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ORIGINAL PAPER

'I am Dying a Slow Death of White Guilt': Spiritual Carers in a South African Hospice Navigate Issues of Race and Cultural Diversity

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Abstract Culturally appropriate spiritual care is increasingly recognised as a crucial component of spiritual care. As part of a larger study, we were interested in cultural and racial issues as experienced by spiritual carers in a hospice in Cape Town, South Africa. We conducted one-on-one interviews and focus group discussions with a cohort of spiritual care workers, who, being volunteers and relatively privileged South Africans, discussed their sensitivity to cultural issues, but also mentioned a host of political, racial and identity issues which profoundly affect their work. The data suggest that the concept of culturally appropriate care must be understood and acted on contextually. We note that the work of transformation of care cannot be separated from broader questions of social inequality and change.

Keywords Hospice spiritual care · Cultural diversity · South Africa · Apartheid · Colonialism · Race

Introduction

Emerging from centuries of colonialism and fragmentation which underpinned the apartheid era, the post-apartheid democratic administration was tasked with addressing the disempowerment and weakened health care system in South Africa (SA) (Coovadia et al. 2009; De la Porte 2016). Twenty-seven years on, there has been a notable lack of progress in addressing health care inequalities. The current

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global pandemic—SARS-CoV-2 adenovirus, that causes the COVID-19 disease—has further accentuated the interplay between inherited and acquired vulnerabilities and how one's positionality on the uneven playing field of life in SA plays out in the quality of health care received (Baldwin-Ragaven 2020). The people of SA are still divided along cultural, racial, and linguistic lines, and SA remains one of the most unequal, if not the most unequal, societies in the world (Francis and Webster 2019; Jansen and Walters 2020).

There is a substantive body of work in the global South, and in SA in particular, that explores the issue of cultural diversity in health care settings and the impact on care outcomes (Chandramohan and Bhagwan 2016; Matthews and Van Wyk 2018; Swartz 1991). Palliative care has very recently obtained recognition in SA, taking its rightful place on the continuum of health care platform (Republic of South Africa 2017). Spiritual care interventions, within the overarching hospice end-of-life care service, seek to support the patient with their 'total pain' (Saunders 2006), and palliative care policies recognise that a terminal diagnosis affects a patient physically, psychologically, spiritually and emotionally. Spiritual care also recognises that patients with terminal illnesses approach their situation in the context of their cultural, religious and racial beliefs and experiences, whether explicitly or implicitly (Mthembu, Wegner, and Roman 2016). The issue of the need for sensitivity regarding culture, religion and ethnicity in palliative care interventions are currently gaining impetus in the global North as a specialised area (Cain, et al. 2018; Curtis, 2019; Elk, et al. 2020). Given SA's history and divided society, however, issues of cultural and spiritual diversity, and race and racism, have long been core concerns in the development of health care interventions, including palliative care interventions (Baldwin-Ragaven, London, and De Gruchy 1999; De Beer and Chipps 2014; Drenth et al. 2018; Swartz 1985, 1998; Mahilall and Swartz 2021a).

The question of how health care workers in SA navigate and deal with issues of racial, cultural, linguistic, religious and spiritual diversity has been studied in a number of areas, including Human Immunodeficiency Virus (HIV) care (Petros et al. 2006); paediatric asthma (Levin 2005); diabetes care (Bosire et al. 2020); emergency services (Penn, Watermeyer, and Nattrass 2017); obstetric care (Lappeman and Swartz 2019) and mental health care (Swartz et al. 2019). Historically, in SA, questions regarding the provision of culturally appropriate care have been bound up with questions of race, racism and racial oppression (Swartz 1986, 1987), not least because a key way in which discriminatory practices were justified ideologically was with the claim that different services were necessary out of respect for cultural difference (Swartz 1985, 1991, 1996). Service providers working in SA have at times felt caught between the wish to provide culturally appropriate care and the fear that providing different services to different people may appear discriminatory (Swartz 1985).

There are numerous problems in the use of terminology around race, culture and ethnicity in SA. A recent volume focussing on this question (Jansen and Walters 2020) notes that in SA, there is considerable slippage across terms, and an added problem is that terms which have in the past been used for purposes of racial and class oppression can also be avoided, with terms like "culture" being used

euphemistically for crude and unscientific divisions of people, often quite arbitrarily, for purposes of oppression. The is a long and contested history of racial and other labelling in SA (Dubow 1995), and there is not the space in this article to unpack all of the issues. For the purposes of our argument, though, it is important to acknowledge the complexity of labelling, and how often there is terminological slippage.

Palliative care as a field is less developed in SA and other parts of Africa than are other fields of care (Court and Olivier 2020). The authors of a recent review on integrating palliative care into health systems in Africa have as their first recommendation (what they describe as 'top tips') the following:

> Make the patient central…by providing responsive care and investigating the PC (palliative care) needs of patients, as well as what type of care is culturally appropriate and desired. (Court and Olivier 2020:14)

Given South Africa's racial history (and, indeed, much of the colonial past on the African continent as a whole), it is interesting that in policy recommendations like this there is no troubling of the term "culturally appropriate", and that it is implicitly assumed that what is "culturally appropriate" must also be "desired". Discursively, the history of the use of "cultural appropriateness" as a smokescreen for racial oppression and exclusion which we have shown elsewhere to be a feature of South African discourse (Swartz 1985, 1986, 1987) and is part of broader colonial history in Africa and elsewhere (Moshabela et al. 2016, Swartz2019), is effaced in this usage.

Given these concerns, in this article, we explore the views of, and dilemmas faced by, spiritual care providers at a hospice in Cape Town, SA, in an attempt to provide what is termed culturally appropriate spiritual care. We demonstrate that concerns about race and racism trouble the idea of "culturally appropriate care" in the context of contemporary South African realities.

Method

St Luke's Combined Hospices (SLCH), a leading hospice organisation in Cape Town, SA, offers a comprehensive palliative care service across a range of physical locations, and in patients' homes in the community. At SLCH, the spiritual care services are offered predominantly by volunteers, with three being paid staff, of whom two are part-time employees. Spiritual care services are offered by very few organisations in SA, with SLCH having one of the largest cohorts of spiritual care workers in SA (Mahilall and Swartz, 2021b).

SLCH currently has 23 registered spiritual care workers, of whom 15 are actively providing spiritual care services. The eight inactive spiritual care workers cited advanced age and personal illness as the main reasons why they have significantly limited their work at SLCH, resulting in their inactive status. We approached all active spiritual care workers to participate in our study, which forms part of a larger national investigation into spiritual care issues in palliative care in SA.

Ethical approval for the study was obtained from the [anonymised for peer review] University (10,237), Hospice Palliative Care Association (HPCA) (02/19), and SLCH itself. HPCA is a national association which has 104 member organisations affiliated to it (Drenth, et al. 2018), with SLCH as one of those member organisations. Nine active spiritual care workers volunteered to be part of this study. The other six active spiritual care workers did not offer a reason for non-participation.

This was a qualitative study using one-on-one interviews and focus group discussions (FGD) from a set of semi-structured questions (see Appendix 1). Table 1 provides biographical data on the nine participants. Face-to-face interviews and FGD were not possible due to lockdown regulations in light of the COVID-19 pandemic. Consequently, interviews were conducted via virtual means such as Zoom and Skype. The interviews were recorded, transcribed, coded and analysed thematically.

Findings

Through one-on-one interviews and FGD with a cohort of spiritual care workers from SLCH, Cape Town, SA, the participants shared their experiences of navigating cultural diversities in their provision of spiritual care services to terminally ill patients. This study identified three prevalent themes, which are listed below and will be discussed in turn:

1. The complexity of race and culture.
2. Culture and superstitions—the (racial) 'elephant in the room'.
3. Organisational culture and constraints to cultural expression.

The Complexity of Race and Culture

The participants unanimously agreed that cultural sensitivities are central to their spiritual care work. To navigate cultural sensitivities, the participants cited having a basic knowledge and understanding of the different cultures, religions and practices in SA as being crucial. Participant 8 explained:

> You should never meet a patient or family with your own preconceived ideas just based on where they live, their surname, their profession…because post-apartheid there are now mixed marriages, freedom of residency, more open access to jobs and education. Because we have this great historic diversity you must first ask a few questions; get to know where the patient and family are at; understand what is important to them; what their belief systems are before you arrive at a spiritual care plan. (Participant 8)

Participant 6 said that in some traditions, displaying affection in public, especially between spouses, is forbidden. Bearing this in mind, he had to weigh the burden of cultural sensitivities against what the distraught husband was feeling and what the

Table 1 Biographical information on research participants

Participant number and 'race'[a] (B-Black; C-Coloured; W-White)	Gender (M- Male; F- Female)	Qualifications	Years of practice and experience as a spiritual care worker	Years of practice and experience as a spiritual care worker at SLCH	Religion	Languages spoken
1 (W)	F	BCom Honours (Economics)	3 years	3 years	Christian by birth Currently, none	English, Afrikaans
2 (C)	F	Higher Dip. Education; Dip. Special Ed (Remedial); MPsych(clinical)	2 years	2 years	Islam by birth Currently: none	English Afrikaans
3 (W)	F	Certified Lifeline Counsellor	30 years	28 years	Christian by birth Currently: none	English
4 (B)	M	Grade 12 Lay councillor in Church	25 years	7 years	Christian	English, Afrikaans, Xhosa, Zulu
5 (W)	F	BA (Social Work) Certificate: Family Constellation Certificate: Gender Reconciliation Capacitar (Energy healing)	35 years	10 years	Quaker (Historical Christian denomination)	English, Afrikaans

Table 1

Participant number and 'race'[a] (B-Black; C-Coloured; W-White)	Gender (M- Male; F- Female)	Qualifications	Years of practice and experience as a spiritual care worker	Years of practice and experience as a spiritual care worker at SLCH	Religion	Languages spoken
6 (C)	M	BSc (Psychology) BA (Psychology)	25 years	15 years	Islam by birth but embraces all religions	English, Afrikaans
7 (B)	M	MA (Practical Theology) MA (Missiology)	15 years	13 years	Christian	English, Afrikaans, Xhosa
8 (C)	M	Dip in Theology BA (Hons)	35 years	3 years	Christian by birth but embraces all religions	English, Afrikaans
9 (W)	M	Dip. Interior Design Dip. Interior Architecture	6 years	6 years	Christian by birth Currently: none	English, German, French

[a]In South Africa, as elsewhere, the use of 'racial' terminology is complex and contested, and certainly still a source of debate and great pain. We make no claim for the scientific validity of the different 'racial' categories, but the labels used still have social significance (Jansen and Walters 2020). In the South African context, the term 'Coloured', which may well be the most contested, is an official term still used in government documents and refers to a very diverse group of people of mixed and diverse origin, with Afrikaans being the predominant language spoken (Jansen and Walters 2020). By contrast, the term 'Black African' commonly refers to people who speak indigenous languages such as isiXhosa, spoken in the Western Cape. Under apartheid, the Western Cape was viewed as a preferential area in which 'Coloured' people could live and work, whereas 'Black Africans' were viewed as not being citizens of South Africa, but of racially defined 'homelands'.

dying wife was yearning for, by giving the husband cultural permission to show affection to his wife:

> That is so inhuman to not to be able to express your love and affection to someone who is dying who happens to be your wife… I happened to be sitting at reception with a husband that was sitting on a chair and his wife was lying on the bed, so I asked the man how are you feeling? And he said, I am actually crying inside. I asked him if his wife knows that you are crying inside, he said no I don't know, so I said would you want to sit on the bed with your wife and he looked at me as if there was something wrong with me. I put him on the bed, and he sat on the bed and I said to him, wouldn't you like to put your arm around your wife? And again, he looked at me as if I was crazy. The minute he put his arm around his wife, his wife gave me such a look as if she won the jackpot or something, that was all she was waiting for. For me that was such a worthwhile experience. (Participant 6)

Participant 5 discussed a similar case study that focussed on racial sensitivities which saw her give the son of a dying mother cultural permission by modelling for him that touching his mother was acceptable:

> I think they were Fish Hoek (a predominantly middle to upper-middle class largely White suburb in the Western Cape, SA) ordinary, pale people (White people) but he (the son) didn't know what to do as she (the mother) was slipping away, and so I stroked her and reassured her, and I actually took his hand and said 'it's ok'. So sometimes non-verbals help you to go where words can't go and I think in the subject of touch, you are touching somebody's soul…you have to be so in tune with yourself and in tune with them because you are touching their soul. (Participant 5)

Participants recognised that there are different layers to culture that are at play in the therapeutic relationship. How the participants navigated their own cultural encapsulation and the level to which they were able to separate themselves, culturally, from the therapeutic relationship determined the quality of that relationship as Participant 3 put it:

> I think you have to be finely tuned into yourself… I mean as a leafy middle-class White woman I have to deal with my own privilege, my own guilt by virtue of my birth… I think again it's sensitivity and the capacity to relate to someone and you're not projecting your own stuff… I have sometimes seen people (colleagues) go…fall over backwards trying to make up for having lived a privileged life…so it's like being centred and being led by the patient's need at the time. (Participant 3)

Participant 3 went on to personify her guilt as a 'leafy middle-class White woman' as an eidetic manifestation of a potential terminal disease that may show up in her future, something we come back to in the discussion:

> I will not be surprised if I develop cancer of the chest or the heart because of the guilt I carry of being a privileged, hierarchical White. I have to constantly

> re-centre myself to know that the patient is the apex because I am more vulnerable than a terminal, actively dying patient… I am dying a slow death of White guilt…this work I do brings me some peace as I unburden myself through my work. (Participant 3)

With racial differences come linguistic divides. The participants further recognised the multiple languages that exist in SA that are protected by the South African Constitution, and the importance of speaking in a language the patient is familiar with even if that meant having to refer a patient to another spiritual care colleague who speaks the same language as the patient. As Participant 5 lamented:

> I know that the one thing that I really can't forgive myself for often is we have so many Black people who come and I don't speak Xhosa (the first language of many SLCH clients). Thankfully I've got massage (therapy) I can fall back on until my Xhosa speaking colleague comes but I still feel that's not good enough that a patient must wait; especially a dying patient. (Participant 5)

Racial tolerance and acceptance of racial difference was identified as a key attribute for an effective spiritual care worker, especially working within a diverse SA context. Participant 4 exemplifies this further:

> I have noticed that the main African belief is in ancestry and spirituality. If you talk about spirituality to them (Black patient and family), they will receive you plentifully. And there are certain words which you must not use with Africans. For example, you never tell a person you are going to die. Don't use that word 'die'. That word alone is a taboo word. You have to use something else instead like…'the ancestral spirits have come to show you the way'. Even after a patient has passed on…we are dealing with a lot of people from the Eastern Cape…the body (corpse) has to be transported to the Eastern Cape. There must be somebody to 'talk to that body' while it is being transported from the current house to the ancestral house in the Eastern Cape. (Participant 4)

Participants recognised that being conscious and aware of such diversities could potentially guide what a spiritual care approach and intervention regime could look like. Participants noted that when facing end-of-life patients' cultural, religious and racial diversity issues tended to hold significantly less value and prominence for them. Being acutely aware and conscious of being culturally sensitive sometimes posed a challenge for the participants on how to respond to patients who had 'abandoned' their culture towards the end of life. Participant 6 explains:

> …the interfaith marriages and the polygamous marriages…for example when you find someone terminally ill and all of a sudden you have another family pitching up…and instead of dealing with the palliating patient and the family, you've got to deal with a second wife or girlfriend because of the Islamic culture of polygamy. Sometimes in spite of the fact that the person was born Muslim there was an interfaith marriage, and at the time of dying then they want to revert back (to religion of birth)…all their clashes and conflicts concerning how the person can retire from his Muslim tradition arise. You need a broader understanding about why people do certain things. Death is a

> great leveller and it's one's presence that is important, but you have to be sensitive to what that person needs or wants, and in that why my background in psychology and religion helps me with this kind of work (spiritual care work). (Participant 6)

Culture and Superstition—The (Racial) 'Elephant in the Room'

Two participants raised the issue of what they termed 'superstition' as an issue in spiritual care. They distinguished between 'good superstition' that is helpful in understanding cultural beliefs and practices, and superstitions that they described as 'bad' and which may evoke fear. Participant 6 had this to say on the role superstition plays in culture, likening it to what he termed the 'elephant in the room' that is not often openly addressed or discussed:

> …there are issues regarding religion or faith but also separated from beliefs which are perhaps irrational but carried on through tradition, like climbing the mountain to find saints, and the family would want to visit the shrine in the mountains. I think one has to differentiate between these practices and pure superstition. An experienced counsellor from the same background would know the difference between what is religion, what is culture, what is custom, what is superstition and while the family or the patient indulges in superstition, as a counsellor one has to be non-judgmental and just go along with it. (Participant 6)

Participant 4, by contrast, regards what others may term 'superstition' as central in the lives of people who speak Xhosa and Zulu (a cognate indigenous language), but in danger of being lost or damaged in the context of the COVID-19 pandemic:

> …with Xhosa and Zulu in connection with spirituality, it is a strong thing to them, and they believe in spirituality fully and they like to observe and follow what their thoughts are about spirituality so they can't be separated from that (superstition) and they will mix it with cultural things and do cultural things. Because they believe if they do not follow what they have heard by or told by a seer or *sangoma* (traditional healer) about but instead just happen to a particular person, more wrong things can happen to a person. That is why they so strongly believe in that (superstitions) and if somebody also says I dream about my father who has passed on and told me to do this and that and if I ignore that, certain bad things will happen. The strong feeling about spirituality and superstition in African people does exist. Except not since we have this COVID-19 pandemic we are having; things are not going right as they used to do, and you'll find that they are complaining because they fear of losing that thread of spirituality that they used to talk with the people that have passed on. This is another thing that is happening, and people are not happy about it. (Participant 4)

South African indigenous belief systems depend heavily on the role of ancestors in maintaining health in a balanced spiritual ecology (Swartz 1991). Participant 4 noted that patients will go to great lengths to consult with and act according to the

wishes of the ancestors, sometimes in hope of reversing a terminal diagnosis, and always in trying to prepare an appropriate burial process. Participant 4 explains:

> I listened yesterday or the day before about the nurse that passed away…and the family was not happy about the way they burials took place because they didn't go according to their cultural tradition to talk to the spirit of that body, and they were not happy. It is not just the family; many people are not happy about this COVID-19. Before they used to know what to do when they are going to bury someone, they need to talk to the spirit of that particular person and now they were not given the chance to do that. This is another angle which a new thing which we are looking are, we are not sure how far it will go, will they go back and do which they used to do out of fear or will they change their practices because of the pandemic. It is a big question mark, but spiritually, African people strongly believe in it and they have to do it so they know that they are at peace with those who have passed on. (Participant 4)

Organisational Culture and Constraints to Cultural Expression

Though issues of culture, as commonly understood, may refer to beliefs held by people from different backgrounds, participants also discussed their work in relation to the culture of SLCH as an organisation.

Participants expressed concern that there is an expectation of the interdisciplinary[1] team to separate hospice care services along the distinct four pillars of palliative care, shaped largely by Western influence, and expressed that while this may be a good model on paper, in practice this was sometimes challenging to achieve. Participant 5 explained:

> …my cousin died on the ward, X (name of spiritual care worker) had a good relationship with my niece, and it was a fantastic moment, and it was incredibly important. She was then referred to bereavement (counselling service) but sometimes that only happens six weeks later, and she needed some holding and I tried to get something going but I didn't want to push too much. It was X that my niece really needed to speak to. There is a lot of variation, and we don't connect with everyone on the ward, we can't follow up with everybody because they say there's a professional service but (we must remember that there is) also a human-needs service. (Participant 5)

There are questions here about the range of work of spiritual carers, and how they fit into the larger pattern of care.

Given resource constraints, almost all of the spiritual care work done for SLCH is done on an unpaid, voluntary basis. The organisation does not have the funding to support culturally expressive activities as part of spiritual care. Participant 5, for example, expressed the need to have assistive tools available to support spiritual care:

[1] The interdisciplinary team at SLCH consists of a clinical palliative care staff such as a medical nurse, doctor, social worker, spiritual care worker and bereavement care worker.

> …hearing is the last facility that goes (in the dying stages) and that is something we haven't got on the ward, and I noticed there was one patient who had gospel music playing from her cell phone and I thought, wouldn't it be fantastic to have a music system where she could play her music from. I would want music… It is a gap. (Participant 5)

Overall, participants believed that because of its voluntary nature and because of lack of resources, spiritual care, though overtly strongly supported by the organisation, did not have as firm a position in the organisation as did other aspects of care.

Discussion

In our interaction with participants, we gained the impression of a strong commitment of the spiritual carers to respect racial cultural, spiritual, and religious diversity – this was clear throughout. But there was also an acute awareness of the complexity of the issue of culture in spiritual care work at SLCH in Cape Town, SA. All participants wished to enact respect for cultural, racial, and religious diversities (Bhagwan 2017; Cain et al. 2018; Elk et al. 2020; Swartz 1991) but the enactment of that sensitivity was more fraught.

Participant 5's reference to 'Fish Hoek ordinary, pale people' and Participant 3's description of herself as a 'leafy middle class White woman' together tell a story about the context of the attempt to provide culturally appropriate palliative care in the contemporary SA context. As in other settler societies, but probably to a greater degree than others, given the particularities of apartheid as a formalised system of racial domination, SA has a history of the denigration and disavowal of indigenous spiritual practices as primitive, damaging, and even evil (Wallace 2015). Even prior to the formal end of apartheid rule, there was recognition of the damage caused by such stigmatising typification of indigenous spiritual practices (Bührmann 1984; Swartz 1985). Indigenous spiritual beliefs are formally recognised and valorised in contemporary SA, to the extent of formal recognition of traditional healing as part of a suite of health services accessed by South Africans (Moshabela et al. 2016; van Niekerk 2012). But the legacy of suspicion and disavowal remain, within a broader social context in which there is widespread dissatisfaction with what is viewed as continued White dominance in many areas of public life, and especially in the economy (Aboobaker 2019) and in education (Cini 2019), as well as in health care (Swartz et al. 2016).

In writings about the continuing spatial inequality in SA, a common trope is that which contrasts 'leafy suburbs' (formerly White areas, some of which remain predominantly White, especially in Cape Town) and 'dusty streets' (referring to impoverished, almost exclusively Black areas) (Baines 2003; Parker 2016). Similarly, the use of the word 'pale' in 'ordinary pale people', as Participant 5 puts it, has a cultural resonance in contemporary SA. For example, a White journalist well known for his anti-apartheid writings titled his memoir *Pale Native* (Du Preez 2011), and White men are commonly referred to as 'pale males',

especially during talk about the incompleteness of economic and social transformation (Morrell 2002; Wesson and du Plessis 2008). So, when participants refer to 'pale people' and their own status as 'leafy', they are signalling a recognition of, and discomfort with, their own continuing privilege. Despite the commitment to providing culturally appropriate spiritual care, this awareness of privilege may signal a view that, by virtue of their Whiteness, participants may feel unequal to providing the best, most culturally appropriate care. This issue is even more strongly addressed by Participant 3's comment, 'I am dying a slow death of White guilt'. Her use of a metaphor of death is of course especially striking in the context of a discussion about providing care for dying people. The metaphor conveys a sense of concern both about her own vulnerability (and the possibility of mortality for her, something which she says she does not fear), but also, crucially, about what she is and is not able to offer to a wide range of patients, given her own social positioning and her discomfort with it.

These issues play out against the background of the history and culture of SLCH itself, embedded and entwined as these are in the broader history of SA. SLCH was founded during the apartheid era, in 1980, and historically served a White clientele. It is currently a diverse organisation, and the first statement in the value proposition of the organisation reads, 'We commit ourselves to professional, loyal, honest, responsible and respectful conduct that engenders trust and values diversity' (https://stlukeshospice.co.za/about/), putting the issue of valuing diversity at the top of the list of SLCH values. But the use by Participant 5 of the word 'ordinary' as a prefix to the use of 'pale people' tells its own cultural story. In this use of 'ordinary' is the implicit signalling that historically, and possibly still today, Whiteness was what was seen as unmarked and normative in the provision of care by SLCH. Though the organisation may have officially changed, as Participant 5 implies that part of what it is doing may be involved in the reproduction of White cultural values and Whiteness itself through its work. There seems to be little question about Participant 5's discomfort with this, and her frankness is to be applauded, but she is raising a broader question of the cultural and implicit racial positioning and role of the organisation as a whole, especially in a fractured society. Is, then, spiritual care as offered by SLCH, however sensitively offered and helpful to many, also, inevitably, partially an enactment of Whiteness?

This is a complex question which we cannot fully answer, but part of the answer lies in the reality of the spiritual care service as provided by volunteers. Participants believe that their volunteer status contributes to them being side-lined, and to an extent invisible, to the broader workings of the SLCH services. But it is not by chance that in a country in which White people are in a minority, most of the spiritual carers are White, and very few are what in South African terms are called 'Black African'. Epidemiologically, 'race' remains a predictor of poor health in SA (Day and Gray 2017), with Black African South Africans as a group facing greater health challenges, and greater likelihood of having poorer access to care offered in their own language, especially in the Western Cape Province (Swartz et al. 2016; Deumert 2010).

Because White South Africans on average earn more than South Africans of colour, they may have more resources to be able to volunteer their time for spiritual

care work; hence the over-representation of White spiritual carers at SLCH. This volunteering is laudable, helpful, and crucial to the work of SLCH. It may also, through no fault of the spiritual carers or other individuals, reproduce the character of SLCH as the services it offers, as culturally 'White', despite all efforts at transformation. Ultimately, this is a resource issue—SLCH is unable to fundraise sufficiently to have as diverse a cadre of spiritual care providers as the organisation, and, indeed, the spiritual carers themselves, may view as ideal. This lack of resources, though, may contribute to an ongoing degree of cultural encapsulation for the organisation.

In this regard, it is interesting that the only two participants to discuss the issue of 'superstition' in relation to cultural beliefs were people of colour. It may well be that the use of what to some may be viewed as a pejorative description of cultural beliefs, a description linked to a history of colonial subjugation (Frosh 2013), could not be articulated by White participants wishing to avoid any possibility of appearing racist (Swartz 1985). It may be that the participants of colour in the group were less concerned about this potential appellation.

Scholars writing about race and culture in relation to spiritual care in the USA suggest that by being immersed in a different culture from one's own may allow for cultural awareness, understanding and tolerance (Elk et al. 2020). While this is a right step forward, our data suggest that there are added layers which need to be considered, certainly in SA, but probably more broadly. A tolerance model, useful though it is, may overlook the possibility embedded in the provision of cross-racial care, that there may well be issues of guilt, which may affect care (Swartz 2007). These issues may be difficult to talk about, but definitely bear discussion. Curtis, et al. (2019) make a call for 'cultural safety' for the purpose of achieving health equity and cultural tolerance. We support such an assertion. Spiritual care workers, and all health care workers for that matter in SA, should be empowered to work through their own prejudices, anger, and guilt to be able to accept their positioning in the apartheid era, and to be supported to negotiate new positions as the post-apartheid landscape takes shape. This working through, though, is not just a question of individual commitment and personal will to provide the best and the most context-sensitive care, something we saw clearly in our participants' responses. It is also an issue to be considered at the organisational and political level, a level over which the spiritual carers themselves, as individuals, have no control.

In this regard, it is important to remember that though culture within the context of spiritual care is commonly understood as people's individual sense of spiritual beliefs and practices, the organisational culture within which the spiritual care service is positioned is also important to consider. Participants mentioned their positionality as playing a decisive role in how they undertake their spiritual care work. The participants' beliefs about patient centeredness apparently did not always align smoothly with organisational imperatives. The organisation has the added real burden of ensuring its financial viability, which made the participants sometimes feel that they were not taken seriously by management; hence 'the gap', as mentioned by one participant. There appeared to be a feeling that people in management seem to be interested only in measurable outcomes that they can take

to funders, or that people in management are not really aware of the value of spiritual care work. The spiritual carers seemed to believe that their voices were not always taken seriously by management; and this may have something to do with their largely volunteer status. This perception of a lack of fit is probably inevitable, given resource constraints and demands, but what they have to say has important implications for the organisation and how it delivers care.

Conclusion: Unpacking Whiteness

Spiritual care is a highly valued service offered as part of a bouquet of services under the umbrella of palliative care at SLCH. SLCH has one of the largest cohorts of spiritual care workers in SA offering services to a multicultural, multilingual and multiracial terminally ill patient population in the greater precinct of Cape Town, SA. From other data we have collected in our research, and from our discussions with the spiritual carers, we do not doubt that care at the individual level is being offered with a high degree of competence and with very good intention. But this admittedly very small study raises broader, and more complex, questions about the enactment of whiteness in the welfare sector in contemporary SA and elsewhere. As Gregory (2021) has noted in relation to social work in the USA, the role of whiteness as a key factor structuring the provision of care services has tended to be overlooked historically, but is very important not least because models of charity are inextricably intertwined with relationships of power and domination. In this regard, it is not irrelevant that central to the history of care services in SA (including palliative care services) was the establishment of social work as a profession catering in the first instance not to the population as a whole but to dealing with what in the 1930s and subsequently was referred to as the "poor white" problem (Willoughby-Herard 2007). In her work on contemporary whiteness in SA, Steyn (2001) notes the importance of ideas of mastery and control to South African whiteness; and it may be argued that the care infrastructure in SA, transformation notwithstanding, may reproduce domination, with charity and care, however well-intentioned, as part of an armamentarium of control.

Given these realities, what becomes difficult analytically is allowing for a bifurcated view of the transformation of care. On the one hand, it is important to recognise, value and expand the benefits of well-intentioned work which is helpful to individuals in distress. On the other hand, the more challenging work of transformation requires a recognition of the patterns of social reproduction of inequality which may be furthered precisely by well-intentioned work which is of individual benefit. We believe that spiritual care is important in palliative care in SA, as elsewhere, as is shown in much of the literature. What is more discomforting is the question of having to engage with questions about spiritual care as reproducing broader inequalities while at the same time doing good by and for individuals. This kind of dilemma can be seen as embodied in the words of our participants working in a particular organisational context. As with many, if not all organisations in SA, the work of transformation of care to be fully appropriate to the SA cultural context is something we believe our participants are committed to, but

the work of change is not yet complete. It has become something of a cliché to refer to South Africa's transition to democracy as unfinished, with continuing inequality being a key feature of South African life (Schotte, Zizzamia, and Leibbrandt 2018). This is reflected in unequal health and care systems, as is well established (Conradie 2018; Omotoso and Koch 2018). What is less explored is how even services which are offered free of charge and with the best of intentions may reproduce inequality. As we have suggested in this article, the question of "cultural appropriateness" of care is far from neutral and is embedded in specific and global power relationships and their histories. In SA, technically, a non-racial democracy now for over 25 years, issues at the intersection between racial oppression and the discourse of culturally appropriate care (something we discussed in this journal almost 40 years ago— Swartz 1985)—remains of concern.

Appendix 1: Guiding Questions for Semi-structured Interviews

Collapsed interview questions	Original questions
A-how and why you became a spiritual care worker	1. Tell me about how you became a spiritual care worker?
	2. Tell me about why you became a spiritual care worker?
B-Positive highlights of spiritual care work	3. Share with me some of the highlights of your work in spiritual care
	4. Can you cite some examples to illustrate those highlights?
C-chat	
D-Difficulties experienced in spiritual care work	5. Share with me some of the difficulties of your work in spiritual care
	6. Can you cite some examples to illustrate those difficulties?
	7. How did you mitigate those difficulties and challenges?
E-Skills and training needed for SCW	8. What would you consider to be your training needs as a spiritual care worker?
	9. What would your thoughts be in professionalising spiritual care?
	10. How would you envisage this happening?
F-Describe your spiritual care work and spiritual care work in general	11. How would you describe your work as a spiritual care worker at SLCH?
	12. Could you perhaps share your experiences of how you engaged with patients as a spiritual care worker?
	13. What is your understanding of spiritual care?
G-Is there a distinction between religion and spirituality	14. For you is there a distinction between spirituality and religion?
H-What role does your religious faith play in your spiritual care work	15. What role does your religious faith play, if any, in your delivery of spiritual care services?

Collapsed interview questions	Original questions
I-What is the spiritual care framework you use	16. What is the framework within which you provide spiritual care intervention?
J-IDT and spiritual care services	17. Can you describe your understanding of the IDT at SLCH?
	18. What role does spiritual care play within the IDT?
	19. How would you describe your work as a spiritual care worker within the IDT?
	20. How would you describe your work within the spiritual care team at SLCH?
	21. Do you feel that having spiritual care workers working at SLCH brings about positive change to the service the hospice offers?
	22. Can you cite examples to illustrate that?
	23. Do you feel that having spiritual care workers working in an IDT at SLCH brings about positive change to the approach of the IDT to the patient?
	24. Can you please cite examples to illustrate that?
K-Diversity and spiritual care	25. Given the range of diversity in SA how would you say this affects the manner in which you provide spiritual care within your hospice?

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Data Availability Data supporting the results can be obtained from the corresponding author upon reasonable request.

Declarations

Conflict of interest The authors declare no potential conflicts of interests with respect to the research and authorship.

Ethical Approval Ethical approval for the study was obtained from Stellenbosch University (10237), Hospice Palliative Care Association (HPCA) (02/19), and St Luke's Combined Hospices. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

Consent to Participate All participants gave written and verbal consent.

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