TABLE 2.—*Suggested "core curriculum" for new-mold medical school*

	Periods per week, rough estimate
Freshman year:	
Anatomy	3
Neurology (1 each of neurobiology, neuroanatomy, and neurosurgery)	3
Radiology	3
Physiology	3
Pharmacology	6
Pathology	6
Epidemiology and medical sociology	2
Medicine	5
Physical diagnosis	3
Psychiatry	3
Medical outpatient clinics	4
Total	41
Sophomore year:	
Pathology	5
Microbiology	5
Physiology	2
Pharmacology	2
Medicine	14
Clinical neurology	2
Pediatrics	2
Psychiatry	2
Epidemiology and medical sociology	2
Elementary physical diagnosis	3
Total	39

Junior and Senior Years

All of the student's time in the *junior year* would be spent in learning practical family medicine. There would be short, explicit courses in family, community, social, political, economic, and historical aspects of medical service. Hospital integration would be minor, consisting merely of brief periods which would serve to acquaint the student with the acute, chronic, emergency, and rehabilitative phases of medicine.

In the *senior year*, during the first 6 months the student should be assigned as an intern in the hospital, getting experience in minor surgery and obstetrics. In the last 6 months of this year, he should be placed as a preceptee to a qualified teacher of general practice or to a group of physicians practicing together.

In both the *junior* and *senior* years, he would be spending a major portion of his time in out-patient work, learning to integrate all the clinical aspects of medicine with his practical and textbook knowledge.

The "Fifth Year" (Mandatory)

The traditional internship would be dispensed with. Instead, the young physician, now appropriately titled, would continue to practice as a preceptee to a solo physician or to a group. During this year of experience, he would continue to enlarge his knowledge and skills, and would learn first-hand about such things as medical economics and his own unique role in the complex community set-up for providing medical services to the public. During this period, his reading material should consist of medical history and two or three scientific journals slanted specifically to the problems of general practice.

He would attend his patient in the hospital, in collaboration with specialists. This arrangement would afford him a working knowledge of how his handling of patients comes under the specialists' surveillance. In turn, it will be the responsibility of the specialists to continue to educate the general practitioner.

Mr. ROGERS. Our next witness is Dr. Samuel P. Martin, who is provost of the Medical Center at the University of Florida. It is my personal pleasure to greet Dr. Martin. I have known him and know of the very excellent work he does and I think he can probably help us and