A comparative health care systems program is described in which students combine classroom seminars with site visits and participant observation in clinical settings. The combination of traditional classroom and experiential education is designed to encourage the linking of concrete experiences to higher levels of abstraction through a sociological perspective.

Experiential Education Abroad

A Comparative Health Care Systems Program

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For the past five summers, Emory University's sociology department has been sponsoring a comparative health care systems program based in London, England. As an attempt to integrate experience in another society with classroom activities, this program might serve as a model for other teachers interested in the development of similar programs.

The course objective, simply put, is to have students approach health care through a "sociological perspective." More specifically, it intends for students to understand the delivery of health services as a subsystem, closely tied to the larger political, economic, and cultural system of a society. The comparison of two societies (in this case, the United States and Britain) enables students to see how variation in the health delivery systems stems from differences in the larger organization of society and its peculiar evolution of social institutions. The first-hand contact

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enables students to perceive how system differences impact the everyday experience of patients and health providers and the interactions between them.

Britain offers an ideal location because of the dramatic contrast in delivery systems with minimal cultural and language barriers. The National Health Service represents a centralized, government-directed system of delivery supported by general taxation with salary or capitation-payment of practitioners and no payment required at point of utilization. By contrast, the United States provides a more heterogeneous, decentralized system (some would say "nonsystem") with an entrepreneurial ideology, usually requiring payment by patient at point of use with fee-for-service compensation. (In reality, the systems may be more alike than different in some aspects of functioning, problems being faced, and organizational responses to the problems. The discovery of unanticipated convergences between systems can be as exciting as discovering contrasts and, in some cases, has a greater educational impact when explanations are sought.)

During the spring prior to the program, students are provided with a reading list and a series of preparatory meetings. The development of the U.S. health care system, major problems facing it, origins of the problems, some proposed policies for coping with them, considerations in making comparative studies of society, and an overview of the NHS are discussed in these preliminary sessions. Readings such as Freidson (1970), Mechanic (1970a, 1970b, 1971, 1976), Sidel and Sidel (1977), Fuchs (1974), Anderson (1972), and Illich (1976) have been used in recent years to introduce the program issues and provide students with an orientation and vocabulary for interpreting their experiences. Students without a first-hand exposure to health care institutions (except as patients) are provided with contacts at area health facilities of special interest to them.

The six-week summer program in London includes a first and last week of classroom meetings. Guest speakers consist of London area academics or health professionals, with an emphasis on using the talents of social scientists researching health-related

problems. The first week provides a general introduction to the development and current functioning of the NHS. The last week focuses more specifically on different occupations or services within the NHS. The Emory-affiliated sociologist serves as a discussant in those sections, relating comments on the NHS to the U.S. health care systems and the previously completed readings.

The middle four weeks involve additional classes with guest lecturers, field trips to representative health facilities (geriatric centers, VD or drug clinics, mental health institutions, hospitals, hospices, and the like) with on-site seminars conducted by the institution's staff. "Walking tours" though parts of London relevant to a study of health and excursions to facilities in other parts of England are also scheduled. The last three days of the middle weeks are reserved for "internships." Students are placed in a health care setting of their choice and both observe and work, utilizing what skills they possess. Most have a variety of experiences in any given setting and, through this personal exposure, are able to gain further insight into how the system operates. In the past, students have worked and observed in causalty units of hospitals, maternity hospitals, geriatric centers, mental health facilities, drug and VD clinics, government administrative agencies, social service units, primary care group practices, dental and ophthalmology centers, and a variety of specialty services in general and teaching hospitals in the London area. The principal danger with individual interships rests in what Freidson (1970: 176-178) has termed the "clinical mentality." Students may place a greater faith in their own (nonrepresentative) experience than in what they have learned in class or readings. Further, some of the students lose sight of the program objectives and concern themselves more with the development of clinical skills. This is paticularly problematic because the program attracts undergraduate pre-health profession students along with a mix of allied health, medical, and nursing students and established health professionals. But the periodic return to the classroom and requirement of a final paper, putting the experiences into a broader context of comparative studies, operate to reinforce program objectives.

To date, evaluation of the program has been somewhat unsystematic and subjective. But the required papers do offer a fairly good indication of whether students were able to achieve course objectives. The indication is that the program succeeds, for it is rare to find a paper in which the student fails to discuss individual experiences in a service without placing them in the context of the NHS and its relationship to the larger political and economic structure. Further, nearly all students have been able to use that insight as a way of understanding reasons for similarities and differences in health care systems of Britain and the United States. The students' own evaluations of the program have been strongly positive and the follow-up contact with students after a year indicates that these reactions apparently do not dissipate.

It is believed that the program's greatest academic strength stems from an integration of experiential with traditional classroom study. As Coleman (1976) has pointed out, the experiences by themselves may be of little value in achievement of course objectives unless they link up with some higher level of abstraction. But because there is an experiential component, abstract symbols or general principles are linked to concrete events, become embedded in the memory, and are therefore more likely to be remembered (Coleman, 1976: 58).

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