Physician migration to the UK from these regions was actively promoted throughout the 20th Century, primarily following World War Two (Jalal et al., 2019).

Equally, EIMGs and IIMGs have a high representation in postgraduate medical education in the UK. Current data suggests that > 40% of general practitioner trainees and 44% of psychiatry trainees are IMGs (Royal College of General Practitioners, 2023; Lagunes-Cordoba et al., 2021). As a discipline, there are many IMGs working in psychiatry in the UK and there are arguments that these positions may be easier for IMGs to attain due to extant recruitment shortages (Lagunes-Cordoba et al., 2021). Nevertheless, researchers have also noted burgeoning patterns of psychiatrists emigrating from the UK to other countries and regions (Kulkarni et al., 2023).

Separately, in other English-speaking nations like Australia, IMGs were estimated to make up 31% of the physician population in 2018, commonly working in rural settings and undersupplied medical specialties (Yeomans et al., 2022), including psychiatry (Hawthorne, 2013). Though doctors from the UK and Ireland historically constituted major nationality groups for IMGs in Australia, there have been notable contemporary patterns of EIMGs migrating from Southern Asia and elsewhere (Yeomans, 2022). In Canada, IMGs account for ~25% of the physician workforce and akin to Australia and other HICs, this is again disproportionately higher in more geographically distant areas and less popular specialties (Wang et al., 2023); again, the latter includes the psychiatric discipline (Kirmayer et al., 2018).

In European HICs like Switzerland, 40% of medical workforce are IMGs based on reports from 2022 (SwissInfo, 2022), and in 2019, 75% of new doctors in Switzerland came from overseas (SwissInfo, 2020). Likewise, in Germany, EIMGs constitute a large proportion of the workforce (Bundesaerztekammer, 2023), especially those from countries within the European Union (EU), such as Czechia, Poland, and Slovakia. Nonetheless, Germany has also seen multifaceted historical trends in IMG migratory movements, with refugee physicians leaving Nazi Germany in the 1930s and 1940s (Stollar, 2014). More recently, prior to German Reunification, West Germany received IMGs from the

former state of East Germany during the communist era due to distinct "push" and "pull" factors (Bruns et al., 2023).

Currently, being a prosperous member of the EU affords Germany advantages as an "importing" country for EIMGs, with freedom of movement for physicians in Europe facilitated by the Schengen Agreement and the recognition of professional qualifications under supranational directives (Costigliola, 2011; Ling, 2014). However, this can simultaneously entail bidirectional migration trends. Hence, EIMGs may move to Germany from other EU nations, primarily seeking better working conditions, and individuals who graduated in Germany may move to Switzerland or Scandinavian regions for comparable reasons (Saadoun et al., 2022). Based on academic evidence, IMGs also leave Germany for other HICs, such as Australia and New Zealand, because of low job satisfaction (Pantenburg et al., 2018). These patterns are distinguishable in European HICs like Spain, where media reports have highlighted how Spanish medical graduates are relocating to the UK, France, and North America (e.g., Faulkner, 2022).

Together with ageing doctor populations, emigration from parts of Europe can result in unmet healthcare needs, concurrently leading to calls to attract additional IMGs. Other European countries continue to experience IMG outward migration to more affluent areas within the EU underpinned by personal, socioeconomic, and work-related motivations, engendering a "knock on effect" in labour movements (Velgan et al., 2023). This can have major economic and healthcare implications and has resulted in suggestions that certain countries in the EU are "training doctors for their richer neighbours" (Hervey, 2017).

Amidst this context, there have been initiatives aimed at allowing greater numbers of EIMGs from outside of the EU to work as medical professionals (e.g., Faulkner, 2022). Yet, these can be undermined by inadequate accreditation equivalence protocols and may lead to "brain waste", with non-EU physicians unable to obtain medical employment. In Spain, per press reports, this has restricted the career opportunities of many Central and South American EIMGs (e.g., Martin and Peinado, 2020). Conversely, there have been discussions around limiting the movement of locally trained doctors from EU countries and beyond. This is influenced by perceived obligations that these professionals should contribute to the healthcare sectors in their country of training, reflecting a notion of "educational debt" tied to taxpayer-funded medical education and workforce gaps.

Since the EU's expansion, East-West physician migration has become a salient phenomenon (Kopetsch, 2009), continuing trends that were evident during the communist era in Eastern Europe (Semánová et al., 2019). For example, in a survey of $n = 4784$ Hungarian doctors in 2018, 16.6% planned to work abroad in the next one to two years, which had wider correlations with burnout (Gyórfy et al., 2018). Concurrently, media sources indicate that longstanding stagnation in physician salaries in Hungary has accelerated outward migration patterns, leading to the implementation of recent policy shifts and salary increases (Hungary Today, 2020).

Elsewhere, there are presently around four thousand eight hundred physicians who graduated in Romania working in France, approximately four thousand in Germany, and around nineteen hundred in Hungary, where they make up around 70% of the Hungarian physician workforce (Szoó, 2020). In turn, in its physician workforce, Romania attracts EIMGs from nations like Moldova and Arabic countries (Szoó, 2020), but doctor shortages may still endure (Apostu et al., 2022).

There has been a growing tendency for students moving abroad from European HICs to undertake medical training in Eastern Europe due to lower course fees and competition for places (e.g., The Economist, 2022). According to published figures, these individuals often return to their home country as IIMGs. For example, two-thousand nine hundred British nationals who qualified in Central or Eastern Europe are currently on the medical register in the UK (The Economist, 2022) and literature shows that French-born IIMGs who qualified in Romania are increasingly looking to continue postgraduate training in France (Delamaire and Lafortune, 2019).

2.2. Africa

Whilst precise data remains inconsistent and difficult to quantify, Africa has been a longstanding contributor to the global pool of IMGs, especially from sub-Saharan regions, which has worsened disease burdens and ongoing infrastructural challenges in certain countries (Clemens and Pettersson, 2008). This “brain drain” is driven by numerous factors, including insufficient medical training facilities in some nations and the desire for advanced career opportunities and different clinical specialties amongst IMGs (Akinfenwa, 2021; Hagopian et al., 2004).

Between 2005 and 2015, researchers noted a 27.1% rise in African IMGs in the US physician workforce, representing 5.9% of total IMGs (Duvivier et al., 2017). The main countries accounting for these IMG figures in the US were Egypt, Nigeria, South Africa, and Ghana, with three medical schools in Egypt, two in Nigeria, and one in South Africa making up a principal proportion of total IMGs in the US in 2015 (Duvivier et al., 2017). Moreover, in this analysis, five hundred and thirty-seven US citizens attended medical school in an African country and returned to the US to practise as IIMGs (Duvivier et al., 2017). More up-to-date statistics highlight how EIMGs from Nigeria frequently emigrate to the US, with estimates of up to eight thousand Nigerian physicians working in the medical sector (Akinfenwa, 2021).

Analogous trends are apparent for Nigerian EIMGs relocating to Canada and the UK. According to media publications, Nigeria loses around twelve doctors per week to the UK (Mwiti, 2018). Through interviews involving $n = 913$ Nigerian physicians, researchers ascertained that 43.9% wished to emigrate, with “push” factors including insufficient remuneration, limited diagnostic facilities, and job insecurity (Onah et al., 2022). Akin to countries in the EU, this has led to proposals for Nigerian-born medical graduates to have a mandated five-year stay in Nigeria following the commencement of their education (Orji, 2023).

Comparable patterns have been noted across other African countries. For example, in a study of $N = 372$ students at medical school in Ghana (Lassey et al., 2013), $n = 113$ emigrated to practise in a different part of the world. Nations such as Morocco, Tunisia, Rwanda, Senegal have introduced countermeasures owing to the attrition of IMGs relocating elsewhere (Wenger, 2022). In educational frameworks, many students born in countries in Africa travel abroad to start or complete medical qualifications, with individuals leaving for HICs like France (Delamaire and Lafortune, 2019), and the US (Hagopian et al., 2004). Work based on Angola, Guinea-Bissau, and Mozambique found that broader opportunities for specialisation and advanced training were associated with individual motivations to pursue medical opportunities abroad (Ferreiro et al., 2011).

By contrast, as an upper-middle income country, South Africa sees more bidirectional migratory movements. Historically, there have been many South African EIMGs who emigrated, notably to Australia during the Apartheid era (Yeomans, 2022). Recently, large numbers of South African IMGs have been practising in the US (Duvivier et al., 2017), the UK (Oberoi and Lin, 2006), and Canada (Mullan, 2005), where the Royal College of Physicians and Surgeons of Canada allow for less onerous certification for South African IMGs (Campbell-Page et al., 2013).

At the same time, South Africa receives an inflow of IMGs within its workforce from Africa and beyond, which accounts for 1.5% of its practising physicians (Motala and Van Wyk, 2019). In an investigation of IMG surgeons in South Africa (Kong et al., 2015), it was found that manageable caseloads, together with attractive medical training, render this country a desirable location for IMGs. Moreover, South Africa has agreements with various nations around IMGs, including Tunisia, Iran and Cuba. Interestingly, the South Africa-Cuba relationship is reciprocal, allowing South African citizens to train and return as IIMGs (Motala and Van Wyk, 2004).

2.3. Asia

The migratory patterns and circumstances of IMGs from and across Asia is equally composite. With some of the largest and fastest-growing economies in the world, Asia has been a major supplier of IMGs to HICs for several years. In countries like India, Pakistan, and the Philippines, this has been conditioned by numerous determinants, including demands for medical professionals in recipient countries, the desire for higher wages, the pursuit of favourable living conditions, and advanced training and specialisation (e.g., Robredo et al., 2022; Xierali, 2013; Astor et al., 2005). For instance, there may be profound international wage discrepancies across medical specialities, demonstrated by the finding that EIMG anaesthetists in the Global North can earn > 600% more than those in India (although proportional differences in the cost of living should be acknowledged) (George and Rhodes, 2017).

Further, burgeoning numbers of medical graduates in Asia are unable to obtain suitable employment or postgraduate training opportunities in their home countries (e.g., Rampal and Sharma, 2022). This is often the case in Pakistan, where the number of medical graduates can exceed available positions, leading to rigorous competition and restricted opportunities for professional advancement (Sheikh et al., 2012). Various results encapsulate the migratory intentions of Pakistani IMGs, with researchers previously showing that 95% and 65% of final year students from two medical schools wished to move overseas for postgraduate training (Syed et al., 2008).

Additionally, in 2015, Indians represented the largest nationality group of IMGs in the US, making up 22.1% of total IMG numbers (Duvivier et al., 2017). For IMG psychiatrists in the US, > 30% graduated in India and Pakistan (Duvivier et al., 2022). Indian and Pakistani IMGs are heavily represented in physician workforces in other HICs, including the UK and Australia (General Medical Council, 2022; Spike, 2006).

Substantial numbers of EIMGs from China are working in the US physician population, with increases in migratory figures noted between 2008–2017 (Duvivier et al., 2019). Correspondingly, as one of the biggest contributors to the IMG population, many Philippine physicians have historically practised in the US (Astor et al., 2005). Scholarly work underlines how Filipino IMGs also migrate to different regions, including Australia (Hawthorne, 2013), and countries across Asia, like Taiwan (Chu et al., 2019). This is in part down to socioeconomic factors and a culture of migration within the Philippines, which has shaped migratory decisions for different healthcare workers (e.g., Philippine nurses working overseas (Robredo et al., 2022).

Recently, there has been an emerging trend of students from countries in Asia studying abroad and then returning to their home countries as IIMGs. This may be motivated by a desire to acquire skills and expertise that can be applied in their country of origin, alongside stringent visa constraints in HICs. In some cases, return migration is motivated by personal factors, such as the desire to be closer to family and cultural ties (e.g., Heist and Torok, 2018).

Separately, nations like Indonesia have encouraged IMGs to return to practise, with the government proposing measures to shorten licensure proceedings and facilitate the reintegration of IIMGs into the healthcare sector (Soeriaatmadja, 2022). For international medical students graduating in China, citizenship of a country in Asia has been found to have correlations with an intention to return to practice in their home countries as IIMGs (Li and Sun, 2019). Notably, China has been an attractive destination for students from Africa and other parts of Asia, primarily due to the lower cost of quality education and English-taught courses (Jiang et al., 2022), although migration restrictions during the COVID-19 pandemic impacted this. Similarly, there have been Taiwanese citizens who matriculated in countries in the EU (e.g., Poland) and sought a return to Taiwan to practise medicine (Ho et al., 2015).

India continues to see complex trends in this regard, where IIMGs may move back after obtaining their medical education or training abroad (Anjali et al., 2016). This return migration is driven by several

factors, including India's economic growth and improving healthcare infrastructure, amongst others. To streamline this process, the Indian government has introduced measures such as a standardised licensing assessment, known as the Foreign Medical Graduate Examination (FGME), for Indians who graduated in specific countries, which is set to be reconceptualised under proposals for the National Exit Test (Ranjan et al., 2020).

Nevertheless, challenges remain for returning IIMGs and a large proportion of these individuals are unable to pass the FGME owing to different curricula or inconsistencies in the quality of medical education. This renders many prospective IIMGs unable to pursue a medical career in India until they obtain a successful result (Anjali et al., 2016). For example, in 2022, 80% of IIMGs failed the FGME (Sharma and Ghosh, 2022) and this rate can be higher for Indian IMGs studying in specific regions like China, as illustrated by Indian media reporting (e.g., (The Hindu., 2022)).

3. IMG characteristics and determinants

For regulatory and accreditation purposes, IMGs are physicians who graduated outside of the country where they wish to practise medicine (Dagher et al., 2020). It should also be clarified that in academic literature, IMGs can be interchangeable with other terms, such as overseas trained graduates or foreign medical graduates (Motala and Van Wyk, 2019). Per the American Academy of Family Physicians (2023), an IMG is defined as an individual who graduated "from a medical school located outside the United States and Canada" and "the location/accreditation of the medical school, not the citizenship [...] determines whether the graduate is an IMG". Though commonly adopted, these generalised classifications do not adequately convey the diverse circumstances of EIMGs and IIMGs, which instead requires a nuanced overview. Instead, the distinctive characteristics and circumstances of IMGs can profoundly influence their contributions across global healthcare and provoke individualised challenges (Rao et al., 2016).

However, holistically describing EIMGs and IIMGs can be complicated due to individual social identities and larger patterns in globalisation, as shown in the multifaceted global migration trends described above. Notably, EIMGs and IIMGs can encompass people across nationalities with variations in religion, culture, sexuality, and gender (e.g., Chen et al., 2011; Hawthorne, 2013). Contingent on both their host and home country, each of these micro-identities can lead to varying intersectional experiences and factors that might impinge upon an IMG's career prospects and wellbeing (Lagunes-Cordoba et al., 2021).

Likewise, IMGs may possess mixed skills and educational backgrounds, particularly since medical training systems recurrently diverge between regions (e.g., in psychiatry (Bhugra et al., 2023)). An obvious case of this is the language of instruction, which can require supplementary courses for IMGs dependent on the country where they wish to work (Hoekje, 2007). Generally speaking, curricula and pedagogy are non-standardised at an international level. In this regard, medical education in the US often prioritises evidence-based approaches and technology over more traditional practices that are common elsewhere (McMahon, 2004). Conversely, for IMGs trained in countries in Asia, educational philosophies and cultural norms can inform contexts and methods of learning (e.g., there may be a greater emphasis on memorisation in certain countries in Asia (Tavakol and Dennick, 2010)).

Dissimilarities in course duration, level of teaching, and means of assessment can also be pronounced owing to a lack of harmonised protocols (Weggemans et al., 2017). For example, the extent to which psychiatry is taught for undergraduates can vary globally (Ng et al., 2020). Correspondingly, certain American medical schools have affiliated schemes abroad, of which graduates would still be classified as IMGs according to US regulations (Rao et al., 2016). In sum, these inconsistencies can render it difficult to compare and evaluate IMG qualifications against domestic standards, a complexity which is heightened by non-uniform accreditation structures around the world

(Frenk et al., 2010).

Dependent on high-level or individualised factors, EIMGs and IIMGs have distinct motivations that underpin their migration, involving heterogeneous "push" and "pull" factors. On the one hand, IMGs might graduate from LMICs and wish to practise or continue advanced training in HICs for career opportunities, diverse subspecialisation, and rigorous competition to enter the workforce or educational programmes in their home country (Rao et al., 2013). IMGs may also be seeking lower unemployment rates, higher wages, or access to advanced technologies (Botezat and Ramos, 2020). Migratory traditions from their country of origin or cultural connections to different regions (including former colonial or diasporic ties) can influence migratory patterns (e.g., Trewby, 2008). Additionally, IMGs may be displaced, seeking asylum, or fleeing persecution and political upheaval and subsequently wish to continue with postgraduate education or medical employment (e.g., (Kureshi et al., 2019; Ha et al., 2019)).

On the other hand, EIMGs and IIMGs might leave HICs for different parts of the world for socioeconomic reasons, like aspirations of a more favourable work-life balance, amenable working conditions, and higher salaries (e.g., Clarke et al., 2017; Gregory, 2023). In this regard, a recent inquiry into psychiatrists who left the UK highlighted the importance of employment conditions and personal "happiness" in these decisions (Kulkarni et al., 2023). Equally, like in LMICs, individuals from HICs may pursue initial medical training abroad because of competition in their home country and seek to return for residency as IIMGs (e.g., US medical students in Caribbean countries (Moon, 2020)). For other IMGs, migratory determinants can include sociocultural traditions of emigration from their home country and personal or familial ties (Suciú et al., 2017; Clarke et al., 2017).

Despite this, it may be that some IMGs relocate to another country or return to their home nation and are unable to pursue further education or a medical career owing to personal, institutional, legal, or geopolitical obstacles (e.g., Wang et al., 2023). As has been described, this so-called "brain waste" can necessitate that EIMGs and IIMGs must take jobs outside of medicine (e.g., (Lofters et al., 2014)). Finally, some graduates from HICs may choose to work elsewhere in LMICs and the Global South for altruistic purposes and the challenges they face may be similar but also different.

4. Challenges for IMGs

IMGs represent a unique subset of doctors who have navigated a variety of situations; therefore certain IMGs may possess higher levels of resilience. However, dependent on their professional and personal circumstances, social identities, and migratory backgrounds, the career prospects and clinical contributions of EIMGs and IIMGs can be hindered. Corresponding socioenvironmental and psychosocial issues experienced by IMGs can adversely affect their wellbeing, potentially precipitating mental health issues or heightening extant symptoms (Hall et al., 2004).

Although epidemiological data on psychiatric disorders amongst IMGs remains underreported, a qualitative investigation showed how cultural and linguistic challenges contributed to the development of an adjustment disorder for a Japanese IMG in the US (Heist and Torok, 2020). Within this same sample, symptoms of depression were also identified (Heist and Torok, 2020). Analogously, in a survey examining the effects of acculturation and social support on mental health, 7.4% of $n = 108$ IMG respondents in the US reached the threshold for severe mental illness (Atri et al., 2011). In a cohort of $n = 326$ international medical students in Hungary, 49.7% reported having poor mental health (Umami et al., 2022).

Below, we explore several specific issues encountered by IMGs and EIMGs internationally.

4.1. Acculturation and sociocultural challenges

Like all migrants, IMGs will experience three stages of migration – premigration, physical and actual migration, and a period of post-migration adjustment; each phase can invoke certain challenges. For example, stressors related to migration and leaving an established social network can be apparent for IMGs (e.g., Al-Haddad et al., 2022), together with socioeconomic difficulties when they arrive in their host country (Murillo Zepeda et al., 2022). Further, evidence suggests that IMGs may face distinctive post-migration difficulties, including precarious working conditions, intersectional vulnerabilities, and pressures associated with cultural capital (Kalra et al., 2012; Gradiski et al., 2022).

Problems stemming from integration and acculturation can be especially detrimental for IMGs. As a key facet of human identity integral to the acculturation process, the notion of cultural capital was initially conceptualised by Bourdieu (Bourdieu, 1984), who distinguished it from social and economic capital. Bourdieu's theory encompasses three primary components of cultural capital, namely: objective, represented by tangible artefacts such as books, music, arts, and folk tales; embodied, encompassing language, preferences, and mannerisms; and institutionalised, which includes qualifications, educational credentials, and training. Over time, this has evolved to incorporate additional dimensions, such as technical capital (marketable skills), emotional capital (empathy), national capital (national stereotypes, sometimes manifesting as stigmatising caricatures), and subcultural capital (Thornton, 1995; Bennett et al., 2008; Holden, 2010). Cultural capital is distinctive from natural, human, and physical capital (Throsby, 1999), and also from social, economic, and political capital, though intersections may exist.

From a migratory perspective, IMGs will bring individualised components of cultural capital with them. Here, interactions with the new and hegemonic culture raises specific challenges. Certain elements of an IMG's cultural capital, like language, diet, or clothing style, might be easier to adapt or modify to align with the new dominant culture. However, more deeply embedded aspects, such as religious values, rituals, and beliefs, could be more difficult to modulate. This highlights the complex dynamics surrounding an individual's cultural capital during the acculturation process and the conceivable protective roles of biculturalism and blended identities (e.g., (Gogineni et al., 2016; Falcone et al., 2014)). For example, cultural capital may give additional status and associated power, which could conflict with how healthcare professionals (i.e., IMGs) are seen in the host country. Anecdotally, it has been noted that certain IMGs can view other medical colleagues (e.g., nurses) as inferior to them and expect them to fulfil responsibilities, which may not be the case in the new country, thereby invoking interpersonal and interprofessional tensions.

Within this context, acculturation can heighten feelings of otherness and increase risks for burnout and mental illness (Gradiski et al., 2022), paradigms that can be particularly pronounced for IMGs from Asia adapting to Western cultural conventions (e.g., Sharif, 2003). Specifically, for some IMGs, migration may entail learning a new language, which can intensify loneliness and social isolation (e.g., (Kirmayer et al., 2018)). Typically, cultural capital facilitates communication (through language and mannerisms) both within cultures and across cultures, which can create obstacles for IMGs. In professional and educational contexts, language may be one of the first things to be assessed post-migration along with mannerisms and behaviours.

Adjusting to a new social environment can present inherent pressures. IMGs may struggle with the consequences of assimilation and deculturation, alongside the effects of culture shocks, stigma, and prejudices. All of this might impinge upon their mental wellbeing, possibly eliciting symptoms of depression, anxiety, and stress (e.g. Falcone et al., 2014; Jalal et al., 2019). For instance, refugee EIMGs from North Korea believed that they were being discriminated against when they migrated to South Korea (Ha et al., 2019). Work on IMGs in the UK indicates that they can be as susceptible to bullying as local trainees but are less likely

to report these experiences (Jalal et al., 2019). Similarly, IMGs in the USA highlighted incidents of racism and discrimination through conscious and unconscious actions (Baldwin et al., 1994), and researchers have previously indicated that there can be embedded prejudices against IMGs in the US residency selection process (Desbiens and Vidaillet, 2010).

Acculturation not only involves adapting to new societal norms, but simultaneously adjusting to a different healthcare system, which can encompass distinctive regulations and cultural norms (Michalski et al., 2017). Here, the institutionalised segment of cultural capital is apposite, as training varies across geographic settings and institutions, which can also be seen as an economic part of cultural capital, thereby creating further complexities for IMGs.

Moreover, the emotional and empathic components of cultural capital can play a major role in adjusting to different healthcare settings, which in turn will influence an IMG's understanding of the weaknesses and strengths of their culture and the dominant culture (Bhugra et al., 2021). Nonetheless, especially early in the post-migration process, acculturative complexities can lead to clinical barriers for EIMGs within patient-doctor interactions and the therapeutic relationship. As has been noted, even small differences in colloquial language and accents can affect care quality (Pemberton et al., 2022). Such scenarios may arise in psychiatric assessments or psychotherapeutic contexts, where effective and empathic communication is central to advancing patient outcomes (Ross and Watling, 2017).

In this regard, a study involving psychiatry residents from Latin America in the US showed that they faced linguistic barriers in accurately diagnosing mental disorders (Hausmann-Stabile et al., 2011). Likewise, contingent on the region of practice, discrepancies between the ICD-11 and the DSM-5 could pose challenges for EIMGs or IIMGs trained in or used to working with one system. Although these latest iterations are closer than previous versions (e.g., First et al., 2021), inter-manual divergences still exist for the classification of certain conditions (e.g., O'Brien, 2022). Conceivably, this may lead to problems treating patients when practising in a country that follows alternative diagnostic standards.

The intricacies of nationally specific healthcare conventions can also be complicated for IMGs (Murillo Zepeda et al., 2022). In an investigation in Australia, IMGs illustrated how the perceived patient expectations of the Australian health system, which has more educated and informed consumers, elicited complexities concerning patient-centred communication (McGrath et al., 2012). Based on academic findings from Canada, some IMGs found it hard to engage within collaborative and non-hierarchical structures (Triscott et al., 2016). Analogous results were observed during a mixed-methods study of IMGs in New Zealand (Mannes et al., 2023).

Furthermore, concerns around patient autonomy, end-of-life care decisions, confidentiality, consent and disclosure of medical errors can be viewed and handled differently across regions (e.g. Jalal et al., 2019; Gopalkrishnan, 2018; Nishimura et al.). This is also relevant for theoretical notions like the concept of distress (Kirmayer et al., 2018) and classified conditions like anxiety and depression, which can be contingent on cultural contexts and thus be considered differently in medical training (Triscott et al., 2016). Based on a personal perspective, an IMG discussed cross-cultural differences in healthcare between the US and India following a patient's death by suicide and the personal psychological pressures this provoked, including feelings of anxiety and guilt (Rao, 2016).

Albeit entailing economic and healthcare benefits, the return to practise in their home countries can present unique sociocultural issues for IMGs. These individuals could struggle to readjust to the cultural and medical norms of their country of origin, essentially undergoing a reverse acculturation process. This was evidenced in an inquiry involving Peruvian IIMGs who trained in the US (Gaviria and Wintrob, 1975). In this sample, participants perceived disorganisation and inefficiency in Peruvian hospital environments compared to their

experiences in the US. Though this may have offered professionals advantages in allowing them to recognise deficiencies within the Peruvian medical system, they also attested that colleagues treated them with caution, envy, and anger (Gaviria and Wintrob, 1975). Findings from Taiwan indicate that IIMGs who studied in Poland and sought to become a physician in Taiwan were subjected to hostile rhetoric about their competencies (Ho et al., 2015).

4.2. Professional challenges

Following their migration, most EIMGs have little control over their geographical location of practice, which might result in high stress levels, burnout, social isolation, job dissatisfaction, and reduced self-esteem (e.g., Kalra et al., 2012).

As described above, IMGs can often be positioned in socioeconomically disadvantaged areas or remote communities that are unpopular amongst locally trained doctors, largely due to wider policy priorities rather than through personal interest or choice (Motala and Van Wyk, 2019). These environments may be high-stress in their nature, involving rigorous working conditions and complex patient interactions (e.g., Nowakowski, 2018). Importantly, the British Medical Association (British Medical Association., 2017) has linked a lack of autonomy about geographical areas of practice with susceptibility for anxiety, depression, and other psychiatric disorders. In an Australian context, IMGs in rural and underprivileged areas have been reported as experiencing professional isolation due to elevated workloads and limited opportunities for training (Han and Humphreys, 2005). Significantly, isolation has been identified as a risk factor for burnout (Gradiński et al., 2022), a condition for which certain evidence suggests that IMGs may have distinct vulnerabilities (Aalto et al., 2014).

Elsewhere, it should be noted the perspectives of physicians compelled to migrate under certain circumstances, such as those from Cuba, might not be adequately captured in the current literature. That said, Human Rights Watch (Human Rights Watch., 2020) has illustrated repressive regulations from the Cuban government towards these individuals.

Additionally, many IMGs are restricted in their choice of specialty, which can be conditioned by pre-existing workforce gaps in the host country. Hence, in Finland, it has been found that EIMGs were more likely to work in primary care because of labour shortages in this area (Kuusio et al., 2014). In the US, similar patterns have been recorded and IMGs have tended to work in internal medicine, paediatrics, and psychiatry, amongst other specialties (Rao, 2012). Alongside geographical setting, practising within unpopular medical disciplines can result in lower self-esteem and reduced motivation amongst IMGs. This has been previously associated with detrimental work environments and psychosocial stressors (e.g., Kalra et al., 2012; Kuusio et al., 2014).

Separately, a lack of choice about areas of practice at both a geographical level and a specialty level can induce barriers for professional development and feelings of career uncertainty (Rao, 2018; Kuusio et al., 2014). Factors like conscious or unconscious bias, communication difficulties, and limited opportunities for research and training can also contribute to inequities in career pathways (Kalra et al., 2012; Essex et al., 2022; Zaidi et al., 2020). For example, in the UK, many EIMGs reportedly hit a “glass ceiling”, serving their medical careers as specialty or associate physicians and unable to attain leadership positions (Pemberton et al., 2022). Again in the UK, researchers explored structural issues with award systems within the healthcare sector, arguing that IMGs might face pronounced disadvantages in receiving formal recognition (Essex et al., 2022).

Visa and work permit restrictions can mean that IMGs may face precarious working conditions (Raghuram, 2014), intensifying socio-environmental risk factors. Alarming, some IMGs have reportedly been scared to take sick leave (British Medical Journal., 2022) or felt higher pressures to perform compared to locally-trained peers (Fiscella et al., 1997). This can lead to a lack of autonomy about working hours

and responsibilities, thereby contributing to burnout and stress (Han and Humphreys, 2005). At the time of writing, it remains to be seen how rising trends in anti-migration policies and authoritarianism in both HICs and LMICs in parts of the world may further affect visa restrictions for IMGs.

Discrepancies in training and experience between the home and host countries may undermine the career prospects of IMGs. In various countries, EIMGs have been unable to work as doctors due to rigorous licensing regulations, resulting in them adopting alternative career pathways (e.g., Turin et al., 2021; Martin and Peinado, 2020). Analogously, a perceived lack of opportunities for professional advancement or leadership positions can create feelings of marginalisation, frustration, and lower career satisfaction, which could be associated with burnout (Dyrbye et al., 2013), and potentially provoke additional psychosocial concerns.

Overseas training may not be valued or recognised in the same way as local qualifications for IIMGs returning to their home country to practise, limiting prospects for career progression and possibly resulting in “brain waste”. This has been observed in Canada, where Canadian-born IIMGs who wish to become licensed doctors in their home country can encounter rigorous licensing barriers (Grossman, 2022) and possibly face stigmatisation (Jung, 2022). Likewise, this became a contentious issue in India during the COVID-19 pandemic, when ninety-thousand foreign-trained IIMGs were left unable to practise despite intense healthcare pressures (Economic Times., 2021). Concomitantly, when IMGs cannot obtain medical vocations or for socioeconomic reasons need to work in a different occupation, this may result in feelings of shame (Lofters et al., 2014).

For IMGs continuing with advanced medical training in a foreign country, learning and teaching styles can vary between different regions, which can elicit adaptive issues (Khan et al., 2015). Concerningly, previous findings showed elevated attrition trends amongst IMGs and poorer performance during residency in the US (van Zanten et al., 2002; Yao and Wright, 2000).

As we have discussed, there can be disparities between curricula and pedagogy in different parts of the world. Notably, the emphasis on self-directed learning and problem-solving skills, common in Western medical education, might diverge from didactic methods favoured across parts of Asia (Shimizu et al., 2019; Nakazawa et al., 2019). Moreover, a lack of familiarity with health information technology in medical programmes could lead to adverse scenarios for IMGs when they migrate to HICs (Mazurenko et al., 2012).

Assessment methods in HICs, like continuous assessment and objective structured clinical examinations, may be challenging for IMGs in residency who are used to traditional written, oral, or bedside methods (Hausmann-Stabile et al., 2011; Murillo Zepeda et al., 2022). In addition, mechanisms for delivering feedback can differ cross-culturally and result in misunderstandings (Broquet and Punwani, 2012).

4.3. Social identities and intersectional challenges

Intersectional vulnerabilities associated with the distinct characteristics and social identities of IMGs, like gender, nationality, race, religion, and sexual orientation, may exacerbate ongoing challenges and lead to discrimination, prejudice, and bias (either overt or unconscious) (e.g., Louis et al., 2010).

Past literature shows that these experiences can result in an unfriendly or hostile work environment (e.g., Neiterman et al., 2015; Yeung, 2022). For example, researchers underlined how IMGs in the US can be exposed to microaggressions within professional contexts (Zaidi et al., 2020). Experiences of racial and religious discrimination were highlighted in a sample of $n = 62$ Muslim IMGs working in the US (Laird et al., 2013). Recent work has illustrated the persistence of discriminatory factors, “medical inferiority” biases, and cultural racism faced by IMGs in academic medicine in the US (Smith and Parkash, 2023). Furthermore, in a personal case study, an IMG revealed how they had

been subject to prejudice based on their nationality, with a patient asking: "Don't you have any American doctors?" (Chakrabary, 2012).

Elsewhere, in Canada, an LGBTQ+ IMG applying for a residency scheme detailed how erroneous assumptions were made based on their sexuality (Suarez, 2020). Female IMGs can face similar scenarios of disadvantage, especially in male-dominated specialties. Previously, IMGs who are women have experienced sexual harassment and pay inequalities and additional gender-based stressors have been emphasised, like role conflicts and gender-based biases (Aggarwal and Anzia, 2016).

Male IMGs may also struggle with gender-based challenges due to cross-cultural differences to the detriment of patient care, such as those working in specialty areas like women's health or those who come from specific religious backgrounds (Sciolla and Lu, 2016). Equally, IMGs who are not regularly exposed to treating different genders and sexualities in their country of origin may experience professional challenges when dealing with certain gender identities and patient populations (Triscott et al., 2016).

5. Personal, institutional, legal and political considerations

To mitigate the varying issues faced by IMGs, comprehensive interventions and procedures at an individual, institutional, legal, and political level should be considered. These could help to advance the mental health and wellbeing of EIMGs and IIMGs, whilst strengthening their contributions to global healthcare.

To that end, we outline several proposals structured around various responsibility areas. Per the above discussion, we acknowledge that each IMG will have heterogeneous intersectional social identities, professional experiences, and migratory circumstances (Rao et al., 2016; Lagunes-Cordoba et al., 2021). This means that it is important to regularly evaluate, individualise, and adjust strategies to meet evolving needs, prioritising responsiveness and flexibility in line with the growing evidence base about IMGs.

5.1. Personal

Given the mental health-related consequences and stressors associated with acculturation, IMGs should take steps to become accustomed to the sociocultural dynamics of their host country and its healthcare system. As has been highlighted, certain aspects of societal integration into the dominant culture can be a protective factor for mental health amongst IMGs (Umami et al., 2022; Atri et al., 2011), as can the ability for IMGs to maintain a positive hybrid identity with bicultural ties to their home country (Gogineni et al., 2016; Falcone et al., 2014). Additionally, IMGs who can successfully overcome personal challenges may conceivably experience enhanced wellbeing (Gozu et al., 2009).

On a personal level, IMGs could consider a stepped approach to migratory decisions (though it must be acknowledged that this may not be suitable or feasible for all IMGs and will depend on individual circumstances and the visa policies of the host country). This may entail initial short-term experiences like clerkships or internships in destination countries, which could provide opportunities for familiarisation and reflection about the healthcare system and working cultures. Equally, the establishment and continuous refinement of realistic career goals must be individually emphasised; IMGs should be encouraged to recognise that returning to their home country from a different region is not a failure on their part.

Cultural competence is a salient component for supporting IMGs, enabling them to develop resilience and manage applicable sociocultural stressors. Resultantly, where necessary, participating in language courses can ameliorate feelings of isolation and advance their clinical capabilities (McGrath et al., 2013). Notably, IMGs across medical specialties have underlined the value of engaging in training around empathy, active listening, and relationship building, amongst other aspects of patient care (e.g., Pilotto et al., 2007). These would be apposite in clinical psychiatric settings, where communication skills are critical

for upholding diagnostic capabilities and treatment goals (Papageorgiou et al., 2017).

Further, understanding the cultural conventions and expectations of specific work environments can reduce feelings of alienation and increase confidence (Sciolla and Lu, 2016). Both pre- and post-migration, IMGs should seek to learn about cultural norms and seek opportunities for intercultural interactions (Michalski et al., 2017).

Active IMG participation in additional training or cultural orientation programmes can assist with their adaptation to healthcare norms in the region and speciality where they practise. This must include education on legal frameworks since issues medical errors and ethical scenarios can cross-culturally diverge. Again, this especially applicable in psychiatry, in which dilemmas around compulsory treatment or court-mandated measures can create professional challenges (e.g., Martinho et al., 2022). As international disparities exist between educational styles, a mixture of learning styles must be considered with these goals in mind, like systems-based techniques, practice-based methodologies, and transformative approaches (Sciolla and Lu, 2016; Kehoe et al., 2016).

Alongside effective integration into the host culture, IMGs should be encouraged to celebrate and maintain aspects of their own cultural identity and cultural capital, which could be advantageous for their mental wellbeing by protecting against acculturative stressors. For IMGs, building bicultural competency could enhance a sense of belonging and potentially help engender resilience (Gogineni et al., 2016). For example, this may be fostered through participation in cultural events or connections with community or diasporic groups. Furthermore, IMG peer support networks can be crucial resources, as fellow IMGs within these settings may share similar social identities and career goals (either as an EIMG or an IIMG) and have experienced comparable challenges. Balint groups or Schwartz rounds could allow for effective learning and knowledge sharing amongst IMGs (Pemberton et al., 2022).

Whilst peer support networks could be difficult to implement and maintain in rural or remote areas of practice where IMGs can often practise in HICs, online and digital solutions can provide platforms for these initiatives. Previously, researchers have reported positive results from a pilot programme of a face-to-face peer support aimed at mitigating social and professional problems for IMGs (Heal and Jacobs, 2005). Elsewhere, promising digital programmes have been adopted and learnings can be taken on how to introduce or expand comparable schemes for IMGs (e.g. Scotland Deanery., 2022; Murugesu, 2022).

Additionally, where feasible, mentorship programmes and professional networking can lead to better and professional outcomes (Nair, 2014). Such initiatives can enable IMGs to navigate unfamiliar personal and work environments, with mentors able to offer guidance and practical advice (Gallo et al., 2022). Likewise, family support can be critical for IMGs (Triscott et al., 2016). Notably, with the distinctive stressors that may arise during the migration process, family support has been found to be a facilitating factor for cultural adaptation in IMGs (Motala and Van Wyk, 2019).

Within the context of mental wellbeing and burnout prevention, IMGs must be urged to adopt stress management strategies. In this regard, peer support networks and continuous learning could again yield benefits. As shown by work in other physician populations, digital wellbeing strategies can improve boundary control and reduce burnout risks (Rich et al., 2020). The importance of forming a personal identity beyond the immediate work environment should be encouraged, again recognising the benefits of biculturalism and hybrid cultural identities as valuable protective factors (Gogineni et al., 2016; Falcone et al., 2014). This could be boosted through interpersonal relationships and leisure activities, which have been found to enhance social integration and professional engagement amongst physician groups (McManus et al., 2011).

Finally, as potential stressors can be multifaceted, adequate help-seeking tendencies could be increasingly important (Pemberton et al., 2022). Nevertheless, we acknowledge that unfamiliar cultural norms

and healthcare structures can present help-seeking barriers and therefore support networks and mentors have a key role to play in identifying pertinent issues and promoting these behaviours. This could assist IMG populations in age groups where help-seeking can be stigmatised, like junior doctors (Wijeratne et al., 2021), and those from regions where self-care can be limited due to cultural reasons; for example, in India, mental health issues amongst doctors can be overlooked and stigmatised (e.g., (Rajasekar and Krishnan, 2021)).

5.2. Institutional

Internationally, EIMGs and IIMG migratory flows frequently serve to alleviate physician shortages and it should be noted that the pragmatic and practical needs of healthcare systems must not outweigh the institutional duty of care towards these individuals. Rather, facilitating effective integration for IMGs will likely yield long-term benefits at an individual level and beyond, conceivably leading to sustained retention periods and better job satisfaction. Accordingly, institutions, healthcare organisations, and professional bodies must assist IMGs in integrating into local medical communities and implementing measures to promote their wellbeing. This should involve multifactorial collaborations and programmes, including around acculturation, tailored educational interventions, mentorship, and policy advocacy.

Structured guidance and supportive induction procedures can allow for smoother transitions into new working environments and host cultures. Relevant initiatives must aim to familiarise IMGs with the socio-cultural and professional expectations of local healthcare systems (e.g., Hodkinson, 2022). These can be coordinated through targeted programmes near the beginning of the migratory period and through rigorous follow-up. For example, the NHS in the UK (National Health Service, 2022) and the American Medical Association (American Medical Association., 2023) have formulated useful documentation for newly-arriving IMGs.

It has been argued that the early entry stages into a medical position are critical for boosting language-based skills and communication techniques (Motala and Van Wyk, 2019). Here, results from a communication course with language and clinical tutors successfully demonstrated how IMGs can develop such capabilities (Cross and Smallbridge, 2011). Correspondingly, researchers previously documented a useful programme run by a university language centre to align IMGs with the language and culture of patients and enhance their socialisation (Hoekje, 2007). For educators, the benefits of targeted feedback within communication courses for IMGs have been underscored (Dahm et al., 2015), which should again reflect the cultural diversity and distinct nuances of international medical education.

Alongside working towards language-based targets, institutions must arrange for ongoing orientation schemes and cross-cultural training (Schumann et al., 2022). Significantly, from a mental health perspective, cultural awareness programmes have been found to attenuate feelings of stress and anxiety in IMGs (Kehoe et al., 2016). In addition, educational interventions can augment clinical knowledge and offer procedural training for practising medicine in an unfamiliar health services (Rao et al., 2016). For instance, institutions have a responsibility to equip IMGs with the knowledge to understand the legal and ethical regulations in the host country (e.g., around compulsory treatment in psychiatry (Pemberton et al., 2022)). In this respect, partnerships with medical boards and other professional bodies would ensure educational protocols for IMGs are comprehensive and in line with optimal standards.

Across scientific literature, effective approaches to boost acculturation and integration for IMGs have been outlined, including clinical attachment programmes in the UK (Thacker et al., 2022). In the US, workshops incorporating didactics, discussion, and roleplay have proven advantageous, leading to the development of an acculturation toolkit (Katz et al., 2020). Moreover, in Australia, researchers have shown how didactic and small-group activities helped improve the migratory transition period for IMGs (Porter et al., 2008).

Yet, in certain regions and medical specialties, gaps have been identified between the needs of IMGs and taught aspects of training (e.g. Osta et al., 2017). Notably, in a sample of $n = 198$ IMGs in New Zealand, 33% acknowledged that their behaviours were not suited to cultural expectations and many reported receiving scarce support during cultural transitions (Mannes et al., 2023).

Resultantly, there have been calls for the extensive roll-out of acculturation curricula; the importance of such educational programmes has been specifically highlighted for psychiatry residents (Atri et al., 2011). When introducing these schemes, institutions must learn from established international evidence and share successful results, allowing for a global exchange of ideas and strategies. Likewise, the role of cultural diversity and the benefits that can stem from biculturalism and blended identities should be accentuated within these courses (Gogineni et al., 2016; Falcone et al., 2014).

Further, institutions have a key function in facilitating personalised mentorship networks for IMGs and must offer specific points-of-contact for help and support (e.g., in the UK Jalal et al., 2019). Dedicated procedures to match IMGs and experienced local physicians could bolster personal wellbeing and social integration, guiding them through the intricacies of specific healthcare systems and cultures (Atri et al., 2011). Importantly, institutional arrangements for mentorship pathways may be especially valuable in remote or rural areas where IMGs commonly practice but lack sufficient social support (Lockyer et al., 2010).

Financial considerations can have a profound impact on the professional progress of IMGs. Presently, the cost of certification exams, travel, and relocation may be prohibitive, as is reflected in anecdotal accounts from IMGs (e.g., (Quora, 2023)). Therefore, the monetary burden on IMGs and their families should be acknowledged by institutions and programme directors. Institutions should implement inclusive protocols in their recruitment processes and adhere to best practices around professional working conditions (e.g., through contract equivalence for IMGs as compared to locally-trained doctors). As has been argued elsewhere, non-discriminatory language in job postings and diversity in hiring panels can uphold fair recruitment outcomes (Rao, 2018).

Training for existing staff about cultural diversity should be mandated to broaden inclusivity and empathy, in turn promoting healthier working environments for IMGs. Relatedly, there must be zero tolerance in situations of discrimination or racism towards IMGs. Furthermore, given the socioenvironmental stressors and risk factors in IMG populations, institutions must advance mental health literacy and promote the availability of appropriate and confidential support services (Winter et al., 2017); as a pre-requisite, these must be embedded within educational or induction schemes and extensively publicised.

Finally, professional organisations and institutions must actively advocate for the rights, interests, and welfare of IMGs. This could entail lobbying for policy changes that remove unnecessary barriers to practise and promote equitable conditions for IMGs (e.g., American Medical Association., 2022). To that end, institutions and organisations should collaborate with regulatory bodies and government agencies to address common issues, such as difficulties obtaining visas and work permits, high costs associated with certification examinations, and the limited availability of residency positions (Philpotts, 2023; MacFarlane, 2021).

Specifically, in psychiatry, scholarly associations have engaged in advocacy and developed bespoke materials for IMGs (e.g., American Psychiatric Association., 2023; Royal Australian and New Zealand College of Psychiatrists, 2023; Royal College of Psychiatrists., 2023). Similar proactive approaches should be widely adopted and enhanced through dedicated committees, working groups, and localised consensus statements (e.g., Kirmayer et al., 2018).

5.3. Political and legal

From a political and legal perspective, governments and stakeholders can shape policies and regulations that facilitate the attraction, integration, and retention of EIMGs and IIMGs in both HICs and LMICs,

concomitantly supporting their wellbeing and welfare.

Firstly, geopolitical patterns, political ideologies, and the COVID-19 pandemic have led to extensive visa restrictions and immigration restrictions in some HICs, rendering it harder for IMGs to migrate (e.g., Mustafa et al., 2017; British Medical Journal., 2017; Elshazly et al., 2020). As has been outlined (Rao et al., 2021), fluctuating immigration policies in HICs may deter EIMGs and IIMGs from relocating or influence their decision to stay and continue to practise in a host country.

Accordingly, policymakers should ideally seek to promote consistent and sensitised immigration strategies for IMGs, with a view to facilitating clearer procedures for mobility and integration (Pemberton et al., 2022). In turn, this could reduce uncertain working conditions and professional stressors. That said, the potential for designing and implementing such policies may be hampered by geopolitical paradigms, governmental changes, and shifts in political ideologies, as has been demonstrated in different contexts (e.g., British Medical Journal., 2017; Prignano, 2020). Moreover, like during the COVID-19 pandemic, unforeseen international crises can lead to fluctuations in immigration controls and migratory flows, impacting the stability of IMG pathways (Elshazly et al., 2020). Again, amidst these frameworks, advocating for improved conditions for IMGs should be a key responsibility for relevant institutions and professional organisations.

Immigration and healthcare policies are equally apposite for supporting physician retention. This may include proactive interventions to attract IIMGs back to their country of origin or encourage graduates to remain by offering better working environments and opportunities for career advancement (Onah et al., 2022). This notion was articulated by EIMGs in Canada, who suggested that financial recompense, welfare benefits, housing provisions, and infrastructural changes could motivate IMGs to remain in their country of training (Lofters et al., 2014). Simultaneously, health services and governments in HICs should be encouraged to prioritise ethical recruitment policies through to prevent exacerbating health workforce shortages in LMICs. This could involve international agreements, acknowledging the complex challenges involved in calibrating global health workforce needs and equitable resource distribution.

These approaches could help reduce physician shortages and health disparities in regions where “brain drain” has had detrimental effects (e.g., Economic Times., 2021). In this regard, several countries have recently implemented plans requiring doctors to serve a mandatory period in their home country before pursuing opportunities elsewhere. The long-term impact of these plans on migratory patterns of IMGs and healthcare inequities is currently unknown and will need ongoing monitoring and longitudinal analysis, especially since similar policies have been suggested more widely across LMICs and HICs (e.g., Orji, 2023; Roberts, 2016). Nevertheless, it should be noted that proposals focussing solely on retaining medical professionals without adequately addressing “push” and “pull” factors, such as enhanced compensation and working conditions, will likely result in personal and job dissatisfaction, conceivably hindering effective healthcare delivery.

Bolstering institutional accreditation structures and quality control mechanisms could allow for the certification of medical degrees intraregionally and improve provisions for IMGs. Here, various supranational bodies have been established to standardise quality control processes, including the World Federation for Medical Education (WFME). Dependent on the host country, accreditation and licensing procedures can often take considerable time, involving additional education or assessments to ensure that IMG qualifications meet locally recognised standards (Whelan et al., 2002; McLean and Bennett; Sachdeva and Batra, 2017). By corollary, this can exacerbate healthcare gaps through “brain waste” and render EIMGs and IIMGs unable to practise either temporarily or permanently (Hervey, 2017; Grossman, 2022). Such situations are universally detrimental, irrespective of ideological stances on the migration of IMGs; these circumstances potentially compromise patient care and physician availability in the host country (where applicable) as well as the country of origin, undermining overall global

health outcomes.

Therefore, more streamlined institutional accreditation provisions could benefit IMGs, particularly those from LMICs, ensuring that they receive a sufficient level of education that meets international standards, regardless of where they undertook their initial training. This may also be important for strengthening healthcare delivery, given discrepancies in the quality, content, and format of medical education structures. Notably, in countries where the medical education system is robust and well-funded, graduates often have access to high-quality facilities. However, in socioeconomically disadvantaged regions, these experiences may not be as common, leading to divergences in content and quality, as has been demonstrated in psychiatry programmes around the world (e.g., ; Bhugra et al., 2023). This can constitute a sizeable “push” factor for both EIMGs and IIMGs to pursue training abroad.

Conversely, expanding accreditation processes could inadvertently exacerbate the “brain drain” phenomenon (Lien, 2006) and neglect the unique and context-specific knowledge and skills of IMGs from diverse educational backgrounds. Additionally, the process of gaining accreditation could be a financial strain for institutions in LMICs or socioeconomically disadvantaged areas and impede the evolution of global medical education.

Consequently, any discussions about streamlining accreditation for IMGs must aim to implement measures that balance quality assurance and fairness and inclusivity, without dictating a one-size-fits all approach. This may necessitate greater investment to augment training facilities and upgrade curricula in line with established standards, whilst accounting for the cultural specificities of localised medical education (Burdick et al., 2007). In recognising that HICs often draw a significant number of IMGs from the Global South, these countries may have a greater responsibility to support these enhancements and this could be encouraged as a strategic aim for stakeholders and policymakers in the context of development budgets and foreign aid; on the other hand, it should be acknowledged that political realities, ideologies, and geopolitical issues may adversely affect these goals.

More generally, all countries and healthcare sectors could benefit from greater international cooperation around medical education and IMGs. Here, the World Health Organization, together with other bodies like WFME, can play a critical role (Weisz and Nannestad, 2021), providing a platform for dialogues and knowledge exchanges. Yet, again, collaborations would require careful consideration of cultural, political, and institutional differences, or risk being hindered by obstacles related to varying healthcare systems, educational philosophies, and resource availability. Ultimately, a comprehensive understanding of these challenges is essential for guiding effective partnerships.

6. World Psychiatric Association-Asian Journal of Psychiatry Commission recommendations

Based on its report, the Commission proposes the following recommendations to support the professional contributions and mental wellbeing of EIMGs and IIMGs:

Personal.

- i. Where feasible, IMGs must make themselves aware of local healthcare systems and policies, either through initial placements or apprenticeship before moving into training posts.
- ii. Wherever possible, IMGs must create new peer support networks or engage in existing schemes to support each other, learn from past experiences, and create shared narratives.
- iii. IMGs must engage with institutional resources and support schemes (as appropriate).
- iv. IMGs must look after their mental health and wellbeing using individualised strategies.
- v. IMGs must not avoid seeking help early, as required.

Institutional.

- i. There must be proper and comprehensive induction delivered at institutional and locally based levels.
- ii. Institutions should appoint a dedicated point of contact responsible for the health and welfare of IMGs.
- iii. Confidential help must be made available to IMGs.
- iv. Relevant services to protect IMG wellbeing should be widely publicised.
- v. Induction must include multi-disciplinary approaches and role development.
- vi. Training in cultural competence must be mandatory so that IMGs are familiar with local cultures and norms. Staff and supervisors must also be aware of an IMG's cultural values.
- vii. There should be zero tolerance on issues related to experiences of racism or discrimination by IMGs.
- viii. Wherever needed, equity in training must be delivered.
- ix. Institutions should form international partnerships to maintain standards of training and develop insights around best practices.
- x. Institutions must provide support to IMGs on arrival, together with ongoing assistance.

Policy and Legal.

- i. Immigration policies need to be appropriate, sensitive, and practical if IMGs are being recruited for service, training, or research purposes.
- ii. Appropriate budgets for training must be made available at all levels.
- iii. Legal support must be easily accessible and available if needed.
- iv. International agreements may be necessary to ensure that lower-income countries are not disproportionately losing doctors to HICs and subsidising healthcare systems.
- v. All IMGs must be supported according to need.

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Declaration of Competing Interest

No competing interests to declare in relation to this manuscript.

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