



UNDEREMPLOYMENT OF INTERNATIONAL MEDICAL GRADUATES IN CANADA

BREAKING DOWN SYSTEMIC BARRIERS

BY: ABHINAV WADHWA, ARNAV MITTAL, ROHIT KAINTH, USAMA NADEEM

Presented To

DR. CHERYL GLADU

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Overview and Objective

Canada is one of the most preferred destinations among immigrants. The high appeal is due to economic stability, a better system for immigration, Canada's diverse culture, and many more positive factors. The country values highly skilled and talented immigrants. Canada plans to welcome 500,000 immigrants in 2025 and 2026 (IRCC, 2023).

However, many of the immigrants we spoke with for this study highlighted the difficulties and sacrifices they had to make, particularly immigrant medical professionals, which clearly demonstrate the fundamental problem of underemployment in this nation. While mapping the system, we have examined the intertwined factors influencing skill mismatch, wage inequality, and employment difficulty among International Medical Graduates or the immigrants who wish to get into the medical field. Given Canada's critical healthcare shortages and its need for skilled professionals, why do so many qualified International Medical Graduates continue to face systemic barriers to practicing medicine in Canada?

Terminology

The term 'Underemployment' is defined as employment that does not fully utilize an individual's education, skills, and experience, or part-time employment of an individual who is available to work full-time (Ewen et al., 2023).

The Medical Council of Canada (MCC) defines International Medical Graduates (IMGs) as graduates of medical schools outside Canada or the United States, excluding US osteopathic schools (Campbell-Page et al., 2013).



Problem Statement

Canada showcases doctor shortages, leaving 6.5 million Canadians without a family doctor

-Duong & Vogel, 2023

Canada's health care is in crisis, in 2021, only 58% of employed IMGs in Canada worked in health occupations where many of them doesn't even work in their specific profession and the rest just works in different fields (Frank et al.,2023). Restrictive licensure policies, residency caps of for IMGs (Singer, 2022), and bias against non-Western medical training prevent qualified physicians from practicing, worsening shortages. Employers prefer Canadian-trained physicians because of entrenched convictions (Olatunde,2023). Unless reformed, Canada will continue losing billions of dollars in untapped talent while patients continue to suffer (Agopsowicz et al., 2019).

ICEBERG MODEL

Events

- Immigrants with medical degrees are facing underemployment.
- Shortage of health care workers across Canada .
- Inadequate access to primary health care.

Patterns

- Employer bias against foreign qualifications, racial background and experience from their home country.
- Wage gaps between immigrants and Canadian-born medical professionals.
- Over representation of IMGs in low-skilled jobs.

Systemic Structures

- Strict Provincial and Medical regulatory bodies hamper professional licensing and foreign accreditation.
- Inadequate residency slots in medical schools for IMGs which results in backlogs within the system.

Mental Model

- Stereotypes about immigrant capabilities affecting hiring decisions.
- Perception that foreign degrees and experience are inferior to Canadian counterparts.
- Employers favor local network rather than diverse global talent.

Events

In 2021, only 58% of employed IMGs in Canada worked in health occupations, however many trained nurses, physicians, pharmacists, and dentists did not work in their specific professions (Frank et al., 2023). Given the enormous demand for medical professionals across the country, Canada's health care system is experiencing a severe labour shortage (Government of Canada, 2023). Access to family physicians in Canada dropped from 93% to 86% between 2016 and 2023 (CIHI, 2024).

Patterns

According to Turin et al. (2023), Employers subject IMGs to "systemic discrimination such as non-recognition of their credentials". International professionals face wage inequities and are often relegated to low-skill occupations despite their medical training, demonstrating structural exclusion. These cycles perpetuate racial hierarchies and credentialing bottlenecks (Turin et al., 2023).

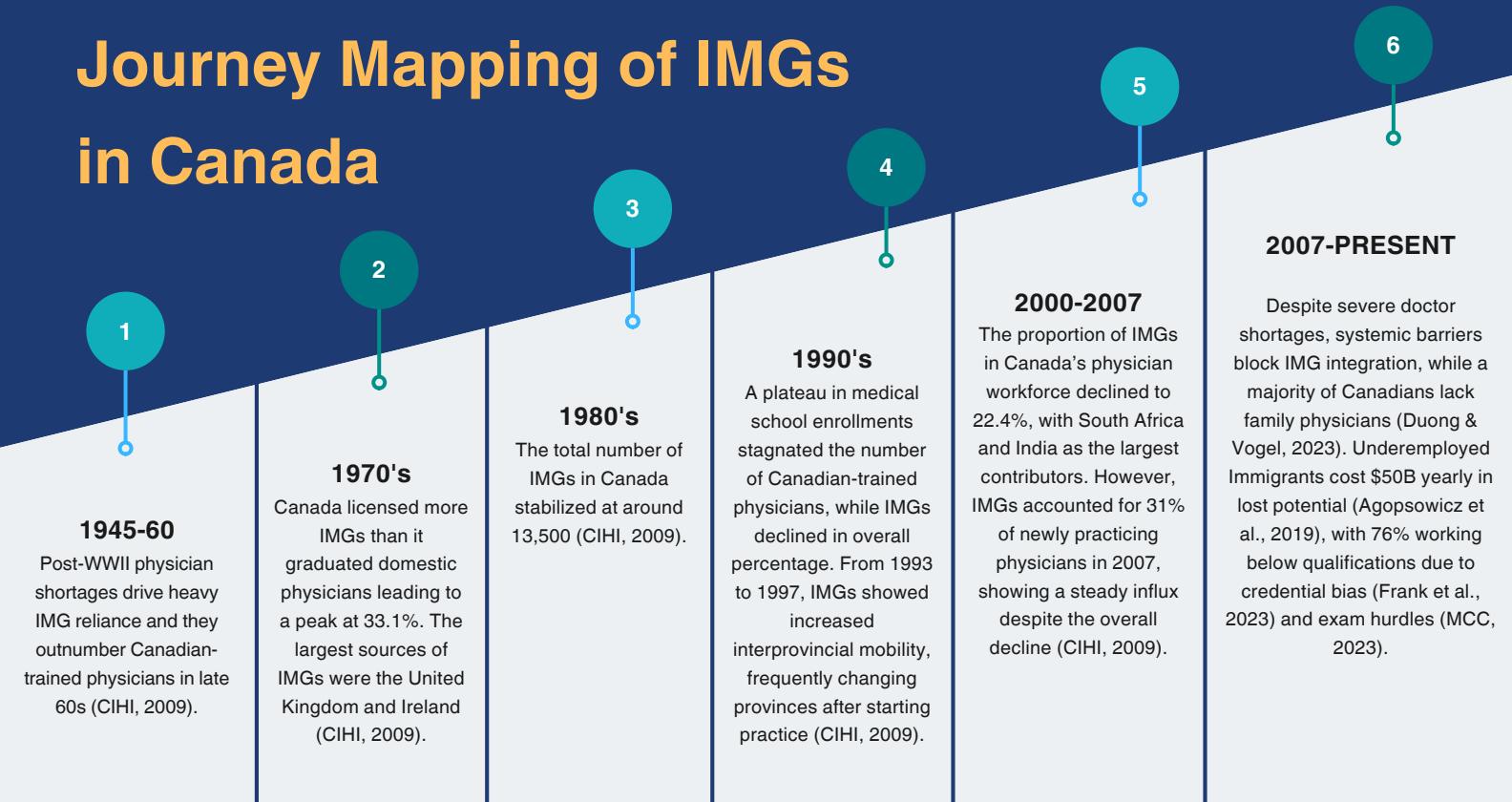
Systemic Structures

Canada's shortage of health workers results from licensing and provincial authorities enacting time-consuming processes that deny internationally trained practitioners (Singer, 2022). Only 13% of residency positions were allocated to IMGs in 2022, which is below from the previous decade (Singer, 2022).

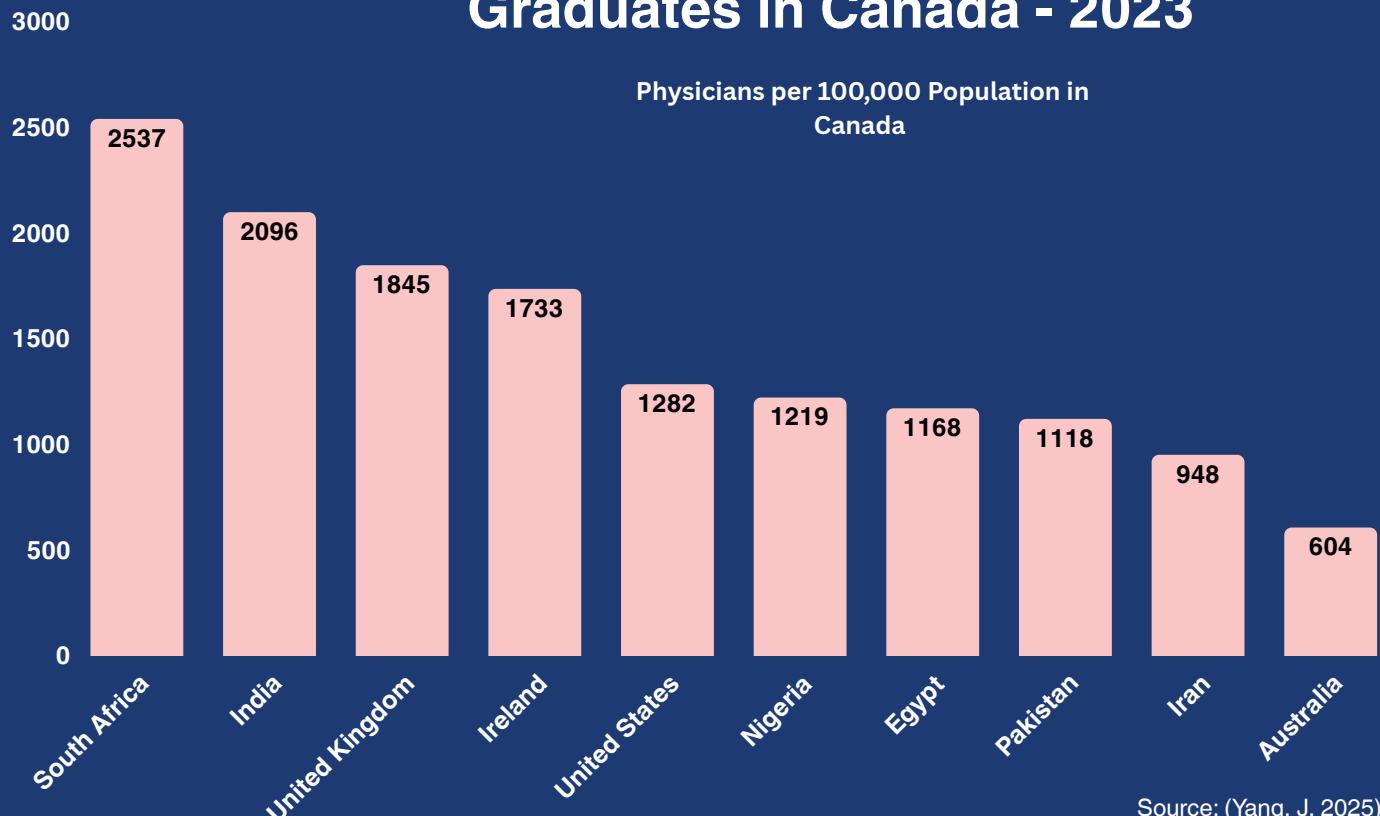
Mental Model

IMGs are routinely questioned about their competence, with employers favoring Canadian-trained doctors due to deep-seated beliefs in local training superiority. Foreign qualifications are undervalued, and local networking preferences further disadvantage IMGs (Olatunde, 2023).

Journey Mapping of IMGs in Canada

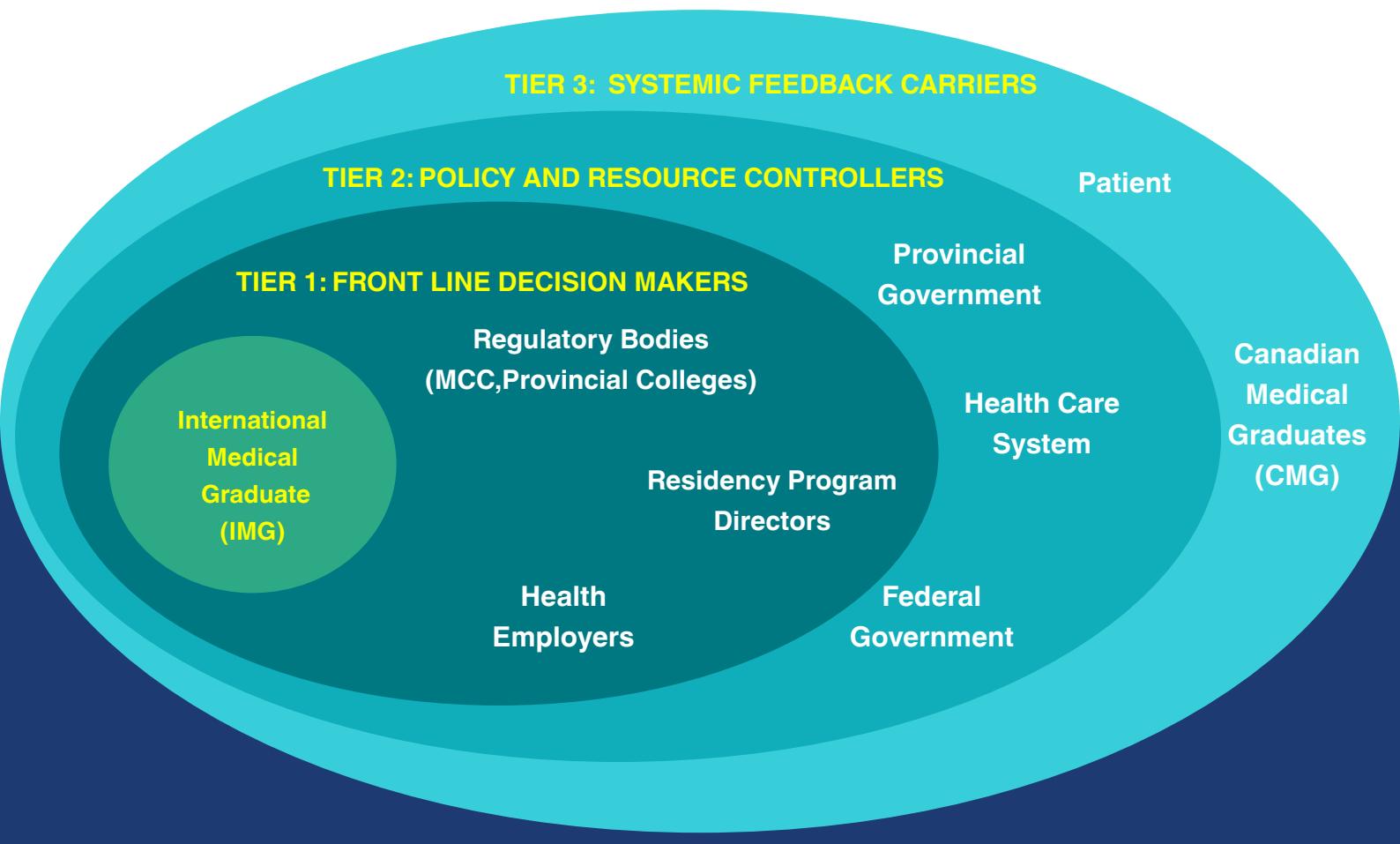


Top Source Countries of Foreign Medical Graduates in Canada - 2023



STAKEHOLDER MAPPING

Closer Stakeholders towards IMGs have more power and influence



CORE LEVEL

International Medical Graduates (IMG)

They are the ones primarily affected. IMGs face significant barriers to the practice of medicine in Canada, including stringent licensing processes and limited residency positions (MOSAIC, 2025).

TIER 1: FRONT LINE DECISION MAKERS

➤ Regulatory Bodies

IMGs often struggle to meet the registration requirements of provincial regulatory bodies, which set the standards for medical licensure in Canada. These requirements such as Canadian-specific education or recent practice can limit IMGs' ability to enter and integrate into the healthcare system (Government of Canada, Health Canada, 2023).

➤ Residency Program Directors

Responsible for selecting candidates for medical residency positions, they play a crucial role in determining the opportunities available to IMGs. (MOSAIC, 2025).

TIER 2: POLICY AND RESOURCE CONTROLLERS

➤ Provincial Government

Provinces control medical licensure, imposing complex and restrictive processes that hinder IMGs' ability to practice (Sood, 2019). Limited residency spots and mobility constraints further contribute to underemployment (Healthcare Excellence Canada, 2022).

➤ Federal Government

Federal immigration policies have encouraged IMGs to immigrate without aligning with provincial licensure systems, leading to professional mismatch (Dirks, 2006). Recent policy shifts aim to improve credential recognition and healthcare workforce integration (Government of Canada, 2023).

TIER 2: POLICY AND RESOURCE CONTROLLERS

➤ Canadian Medical Graduates (CMGs)

As counterparts to IMGs, CMGs may be perceived as competitors for residency positions and employment opportunities, influencing the dynamics of medical training and employment (MOSAIC, 2025).

➤ Patients

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Root Causes

Canada's physician shortages persist while thousands of skilled international medical graduates are underemployed due to systemic barriers. These structural barriers span credentialing, cultural adjustment, and professional isolation, wasting precious medical talent.

1. UNDERUTILIZATION OF SUPPORT PROGRAMS

In spite of the availability of bridging programs, there are IMGs who are unable to access such programs because of systemic issues. Lack of awareness of available resources is one of these issues, as the Medical Council of Canada's licensure process is still complicated and not publicized sufficiently (Medical Council of Canada, 2023). Inaccessibility within the geographical area further limits access, particularly by IMGs whose areas are poor and have meager support structures (Campbell-Page et al., 2013). High program fees also disenfranchise economically tight-lipped IMGs, a discriminatory system in which wealthed individuals are the only ones able to move forward (Frank et al., 2023).

2. HOSTILITY TO ALTERNATE CAREER PATHS

The majority of IMGs face cultural and psychological barriers in seeking non-clinical careers. Their professional identity, which is conventionally linked only with clinical practice, leads to opposition to career growth in public health, research, or administration (Turin et al., 2023). It is also driven by a common stigma that perceives non-clinical jobs as the second best option or a failure, discouraging IMGs from seeking realistically feasible alternatives (Turin et al., 2023).

3. LANGUAGE AND CULTURAL ADJUSTMENT BARRIERS

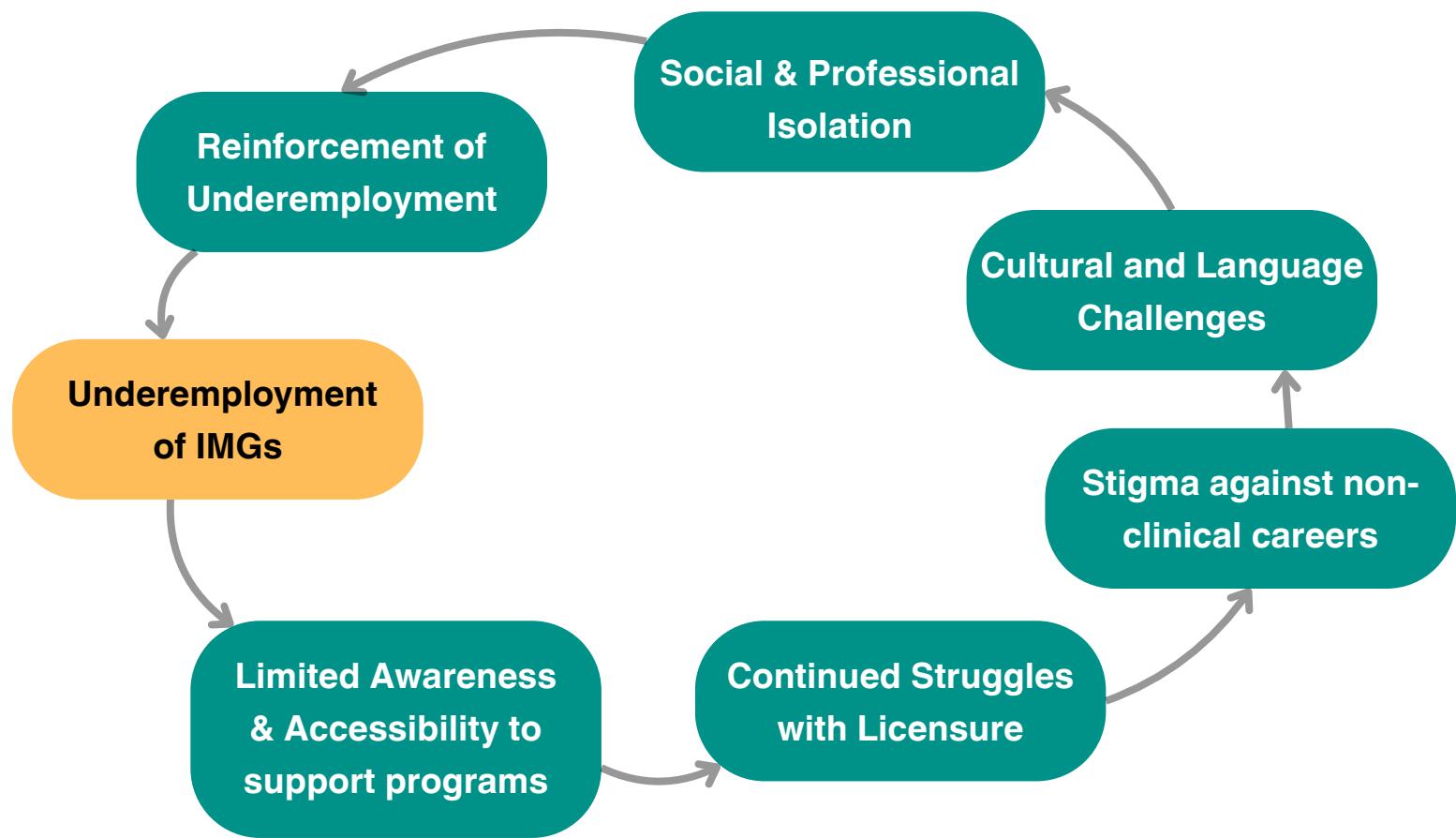
Communication barriers are a significant obstacle, particularly in adapting to Canada's patient autonomy model of care.

Hierarchical training experience IMGs do not have working together and therefore perform poorly in clinical exams and certification (Olatunde, 2023). Incongruity in workplace culture also expands these issues since most IMGs are not prepared to handle the emphasis on patient autonomy and interprofessional collaboration in Canadian health care settings (Olatunde, 2023).

4. PROFESSIONAL AND SOCIAL ISOLATION

Rural or underserved placements tend to lead to attrition since IMGs feel double isolation from professional networks and community support systems (Campbell-Page et al., 2013). Formal mentorship programs and being excluded from informal referral networks also isolate IMGs, limiting their access to employment opportunities and career advancement (Turin et al., 2023).

BALANCING LOOP



Canada's underutilization of IMGs is caused by a balancing circular loop. Unawareness and unavailability of support programs, including high costs and distance, lead to low utilization (Campbell-Page et al., 2013). Professional and cultural stigma and resistance from IMG to non-clinical careers is perceived as a "failure" (Turin et al., 2023). Aside from cultural and lingual accommodation problems such as medicine and corporate cultural diversity communication, their test and licensure performance is impacted (Olatunde, 2023). Profession and isolation, in particular to rural areas, deprives IMGs of an opportunity of networking and mentoring (Turin et al., 2023; Olatunde, 2023). This creates a cycle of underemployment, thus it is difficult for IMGs to settle into the Canadian health care system.

Long - Term Impact

Wasted Medical Intellect & Economic Loss

Canada's underutilization of IMGs is a huge waste of medical resources in the face of ongoing shortages of doctors. Studies indicate that institutional licensure obstacles limit IMGs from practicing at their best levels, placing them in roles lower than their potential (Frank et al., 2023). This wasteful deployment of human resources is a paradoxical situation whereby Canada welcomes high-skilled health care professionals as immigrants but nonetheless has artificial barriers that prevent them from occupying vacant health care needs. These economic losses cross-cut the health industry because the professional contribution of IMGs does not occur, and therefore is latent productivity and taxation on a nationwide scale.

Pressure on Healthcare System & Regional Disparities

Systematic failure of IMGs work practice rights continues health access inequities, particularly in rural and underserved communities. IMGs frequently relocate to other areas or quit medicine entirely in the provinces with the worst doctor shortages (Campbell-Page et al., 2013). Because provinces invest money in educating IMGs but receive little return on their investment, this brain drain exacerbates regional healthcare discrepancies. The failure of the current system to effectively integrate IMGs not only burdens overburdened health care providers but also erodes Canada's stated values of health equity and resource efficiency.



GAPS IN THE SYSTEM

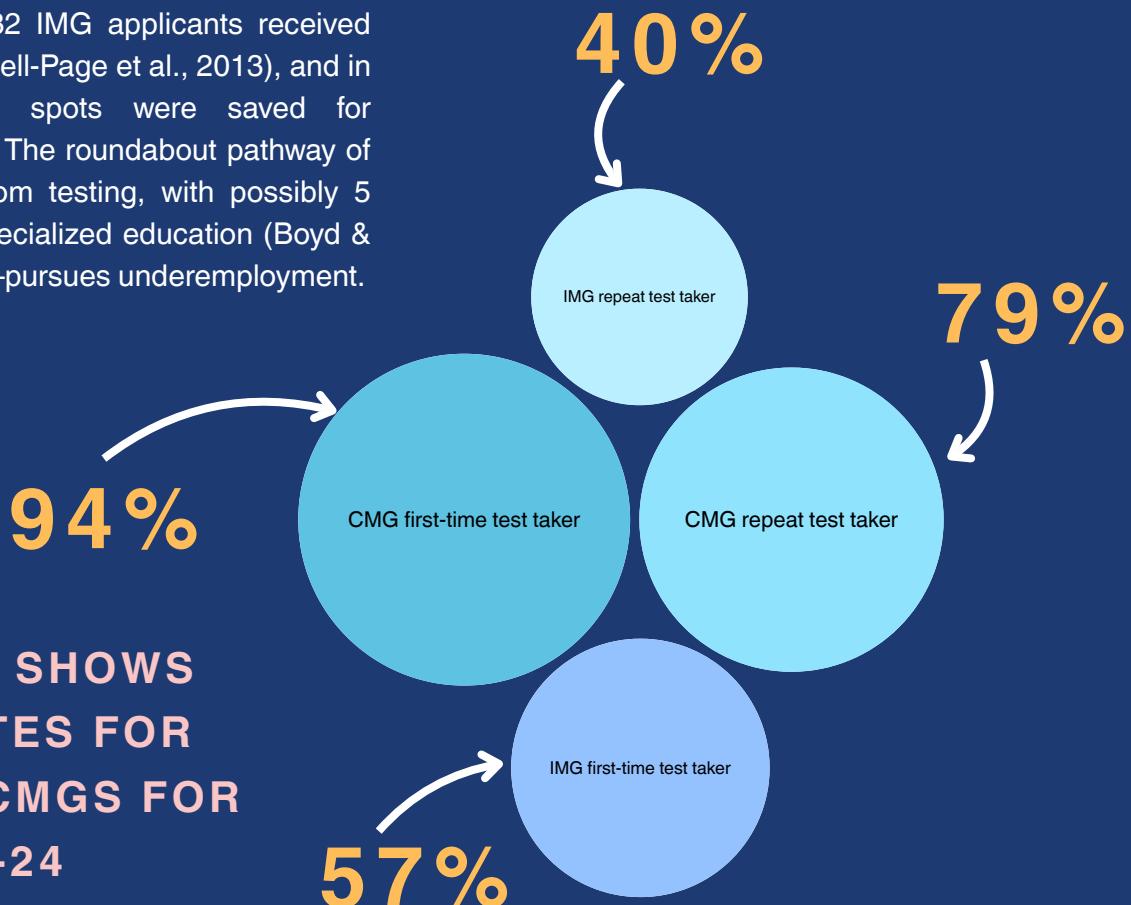
▷ Exclusionary Examination and Residency Systems

- Bias in Examination

IMGs score 47.7% in comparison to 93.9% of Canadian graduates, even though they write 60–66% of exams (MCC, 2023). The shortcoming is in technical reliability of exam, which suggests cultural biases in test development (MCC, 2023).

- Residency bottlenecks

Only 299 of the 1,532 IMG applicants received spots in 2010 (Campbell-Page et al., 2013), and in many cases, these spots were saved for graduates of Canada. The roundabout pathway of certification—apart from testing, with possibly 5 additional years of specialized education (Boyd & Schellenberg, 2007)—pursues underemployment.



THIS MAP SHOWS
PASS RATES FOR
IMGS AND CMGS FOR
2023-24

GAPS IN THE SYSTEM

➤ Devaluation of Credentials

Only 58% of IMGs are employed in their field, often held back to secondary ranks as opposed to 95% CMGs (Frank et al., 2023).

- **Provincial Disparity**

Ontario holds 34% of IMGs in bridging programs, and Newfoundland holds 7% just due to inadequate support (Campbell-Page et al., 2013).

➤ Retention failure & exploitative licensing

- **Provisional license Shortcomings**

IMGs in provinces like Newfoundland experience 93% attrition after decades of restricted practice (Campbell-Page et al., 2013).

- **Feeder System Costs**

Smaller provinces incur costs to train IMGs that lose 63–92% to larger provinces at licensure (Campbell-Page et al., 2013).

Solution Landscape

➤ Reforms in Examination and Residency Systems

- **Standardizing Assessment Criteria:** Consistent evaluation criteria should be applied to both Canadian Medical Graduates (CMGs) and IMGs so that equity could be maintained. Before applying for residency, all candidates must pass the same tests, such as the Medical Council of Canada Qualifying Examination (MCCQE) to minimize cultural bias (Raza, 2025).
- **Increase Residency Positions for IMGs:** The amount of residency spots which are available to IMGs should be increased in order to better represent regional physician shortages. This strategy could address the bottleneck issue; for example, in 2010, only 299 out of 1,532 IMG applicants were able to acquire places(Campbell-Page et al., 2013).

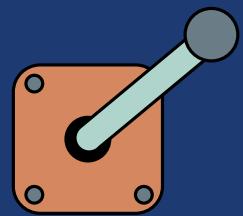
➤ Enhance Credential Recognition

- **Develop Bridging Programs:** Establishing and funding the comprehensive bridging programs across all provinces could help in assisting the IMGs in transitioning into the Canadian healthcare system (Raza, 2025).
- **Streamline Licensing Processes:** Simplifying and speeding up licensing processes could lead to better acknowledgement of IMGs' credentials and can make sure that their foreign experience is fairly compensated (Raza, 2025).

➤ Improvement in Retention and Addressing License Challenges

- **Offering Full Licensure Pathways:** Transition of IMGs from provisional to full licensure would prevent undue attrition in provinces like Newfoundland, where there was 93% attrition of IMGs after extended periods of restricted practice (Campbell-Page et al., 2013).
- **Implementation of Return-of-Service Agreements:** Return-of-service agreements should be implemented in a way that balances regional healthcare needs with opportunities for professional development, encouraging IMGs to serve in underprivileged areas while facilitating mobility.

Levers of Change



➊ 1. Policy and Regulatory Reform

❖ Lever: National Framework for Licensing

In order to impact legislative change and consolidate resources, IMG advocacy organizations need to strengthen or create national networks. IMGs should be able to engage in governance and health system advisory board positions.

❖ Lever: National Framework for Licensing

CaRMS regulations must be modified to provide equitable access for IMGs to resident spots. Furthermore, legislation that calls for equity and transparency in the resident matching process must be contemplated.

➋ 2. Fiscal and Institutional Incentives

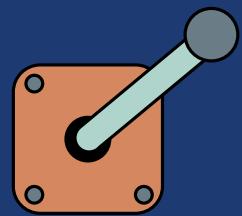
❖ Lever: Funded Residency & Bridging Seats

To improve access and reduce dropping-out rates, funding for mentorship and bridging programs must be offered, and specific federal and provincial funding must be provided for IMG-only resident spots.

❖ Lever: Rural Retention Incentives

IMGs practicing in underserved communities should be given housing allowances, tax breaks, and loan forgiveness. Where IMGs tend to leave after acquiring their licenses, economic incentives should be employed to keep talent.

Levers of Change



⚙️ 3. Cultural and Institutional Responsibility

❖ Lever: Exam Reform and Anti-Bias Training

It is extremely important to incorporate cultural safety and justice in preparing and administering the medical examinations. It is also important to look into training instructors and program directors in unconscious bias and cultural humility.

❖ Lever: Recognition of Prior Learning Framework

There is a need to consider establishing a routine Recognition of Prior Learning system for recognizing foreign work experience and training. It's important to use RPL to enable licensure for experienced IMGs through the evasion of needless retraining.

⚙️ 4. Systems-Level Data and Transparency

❖ Lever: Dashboard for IMG Integration

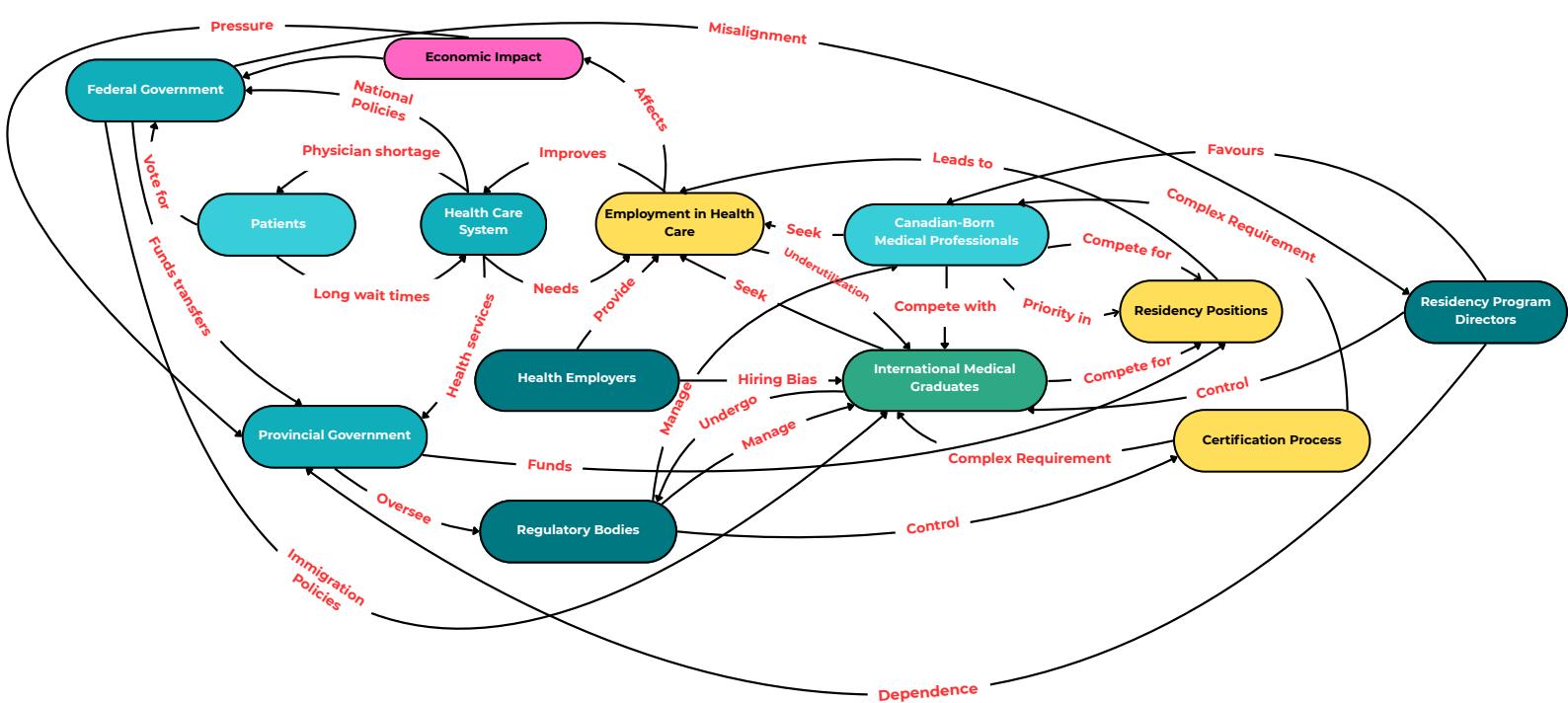
It could be useful to develop a public dashboard that monitors IMG employment, attrition, residency match rates, and application. Utilizing data to direct targeted efforts and hold organizations accountable is a further option.

❖ Lever: IMG Observatory Council

Establishing a separate, government-supported organization to oversee IMG integration, provide policy recommendations, and represent IMGs should be taken into consideration.

MAP THE SYSTEM

Below are the details of systemic stories or causes that influence the barriers and challenges faced by International Medical Graduates. Every narrative is a component of a broader causal loop map.



LOW Stakeholder Power and Interest HIGH

TIER 1: FRONT LINE DECISION MAKERS



TIER 2: POLICY AND RESOURCE CONTROLLERS



TIER 3: SYSTEMIC FEEDBACK CARRIERS



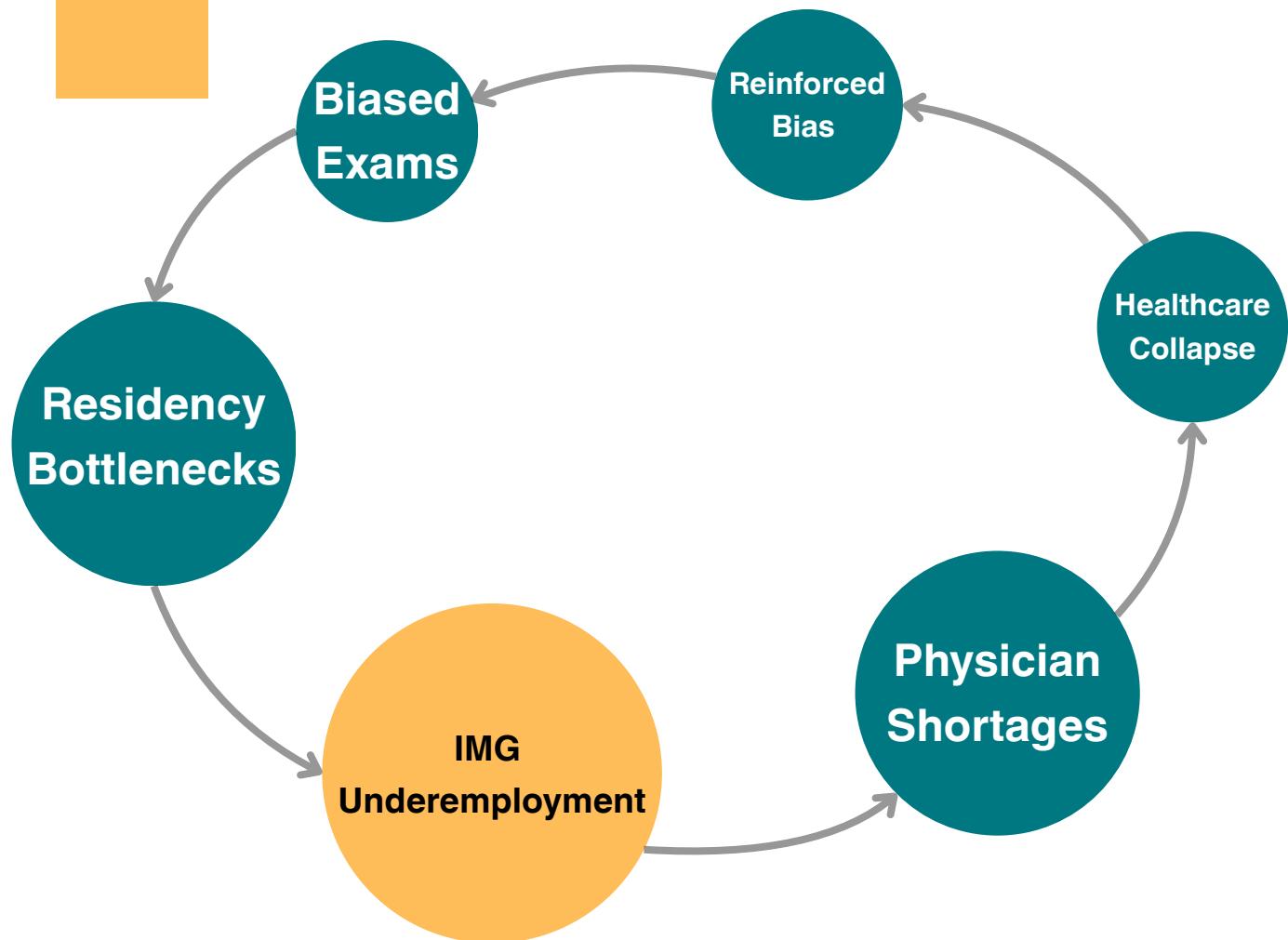
SYSTEM OUTCOME



SYSTEM PROCESS



REINFORCING LOOP



Canada's medical licensing process is self-sustaining in a cycle: Culture-tainted exams (MCC, 2023) disproportionately constrain IMGs, fueling residency shortages (Campbell-Page et al., 2013). This expulsion pushes IMGs into underemployment (Frank et al., 2023), which further fuels physician shortages, particularly in rural communities (CIHI, 2025). Rather than addressing systemic failings, however, regulators view low licensure rates as evidence of necessary stringency, thus embedding the very policies generating the shortages leading to healthcare collapse. The result is a self-reinforcing, closed circle where exclusionary practice creates its own legitimacy.

LESSONS LEARNED

Through this research, it came to our understanding that the underuse of International Medical Graduates (IMGs) in Canada is not merely an administrative problem, but also a self-sustaining systemic breakdown. We had originally grasped the problem in terms of the backlog of recognition of credentials and residencies shortages, but further research showed us how discriminatory policy, cultural bias, and institutional resistance all come together to exclude competent physicians, while access to healthcare deteriorates.

What is created is a system that produces scarcity. Restricted exams and arbitrary certification of limits on IMG residency positions are rationalized on "quality control" grounds but function to exacerbate racialized and ethnically linked shortages that they are ostensibly minimizing. Provincial bridging programs and temporarily exploitative certification function to create racialized disparity, losing the talent while patients suffer. Most illuminating was recognition of our own complicity in this cycle, the researcher, policymaker, or health advocate of resisting or inadvertently strengthening these barriers.

It was put into perspective by this project that effective solutions require systemic courage: addressing the colonial roots and protectionist ideologies discounting international training, reforming examinations to prize competency over conformity, and balancing immigration policy with healthcare demands. Most profoundly, it calls for a shift in attitude away from viewing IMGs as "foreign-trained" and toward embracing them as vital colleagues in creating an equitable, sustainable health care system. The exit is not through incremental solutions, but through deconstructing the presupposition that exclusion can guarantee excellence. Ultimately, by embracing the truth that Canada's well-being is now in the hands of the ones that Canada has so long marginalized.

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