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ORIGINAL RESEARCH

Arts to change hearts: lessons learned from six years of arts-based cultural humility workshops with healthcare professionals in northern British Columbia

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Abstract

Introduction: Although a proliferation of anti-racism and Indigenous cultural safety and humility work exists in Canadian healthcare settings, few related learning opportunities address how healthcare professionals *feel* or *orient emotionally* to these concepts. We examined arts-based anti-colonial cultural humility training rooted in Indigenous ways of knowing and being to foster empathetic sociocultural attunement, awareness of anti-Indigenous racism, and practical skills for cultivating culturally safer healthcare environments.

Methods: We facilitated cultural humility workshops anchored in anti-colonial and health humanities methodologies with practicing healthcare professionals across northern British Columbia. Workshops used art, storytelling, and creative reflective practices to help healthcare workers learn about anti-Indigenous racism and develop deeper commitments to cultural safety and humility. We used Interpretive Description to analyze participant evaluations and facilitators' autoethnographic reflections.

Results: Since 2019, 661 healthcare workers attended 29 workshops led by 24 Indigenous and non-Indigenous facilitators. 82 workshop participants completed evaluations. Findings highlight three insights: 1) how arts-based anti-colonial learning offers emotionally resonant ways to foster empathy, self-reflection, and practice new ways of thinking and doing, 2) how our work is situated within broader possibilities for systemic change, and 3) how place-based and relational approaches inform these outcomes.

Conclusion: Arts-based, heart-centred tools and practices grounded in Indigenous ways of knowing and being can account for people's emotionality and support anyone working to cultivate culturally safer healthcare environments, especially those in medical education. Strategies developed in our work may inform geographically specific, emotionally attuned, relationship-based, creative, adaptive, and flexible ways to combat anti-Indigenous racism in healthcare

Les arts pour changer les cœurs: enseignements tirés de six années d'ateliers sur l'humilité culturelle par le biais des arts destinés aux professionnels de la santé dans le nord de la Colombie-Britannique

Résumé

Introduction : Bien que les initiatives en matière de lutte contre le racisme et de sécurité et d'humilité culturelles autochtones se multiplient dans les milieux de soins de santé canadiens, rares sont les formations qui abordent la manière dont les professionnels de la santé perçoivent ces concepts ou s'y rapportent sur le plan émotionnel. Nous avons examiné une formation à l'humilité culturelle anticoloniale fondée sur les arts, ancrée dans les modes de savoir et d'être autochtones, afin de favoriser une harmonisation socioculturelle empathique, une prise de conscience du racisme anti-autochtone et l'acquisition de compétences pratiques pour créer des environnements de soins de santé culturellement plus sûrs.

Méthodes : Nous avons animé des ateliers sur l'humilité culturelle, fondés sur des méthodologies anticoloniales et issues des sciences humaines de la santé, auprès de professionnels de la santé en exercice dans le nord de la Colombie-Britannique. Les ateliers ont utilisé l'art, la narration et des pratiques de réflexion créatives pour aider les professionnels de santé à mieux comprendre le racisme anti-autochtone et à développer un engagement plus profond envers la sécurité culturelle et l'humilité. Nous avons utilisé la description interprétative pour analyser les évaluations des participants et les réflexions autoethnographiques des animateurs.

Résultats : Depuis 2019, 661 professionnels de santé ont participé à 29 ateliers animés par 24 animateurs autochtones et non autochtones. Quatre-ving-deux participants aux ateliers ont rempli des évaluations. Les résultats mettent en évidence trois enseignements : 1) comment l'apprentissage anticolonial fondé sur les arts offre des moyens émotionnellement parlants de favoriser l'empathie, l'autoréflexion et la mise en pratique de nouvelles façons de penser et d'agir ; 2) comment notre travail s'inscrit dans des possibilités plus larges de changement systémique ; et 3) comment les approches fondées sur le lieu et relationnelles influencent ces résultats.

Conclusion : Les outils et pratiques artistiques, centrés sur le cœur et ancrés dans les modes de savoir et d'être autochtones, peuvent prendre en compte l'émotivité des personnes et soutenir quiconque s'efforce de cultiver des environnements de soins de santé culturellement plus sûrs, en particulier dans le domaine de l'enseignement médical. Les stratégies développées dans le cadre de notre travail pourraient éclairer les approches relationnelles et fondées sur le lieu influencent en phase avec les émotions, créatives, adaptative et flexibles pour lutter contre le racisme anti-autochtone dans le secteur de la santé.

Introduction

Uptake of anti-racist and cultural humility learning opportunities marks welcome shifts in healthcare, with many people actively working to cultivate culturally safer environments for Indigenous patients and healthcare professionals.[1–6] Landmark reports in Canada (e.g., *Truth and Reconciliation Commission Final Report*, *First Peoples, Second Class Treatment,* and *In Plain Sight*) highlighted links between government policies and health disparities affecting First Nations, Métis, and Inuit peoples, underscoring the need for healthcare training in intercultural competency, anti-racism, and human rights.[7-9] Health colleges and regulatory bodies have responded with cultural safety and humility commitments, competency standards, practice guidelines, and some training opportunities.[3–5,10–14]

Even so, reshaping healthcare environments for Indigenous patients and providers remains urgent, particularly in rural and northern geographies, where anti-Indigenous racism is so widespread that many Indigenous people remain reluctant to engage in the healthcare system.[9,15] Indigenous peoples and communities have long emphasized that culturally safer healthcare requires respecting and valuing Indigenous ways of knowing and being.[2,6,16,17] As regulatory and ethical standards emphasizing collaboration with Indigenous peoples and communities evolve, demand for cultural safety and humility training will grow. But how can this be effectively achieved?

Tailoring training practices to rural and northern regions and health systems, which face unique health system challenges, remains under-documented.[4,15,18–20] Critics are increasingly showing that much existing training inadequately confronts colonial/white supremacist power structures and thus risks reinscribing racial–colonial hierarchies and reproducing health disparities.[6,16,17] Further, there is wide agreement that evidencing or measuring the actual impact of cultural safety training remains elusive at best.[21,22] Finally, few training opportunities attend to healthcare providers' emotional responses to difficult workplace dilemmas, even as they face unprecedented rates of burnout, exhaustion, and stress.[23–25] Given this landscape, our research addresses *In Plain Sight* recommendation 20, which calls for "a refreshed approach to anti-racism, cultural humility and trauma-informed training for health workers."[9(p.199)]

The diverse authors of this paper are collectively invested in the research question: *How can the healthcare sector become stronger, more diverse and inclusive, and culturally safer for Indigenous peoples, both as employees and patients?* The regional focus of our work is on rural and remote geographies across northern British Columbia (BC), where we examine how arts-based and anti-colonial approaches can combat anti-Indigenous racism and deepen commitments to cultural safety through creative, reflective practices. This paper shares lessons from six years of facilitating workshops that invited healthcare professionals to recognize their potential for professional transformation, even in the midst of mistakes.

Methods

Theoretical & methodological approach

We take a community-informed, strengths-based, *anti-colonial* approach to action-oriented research.[26–30] Anti-colonial methodologies, while keenly and sharply aligned with Indigenous methodologies, are taken up more productively by teams (like ours) who include Indigenous, Black, and settler scholars. Indeed, anti-colonial methodologies are deeply relational and place-based*,* necessarily uplifting Indigenous sovereignty and ways of knowing and being while also countering colonizing structures, practices, mentalities, land thefts, and Indigenous erasures.[26–29]

To this end, we also draw on critical and Indigenous health humanities that understand health and healthcare as involving *both* the sciences and the arts.[31–37] These fields use approaches like critical self-reflection, narrative medicine, visual storytelling, and theatre to create safer and non-threatening spaces to explore difficult health-related subjects

like prejudices, error, uncertainty, compromised professionalism, grief, confusion, and alienation.[38–44] In this way, creative arts-based modalities advance capacities for fostering relational and emotionally attuned health encounters, conceptualizing ill/health within uneven societal formations, and reimagining health and well-being beyond biomedical sciences and routine clinical encounters.[31-41] Indigenous health humanities, more specifically, provides "an invitation to explore the ways in which Indigenous and Western medicine can coexist, and a critique of biomedicine's colonial practices."[37(p.96)]

Critical and Indigenous health humanities remain underexplored and minimally applied as strategies for cultivating empathetic sociocultural attunement to Indigenous peoples, combating anti-Indigenous racism, or building culturally safer healthcare environments, especially within Canadian contexts. Recognizing their potential, we sought to extend these strategies, helping healthcare professionals adopt anti-colonial, culturally safer practices without increasing fatigue or overwhelm.

Setting & workshop design

Our research is anchored in northern BC, home to ~300,000 people, 20% of whom are Indigenous, where even the region's so-called "cities" are effectively rural or remote, spread across an area larger than France.[45] Healthcare services are provided by Northern Health Authority (NHA) and First Nations Health Authority, with NHA serving the highest proportion of First Nations in BC (over 35%) and ranking among the largest regional employers.[46] To address the need for geographically situated cultural humility and safety training, our team began offering workshops in 2019, open to any healthcare group and advertised on the NHA website.

The workshops used an iterative, non-linear, and cumulative pedagogy to help participants learn about anti-Indigenous racism and deepen commitments to cultural safety and humility through creative reflective practices. The "lessons" only became clear at the conclusion, after several seemingly disconnected activities. This circuitous learning journey, unfolding over two to three hours, followed a five-part structure: 1) Elders' words, introductions, orientations to colonial violence, and articulations of personal purposes for attending; 2) orientation to arts-based learning; 3) theatrical and creative writing activities; 4) visual art production, storytelling, and material crafting; and 5) personal reflections, commitment-making, and sharing of vulnerabilities. While the structure and purpose of each workshop stayed constant, the methods used in each workshop changed over time and place, iteratively incorporating lessons learned, and tailoring activities and discussions to specific settings.

The workshop facilitation teams were also adapted to suit each workshop's place and time. Teams were varied for both practical and methodological reasons, assembling combinations of artists, researchers, language teachers, Elders, and healthcare providers based on the healthcare setting, participants' priorities, and local contacts available to co-facilitate. Each workshop had at least three co-facilitators, whose place-based lived experiences shaped their content and delivery. Indigenous facilitators and Elders were always included and centred.

For example, a recent (Feb 2025) workshop with resident physicians and health administrators in Ts'msyen Territory included forum theatre, colouring, sewing, storytelling, and a Sm'algyax language lesson. Led by six co-facilitators, these activities allowed participants to interrupt and rewrite potentially harmful interactions in healthcare settings, learn about Lejac Residential School, and connect with Ts'msyen language and lands. Other workshops engaged healthcare professionals in activities like cedar weaving, porcupine quill making, Métis dot painting, singing songs in Dakelh, blind contour drawing, collage making, writing, and poetry (Figure 1).

Figure 1. Examples of arts-based workshop activities. Top left: Métis dot painting. Top right: Sewing. Bottom left: Blind contour drawing. Bottom right: Porcupine quill dyeing.

Data collection

At the end of each workshop, we invited participants to complete feedback and evaluation forms about key lessons, how they could apply them at work, barriers to application, and any additional comments. We also gathered autoethnographic reflections from facilitators, including notes from post-workshop debriefs, email communications, and journal-based reflections. We used autoethnography as a complementary form of inquiry to unsettle researcher/researched dichotomies and allow us, as researchers, to "think *with* our narratives instead of simply about them."[47(p.19)] Incorporating participant *and* facilitator reflections into each workshop iteration was an essential part of this research being action-oriented. Our final analysis also needed to demonstrate this dialogical relationship between facilitator and participant impressions.

Data analysis

We analyzed the data in two stages. Because this research was action-oriented, the primary analysis was iterative, occurring over the six years we facilitated workshops and incorporating participants' and facilitators' insights into subsequent workshops. The second stage of analysis took place in the final year and was informed by Interpretive Description, which "orients data analysis towards the development of findings that will contribute to the understanding of the complexities of health care education."[48(p.337),49] In this process, SdL and LS shared insights from the first stage of analysis with KC who then coded and categorized the entire dataset from participants and facilitators to develop a set of shared patterns and connections. These were discussed and re-interpreted with SdL and LS before being shared for feedback and input from the remaining authors. The findings, documented below, are broad insights based on the experiences and perspectives of participants and facilitators interpreted through our anti-colonial and arts-based methodological framework.[26–37]

Ethics, relational validity & accountability

Our research is rooted in relational validity, which "impels action and increased accountability to people and place."[50(p.636)] This study was informed by a Community Advisory Committee that oversaw the broader research project the present study was housed within. Ten facilitators are of/from First Nations in northern BC, including Dakelh, Haida, Gitxsan, Witsuwit'en, Tse'khene, and Ts'msyen Nations. Four are Métis or from other rural and northern First Nations, including Deninu Kųé and Secwépemc Nations. Ten are non-Indigenous settlers with multiple ancestral homelands (e.g. Netherlands, Ghana, China, Ireland) and thus have various experiences of migration to northern BC driven by uneven relationships to settler coloniality.

We are accountable to all our relations, especially to those who contributed to the research process. Elders and facilitators were always fairly compensated. Whenever possible, workshops included shared meals as a key method for building trust necessary for embarking on vulnerable learning journeys.[50] Some workshops were accredited by the College of Family Physicians of Canada to support physicians and medical trainees. Our research protocol was approved by UNBC Research Ethics Board.

Findings

Over six years, 24 facilitators held 29 workshops across northern BC. In total, 661 practicing healthcare professionals participated, including pharmacists, physicians, nurses, dentists, surgeons, medical students and educators, healthcare trainees, allied providers, technicians, administrators, health policy experts, and leadership staff. In total, 82 participants voluntarily completed an evaluation form, providing a 12.4% response rate. Our analysis of participant and facilitator reflections resulted in three insights: 1) how arts-based anti-colonial learning offers emotionally resonant ways to foster empathy, self-reflection, and practice new ways of thinking and doing, 2) how work such as ours is situated within broader possibilities for systemic change, and 3) how place-based and relational approaches underpin these outcomes.

Engaging emotionality through arts-based anti-colonial learning

Arts-based anti-colonial learning offers an accessible, engaging, and emotionally resonant way to examine colonialism, anti-Indigenous racism, and culturally safer healthcare practices—a point demonstrated by the overwhelming interest we received in our workshops. Between 2022 and 2024, demand for workshops surpassed facilitators' capacity to meet requests from within and beyond healthcare fields, with many requests coming via word-of-mouth, as workshop participants recommend the event to colleagues in other communities and healthcare settings. Participants' reflections highlighted their positive evaluations, often noting their appreciation for the interactive and creative approaches. For example:

> *This type of participatory learning is fantastic! (P60)*

> *It was transformative. Such great rhythm between listening, doing, embodied learning, role playing, sharing, self-reflection, etc. (P59)*

> *The workshop was very powerful. The messages were clear and touching to the core. (P21)*

> *Enjoyable, emotional, educational. (P20)*

The last two quotations point to the workshops' emotionally resonant aspects. This was also a common discussion point among facilitators, who invariably witnessed a range of emotional and affective responses from participants: deep sadness, awkwardness, discomfort, embarrassment, frustration, anger, dismay, joy, laughter, and humour.

Engaging in creative arts, listening to stories, and being invited into spaces that welcomed vulnerability helped participants cultivate empathy and self-reflection. Many participants described the workshop as "eye opening" and helpful for developing "empathy" and "perspective." Storytelling was especially powerful for allowing participants to develop a deeper understanding of "how others experience the world" (P58). As one facilitator observed, arts-based and creative approaches can compassionately cultivate personal self-reflection:

> *With time, I realized [art] was a compassionate and ethical way of bringing people to realize what they may be blinded to. It was a humane and non-judgmental way of pointing the truth out to people without necessarily putting them on the spot and casting accusations and blaming them. Using art to do that was a gentle but intentional way of getting that message across. It pierced people's hearts. (F8)*

Participants similarly expressed various ways that pairing arts-based methods with discussions on difficult topics encouraged self-reflection without causing overwhelm. As one participant reflected, "[when] engag[ing] with art and difficult questions at the same time, the art softens the questions" (P67).

Similarly, workshop activities offered participants safe and welcoming ways to move reflection into action and practice skills for cultivating culturally safer healthcare environments. For example, the use of forum theatre—where spectators stop and change

a problem experienced by the play actors[43]—was mentioned as being particularly impactful: "the part where we interrupted the racism in HR scenario was especially powerful" (P28). One facilitator, who often led the forum theatre activities, noted this part of the workshop often generated the most laughter and joy, which she observed occurred when people stepped outside their comfort zones and were encouraged to make mistakes. In this way, an important finding, as one participant expressed, is "the chance to practice in a safe environment" (P30).

Creating a supportive environment and inviting participants to listen, feel, reflect, and act, mobilized deeper commitments to culturally safer healthcare practices, with participants expressing numerous sentiments like:

> *[I will] be more proactive in combatting anti-Indigenous racism. (P52)*

> *[I'm going] to be more diligent about checking my own bias and recognize the influence of culture on my perspective. (P80)*

These reflections underscore the power of pairing hands-on creative engagements about coloniality and anti-Indigenous racism with facilitated opportunities to practice new ways of thinking and doing.

Possibilities for systemic change

Participant and facilitator reflections demonstrated how creative and arts-based approaches can cultivate personal transformation. However, participants commonly expressed limited organizational and leadership support for applying their learnings, alongside feeling burnout and fatigue from the burden of driving culture change. Several participants described feeling "isolated," "exhausted," and challenged by navigating power differentials that put them at risk of "being penalized for speaking out" (P52). Others reflected on the difficulty of incorporate their learnings within "environments that don't respect storytelling" (P44) or in "healthcare systems not aware of social injustices experienced in northern and rural remote communities" (P56).

Conversely, one participant revealed, "It is really helpful when learning opportunities around anti-Indigenous racism and cultural safety are built into the work, so there is a formalized structure to such learning" (P28). This reflection echoes facilitators' consistent observation that workshops were effective in part because they were integrated into healthcare providers' workday. As one facilitator shared:

> *There's a big difference between healthcare providers having to go off and seek opportunities for learning on their own and having an institution make this type of learning a part of the workday. It tells healthcare providers that Indigenous and creative ways of thinking and doing are welcome and valued here. (F2)*

Similarly, as one participant described, systemic change requires "commitment from leadership at every level of healthcare to working towards culturally safe spaces and dismantling colonial white supremacist structures and processes, not just placating words and gestures" (P67).

Experiences of limited systemic support were accompanied by a shared recognition that healthcare systems are formed by individuals, who each hold responsibilities and capacities to make change. For example, participants shared sentiments like, "we all play a role in the system" (P6) and "we all have a role in treating others fairly and respectfully" (P21). One facilitator's reflection captured this relationship between individual transformation and broader systemic change:

> *As practitioners, we are individuals. If we can change our attitude and our way of doing things, practice differently, we can brighten the corner where we find ourselves. And if we have glows in different corners, little sparks everywhere, they come together to illuminate the whole system. And those of us sitting in the consulting rooms and labs and pharmacies today, we become the management tomorrow. And if our mindsets and our hearts are changed and our approach to things are different, we carry that with us when we become leaders. Truth be told, we might not feel the*

impacts broadly today. But if each of us brightens the corner where we are, one day at a time, one small office at a time... [Before] we realise, the whole system will catch fire, and everybody will see and feel the change. (F8)

This reflection also underscores how systemic change can take time. As facilitators, we see and experience this as deeply tethered to the burnout and fatigue participants expressed, which is becoming increasingly problematic across healthcare. In such a landscape, meaningful support from leadership, institutions, and systems is required for enacting change.

Place-based & relational approaches

Participants' learning outcomes and commitments to change were grounded in our place-based and relational approach to facilitation—a point evidenced by frequent references to the valuable lessons gained from Elders' and facilitators' personal stories, paired with creative activities and First Nations language lessons. One participant shared how "listening to Marion, the story and creating a pocket brought everything together for me" (P30). Another shared how much they appreciated "learnings of language from the Elder and in activities" (P73). Participants also expressed how workshop activities facilitated "connection with colleagues" (P10) and helped them "see my peers in another way" (P16). As facilitators, we witnessed how workshops allowed healthcare providers to come into closer relationship to the peoples and places within and beyond their workplaces.

From facilitator perspectives, the transformative potential of stories, language, and art depends upon two key elements underpinning *how* these methods are engaged. The first was the importance of relationality and responsibility when centring Indigenous ways of knowing and being, a point captured by one facilitator's reflection:

We struggle every day to be seen, to be heard, to carry our burdens. Our hearts ache for those that come after us. We scrape our knuckles to the bones to try and leave a better world than the one we inherited. This is the cry of generations of Ts'msyen women born into colonial patriarchy, where disappearance is an ongoing threat. Disappearance of our person, our knowledge, our language, our children, and our land. In these workshops, we come together as Indigenous and non-Indigenous facilitators to carry this burden. But this can only be done when everyone has relationships to land, place, and each other. Otherwise, it risks appropriating, disappearing, and capitalizing on Indigenous stories, knowledges, lands, and cultures. Who can share and learn from Indigenous ways of being and knowing isn't about identity alone, it's about relationship and responsibility. (F17)

Our relationships and responsibilities as facilitators underpinned our capacity to share language lessons, stories, and creative practices rooted in Indigenous ways of knowing and being. It is important that many workshop facilitators are friends or kin. Several of our relationships to each other and this place span decades and generations, and, for some, millennia. These relationships are necessary for community-centred, culturally-specific work, guiding everything from knowing an appropriate Elder to invite, to hiring a local caterer, or gaining the authority to teach the first languages spoken on these lands.

The second was our approach to facilitation, which enacted and modeled the anti-colonial ways of working together our workshops sought to promote. As one facilitator shared:

We each bring something different to the workshop [...] but we also demonstrate the kind of teamwork that provides a model for working together. This couldn't happen without facilitators feeling supported and valued for what each of us brings—our skills, our lived experience inside and outside health systems, and our knowledge of local geographies and languages. (F4)

For most facilitators, this model for working together was refreshing and inspiring, having rarely encountered teaching and learning opportunities

like this in healthcare environments. As another facilitator shared:

> *I have journals that date back many years asking my ancestors for guidance [...]. All I ever strived to do was make a difference in any way I could for my people and today I saw my dreams come to fruition. I feel like I found my voice and I am so inspired to keep fighting, what felt like a losing fight! You all came to me at a point in my life where I felt drained, let down and defeated and after today I feel so refreshed and grounded. (F11)*

As these reflections highlight, relationality not only underpinned facilitators' capacity to share language lessons, stories, and creative practices rooted in Indigenous ways of knowing and being but it also provided a refreshed model for creating culturally safer healthcare systems. Facilitators' relationships are critical for modelling the trust that is necessary for workshop participants *and* facilitators to engage in vulnerable learning journeys together.

Discussion

Our study concludes a decade into a post-Truth and Reconciliation Commission Canada, where the need to develop and implement culturally safer healthcare practices remains an urgent priority, especially in rural and northern geographies.[15,19] Our research responded to this need, aiming to provide a "refreshed" approach to cultural humility and anti-racism training. Over six years, we iteratively developed cultural humility workshops to engage healthcare workers across northern BC in creative reflective practices. Our findings demonstrate that creative interventions that speak to the heart and incorporate Indigenous was of knowing and being have significant potential to be broadly appealing and provide emotionally resonant ways to learn about colonialism, anti-Indigenous racism, and culturally safer healthcare practices.

Our research offers something new to the landscape of cultural safety and humility education. Notably, it contributes to evolving responses to calls for epistemic diversity and the need for paradigm shifts that respect and value Indigenous ways of knowing and being.[1-9] Despite under-deployment of health humanities toward Indigenous cultural safety, we are excited by recent discussions about Indigenous health humanities as a field of practice and research that:

> *Demands attention to different ways of knowing and being in a relational, rather than hierarchical, manner; recognizing the limitations of different knowledge systems as well as their strengths, so that the most appropriate conceptual tools are brought to bear in addressing the grand challenges we face both now and into the future.*[36(p.9)]

Our research adds to these conversations by showing how strategies developed in critical and Indigenous health humanities can foster empathetic sociocultural attunement to Indigenous peoples and develop skills to combat anti-Indigenous racism and build culturally safer healthcare environments. However, our findings also highlight the need for meaningful action from healthcare management and leadership to support healthcare workers in developing and implementing new skills and culturally safer practices. While incorporating learning opportunities into the workplace is one way to continue igniting '*little sparks everywhere,'* multi-level and multi-disciplinary approaches are required to scale up and affect system-wide change.[1,2,15]

For many participants, engaging in art and creative activities in healthcare settings—often a novel experience—elicited a range of emotions as they stepped outside their comfort zone. The intent was *not* to incite feelings of failure or incompetence, but simply to incite *feelings.* In this way, our work aligns with education literature on 'pedagogies of discomfort,' which posits emotions and discomfort as potent pedagogical tools capable of inciting personal and social transformation.[51-53] Similarly, while inviting healthcare professionals to act out scenarios in front of their colleagues can elicit uncomfortable feelings, so too does it invite joy, laughter, and humour—potent anti-oppressive tools for negotiating tension, challenging contradictions, and reclaiming power.[54-56]

As Indigenous and anti-colonial scholars posit, it is in these 'felt knowledges' that the limits of settler coloniality and harms of white supremacy can be exposed and alternative sentiments can be mobilized to challenge (white) settler states.[57-61] As we witnessed and other scholarship describes, unearthing and critiquing settler coloniality, can and may necessarily produce deeply emotional and affective responses.[51,62-64] This may be especially true for healthcare workers whose roles in settler society are framed as benevolent helping professionals.[63-65] As Mikdashi writes, "We forget that ideological and political commitments are, deep down, affective states."[59(p.30)] Efforts to repattern those commitments must attend to such deeply embedded affective states. As our work demonstrates, art, storytelling, and spaces that welcome vulnerability and mistakes can do just that.

Notably, several of our findings show how coming together in a synchronous learning space can be transformative. The hands-on, participatory, and deeply relational nature of our workshop was central to our capacity to cultivate an environment that encouraged openness and mistakes. This gave healthcare workers a 'safe environment to practice' and opportunities to experience a range of emotions arising from hearing personal stories, acting out scenarios in front of colleagues, and taking risks. This approach differs from many cultural safety and humility training opportunities available to *practicing* healthcare professionals, who predominantly access asynchronous curriculum designed for individual learning, as compared to medical students and trainees, who more commonly access experiential, group-based, and synchronous learning opportunities.[3,5,17,18,22,66] While a range of modalities may be important, learning outcomes and relative impacts of each warrants further investigation.

Our work also illustrates the transformative potential of emotionally resonant humanities-based approaches depends on relationships with peoples and places. This aligns with other scholarship highlighting the importance of collaboratively carrying the burdens of teaching settler healthcare workers about the impacts of colonialism and culturally appropriate pathways forward.[15–17,19] Only in such relationships can trusting, grounded, and serendipitous solidarities arise, and underlying power asymmetries can be unsettled.[50,67-69] From such approaches, stories arise sources of strength, innovation, and potential—all of which can transform how health and healthcare are understood, taught, and practiced. As this paper has shown, this is especially important in regions "on the margins," that is, rural, northern, and Indigenous healthcare geographies.

Limitations

Our research does not offer a prescriptive model for cultural humility education. Rather, it uplifts and demonstrates the potential of adaptive, flexible, creative methods and tools, applied in relational and geographically specific ways. By sharing our lessons learned, we hope others can take up this work in many more creative ways in many more places. Given how relatively new literature is on developing culturally safer healthcare environments in settler colonial contexts, there remains a need for exploratory research that continues relearning, reimagining, and rekindling new—and often quite old—ways of knowing and being.[16,19,36,37,57,69]

Another limitation is that participant reflections were collected through feedback and evaluation forms which, while useful for informing our iterative analysis and workshop development, offered limited depth. Including facilitator perspectives enriched our data and understanding of participant experiences. Importantly, our findings draw unevenly on participant and facilitator reflections. This was a deliberate methodological choice for situating and contextualizing participant and facilitator perspectives. For example, participant perspectives focused on the effectiveness of arts-based anti-colonial learning for cultivating empathy and self-reflection and igniting new ways of thinking and doing. While these are important findings, facilitator perspectives situate these possibilities within our place-based and deeply relational approach, which is necessary for these outcomes to avoid extractive, de-contextual, and colonial slippages.[16,50,69]

Conclusion

We hope the novel contribution this paper makes to cultural humility education can be creatively adapted and expanded to meet the unique needs of diverse regions striving for culture change in settler colonial healthcare environments. We offer an invitation to ignite *little sparks everywhere*: to engage healthcare professionals' hearts and minds in critical reflective practice informed by story and art. Doing so requires a commitment to relationship-based, adaptive, and flexible approaches, taken up in geographically specific ways. As we have come to know, deep relationships to people and place are essential for building and advancing critical, politicized, anti-colonial, and anti-oppressive healthcare systems in Canada and beyond.

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