

COME ON IN THE ROOM

“Come on in the room”: A look at Gullah culture and the importance of culturally competent health care providers

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Abstract

The Gullah culture embodies many distinct characteristics that pose as obstacles for healthcare providers. These characteristics include ideas about nature, family, language and religion. In order to provide quality health care to the Gullah people, healthcare providers must be sensitive to their cultural differences. Two models used to promote cultural competency include the Campinha-Bacote model and the LEARN model. Becoming culturally competent is important to health care professionals in general, and with regard to the Gullah community, doing so may preserve a unique and important culture that has survived in a small part of the United States.

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Introduction

In a hymn central to the religious practices of Gullah, the congregation sings “Come on in the room/ Jesus is my doctor/ He writes out all of my prescriptions/ He gives me all of my medicine in the room” (Georgia Mass Choir, 2009). This hymn exemplifies a central part of the Gullah culture that is derived from their African ancestry. In the late 18th century, slaves from West and Central Africa were brought to the United States through the main port of Charleston, South Carolina (Cross, 2008). Segregation during the time of slavery and the Civil War strengthened the bond among the Gullah people. As a result, Gullah communities still remain isolated today. The history of separation between white and black communities has fueled tensions and made communication difficult. This obstacle, coupled with the unique aspects of Gullah culture, makes the dynamics of interaction challenging. Specifically in the field of healthcare, these challenges must be addressed with conscious effort. A health care provider’s role in becoming culturally competent amongst the Gullah population requires a thorough understanding of their cultural practices and beliefs and the ability to identify existing barriers. Two strategies that offer providers means to approach caring for those of Gullah backgrounds are the Campinha-Bacote model and the LEARN model.

Gullah Culture

The homeland of the Gullah people is a coastal strip 250 miles long stretching between Georgia and South Carolina, where low, flat islands are separated from the mainland by salt-water creeks (Pollitzer, 1999). Because of the land’s unique climate and geographic location, nature has become an essential part of their culture and belief

system. The isolation of Gullah people, their rural surroundings and the absence of medical practitioners fostered a dependence on nature. This influence can be seen in all aspects of their lives, specifically in their faith in natural remedies as opposed to Western medicine. Most kitchen cupboards held ingredients for prescriptions used to cure illnesses (Kinlaw-Ross 1996). For example, in the Gullah culture, a common remedy for a stomachache is a mix of two teaspoons of flour in a glass of water (Kinlaw-Ross, 1996).

The family is another central aspect of Gullah culture that may differ from mainstream U.S. cultures. Throughout these communities, family has been an important yet flexible social unit (Pollitzer, 1999). The role of family developed from the traditions of their African ancestry and is still prevalent today. In contrast to the nuclear family in much of the Western world, most in the Gullah community live in extended families with a woman as the most central member. “Mammies” or elderly women in the community play a vital role in their practices of teaching children communal proprieties and family lore (Pollitzer, 1999). Polygamy has also had an impact in defining family roles, and marriage is established through the members of the community as opposed to being legally sanctioned. The practice of polygamy and the importance of kinship in Gullah culture have created a network of interdependent families dedicated to the well being and survival of the community. The family is one of the most important factors among the Gullah people (Demerson, 1991).

Another distinct aspect of Gullah is their language, which is often indecipherable to people outside the culture. A lack of formal education and access to resources left most Gullah individuals illiterate and unable to communicate verbally with outsiders (Pollitzer, 1999). In an attempt to communicate among Africans speaking different dialects and

neighboring Europeans, the Gullah language was born. The language is composed of short sentences lacking verb tense, Western sentence structure and gender pronouns. It is discernible by its rhythm, tempo and beat (Pollitzer, 1999). An example of the Gullah language is expressed in the common proverb, “Mus tek cyear a de root fa heal de tree,” meaning “take care of the roots in order to heal the tree” (Cross, 2008). Along with the history of the language, the naming of children is also strongly influenced by the Gullah African heritage. Gullah newborns are typically assigned two names, the first of which is an official and generally English name, whereas the second is usually a nickname known and used only by those in the community (Demerson, 1991). The unique language and proverbs of the Gullah people are a distinct part of their culture and greatly affect how they communicate with others outside the community.

Religion plays a profound role in the Gullah heritage, and the practices today parallel those of centuries ago (Cross, 2008). Due to geographic isolation, rural setting, lack of resources and the belief that God and nature are one and the same, the Gullah people have relied on their faith to cure life’s ailments. As a result, rather than seeking medical attention, they believe illnesses are a direct result of God’s wrath and therefore turn to divine intervention as the only means for a cure (Blake, 1984). Root doctors were common in the Gullah community, and along with providing herbal remedies to cure illnesses, they also served as spiritual advisors and counselors. It was believed that their powers were a gift from God intended to help mankind (Demerson, 1991). These practices and beliefs demonstrate the importance of religion in daily life and particularly in relation to health and wellness.

Barriers to Healthcare

While the Gullah culture is rich and unique, it is not consistent with westernized medicine. This conflict can present many challenges to become culturally competent and bridge the gap to provide quality healthcare for the Gullah community. Because of their strong belief in the cure-all properties of nature, modern medicine is often viewed as foreign and irrelevant. Even when given medicine, most Gullah individuals choose not to follow the instructions provided by medical practitioners. For example, when a Gullah woman was given pills to treat her high blood pressure, she instead chose to put moss in her shoes, believing it to be the better remedy (Blake, 1984). Health care providers are often seen as meddlers as opposed to healers because their treatments usually contrast with Gullah traditional beliefs (Blake, 1984). This system of beliefs is based on years of limited modern health care and has consequently perpetuated a fear and stigma that associates medical treatment with death. According to Dr. J. Herman Blake, a noted Gullah scholar in residence at the Medical University of South Carolina, this fear is exemplified in the Gullah expression of “taking the table,” which is a saying that means a person is undergoing surgery and it is used to prepare others for the likelihood of death (personal communication, July 10, 2009).

While the Gullah language is a defining aspect of their culture, it puts them at a disadvantage for receiving proper healthcare. The language is only fully understood by those within the community, which causes a major communication barrier between the medical provider and the patient, specifically in relation to history taking, physical assessment, and follow up treatment. Their lack of education also contributes to the communication barrier. While education has improved, many of the older generations

have a very limited exposure to schooling often not completing education beyond the 8th grade (Blake & Simmons 2008). This limited education makes patient compliance with prescriptions very complex because they are often unable to understand the written instructions. Another way this illiteracy affects the Gullah people is evident in their avoidance of doctor visits for fear of having to sign their name. This fear demonstrates the perception that outsiders may have about Gullah people that life is passing them by and they don't belong in the modern world (Blake, personal communication, July 10, 2009).

The Gullah belief that God and nature are intertwined has laid the foundation for their rituals and medical interventions. They believe that, with the adequate amount of faith, God will heal whatever ailment they may suffer. This contributes to their reluctance to accept modern medical practices and to seek preventative care. Corey Roper, for example, is a member of the Gullah community who stepped outside the confines of traditional Gullah medicinal practices and received a kidney transplant at the Medical University of South Carolina in 2007. Although the transplant was successful, Corey went on to preach to the Gullah community that he was healed by his faith alone (Blake, personal communication, July 10, 2009). Examples such as this continue to solidify the Gullah belief that faith plays a more significant role in healing than Western medicine.

Cultural Competence

Understanding the dynamics of cultural competency is essential to bridge the gap between the Gullah community and modern medical care. Being aware and knowledgeable of another's culture is one way to overcome the barriers of providing healthcare. The Campinha-Bacote model is an instrument used to promote cultural

competency among health care providers. This model entails having cultural awareness, skill, knowledge, encounters and desire (Campinha-Bacote, 2009). Having awareness of Gullah culture, actively seeking out knowledge about it, and acquiring skills to treat patients by engaging in cultural encounters increase one's ability to practice culturally competent medicine. A medical interpreter educated in both cultures is one way to implement this model. This type of interpreter can prevent poor communication and can help strengthen the relationship between the provider and the patient while also avoiding expensive and detrimental consequences. In addition, the interpreter can help clarify any ambiguous body language that the patient may find confusing or offensive (AMSA, 2009). Another way to use this model to overcome healthcare disparities in the Gullah community would be to have an inside spokesperson convey the intentions of the health providers and to gain their trust in Western medicine. It is vital to explain to the Gullah people that a culture that wants to flourish must be preserved (Blake, personal communication, July 10, 2009). Thus, the community must become active in pursuing preventative and curative treatments to ensure life for future generations.

The LEARN model is a general tool to use in the clinical setting not only in the Gullah community but for all other cultures as well. Faced with a patient of differing cultural background, the medical practitioner should *listen* to the patient's point of view, *explain* his or her own point of view of the problem, *acknowledge* the differences that may arise between the two perceptions, *recommend* treatment with respect to the patient's culture, and *negotiate* an agreement with the patient (AMSA, 2009). Although having an interpreter and inside spokesperson present is ideal, the LEARN model can

serve as a good starting point to open communication between the patient and health care provider.

Conclusion

The Gullah culture can be traced back to the settlement of the Sea Islands by slaves from West and Central Africa. This isolation, accompanied with an influence from their African heritage, has contributed to their distinct language, culture and traditions. While these unique aspects have strengthened the bonds within the Gullah community, they present challenges to healthcare providers. Overcoming these obstacles requires having knowledge of the Gullah culture and a desire to incorporate their beliefs into Western medicine. Tools used to promote cultural competency include the Campinha-Bacote model and the LEARN model. Implementing these models allow health care providers to press through the barriers of caring for the Gullah people. Taking these steps is essential in ensuring the quality of life and preservation of the Gullah people.

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