AUSTRALIAN MEDICAL COUNCIL LIMITED

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ANNUAL REPORT 2009

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1 Year in review

Highlights

In 2009, the AMC:

- moved to new premises, upgrading the IT and secretariat support for AMC operations
- published *Good Medical Practice: A Code of Conduct for Doctors in Australia*
- published the *Handbook of Multiple Choice Questions*
- processed 7,146 primary source verification requests
- conducted the AMC MCQ Examination for 4,851 candidates
- conducted the AMC Clinical Examination for 1,261 candidates
- was appointed the provider of medical profession accreditation functions during the transitional period of the National Registration and Accreditation Scheme
- completed seven assessments of medical school programs: six follow-up assessments and one comprehensive report assessment
- completed three accreditation reviews of specialist medical training providers and one assessment of plans to establish an independent specialist college.

President's report

I am pleased to present the annual report of the Australian Medical Council for 2009, another productive year for the council.

During the year, we focused on preparing for the introduction of the National Registration and Accreditation Scheme (NRAS), which will come into effect on 1 July 2010. The AMC, the Joint Medical Boards Advisory Committee and the Forum of Australian Health Professions Councils contributed significantly to the consultation process to refine the legislation to implement the scheme.

For the first three years of the NRAS, the AMC will be responsible for accrediting education providers and programs of study for the medical profession. We value this opportunity to support the new Medical Board of Australia by working to ensure the continuance of high standards in medical education and training.

In collaboration with an expert working group, for two years we worked on developing a nationally consistent code of professional conduct for doctors practising in Australia. In August 2009, after wide-ranging consultation with stakeholders, we released the result of that work, *Good Medical Practice: A Code of Conduct for Doctors in Australia*. We expect it to form the basis of the national code to be implemented under the NRAS.

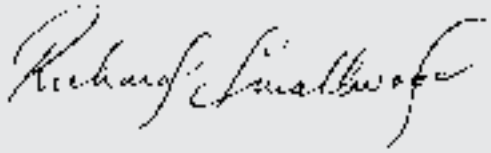
On the operational front, the AMC relocated to new premises in 2009, providing the secretariat with modern facilities and equipment and strengthening its ability to operate effectively and efficiently.

The year 2010 is shaping up to be an exciting year for the AMC: we will celebrate our 25-year anniversary and will enter a time of significant change with the introduction of the NRAS. We will continue to be adaptable and responsive to change as we support the work of the new national medical board.

On behalf of the council, I thank all those who have dedicated their time and energy to the AMC's work. Without the input of the clinicians, academics, staff, health consumers and trainees who work closely with us, we would function less effectively.

Finally, I acknowledge the work provided by the AMC Secretariat and their leaders, Mr Ian Frank, the Chief Executive Officer, and Ms Theanne Walters, the Deputy Chief Executive Officer. Their professionalism and commitment to excellence embody the AMC's values and standards.

Richard Smallwood AO, President



Chief Executive Officer's report

A major challenge for the AMC secretariat in 2009 was the relocation of the AMC offices from Barton to a purpose-designed facility at Majura Park within the Canberra Airport Business Park precinct. The relocation was undertaken during a period of some uncertainty about the ongoing role of the AMC in the new National Registration and Accreditation Scheme (NRAS).

During 2008, the increased workloads arising from the Council of Australia Governments (COAG) international medical graduate (IMG) assessment initiative and increased accreditation activity resulted in an expansion of secretariat staff, which in turn placed a strain on the available accommodation. Previously, the secretariat had expanded at its Barton site to include accommodation in two adjacent buildings—Arts House and the AMA building. By mid-2008, these two sites had reached their maximum capacity and were no longer functioning efficiently.

A number of alternative sites were surveyed before AMC directors decided on the Majura Park site. This was a completely new development using the latest technologies, including a reduction in carbon dioxide emissions by 75% over conventional buildings. The site also included a conference facility, including a lecture theatre and conference rooms. Because of the uncertainty regarding the rollout of the NRAS and the ongoing involvement of the AMC in accreditation activities under the new national scheme, the new offices were leased for a period of five years in the first instance.

Since the new offices were pre–fit-out, the AMC engaged the architectural firm of Daryl Jackson Alistair Swayn to design the fit-out and Point Project Management to oversee the implementation and relocation. Although the major construction was carried out over the Christmas period and with a very tight time frame for completion, the project was completed on time and within the budget of $2.9 million.

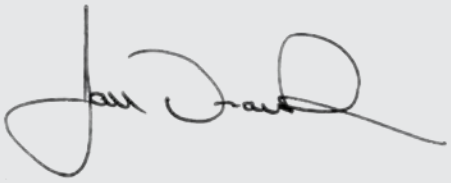
The relocation was completed on 20 March and the AMC now has its staff located in a single building with purpose-designed facilities, including advanced IT applications. The physical relocation was undertaken without interruption to the work program of the AMC. The new facilities have already enabled the AMC to achieve efficiencies in the processing of applications for assessment, and further efficiencies are expected to be realised when videoconferencing and other remote IT support services are brought online.

The workloads within the secretariat continued to expand on the 2008 levels in all areas: notably, there was a doubling of the MCQ examination load and a significant increase in the numbers of clinical examinations conducted. Similarly, a substantial accreditation workload was maintained, both in the medical school and specialist education areas. In addition, in

anticipation of the national registration scheme, following an extensive consultation process, the AMC published *Good Medical Practice: A Code of Conduct for Doctors in Australia.*

By the end of 2009, although a number of issues regarding the NRAS were still to be clarified, the AMC had been approved as the authority responsible for the accreditation of medicine for the first three years of the scheme.

I would like to acknowledge the ongoing commitment and dedication of the staff of the AMC secretariat during 2009 in supporting the work of the council, despite the uncertainties of the new national regulatory environment.



Ian Frank

Chief Executive Officer

2 About the Australian Medical Council

The purpose of the Australian Medical Council is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

Role

The Australian Medical Council Limited (AMC) is an independent national standards and assessment body for medical education and training.

The AMC has four core functions:

- the accreditation of medical schools based mainly in Australia and New Zealand and of courses leading to admission to medical practice in Australia of the graduates of those schools
- the accreditation of Australian and Australasian providers of specialist medical training and of their specialist medical training and professional development programs
- the assessment for admission to medical practice in Australia of international medical graduates (IMGs)
- the provision of advice and recommendations to federal, state and territory governments and state and territory medical boards in relation to the registration of medical practitioners; the recognition of the overseas qualifications of medical practitioners; and the recognition of medical specialties.

A general description of what is involved in carrying out these functions is given in this section under the heading 'Operations overview'. Statistical and other information on the AMC's operational performance in carrying out its functions in the reporting year is in section 4.

Stakeholders

The AMC recognises the value of working with stakeholders to ensure that Australia is serviced by a safe and competent medical workforce. The AMC's committees and decision-making processes have been structured to ensure that diverse perspectives are reflected. A range of stakeholders across the medical profession, the community, governments and others in the health sector contribute to:

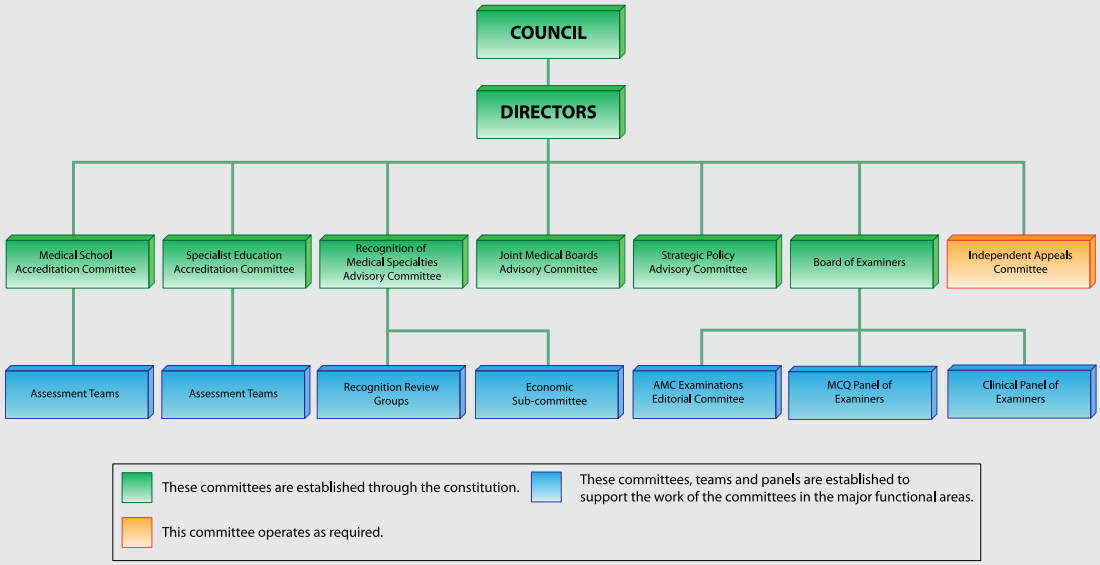
- decisions about the knowledge, skills and attitudes recognised for safe and competent medical practice
- decisions about assessing the knowledge, skills and professional attributes of individual doctors
- assessing courses against standards and identifying challenges to high-quality training.

Section 3 gives specific information on the AMC's support for stakeholders during the reporting year.

Governance structure

The AMC is a company limited by guarantee. It is an independent body and is not part of the Australian Government. Although the AMC is not a statutory body, its accreditation and examination functions are reflected in the relevant state and territory medical acts and associated schedules. The AMC's governance structure is set out in Figure 1.

Figure 1 Governance structure, 31 December 2009



Council and directors

Members of the AMC represent a broad cross-section of the groups associated with the standards of medical practice in Australia. They include persons with a background in and knowledge of consumer health issues, as well as nominees of:

- state and territory medical boards
- universities, through Universities Australia
- specialist medical colleges, through the Committee of Presidents of Medical Colleges
- postgraduate medical education councils, through the Confederation of Postgraduate Medical Education Councils
- the Federal Council of the Australian Medical Association
- Commonwealth, state and territory health departments
- health consumers and community members.

The full council is responsible for determining the AMC's future and for appointing and removing the directors, who are responsible for the day-to-day management of the AMC.

The directors are listed both in the directors' report in the financial statements and in Appendix A; their attendance at meetings is detailed in the directors' report.

Figure 2 Council members and CEO, annual general meeting, Melbourne, November 2009

Committees

AMC committees and working parties provide expert advice to the directors and the council. Each committee is responsible for advising on matters under its specific area of operations. The AMC works closely with health consumers and values community input into its processes. In 2009, this collaboration was reflected in the representation of community members and health consumers on the council and on most AMC committees.

Table 1 lists the committees and their functions. A list of the members of each committee is at Appendix B.

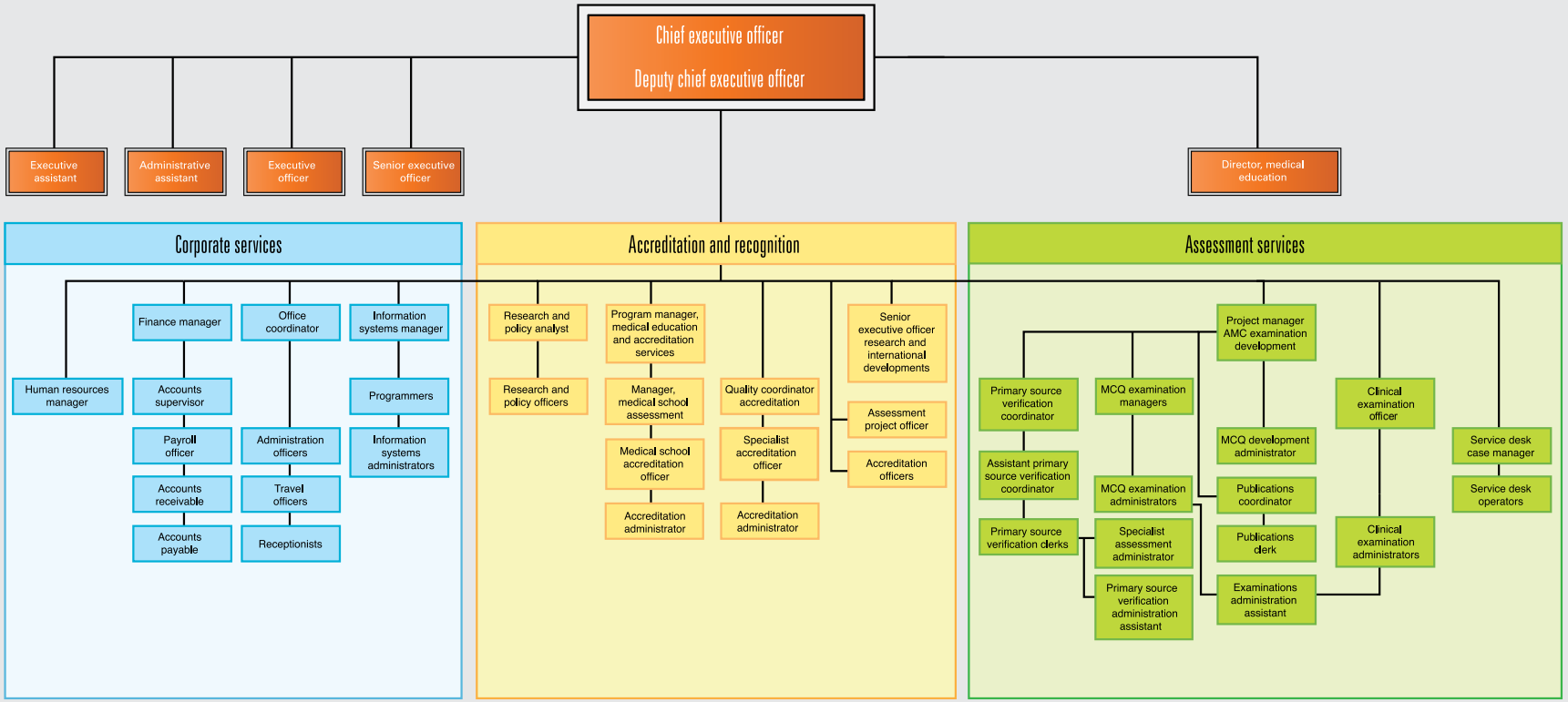
Table 1 Committees and their functions

Committee	Function
Medical School Accreditation Committee	Manages the AMC process for assessment and accreditation of the medical programs of Australian and New Zealand university medical schools
Specialist Education Accreditation Committee	Manages the AMC process for assessment and accreditation of specialist medical education, training and professional development programs in Australia
Recognition of Medical Specialties Advisory Committee	Advises the directors on recognition of fields of medical practice as medical specialties, enabling the AMC to provide this advice to the Australian Government Minister for Health and Ageing
Board of Examiners	Oversees the AMC examination process and advises the directors on international medical graduate assessment issues
Joint Medical Boards Advisory Committee	Addresses issues of national relevance and develops uniform national standards for medical regulation
Strategic Policy Advisory Committee	Provides high-level advice to the AMC on medical education and health system policy matters

Organisation structure

The council and its directors are supported by a secretariat of 80 staff, based in Canberra, responsible for the administration of AMC operations. The AMC organisation structure is set out in Figure 2. A list of employees is at Appendix C.

Figure 3 Organisation structure, 31 December 2009



Operations overview

The AMC reviews and accredits medical courses and specialist training programs that meet the AMC standards of medical education and training and conducts nationally consistent assessments of international medical graduates (IMGs). It gives advice and makes recommendations on the registration of medical practitioners, the recognition of the overseas qualifications of medical practitioners and the recognition of medical specialties.

Accreditation of medical schools and specialist medical training programs

In a peer review process, AMC expert assessors assess medical programs provided by both universities and specialist medical colleges against AMC standards that define the knowledge, skills and professional attributes expected at the end of basic medical training and specialist medical training and, in broad terms, how the universities and colleges should deliver education and training.

Graduates of medical school courses accredited by the AMC are recognised as being competent to practise safely and effectively under supervision as interns in Australia and New Zealand; following completion of an internship, they are eligible to apply for unconditional medical registration in Australia.

The Medical School Accreditation Committee and the Specialist Education Accreditation Committee are responsible for setting the AMC's policy and accreditation standards, which are benchmarked against international standards for medical education. The AMC regularly reviews its own accreditation standards and processes by:

- considering feedback from AMC expert teams and institutions undergoing accreditation
- considering reports by AMC team chairs
- considering government policy and health services developments that affect clinical training and medical education
- periodically establishing working parties to review standards and procedures, informed by extensive stakeholder consultation
- networking with regional, national and international medical education standard-setting and accreditation agencies
- considering national and international standards for good practice in accreditation.

Assessment of international medical graduates

The AMC administers three pathways for IMGs seeking registration with state and territory medical boards to practise in Australia.

Competent Authority Pathway. IMGs applying for non-specialist positions who have completed training and assessment through AMC-designated and approved competent authorities are eligible to apply for advanced standing towards the AMC Certificate. If granted advanced standing, they are not required to sit the AMC MCQ Examination or the AMC Clinical Examination, but are required to undertake a workplace-based assessment while working under supervision.

Standard Pathway. IMGs applying for non-specialist positions who are not eligible for registration under the Competent Authority Pathway can apply through the Standard Pathway. They must sit for both the AMC MCQ Examination and the AMC Clinical Examination. A workplace-based alternative to the Standard Pathway is being developed; it will test the performance of IMGs in a real clinical environment. The AMC, as part of the Council of Australian Governments (COAG) IMG assessment initiative, has been working with the states and territories to roll out this assessment pathway, the Standard Pathway (Workplace-based assessment).

Specialist Pathway. Overseas-trained specialists seeking to register in Australia to practise in their specialty may apply for assessment by the relevant specialist medical college for registration limited to the field of specialty. They are assessed by the relevant medical specialist college against either the criteria for an Australian-trained specialist in the same field or the position description for a specific area of need position.

The specialist medical colleges set the standards of specialist medical training and practice in Australia. The AMC administers a national process, in conjunction with the specialist medical colleges, through which specialists trained overseas may have their specialist qualifications assessed by the relevant specialist college without having to pass the AMC examinations.

Statistical and other information on the assessment of IMGs applying under the available pathways is in section 4.

Recognition of medical specialties

The AMC advises the Australian Government Minister for Health and Ageing on the recognition of fields of medical practice as medical specialties. Recognition acknowledges:

- areas of medical practice that are developing in response to a need for specialist medical expertise and that will contribute to improved standards of health care
- medical specialties based on sound clinical and scientific principles
- medical specialties that have a group of practitioners able to define, promote and maintain standards of medical practice that lead to high-quality health care
- specialist skills and knowledge gained through training and professional development programs.

The AMC develops policy on recognition and the process for assessing the case for recognition, selects review groups for each assessment, considers assessment reports, and decides on the confidential advice to the minister on the case for recognition of each assessed application. The minister then decides if a new specialty will be recognised. AMC guidelines, developed through a consultative process, define the information and evidence that applicants must provide to make the case for recognition.

Information on the medical specialties recognised or assessed in 2009 is in section 4.

3 Support for Stakeholders

In 2009, the AMC continued to collaborate with and support its stakeholders, including government bodies, health profession and health consumer organisations, medical education providers and state and territory medical boards. It also prepared for a new collaboration with the newly formed Medical Board of Australia.

Some of its many stakeholder support activities in 2009 are outlined below. They included:

- preparing submissions on the National Registration and Accreditation Scheme (NRAS) and on reform of the health workforce
- giving secretariat support to the Forum of Australian Health Professions Councils
- taking part in and sponsoring a medical education conference hosted by Medical Deans Australia and New Zealand
- hosting a competency-based training workshop
- releasing a nationally consistent code of professional conduct for doctors practising in Australia.

Medical boards

To practise medicine in Australia, doctors must be registered with a state or territory medical board. Each state and territory has its own legislation for regulating registration, and registration regimes vary between the states and territories. Through the Joint Medical Boards Advisory Committee (JMBAC), the AMC advises the boards on uniform approaches to the registration of medical practitioners and, at their request, researches approaches to streamline interactions between boards. The JMBAC is a vehicle to discuss uniform policies and develop national position papers.

Registration of medical practitioners

Through the JMBAC, the AMC continued to support medical boards in the implementation of nationally consistent assessment through the COAG IMG Technical Committee.

In 2009, state and territory medical boards considered options for improving the understanding of the COAG IMG assessment pathways for IMGs applying for assessment through the AMC.

The JMBAC also supported medical boards in the implementation of uniform approaches to prerequisites for medical registration in Australia: English language proficiency, verification of

documentation of primary medical qualifications and proof of identification. As a result of this work, the AMC made demonstrated evidence of English language proficiency a prerequisite for sitting AMC examinations for IMGs applying under the Specialist Pathway.

National Registration and Accreditation Scheme

In 2009, the AMC, through the JMBAC, supported the state and territory medical boards in the lead-up to the implementation of the NRAS in July 2010, focusing on the transfer of registration functions from the state and territory medical boards to the Medical Board of Australia.

The Joint Medical Boards Advisory Committee Registers Sub-group met with the director of the NRAS Implementation Project to discuss the exposure draft of the Health Practitioner Regulation National Law and made a joint submission on the proposed law, specifically addressing the complaints, performance and health provisions within the bill and the transitional provisions concerning complaints.

During 2009, the AMC also made submissions to the Senate Community Affairs Committee Inquiry into the National Registration and Accreditation Scheme for Doctors and Other Health Workers, addressing:

- the strategic considerations for implementation of the new scheme, including the need to retain the expertise of staff in the existing medical boards
- the need to continue to foster a culture of innovation and continuous quality improvement in medical education and training under the scheme
- the need to retain the elements of strength of the current system, such as the high level of professional commitment and the active involvement of health consumers, trainees and allied health professions in AMC accreditation processes.

The AMC will continue to support the development of the NRAS and the work of the new national Medical Board of Australia.

National Registration and Accreditation Scheme: background

After considering a 2005 Productivity Commission report on Australia's health workforce, in July 2006 the Council of Australian Governments (COAG) announced its intention to establish a national registration scheme for the health professions currently regulated by existing jurisdictions, a national accreditation scheme for all health education and training, and a national process for the assessment of all international medical graduates.

By its April 2007 meeting, COAG had modified its proposal: instead of separate schemes for registration and accreditation, there would be one scheme, with separate national boards for each profession and the possibility of accreditation functions being delegated to an existing accrediting body.

In March 2008, COAG decided to establish a single national registration and accreditation scheme for health professions, for introduction on 1 July 2010. The accreditation function for the first three years of the National Registration and Accreditation Scheme was delegated to the AMC.

Code of conduct for doctors in Australia

In August 2009, the AMC published *Good Medical Practice: A Code of Conduct for Doctors in Australia*, which sets out the principles that characterise good medical practice and the standards and ethical practices expected of doctors by their peers and the community. Development of the code, undertaken by the AMC on behalf of the state and territory medical boards, gained impetus with the signing of the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions in 2008, in preparation for the establishment of the Medical Board of Australia and the implementation of the National Registration and Accreditation Scheme in 2010. The process of national consultation that the AMC undertook in developing the code exemplifies its approach to engaging its stakeholders at all levels of activity. That process is described in the box 'National consultation on a code of conduct for doctors in Australia'.

National consultation on a code of conduct for doctors in Australia

In mid-2007, the AMC formed the Code of Professional Conduct Working Group, chaired by former AMC President Dr Joanna Flynn, to lead the development of a nationally consistent code of professional conduct for doctors in Australia. The group included representatives from the clinical sector, junior doctors, medical regulators, educators, administrators, consumers, community groups and the Australian Medical Association (AMA).

To ensure that the medical profession, medical regulators and the broader Australian community accepted the code and recognised its legitimacy, the AMC involved stakeholders in its formulation.

With funding provided by the Australian Government, the AMC managed a broad, inclusive, multidimensional national consultation process with consumers, the community and the medical profession. The process included forming an alliance with the Consumers Health Forum of Australia (CHF) to ensure wide consultation with consumers as well as the community. Both the AMC and the CHF believe this partnership in the consultation process of the development of the code ensured effective consumer input and improved the quality of consumer and community consultation.

The first draft of the code received considerable publicity, particularly in the medical press. To promote maximum participation in the consultation process, the AMC used a range of media and public relations opportunities, including paid advertisements, media releases, and a series of articles and interviews in the medical press. The federal AMA and the CHF also included several articles in their national publications.

The level of engagement in the consultation process was high: many people attended public and targeted discussions, completed the online survey or made written submissions. While there was considerable consistency in the feedback on the draft, new insights were presented on many issues. The feedback showed strong support for the code, an appreciation of the consultation process and confirmation that the scope of the content was correct. However, it became clear that a second draft was needed to address specific issues raised throughout the consultation process, including concerns about the code's tone.

The second draft of the code, which resolved many of the concerns raised previously, was released for a further round of consultations in April 2009.

The AMC directors endorsed the code, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, and recommended it to state and territory medical boards for their endorsement or adoption, pending the establishment of the Medical Board of Australia and the commencement of the National Registration and Accreditation Scheme in July 2010.

The code, available in hard copy and on the dedicated website www.goodmedicalpractice.org.au, has been widely distributed.

National Compendium of Medical Registers

The AMC has a contractual obligation under its funding agreement with the Commonwealth to maintain the National Compendium of Medical Registers. Although state and territory medical boards have not relied on the compendium, the AMC has undertaken a major upgrade of the system in anticipation that it may be used to assist the migration of registration data to the new national register when it is established.

Forum of Australian Health Professions Councils

In 2009, the AMC continued to provide secretariat support to the Forum of Australian Health Professions Councils, in addition to contributing to discussion and debate and the development of submissions made by the forum in the lead-up to the implementation of the NRAS.

The forum is a coalition of the councils of a number of the regulated professions, particularly the accreditation councils of each of the 10 professions to be covered by the NRAS:

- Australian Dental Council
- Australian Medical Council
- Australian Nursing and Midwifery Council
- Australian Osteopathic Council
- Australian Pharmacy Council
- Australian Physiotherapy Council
- Australian Psychology Accreditation Council
- Australian and New Zealand Podiatry Accreditation Council
- Council on Chiropractic Education Australasia
- Optometry Council of Australia and New Zealand.

In 2009, the forum provided a point of consultation across the professions for the NRAS Implementation Project. It met on several occasions with the NRAS project implementation team and served as a reference group on accreditation matters for the team. In addition, it had

representatives on both the NRAS Registration Reference Group and the NRAS Professions Reference Group.

The forum made several submissions in response to the consultation papers, concentrating on issues common to all the professions in accreditation matters.

The AMC values its involvement with the forum, which is mutually beneficial.

Health workforce

Following COAG's decision to introduce a health workforce reform package, the National Health Workforce Taskforce was created to develop strategies that meet the National Health Workforce Strategic Framework outcomes, encompassing education and training, innovation and reform, planning, research and data.

In 2009, the AMC was active in the consultation process of the reform, and made formal submissions on education and training to the taskforce. Specifically, the submissions addressed:

- clinical placements
- the governance and organisation of clinical training in Australia.

The AMC also made a submission to the Senate Community Affairs Legislation Committee's inquiry into the provisions of the Health Workforce Australia Bill 2009. The submission focused on concerns about:

- the broad scope of the proposed functions and powers of the new authority, Health Workforce Australia
- the lack of transitional provisions for the change from the National Health Workforce Taskforce to Health Workforce Australia
- the limited stakeholder consultations on the establishment and governance arrangements of Health Workforce Australia and the lack of a mechanism for engagement with the range of stakeholders whose roles relate directly to the work of the new authority.

The AMC met with members of the National Health Workforce Taskforce to discuss the reform package and the new authority, Health Workforce Australia. The AMC will seek opportunities for collaboration with the new body on issues of common interest.

Medical education conferences

The two-yearly medical education (MedEd) conferences hosted by Medical Deans Australia and New Zealand provide a forum for debate on the future of medical education and training. In 2009, the AMC continued its support for the conferences, participating in, and sponsoring, MedEd09, 'Investing in our Medical Workforce'. The conference drew together the key stakeholders in medical education and focused on three areas of importance in Australia's medical workforce:

- increasing health workforce flexibility
- achieving vertical integration
- building training capacity.

Following MedEd09 and the completion of the final report, Medical Deans Australia and New Zealand established the MedEd09 Implementation Group. The key task of the group will be to facilitate action, where appropriate, to progress the 17 recommendations that came out of the conference. The group will comprise representatives of the key stakeholders in medical education, including:

- Medical Deans Australia and New Zealand
- Confederation of Postgraduate Medical Education Councils
- Committee of Presidents of Medical Colleges
- Australian Government Department of Health and Ageing
- Australian Medical Students' Association
- Australian Medical Council
- Australian Medical Association Council of Doctors-in-Training and junior medical officers
- Australian Indigenous Doctors Association.

As the accreditation body for medical education, the AMC values its association with the MedEd conferences.

Competency-based training workshop

In April 2009, the AMC hosted a workshop on competency-based training to extend its understanding of competency-based training models and to identify areas for improvement in AMC accreditation standards. The workshop drew on the work of the Strategic Policy Advisory Committee on competency-based training and involved a range of stakeholders, including medical schools, specialist colleges, medical boards, professional associations and government health departments.

Health consumers

In 2009, the AMC continued its now well-established relationship with health consumer organisations to ensure effective community input into all the AMC processes and health consumer representation on most committees, including the council. The input of health consumers to the development of *Good Medical Practice: A Code of Conduct for Doctors in Australia,* and the role of the Health Consumers' Forum of Australia in supporting this input is particularly acknowledged.

4 Report on operations

This report on the AMC's operations in 2009 covers:

- accreditation of university medical school courses and training programs
- accreditation of specialist education providers and programs
- international accreditation activities
- assessment of IMGs
- the recognition of medical specialties.

Accreditation of medical school courses and training programs

The Medical School Accreditation Committee is responsible for managing the AMC's program of assessment and accreditation of medical education programs provided by university-based medical schools in Australia and New Zealand. The committee is responsible for:

- developing guidelines, policy and procedures for the accreditation of medical schools and medical courses
- overseeing the AMC's program of accreditation
- seeking to encourage improvement in medical education in response to evolving health needs and practices, and educational and scientific developments.

Assessments

In 2009, the AMC completed seven assessments of medical school programs in accordance with its guidelines on the assessment and accreditation of medical schools: six were follow-up assessments undertaken to review the school's progress in implementing its medical program and one was a comprehensive report assessment. The assessments resulted in confirmation of accreditation for four schools and an extension of accreditation for three schools (Table 2).

Table 2 Medical school programs, reviews completed, 2009

Medical school program	Type of assessment	Purpose of assessment	Result	Reporting condition
Bond University Five-year program MBBS	Follow-up	To consider the school's progress in implementing the curriculum and in addressing the critical issues raised in the 2008 assessment	Accreditation extended to December 2011	Annual
Deakin University Four-year program MBBS	Follow-up	To review the implementation of the first year of the course and detailed plans for later years	Accreditation to December 2013 confirmed	Annual
Griffith University Four-year program MBBS	Comprehensive report	To consider extending accreditation based on the school's comprehensive report	Accreditation extended to December 2014	Periodic
Monash University Gippsland campus Four-year program MBBS	Follow-up	To review implementation of the graduate stream at the Gippsland medical school	Accreditation to December 2013 confirmed	Annual
University of Notre Dame, Fremantle Four-year program MBBS	Follow-up	To consider the school's response to concerns identified in the 2007 AMC assessment	Accreditation extended to December 2013	Annual

Table continues

University of Newcastle and the University of New England Joint Medical Program Five-year program BMed	Follow-up	To review implementation of the medical program provided jointly by the universities	Accreditation to December 2014 confirmed	Annual
University of Notre Dame, Sydney Four-year program MBBS	Follow-up	To review implementation of the first year of the course and detailed plans for later years	Accreditation to December 2013 confirmed	Annual

BMed = Bachelor of Medicine

MBBS = Bachelor of Medicine and Bachelor of Surgery

Major change assessments

The AMC conducts accreditation assessments of proposed major changes to accredited medical courses. The assessment process has two stages:

- *Stage 1*. The AMC considers a submission by the accredited medical school which addresses the capacity to implement the change to the medical course and AMC accreditation standards. The Medical School Accreditation Committee advises the AMC directors on whether the university is ready to proceed to Stage 2.
- *Stage 2*. An AMC team conducts an accreditation assessment of the school, and considers the curriculum for the full course and details of the financial, physical and staff resources available to design and implement all years of the proposed course.

In 2009, the AMC considered Stage 1 submissions from the schools of medicine at the University of Melbourne, the University of Queensland and Flinders University.

- *University of Melbourne*. The submission proposed the implementation of Australia's first master's medical course leading to the award of a Doctor of Medicine (MD), following changes across the university to move to postgraduate degrees for professional qualifications. The AMC accepted the submission and gave approval for the school to move to Stage 2.
- *University of Queensland*. The submission proposed a number of changes, including a substantially expanded student intake, offering the first two years of the University's four-year program at its Ipswich campus, and the introduction of an offshore clinical school, involving up to 120 University of Queensland students (who are US citizens) having the opportunity to do the bulk of their clinical training with the Ochsner Health Facility in New Orleans once they have completed the first two years of their medical course in Australia. The AMC accepted the submission and agreed to the university proceeding to Stage 2.

- *Flinders University*. Flinders University School of Medicine presented a comprehensive report to the Medical School Accreditation Committee in 2009 proposing a major change to the accredited program. The major change proposed was to offer all years of the Flinders course in the Northern Territory and to provide for a school leaver intake in the program. The AMC agreed to accept the report as meeting the requirements of a Stage 1 submission for major change and invited the medical school to proceed to Stage 2.

Progress reports

Between formal accreditations, the AMC monitors progress in the accredited medical schools through progress reports.

Medical schools are required to provide the AMC with reports informing the AMC of changes in their programs and emerging issues that may affect their ability to deliver their medical curriculum and responding to issues raised in AMC accreditation reports.

Medical schools granted the full period of accreditation submit written reports to the AMC two, five and seven years after the school's assessment by the AMC. Medical schools granted accreditation of major structural changes and new medical schools submit annual reports.

In the year before accreditation expires, medical schools are asked to submit a comprehensive report enabling the Medical School Accreditation Committee to decide whether future accreditation should be given to the school. Reports are reviewed by an external reviewer.

In 2009, the AMC considered reports from the medical schools of 11 universities:

- The Australian National University
- Bond University
- Flinders University (comprehensive report)
- Griffith University (comprehensive report)
- James Cook University
- The University of Melbourne
- Monash University
- The University of New South Wales
- University of Tasmania
- University of Wollongong
- University of Western Sydney.

The AMC accepted all the reports, and advised the schools of the specific issues that they will need to address in their future reports.

Accreditation of specialist education providers and programs

The AMC accredits Australian providers of specialist medical training and their programs. Most of the accredited training organisations, the specialist medical colleges, operate training programs in Australia and New Zealand. The AMC collaborates with the Medical Council of New Zealand in the assessment of bi-national programs. All colleges voluntarily undergo AMC review to ensure quality assurance and improvement. The Specialist Education Accreditation Committee oversees their assessment and accreditation. The committee is responsible for:

- developing guidelines, policy and procedures for the accreditation of specialist medical education and training programs
- overseeing the AMC's program of accreditation
- encouraging improvements in postgraduate medical education that respond to evolving health needs and practices, and educational and scientific developments.

In 2009, Associate Professor Jill Sewell AM was appointed Chair of the committee, succeeding Professor Richard Smallwood AO.

> *We are delighted to have a person of Professor Sewell's integrity, calibre and experience in the operations of the AMC.*
>
> *AMC President Richard Smallwood, August 2009*

Reviews and assessments

In 2009, the AMC completed three accreditation reviews of specialist medical training providers and one assessment of plans to establish an independent specialist college in 2009 in accordance with the AMC's guidelines on the accreditation of specialist medical education and training and professional development programs.

- *Royal Australian and New Zealand College of Psychiatrists*. The AMC reviewed the college's progress in relation to the recommendations of the 2005 AMC accreditation report. The AMC extended the college's accreditation to December 2011, subject to satisfactory annual reports to the AMC addressing recommendations in the accreditation report.
- *Royal Australian and New Zealand College of Radiologists*. The AMC conducted a re-accreditation review of the college in 2009. The AMC confirmed accreditation of the college's radiology and radiation oncology education, training and continuing professional development programs to December 2014, subject to conditions outlined in the accreditation report.
- *Royal Australasian College of Dental Surgeons*. The AMC, in conjunction with the Australian Dental Council, conducted a joint review of the college's oral and maxillofacial education and training programs. The AMC granted accreditation to December 2012, subject to satisfactory annual reports.

- *College of Intensive Care Medicine of Australia and New Zealand.* After assessing plans by the Joint Faculty of Intensive Care Medicine to establish a standalone specialist college, the AMC granted initial accreditation of the college's programs from 1 January 2010, subject to satisfactory annual reports and a full assessment of the college's training programs within 12 to 18 months.

Accreditation extensions

The AMC extended to December 2013 the accreditation of education and training leading to fellowship of the Royal Australian College of General Practitioners and of the quality assurance and continuing professional development programs of the Royal Australian College of General Practitioners, subject to the provision of satisfactory annual reports to the AMC.

Progress reports

The AMC monitors developments in education and training and professional development programs through periodic and annual reports from AMC-accredited training organisations to ensure that the AMC remains informed of responses to issues raised in the accreditation report, new developments, and issues that may affect a training organisation's accreditation.

Reports are normally required annually, and usually exclude the year in which a training organisation is preparing for assessment.

In 2009, the AMC considered the annual reports from nine colleges:

- Australasian College for Emergency Medicine
- Royal Australian and New Zealand College of Ophthalmologists
- Royal College of Pathologists of Australasia
- Australasian College of Sports Physicians
- Australian and New Zealand College of Anaesthetists
- Royal Australasian College of Medical Administrators
- Royal Australasian College of Physicians
- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

The AMC accepted all annual reports, and advised colleges of the specific issues that they will need to address in their 2010 reports.

International accreditation activities

In 2009, the AMC collaborated with bodies from New Zealand and China, as well as with the World Federation for Medical Education.

Medical Council of New Zealand

In assessing and accrediting Australian and New Zealand medical schools and specialist training programs, the AMC works with the Medical Council of New Zealand. In 2009, work continued on producing a memorandum of understanding between the two councils, identifying areas for closer cooperation.

People's Republic of China

> *The AMC worked with medical accreditation authorities in the People's Republic of China to help develop and strengthen China's emerging accreditation processes and share the AMC's experience and expertise in this area.*
>
> *AMC President Richard Smallwood, November 2009*

In 2009, the AMC continued to support the development of medical school accreditation in the People's Republic of China. AMC assessors contributed to a workshop with the Association of Medical Universities and Colleges of China in Beijing; took a leading role in a pilot accreditation visit to a Chinese university medical college; and trained Australian speakers of Chinese as accreditation assessors for future accreditation visits to Chinese medical schools.

Delegates from more than 50 of China's leading medical schools attended the Beijing workshop, which was aimed at developing China's platform for medical school accreditation following the success of the pilot accreditation programs supported by the AMC in 2008. The workshop resulted in the planning of a future series of pilot accreditation visits to Chinese medical schools.

To further the aims of its collaboration with Chinese medical schools, the AMC has trained Australian speakers of Chinese as accreditation assessors. As part of their training, in September 2009 they attended a workshop in Sydney on the accreditation of medical schools in China. The pilot accreditation visit to Shantou University Medical College in November 2009 was the first to include a Chinese-speaking AMC-trained assessor. The participation of such assessors in future accreditation assessment visits to China will contribute to advancing the standing of Australian medical education and accreditation processes in that country.

World Federation for Medical Education

The AMC has contributed to the work towards a new world directory of medical schools to replace the former World Health Organisation directory. It also contributed to the 2009 Symposium, Global Imperatives in Medical Education, held in association with the 2009 Association for Medical Education in Europe Conference.

Assessment of international medical graduates

The AMC is responsible for the assessment of IMGs wishing to register with state and territory medical boards. The AMC assesses IMGs through one of three assessment pathways—the competent authority, standard and specialist pathways, as described in section 2. All three pathways involve initial verification of the primary qualifications of IMGs.

Primary source verification

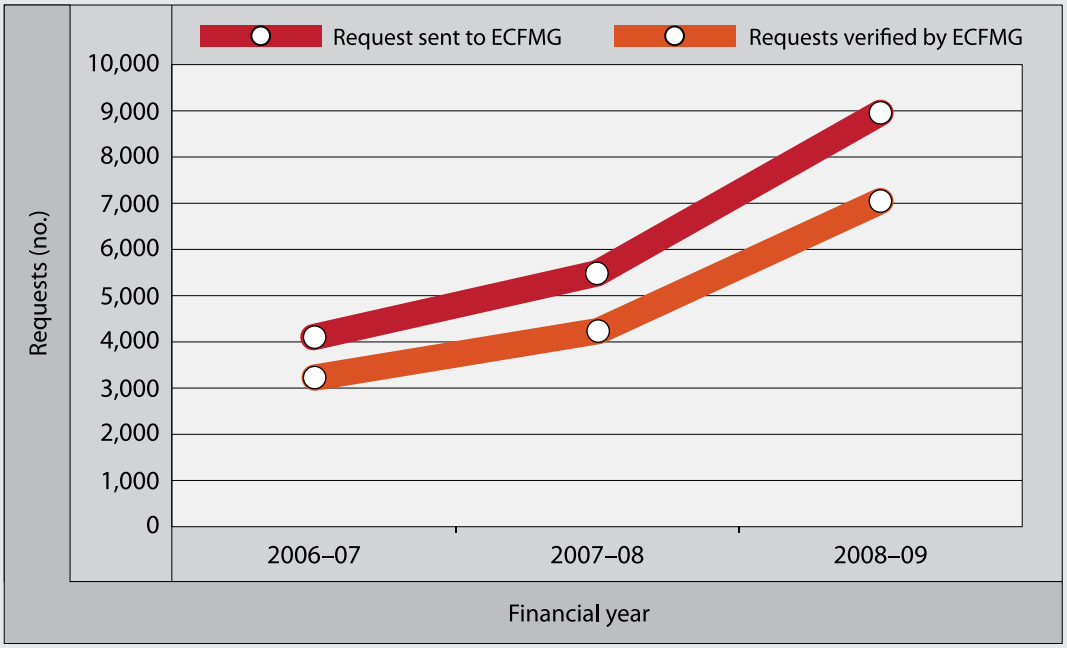
The AMC verifies the primary qualifications of IMGs by submitting their primary medical qualifications to the International Credentials Services (EICS) of the Educational Commission for Foreign Medical Graduates (ECFMG) for verification. In 2009, the ECFMG verified 5,083 (71 per cent) of the 7,146 requests that the AMC sent to it (Table 3).

Table 3 Primary source verification statistics, 2009

Pathway	Total requests	Total requests verified	
		Number	Proportion (%)
Medical board registration only	882	616	69.8
Area of need specialist	169	116	68.6
Competent authority	1,437	1,308	91.0
Non-specialist	3,671	2,514	68.5
Specialist	648	355	54.8
Dual (Non-specialist and specialist)	339	174	51.3
Total	7,146	5,083	71.1

Figure 4 shows the growing trend in the number of verification requests since 2006–07.

Figure 4 Primary source verification requests, 2006–07 to 2008–09



At the end of 2008, the AMC established a web portal to streamline verification requests and enable state and territory medical boards to track candidates' verification status online. The medical boards can view a candidate's verification status, as well as their primary medical qualifications and EICS certificate, effectively saving them time and reducing paperwork.

After receiving positive feedback from the medical boards, at the end of 2009 the AMC decided to include on the portal the reports it receives from specialist medical colleges on the outcomes of their assessments of overseas-trained specialists.

Competent Authority Pathway

The AMC offers an assessment pathway for IMGs from designated 'competent authority' countries (Table 4). Competent authority countries have medical licensing examinations and assessment pathways comparable to those that the AMC conducts for non-specialist candidates. IMGs in the Competent Authority Pathway are not required to complete the AMC MCQ or clinical examinations; however, they must complete an accredited performance assessment in an Australian clinical setting before general registration can be granted. IMGs from competent authority countries are able to apply for advanced standing for the AMC Certificate, enabling them to apply for limited registration to complete the required performance assessment.

Table 4 Designated competent authority countries

Country	Authority	Qualification/Award/Assessment	Effective date
United Kingdom	General Medical Council of the United Kingdom (GMC)	1. Professional and Linguistic Assessments Board (PLAB) Test plus 12 months supervised training in a competent authority (CA) country approved by the GMC OR Foundation Year 1	Post-1975
		2. Graduates of Medical Schools in the United Kingdom accredited by the General Medical Council PLUS 12 months supervised training in a CA country approved by the GMC or Foundation Year 1	No date limit
Canada	Medical Council of Canada (MCC)	Licentiate of the Medical Council of Canada (LMCC) (includes the period of residency completed between the Part 1 LMCC and the Part 2 LMCC)	No date limit
United States of America	Education Commission for Foreign Medical Graduates (ECFMG)	United States Medical Licensing Examination Step 1, Step 2 and Step 3 (USMLE 1, 2 & 3) PLUS Minimum two years of Graduate Medical Education (GME) within a residency program accredited by the Accreditation Council of Graduate Medical Education (ACGME)	Post-1992
New Zealand	Medical Council of New Zealand (MCNZ)	New Zealand Registration Examination (NZREX) PLUS Evidence of satisfactory completion of rotating internship (four runs accredited by the MCNZ)*	No date limit

Table continues

Country	Authority	Qualification/Award/Assessment	Effective date
Ireland	Medical Council of Ireland (MCI)	Graduates of medical schools in Ireland accredited by the Medical Council of Ireland PLUS Evidence of completion of an internship in Ireland (certificate of experience) or in a CA country approved by the Medical Council of Ireland	2003

* The Competent Authority Pathway is not applicable to graduates of AMC-accredited New Zealand medical schools who have completed an approved period of intern training.

In 2009, the AMC processed 1,626 Competent Authority Pathway applications; granted advanced standing towards the AMC Certificate to1,325 applicants, an increase of 64.5 per cent on the number granted in 2008; and issued certificates to 853 applicants. Holders of AMC certificates can apply for general registration with Australian medical boards.

Table D1 in Appendix D shows the number of applications for competent authority assessment, by country of training; it also shows the number granted advanced standing or issued with AMC certificates.

Standard Pathway

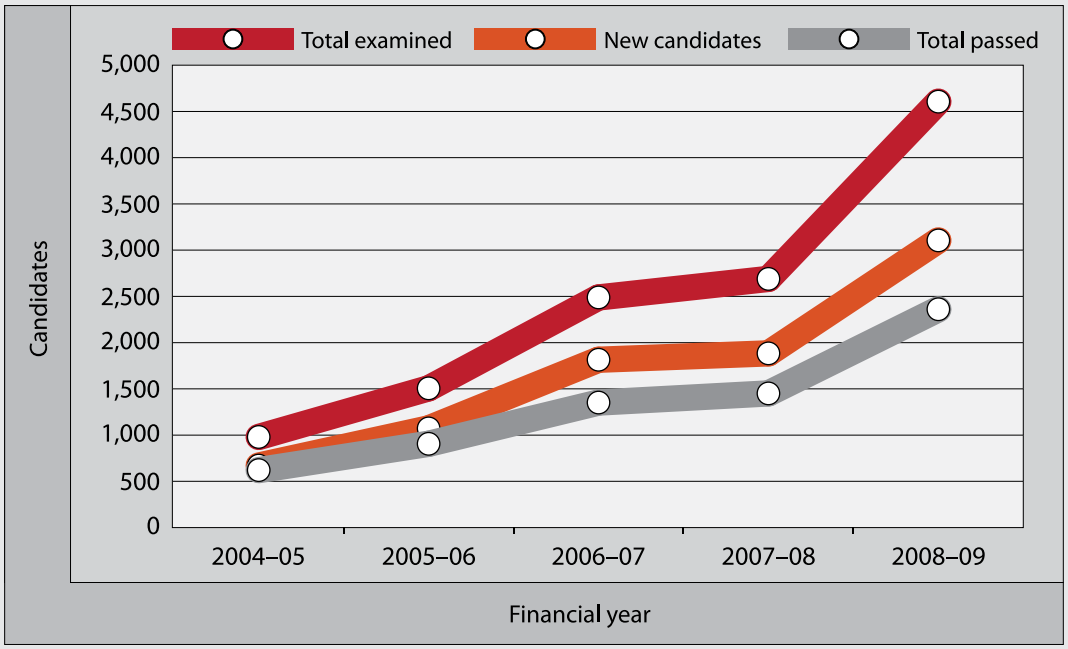
The AMC assesses the medical knowledge and clinical skills of IMGs applying for registration through the Standard Pathway by conducting examinations: the AMC MCQ Examination and the AMC Clinical Examination.

AMC MCQ Examination

The MCQ examination tests candidates' basic or essential core medical knowledge and its clinical applications. It is a computer-administered test in the form of multiple-choice questions. The examination includes questions from internal medicine, paediatrics, obstetrics and gynaecology, psychiatry and surgery, as well as general practice.

The demand for MCQ examination places has grown every year since 2004–05. In the 2008–09 financial year, the number of candidates examined (4,646) increased by 72.4 per cent compared with the number examined in the 2007–08 financial year (2,695). The MCQ examination pass rates in the past five financial years have fluctuated between a high of 63.4 per cent in 2004–05 and a low of 50.9 per cent in 2008–09.

Figure 5 AMC MCQ Examination, passes, 2004–05 to 2008–09



In calendar year 2009, the AMC conducted the MCQ examination at onshore and offshore secure locations for 4,851 candidates, 62.6 per cent of whom were presenting for the first time. Of the 4,851 candidates examined in 2009, 2,460 (50.7 per cent) passed the examination. Of those who passed, 67.4 per cent were sitting the examination for the first time. This continues the trend seen in previous years (Figure 5).

Table D2 in Appendix D gives a breakdown of the number of MCQ examination candidates by country of training, number of attempts and number passed in 2009.

Offshore examinations

The AMC has administered computer-based MCQ examinations in venues outside Australia since November 2006 as part of a joint project with the Medical Council of Canada. The provider of the computer-based tests in 2009 was Pearson VUE, an international education and information company.

In 2009, Pearson VUE delivered11 MCQ offshore examinations through 21 test centres in 15 countries (Table 5). The most popular venues are in India, the Philippines, Singapore, Thailand, Turkey and the United Kingdom. The AMC is negotiating with Pearson VUE to provide centres in Dubai and Cairo to satisfy demand from potential candidates in the United Arab Emirates and Egypt.

Table 5 Offshore test centres, AMC MCQ Examination, 2009

Country	City
China	Beijing
	Guangzhou
	Shanghai
France	Paris
Germany	Frankfurt
Greece	Athens
Hong Kong	Hong Kong
India	Bangalore
	Chennai
	Hyderabad
	Mumbai
	New Delhi
Israel	Tel Aviv
Korea	Seoul
Philippines	Manila
Singapore	Singapore
Spain	Madrid
Taiwan	Taipei
Thailand	Bangkok
Turkey	Istanbul
United Kingdom	London

MCQ item-writing workshops

Since 2004, the AMC has conducted MCQ item-writing workshops for members of the MCQ Panel of Examiners as part of the development of AMC computer-based testing. The workshops are held over two days four times a year. Each member of the panel is requested to nominate additional participants to be invited to the workshop, with the nominee expected

to be a person involved in the development of the MCQ items in the member's university or college, or a colleague interested in developing skills in writing MCQ items. Table 6 gives details of the MCQ writing workshops held in 2009.

Table 6 MCQ item-writing workshops, 2009

Workshop series	Date	Participants	MCQ items
16th workshop—review	28–29 March	47	0*
17th workshop—review and production	13–14 June	36	424
18th workshop—review and production	15–16 August	33	349
19th workshop—review and production	17–18 October	42	399

* No MCQ items were produced at this workshop, because it was a review only workshop.

Before June 2009, the AMC alternated between two different workshop types: review and production. In review workshops, participants reviewed questions created at previous workshops or in need of editing; in production workshops, they created new questions.

Since June 2009, workshops have incorporated both review and production functions. A small group of participants within a discipline review the questions created in the last workshop, while others create new questions. The focus is on producing quality items that are representative of the blueprint for AMC examinations.

AMC Clinical Examination

The AMC Clinical Examination, a 16-station assessment conducted in hospitals across Australia, evaluates candidates' clinical competence and performance in terms of medical knowledge and clinical skills in medicine, surgery, paediatrics, obstetrics and gynaecology; and psychiatry. All stations are designed to be similar to common clinical events seen in general medical practice. Main clinical examination candidates do the full 16-station examination; those being retested (to confirm borderline results in the main examination) do an eight-station examination.

In calendar year 2009, the AMC conducted 19 main clinical examination sessions for 1,261 candidates and four retest examination sessions for 216 candidates. To accommodate the increasing number of candidates undertaking the clinical examination, in 2009 the AMC conducted simultaneous examination sessions in multiple cities. The sessions were conducted in New South Wales, Queensland, South Australia, Victoria and Western Australia.

A total of 760 candidates (60.3 per cent) passed the 2009 clinical examination and qualified for the AMC Certificate, entitling them to general medical registration in Australia. Of the 216 candidates attempting the retest examinations, 126 (58.3 per cent) passed.

Figure 6 shows the number of candidates who attempted and passed the clinical examination over the past five financial years, 2004–05 to 2008–09. Although the number who passed in 2008–09 (714) was approximately the same as in 2007–08 (711), the proportion relative to the total number attempting the examination in those years was lower, falling from 66.4 per cent in 2007–08 to 59.8 per cent in 2008–09.

Figure 6 AMC Clinical Examination, passes, 2004–05 to 2008–09

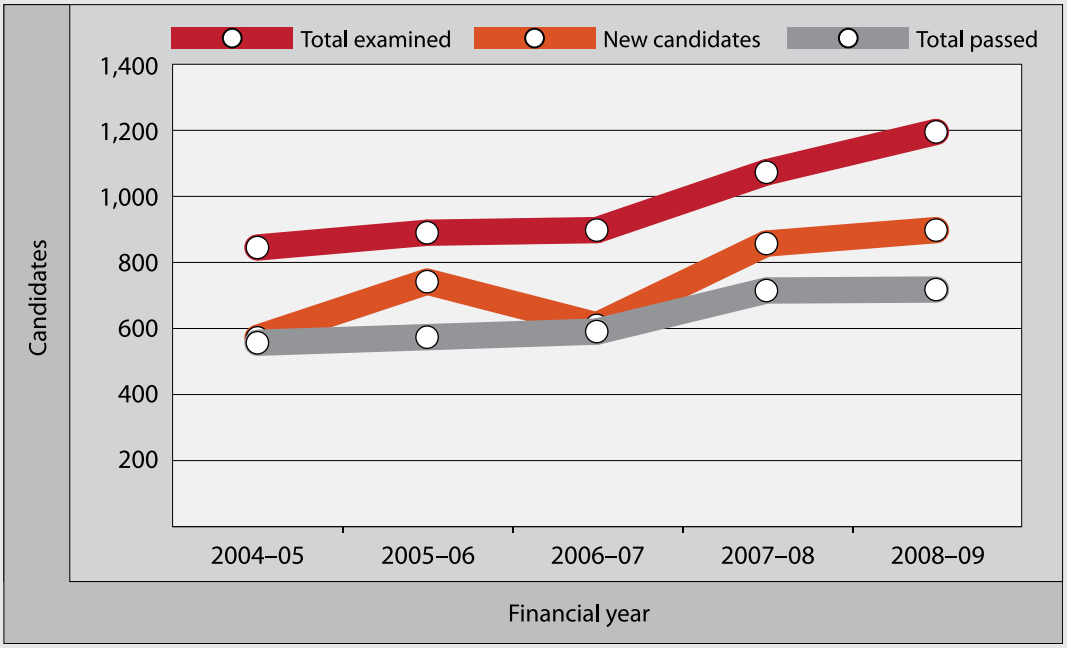


Table D3 in Appendix D sets out clinical examination passes by candidates' country of training and number of attempts.

Specialist Pathway

Under the Specialist Pathway, overseas-trained specialists can apply to the AMC for assessment by the relevant specialist medical college against the criteria for a fully qualified Australian-trained specialist in the relevant specialty field (full comparability) or against specific position descriptions that specify the levels of clinical responsibility, specialist skills and levels of supervision for a particular area of need position. The criteria and assessment processes for both categories are described in Table 7.

Table 7 Specialist assessment, criteria and assessment processes

Category	Assessment process/Criteria
Full comparability (Independent practice in a field of specialty)	Assessed by the relevant specialist medical college against the criteria for an Australian-trained specialist in the same field of specialty.
Area of need (Registration restricted by scope of practice, location and/or time)	Assessed by the relevant specialist medical college against the position description for the specific area of need position.

The number of specialist assessment applications increased dramatically in 2009. The number of new applications was more than double that in 2008 (Table 8). In 2009, 825 of the 2,682 overseas-trained specialists who applied were assessed as partially comparable to an Australian-trained specialist in the same field of specialty. In order to be granted substantial comparability and the option of registration for specialist practice in Australia, applicants granted partial comparability must undertake further training and/or examinations. In 2009, 351 applicants were granted substantial comparability, 65.6 per cent more than in 2008.

Table 8 Specialist assessment, applications and outcomes, 2008 and 2009

	2008	2009	Increase (%)
Total new applicants	923	2,682	190.6
Partial comparability	440	825	87.5
Substantial comparability	212	351	65.6

The growth in specialist assessment applications is due to the development of the COAG IMG assessment scheme in 2008, which streamlined the access of overseas-trained medical graduates to assessment by the AMC for registration to practise medicine with Australian state and territory medical boards.

Table 9 shows the number of new applications processed by specialist colleges and the assessment outcome.

Table 9 Specialist assessment applications, by college and outcome, 2009

College	Total received	Outcome	No.
Australasian Chapter of Palliative Medicine	15	Initial processing	13
		Withdrawn	1
		Approved	1
Australasian College for Emergency Medicine	82	Initial processing	64
		Withdrawn	1
		Lapsed	1
		Rejected	1
		Further training and/or examinations	2
		Approved	13
Australasian College of Dermatologists	37	Initial processing	25
		Rejected	5
		Further training and/or examinations	5
		Approved	2
Australian and New Zealand College of Anaesthetists	618	Initial processing	340
		Withdrawn	1
		Lapsed	11
		Rejected	43
		Further training and/or examinations	192
		Approved	31
Australian and New Zealand College of Anaesthetists, Faculty of Pain Medicine	2	Initial processing	2

College	Total received	Outcome	No.
College of Intensive Care Medicine of Australia and New Zealand	50	Initial processing	37
		Withdrawn	3
		Lapsed	1
		Further training and/or examinations	6
		Approved	3
Royal Australasian College of Dental Surgeons	2	Initial processing	2
Royal Australasian College of Medical Administrators	7	Initial processing	5
		Further training and/or examinations	2
Royal Australasian College of Physicians, Adult Medicine Division	619	Initial processing	407
		Withdrawn	5
		Lapsed	3
		Rejected	30
		Further training and/or examinations	68
		Approved	106
Royal Australasian College of Physicians, Australasian Faculty of Occupational and Environmental Medicine	8	Initial processing	6
		Approved	2
Royal Australasian College of Physicians, Australasian Faculty of Public Health Medicine	18	Initial processing	14
		Lapsed	1
		Rejected	1
		Further training and/or examinations	2

Table continues

College	Total received	Outcome	No.
Royal Australasian College of Physicians, Australasian Faculty of Rehabilitation Medicine	33	Initial processing	19
		Withdrawn	1
		Lapsed	1
		Further training and/or examinations	8
		Approved	4
Royal Australasian College of Physicians, Paediatrics and Child Health Division	288	Initial processing	184
		Lapsed	2
		Rejected	15
		Further training and/or examinations	41
		Approved	46
Royal Australasian College of Surgeons	858	Initial processing	592
		Withdrawn	47
		Lapsed	12
		Rejected	51
		Further training and/or examinations	139
		Approved	17
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	259	Initial processing	172
		Withdrawn	1
		Lapsed	4
		Rejected	23
		Further training and/or examinations	29
		Approved	30

College	Total received	Outcome	No.
Royal Australian and New Zealand College of Ophthalmologists	117	Initial processing	80
		Withdrawn	1
		Lapsed	3
		Rejected	11
		Further training and/or examinations	16
		Approved	6
Royal Australian and New Zealand College of Psychiatrists	495	Initial processing	307
		Withdrawn	3
		Further training and/or examinations	149
		Approved	36
Royal Australian and New Zealand College of Radiologists	379	Initial processing	269
		Deferred	1
		Lapsed	2
		Rejected	3
		Further training and/or examinations	75
		Approved	29
Royal Australian College of General Practitioners	34	Initial processing	29
		Withdrawn	2
		Lapsed	1
		Further training and/or examinations	1
		Approved	1

Table continues

College	Total received	Outcome	No.
Royal College of Pathologists of Australasia	237	Initial processing	115
		Withdrawn	3
		Lapsed	1
		Rejected	4
		Further training and/or examinations	90
		Approved	24
Total	4,158		

Publications

In 2009, the AMC continued to publish works to help IMGs prepare for the MCQ examination (a handbook of multiple choice questions, complemented by a web-based online trial examination). It also published a resource guide to help assessors of clinical performance in the workplace.

Resource guide

The *Workplace-based Assessment: Resource Guide*, published in April 2009, outlines the principles that underpin effective assessment and how those principles apply to assessment of clinical performance in the workplace. The information contained in the guide is generally applicable to any health profession introducing workplace-based assessment.

The guide provides practical advice on developing an assessment program. It takes the reader through the steps in the process: deciding what is being tested, choosing the best assessment methods, developing a blueprint, determining the passing standard, providing feedback, and training and calibrating assessors. In addition, it sets out the essential resource requirements for a successful workplace-based assessment program. The guide has the added benefit of sample assessment forms and a training DVD produced by the AMC publications team.

Handbook of multiple choice questions

On 11 December 2009, the AMC officially launched a major AMC publication, the *Handbook of Multiple Choice Questions.* The publication represents three years work by AMC examiners, under the leadership of the AMC Editor-in-Chief, Professor Vernon Marshall, and contains more than 600 multiple choice questions drawn from AMC examination banks. The handbook is designed to help IMGs prepare for the AMC MCQ Examination; to provide information covering all disciplines and clinical categories; and to make it easier for IMGs to enter the medical workforce in Australia.

As with previous AMC publications, the *Handbook of Multiple Choice Questions* is a comprehensive guide to the format, scope and standard of the AMC MCQ Examination. All questions are accompanied by commentaries on each response, details of best practice principles and correct answers.

The handbook is a companion to the *Handbook of Clinical Assessment*, published in 2007, which contains a representative selection of clinical assessment tasks (scenarios) drawn from the AMC Clinical Examination, accompanied by performance guidelines and commentaries to help candidates prepare for the examination.

MCQ online trial examination

A new online trial examination for prospective MCQ examination candidates was launched to coincide with the release of the *Handbook of Multiple Choice Questions*. The trial examination, which is accessible from the AMC website, is user friendly and up to date; it is a significant improvement on the previously available MCQ-trial facility.

The examination includes a selection of 50 multiple choice questions from the *Handbook of Multiple Choice Questions*. The questions, which are presented in the format of the current MCQ examination, are set at the standard expected of a graduating Australian medical student.

Recognition of medical specialties

The AMC advises the Australian Government Minister for Health and Ageing on the recognition of fields of medical practice as medical specialties. In 2009, the minister announced the recognition of three new medical specialties for inclusion in the AMC-managed List of Australian Recognised Medical Specialties:

- sports and exercise medicine
- addiction medicine
- sexual health medicine.

During 2009, the Recognition of Medical Specialties Advisory Committee began its full assessment of the case for recognition of cosmetic medical practice as a medical specialty.

The AMC has contributed to the debate about the proposed list of specialties, fields of specialty practice, and related specialist titles under the NRAS, including providing advice to the Department of Health and Ageing and the Medical Board of Australia.

Sports and exercise medicine

In November 2008, the AMC assessed the education and training programs of the Australasian College of Sports Physicians. The AMC then advised the Minister for Health and Ageing that the education and training programs of the college met the AMC standards for accreditation, thereby completing Stage 2 of the recognition procedure.

In November 2009, the minister announced the decision to recognise sport and exercise medicine as a medical specialty for the purpose of inclusion in the AMC List of Australian Recognised Medical Specialties.

This decision does not automatically lead to the inclusion of this specialty in Schedule 4 of the Health Insurance Regulations 1975 (Cth), which would grant patients access to rebates through Medicare Australia.

Addiction medicine

In November 2008, as part of the accreditation review of the Royal Australasian College of Physicians, the AMC assessed the education and training programs of the Australasian Chapter of Addiction Medicine. The AMC then advised the Minister for Health and Ageing that the education and training programs of the chapter met the AMC standards of accreditation, thereby completing Stage 2 of the recognition procedure.

In December 2009, the minister announced the decision to recognise addiction medicine as a medical specialty for the purpose of inclusion in the AMC List of Australian Recognised Medical Specialties.

This decision does not automatically lead to the inclusion of this specialty in Schedule 4 of the Health Insurance Regulations 1975 (Cth), which would grant patients access to rebates through Medicare Australia.

Sexual health medicine

In November 2008, as part of the accreditation review of the Royal Australasian College of Physicians, the AMC assessed the education and training programs of the Australasian Chapter of Sexual Health Medicine. The AMC then advised the Minister for Health and Ageing that the education and training programs of the college met the criteria for AMC accreditation, thereby completing Stage 2 of the recognition procedure.

In December 2009, the minister announced the decision to recognise sexual health medicine as a medical specialty for the purpose of inclusion in the AMC List of Australian Recognised Medical Specialties.

This decision does not automatically lead to the inclusion of this specialty in Schedule 4 of the Health Insurance Regulations 1975 (Cth), which would grant patients access to rebates through Medicare Australia.

Cosmetic medical practice

In October 2008, the Australasian College of Cosmetic Surgery (ACCS) lodged its full application for recognition of cosmetic medical practice as a medical specialty. After careful consideration of the application against the four criteria for recognition, the AMC accepted the college's application for assessment and agreed to establish a recognition review group.

Public consultations began on 4 April 2009, with the call for public submissions on the application placed in the public notices section of the national and regional press and on the AMC website. The AMC also wrote to stakeholders inviting submissions on the application. The closing date for submissions was 4 June 2009. More than 80 submissions were received from a range of stakeholders.

In June 2009, the recognition review group began its detailed assessment of the case for recognition of cosmetic medical practice as a medical specialty. It requested that the ACCS provide supplementary information against the four core recognition criteria outlined in the guidelines.

The ACCS requested an extension to the original deadline. The recognition review group will resume its assessment of the application in 2010 when it receives the supplementary information requested.

5 Financial Report

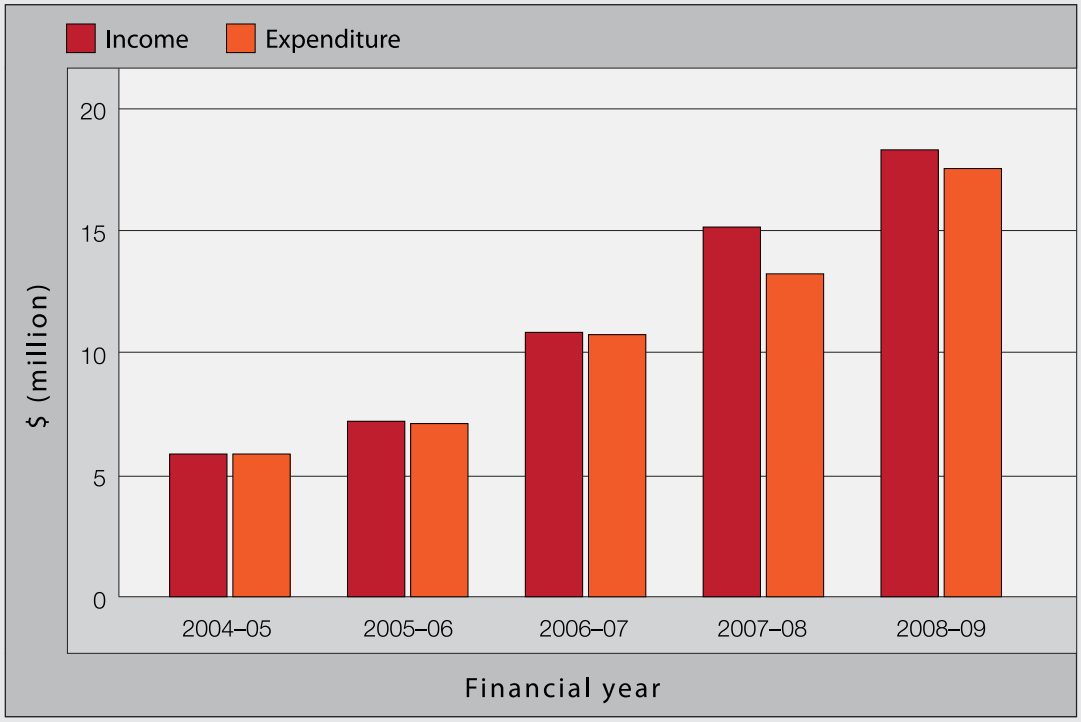
For the year ending 30 June 2009

Summary

For the whole of the financial year ended 30 June 2009, the Australian Medical Council operated as a company limited by guarantee. The financial statements for 2008–09 have been prepared according to the Australian Accounting Standards and the *Corporations Act 2001* (Cth), and have been audited by Walter Turnbull. The audited financial statements for 2008–09 follow this summary.

In 2008–09, both revenue and expenditure were higher than in 2007–08: total revenue grew to $18.4 million, a 20.8 per cent increase, and total expenditure grew to $17.6 million, a 23.7 per cent increase. The surplus was $0.8 million for the financial year. A comparison of total income and expenditure over the past five years is set out in Figure 7.

Figure 7 Income and expenditure ($ million), 2004–05 to 2008–09



The increase in revenue reflects the expanded services of the AMC. The major contributors to revenue were examination fees, primary source verification fees and the sale of publications.

Other revenue sources were grants from the Commonwealth and from state and territory medical boards. Commonwealth grants in 2008–09 totalled $2.2 million: $0.5 million for Specialist Education Accreditation; $0.3 million for Recognition of Medical Specialties; $0.8 million to support the implementation of the COAG IMG assessment initiative; and $0.6 million for the core area of activity of the AMC. State and territory medical boards contributed $0.6 million.

The major contributing factors to the increase in expenditure were direct examination expenditure; payments to the Educational Commission for Foreign Medical Graduates for primary source verification; costs associated with accreditation of medical schools; and costs associated with the council, standing committees and directors. Management and administration expenses accounted for about $8.1 million.

Audited financial statements

Directors' report

AUSTRALIAN MEDICAL COUNCIL LIMITED
ABN 97 131 796 980
DIRECTORS' REPORT

Your Directors submit the financial report of the Australian Medical Council Limited for the financial year ended 30 June 2009.

DIRECTORS
The names of each person who has been a Director during the year and to the date of this report are:

Professor Richard Smallwood AO	**President** and Chair, Strategic Policy Advisory Committee
Dr Robin Mortimer AO	**Deputy President** and Chair, Recognition Of Medical Specialities Advisory Committee
Mr Ian Frank	**Chief Executive Officer,** Australian Medical Council Ltd
Dr Mary Cohn	Nominee, Medical Board of Queensland
Professor Richard Doherty	Chair, Board of Examiners
Professor Michael Field	Chair, Medical School Accreditation Committee
Professor Con Michael AO	Nominee, Medical Board of Western Australia
Dr Trevor Mudge	Nominee, Medical Board of South Australia
Assoc Professor Peter Procopis AM	Nominee, New South Wales Medical Board and Chair, Joint Medical Boards Advisory Committee

The Directors have been in office since the start of the financial year to the date of this report unless otherwise stated.

COMPANY SERETARY
Ms Peggy Sanders held the position of Company Secretary at the end of the financial year.

PRINCIPAL ACTIVITIES
The principal activity of the Council during the financial year was to be a national standards advisory body for medical education and training. In addition, the Council also accredits Australian and New Zealand medical schools and medical courses, accredits specialised programs of medical training, and advises and assesses overseas trained doctors.

REVIEW OF OPERATIONS
The profit of the entity amounted to $814,407 (2008: $1,960,538).

DIVIDENDS PAID OR RECOMMENDED
No dividends were paid or declared since the start of the financial year. No recommendation for payment of dividends will be made.

REVIEW OF OPERATIONS
A review of operations of the Australian Medical Council Limited during the financial year indicated that revenue increased by 20.8% compared to the previous year mainly due to the increase in numbers of candidates sitting examinations. The overall expenditure for different activities increased during the year and as a result the financial year ended with a surplus of $814,407.

SIGNIFICANT CHANGES
No significant change in the nature of these activities occurred during the year.

AFTER BALANCE DATE EVENTS
No matters or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the Australian Medical Council Limited in future years.

FUTURE DEVELOPMENTS
The Australian Medical Council Limited expects to maintain the present status and the level of operations and hence there are no likely new developments in Australian Medical Council Limited's operation.

ENVIRONMENTAL ISSUES
The Australian Medical Council Limited operations are not regulated by any significant environmental regulation under the law of the Commonwealth or of a state or territory.

OPTIONS
No options were issued or granted during or since the end of the financial year and there were no options outstanding at the date of this report.

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Directors' report (continued)

AUSTRALIAN MEDICAL COUNCIL LIMITED
ABN 97 131 796 980
DIRECTORS' REPORT (Cont'd)

MEETINGS OF DIRECTORS

During the financial year 9 meeting of Directors and 2 General Meetings were held. The Attendance by each Director was as follows:

	Meeting of Directors attended	General Meetings attended
Professor Richard Smallwood AO	09	02
Dr Robin Mortimer AO	09	02
Mr Ian Frank	09	02
Dr Mary Cohn	07	01
Professor Richard Doherty	09	02
Professor Michael Field	09	02
Professor Con Michael AO	09	02
Dr Trevor Mudge	05	01
Assoc Professor Peter Procopis AM	08	02

INDEMNIFYING OFFICERS OR AUDITOR

No indemnities have been given or insurance premiums paid, during or since the end of the financial year for any person who is or has been an officer or auditor of the Australian Medical Council Limited.

PROCEEDINGS ON BEHALF OF THE AUSTRALIAN MEDICAL COUNCIL LIMITED

No person has applied for leave of court to bring proceedings on behalf of the Australian Medical Council Limited or intervene in any proceedings to which Australian Medical Council Limited is a party for the purpose of taking responsibility on behalf of the Australian Medical Council Limited for all or any part of those proceedings. The Australian Medical Council Limited was not a party to any such proceedings during the year.

AUDITOR'S INDEPENDENCE DECLARATION

The lead auditor's independence declaration for the year 30 June 2009 has been received and can be found on page 3 of the Directors' report.

Signed in accordance with a resolution of the Directors

Director

26 October 2009

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Auditor's independence declaration

WALTERTURNBULL
your extra asset

AUDITOR'S INDEPENDENCE DECLARATION UNDER S 307C OF THE *CORPORATIONS ACT 2001* TO THE DIRECTORS OF THE AUSTRALIAN MEDICAL COUNCIL LIMITED

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2009 there have been:

i. no contraventions of the auditor independence requirements as set out in the *Corporations Act* 2001 in relation to the audit; and

ii. no contraventions of any applicable code of professional conduct in relation to the audit.

Shane Bellchambers, CA
WalterTurnbull
Registered Company Auditor

26 October 2009
Canberra ACT

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CANBERRA SYDNEY

Independent auditor's report

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF THE AUSTRALIAN MEDICAL COUNCIL LIMITED

WALTERTURNBULL
your extra asset

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Report on the Financial Report

We have audited the accompanying financial report of the Australian Medical Council Limited (the Council) which comprises the balance sheet as at 30 June 2009 and the income statement, statement of recognised income and expenditure and cash flow statement for the year ended on that date, a summary of significant accounting policies and other explanatory notes and the directors' declaration.

The Responsibility of the Directors for the Financial Report

The directors of the council are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the *Corporations Act 2001*. This responsibility includes designing, implementing and maintaining internal control relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to Australian Medical Council Limited's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Australian Medical Council Limited's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independent auditor's report (continued)

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE AUSTRALIAN MEDICAL COUNCIL LIMITED (Continued)

Independence

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*.

We confirm that the Auditor's Independence Declaration set out on page 3 of the financial report has not changed as at the date of providing our audit opinion.

Auditor's Opinion

In our opinion, the financial report of the Australian Medical Council Limited is in accordance with the *Corporations Act 2001*, including:

a. giving a true and fair view of the council's financial position as at 30 June 2009 and of their performance for the year ended on that date; and

b. complying with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Corporations Regulations 2001.

Shane Bellchambers, CA
WalterTurnbull
Registered Company Auditor

26 October 2009
Canberra ACT

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Income statement for the year ended 30 June 2009

	Note	2009 $	2008 $
Revenue	2	18,388,867	15,256,482
Accreditation expense		(520,557)	(469,761)
Specialist education accreditation expenses		(762,266)	(769,709)
Recognition of medical specialties expenses		(355,346)	(286,888)
Specialist assessment		(88,600)	(74,551)
Credentialing expenses		(629,158)	(358,112)
Code of professional conduct		(295,221)	-
COAG IMG assessment project		(417,089)	(287,050)
Competent authority model to medical boards		-	(432,727)
Publishing expenses		(79,349)	(94,866)
Examination running expenses		(4,894,385)	(3,704,340)
Uniformity expenses		(139,906)	(140,388)
Council committees and executive expenses		(556,592)	(592,117)
Management and administration expenses		(8,835,991)	(6,085,435)
Surplus	3	814,407	1,960,538

The accompanying notes form part of these financial statements

Balance sheet as at 30 June 2009

	Note	2009 $	2008 $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	6	1,066,448	683,139
Financial assets	7	3,627,156	4,501,720
Trade and other receivables	8	509,682	1,063,149
Inventories		57,842	16,184
Other current assets	9	31,291	24,827
TOTAL CURRENT ASSETS		5,292,419	6,289,019
NON-CURRENT ASSETS			
Plant and equipment	10	3,153,757	557,692
TOTAL NON-CURRENT ASSETS		3,153,757	557,692
TOTAL ASSETS		8,446,176	6,846,711
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	11	1,156,933	954,949
Borrowings	14	44,852	52,258
Short-term provisions	13	226,387	196,403
Other liabilities	12	2,815,026	2,317,566
TOTAL CURRENT LIABILITIES		4,243,198	3,521,176

The accompanying notes form part of these financial statements

	Note	2009 $	2008 $
NON-CURRENT LIABILITIES			
Borrowings	14	68,984	75,565
Long-term provisions	13	117,940	48,323
TOTAL NON-CURRENT LIABILITIES		186,924	123,888
TOTAL LIABILITIES		4,430,122	3,645,064
NET ASSETS		4,016,054	3,201,647
EQUITY			
Reserves	15	160,287	160,287
Retained earnings		3,855,767	3,041,360
TOTAL EQUITY		4,016,054	3,201,647

The accompanying notes form part of these financial statements

Statement of recognised income and expenditure for the year ended 30 June 2009

	Retained Earnings $	Development Fund Reserve $	Examination Development Reserve $	Total $
Balance at 1 July 2007	1,080,822	10,286	150,001	1,241,109
Profit attributable to the Council	1,960,538	-	-	1,960,538
Balance at 30 June 2008	3,041,360	10,286	150,001	3,201,647
Profit attributable to the Council	814,407	-	-	814,407
Balance at 30 June 2009	3,855,767	10,286	150,001	4,016,054

For a description of each reserve, refer to Note 15.

The accompanying notes form part of these financial statements

Cash flow statement for the year ended 30 June 2009

	Note	2009 $	2008 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from candidates and grants		20,248,355	15,054,522
Payments to suppliers and employees		(18,000,683)	(12,987,731)
Interest received		353,885	287,537
Net cash generated from operating activities	21 b)	2,606,557	2,354,328
CASH FLOW FROM INVESTING ACTIVITIES			
Purchase of plant and equipment		(3,028,508)	(223,964)
Proceeds from disposal of plant and equipment		5,000	10,196
Net cash (used in) investing activities		(3,023,508)	(213,768)
CASH FLOW FROM FINANCING ACTIVITIES			
Payment of borrowings		(69,304)	(41,717)
Net cash (used in) financing activities		(69,304)	(41,717)
Net increase in cash held		(491,255)	2,098,843
Cash at the beginning of financial year		5,184,859	3,086,016
Cash at the end of financial year	21 a)	4,693,604	5,184,859

The accompanying notes form part of these financial statements

Notes to the financial statements for the year ended 30 June 2009

The financial report is for the Australian Medical Council Limited as an individual entity, incorporated and domiciled in Australia. The Australian Medical Council Limited is a company limited by guarantee.

Note 1: Statement of Significant Accounting Policies

Basis of Preparation

The financial report is a general purpose financial report that has been prepared in accordance with Australian Accounting Standards (including Australian Accounting Interpretations) and the *Corporations Act 2001*.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in a financial report containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of this financial report are presented below and have been consistently applied unless otherwise stated.

The financial report has been prepared on an accruals basis and is based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities.

(a) Income Tax

The Council has not provided for income tax as the Council is exempt from income tax under the provisions of Section 50-5 of the *Income Tax Assessment Act 1997*.

(b) Plant and equipment

Each class of property, plant and equipment is carried at cost or fair value as indicated less, where applicable, any accumulated depreciation and impairment losses.

Plant and equipment

Plant and equipment are measured on the cost basis less depreciation and impairment losses.

The carrying amount of plant and equipment is reviewed annually by directors to ensure it is not in excess of the recoverable amount from these assets. The recoverable amount is assessed on the basis of the expected net cash flows that will be received from the assets employment and subsequent disposal. The expected net cash flows have been discounted to their present values in determining recoverable amounts.

Plant and equipment that have been contributed at no cost, or for nominal cost are valued and recognised at the fair value of the asset at the date it is acquired.

Depreciation

The depreciable amount of all fixed assets is depreciated on a straight-line basis over the asset's useful life to the Australian Medical Council Limited commencing from the time the asset is held ready for use. Leasehold improvements are depreciated over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

The depreciation rates used for each class of depreciable asset are:

Class of Fixed Asset	Depreciation Rate
Furniture and Fittings	20%
Office Equipment	20%
Computer Equipment	40%

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each balance sheet date.

An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are included in the income statement. When revalued assets are sold, amounts included in the revaluation reserve relating to that asset are transferred to retained earnings.

(c) Inventories

Inventories are measured at the lower of cost and current replacement cost.

Inventories acquired at no cost, or for nominal consideration are valued at the current replacement cost as at the date of acquisition.

(d) Leases

Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset, but not the legal ownership, are transferred to the Australian Medical Council Limited are classified as finance leases.

Finance leases are capitalised, recording an asset and a liability equal to the present value of the minimum lease payments, including any guaranteed residual values.

Leased assets are depreciated on a straight-line basis over their estimated useful lives where it is likely that the Australian Medical Council Limited will obtain ownership of the asset. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses on a straight-line basis over the lease term.

Lease incentives under operating leases are recognised as a liability and amortised on a straight-line basis over the life of the lease term.

Notes to the financial statements for the year ended 30 June 2009

Note 1: Statement of Significant Accounting Policies (continued)

(e) Financial Instruments

Initial recognition and measurement

Financial assets and financial liabilities are recognised when the Australian Medical Council Limited becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the company commits itself to either purchase or sell the asset (ie trade date accounting is adopted). Financial instruments are initially measured at fair value plus transactions costs except where the instrument is classified 'at fair value through profit or loss' in which case transaction costs are expensed to profit or loss immediately.

Classification and subsequent measurement

Finance instruments are subsequently measured at either fair value, amortised cost using the effective interest rate method, or cost. Fair value represents the amount for which an asset could be exchanged or a liability settled, between knowledgeable, willing parties. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as:

i. the amount at which the financial asset or financial liability is measured at initial recognition;
ii. less principal repayments;
iii. plus or minus the cumulative amortisation of the difference, if any, between the amount initially recognised and the maturity amount calculated using the effective interest method; and
iv. less any reduction for impairment.

The effective interest method is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability. Revisions to expected future net cash flows will necessitate an adjustment to the carrying value with a consequential recognition of an income or expense in profit or loss.

(i) Financial assets at fair value through profit or loss

Financial assets are classified at 'fair value through profit or loss' when they are held for trading for the purpose of short-term profit taking, or where they are derivatives not held for hedging purposes, or when they are designated as such to avoid an accounting mismatch or to enable performance evaluation where a group of financial assets is managed by key management personnel on a fair value basis in accordance with a documented risk management or investment strategy. Such assets are subsequently measured at fair value with changes in carrying value being included in profit or loss.

(ii) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost.

(iii) Held-to-maturity investments

Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the Australian Medical Council Limited's intention to hold these investments to maturity. They are subsequently measured at amortised cost.

(iv) Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets that are either not capable of being classified into other categories of financial assets due to their nature, or they are designated as such by management. They comprise investments in the equity of other entities where there is neither a fixed maturity nor fixed or determinable payments.

(v) Financial liabilities

Non-derivative financial liabilities (excluding financial guarantees) are subsequently measured at amortised cost.

Fair value

Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine the fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models.

Impairment

At each reporting date, the Australian Medical Council Limited assesses whether there is objective evidence that a financial instrument has been impaired. In the case of available-for-sale financial instruments, a prolonged decline in the value of the instrument is considered to determine whether an impairment has arisen. Impairment losses are recognised in the Income Statement.

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the Australian Medical Council Limited no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expired. The difference between the carrying value of the financial liability, which is extinguished or transferred to another party and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed, is recognised in profit or loss.

Notes to the financial statements for the year ended 30 June 2009

Note 1: Statement of Significant Accounting Policies (continued)

(e) Financial Instruments (continued)

Impairment of assets

At each reporting date, the Australian Medical Council Limited reviews the carrying values of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to the asset's carrying value. Any excess of the asset's carrying value over its recoverable amount is expensed to the Income Statement.

Where the future economic benefits of the asset are not primarily dependent upon the asset's ability to generate net cash inflows and when the Australian Medical Council Limited would, if deprived of the asset, replace its remaining future economic benefits, value in use is determined as the depreciated replacement cost of an asset.

Where it is not possible to estimate the recoverable amount of an assets class, the Australian Medical Council Limited estimates the recoverable amount of the cash-generating unit to which the class of assets belong.

Where an impairment loss on a revalued asset is identified, this is debited against the revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for that same class of asset.

(f) Employee benefits

Provision is made for the Australian Medical Council Limited's liability for employee benefits arising from services rendered by employees to Balance Sheet date. Employee benefits expected to be settled within one year together with benefits arising from wages, salaries and annual leave which may be settled after one year, have been measured at the amounts expected to be paid when the liability is settled. Other employee benefits payable later than one year have been measured at the net present value.

Contributions are made by the Australian Medical Council Limited to an employee superannuation fund and are charged as expenses when incurred.

(g) Investments

Non-current investments are measured on the cost basis.

The carrying amount of investments is reviewed annually by directors to ensure it is not in excess of the recoverable amount of these investments. The recoverable amount is assessed from the relevant market values. The expected net cash flows from investments have not been discounted to their present value in determining the recoverable amounts.

(h) Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at-call with banks, other short-term highly liquid investments with original maturities of three months or less, and

bank overdrafts. Bank overdrafts are shown within the short-term borrowings in current liabilities on the balance sheet.

(i) Revenue

Revenue is measured at the fair value of the consideration received or receivable after taking into account any trade discounts and volume rebates allowed. Any consideration deferred is treated as the provision of finance and is discounted at a rate of interest that is generally accepted in the market for similar arrangements. The difference between the amount initially recognised and the amount ultimately received is interest revenue.

Revenue from exam fees is recognised when the exam takes place.

Grant revenue is recognised in the income statement when the Australian Medical Council Limited obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the Australian Medical Council Limited and the amount of the grant can be measured reliably.

If conditions are attached to the grant which must be satisfied before it is eligible to receive the contribution, the recognition of the grant as revenue will be deferred until those conditions are satisfied.

When grant revenue is received whereby the Australian Medical Council Limited incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the balance sheet as a liability until the service has been delivered to the contributor, otherwise the grant is recognised as income on receipt.

Interest revenue is recognised using the effective interest rate method, which for floating rate financial assets is the rate inherent in the instrument. Dividend revenue is recognised when the right to receive a dividend has been established.

Revenue from the rendering of a service is recognised upon the delivery of the service to the customers.

All revenue is stated net of the amount of goods and services tax (GST).

(j) Goods and Services Tax

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense. Receivables and payables in the balance sheet are shown inclusive of GST.

Cash flows are presented in the cash flow statement on a gross basis, except for the GST component of investing and financing activities, which are disclosed as operating cash flows.

Notes to the financial statements for the year ended 30 June 2009

Note 1: Statement of Significant Accounting Policies (continued)

(k) Provisions

Provisions are recognised when the Council has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at reporting date.

(l) Comparative Figures

Where required by Accounting Standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

(m) Key Estimates

Impairment

The Council assesses impairment at each reporting date by evaluating conditions specific to the Council that may lead to impairment of assets. Where an impairment trigger exists, the recoverable amount of the asset is determined. Value-in-use calculations performed in assessing recoverable amounts incorporate a number of key estimates.

Provision for doubtful debts

The directors believe that the full amount of trade and other receivables are recoverable and no doubtful debt provision has been made at 30 June 2009.

(n) New Accounting Standards for Application in Future Periods

The AASB has issued new, revised and amended standards and interpretations that have mandatory application dates for future reporting periods. The company has decided against early adoption of these standards. A discussion of those future requirements and their impact on the company is as follows:

- AASB 2008-11: Amendments to Australian Accounting Standard — Business Combinations among Not-for-Profit Entities (applicable to annual reporting periods beginning on or after 1 July 2009). These amendments make the requirements in AASB 3: Business Combinations applicable to business combinations among not-for-profit entities (other than restructures of local governments) that are not commonly controlled, and to include specific recognition, measurement and disclosure requirements in AASB 3 for restructures of local governments.
- AASB 101: Presentation of Financial Statements, AASB 2007-8: Amendments to Australian Accounting Standards arising from AASB 101, and AASB 2007-10: Further Amendments to Australian Accounting Standards arising from AASB 101 (all applicable to annual reporting periods commencing from 1 January 2009). The revised AASB 101 and amendments supersede the previous AASB 101 and redefines the composition of financial statements including the inclusion of a statement of comprehensive income. There will be no measurement or recognition impact on the company. If an entity has made a prior period adjustment or reclassification, a third balance sheet as at the beginning of the comparative period will be required.

- AASB 123: Borrowing Costs and AASB 2007-6: Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 and AASB 138 and Interpretations 1 and 12] (applicable for annual reporting periods commencing from 1 January 2009). The revised AASB 123 has removed the option to expense all borrowing costs and will therefore require the capitalisation of all borrowing costs directly attributable to the acquisition, construction or production of a qualifying asset. Management has determined that there will be no effect on the company as a policy of capitalising qualifying borrowing costs has been maintained by the company.
- AASB 2008-5: Amendments to Australian Accounting Standards arising from the Annual Improvements Project (July 2008) (AASB 2008-5) and AASB 2008-6: Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project (July 2008) (AASB 2008-6) detail numerous non-urgent but necessary changes to accounting standards arising from the IASB's annual improvements project. No changes are expected to materially affect the company.
- AASB 2008-13: Amendments to Australian Accounting Standards arising from AASB Interpretation 17 — Distributions of Non-cash Assets to Owners [AASB 5 and AASB 110] (applicable for annual reporting periods commencing from 1 July 2009). This amendment requires that non-current assets held for distribution to owners to be measured at the lower of carrying value and fair value less costs to distribute.
- AASB Interpretation 17: Distributions of Non-cash Assets to Owners (applicable for annual reporting periods commencing from 1 July 2009). This guidance applies prospectively only and clarifies that non-cash dividends payable should be measured at the fair value of the net assets to be distributed where the difference between the fair value and carrying value of the assets is recognised in profit or loss.

The company does not anticipate early adoption of any of the above reporting requirements and does not expect them to have any material effect on the company's financial statements.

Notes to the financial statements for the year ended 30 June 2009

Note 2: Revenue and Other Income

	2009 $	2008 $
Revenue		
– grant from Commonwealth	553,131	443,034
– grants from State Medical Boards	577,024	544,270
– special grant from Commonwealth	767,657	618,744
– special grant from Commonwealth to Medical Boards	-	432,727
– recognition of medical specialties grant from Commonwealth	337,134	336,852
– specialist education accreditation from Commonwealth	519,166	502,390
– specialist education accreditation fees	243,131	216,356
– recognition of medical specialties fees	18,182	1,000
– IMG fees	1,272,300	891,384
– credentialing fees	1,139,694	1,507,385
– accreditation fees	278,450	362,241
– examination fees	11,204,094	7,774,744
– sale of publications	483,336	841,253
– miscellaneous revenue	641,683	467,120
	18,034,982	14,939,500
Other Revenue		
– interest	353,885	316,928
Total Revenue	18,388,867	15,256,428
Other Income		
– gain on disposal of plant and equipment	-	54
Total Revenue and Other Income	18,388,867	15,256,482

Notes to the financial statements for the year ended 30 June 2009

Note 3: Profit for the Year

	2009 $	2008 $
(a) Expenses		
Rental expense on operating leases		
– minimum lease payments	702,858	361,311
Depreciation and amortisation		
– furniture and equipment	289,576	264,717
– software	37,765	29,428
– leasehold improvements	117,512	-
	444,853	294,145

Note 4: Key Management Personnel

	Short Term Benefits			Post Employment Benefit	
	Salary and Fees	Superannuation Contribution	Non-cash Benefits	Long Service Leave	Total
	$	$	$	$	$
2009					
Total compensation	275,217	71,798	-	-	347,015
2008					
Total compensation	250,370	67,680	-	-	318,050

Notes to the financial statements for the year ended 30 June 2009

Note 5: Auditor's Remuneration

	2009 $	2008 $
Remuneration of the auditor for:		
– auditing services	11,500	11,225
– other services	-	670
	11,500	11,895

Note 6: Cash and Cash Equivalents

	2009 $	2008 $
CURRENT		
Cash in hand	1,500	1,500
Cash at bank	1,064,948	681,639
	1,066,448	683,139

Note 7: Financial Assets

	2009 $	2008 $
CURRENT		
Held to maturity financial assets		
Term deposits	3,627,156	4,501,720

The effective interest rate on short-term investments was 5.5% (2008: 7.28%), these investments have an average maturity of 90 days.

Notes to the financial statements for the year ended 30 June 2009

Note 8: Trade and Other Receivables

	2009 $	2008 $
CURRENT		
Trade receivables	250,650	750,982
GST recievable	-	-
Accrued interest	8,446	42,949
Accrued income	250,586	269,218
	509,682	1,063,149

i. Provision for Impairment of Receivables

Current trade and other receivables are non-interest bearing loans and generally are receivable within 30 days. A provision for impairment is recognised against revenue where there is subjective evidence that an individual trade receivable is impaired. No impairment was required at 30 June 2009 (2008: Nil).

ii. Credit Risk – Trade and Other Receivables

The company does not have any material credit risk exposure to any single receivable or group of receivables.

The following table details the company's trade and other receivables exposed to credit risk (prior to collateral and other credit enhancements) with ageing analysis and impairment provided for thereon. Amounts are considered as 'past due' when the debt has not been settled within the terms and conditions agreed between the company and the customer or counter party to the transaction. Receivables that are past due are assessed for impairment by ascertaining solvency of the debtors and are provided for where there are specific circumstances indicating that the debt may not be fully repaid to the company.

The balances of receivables that remain within initial trade terms (as detailed in the table) are considered to be of high credit quality.

Notes to the financial statements for the year ended 30 June 2009

Note 8: Trade and Other Receivables (continued)

			Past due but not impaired (days overdue)				
	Gross amount $	Past due and impaired $	< 30 $	31-60 $	61-90 $	> 90 $	Within initial trade terms $
2009							
Trade and term receivables	509,682	-	487,470	3,509	2,709	15,994	487,470
Other receivables	-	-	-	-	-	-	-
Total	509,682	-	588,942	3,509	2,709	15,994	588,942
2008							
Trade and term receivables	1,063,149	-	537,873	514,218	-	11,058	537,873
Other receivables	-	-	-	-	-	-	-
Total	1,063,149	-	537,873	514,218	-	11,058	537,873

Note 9: Other Current Assets

	2009 $	2008 $
CURRENT		
Prepayments	31,291	24,827

Notes to the financial statements for the year ended 30 June 2009

Note 10: Plant and Equipment

	2009 $	2008 $
Computer equipment - at cost	935,305	651,281
Less accumulated depreciation	(437,463)	(346,008)
	497,842	305,273
Office equipment - at cost	342,599	361,233
Less accumulated depreciation	(161,511)	(228,423)
	181,088	132,810
Furniture and fittings - at cost	343,012	332,248
Less accumulated depreciation	(47,577)	(277,318)
	295,435	54,930
Software - at cost	147,752	123,752
Less accumulated depreciation	(96,838)	(59,073)
	50,914	64,679
Leasehold improvement	2,245,990	-
Less accumulated depreciation	(117,512)	-
	2,128,478	-
	3,153,757	557,692

Notes to the financial statements for the year ended 30 June 2009

Note 10: Plant and Equipment (continued)

(a) Movements in carrying amounts

Movement in the carrying amounts for each class of plant and equipment between the beginning and the end of the current financial year:

	Computer Equipment	Office Equipment	Furniture & Fittings	Software	Leasehold Improvements	Total
	$	$	$	$	$	$
2008						
Balance at beginning of year	259,142	130,645	138,200	67,028	-	595,015
Additions	172,059	56,761	11,065	27,079	-	266,964
Disposal	(40,006)	(44,221)	-	-	-	(84,227)
Depreciation expense	(115,786)	(54,596)	(94,335)	(29,428)	-	(294,145)
Depreciation written back	29,864	44,221	-	-	-	74,085
Carrying amount at the end of the year	305,273	132,810	54,930	64,679	-	557,692
2009						
Balance at beginning of year	371,013	132,428	310,395	24,000	2,245,990	3,083,826
Disposal	(86,989)	(151,062)	(299,630)	-	-	(537,681)
Depreciation expense	(176,418)	(65,987)	(47,171)	(37,765)	(117,512)	(444,853)
Depreciation written back	84,963	132,899	276,911	-	-	494,773
Carrying amount at the end of the year	497,842	181,088	295,435	50,914	2,128,478	3,153,757

Notes to the financial statements for the year ended 30 June 2009

Note 11: Trade and Other Payables

	2009 $	2008 $
CURRENT		
Trade payables	65,571	108,593
GST Payable	102,184	22,371
PAYG Payable	1,212	54,896
Withholding Tax Payable	15,695	19,533
Short-term employee benefits	528,266	377,877
Accrued expenses	444,005	371,679
	1,156,933	954,949

(a) Financial liabilities at amortised cost classified as trade and other payables

	2009 $	2008 $
Trade and other payables		
– Total current	1,156,933	954,949
– Total non-current	–	–
	1,156,933	954,949
Less accrued expenses	(444,005)	(371,679)
Less annual leave entitlements	(528,266)	(377,877)
Financial assets as trade and other payables	184,662	205,393

Notes to the financial statements for the year ended 30 June 2009

Note 12: Other Liabilities

	2009 $	2008 $
CURRENT		
Income recieved in advance	2,671,207	2,173,747
Department of Health & Ageing - grants in advance	143,819	143,819
	2,815,026	2,317,566

Note 13: Provisions

	Lease Provision $	Employee Benefits $	Total $
Opening balance at 1 July 2008	–	244,726	244,726
Additional provisions raised during the year	30,038	69,563	99,601
Balance at 30 June 2009	30,038	314,289	344,327

Analysis of total provisions

	2009 $	2008 $
Current	226,387	196,403
Non-current	117,940	48,323
	344,327	244,726

Provision for Long-term Employee Benefits

A provision has been recognised for non-current employee benefits relating to long service leave for employees.

In calculating the present value of future cash flows in respect of long service leave, the probability of long service leave being taken is based upon historical data. The measurement and recognition criteria for employee benefits have been included in Note 1.

A provision has been recognised for the lease of the Majura Park premises to align the current year lease expenditure with the average monthly expenditure over the entire term of the lease.

Notes to the financial statements for the year ended 30 June 2009

Note 14: Borrowings

	2009 $	2008 $
CURRENT		
Lease liabilities	44,852	52,258
NON CURRENT		
Lease liabilites	68,984	75,565

Leased liabilities are secured by the underlying assets which includes the Canon photocopiers, Sedcom telephone equipment, Lenovo and Dell notebook computers and video conferencing equipment.

Note 15: Reserves

Development Fund Reserve

The development fund consists of a reserve for future new development activities.

Examination Development Reserve

The examination development reserve consists of funds allocated for the development of new examinations.

Note 16: Leasing Commitments

		2009 $	2008 $
(a)	Finance Lease Commitments		
	Payable – minimum lease payments		
	– not later than 1 year	52,600	67,019
	– later than 1 year but not later than 5 years	96,476	74,047
	Minimum lease payments	149,076	141,066
	Less: future finance charges	(35,240)	(13,243)
	Present value of minimum lease payments	113,836	127,823

Notes to the financial statements for the year ended 30 June 2009

Note 16: Leasing Commitments (continued)

Finance lease commitments contain multiple equipment leases with between three and five year terms. No debt covenants or other such arrangements are in place.

(b) Operating Lease Commitments	2009 $	2008 $
Non-cancellable operating leases contracted for but not capitalised in the financial statements		
Being for rent of office		
Payable – minimum lease payments		
- not later than 1 year	868,663	266,123
- later than 1 year but not later than 5 years	3,495,733	266,132
	4,364,396	532,255

Note 17: Economic Dependency

A significant portion of the Council's income consists of grants from the State Medical Boards and the Commonwealth Government and Fees from Examinations.

Note 18: Events After Balance Sheet Date

No matters or circumstances have arisen since the end of the financial year, which significantly affected or may significantly affect the operations of the Australian Medical Council, the results of those operations, or the state of affairs in subsequent financial years.

Note 19: Related Party Transactions

The Board members receive an allowance for attendance at board meetings to the value of $260 per session. No other remuneration was received in connection with services provided.

Note 20: Contingent Assets and Liabilities

The Council has not identified any contingent assets or liabilities that are either measurable or probable.

Notes to the financial statements for the year ended 30 June 2009

Note 21: Cash Flow Information

		2009 $	2008 $
(a)	Reconciliation of Cash		
	Cash at bank	1,066,448	683,139
	Investments – short-term term deposits	3,627,156	4,501,720
		4,693,604	5,184,859
(b)	Reconciliation Cash Flow from Operations with Profit		
	Profit	814,407	1,960,538
	Non-cash flows:		
	Depreciation and amortisation	444,853	294,145
	Net loss/(gain) on disposal of plant and equipment	37,907	(54)
	Changes in assets and liabilities:		
	Decrease/(Increase) in trade & other receivables	452,269	(572,512)
	(Increase)/Decrease in prepayments	(6,464)	2,633
	(Increase) in inventories	(41,658)	(16,184)
	Increase in trade and other payables	303,182	114,656
	Increase in provisions	99,601	28,071
	Increase in other liabilities	497,460	543,035
		2,606,557	2,354,328

Notes to the financial statements for the year ended 30 June 2009

Note 21: Cash Flow Information (continued)

(c) Credit Stand-by Arrangement and Loan Facilities

The Council has no credit stand-by or financing facilities in place.

(d) Non-cash Financing and Investing Activities

During the financial year, the Council acquired plant and equipment with an aggregate fair value of $55,317 (2008: $43,000) by means of hire purchase agreements. These acquisitions are not reflected in the cash flow statement.

Note 22: Financial Risk Management

The Council's overall risk management strategy seeks to assist the company in meeting its financial targets, whilst minimising potential adverse effects on financial performance. Risk management policies are approved and reviewed by the Board on a regular basis. These include credit risk policies and future cash flow requirements.

Specific Financial Risk Exposures and Management

The main risks the company is exposed to through its financial instruments are interest rate risk, liquidity risk, credit risk and equity price risk.

(a) Interest rate risk

Exposure to interest rate risk arises on financial assets and financial liabilities recognised at reporting date whereby a future change in interest rates will affect future cash flows or the fair value of fixed rate financial instruments.

(b) Liquidity risk

Liquidity risk arises from the possibility that the company might encounter difficulty in settling its debts or otherwise meeting its obligations related to financial liabilities. The company manages this risk through the following mechanisms:

- preparing forward looking cash flow analysis in relation to its operational, investing and financing activities;
- maintaining a reputable credit profile;
- managing credit risk related to financial assets;
- investing only in surplus cash with major financial institutions; and
- comparing the maturity profile of financial liabilities with the realisation profile of financial assets.

Cash flows realised from financial assets reflect management's expectation as to the timing of realisation. Actual timing may therefore differ from that disclosed. The timing of cash flows presented in the table to settle financial liabilities reflects the earliest contractual settlement dates.

Financial liability and financial asset maturity

	Within 1 Year		1 to 5 Years		Over 5 Years		Total contractual cash flow	
	2009 $	2008 $	2009 $	2008 $	2009 $	2008 $	2009 $	2008 $
Financial liabilities due for payment					-	-		
Lease liabilities	(913,515)	(318,381)	(3,564,717)	(341,697)	-		(4,478,232)	(660,078)
Trade and other payables (excluding estimated annual leave and accrued expenses)	(184,662)	(205,393)	-	-	-	-	(184,662)	(205,393)
Total expected outflows	(1,098,177)	(523,774)	-	-	-	-	(4,662,894)	(865,471)
Financial assets – cash flows realisable					-	-		
Cash and cash equivalents	1,066,448	683,139	-	-	-	-	1,066,448	683,139
Trade, term and loans receivable	4,136,838	5,564,869	-	-	-	-	4,136,838	5,564,869
Other investments	-	-	-	-	-	-	-	-
Total anticipated inflows	5,203,286	6,248,008			-	-	5,203,286	6,248,008
Net (outflow)/inflow on financial instruments	4,105,109	5,724,234	(3,563,717)	(341,697)	-	-	540,392	5,382,537

(c) Credit risk

Exposure to credit risk relating to financial assets arises from the potential non-performance by counter parties of contract obligations that could lead to a financial loss to the company.

Credit risk is managed through the maintenance of procedures (such procedures include the utilisation of systems for the approval, granting and removal of credit limits, regular monitoring of exposures against such limits and monitoring of the financial stability of significant customers and counter parties) ensuring to the extent possible, that customers and counter parties to transactions are of sound credit worthiness. Such monitoring is used in assessing receivables for impairment. Credit terms are generally 14 to 30 days from the invoice date. Customers who do not meet the company's strict credit policies may only purchase in cash or only use recognised credit cards.

Note 22: Financial Risk Management (continued)

Risk is also minimised through investing surplus funds in financial institutions that maintain a high credit rating, or in entities that the finance committee has otherwise cleared as being financially sound. Where the company is unable to ascertain a satisfactory credit risk profile in relation to a customer or counter party, then risk may be further managed by retention clauses over goods or obtaining security by way of personal or commercial guarantees over assets of sufficient value which can be claimed against in the event of any default.

Credit Risk Exposures

The maximum exposure to credit risk by class of recognised financial assets at balance date is equivalent to the carrying value and classification of those financial assets (net of any provisions) as presented in the balance sheet. Trade and other receivables that are neither past due or impaired are considered to be of high credit quality.

The Council does not have any material credit risk exposure to any single receivable or group of receivables under financial instruments entered into by the company. The trade receivables balance at 30 June 2009 and 30 June 2008 do not include any counter parties with external credit ratings. Customers are assessed for credit worthiness using the criteria detailed above.

(d) Net Fair Values

Fair value estimation

The fair values of financial assets and financial liabilities are presented in the following table and can be compared to their carrying values as presented in the balance sheet. Fair values are those amounts at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

Fair values derived may be based on information that is estimated or subject to judgment, where changes in assumptions may have a material impact on the amounts estimated. Areas of judgment and the assumptions have been detailed below. Where possible, valuation information used to calculate fair value is extracted from the market, with more reliable information available from markets that are actively traded. In this regard, fair values for listed securities are obtained from quoted market bid prices. Where securities are unlisted and no market quotes are available, fair value is obtained using discounted cash flow analysis and other valuation techniques commonly used by market participants.

Differences between fair values and carrying values of financial instruments with fixed interest rates are due to the change in discount rates being applied by the market since their initial recognition by the company. Most of these instruments which are carried at amortised cost are to be held until maturity and therefore the net fair value figures calculated bear little relevance to the company.

	2009		2008	
	Net Carrying Value	Net Fair Value	Net Carrying Value	Net Fair Value
Financial Assets				
Cash and cash equivalents	1,066,448	1,066,448	683,139	683,139
Trade and other receivables	250,650	250,650	750,982	750,982
Inventories	57,842	57,842	16,184	16,184
Investments	3,627,156	3,627,156	4,501,720	4,501,720
Total Financial Assets	5,002,096	5,002,096	5,952,025	5,952,025
Financial Liabilities				
Trade and other payables	610,744	610,744	560,899	560,899
Lease Liabilities	113,836	113,836	127,823	127,823
	724,580	724,580	688,722	688,722

Sensitivity Analysis

Interest rate risk

The following table illustrates sensitivities to the Council's exposures to changes in interest rates and equity prices. The table indicates the impact on how profit and equity values reported at balance date would have been affected by changes in the relevant risk variable that management considers to be reasonably possible. These sensitivities assume that the movement in a particular variable is independent of other variables.

Notes to the financial statements for the year ended 30 June 2009

Note 22: Financial Risk Management (continued)

	2009 $	2008 $
Change in profit		
– Increase in interest rate by 1%	8,748	45,865
– Decrease in interest rate by 1%	(8,748)	(45,865)
Change in equity		
– Increase in interest rate by 1%	-	-
– Decrease in interest rate by 1%	-	-

This sensitivity analysis has been performed on the assumption that all other variables remain unchanged.

Term deposit investments have been excluded from the sensitivity analysis as they involve fixed interest rates.

Note 23: Capital Management

Management control the capital of the Council to ensure that adequate cash flows are generated to fund its programs and that returns from investments are maximised. The board ensures that the overall risk management strategy is in line with this objective.

The Council does not have formal risk management policies, however the board closely manages and reviews the Council at its regular board meetings.

The Council's capital consists of financial liabilities, supported by financial assets.

Management effectively manage the Council's capital by assessing the Council's financial risks and responding to changes in these risks and in the market. These responses may include the consideration of debt levels.

The Company does not have a formal policy on capital management and gearing ratios.

Notes to the financial statements for the year ended 30 June 2009

Note 24: Company Details

The principal place of business of the Council is:

Australian Medical Council Limited
Level 3/11 Lancaster Place
MAJURA ACT 2609

Note 25: Members Guarantee

The entity is incorporated under the *Corporations Act 2001* and is an entity limited by guarantee. If the entity is wound up, the constitution states that each member is required to contribute a maximum of $10 each towards meeting any outstandings and obligations of the entity. At 30 June 2009 the number of members was 21.

Directors' declaration

AUSTRALIAN MEDICAL COUNCIL LIMITED
ACN 131 796 980
("Company")

DIRECTORS' DECLARATION

The Directors declare that, in the opinion of the Directors:

(a) the financial statements and notes for the financial year ending 30 June 2009 are in accordance with the *Corporations Act 2001* (Cth), including:

(i) giving a true and fair view of the Company's financial position as at 30 June 2009 and of the Company's performance for the year ended that date; and

(ii) complying with the Australian Accounting Standards (including the Australian Accounting Interpretations) and the Corporations Regulations 2001; and

(b) there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable.

Signed in accordance with a resolution of the Directors:

.....
Signature of Director

RICHARD ALAN SMALLWOOD
.....
Full name of Director (block letters)

Dated: 26 October 2009

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Compilation report

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COMPILATION REPORT

To the directors of the Australian Medical Council Limited

We have compiled the accompanying special purpose financial statements of the Australia Medical Council Limited, which comprise the Income and Expenditure Statement and are set out on pages 29 to 32. The specific purpose for which the special purpose financial statements have been prepared is to provide information relating to the performance of the entity that satisfies the information needs of the directors.

The Responsibility of the Directors

The directors are solely responsible for the information contained in the special purpose financial statements and have determined that the basis of accounting used is appropriate to meet their needs and for the purpose that the financial statements were prepared.

Our Responsibility

On the basis of information provided by the directors we have compiled the accompanying special purpose financial statements in accordance with the basis of accounting adopted and APES 315: Compilation of Financial Information.

Our procedures use accounting expertise to collect, classify and summarise the financial information, which the directors provided, in compiling the financial statements. Our procedures do not include verification or validation procedures. No audit or review has been performed and accordingly no assurance is expressed.

The special purpose financial statements were compiled exclusively for the benefit of the directors. We do not accept responsibility to any other person for the contents of the special purpose financial statements.

Shane Bellchambers, CA
Registered Company Auditor
WalterTurnbull
Canberra ACT
Dated: 26 October 2009

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CANBERRA SYDNEY

Supplementary information: income and expenditure statement for core activities

	2009 $	2008 $
INCOME		
Commonwealth Grant	1,320,788	1,061,778
Medical Board Grants	577,024	544,270
Commonwealth Grant to Medical Board	-	432,727
Accreditation of Medical Schools Fees	278,450	362,241
Examination Fees and Charges	12,597,760	9,528,827
IMG Assessment	1,272,300	891,384
Interest Income	353,885	316,928
Book Sales	483,336	641,505
Miscellaneous Income	17,268	77,143
Management/Administration Fees	370,444	343,081
TOTAL OPERATIONAL INCOME	17,271,255	14,199,884
LESS: EXPENDITURE		
ACCREDITATION OF MEDICAL SCHOOLS		
Accommodation & Fares	331,615	281,094
Fees to Members	138,958	133,618
Taxis/Incidentals/Other	47,512	52,453
Teleconferences	2,472	2,596
	520,557	469,761

Supplementary information: income and expenditure statement for core activities

	2009 $	2008 $
CLINICAL EXAMINATIONS		
Accommodation and Fares	769,991	609,969
Examination Running Expenses	355,287	272,762
Fees Paid to Members	555,575	528,662
Taxis and Incidentals	111,753	102,553
TOTAL CLINICAL EXAMINATIONS COSTS	1,792,606	1,513,946
MCQ EXAMINATIONS		
Accommodation and Fares	808,476	632,227
Examination Running Expenses	1,682,863	884,922
Fees Paid to Members	527,252	603,462
Taxis and Incidentals	78,945	63,771
Teleconferences	4,243	6,012
TOTAL MCQ EXAMINATIONS COSTS	3,101,779	2,190,394
TOTAL EXAMINATIONS COSTS	4,894,385	3,704,340
CREDENTIALING		
Accommodation and Fares	-	-
Fees to ECFMG	629,158	358,112
	629,158	358,112
UNIFORMITY		
Accommodation and Fares	122,356	115,274
Fees Paid to Members	3,128	9,510

Table continues

Supplementary information: income and expenditure statement for core activities

	2009 $	2008 $
Meeting Expenses	9,187	8,314
Taxis and Incidentals	5,235	7,290
	139,906	140,388
COMPETENT AUTHORITY MODEL MEDICAL BOARD		
Grant Disbursement	-	432,727
	-	432,727
SPECIALIST ASSESSMENT		
Accommodation and Fares	67,538	54,695
Fees Paid to Members	7,001	10,214
Meeting Expenses	7,674	5,373
Taxis and Incidentals	6,387	4,269
	88,600	74,551
CODE OF PROFESSIONAL CONDUCT		
Accommodation and Fares	116,381	-
Fees Paid to Members	32,638	-
Meeting Expenses	133,623	-
Taxis and Incidentals	12,579	-
	295,221	-
PUBLISHING		
Accommodation and Fares	-	17,721
Fees Paid to Members	-	12,494
Printing and Distribution Costs	56,955	41,867
Royalties	22,349	16,979
Taxis and Incidentals	45	5,805
	79,349	94,866

Supplementary information: income and expenditure statement for core activities

	2009 $	2008 $
COAG IMG ASSESSMENT PROJECT		
Accommodation and Fares	258,077	174,562
Fees Paid to Members	87,806	78,642
Meeting Expenses	35,891	15,566
Taxis and Incidentals	32,375	14,484
Teleconferences	2,940	3,796
	417,089	287,050
COUNCIL COMMITTEES AND DIRECTORS		
Accommodation and Fares	416,868	366,195
Fees Paid to Members	49,731	125,030
Consultancy Fees	-	1,920
Conference Fees	-	6,973
Meeting Expenses	47,329	62,776
Taxis and Incidentals	40,881	27,381
Teleconferences	1,783	1,842
	556,592	592,117
MANAGEMENT		
Audit Fee	11,500	11,895
Bank Fees	277,300	172,831
Finance Charges	27,214	809
Consultant – Other	1,273	59,516
	317,287	245,051

Table continues

Supplementary information: income and expenditure statement for core activities

	2009 $	2008 $
COMPUTER EXPENDITURE		
Computer Consultant	224,700	433,864
Computer Software and Consumables	150,482	80,503
Computer Maintenance and Repairs	18,459	10,294
	393,641	524,661
OTHER MANAGEMENT EXPENDITURE		
Depreciation	444,853	294,145
Electricity	22,413	21,957
Advertising	88,068	31,514
Equipment Maintenance	130,983	31,500
Freight Costs	46,828	72,825
Insurances	38,409	82,134
Legal Fees General	127,352	94,641
Interest and Finance Charges	22,376	45,234
Maintenance General	4,891	8,870
Miscellaneous Expenses	27,544	12,495
Postage and Stationery	260,423	190,274
Printing Costs	72,978	105,052
Records Management	28,356	39,615
Rent	702,858	361,311
Relocation Costs	53,311	-
Salary Costs	5,188,062	3,357,243
Other Staff Costs	638,732	402,182
Security	1,354	682

Supplementary information: income and expenditure statement for core activities

	2009 $	2008 $
Subscriptions	17,146	12,426
Superannuation Other	43,364	66,167
Development Fund Expenditure	-	27,773
Telephone	92,745	57,972
Other Adjustments	34,110	(290)
Disposal of Equipment	37,907	-
TOTAL MANAGEMENT EXPENDITURE	8,125,063	5,315,722
TOTAL EXPENDITURE	16,456,848	12,239,346
NET OPERATING SURPLUS	814,407	1,960,538

Supplementary information: income and expenditure statement for accreditation of medical specialties

	2009	2008
	$	$
INCOME		
Specialist Education Accreditation Grant	519,166	502,390
Recognition of Medical Specialties Grant	337,134	336,852
Specialist Education Accreditation Fees	243,131	216,355
Recognition of Medical Specialties Fees	18,181	1,000
TOTAL INCOME	1,117,612	1,056,597
LESS: EXPENDITURE		
RECOGNITION OF MEDICAL SPECIALTIES		
Accommodation & Fares	30,453	11,244
Fees to Members	7,754	4,824
Taxis and Incidentals	3,321	1,650
Printing and Survey Costs	-	-
Meeting Expenses	3,428	2,565
Teleconferences	1,126	274
Management/Administration Costs	138,381	136,108
Salaries and Oncosts	170,883	130,223
	355,346	286,888

Supplementary information: income and expenditure statement for accreditation of medical specialties

	2009	2008
	$	$
SPECIALIST EDUCATION ACCREDITATION		
Accommodation and Fares	168,572	226,316
Fees to Members	87,828	90,205
Meeting Expenses	18,966	16,439
Taxis and Incidentals	17,486	24,517
Teleconference	3,024	2,409
Development Processes – Consultancy	-	-
Management/Administration Costs	232,063	206,973
Salaries and Oncosts	234,327	202,850
	762,266	769,709
TOTAL EXPENDITURE	1,117,612	1,056,597
NET OPERATING SURPLUS (DEFICIT)	-	-

Council members and directors

For the year ending 31 December 2009

Council members

Professor Richard Smallwood AO (President)

Professor Robin Mortimer AO (Deputy President)

Dr Robert Adler

Dr Stephen Bradshaw

Dr E Mary Cohn

Professor Brendan Crotty

Professor Richard Doherty

Professor Michael Field

Dr Charles Kilburn

Professor Constantine Michael AO

Dr Trevor Mudge

Associate Professor Peter Procopis AM

Mr David Roberts

Professor Judith Searle

Associate Professor Jillian Sewell AM

Dr Peter Sexton

Professor Russell Stitz AM RFD

Dr Kendra Sundquist

Professor Anne Tonkin

Dr Dana Wainwright

Ms Diane Walsh

Dr Glenda Wood

Emeritus Professor Neville Yeomans

Directors

Professor Richard Smallwood AO (President)

Professor Robin Mortimer AO (Deputy President)

Dr Robert Adler

Professor Richard Doherty

Professor Michael Field

Mr Ian Frank

Professor Constantine Michael AO

Associate Professor Peter Procopis AM

Associate Professor Jillian Sewell AM

Professor Russell Stitz AM RFD

Committee members

For the year ending 31 December 2009

Medical School Accreditation Committee

Professor Michael Field (Chair)
Professor James Angus
Professor Justin Beilby
Ms Barbara Daniels
Professor Peter Ellis
Miss Tiffany Fulde
Professor Brian Jolly
Dr Fiona Joske
Professor Lou Landau AO
Associate Professor Jenepher Martin
Associate Professor Richard Murray
Professor Don Roberton
Professor Napier Thomson AM
Emeritus Professor Neville Yeomans

Specialist Education Accreditation Committee

Associate Professor Jillian Sewell AM (Chair)
Dr John Adams
Dr Robert Broadbent
Professor Michael Field
Dr Gavin Frost
Dr Linda MacPherson
Dr Alex Markwell
Professor Iain Martin
Associate Professor Jenepher Martin
Mr Russell McGowan
Professor Robin Mortimer AO
Associate Professor Peter Procopis AM
Ms Sheila Rimmer AM
Professor Judith Searle
Dr Dana Wainwright
Dr Peter White

Recognition of Medical Specialties Advisory Committee

Professor Robin Mortimer AO (Chair)
Dr Richard Ashby AM
Professor Mark Bassett
Professor A John Campbell
Professor Ian Gough
Ms Tricia Greenway
Ms Janne Graham AM
Dr David Jeacocke

Dr Omar Khorshid
Dr Linda McPherson
Mr Ian McRae
Professor Geoffrey Metz AM
Dr Trevor Mudge
Professor Richard Smallwood AO
Dr Edward Weaver
Professor Steve Wesselingh
Mr Craig Winfield

Board of Examiners

Professor Richard Doherty (Chair)
Associate Professor Peter Devitt
Professor Phillipa Hay
Professor Michael Kidd AM
Professor Vernon Marshall
Professor Barry McGrath
Professor Kichu Nair AM
Professor Roger Pepperell
Professor Constance Pond
Dr Kendra Sundquist
Dr Ross Sweet AM

Strategic Policy Advisory Committee

Professor Richard Smallwood AO (Chair)
Mr Peter Forster
Mr Ian Frank
Professor Janet Greeley
Professor Robin Mortimer AO
Dr Melissa Naidoo
Mr John Ramsay
Emeritus Professor Lloyd Sansom AO
Professor Leonie Segal

Joint Medical Boards Advisory Committee

Associate Professor Peter Procopis AM (Chair)
Dr Robert Adler
Dr Stephen Bradshaw
Dr E Mary Cohn
Dr Charles Kilburn
Professor Constantine Michael AO
Dr Trevor Mudge
Dr Peter Sexton

Registrars Sub-group

Mr Robert Bradford (Chair)
Mr Andrew Dix
Mr Joseph Hooper
Ms Jill Huck
Ms Pamela Malcolm
Mrs Annette McLean-Aherne
Mr Richard Mullaly
Ms Kaye Pulsford

Staff list

For the year ending 31 December 2009

Heather Alexander
Sarah Anderson
Keeley Anderson
Haider Azam
Samantha Barnard
Anna Boots
Toija Brady
Susan Buick
Kapila Chaplot
Andrew Cole
Felicity Corbin
Brendan Cumpston
Josie Cunningham
Karoline Dawe
Robin Dearlove
Gillian Drew
Kylie Edwards
Jill Elderton
Hugh Evans
Carol Ford
Ian Frank
Jared Fraser
Deborah Govier
Alexander Gundry
Matthew Haggan
Casey Hamilton
Helen Harper
Karan Hazell
Andrew Hing
Jessica Hofsteede
Jeremy Holley
Ariful Hoque
Simone Horvat
Alison Howard
John Hunter
Martin Jagodzki
John Jamieson
Hsi Lim
Trevor Lockyer
Megan Lovett
Michael MacDonald
Ana Maljevac
Leesa Marshall
Sophie McAllister
Jane McGovern
Drew Menzies-McVey
Amanda Murphy
Steven Murphy
Kevin Ng
Sean O'Dowd
Karin Oldfield
Phillip O'Sullivan
Liesl Perryman
Slavica Petreska
Helen Rakowski
Amanda Room
Viviana Rozas
Peggy Sanders
Debra Scanes
Wendy Schubert
Robert Shaw
Emma Lea Sheather
Sarah Simeoni
Josephine Srivastava
Michelle Sykes
Christine Thompson
Nancy Van Bael
Zuzette Van Vuuren
Sarah Vaughan
Judy Vilimaina
Theanne Walters
Caroline Watkin
Merryn Watts
Ravindra Wickramaratna
Nejla Williamson
Nicole Wilson
Stacey Yeats
Brioni Young
Bernard Zachulski

Country of training statistics

Table D1 Competent authority statistics, applications and outcomes, by country of training, 2009

Country of training	Applications	Advanced standing	Certificates
Afghanistan	0	1	0
Albania	0	1	0
Armenia	0	0	1
Austria	1	0	1
Bangladesh	12	8	6
Belarus	0	0	1
Canada	27	28	2
China	0	0	1
Colombia	2	2	0
Croatia	2	1	0
Czech Republic	1	1	2
Egypt	9	6	6
Germany	5	0	2
Ghana	4	0	3
Greece	1	0	0
Grenada	2	0	1
Guyana	1	0	0

Country of training	Applications	Advanced standing	Certificates
India	142	83	169
Indonesia	0	0	1
Iran	3	2	3
Iraq	15	13	7
Ireland	266	234	83
Jamaica	1	0	1
Jordan	0	0	2
Latvia	0	0	2
Libya	1	1	1
Malaysia	1	1	1
Myanmar	9	6	9
Nepal	3	5	3
Netherlands	1	1	0
Netherlands Antilles	1	0	0
Nigeria	16	12	5
Pakistan	41	26	23
Philippines	2	2	2
Poland	1	0	3
Romania	4	3	4
Russia	4	5	6
Saint Lucia	1	0	0
Saudi Arabia	2	0	0
Serbia	1	1	4
Singapore	1	0	0

Table continues

Country of training	Applications	Advanced standing	Certificates
Slovak Republic	0	0	1
Somalia	1	1	0
South Africa	7	5	4
Sri Lanka	14	8	16
Sudan	5	4	6
Sweden	0	0	1
Syria	1	1	1
Trinidad and Tobago	0	0	1
Turkey	1	0	1
Uganda	1	1	2
Ukraine	4	2	3
United Kingdom	964	829	454
USA	37	25	2
Zambia	2	2	1
Zimbabwe	6	4	5
Total	1,626	1,325	853

Note: There is no direct relationship between the number of applications made in 2009 and the numbers issued with certificates or granted advanced standing, as those determinations may have been made in 2009 for applications made in a previous year or in 2009.

Table D2 AMC MCQ Examination, pass rates by country of training and number of attempts, 2009

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Afghanistan	3	6	1	3	13	0	5	0	1	6
Albania	1	0	0	0	1	0	0	0	0	0
Argentina	6	6	2	0	14	1	2	0	0	3
Armenia	1	0	0	0	1	0	0	0	0	0
Austria	10	4	1	0	15	5	1	1	0	7
Azerbaijan	0	1	0	3	4	0	1	0	0	1
Bahrain	2	0	0	0	2	1	0	0	0	1
Balearic Islands	1	1	0	0	2	0	0	0	0	0
Bangladesh	115	56	28	27	226	44	22	7	12	85
Belarus	4	3	1	0	8	1	1	1	0	3
Belgium	6	1	0	0	7	6	0	0	0	6
Belize	1	1	0	0	2	0	0	0	0	0
Bolivia	2	1	1	0	4	0	0	1	0	1
Bosnia-Herzegovina	0	1	1	0	2	0	0	0	0	0
Brazil	11	8	3	1	23	9	1	1	0	11
Bulgaria	7	2	2	5	16	4	1	0	2	7
Cambodia	2	2	1	0	5	0	1	1	0	2
Canada	2	0	0	0	2	2	0	0	0	2
Cayman Islands	3	1	0	0	4	2	0	0	0	2
Chile	3	0	0	0	3	3	0	0	0	3
China	102	59	10	12	183	39	34	3	3	79

Table continues

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Colombia	19	9	4	4	36	7	7	3	1	18
Cuba	3	1	0	0	4	0	0	0	0	0
Czech Republic	3	3	1	0	7	0	0	1	0	1
Czechoslovakia	1	0	0	0	1	0	0	0	0	0
Democratic Republic of the Congo	1	0	1	0	2	0	0	1	0	1
Denmark	2	0	0	0	2	1	0	0	0	1
Dominica	1	0	0	0	1	0	0	0	0	0
Dominican Republic	1	1	1	0	3	0	0	1	0	1
Ecuador	1	3	1	0	5	1	3	1	0	5
Egypt	89	27	14	12	142	51	14	7	4	76
El Salvador	1	0	0	0	1	0	0	0	0	0
Estonia	2	0	0	0	2	1	0	0	0	1
Ethiopia	1	0	0	0	1	0	0	0	0	0
Fiji	21	9	4	5	39	11	3	0	3	17
France	4	1	0	0	5	3	0	0	0	3
Georgia	0	1	1	0	2	0	0	0	0	0
Germany	61	10	3	1	75	49	5	3	1	58
Ghana	1	0	0	0	1	1	0	0	0	1
Greece	0	1	0	0	1	0	0	0	0	0
Grenada	1	1	1	0	3	0	1	1	0	2
Guyana	2	0	0	0	2	2	0	0	0	2
Hong Kong	2	0	0	0	2	2	0	0	0	2

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Hungary	2	1	0	1	4	0	1	0	0	1
India	597	210	93	74	974	332	103	47	28	510
Indonesia	17	6	6	7	36	6	3	5	2	16
Iran	190	55	17	7	269	103	38	7	6	154
Iraq	62	16	5	4	87	33	10	1	2	46
Ireland	8	6	2	0	16	5	3	2	0	10
Israel	1	0	0	0	1	1	0	0	0	1
Italy	2	2	1	3	8	0	1	0	0	1
Jamaica	1	0	0	0	1	1	0	0	0	1
Japan	3	2	0	0	5	1	2	0	0	3
Jordan	37	5	2	1	45	26	4	1	1	32
Kazakhstan	2	3	2	3	10	1	0	1	0	2
Kenya	5	0	1	0	6	3	0	1	0	4
Kyrgyzstan	1	1	0	0	2	0	1	0	0	1
Latvia	6	5	2	0	13	1	4	1	0	6
Lebanon	2	0	0	0	2	2	0	0	0	2
Libya	7	3	0	0	10	3	2	0	0	5
Lithuania	1	1	0	1	3	0	0	0	1	1
Malaysia	40	18	4	2	64	24	4	2	1	31
Malta	3	0	0	0	3	3	0	0	0	3
Mauritius	1	1	0	0	2	0	1	0	0	1
Mexico	3	0	0	0	3	1	0	0	0	1
Moldova	1	0	0	0	1	1	0	0	0	1
Montenegro	0	1	0	0	1	0	0	0	0	0

Table continues

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Myanmar	139	19	8	11	177	101	7	5	4	117
Nepal	42	14	9	3	68	22	7	6	2	37
Netherlands	9	4	2	1	16	6	2	2	1	11
Netherlands Antilles	1	1	0	0	2	0	0	0	0	0
Nigeria	78	30	15	9	132	32	11	9	1	53
Oman	3	0	0	0	3	3	0	0	0	3
Pakistan	312	102	45	38	497	170	47	23	13	253
Papua New Guinea	7	6	4	2	19	1	1	3	0	5
Paraguay	0	1	0	0	1	0	1	0	0	1
Peru	7	3	1	0	11	6	2	1	0	9
Philippines	214	92	43	41	390	63	33	11	11	118
Poland	7	5	0	0	12	3	2	0	0	5
Romania	10	10	8	9	37	3	3	0	1	7
Russia	81	43	21	23	168	24	15	8	10	57
Saint Kitts and Nevis	2	2	1	1	6	1	2	0	0	3
Samoa	4	2	1	0	7	2	2	0	0	4
Saudi Arabia	21	8	3	0	32	6	1	3	0	10
Serbia	3	2	1	6	12	1	1	0	2	4
Seychelles	1	1	0	0	2	1	1	0	0	2
Singapore	4	0	0	0	4	3	0	0	0	3
Slovak Republic	0	1	0	3	4	0	1	0	0	1
Somalia	1	0	0	0	1	1	0	0	0	1

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
South Africa	139	15	6	1	161	118	8	4	0	130
South Korea	16	4	2	1	23	7	0	0	0	7
Sri Lanka	292	45	18	13	368	220	30	10	9	269
Sudan	30	10	2	5	47	17	4	2	1	24
Sweden	1	0	0	0	1	1	0	0	0	1
Switzerland	4	0	0	0	4	1	0	0	0	1
Syria	5	5	2	2	14	4	1	0	0	5
Taiwan	4	0	2	2	8	3	0	1	1	5
Tajikistan	1	0	0	0	1	0	0	0	0	0
Tanzania	4	3	0	0	7	0	1	0	0	1
Thailand	5	1	1	0	7	2	0	0	0	2
Trinidad and Tobago	4	0	1	0	5	2	0	1	0	3
Turkey	1	1	0	1	3	1	1	0	1	3
Uganda	2	1	0	0	3	0	1	0	0	1
Ukraine	39	15	12	16	82	9	3	3	7	22
United Arab Emirates	7	0	0	0	7	3	0	0	0	3
United Kingdom	3	0	0	0	3	3	0	0	0	3
Uruguay	2	0	0	0	2	0	0	0	0	0
USA	2	1	0	0	3	2	1	0	0	3
USSR	1	0	0	3	4	0	0	0	0	0
Uzbekistan	2	0	0	0	2	1	0	0	0	1
Venezuela	3	1	0	0	4	1	1	0	0	2
Vietnam	7	8	1	3	19	2	4	1	0	7

Table continues

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Yemen	3	0	0	0	3	2	0	0	0	2
Zambia	1	0	0	0	1	1	0	0	0	1
Zimbabwe	22	5	0	1	28	16	3	0	0	19
Total	3,037	1,017	426	371	4,851	1,658	476	194	132	2,460

Table D3 AMC Clinical Examination, passes by country of training and number of attempts, 2009

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Afghanistan	4	4	0	0	8	1	4	0	0	5
Argentina	4	0	1	0	5	3	0	1	0	4
Austria	1	0	0	0	1	1	0	0	0	1
Bangladesh	61	32	4	1	98	37	16	1	0	54
Belarus	1	2	0	0	3	1	1	0	0	2
Bolivia	1	0	0	0	1	0	0	0	0	0
Bosnia-Herzegovina	0	1	0	0	1	0	0	0	0	0
Brazil	5	0	0	0	5	3	0	0	0	3
Bulgaria	2	3	1	0	6	1	1	0	0	2
China	57	14	2	0	73	44	9	2	0	55
Colombia	7	1	0	0	8	5	1	0	0	6
Croatia	1	0	0	0	1	0	0	0	0	0
Cuba	1	0	0	0	1	1	0	0	0	1
Democratic Republic of the Congo	1	1	0	0	2	1	0	0	0	1

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Ecuador	1	0	0	0	1	1	0	0	0	1
Egypt	23	15	0	0	38	15	6	0	0	21
El Salvador	1	0	0	0	1	0	0	0	0	0
Ethiopia	2	1	0	0	3	1	1	0	0	2
Fiji	8	1	0	0	9	4	0	0	0	4
France	1	1	0	0	2	1	1	0	0	2
Germany	22	5	0	0	27	12	4	0	0	16
Ghana	1	0	0	0	1	1	0	0	0	1
Greece	1	0	0	0	1	1	0	0	0	1
Hungary	3	0	0	0	3	1	0	0	0	1
India	204	75	5	0	284	118	46	2	0	166
Indonesia	1	2	0	0	3	0	0	0	0	0
Iran	77	25	1	0	103	43	16	1	0	60
Iraq	16	7	0	0	23	13	4	0	0	17
Ireland	2	1	0	0	3	2	1	0	0	3
Japan	1	0	0	0	1	1	0	0	0	1
Jordan	3	1	0	0	4	0	1	0	0	1
Kazakhstan	2	0	0	0	2	1	0	0	0	1
Kenya	3	0	0	0	3	3	0	0	0	3
Latvia	2	0	0	0	2	2	0	0	0	2
Macedonia	2	0	0	0	2	1	0	0	0	1
Malaysia	2	1	0	0	3	1	0	0	0	1
Malta	2	0	0	0	2	2	0	0	0	2
Mexico	1	1	0	0	2	0	1	0	0	1

Table continues

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Moldova	0	1	0	0	1	0	0	0	0	0
Myanmar	36	8	1	0	45	28	4	1	0	33
Nepal	8	3	0	0	11	7	1	0	0	8
Netherlands	3	2	0	0	5	3	2	0	0	5
Nigeria	12	5	0	0	17	7	4	0	0	11
Pakistan	71	25	1	0	97	35	12	0	0	47
Palestinian Authority	1	0	0	0	1	0	0	0	0	0
Papua New Guinea	1	0	0	0	1	1	0	0	0	1
Peru	1	0	0	0	1	0	0	0	0	0
Philippines	45	20	1	1	67	16	12	0	0	28
Poland	4	2	0	0	6	3	2	0	0	5
Romania	6	3	0	0	9	5	1	0	0	6
Russia	18	8	1	0	27	11	4	0	0	15
Saint Kitts and Nevis	1	1	0	0	2	1	0	0	0	1
Serbia	3	4	1	0	8	1	1	0	0	2
Slovak Republic	0	1	0	0	1	0	1	0	0	1
South Africa	35	3	0	0	38	32	3	0	0	35
South Korea	2	1	0	0	3	1	0	0	0	1
Sri Lanka	103	22	0	0	125	68	18	0	0	86
Sudan	2	3	0	0	5	1	1	0	0	2
Syria	1	2	0	0	3	1	1	0	0	2
Thailand	1	0	0	0	1	0	0	0	0	0

Country of training	Sat 1	Sat 2	Sat 3	Sat 4 +	Total	Pass 1	Pass 2	Pass 3	Pass 4 +	Total
Trinidad and Tobago	5	0	0	0	5	3	0	0	0	3
Turkey	2	2	0	0	4	2	0	0	0	2
Uganda	1	1	0	0	2	1	0	0	0	1
Ukraine	9	6	0	0	15	4	4	0	0	8
United Arab Emirates	2	0	0	0	2	1	0	0	0	1
United Kingdom	1	0	0	0	1	0	0	0	0	0
USSR	3	1	0	0	4	2	0	0	0	2
Uzbekistan	2	0	0	0	2	1	0	0	0	1
Venezuela	1	0	0	0	1	0	0	0	0	0
Viet Nam	3	3	0	0	6	3	1	0	0	4
Zimbabwe	9	0	0	0	9	7	0	0	0	7
Totals	919	321	19	2	1,261	567	185	8	0	760

Note: There is no direct relationship between the number of applications made in 2009 and the numbers issued with certificates or granted advanced standing, as those determinations may have been made in 2009 for applications made in a previous year or in 2009.