ABSTRACT. An analytic description of the inpatient consultation in a pediatrics teaching clinic in an urban hospital in Zaire is presented. Participant observation revealed that in order to practice biomedicine in Zaire, the physicians establish a working, clinical model which takes into account particular aspects of the social, cultural and material environment. The hospital room changes from classroom, to examination room, to social/convalescent room as the definition of the situation shifts along with the role shifts of the actors. Contrasting health and illness expectations of the medical personnel and the parents, as well as French and vernacular language switching, emphasize the distinction among definitions of the situation and corresponding role behavior.

Case studies of physicians when actually engaged in practicing medicine raise the issue of the relation between the biomedical model of western medicine and the actual manner in which physicians carry out their practice. The biomedical model has been defined as characterized by a focus on the treatment of the body alone as a pathogenic agent independent from the social and psychological context of the patient. It is thought to be based on scientifically accepted knowledge and rationalistic thought processes from which diagnosis is derived and therapies determined. (See Fabrega 1974, Engel 1977.) Hahn (1982) concluded from his case study of a physician practicing internal medicine in the United States that he mainly used this biomedical model as the basis for decision-making and consultation. Any attention paid to personal histories or the social conditions or emotional states of the patient was superficial and considered irrelevant to the medical practice unless it was necessary for compliance. Hahn (1982) further suggested that this view of the physician studied was consistent with the American institution of medicine as well as the social environment in which the physician practiced. This position of Hahn suggests that at least one type of relation between the biomedical model and actual practice is one in which the physician follows the model as rigidly as possible, or perhaps, as rigidly as the patient will tolerate.

Lock (1982), on the other hand, concluded from her study of physicians treating menopause in Canada that the physician developed his or her own working clinical model which diverges significantly from the scientific biomedical or biopsychosocial medical model currently being taught in medical schools. The biopsychosocial medical model is basically a biomedical model that is expanded to include the recognition that diseases of the body can be or are influenced by the psychological and social conditions of the sick person. In this model diagnosis and treatment takes into consideration these additional
dimensions (Engel 1977, 1978). The various working clinical models or “folk” models, as Lock called them, appear from her descriptions to be highly influenced by the physician's ideology concerning the controversy over the definition of menopause as a disease or as a normal state of the female body in transition. In addition it is influenced by the physician's ideology concerning women's place in society. Lock emphasized the non-scientific content of the clinical models used by the physicians when actually practicing medicine as compared to the rational, scientific content of the biomedical model as taught in medical school.

In the study I conducted of consultations of physicians making rounds in a pediatrics teaching hospital in Lubumbashi, Zaire, I found, like Lock (1982), that the physicians developed clinical models based on the biomedical model. The clinical models diverged from the biomedical model to the extent that it was “workable” in the particular cultural and material context in which they practiced medicine. I also found this study to corroborate Hahn's (1982) position that the view of the physician practicing medicine is consistent with that of the medical institution in which the physician practices. The physician in Zaire did not practice medicine in the same manner as Hahn's physician, Barry, did in the United States. Rather, he varied his practice to conform to contingencies of the Zairian biomedical institution as it exists along side other Zairian medical institutions. The models of the physicians in Zaire were mainly influenced by three factors, which were a direct response to the social, cultural, and material environment in which they were practicing medicine:

1. the need to adapt the biomedical model to Zairian medical models prevalent among their patients in order to obtain compliance from their patients;
2. the need to adapt the biomedical model to the material contingencies of the medical facility, which lacked much of the equipment and personnel considered necessary to carry out the biomedicine satisfactorily or successfully;
3. the establishment of a clinical model which took into account the various people present during a consultation (Kornfield 1978).

It is this third aspect of the influence of the working clinical model that I will focus on in this paper.

In the teaching consultations in the Zairian pediatrics hospital, mothers were hospitalized with their babies mainly because of insufficient medical staff and the need for mothers to provide care. As a result, physicians were obligated to allow the mothers to remain in the hospital room with their babies during the consultation. Their presence was required both for aid in caring for the sick infant and because of a belief system that aroused suspicion of and lack of