

---

# An African American Looks at Death

by Marian Gray Secundy

---

**B**lack folks have always known how to die in style.

We've always known how to send our loved ones off to the Kingdom in proper fashion, how to mourn with grace and move on with life with as much joy and enthusiasm as one can muster in this vale of tears that we call life. Our poets and novelists have written extensively and with beauty and poignancy about dying and surviving loss.

When one thinks about a "good death," one must consider the question of "good" for whom? The experiences of the patient, of the survivors, and of health care providers are all different; their perceptions of what is "good," then, are most certainly likely to differ. When, how, where, and why one dies is important to the ways in which that death is viewed as well. There is a true sense in which some deaths are seen as appropriate and within God's plan in the minds and hearts of truly spiritual black people, but there is also a true outrage, confusion, and hurt when one sees senseless, premature, violent death visited upon the "innocent," testing the faith of the strongest believers.

Death is no stranger to black folk; the reality of our lives and the historical circumstances in which we have lived have made it impossible for most of us to develop the denial mechanisms about death that can be seen in many of our Caucasian brothers and sisters. Slavery brought violent, traumatic experiences often resulting in death from beatings, suicide, inadequate treatment for illnesses, and murder. The Jim Crow era of the South saw lynch mobs, massacres of entire

towns, and refusals to treat blacks in many hospitals and health care facilities. Random murders, black on black violence, self-inflicted death due to drug overdoses and alcoholism, AIDS, chronic diseases, and acute illness creating higher rates of mortality in this modern era have blacks spending more time at funerals than perhaps any other group in American history. In the midst of this reality, the mainstream conversations about dying in America seem somewhat surreal. Blacks are suspicious and distrustful that they will not receive fair and equitable treatment, that their organs will be harvested prematurely, that their lives are expendable because they are uninsured. Thus conversations in the medical corridors, academic centers, halls of Congress and, indeed, the Supreme Court about the efficacy of physician-assisted suicide and the importance of having advanced directives seem irrelevant. While mortality rates remain high from poorly managed chronic diseases, noncompliant patient behaviors and self-destructive life-styles, emphasis is shifting in health care to more and more depersonalized services, fewer and fewer culturally competent providers, and more and more organizational bureaucracies that confuses, discourages, and turns the patient away, guaranteeing a continuation of the patterns of morbidity and mortality.

---

*Marian Gray Secundy, ACSW, PhD, is a professor at Howard University, College of Medicine, Washington, DC. She is editor of the book, Trials, Tribulations, and Celebrations: African-American Perspectives on Health, Illness, Aging, Aging and Loss, published by Intercultural Press, Inc.*

In a real sense, there is something inappropriate about asking black folk to talk about a "good" death when they continue to be confronted with comprehensive, basic problems such as those discussed above. Some might suggest that such discussions constitute a diversionary tactic. There is absolutely no doubt that we ought to attend to the social and political environment with the same fervor that we attend to the health care environment. Prevention and health education are essential. Adequate housing, employment, nutrition, and criminal justice are required. Serious control of drugs and guns are mandatory. Discussions of a "good" death can occur meaningfully only when these are addressed concurrently.

Few studies discuss attitudes of blacks to issues of advance directives or physician-assisted suicide. Most blacks do not trust the medical establishment and are not comfortable with issues related to advance directives. With data we do have, we know that they are more likely to opt for "full court press" and not request or allow any limitation of treatment or treatment options. Socioeconomic background appears to be a relevant variable in that those who are more educated are more willing to consider limitation options. Very little is known relative to attitudes about physician-assisted suicide, but in light of evidence about advance directives, it is safe to assume that such an interest is not extensive in the black community. We need more research to make any definitive statements or draw any conclusions about these observations, however.

African Americans are not very different from other people when confronted with illness and the dying process itself. Literary representations, conversations with caregivers and surviving family members reflect universal concerns and values. No one wants to suffer, die in pain, or be abandoned by caregivers and loved ones when they are dying. Most of us experience the dying of our significant others with anxiety, grief, ambivalence, and confusion. Many of us prefer to leave the hard decisions to the health care providers despite the existence of high levels of distrust and suspicion.

Family dynamics, individual personalities, and the actual experiences with caregivers and institutions are clearly factors that influence responses and reactions. Prior relationships with the dying person and previous experiences in health care settings are also relevant. Issues of guilt, control or lack of control, financial circumstances, and, fundamentally, the why and how of the dying process surface as well.

---

*High technology should be used only if appropriate for realizing the goals of comfort care or to be responsive to the patients' and families' wishes if those wishes are consistent with clinical realities. And when the above idealistic picture cannot be created, then we must do all we can to limit the extent to which we are forced to manage "inappropriate death."*

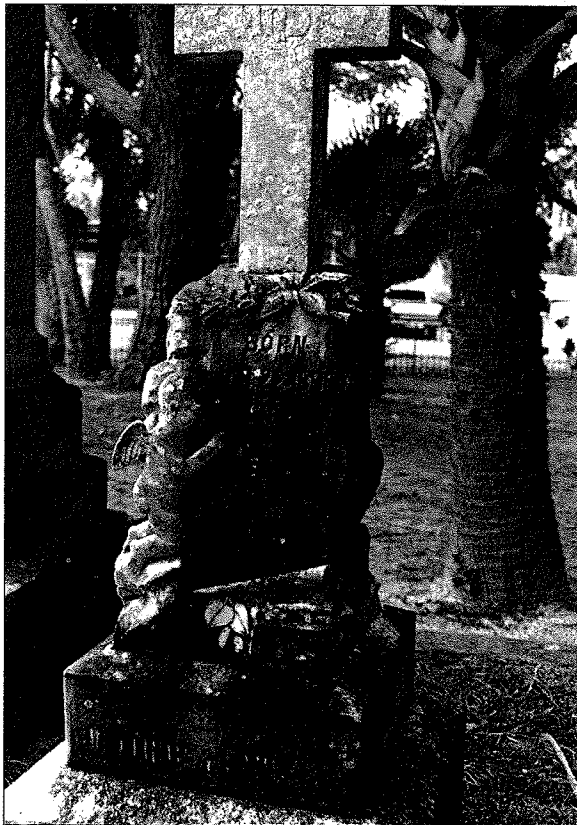
---

Most of us, black and white, have a sense of the "order" of things. We understand better when the person dying has been ill, is elderly, and has lived a long life. We do not understand when children die from illness or senseless violence. We do not accept the deaths of young black men like Ennis Cosby or lesser known persons shot down in their prime. We suffer extreme pain when young people develop terminal illnesses, and we do not comprehend sudden unanticipated deaths. Most blacks seek spiritual understanding and focus upon conspiracy theories in efforts to comprehend the awesome impact of AIDS upon our community. We do not understand depersonalized responses to those dying in extreme pain or

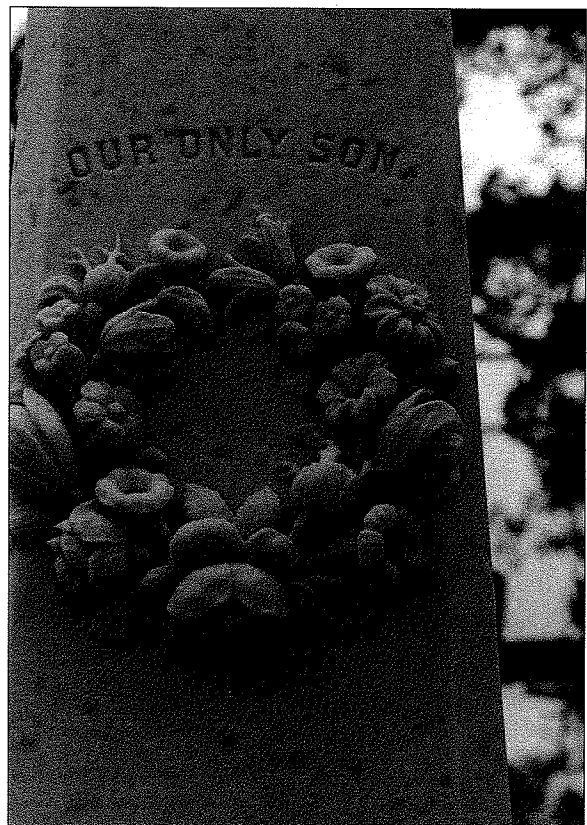
the technological innovations that appear to sustain life but, in fact, do not.

Black folk, for the most part, tend to rely upon their understandings of spiritual mysteries of the Almighty and prefer to let "things take their natural course." We are historically long suffering and stoic, looking to a better life in heaven. However, there are serious contradictions in our traditional approaches to death and dying, for we also see younger ghetto-bound blacks who are cynical, psychologically damaged, and so totally defiant in the face of death that they seem to seek it actively. Their psychic numbness and disregard for the value of human life are new phenomena within the black community. The interrelationships of the state of society and this situation are clear. What is not clear is how to reverse this trend of self-destruction without fundamental changes within the entire society.

Ideally, death should be anticipated and come only to the old and infirm. The dying should be surrounded by loved ones, comfort care, and sufficient pain medication. Those fortunate enough to have families should have those families at their bedside, their primary caregiver nearby to assure that they are cared for, cared about, and never to be abandoned. High technology should be used only if appropriate for realizing the goals of comfort care or to be responsive to the patients' and families' wishes if those wishes are consistent with clinical realities. And when the above idealistic picture cannot be created, then we must do all we can to limit the extent to which we are forced to manage "inappropriate death." That challenge is truly awesome, but constitutes a moral imperative. Death, after all, is perhaps not a black or white issue, but simply a human one.



*Apalachicola, Florida, 1995*



*Photographs by Donna Blackwood*