pital—this was Mount Drury Hospital where the practice was being conducted—on one occasion I would see Dr. X and on the return visit I would see Dr. Y and on the third visit, I would see Dr. Z. And one didn't know what the other had done, and what my ailment was and what my problem was and he would have to read the chart. And it sort of disturbed me. I didn't feel that I was getting the proper medical care and attention.

This is the only objection that I have to this group practice.

Do you have any thoughts on that, Mr. Cohen?

Mr. COHEN. Yes.

I am quite well aware of the point that you make. I have been a member of the group practice plan myself for many, many years. And I recognize what you have to say there.

I should say first that the term "medical group" as it is used in the bill is not necessarily a prepaid medical care plan, and an insured plan like HIP in New York. It could either be a plan with a fee for service of a group of people, or prepaid and group practice like HIP. So HIP is not the sole type of arrangement that we are talking about here.

Now, with regard to the rest of your questions, I would like to turn that over to Dr. Lee. He has actually as a physician practiced in a group practice plan, and I think he could probably answer your question better from the professional standpoint than I could.

Dr. LEE. This arrangement, of course, varies with different groups. I happen to have been in a group of approximately 100 physicians. About 85 percent of the practice was fee for service, and about 15 percent was prepaid. The prepaid group consisted mainly of the students and about one-half of the faculty of Stanford University. Patients could select any physician within the group of 100. Of course, there were some pediatricians, some internists, and some general practitioners. But they had to select one of the physicians in the group. Patients could not choose, having entered the group practice plan, a physician outside the group.

In addition, I would like to comment regarding your concern about family practice. I think many people now, with the development of groups, turn to the group as their family physician. There may be a pediatrician and an internist that will look after the entire family. There are many groups that are now adding general practitioners. Moreover, this is an ideal environment for a general practitioner, because he works even more closely with the specialists within a group. So it does—to some extent—solve one of the really knotty problems caused by the decrease in the number of general practitioners.

Mr. FINO. Just one other question, Mr. Cohen. Would somebody in this area be somewhat handicapped by requiring that there be five doctors in the group before they could benefit from this legislation?

Mr. COHEN. We would certainly want to keep that flexible in the administration of the law. I think that there may be situations in which you would have three or four or five physicians and perhaps some part-time people. But on the other hand, I don't think that we should go as far as to make no judgments on this score and make the financing available to plans that would not, from a medical standpoint, be able to really operate efficiently and properly. We would want to balance these considerations.

Dr. LEE. I might just add one thing on that, Mr. Fino. That is interesting. Actually, in isolated areas such as North Dakota, South