Abesway Medical Practice – From cottage beginnings to new age clinic

Dr Abraham Assef MBBS, FRACGP, FAAPM, DObstRCOG, Dip PM

Prologue

I reflect that I am writing the history of the development of our medical practice now, as an octogenarian, about a time when I was in my forties. I try to capture the uncertainty that prevailed at the time, as to whether general practice would survive as a discipline. What I write is supported by my diary notes, articles in the medical journals, and the albums of our practice. I have tried to free my memory from bias kindled by hindsight.

I was vaguely aware of some of the discussions taking place in the New South Wales (NSW) faculty of The Royal Australian College of General Practitioners (RACGP). I was aware that there was a general quandary as to whether medical students would be attracted towards general practice. Their mentors were specialists and their experience confined to hospitals and outpatient clinics.

Graduation photographs;
Left: Olga Voloshin.
Right: Abe Assef.

My objective in writing is to give a chronological history of a general practice in the latter half of the 20th century. Our story will take in a little personal history, but the emphasis will be on the development of the practice through various stages to a model that many have chosen to emulate.

Our threshold years – The 1950s

It was a summer afternoon in 1954 when Olga and I met in rural Tamworth, NSW. Within 12 months we were pursuing our careers in the United Kingdom. I was freelancing with terms in orthopaedics, gynaecology and obstetrics while Olga studied at the Institute of Ophthalmology at Moorfields, London.

We returned to Australia in early May 1957, Olga with her Diploma in Ophthalmology and me with my Diploma in Obstetrics. We were yearning to go! Our confidence was high, our finances low, and our drive strong. Our basic practice management skills were already evident in the manner we chose our address. The house was situated on a T-junction facing a street leading to Panania and the end of the railway line, East Hills.

Olga and I were already members of the NSW branch of the British Medical Association (BMA). A fully independent Australian Medical Association (AMA)

was not established until 1962. The medical secretary guided us in the protocol of where we could practice and the etiquette for dealing with colleagues. There was a need for doctors in the developing western suburbs of Sydney where it was quite acceptable to ‘squat’ – a term for starting a professional practice from scratch. We were excited by this prospect and rejected the idea of joining an established practice.

On a crisp, bright and frosty morning in mid-July 1957, we officially started our medical practice. Patient numbers built up rapidly. The learning curve in everyday clinical medicine and the skills required to manage a busy practice also grew rapidly. Soon I had bookings for confinements and my career as a general practice obstetrician had begun. At the time, the nearest public hospital was Canterbury District Hospital in Campsie. Ardee Private Hospital was located in the nearby suburb of Belmore. Both were well staffed and accepted maternity patients. As was expected of GPs of that time, I carried out minor surgery and some gynaecological procedures. Olga curtailed her ophthalmic skills to medical procedures and turned back offers to join the hospital staff.

General practice was a ‘cottage’ industry. Specialist practice was centred on public hospital staff appointments where the honorary system prevailed. Public patients were accepted after being ‘means tested.’ By providing free services to public patients, specialists had the rights to beds for their private patients. Specialists usually relied on referrals from GPs, and some supplemented their income by working as GPs.

At our graduation ceremony in 1953, Sir Charles Bickerton Blackburn, then vice-chancellor of the University of Sydney, addressed us. He stressed that GPs were the backbone of the profession, spoke of the difficulties they would encounter and how they were expected to be available to patients by day and night. The rewards would not only be material but also spiritual. It was a most inspiring talk and the message resonated deeply.

Our success had a flip side – within months we needed to consider alterations and additions. Living on the premises and working day and night proved very difficult. We endured nine months of ‘renovative bliss.’ The tradesmen working on the project and their families eventually became our patients.

Television began to impact our lives. Community attitudes and behaviour began to change. Consumers became more demanding. One example of this, in relation to general practice, was the manner by which out-of-hours house calls were often requested after watching favourite television programs.

Both state and federal governments became more involved with healthcare. A voucher system was already in operation for payment on medical services to the aged, the invalid and ex-service personnel. Medical, hospital and pharmaceutical schemes were being developed. There were discussions on fee structure and the coordination of health benefits to providers. To keep up with medical politics I regularly attended the Canterbury/Bankstown branch meetings of the BMA (AMA from 1962), which were held in the boardroom of the Canterbury District Hospital. In 1963 I was elected chairman.

Poliomyelitis was the scourge of the time. Regular screening for tuberculosis was mandatory and mobile chest X-ray units combed the suburbs. Heart attacks and cancer were certain killers and were greatly feared by the community. Routine vaccination of children for diphtheria, tetanus and pertussis was effective and strongly promoted as preventive medicine. Penicillin by injection and sulphanilamide tablets were great adjuncts for keeping some common infections under control.

Left and middle: The original practice. Right: the practice renovated.

Unwanted pregnancies were socially unacceptable and abortion was a criminal offence. Family planning and contraceptive methods were rarely talked about.

The unrelenting 1960s

The 1960s were unrelenting, not only in the practice but also in our personal lives. Each day was structured to allow time for morning and afternoon house calls for those who were too sick to come to the surgery and for the elderly and infirm. There were several consulting sessions each day at the surgery: 10.00 am – 1.00 pm, 4.00–6.00 pm and 7.00–8.00 pm, the latter to cater for workers returning home late. Maternity patients had two sessions per week dedicated to their special needs.

In an attempt to ease the burden of weekend out-of-hours house calls for my colleagues, myself and two other doctors, Bethune Wells from Padstow and Tony Gardiner from Kingsgrove, organised a 24-hour medical emergency service. The scheme had the support of our local AMA and was well received and appreciated. A decade later it was acquired by the Sydney Medical Emergency Service and is still in operation.

Our prayers were answered when on 21 September 1962, Nicholas Andrew Assef was born! This happy event changed our lives forever. Olga and I remained dedicated to the practice but our priorities were appropriately adjusted. We adored having Nicholas, but nurturing a child while living and working on the premises was far from ideal. We wanted to maintain our practice at Revesby but needed to provide the best environment for Nicholas. After living nearly a decade in Revesby, we moved to Bellevue Hill.

The 1960s were a time when seasonal epidemics of measles, mumps, chicken pox, rubella and influenza occurred. One had to be constantly vigilant of more rare cases of poliomyelitis, meningitis, glandular fever and tuberculosis. The adage that common ailments occur commonly was useful, but having a wide differential diagnostic profile to take into consideration was a good basic clinical strategy for GPs.

A number of issues concerned me. Many suburban GPs were unhappy with their lot. Long working hours and disrupted family life at weekends, sometimes for frivolous medical complaints, annoyed them. Many resented the pejorative term, ‘just a GP’ and envied the added status shown to specialists. Many believed that there was no future in general practice and opted to become anaesthetists, dermatologists, physicians and surgeons. I argued that as a college of GPs was in progress, there would be a bright future for the backbone of the profession. My colleagues were sceptical and regarded the fledgling college as an elitist club.

Another concern was the dramatic increase in knowledge across the medical spectrum. Relevant to general practice were:

- the development of a variety of antibiotics which could be taken orally, such as penicillin, tetracycline, chloromycetin, and terramycin
- an oral vaccine (triple antigen) for diphtheria, pertussis and tetanus
- an oral contraceptive pill for women which offered over 95% efficiency if taken correctly.

It was an exciting time to be engaged in medical practice. About the same time as our move to a new residence, I was appointed an honorary associate obstetrician and gynaecologist at Bankstown Hospital and held that position for over 15 years. I was elated that I was able to cope with the practice, meet the responsibilities at the hospital and continue to live in Bellevue Hill. The practice was well equipped – we had a mobile ECG machine and a vitalograph, air-conditioning had been installed and sound-rated doors were fitted in the consulting rooms to ensure privacy. The practice met the accreditation standards set out by the college. I consulted with a wonderful selection of specialists, and we had two full-time receptionists to cover surgery hours from 7.00 am – 7.00 pm. We appreciated the respect and support from a wonderful cross-section of people in our community.

In 1968, together with some of my peers in the area, notably Dr Lyndsay Thompson, Dr Kevin Byrne and Dr Paul d’Arbon, I sat for the inaugural Fellowship examination of the Australian College of General Practitioners. The examination was comprehensive and difficult, and some innovative and new techniques were used to assess competence in a clinical situation. For example, we were expected to complete 350 multiple-choice questions in three hours! There were several case studies and one-on-one interviews on making a diagnosis as well as responses to frequently asked questions. As we could choose an elective for the examination, I chose obstetrics and gynaecology.

We were all delighted to pass! Apart from self-satisfaction, Fellowship of the Australian College of General Practitioners (FACGP) conferred no additional privileges. Indeed, the examination generated more criticism of the college from its detractors for continued elitism and for pursuing an academic path. The backbone of the medical profession was breaking and nobody apart from the college seemed to be aware. Medical politics was a heady mix.

My obstetrics practice flourished and I had confinements weekly. There were inevitable delays and interruptions to practice routines. For those patients requiring more

Dr Olga Voloshin and Dr Abe Assef.

urgent care, I engaged a full-time medical assistant to live on the premises with his young family. This was one of my key strategies. It came unstuck when he had a marital crisis and left his wife and the practice. He returned a week or so later, but the damage was done and I had to move on from this experience. The number of patients at the practice dropped dramatically and, paradoxically, this helped me to cope with the situation. I resorted to sleeping overnight on some occasions and again fell back to relying on specialists in training for help with some sessions; but this was now, plainly, not ideal. I needed help from like-minded colleagues interested in general practice.

While working at Bankstown Hospital, I became friendly with a senior resident medical officer who wanted a career in general medicine and administration at the end of her term. In 1969 Dr Susan Britton became my full-time assistant and spent the next two-and-a-half years working for me. It provided the opportunity to plan our first overseas trip since our return from London in 1957. What could be more exciting than to attend the sixth World Conference in Gynaecology and Obstetrics, which was to be held in New York in April 1970?

Medical science was on the move. Great advances were taking place across the medical spectrum, especially in diagnostic procedures, therapeutics and improved surgical techniques. Blood samples were subjected to multiple biochemical analysis. We now had tablets for treating hypertension and congestive heart failure. In Sydney, Dr Frank Mills pioneered open-heart surgery at the Royal Prince Alfred Hospital. Medical topics not previously addressed nor well understood began to appear in journals and textbooks.

The challenging 1970s

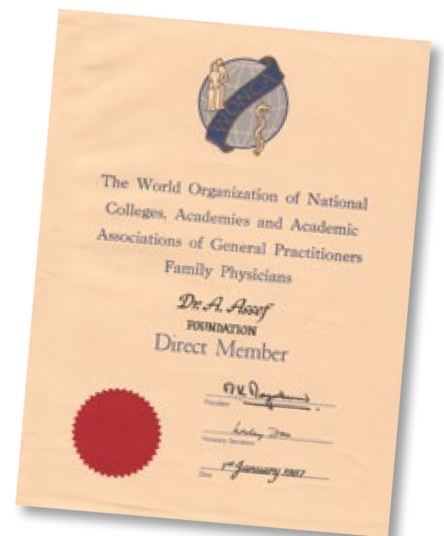
In 1970, the Liberal Government enacted a differential rebate system of payment for medical and surgical procedures. The legislation favoured specialists and discriminated financially and spiritually against general practice. The AMA had been consulted and the specialist lobby within the AMA had prevailed. There was outright hostility towards the association by disenchanted colleagues. Many practitioners felt betrayed and many more resigned. Overseas graduates now practicing in Australia were especially vocal about government intrusion into medical practice and interference in the doctor–patient relationship. Political ideologies polarised the medical community. Two groups emerged nationally, both espoused radical ideas and both were spawned by anger at the AMA.

Olga and I both remained members of the AMA and I remained dogged in my support of general practice. After all, Her Majesty Queen Elizabeth II had conferred the prefix ‘Royal’ to the college in 1969, so I reasoned that there must be a future for GPs. A world conference on general practice, hosted by our royal college (the RACGP), was to be held in Melbourne in 1972.

In October 1972 we attended the fifth World Conference in General Practice. The conference theme ‘Patient care – Now to the year 2000’ was full of optimism for the future of general practice. The importance of family medicine worldwide was reiterated in the plenary sessions and seminars. One could feel the effort being made to define the work of general medical practitioners and to structure it into a discipline. I was sufficiently moved to become a foundation member of WONCA – an unusual acronym comprising the first five initials of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners and Family Physicians.

Olga and I returned home with renewed hope for general practice and enthusiasm for GPs in this new era of medicine. It would take another two years for events to unfold before I was able to recognise the role I was destined to play and to fully commit to the practice at Revesby.

In December 1972 the Labor Party, led by Gough Whitlam, was elected into federal office after 23 years in opposition. In 1975, Health Minister Bill Hayden introduced Medibank (a national hospital healthcare system



Right: Dr Assef’s WONCA certificate.

which was means-tested at point-of-entry). It was supplemented in 1976 by a government-owned private health insurance fund, Medibank Private, established by Prime Minister Malcolm Fraser, a Liberal Party-Country Party coalition government.

Some years later in 1984, a re-elected Labor Party under Bob Hawke and Paul Keating, and Health Minister Neal Blewett, replaced Medibank with Medicare. Medicare is a publicly-funded universal healthcare scheme operated by the government authority, Medicare Australia, funding primary healthcare for Australian citizens and permanent residents. Residents can obtain free treatment in public hospitals and are entitled to subsidised treatment from medical practitioners, eligible midwives, nurse practitioners and allied health professionals who have been issued a Medicare provider number. Private health insurance was also available then, but not encouraged.

GPs were central to the implementation of this scheme, and provided a gateway to specialist care through a letter of referral. The GP was to be the lynchpin of the Australian healthcare system. As an added inducement for full participation by GPs the government introduced 'bulk-billing' which would eliminate the need for patients to bear the cost of medical consultations and guarantee a set percentage payment to the doctor. A necessary accompaniment was added paperwork and closer government scrutiny of practice procedures.

Moscow, capital of the Union of Soviet Socialist Republics, was to host the seventh World Conference in Obstetrics and Gynaecology in late August 1973. A window of opportunity presented – if we were to attend, Olga would be able to visit the land from which her parents were forced to flee during Russian Revolution. It would give us the chance to witness first-hand the economic and social effects of this revolution, and to introduce Nicholas, now 11 years old, to international travel and allow him to experience different cultures and see some great cities.

We returned home on 18 September 1973 with a renewed sense of purpose. I concluded that my future career rested in Revesby. The daily trial of commuting from Bellevue Hill was mitigated by the problems associated with inner city traffic and parking. High rental costs clinched it. Revesby was to be my future and our loyal patients would be the primary focus of my attention. Better practice management was my goal.

Clinical general practice had changed – GPs were doing fewer office and hospital procedures and more referrals to their specialist colleagues. Consultation management had become more difficult. The ever important doctor–patient interface at the primary care level had become more varied and, at times, extremely complex.

Bankstown Hospital had become an accredited teaching hospital for obstetrics and gynaecology. Professor Harvey Carey and his students were often involved with deliveries and tutorials that I attended and sometimes called upon to orchestrate. Pelvic ultrasounds and mammograms were developing into useful diagnostic tools. Epidural anaesthesia was a great advance in the management of difficult obstetric cases, but required a skilled anaesthetist to be available. Husbands were now encouraged to be present at the birth of their child.

The biggest challenge to the practice was how to update our clinical health record system. I considered this a crucial step towards having a quality practice. The 6×4 inch card system with its modifications could not cope with the growth of clinical data on so many patients. I further resented the ever-increasing steel cabinets required to house the ever-increasing bulk of record cards. In a dynamic interactive doctor–patient situation, how do you record diverse data so that you can retrieve relevant information to make a diagnosis, or for the purpose of a special consultation? Moreover, it was a tedious task to provide a good referral letter. While I needed to address this problem, I did not know how.

Family Medicine Programme

In this relatively comfortable phase of my life, the stage was now set for a dramatic change to my career and the raison d'être for telling this story. In the winter of 1974, I received a telephone call from Dr John Dowsett. He introduced himself as the newly appointed NSW Director of the Family Medicine Programme (FMP), a national vocational training scheme for medical graduates, which was an initiative of the RACGP. He went on to explain that the young South Australian doctor whom I had recently employed had also approached the FMP to be a trainee. As my practice was already accredited, would I consider joining the program and be his supervisor? I was surprised and excited. How could I decline?

We were in unchartered waters and I would need to acquire new skills. Dr Steven Woodards became our first FMP trainee. At a meeting of colleagues assembled from NSW and the ACT, Dr Michael Heffernan and Dr Wes Fabb spelt out the challenge. They said the aim of the FMP was to help develop a well-rounded and experienced GP capable of meeting the complex medical challenges for a changing profession – the idea was to accelerate the learning process by sharing our experiences and to nurture medical graduates through the uncertainties and travails that abound in general practice. It would also be an opportunity for medical graduates to sample another side of medicine that hitherto they had not experienced.

PROFILE ON A SUPERVISOR

PROFILE ON ...

DR ABE ASSEF

by
Dr Peter Clyne
Medical Educator

Dr Abe Assef
GP Supervisor

"The magic of the consultation - the way a good general practitioner can accomplish in minutes things that could take another practitioner a half hour."

Page 11

RACGP Training Program

Profile on a supervisor – Dr Abe Assef.

The history of the FMP is thoroughly documented, but I want to give a brief and personal account of the remarkable initiative. In the first few years it withered and could have died on several occasions had it not been for the concerted efforts of all who were involved and believed in the program. We lobbied members of parliament and demonstrated the value of what we were doing and what was being achieved. Regardless of those holding political power at the time, the college successfully negotiated the additional funds to keep the program alive. Integral to the program was the initial general practice term, which was the beginning of the four-year vocational course. Here is where our practice fitted into the scheme.

At FMP workshops we came under the tutorship of a young, dynamic personality and educator, Dr Warren Ogborne. These 'think tank' seminars were to become legendary. Several years later in 1979, Dr Douglas Killer was appointed to assist Dr Ogborne and together, they became known as the 'dynamic duo.'

Feedback as a supervisor was very good, but I was far from satisfied on several counts. The practice had slowed down, and although not unexpected, it was a disappointment. The concept of a teaching practice was a new experience and not readily accepted. The ten-week changeover of doctors was not helpful either and highlighted a weakness in the FMP. I was grateful for the support of the majority of patients. I was also bothered by not exposing my younger colleagues to the 'out-of-hours' experience. Patients never forget you for being available for them in their time of need. I would have liked my younger colleagues to have this experience, but it was not yet to be.

Health Record System

The RACGP was to hold its 18th Annual General Meeting (AGM) in Sydney in August 1975. For the first time, I became aware that our practice was the same age as our college!

The Practice Management Committee of Council (PMCC) was to launch a health record system at 'Convention 75.' Under the chairmanship of a South Australian colleague, Dr Clive Auricht, they had been working on it for several years. It was a problem-oriented medical record system, the idea for which was sparked by a keynote speaker, Dr Lawrence Weed, at the 1972 World Conference in Melbourne.

At the practice management display area of the convention, I was presented with my own A4-sized manila folder containing a health summary sheet and a problem-oriented progress note sheet. I was impressed with the system and began my excursion into health records management. I placed a substantial order for the Health Record System (HRS) on behalf of our practice.

Now I had to plan for the introduction of this comprehensive HRS into our busy practice. Not only did I require special alterations to accommodate floor to ceiling shelves, but also the right person to convert the relevant and confidential contents held in the card system into the new HRS. My search for the right person led me to select Barbara Taylor, a former head sister at the Paediatric Department of Bankstown Hospital. I saw the potential of the new HRS immediately. Imagine the ease of providing an excellent referral to a consultant for their opinion, especially for those patients from a multicultural background. Imagine each patient having access to, and being responsible for, their own health summary sheet. Imagine the importance of a patient-held summary sheet when travelling or moving interstate or overseas.

The introduction of the office photocopy machine added to the potential applications of the system. Think of the chronically ill patients needing out-of-hours and emergency care – a special column devoted to coding diseases enhanced the health summary sheet to a research tool. I saw the clinical usefulness of the health summary sheet as a breakthrough in practical patient management.

Office filing in the practice.

The NSW faculty was calling for members to show more interest in their college. Dr Richard Finch, a mentor from Tamworth days and now NSW faculty chairman, suggested I join the PMCC. Two regular committee attendees were Dr Richard Willcocks and Dr Kingston Kinder. When Dr Kinder was appointed chairman of the national PMCC, I replaced him as chairman of the NSW PMCC.

As chairman I was called upon to perform tasks, some of which were beyond my comfort zone. We were beginning to show the flag in academic circles. Dr Peter Manzie organised sessions at the University of Sydney where we addressed medical students on activities relating to general practice. I was called upon to write several articles, which were published in the college journal, *Australian Family Physician* (AFP) and helped to edit a national quarterly bulletin for users of the HRS. I also enjoyed a relationship with the 'founding fathers' of the college, Dr Bill Conolly and Dr Chad Saxby. Dr Conolly had me become his assistant treasurer of the NSW faculty. Dr Saxby persuaded me to take over his position as the college representative on the Australian Council on Smoking and Health (ACOSH).

As chairman of the NSW PMCC, I liaised with the FMP secretariat to convene the first receptionist training seminar in the state in April 1977. The successful format was the forerunner of many more suchlike events. In February 1978, I was a session leader on medical practice records at the inaugural Residential Five Day Workshop held at the University of New England, Armidale.

It was on 12 April 1976 when Dr Peter Keong Kor Yap became our sixth trainee. He was excited by what was being done in the practice and was looking for a long-term commitment. I turned to Dr Dowsett for advice. There were already precedents within the FMP – Peter could remain a participant. After all, was not this aspect of replenishment of GPs one of the main objectives of the FMP?

Abesway Medical Practice

It was now appropriate for Olga to move laterally into an administrative role and wind up her practice. It was also now time for me to discontinue my obstetric practice and resign my honorary position at Bankstown Hospital. On 1 July 1978, Olga and I entered into a full partnership with Dr Yap. Thus, Abesway Medical Practice emerged as a working entity with 'ABANOL' as the registered company name and administrative instrument.

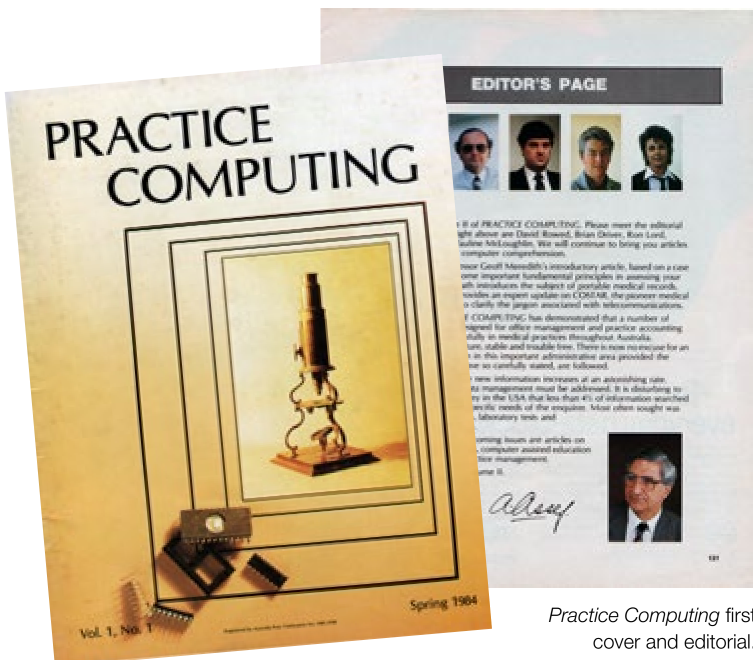
Our superb HRS was up and running well. We were already using it for preparing good referrals to consultants. We were able to link family files, codify diseases and identify the immunisation status of our patients. It was a godsend for managing patients with multiple and complex problems, especially those from a multicultural background who had a word-picture tool available to those responsible for their healthcare. I shared the versatility and value of this resource with my colleagues at every opportunity.

The FMP was also evolving and learning from experience. Trainees were now given a more appropriate title of 'registrar.' More flexible six-monthly attachments were now on offer. An excellent method of formative assessment was developed to help the registrar assess their progress during their attachment to the practice and provide valuable feedback to the FMP.

Australian Council on Smoking and Health

The 1978 AGM of the RACGP was held in Sydney and I was asked to organise the pharmaceutical trade exhibits. As the college representative on the ACOSH, I was moved to address convocation on the health risks of smoking cigarettes. Convocation is our general assembly of colleagues where matters considered important can be discussed and, if approved, the RACGP Council is obliged to give the matter further consideration.

I had already raised the issue of smoking as a health hazard at Bankstown Hospital and Green Oaks Private Hospital, where patients, staff and visitors were discouraged from smoking in the maternity wards. I led the debate that resulted in our college being the first of the learned colleges in Australia to publish a



Practice Computing first cover and editorial.

policy statement condemning the smoking of cigarettes. Then-president of the RACGP, Dr Bill Jackson from Tasmania, issued the policy statement, which was published in the *Sydney Morning Herald* in April 1979. It was a brave move by our young college. Retaliation from the tobacco industry and their subsidiary companies was swift. Much needed financial support and goodwill was withdrawn. Such is the vagary of taking a political and moral stand!

Gateway to the rewarding 1980s and beyond

I have chosen 1980 to end this story of the development of the medical practice from a humble cottage beginning to a new age teaching clinic – Abesway Medical Practice. My story demonstrates how the FMP helped save general practice for the next generation of family doctors.

The year 1980 saw me assume the role of chairman of the Medical Practice Computer Sub-Committee of the PMCC. This was to open a new chapter in my career. Our college was to lead the medical profession into the information technology revolution and its application to the computer. The computer became smaller and portable and, with sophisticated software, became a flexible and versatile tool that would begin a new frontier in human endeavour.

In May 1979, I convened the second AGM on the computer in general practice, held at the Sydney Boulevard Hotel. The conference was highly successful educationally and financially, and enabled the PMCC to develop a computerised medical records system.

The third national conference followed up this meeting in 1981 on computers in medical practice, which was held at the Sydney Hilton. It attracted an international audience and confirmed that the application for computers in medicine was established.

Abesway Medical Practice seized the initiative to apply the computer in the management of the front desk. The difficulties encountered with the changeover were documented and shared with colleagues throughout Australia.

After a successful international conference on computers, held in Melbourne, I was approached by a commercial organisation in Sydney to manage and edit a computer magazine devoted to medical practice. A British pharmaceutical company wanted to be involved in the development of technology by sponsoring the magazine. Dr Peter Grieve, Secretary General of the RACGP, encouraged me to accept the editorial position so that it did not fall into the hands of someone outside the college. The project commenced in 1984 and was successfully received. I was proud of my editorial panel: David Rowed, Brian Driver, Ron Lord, Alison Titchen and Pauline McLoughlin. After two years the sponsorship was withdrawn.

My vision for GPs began to develop – in March 1989, I had an article published in AFP titled 'A vision splendid – Primary and continuing care clinics (PACCC)'.*

Dr Abe Assef with a computer in the practice.

Epilogue

Over 50 registrars practised their skills under our supervision. Australia developed into a vibrant multicultural society. Our practice reflected this development. Many of our registrars were graduates from foreign universities. There were more female graduates, many of whom chose general practice as their preferred vocation. Abesway Medical Practice was well geared to accommodate change.

In 1993 Peter and Meefong Yap purchased the property and practice from Olga and me. Dr Yap continues to take in registrars and maintains the tradition of Abesway Medical Practice.

Although I retired in 1998, Abesway Medical Practice continues with Dr Yap at the helm.

*This article is available on request from the RACGP John Murtagh Library at www.racgp.org.au/support/library/services

The office mascot: Olga's bear from China, 1930.

Dr Assef is the only man [we] know who got both the Waugh boys out in one delivery

A tribute to Dr Assef from Mark and Steve Waugh