Rehearsing for the Revolution: Using Forum Theatre to Engage Nursing Educators, Students and

Health Care Providers with the Priorities of the Manitoba Collaborative Indigenous Education

Blueprint

by

Vanessa Van Bewer

A thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

College of Nursing, Rady Faculty of Health Sciences

University of Manitoba

ABSTRACT

This research is at the intersection of artistic, Indigenous and nursing knowledge. The objectives of this research were to explore several priorities of the Manitoba Collaborative Indigenous Education Blueprint with health care providers, nursing educators and nursing students through Theatre of the Oppressed and forum theatre; to offer possibilities for integrating the priorities within nursing education; and to determine the receptivity of health care providers, nurse educators and students to Theatre of the Oppressed and forum theatre as pedagogical methods.

Using an arts-based methodology and a Two-Eyed Seeing lens, a Theatre of the Oppressed workshop infused with Indigenous approaches was developed. The workshop was facilitated by a workshop team (including a forum theatre facilitator and an Indigenous nurse-Elder) and included eight health care providers who dialogued, shared stories and generated knowledge and vignettes performed to an audience of students and educators (n=7). The discussions, dialogue and stories shared during the workshop supported the dramatic exploration of the priorities of the Manitoba Collaborative Indigenous Education Blueprint and the creation of the vignettes. The data (including theatre games, exercises, image theatre, forum theatre, sharing circles, photographs and vignettes) were analyzed using thematic analysis. The themes emerging from the exploration of research objective #1 were: 1) colonialism is ongoing; 2) the multiple faces of racism; 3) challenges in negotiating identity; 4) struggles in finding safe spaces and people.

This inquiry also included the development of a framework for nursing education that engendered an anti-racist praxis and transformative learning opportunities. The framework also serves as one example of how Indigenous methods, models and approaches can be employed in nursing education, thus connecting to research objective #2 of this study. Other suggestions

proposed for integrating the priorities of the Manitoba Collaborative Indigenous Education Blueprint within nursing education and addressing research objective #2 included scaffolding student learning opportunities, increasing Indigenous faculty representation, creating an Indigenous advisory board, and hiring an Elder.

The perspectives and responses to Theatre of the Oppressed and forum theatre as pedagogies in nursing education were also revealed through this inquiry. The findings from health care providers indicated that Theatre of the Oppressed may support health care providers' reflection and growth, strengthen relationships and encourage the expression of vulnerability. The findings of this study demonstrated that forum theatre is positively received by nursing students and has practical applications.

ACKNOWLEDGMENTS

Chi-miigwetch to Dr. Carrie Bourassa for serving as my external examiner and providing thoughtful feedback, encouragement as well as inspiration for so many Métis girls who have of a vision of a better Canada.

To my family, dearest friends and community who lifted me up, who believed in me even when I doubted myself. I am eternally grateful.

Lastly, to the spirit of my ancestors who gave me my stout-heartedness, my creativity and lit my path on the darkest of nights.

Marsi/Miigwetch/Ekosani

DEDICATION

To my husband

And to my children

And to the generation of children to come

May we keep dreaming, hoping and working towards a better future

Preface

This thesis is an original work by Vanessa Van Bewer. The research project included in this thesis received research ethics approval from the Health Research Ethics Board of the University of Manitoba- Bannatyne campus for the study entitled "Rehearsing for the Revolution: Using Forum Theatre to Engage Nursing Educators, Students and Health Care Providers with the Priorities of the Manitoba Collaborative Indigenous Education Blueprint" [Ethics# HS22624 (H2019:090), March 11, 2019].

The paper contained in chapter 2 has been published as Van Bewer, V., Woodgate, R. L., Martin, D., & Deer, F. (2020). The importance and promise of integrating Indigenous knowledges in nursing education. *Witness: The Canadian Journal of Critical Nursing Discourse, 2*(1), 11-24. https://doi.org/10.25071/2291-5796.46. I was responsible for the conception and writing of the manuscript. Dr. Woodgate assisted in a supervisory role and contributed in conceptual formation, as well as editing and reviewing the manuscript. Dr. Martin and Dr. Deer contributed to reviewing and editing the manuscript.

The manuscript contained in Chapter 5 was submitted and is being reviewed for publication as Van Bewer, V; Woodgate, R.L.; Martin, D; Deer, F. I was responsible for conducting the research study and methodology, formal analysis and writing. Dr. Woodgate assisted in a supervisory role with conceptual formation as well as contributing to organizing and editing the manuscript. Dr. Martin and Dr. Deer contributed to reviewing and editing.

The manuscript contained in Chapter 6 was submitted for publication as Van Bewer, V; Woodgate, R.L.; Martin, D; Deer, F. to the *Journal of Professional Nursing*. I was responsible for the conceptualization, conducting the research study, methodology, formal analysis and writing. Dr. Woodgate assisted in a supervisory role as well as contributing to reviewing and editing the manuscript. Dr. Martin and Dr. Deer contributed to reviewing and editing. The manuscript contained herein is the pre-print of the article accepted for publication in the *Journal of Professional Nursing*. The DOI for the accepted publication is

https://doi.org/10.1016/j.profnurs.2020.11.002

The manuscript contained in Chapter 7 is under consideration as Van Bewer, V; Woodgate, R.L.; Martin, D; Deer, F. to *Nurse Education Today*. I was responsible for the conceptualization, conducting the research study and methodology, formal analysis and writing. Dr. Woodgate assisted in a supervisory role as well as contributing to reviewing and editing the manuscript. Dr. Martin and Dr. Deer contributed to reviewing and editing

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CHAPTER 1: INTRODUCTION

Prologue

What does it mean to teach and to learn about Indigenous knowledge, colonization, oppression and racism in nursing education and in other campus spaces? What kind of pedagogical practices might engage us with these complex and difficult issues? Why is this important for nurse educators, just as much as it is for nursing students and practicing nurses? This dissertation sets out to address these thorny questions, making the case for the transformative possibilities of Theatre of the Oppressed along with Indigenous sharing circles. Through this research, I seek to both affirm Indigenous perspectives while reducing the space that divides us as Indigenous and non-Indigenous peoples. The methodological and pedagogical approach in this research is relational, participatory and respectful. It is a place for dialogue, for meaning-making, for agency, for alternative imaginings and for hope. I invite you upon a journey of discovery, not only a journey of discovery for my co-conspirators (participants and research team) but of my own, and of yours as a reader.

This dissertation begins in chapter one, with my own story and then using Crotty's (1998) scaffolding approach, I frame how this research came to be from inspiration, to epistemology, theoretical orientation, methodology and methods. In chapter two, I review literature in relation to Indigenous perspectives and approaches in nursing education. This chapter explores Indigenous nurses' perspectives, affirms the potential benefits and challenges with integrating Indigenous knowledge in nursing education and explores literature on schools of nursing who have begun the work of decolonizing nursing education (paper 1). However, reviewed literature is also woven throughout the dissertation as considerations regarding topic, methodology and analysis emerged. Chapter 3 explains the research design employed in this research project

including methods, events of the research, activities, recruitment, sources of data collection and data analysis. Chapter 4 presents an overview of the findings of this research. Chapter 5 is a manuscript (Paper 2) that presents several findings of the research project relating to research objective #1. This paper illuminates Indigenous health care providers' experiences in health care and nursing education. Chapter 6 is devoted to a theoretical discussion paper (Paper 3) that explores Theatre of the Oppressed along with Indigenous sharing circles as pedagogical methods that support anti-racist praxis in nursing education. This paper presents several findings relating to the research objective #1 but also serves as one example of how Indigenous approaches can be integrated into nursing education and research (research objective #2). Chapter 7 presents the findings supporting research objective #3 and describes health care providers' and nursing students' responses to Theatre of the Oppressed and forum theatre as pedagogies in nursing education (Paper 4). Chapter 8 presents a discussion on the findings of this research. Chapter 9 summarizes some of my reflections and implications for nursing practice and education as well as suggestions for future research.

Given this is a paper-based thesis, there is some repetition in this dissertation. This was necessary given that the papers are intended to "stand alone" as publications within peer-reviewed journals. But perhaps through this repetition, the reader might also find new meaning or deeper understanding.

Scaffolding approach in arts and Indigenous-informed research

Some students embark upon their doctoral education with a strong sense of how the world is shaped, the nature of truth, the lens through which they see the world and have decided upon their research methodology, methods and questions. However, many students have struggled with these complex issues throughout the beginning stages of their doctoral program.

If the litany of textbooks, peer-reviewed articles, blogs and message boards on how to approach the research process are indicative, the issue remains problematic and contentious. While some authors emphasize epistemological and ontological assumptions as the beginning point of the research process (Grix, 2002; Mason, 2002), others focus exclusively on practical elements (the aims, research questions and methods) within a research project while ignoring epistemological and theoretical issues (Cunningham, 2014). In response to the predictable bewilderment these different stances create for novice researchers, Crotty (1998) proposes a scaffolding approach that compels researchers to answer four questions: "What methods do we propose to use? What methodology governs our choice and use of methods? What theoretical perspective lies behind the methodology in question? What epistemology informs this theoretical perspective" (p. 2). By critically thinking about these basic elements and carefully selecting methods, methodologies, theoretical frameworks and epistemologies that align with each other, the researcher can scaffold their research in a logical and defensible manner.

Using my own doctoral research as fodder for this paper, I will begin by briefly situating myself as well as the context of this research project. I will then explore how Crotty's (1998) scaffolding approach was used to critically reflect upon the basic elements of the research process and how these reflections were used to inform my doctoral project. By employing Crotty's scaffolding method, I am able to better define and conceptualize my research examining the use of Theatre of the Oppressed and forum theatre as methods to facilitate a dialogue with health care providers (HCPs) and nursing students about race and racism as well as engage HCPs and nursing students with Indigenous knowledge and traditions as they pertain to nursing education. However, Crotty's framework is but one guide, and woven into this frame is a

personal account of my developing conscience as a scholar. But first we start with story, as this is how we all began.

My story

My name is Vanessa Van Bewer and I am a nurse and doctoral student of French-Métis parentage on my mother's side and of English-settler ancestry on my father's side. I am the descendant of Cuthbert Grant, Métis leader in the 19th Century (who led the Battle of Seven Oaks), and André Beauchemin, MLA for St-Vital in Louis Riel's provisional government in 1870. I am also the descendant of many Indigenous women, several of whom remain unnamed in my family's genealogy. Cuthbert and André's achievements are notable and noted, but it is the grandmothers before me, those unheralded by history and undocumented by the written word for whom I hope to pay homage to through my work.

Though not as familiar with my English-settler ancestry, both my paternal grandmother and grandfather's families were homesteaders in Canada and pre-Canada for hundreds of years. I have always identified more with my maternal side and felt stronger kinship bonds with my maternal relatives. The formative years of my life were spent playing, learning and living with my maternal cousins, aunts, uncles and grand-father. We spent every week-end together, every camping trip, celebrated every birthday, and every holiday together. Our stories are forever tied together. However, I cannot deny my English-settler roots. I had a lovely paternal grandmother, who taught me many wonderful things (the love of reading, the importance of ecological conservation and social justice among many others). To deny my English-settler origins would be to deny her presence in the world and to deny the complexity of my being and involvement on both sides of the colonial project.

I grew up in Winnipeg, Manitoba, on Treaty One territory and on the historic Métis homeland, a stone's throw from where André Beauchemin was evicted from his scrip land. I grew up speaking French as a primary language, at school and with my mother, my extended family and my community. If not teased for speaking French by English-speaking children, we were often reminded by many Québécois people that our spoken French was not "real French", not comparable to the French or Québécois standard. For many francophone Métis in Manitoba, there is a heaviness to our mother tongue, a hybridity and mixing of the language, and the use of French words from long ago, when the voyageurs first came to Manitoba. As is the case across the prairies, many French-Métis abandoned the French language after being told they spoke it poorly. Others abandoned French after it was forbidden as a language of instruction in schools, despite the fact that Riel's provincial government negotiated Canada into confederation securing the rights of Métis people (including the rights to education in French). My mother's family adapted by speaking French at home only. More recent adaptations include standardizing one's French in order to sound more acceptable to the ears of others. While I fall into the latter category, I mourn the fact that André Beauchemin and his children were polyglots, speaking Cree, Ojibway, French and English fluently while all that remains for my me and my family are two colonial languages. As my Métis grandfather was prone to saying "I speak two languages, neither of them well".

I would be remiss to not acknowledge that I am also fair skinned and light eyed. Unlike some members of my extended family, I was spared the questions, teasing and hurtful comments about my ethnicity. This has been an indisputable form of privilege for me. However, I have also faced innumerable comments over the years, hurtful and uninformed, either maligning Indigenous people (unaware of my background) or questioning the authenticity of my

Indigeneity. Though the former comments are hurtful, the latter comments have been no less, as Métis people have struggled for recognition as Indigenous peoples, but also because these comments reinforced complex choices that Métis people have made in the name of belonging.

Background

Manitoba Collaborative Indigenous Education Blueprint

In December 2015, post-secondary universities, colleges, and school boards across the province of Manitoba (Canada) signed a historic "Manitoba Collaborative Indigenous Education Blueprint" (MCIEB). The MCIEB is intended to act upon the Truth and Reconciliation Commission of Canada's (2015) recommendations on education. The MCIEB identifies key priorities which include:

1) Engaging with Indigenous peoples in respectful and reciprocal relationships and to realize the right to self-determination, and to advance reconciliation, language and culture through education, research and skill development.

2) Bringing Indigenous knowledge, languages and intellectual traditions, models and approaches into curriculum and pedagogy.

3) Promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples.

4) Increasing access to services, programs and supports to Indigenous students, to ensure a learning environment is established that fosters learner success;

5) Collaborating to increase student mobility to better serve the needs of Indigenous students;

6) Building school and campus communities that are free of racism, value diversity and foster cultural safety.

7) Increasing and measuring Indigenous school and post-secondary participation and success rates

8) Showcasing successes of Indigenous students and educators;

9) Reflecting the diversity of First Nations, Inuit and Métis cultures in Manitoba through Institutional governance and staffing policies and practices; and

10) Encouraging governments and the private and public sectors to increase labour market opportunities for Indigenous graduates (University of Manitoba, 2015).

The successful implementation of these key priorities will require all citizens of post-secondary educational communities to broaden and deepen their engagement with these priorities. Some priorities outlined in the MCIEB are not within the purview of nursing educators or students and require broader organizational and structural changes. However, nursing educators and students should meaningfully contribute to the flourishing of priorities 2, 3 and 6 within the discipline. Building school and campus communities that are free of racism, value diversity and foster cultural safety is an essential task for all post-secondary citizens, and few students or educators would refute this obligation. However, nursing classrooms are not safe havens for all students, and racism, stereotypes and discrimination persist in nursing and in health care for Indigenous people (Allan & Smylie, 2015; McGibbon & Etowa, 2009; Tang & Browne, 2008; Varcoe & McCormick, 2007).

Furthermore, bringing Indigenous knowledge, languages and intellectual traditions, models and approaches into curriculum and pedagogy is rarely acknowledged within prevalent nursing discourses. While some nursing scholars are engaging in scholarship relating to Indigenous knowledge in nursing practice (Bearskin et al., 2016; Bearskin, 2011; Etowa et al., 2011; Lowe & Struthers, 2001), this scholarship remains largely unrecognized and unexplored in

Canadian nursing curriculum. Consequently, connecting with the priorities of the MCIEB requires a shift within nursing education. This shift requires a deeper understanding amongst nursing educators and students about Indigenous worldviews, Indigenous knowledge as well as historic and current Indigenous and non-Indigenous relations as they relate to the context of health care and beyond. Cote-Meek (2014) describes this type of knowledge as "difficult knowledge" and maintains that to convey this difficult knowledge without re-traumatizing the colonizer-colonized relationship, transformative pedagogies are needed.

Epistemology

The alternative to philosophy is not no philosophy, but bad philosophy. The 'unphilosophical' person has an unconscious philosophy, which they apply in their practice - whether of science or politics or daily life (Collier, 1994, p. 17).

Returning to Crotty's (1998) scaffold, I now begin by identifying the epistemology that underpins this research. Though Crotty maintains that most researchers begin by describing the aims and objectives of their research, the scaffolding process allows researchers the flexibility to choose at which stage to begin whether it be aims and objectives, epistemological, theoretical, methods or methodology. For the purposes of my doctoral research, I initially began by conceptualizing my research aims and objectives. However, a change in research project and subsequent research aims and objectives partway through my doctoral program resulted in a different methodology and methods. What remained of my original scaffold was my epistemology. Though I had used Crotty's scaffolding approach for both my first and second conceptualizations of my research, the arrangement created with the scaffold was entirely different. Therein lies the beauty of the scaffold. Like a weaver's loom, the scaffold creates a different tapestry with each new attempt.

In grounding this research in my epistemological and ontological position first and foremost, I hope to avoid what Flinders and Mills (1993) describe as "immaculate perception", the inclination to present a clear and concise research project without mention of the ways in which I arrived at this intricate and evolving subjectivity. Though Crotty (1998) might argue that the researcher can choose at which stage to begin, this is incompatible with my worldview and an Indigenous paradigmatic approach. In my estimate, though researchers might come to identify research aims and objectives first (or believe they have identified these first), the researcher's intentions, goals and philosophical assumptions are inextricably linked with the research they do and the questions they ask. Indeed, Grix (2004) warns that people who want to conduct clear, precise research and evaluate other's research need to understand the philosophical underpinnings that inform their choice of research questions, methodology, methods and intentions (p. 57). Therefore, how one views the constructs of social reality and knowledge affects how they will go about uncovering knowledge of relationships among phenomena and social behavior and how they evaluate their own and other's research.

What is an epistemology?

"Epistemology is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate" (Crotty, 1998, p. 10). Simply, epistemology is asking "How do I know what is real?" (Wilson, 2008, p. 33). In broadly exploring the research area for this project, I reflected on numerous epistemologies trying to find my epistemic beliefs within an identified tradition. Though Crotty's (1998) scaffolding approach is sound, the narrow identification of different epistemological positions is a critique of his text. He acknowledges that Table 1 in his textbook is not an exhaustive list of theoretical perspectives, methodologies and methods (denoted by

several "etceteras" in those categories). However, in listing epistemological stances, Crotty only

identifies objectivism, constructionism and subjectivism (and their variants). There are no

"etceteras" provided in this category and the emerging scholar may be left with the impression

that no other distinct epistemological traditions exist. Indeed, there are many other

epistemologies including the notably absent Indigenous and relational epistemologies. Crotty

does suggest that epistemologies should not be viewed as "watertight compartments" (p. 9).

However, he maintains that to avoid contradiction, researchers should be consistently objectivist

or constructionist (or subjectictivist). Such assertions are of little comfort to scholars and

researchers who fail to find their own unique epistemic views and beliefs within the boundaries

of previously established epistemological traditions.

Métissage: a personal epistemology

In reality, some of my own epistemic beliefs align with some constructionist claims. For

example, I do believe that human beings construct meanings, and that there are multiple

interpretations of reality. However, I disagree that humans alone construct meaning and that

prior to human consciousness on earth, the world held no meaning at all (Crotty, 1998). Rather, I

believe that all "worldstuff" (a term invented by Humphrey's and cited by Crotty, p. 43) can be

viewed as interconnected and interacting. Inspired by Wilson (2008), I also believe knowledge is

shared between all things, and the relationship between these things matters. As such, my

epistemology draws deeply from a relational one. According to Chilisa (2012), a relational

epistemology acknowledges that "knowers are seen as beings with connections to other beings,

the spirits of the ancestors and the worlds around them, that informs what they know and how

they can know it" (p. 116). However, my research aims are also influenced by certain tenets of

critical realism such as a reality independent of human perceptions and a focus on explanations and methodological eclecticism (Clark et al., 2014).

Rather than viewing multi-epistemic beliefs as problematic, I am drawing and building upon notions of epistemological pluralism as the basis for my personal epistemology. In describing epistemic pluralism, Andreotti et al. (2011) assert that pluralism involves understanding two or more ways of knowing that promotes the understanding of different social, historical and dynamic processes involved in knowledge construction. It also involves being able to reference and apply the appropriate frame to the appropriate context. However, pluralism falls terminologically and conceptually short and my own episteme extends beyond the notions of what pluralism entails. In lieu of pluralism, I propose the term *métissage*. Within literary circles, métissage is described as a "way of merging and blurring genres, texts and identities; an active literary stance, political strategy and pedagogical praxis" (Chambers et al., 2002, p. 1).

Inspired by the above definition, I view epistemological métissage as a weaving of epistemologies, identities and practices. It is an active scholarly stance, a political strategy and a pedagogical praxis. Examining my research questions through the lens of epistemic métissage allows me to weave notions of constructionism, relationality and pragmatism together in a manner that authentically underpins my research purpose. In essence, I hope to creatively and generatively engage nursing students and faculty both Indigenous and non-Indigenous, in embodied conversations about the priorities outlined in the MCIEB. However, realist notions about the fallibility of my knowledge remain. As an important proviso, I make no claims that other people, Métis or otherwise, think as I do. Though I use the term métissage, this account is not intended to define Métis epistemology (an impossible task given the complexity of the Métis

identity and experience). The above description, is merely my unique epistemology, and an attempt at self-authorship (Kegan, 1994).

Kindling and lighting the fire: Aims and objectives

Originating from a desire to explore the priorities of the MCIEB, my research began with a broad review of the literature on colonialism and its effects on Indigenous peoples. This literature search served as the kindling for my research purpose. However, the fire had yet to be lit and my specific aims and focus remained undefined. As I have moved along this doctoral path, a groundswell of conversations and events relating to Indigenous peoples have also been brought to the fore. From the Dakota pipeline protests, to the Inquiry into Missing and Murdered Indigenous Women… I had hoped that a largely unaware public might become sensitized and responsive to Indigenous knowledges and Indigenous lived experiences. However, as the ignorant or racist rhetoric surrounding these issues emerged, I recognized that hope had revealed itself prematurely. Nonetheless, through fruitful conversations with friends, families, Elders and mentors, and historic moments such as the signing of the MCIEB by the University of Manitoba along with other educational institutions in Manitoba, I was encouraged to explore this topic further. My research aims began to take root as I pondered: Is reconciliation optional? How do we ensure that all Canadians engage in "difficult conversations" about our colonial past? What responsibilities do I have on both sides of the colonial project as a Métis person who also has English-settler roots? From these general questions emerged more specific ones about my responsibility as a nursing educator, and the nursing faculty's responsibility to educating students about Canada's colonial legacy. Pertinent questions also emerged about how to engage with the MCIEB and represent Indigenous worldviews, knowledges, languages and beliefs within the discipline of nursing. Further yet, what pedagogy would allow for creative engagement with

these issues but also foster social change or wider human flourishing amongst nursing educators and students? Can this be done in a way that is humanizing, dialogical and respectful to the learners, the content, and to Indigenous and non-Indigenous ways of knowing and being?

Though many approaches may have been taken to achieve the above aims, forum theatre, a form of participatory theatre from Augusto Boal's "Theatre of the Oppressed", emerged as a suggestion from my research advisor. I initially rejected this approach due to my limited experience with the pedagogy and the vulnerability I felt in attempting such a pedagogy with educators and students. My last experience engaging with theatre had occurred during undergraduate studies when I had studied drama in education as an elective. However, many moons before, during my primary and secondary education, I had participated as a student in numerous creative outlets including drama, dance, poetry, storytelling and song. As a child, I had learned in pluralistic ways that celebrated our Métis heritage. In my elementary and junior high school, all students, regardless of their heritage (Métis or other), practiced storytelling and spoken word; had the opportunity to engage in hunting and hunter safety lessons with an Elder; and had the opportunity to participate in theatre and drama classes led by a Métis teacher. I had thrived in this environment, even winning a provincial storytelling contest three years in a row while in junior high. While unaware it even existed, we learned in ways that straddled the border between Indigenous approaches to learning and mainstream (or Western) ones. That border, however, came into vivid focus during my first years in university. Like an appendix, or wisdom teeth or some other vestigial organ that is no longer necessary, the Métis teachings and skills I had received as a child were completely useless within the post-secondary setting. Success in university required fluency in one language and knowledge system only. I can still recall diligently working on my first English Literature essay, believing I was a good writer and a good

storyteller, only to receive the grade of C- and feedback that my writing was not "scholarly", and that my essay lacked "structure".

I quickly learned to master the strategies required to succeed in a university setting. After all, it was simply a formula…Insert "To begin" here and "In conclusion" there; use transition words; don't forget to research and cite prolifically! However, this success came at the cost of criticality. As a master's student, I blindly accepted the choices presented through lecture and textbooks as the only choices that existed for researchers. And rather than being angry at a post-secondary educational milieu that only valued one form of learning, I was angry at the elementary and secondary school system that clearly rendered me unprepared for the "real world". In hindsight, for the majority of my post-secondary education, my mind had been held captive by Western thought and practice. The Malaysian sociologist Alatas (1974) coined the term *captive mind* to describe the "uncritical and imitative mind dominated by an external source, whose thinking is deflected from an independent perspective" (p. 692). As such, I recognized that though my captive mind felt immensely vulnerable when presented with forum theatre as a transformative pedagogy, I had once embraced and flourished as a learner within such pedagogical approaches. Further yet, though Theatre of the Oppressed does not emerge as specific to Indigenous ways of knowing or being, its artistic and transformative notions align with Indigenous epistemologies and ontologies. Kenny (1998) argues that from a First Nations' perspective, art is related to coherence, authenticity, health and spirituality. For First Peoples, "art is not a separate language, but rather the way we live" (p. 77). Indeed, Tewa author, Cajete (2000) maintains that Indigenous people have long learned and lived in holistic, relational and artistic ways. While Métis people embrace a combination of European and Indigenous beliefs,

Métis culture has always been grounded in music, dance, art and storytelling (First Peoples of Canada, 2007), and for many of us, art is what binds us to our heritage and to each other.

The above questions and reflections resulted in the formulation of my research purpose and objectives. The overall purpose of this research study was to advance awareness and understanding about the priorities of the MCIEB and about forum theatre more broadly with nurses, nurse educators, students and health care providers. The research objectives were to:

1) Explore several priorities of the MCIEB (priorities #2, 3 & 6) through Theatre of the Oppressed and forum theatre with nursing educators, students and health care providers.

2) Explore possibilities for integrating the priorities of the MCIEB within nursing education through Theatre of the Oppressed and forum theatre.

3) Explore nursing educators, health care providers', and nursing students' experiences of Theatre of the Oppressed and forum theatre as pedagogical approaches.

Two-eyed seeing as a theoretical framework

Guided by Crotty's (1998) scaffolding approach again, the next element I considered was the theoretical perspective that would underpin my research. Crotty asserts that we bring a number of assumptions about the human and social world to our chosen methodology. It is through our theoretical framework that we are able to make these assumptions explicit. When reflecting upon my assumptions about the world, I recognized that I wanted to acknowledge and validate Indigenous ways of knowing and thus, a decolonial current runs through the research. However, it is the interface or the relationship between mainstream ways of knowing and Indigenous ones that I wish to explore with students and educators. Given my own personal educational experiences, and my interest at the interface of two knowledge systems, the Two-Eyed Seeing approach emerged as a natural fit for this research. Two-Eyed Seeing is a

theoretical perspective introduced by Mi'kmaw Elders Albert and Murdena Marshall from

Eskasoni, a First Nation in Cape Breton, Nova Scotia (Martin, 2012). Two-Eyed Seeing was

advanced as a way to weave Indigenous and mainstream knowledges within science education

curriculum. Without privileging one perspective over another, Bartlett et al. (2012) contend that

within Two-Eyed Seeing both "eyes", the Western (Euro-centric) eye and the Indigenous one,

contribute to our understanding of the world. Additionally, learning from both eyes results in

greater benefit for all (Bartlett et al., 2012). Importantly, as it relates to my research objectives

and aims, Two-Eyed Seeing acknowledges Indigenous philosophies in which the world is

viewed as interdependent, fluid and ever-changing. Moreover, Two-Eyed Seeing recognizes that

though Indigenous knowledge emerges from a distinct epistemological system, it can exist side

by side with Western science (Bartlett et al., 2012; Iwama et al., 2009).

Though Two-Eyed Seeing has emerged as a theoretical perspective within the past few

decades, the weaving of multiple perspectives in Indigenous culture is not new and has long been

cherished by Indigenous peoples. While Western academic perspectives tend to categorize or

colonize knowledge, ways of knowing, and learning into a discipline or specific content/subject

area, Marshall and colleagues (2007) claim that:

> Two-Eyed Seeing is hard to convey to academics as it does not fit into any particular
>
> subject area or discipline. Rather, it is about life: what you do, what kind of
>
> responsibilities you have, how you should live while on Earth . . . i.e., a guiding principle
>
> that covers all aspects of our lives: social, economic, environmental, etc. The advantage
>
> of Two-Eyed Seeing is that you are always fine-tuning your mind into different places at
>
> once, you are always looking for another perspective and better way of doing things.
>
> (para 1).

Martin (2012) advances that Two-Eyed Seeing legitimizes the benefits of different and contradictory perspectives. Integrating perspectives is not sought as this can result in the domination of one over the other. One is never seeking to have one "eye" dominated by the other. Rather, each eye represents the partial and limited way in which we can see the world. The use of both eyes does not create a holistic or complete worldview, but a unique way of seeing the world while respecting the differences that each view brings. The fluidity inherent in this theoretical perspective provides a more complete understanding of the world and encourages the acceptance of diverse perspectives. Seeking solutions through a Two-Eyed Seeing lens may result in a Western approach in some contexts or an Indigenous approach in another (Martin). However, Levac et al. (2018) maintain there are grave risks associated with attempting to integrate Indigenous and Western knowledge systems because this implies that one is supplanted by the other. Through Two-Eyed Seeing, one approach is never subsumed by the other, rather both perspectives are cultivated as is the capacity to navigate between multiple perspectives and approaches. As Vukic et al. (2012) assert in the context of nursing research "Two-Eyed seeing promotes common ground between researcher and participants by acknowledging and respecting different worldviews" (p. 4).

Arts-based research methodology

Methodology is often referred to as research design or as a "strategy or plan of action" (Crotty, 1998, p.7). Arts-based research is described as "research that uses the arts, in the broadest sense, to explore, understand, represent and even challenge human action and experience (Savin-Baden & Wimpenny, 2014, p.1). Several methodologies may have been appropriate for this research project given my proposed study's aims, epistemology and theoretical perspective. However, many methodologies are aligned with specific epistemological

and theoretical positions that guide the research process. Arts-based research (ABR) on the other hand, is epistemologically pluralistic, accommodating varied epistemological positions (Latham, 2013). Rather, ABR is characterized epistemologically more by what it resists, than what it endorses. ABR challenges logical positivism, technical rationality, and the quest for objective truth that dominates academic discourses (Knowles & Cole, 2008; Latham, 2013). Barone (2008) describes ABR as epistemologically humble research that takes on the master narrative and its monolithic view of the world. By adopting epistemological modesty, ABR avoids epistemic violence or epistemological "terrorism" and has the power to involve the public in what Barone calls "conspiratorial conversations" about possible and desirable worlds (as cited in Barone, 2008, p. 39). Rolling (2010) defines ABR as epistemic antifoundationalism, an epistemology that "destabilizes the footings of sacred monuments we make of our scientific and social scientific research methods and outcomes" and as "poststructural and erosive pathways, flowing over, through, around, and under scientific and social scientific, quantitative and qualitative epistemologies (p. 107).

Arts-based research is grounded ontologically in the belief that "we are all, at a fundamental level, creative and aesthetic beings in intersubjective relation with each other and our environment" (Conrad & Beck, 2015, p. 1). Arts-based research is both inspired by relational and Indigenous paradigms and encourages creativity and artistic contributions that honour relationships, human and non-human flourishing, and celebrate art's potential to transforming the world (Conrad & Beck, 2015). Chilton (2013) describes that in ABR, reality is made and re-made anew by "artistic experience of story, image, metaphor, and symbol, which have real, though multiple, meanings that increase human meaning, purpose, and capacity for positive transformation" (p. 460). Bergdoff (2007) argues that ontologically, ABR is concerned with

different types of facts than scientific or qualitative ones. Artistic facts have their own intrinsic status that have been described as philosophically aesthetic and immaterial. Given that the purpose of this research is to destabilize, challenge and decolonize mainstream nursing pedagogy and practice as well as honour Indigenous perspectives and approaches, ABR is particularly suited as a methodological approach.

Methods

Crotty (1998) describes research methods as "the concrete techniques or procedures we plan to use" (p. 6). In identifying and justifying the research process, the goal is to describe the research methods to be used as specifically as possible. While a questionnaire was used to ascertain demographic information about the participants, the methods used in the project were a Theatre of the Oppressed workshop including a forum theatre performance and sharing circles.

Theatre of the Oppressed (TO) workshop

Theatre of the Oppressed is noted for its critical and transformative potential. TO was developed by Augusto Boal (2000) while he lived under dictatorship in Brazil during the 1960s. Boal developed TO as an explicitly political theatre, designed to be used by oppressed and minority groups to enable them to take on the leading role in their own lives (Quinlan, 2009). Boal was inspired by his compatriot Paolo Freire's (2000) *Pedagogy of the Oppressed,* and Freire's notions about conscientization, social transformation, praxis and dialogic education. Like Freire, Boal believed that people should have the opportunity to develop the critical consciousness needed to recognize and challenge the social structures that oppress them. Boal's assumption was premised on the notion that we live in a "culture of oppression" and through theatrical techniques we could become more conscious about it and empower ourselves. Boal argued that conventional theatre, like conventional education reflects and reproduces hegemonic

values in society. Audience members are passive observers and do not share the struggle of the characters on stage and are lulled into a state of passivity that undermines potential agency (Thomson & Wood, 2001). In order to counteract the hegemony of conventional theatre, Boal developed TO, which includes a repertoire of theatrical games and exercises (i.e. Image Theatre, Cops in the Head, Rainbow of Desire, Forum Theatre and Legislative Theatre, etc.), as a search for dialogical forms of theatre through which a possibility for dialogue about and on social activity, pedagogy, psychotherapy and politics occurs.

Forum theatre (FT) is a form of participatory theatre between actors and the audience, or what Boal calls "spect-actors" (Boal, 1995). Within FT, spect-actors are invited to watch a play in which the struggle between an oppressed protagonist and his or her antagonist is portrayed. The play is shown once, without interruptions, until it reaches some kind of tragedy or catastrophe. The play is then shown a second time, with the spect-actors shouting "stop" to intervene and attempt to improvise alternate strategies to modify the course of the play to help the cause of the oppressed protagonist (Brett-MacLean et al., 2012). The other actors on stage remain in character and attempt to escalate the oppression, not allowing facile solutions (Boal, 2002). Typically, in FT members of a community or group create a play with a pertinent issue in mind. The questions asked by the model (Boal uses the term model rather than script), are usually specific to the group's context but can be extrapolated to a larger audience (Baxter, 2005). This extrapolation of the model to a broader application is known as *ascesis* (Boal, 1995). In FT, there is an invitation to experiment ways in which to break the oppression presented in the model. Within traditional FT, there is also a joker, who is the antithesis of a facilitator, who interacts with the audience to provide deeper thinking and understanding of the issue presented.

Boal (1995) describes the joker as a "difficultator" who makes it impossible for the spect-actors to arrive at magical or naïve solutions to the issue in the model (p. xix).

Boal's FT has found expression in many different communities and contexts helping people to develop more effective approaches for solving a wide range of problems and has shown significant promise for mobilizing masses toward community dialogue and social change (Mitchell & Freitag, 2011). A modern adaptation of FT developed by David Diamond entitled *Theatre for Living*, has moved beyond binary notions of oppressor and oppressed, by viewing living communities as complex, living entities (Diamond, 2007). Diamond (2007) maintains that "the binary poles of oppressor and oppressed are actually part of the same large organism living in some kind of dysfunction" (p. 38). Like FT, Theatre for Living performances continue to explore how individuals can address oppressive circumstance but also explicitly emphasize how those circumstances involve large networks and power structures.

Boal (1995) argued that enactment is worth more than speech and is more accurate than words. A certain type of knowledge along with an understanding of power is apprehended in FT, and this knowledge and power differs from what would develop if audience members remained as passive observers in their seats (Dwyer, 2004). In FT, silent witnesses are invited to break their silence and act (Weinblatt & Harrison, 2011). Other advantages of FT include invigorating and cultivating agency and sharpening people's abilities to challenge oppressive scripts. In the use of FT to teach feminist agency to university students, Thomson and Wood (2001) found that FT moved students beyond the desire for change to the possession of concrete skills to instigate change. Used for research, the construction and performance of FT can provide critical ethnographic information (Baxter, 2005), inspire dialogue, and encourage people to explore

choices, and help citizens to practice community development within a safe space (Boal, 2000; Mitchell & Freitag, 2011).

In light of the research objectives proposed in this project, a Theatre of the Oppressed workshop that included verbal and non-verbal theatrical games, image theatre and forum theatre with nursing educators, nurses and health care providers was employed as one the primary research methods. In the context of my research, a Theatre of the Oppressed workshop allowed a verbal, preverbal, kinesthetic and artistic knowledge and exploration of how the priorities of the MCIEB are understood.

Sharing circles

Sharing circles are an open-structured, conversational style method that respects story sharing and storytelling within Indigenous cultures (Kovach, 2009). Wolf and Rickard (2003) describe that sharing circles allows individuals to express their thoughts on a topic by continuing to go around the circle. The value of each speaker is recognized until a mutual consensus is achieved (Sams, 1990). Sharing circles have been traditionally used as a healing method (Berthelette et al., 2001), as spiritual practice, and as a method to teach culture and tradition (Archibald, 2008). Sharing circles have been practiced from generation to generation in many Indigenous cultures (Tachine et al., 2016). While sharing similarities with focus groups, the principles that underpin a sharing circle are different. Inherent within sharing circles is the notion of equality, sharing ideas, respect, togetherness, compassion, love and respect for one and other (Chilisa, 2012). They also differ from focus groups based on the sacred meaning they have in many Indigenous cultures and may support the growth and transformation of participants (Lavallée, 2009). Given this research aims to offer possibilities for including Indigenous approaches to research and education within nursing, using sharing circles as a research method

is crucial to that aim. In essence, this research seeks to not only discuss how Indigenous approaches could be included in nursing and higher education, but authentically feature Indigenous approaches as tangible manifestations of the MCIEB's priorities.

In conclusion, as schools of nursing and medicine are being called on to address issues relating to reconciliation (including discussions on Indigenous perspectives, Indigenous history and racism) in their curriculum, researchers must consider the types of pedagogies used to engage learners in these topics, and tend to the development and transformation of not only nursing students but of nurses, and nurse educators as well. By employing Crotty's (1998) approach to my research project and delineating the relationships between the elements of my research (i.e. aims, epistemology, theoretical framework, methodology and methods), I sought to craft a sound scaffolding structure that supports outcomes that merit respect, not only from a Western perspective but from an Indigenous one.

In the next chapter, I explore the literature that initially informed this research project. However, given this research study was an emergent investigation, reviewed literature is also woven through the methodology and discussion chapters.

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CHAPTER 2: PAPER 1

The importance and promise of integrating Indigenous perspectives in nursing education

Chapter 2 consists of a manuscript which contextualizes and explores the literature on Indigenous perspectives in nursing, offers reasons for why integrating Indigenous perspectives is valuable and important, and offers exemplars of schools of nursing that have already begun integrating Indigenous perspectives into curricula and programming. Unfortunately, the body of such scholarship is not huge, and not well disseminated. I hope this paper contributes to the canon of Indigenous perspectives in nursing, raising awareness and understanding. Through this review I also affirm and honour the Indigenous nursing and multidisciplinary scholars that have come before …those who blazed a trail for everyone that has come after.

This paper was published as Van Bewer, V., Woodgate, R. L., Martin, D., & Deer, F. (2020). The importance and promise of integrating Indigenous knowledges in nursing education. *Witness: The Canadian Journal of Critical Nursing Discourse, 2*(1), 11-24. https://doi.org/10.25071/2291-5796.46.

Abstract

This paper explores the relevance of Indigenous perspectives within the nursing profession, and the importance of weaving these perspectives into nursing education. We suggest that Indigenous perspectives can support nursing's core ethical values of relationality and holism and may hold representational and transformational possibilities for students and educators alike. Guided by principles of Indigenous learning, we provide several exemplars from Canadian schools of nursing that have already begun the process of decolonizing their programs. We conclude by describing some of the challenges and considerations that may arise when Indigenous perspectives and approaches are considered for inclusion into nursing education programs.

Prologue

We wish to acknowledge that our campuses are located upon the ancestral lands of the Anishinaabeg, Cree, Oji-Cree, Dakota and Dene peoples and on the homeland of the Métis Nation. We also wish to pay respect to the Elders, both past and present, who are the traditional custodians of knowledge on Turtle Island and whose guidance is needed as we move forward in a spirit of reconciliation. This paper emerges from our collective interests as scholars, nurses and educators, from diverse backgrounds (Franco-Métis-1st author; settlers-2nd and 3rd authors; & Kanien'keha:ka- 4th author), concerned with decolonizing nursing education and research and our commitment to the Truth and Reconciliation Commission of Canada's [TRCC's] (2015) *Calls to Action* as well as the *United Nations Declaration on the Rights of Indigenous Peoples* [UNDRIP] (United Nations, 2007). In this paper, we use the term Indigenous knowledge to discuss the broad application of Indigenous knowledge systems and Indigenous perspectives to nursing. Our intentions are not to pan-Indianize Indigenous knowledge but to highlight key attributes that are important to nursing.

Before moving further, we must highlight our own privilege as nurses, educators and scholars. We are fortunate as Indigenous and non-Indigenous scholars to see our words on the page, when so many Indigenous people have been denied this opportunity. We are also mindful that for many Indigenous societies, knowledge and learning is imparted through oral and symbolic ways, rather than through the written word (Battiste, 2002). Thus, this paper (and any others like it), represents an imperfect interpretation. We do not wish to essentialize Indigenous perspectives and are cognizant that Indigenous peoples of Canada are varied peoples with distinct knowledge and perspectives. We have attempted to emphasize First Nations, Métis and Inuit perspectives within the paper, but there are undoubtedly perspectives that we have not

acknowledged. As such, we caution the reader of the limits of our paper and the finite perspectives that can be shared through this approach.

Foreground

Subordinating colonial policies have existed for many generations in Canada, leading to the chronic subjugation of Indigenous peoples. These policies were developed and enforced by colonial governments as a way to silence Indigenous peoples' voices and delegitimize their cultures (Louis, 2007; TRCC, 2015). Even though these policies were historically employed as tools of settler colonization, they continue to influence the health of Indigenous peoples of Canada today and have contributed little to supporting Indigenous peoples' sovereign rights in the design and delivery of their own Indigenous knowledge systems. Indeed, Indigenous people face significantly higher rates of mortality and morbidity compared to non-Indigenous people in Canada (Beavis et al., 2015). In order to improve health outcomes, Indigenous people need access to culturally safe health care provided by professionals who understand Indigenous perspectives (Mahara et al., 2011). Within the health care context, the understanding of Indigenous perspectives must extend beyond health inequities. This understanding must include Indigenous peoples' history, including the historical and ongoing effects of colonization, as well as erasure of Indigenous worldviews and Indigenous knowledge (Beavis et al., 2015).

Indigenous perspectives are frequently marginalized or only featured in the periphery of many Canadian nursing programs (Canadian Nurses Association & Aboriginal Nursing Association of Canada, 2014). As we argue in this paper, there is value in finding ways to integrate Indigenous perspectives into nursing curricula, that will highlight the inequities in current programming but also the strength of Indigenous perspectives. In particular, Indigenous perspectives may allow nurses to build a stronger connection with the discipline's core values of

relationality, individual-centered care, and holism, as well as offer representational and transformational opportunities for Indigenous and non-Indigenous students and faculty alike Echoing the words of Indigenous nursing scholars Dion Stout and Downey (2006), Indigenous knowledge is not just "nice to know" (p.331), but essential concepts that need to be captured in nursing curricula in order to enhance nurses' awareness and understanding of Indigenous perspectives.

We begin this inquiry by addressing the questions "In what ways are Indigenous perspectives relevant to the discipline of nursing?" and "Why is this important?" Emerging from First Nations, Métis and Inuit principles of learning, several possibilities for weaving Indigenous perspectives into nursing education are then described using current examples from Canadian nursing programs. Lastly, we reflect on some of the possible challenges to embedding Indigenous perspectives within the nursing curriculum.

In What Ways are Indigenous Perspectives Relevant to the Discipline of Nursing?

McGibbon and Lukeman (2019) argue that the profession of nursing developed historically from a colonial, white, upper-class, Eurocentric context. As a result, the knowledge, philosophical assumptions, beliefs and practices engrained in current nursing curricula reflect this colonial context. For example, the discourses of multiculturalism and egalitarianism are now being understood as assumptions that serve to conceal imperialism, white privilege and structural inequalities (McGibbon et al., 2014). Colonization in nursing also takes form in other powerful discourses such as the evidence-based practice movement and the biomedical model (Holmes et al., 2008; McGibbon & Lukeman). These colonial discourses have largely medicalized and pathologized Indigenous peoples' health, producing a limited understanding of Indigenous perspectives using a deficit-based approach (Stansfield & Browne, 2013).

However, Indigenous knowledge and nursing knowledge are not binary opposites. Battiste (2002) argues that Indigenous knowledge may be used to bridge the ethical and knowledge gaps in modern Eurocentric education, research and scholarship. What continues to present an important challenge is a lack of appreciation and value regarding what Indigenous knowledge might bring to nursing practice and how Indigenous knowledge might be enacted. Indigenous nurses have long been critical observers and participants in the transfer of knowledge about Indigenous knowledge and traditional medicine, and were the first group of Indigenous professionals to organize for political activism and self-determination in education and health (Aboriginal Nurses Association of Canada, 2007). Thus, one of the ways non-Indigenous nurses might develop an understanding of Indigenous perspectives is through greater engagement with Indigenous nursing scholarship.

In one of the largest studies of its kind, Lowe and Struthers (2001) conducted initial focus groups with 203 Native American nurses, and follow-up focus groups with 192 Native American nurses to understand how Indigenous knowledge manifested itself in their practice. Seven themes were identified by Native American nurses as core principles of Indigenous nursing: caring, traditions, respect, connection, holism, trust, and spirituality. From these seven themes, Lowe and Struthers developed a conceptual model of nursing in Native American culture. The model is depicted as a circle representing the interrelatedness, intertwining, and interlacing of all seven core principles. Lowe and Struthers' model is described as intertribal and emphasizes Indigenous oneness (harmony with all forms of life). Though this model emerges from Native American nurses, it may provide a useful starting point for dialogue on the core principles of Indigenous nursing in Canada or assist in mapping Indigenous content across a nursing curriculum.

From a Canadian perspective, Etowa et al. (2011) explored the practices of Indigenous (Mi'kmak) nurses in Atlantic Canada. Nurses in Etowa et al.'s study identified that they integrated Indigenous ways of knowing and Mi'kmac ideologies into their practice which included practicing cultural traditions they shared with their Mi'kmac patients, traditional medicines, and spirituality. Communication including good listening skills, and the use of humour, along with the primacy of family and community were also essential to their Indigenous nursing practice.

Similarly, Bourque-Bearskin et al.'s (2016) recent study explored Indigenous nursing knowledge among three Cree/Métis nurses from Alberta and one Dzawada'enuxw First Nations nurse from British Columbia. The aim of this study was to understand how Indigenous knowledge manifested in the practices of Indigenous nurses as a means to facilitate and create healing and wellness. For the nurses in Bearskin et al.'s study, practicing in a relational manner, understanding the connection to their roots, their family, their history, and their land of origin is crucial to their nursing practice. For example, Alice Reid, a Cree/Métis nurse with advanced nursing knowledge as a nurse practitioner described that to survive the harshness, remoteness, and isolation of Northern Alberta, she relied on both Indigenous knowledge of the land, as well as her advanced nursing knowledge. Voyageur described how Indigenous knowledge contributes to decolonizing schools of nursing; Dion Stout described the politics of Indigenous knowledge as a new currency, and Lea Bill reminds us of the importance of spiritual self-care (Bourque-Bearskin et al.).

Some of the knowledge Indigenous nurses employ in their practice will always remain inaccessible to non-Indigenous nurses. However, Bourque-Bearskin (2011) argues that the depth of Indigenous knowledge can benefit everyone, at all levels of the nursing discipline (p. 549). It

is beyond the scope of this paper to outline all of the ways in which Indigenous knowledge are relevant to nursing education. Rather, we discuss our broad understanding of Indigenous knowledge as a means of triggering critical reflexive questioning into the ethical dimensions of nursing, most notably with respect to relationality and holism.

Relationality: To Help Each Other in a Collective Sense

Relationality is an important concept within nursing practice and can be described as a respectful and reflexive approach to inquire into patients' lived experiences and health care needs (Doane, 2002). A relational approach recognizes the relationships between people as significant and prioritizes respect, honesty, authenticity and compassion. Nurses who engage with clients in a relational manner are more apt to be sensitive to clients' needs, intentional in their own practice and aware of nurse-client similarities and differences (Hartrick Doane & Varcoe, 2005).

Relationality is central to Indigenous epistemologies and ontologies. From a Cree perspective, relationality is described as *mâmawoh kamâtowin*, or to "help each other in a collective sense" indicating nursing care moves nurses beyond the nurse client boundary (Bourque-Bearskin et al., 2016, p. 21). The Bantu Indigenous peoples of Africa have a similar adage that captures the fundamental nature of being in a relational manner: *Ubuntu*, meaning "I am because we are" (Chilisa, 2012). Lowe and Struthers (2001) refer to relationality as the honoring of all people, the past, the present, the future, nature, and the nursing profession. From these Indigenous perspectives, relationality extends beyond the boundaries of interpersonal relationships, the nurse-patient therapeutic relationship and traditional contextual factors considered in nursing care (Bourque-Bearskin et al., 2016; Stansfield & Browne, 2013). While Indigenous relationality considers the above contextual factors, it also identifies the importance

of land and the relationships that people have with the land and their environments. Furthermore, Indigenous peoples' notions of relationality also draw attention to issues related to identity and self-determination (Bourque Bearskin 2016, Stansfield & Browne, 2013). These perspectives recognize that health rights are set in a complicated interplay between emotional, mental, spiritual, physical, geographical, and historical factors. As a result, Indigenous knowledge may help nurses reaffirm and honour relationality within their practice and help nurses provide better care for clients, families and communities from a rights-based approach as describes by the TRCC and UNDRIP.

Holism

Florence Nightingale introduced the concept of holism in nursing over 100 years ago (Hunter et al., 2004). Holistic nursing care embraces the patient as a whole person, and is concerned with the interrelationship of body, mind, and spirit (McEvoy & Duffy, 2008). Stansfield and Browne (2013) define nurses as holistic practitioners who draw on a multitude of epistemological perspectives in their work. However, Indigenous epistemologies and ontologies have not been embraced within the nursing profession as traditional ways of knowing and being. Nursing knowledge continues to privilege the Western biomedical model that views health merely as the absence of disease without regard for the role of social, environmental, and psychological influences (Holmes et al., 2008; McGibbon et al., 2014). In addition, the realities of the current health care system also challenge nurses' abilities to practice holistically. Nurses are being tasked with caring for higher acuity patients in both hospital and community settings while also adjusting to new medical technologies, dealing with staffing shortages, and coping with increased workloads. Against this backdrop, Allen (2014) argues that modern nursing bears only a fleeting resemblance to the profession's holistic ideals.

Although there are some commonalities between Indigenous and nursing perspectives of holism, the concept in nursing, as described above, is much narrower in scope. Indigenous perspectives of holism include a broader definition of healing and caring including concepts such as balance, culture, relationships, male, female, non-compartmentalization, flowing with harmony, and pursuing peace (Lowe & Struthers, 2001). While certainly Indigenous knowledge is important to Indigenous peoples' health, it also has important implications for how nurses conceive of their nursing practice and fulfill their responsibilities to all clients. Indigenous knowledge is rooted in holistic beliefs and practices and has a multidisciplinary focus (Hill, 2003). For example, nurses practicing from an Indigenous holistic lens recognize the wholeness of a person and understand health as a balance of the mind, body and spirit. Furthermore, viewing health care encounters through an Indigenous lens encourages reciprocal relationships between clients (Indigenous and non-Indigenous). These reciprocal relationships allow for balanced communication between clients and nurses, dismantling the distinctions and hierarchy between them. By engaging with clients through an Indigenous holistic lens, nurses are also able to acknowledge the potential all humans have for self-awareness, self-determination, self-responsibility and self-healing (Hunter et al., 2004).

Why is it Important to Weave Indigenous Perspectives in Nursing Education?

There is an uncomfortable reality hidden within schools of nursing, their buildings and the curricula they have produced. There is hardly a mention within nursing education of the complicated history colonial institutions have had with Indigenous peoples and their knowledge. As Sium et al. (2012) contend, colonial governments and the academy are institutions born from and premised on knowledge theft, muzzling, and selective storytelling. However, much of education has been cleansed of this complicated history. But in Canada, the past echoes into the

present and continues to shape contemporary First Nations, Inuit and Métis inequalities as well

as contribute to conflicts and confusion over how Indigenous knowledge is adopted in academia.

We contend that Indigenous perspectives are relevant to nursing education as a way to explicitly

address the injustices committed towards Indigenous peoples and as a form of epistemic and

restorative justice for Indigenous peoples. By explicitly acknowledging Canada's history of

genocide (e.g., unfair land negotiations, residential schooling, removing Indigenous children

from their homes, quarantining and segregating Indigenous people and the sterilization of

Indigenous women), and the role nurses played in this genocide, schools of nursing have an

opportunity to make non-Indigenous Canadians more attentive to the complexities of living in

Canada, of a difficult history with Indigenous people, and how colonial structures, including

education and health care, continue to reproduce this genocide. We echo Thorne's (2019)

sentiment that within the nursing profession:

> …we will not be able to move forward as agents of constructive change until we have
>
> found a way to open our eyes and ears to the experiences of those harmed by the systemic
>
> injustices that our societies have created and sustained, and in which we have received a
>
> measure of privilege. This will necessarily include hearing and receiving their painful
>
> truths without judgement and without defensiveness (p.2).

Indeed, due to the ongoing effects of colonization, Indigenous people face persistent and

deepening social and health inequities when compared to non-Indigenous populations and are

disproportionately represented as clients within the health care system (Browne et al., 2016). In

addition, 4.9% of Canadians identify as Indigenous and the population of Indigenous people in

Canada is rapidly expanding. The Indigenous population in Canada has grown by 42.5% since

2006, a rate four times higher than the non-Indigenous population during that same time frame

(Statistics Canada, 2017). In Manitoba, our home province, 17% of the population identifies as Indigenous (First Nations, Métis or Inuit) which represents the highest percentage of Indigenous people within a Canadian province (Statistics Canada, 2017). Through a commitment to weaving Indigenous knowledge in nursing education, there is also an opportunity to honour the *United Nations Declaration on the Rights of Indigenous Peoples* (2007), in particular the right Indigenous peoples have to the "dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information" (p. 14).

There is also an urgent need for nurses to create space where concepts of cultural safety, racism, discrimination and Indigeneity are critically examined and discussed in order to comply with new standards for entry-to-practice. In an attempt to redress historical and ongoing injustices, the Canadian Nurses Association (CNA), the Canadian Association of Schools of Nursing (CASN) and the Aboriginal Nurses Association of Canada (ANAC)[1] have developed policies, statements and frameworks related to Indigenous peoples' health. For example, the framework, entitled *Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing* (ANAC, 2009), was developed collaboratively by CASN, ANAC and the CNA to assist educators to foster cultural competence and cultural safety among nursing students and outlines necessary competencies for nursing graduates. These competencies include a postcolonial understanding of Indigenous health, culturally safe communication, inclusivity, respect, understanding Indigenous knowledge, as well as mentoring and supporting Indigenous students for academic success. The framework also highlights the structures (community engagement/collaboration; supports for students) required

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[1] The Aboriginal Nursing Association of Canada is now re-named the Canadian Indigenous Nurses Association.

to achieve the necessary levels of awareness among students and faculty, both Indigenous and non-Indigenous (ANAC). However, beyond external considerations and mandates, there remains a broader, more salient need for schools of nursing to bring Indigenous perspectives into nursing curricula and pedagogy. Indigenous knowledge within nursing education has the potential to authentically *represent* Indigenous peoples' worldviews within the nursing profession and deeply *transform* all nursing students and faculty members.

Representational Possibilities

One of the most significant reasons for weaving Indigenous perspectives within nursing curriculum and pedagogy is to increase Indigenous representation in the profession. This is not to tokenize the nursing profession but rather to include diverse ways of knowing and understanding that authentically addresses Indigenous peoples' rights in Canada. Currently, the representation of Indigenous people in nursing programs, and in the profession, is exceedingly low. In 2014, only 2.9% of the registered nurse population identified as Indigenous (Rohatinsky et al., 2018). In recent years, the percentage of Indigenous nursing students has varied between 1% and 10% depending on the institution. The representation of Indigenous faculty is unknown but believed to be even lower than that of students (Rowan et al., 2013). Common strategies to improve Indigenous student recruitment and retention into nursing programs have focused on minor correctives measures such as remedial pedagogical and external supports (Pijl-Zieber & Hagen, 2011; Rowan et al., 2013). These measures have largely been ineffective in retaining Indigenous nursing students, as demonstrated by consistent attrition rates (Pijl-Zieber & Hagen, 2011). Furthermore, these minor corrective measures have only served to help Indigenous students adapt to Western educational institutions and have not challenged or questioned the core values of these institutions (Pijl-Zieber & Hagen, 2011). In their report, *Aboriginal Health Nursing and*

Aboriginal Health: Charting Policy Direction for Nursing in Canada, the CNA and ANAC (2014) note that Indigenous content is only marginally included within nursing curricula in Canada and that any existing content was generally deficit-oriented. Pijl-Zieber and Hagen (2011) maintain that nurse educators tend to overlook systemic issues, such as cultural discontinuity, as well as Indigenous epistemologies, values, and languages in nursing programs. In other words, current programs have been designed to remediate Indigenous students with tools of the Western academy and Western knowledge.

The integration of Indigenous knowledge is challenging nurses to question what is represented and whose voice is heard in nursing education, while being attentive to who benefits from this integration. In addition, Indigenous knowledge can serve as a mirror through which Indigenous peoples can see themselves, fostering a sense of inclusivity and belonging. Nurses can begin correcting the impacts of colonization by exploring how Indigenous knowledge can serve to challenge the dominant Western representations of knowledge. In this way, the integration of Indigenous knowledge may promote epistemic justice for Indigenous people and counter the deficit-based view of Indigenous people that has become pervasive in health care.

Transformational Possibilities

Indigenous pedagogies such as storytelling, land- and community-based learning activities and sharing circles, allow students and educators to engage with one other differently than in Western pedagogical models (Battiste, 2002). Accordingly, Indigenous knowledge and pedagogy can build and nurture intercultural and interpersonal respect, responsibilities, and relationships in a holistic manner. Encounters with Indigenous knowledge can enrich the ways students and faculty engage in learning, research and conceptualize education; can disrupt master

narratives; can help change the consciousness of students; and promote the dignity, self-determination, and survival of Indigenous people (Kincheloe & Steinberg, 2008).

Dei (2000) asserts that Indigenous knowledge can affirm the collaborative dimension of knowledge and challenge the academy to acknowledge the diversity of histories, events, experiences, and philosophies that have influenced human growth and development. Engagement with Indigenous knowledge systems may help students recognize that there are other types of knowledge that may have been hidden or marginalized within Western society. Working with Indigenous communities may also help students acknowledge the widespread effects of Western domination of Indigenous knowledge. During critical discussions about Indigenous knowledge, students gain foundational knowledge of the socio-political dimension of "Indigenous people's health, identity, culture, values, ownership, power relations, historical exploitations, appropriation of knowledge and racialization" (Stansfield & Brown, 2013, p.149). Through direct engagement with Indigenous perspectives, students and educators can evolve from cognitive understanding and sympathy to empathy and unified consciousness. As a result, Indigenous knowledge systems can expose possibilities for contestation, transformation and reconciliation within one's self and beyond the scope of nursing education or practice.

Strategies for Weaving Indigenous knowledge into Nursing Education

Given the diversity of Indigenous people in Canada, there is no one single strategy for weaving Indigenous perspectives into nursing education; the local context must always be situated, contextualized and appreciated. However, there are common principles of Indigenous learning that extend across First Nations, Métis and Inuit peoples. Schools of nursing are most likely to successfully and authentically integrate Indigenous perspectives into their curricula if they structure their programs around these principles, guided by the local community and its

knowledge holders. We offer the words of Battiste (2010), a Mi'kmaw scholar and educational researcher, to describe the principles of Indigenous learning:

> Through our families, peers, and communities, we come to learn about ourselves through our ecologies, land, and environments. Our Elders and families share their knowledge of place in their daily personal and communal adventures on the land, in traditional tales, timed with the seasons, and in the context of everyday life. We come to know ourselves in place, and by its depth of beauty, abundance, and gifts, we learn to respect and honour that place. All Indigenous peoples have, then, a land base and ecology from which they have learned, and it is there that they honour the spirit of that land in ceremonies, traditions, prayers, customs, and beliefs. These, then, are the core foundations of Indigenous knowledge, learned within a language and culture (p. 14).

While not an exhaustive list, we have chosen to highlight several Canadian schools of nursing that have already begun to integrate Indigenous knowledge throughout their programs. These schools of nursing utilized the following Indigenous principles to guide their programs: intergenerational learning; dependence on community and land; and the importance of Indigenous values, culture, tradition and languages (Edgecombe & Robertson, 2016; Moffitt, 2016; Zeran, 2016).

Intergenerational Learning

Indigenous learning involves the intergenerational transmission of knowledge, relationships, and responsibilities (Bouvier et al., 2016). Within Indigenous cultures, Elders impart learning to the younger generation and are a crucial part of a community's social, spiritual, ancestral, and natural environment (Dei, 2000). Intergenerational wisdom and learning are crucial elements when considering the inclusion of Indigenous knowledge within nursing

curricula. Several schools of nursing, including Nunavut Arctic College, Aurora College, University College of the North (UCN) and First Nations University, have included intergenerational learning as an integral component of their programs (Edgecombe & Robertson, 2016; Green, 2016; Moffitt, 2016; Zeran, 2016). As an initial first step, all of these schools invited Indigenous Elders into their classrooms to share traditional knowledge, wisdom, beliefs, and values (Edgecombe & Robertson, 2016; Green, 2016; Moffitt, 2016; Zeran, 2016). At UCN, students have access to Resident Elders who serve as role models, resources, advisors, and provide guidance and support to students, staff and administration (Zeran, 2016). At Nunavut Artic College, Inuit resource people are involved in some courses and help new faculty incorporate Inuit ways and knowledge into classroom teaching (Edgecombe & Robertson, 2016). Similarly, at Aurora College, Elders are seen as knowledge holders when it comes to specific topics such as women's health and the care of children, and are invited to sharing circles to disseminate this knowledge to students (Moffitt, 2016). Though First Nation and Métis Elders provided important support for students through consultation and talking circles at the First Nations University of Canada, another important aspect of intergenerational learning included encouraging nursing students to bring their children into the classroom. Dedicated play areas were set up to accommodate toddlers and under-school age children, while infants were cared for by their mother and other students. This aspect of the program reflected the communal responsibility for childrearing but also provided a foundation on which lifelong learning was passed on to younger generations (Green, 2016).

Land-Based Education

There is a large body of scholarship that demonstrates the relatedness of people, land, and health; and land is indelibly tied to Indigenous ways of living, including the sharing of

knowledge (Richmond, 2015). However, the Western biomedical model and its tendency to focus on acute health concerns, has limited the inclusion of land as a determinant of health. As a result, a Western perspective has also suppressed the knowledge that can be learned on and through the land (Richmond, 2015). Therefore, nursing programs must restore land-based education if they wish to authentically integrate Indigenous perspectives in their curricula (Battiste, 2002). Past and present decolonizing initiatives have encouraged students to engage in land-based learning by going out on the land with Elders and participating in traditional practices such as storytelling, filleting fish, drum dancing, and collecting medicines (Edgecombe & Robertson, 2016; Moffitt, 2016; Zeran, 2016). These strategies could be incorporated into nursing programs to safeguard authentic representation of Indigenous perspectives, and create opportunities for further conversations on systemic and structural factors needed to create a safe and secure place of learning.

Indigenous Values, Culture, Traditions, and Language

Schools of nursing interested in weaving Indigenous perspectives into their curricula and pedagogy must focus on the Indigenous context, including Indigenous values, culture, tradition, language, and community. Most of the exemplars included in this review have already incorporated the Indigenous context throughout their nursing programs (Edgecombe & Robertson, 2016; Green, 2016; Moffitt, 2016; Zeran, 2016). For example, UCN offers a variety of courses on Indigenous history and culture; politics, governance, and justice; community development; and Indigenous knowledge and languages. The UCN program also acknowledges that Indigenous knowledge is holistic and inclusive of all aspects of life. The UCN nursing program uses Indigenous traditional teachings such as sharing circles, storytelling, group activities, and other Indigenous cultural practices to teach students and faculty (Zeran, 2016).

The nursing program at First Nations University affirmed the importance of language and encouraged students to use Dene or Cree words in lieu of English words (or vice versa) to increase their understanding of medical terminology. Furthermore, cultural events such as sweats, pipe and sweet grass ceremonies, round dances, Asahkewin (feasts) were organized and supported by all levels of the university. These cultural ceremonies were performed in classrooms and in ceremonial rooms (Green, 2016).

The Nunavut Arctic College nursing program is explicitly based on Inuit Qaujisarvingat (Inuit knowledge) and Inuit values that are congruent with nursing principles and concepts. These values include: pijistsirniq (the concept of service); asjiiqatigiinsgniq (consensus decision-making); pilmmaksarniq (skill and knowledge acquisition); piliriqatigiingniq (collaborative decision-making); avatimak kamattiarniq (environmental stewardship); and qanauqtuurunnarniq (resourceful problem-solving). Importantly, the Nunavut Artic College nursing program encourages students to use their traditional languages with clients who also speak the same language. In addition, all nursing students participate in the College's Inuktitut language models to ensure a basic understanding of medical terminology in Inuktitut (Edgecombe & Robertson, 2016). Likewise, Aurora College recognizes that traditional knowledge, also referred to as "northern knowledge", is fundamental to students' learning across all programs. Their nursing program is based on four pillars that recognize the equal importance of traditional knowledge, individual community values, nursing curriculum, and scientific knowledge and culture (Moffitt, 2016, p. 74).

Challenges and Considerations

One of the most challenging aspects of weaving Indigenous knowledge into the academy is determining *who* decides *what* Indigenous knowledge is included and *how* Indigenous

knowledge is woven into the curriculum. Due to differences in Western and Indigenous perspectives, several problems may arise when attempting to insert Indigenous content into existing curricula (Nakata, 2007). Accordingly, nursing faculty administrators, curriculum developers, and educators must be mindful of the ways in which Indigenous knowledge is thread through the curriculum. Issues of authenticity, ownership, and misappropriation of Indigenous knowledge remain a growing concern in Canada as well as worldwide. Nakata (2007) argues that most people within academic institutions develop their understandings of Indigenous knowledge through the interpretations and representations of it in the English language by Western knowledge specialists. Nakata explains:

> What aspect of Indigenous knowledge gets representation, and how it is represented in this space reflects a complex set of intersections of interests and contestations: from what aspects of knowledge are recognized or valued, what can be envisioned in terms of representation or utility, what sorts of collaborations are practical or possible, the capacity of current technologies to represent aspects of Indigenous knowledge without destroying its integrity; to what research projects are funded, to the quality of experts in both knowledge traditions, to the particular interests of scientists or disciplinary sectors, to what is finally included in databases, or published and circulated in the public or scholarly domain (p. 190-191).

Indigenous societies have historically considered Indigenous knowledge to be sacred knowledge, restricted to particular individuals (Hill, 2003). Therefore, embedding Indigenous knowledge into nursing curriculum requires a careful consideration of who will orient and deliver the content (Stansfield & Browne, 2013). Beavis et al. (2015) remark that non-Indigenous educators should be cautious about teaching Indigenous lived experience if they are

"outside the experience" (p. 11), while Marker (1998) argues that non-Indigenous instructors teaching Indigenous knowledge risk trivializing and exoticizing Indigenous knowledge. Non-Indigenous scholars and allies, Stansfield and Browne (2013), have proposed the creation of an Indigenous advisory committee or an Elders committee to provide ongoing support for educators when exploring ways of weaving Indigenous knowledge. Similarly, Beavis et al. (2015) maintain that Indigenous educators must be directly involved in the design, review, and teaching of curriculum related to Indigenous perspectives. While the creation of Indigenous advisory committees can certainly obviate some challenges relating to authentic curriculum inclusion, the assertion that non-Indigenous instructors should not teach Indigenous knowledge also remains contentious. In the context of teacher education, Kovach (2013) affirms that "as Canadian citizens (certainly academics) should we not be prepared to lead informed discussions on aspects of Indigenous experience…from both a western and Indigenous perspectives?" (p. 117). Should the same not be required of nurse educators and academics?

However, past research has indicated that non-Indigenous nurse educators are often apprehensive of exploring differences between Indigenous and non-Indigenous perspectives for fear of being offensive, insensitive, or promoting stereotypes (Varcoe & McCormick, 2007). In Australia, the rush to Indigenize the curriculum as led to the assumption that anyone can teach it effectively (Bullen & Flavell, 2017). Bullen and Flavell (2017) assert that educators must undergo the same process of transformation that is being asked and expected of students. Consequently, nurse educators and nurse academics must be encouraged through their own higher education and professional development opportunities to become reflexive and to "critically reflect on their own assumptions, biases, blindspots, viewpoint, and need for epistemological learning related to Indigenous knowledge" (Stansfield & Browne, 2013, p. 149).

This type of critical reflection must extend beyond gaining knowledge about Indigenous Canadian history or acknowledging cultural differences. It requires a questioning of systemic injustices, racism and epistemological violence that continue to oppress Indigenous peoples.

Nurses in Etowa et al.'s (2011) study share the unspoken weight of the expectations and stress placed upon them as Indigenous nurses in Indigenous communities. Similarly, the weaving of Indigenous knowledge into nursing education involves a considerable amount of emotional and relational labour from Indigenous academics, educators and Elders engaged in this work. These sacrifices are seldom appreciated or conceived but may present significant challenges. Weaving and teaching Indigenous perspectives within higher education also requires a range of capabilities, dispositions, and knowledge that are often unacknowledged and under-appreciated including highly developed cross-cultural facilitation skills and Indigenous content specific knowledge (Bullen & Flavell, 2017). We are also concerned that the recent attention on Indigenous knowledge by schools of nursing may tend to place a great deal of expectation on Indigenous academics and scholars to "produce" a vision of a nursing curriculum infused with Indigenous knowledge, without changing the actual structures that perpetuate Indigenous injustices. To produce a vision of Indigenous knowledge that is distorted and altered for the purposes of nursing education, that is cleaved from its context, that is cleansed of its history and dislocated from its knowledge holders is a form of epistemic violence and may simply serve to appease settler-guilt. We argue that such evasions of guilt represent another iteration of what Tuck and Yang (2012) refer to as "settler moves to innocence…a settler desire to be made innocent, to find some mercy or relief in face of the relentlessness of settler guilt and haunting" (p. 9).

As some Indigenous nurses have argued, it is disrespectful to think of Indigenous knowledge as something that can be learned through coursework (CNA & ANAC, 2014). Likewise, Kovach (2013) has queried the appropriateness of allowing largely white, young, settler students to take up Indigenous knowledge. These beliefs serve to highlight the prevailing differences between Western and Indigenous ways of thinking. Indigenous knowledge originates from "each specific community/band/nation…it is not generalizable, which we (nurses) always try to do" (CNA & ANAC, 2014, p. 20). Moreover, Indigenous knowledge is not a commodity that can be "given" but rather is "borrowed" for a period of time for an agreed upon purpose (Stansfield & Browne, 2013, p. 8). To that end, we emphasize that Elders and Indigenous knowledge holders must be involved as curriculum designers, planners, teachers and guides; not as sources to be mined but as epistemic partners.

Conclusion

Indigenous perspectives and Indigenous knowledge hold promising opportunities for nursing education and practice. Indigenous perspectives in nursing may enhance nursing's notions of relationality and holism and reaffirm the discipline's most foundational values. Indigenous knowledge also offers representational and transformational possibilities for nursing and the broader community. The inclusion of Indigenous perspectives in nursing curricula can provide balance to a system historically dominated by Western hegemony. In addition, the inclusion of Indigenous perspectives can contribute to epistemic justice for Indigenous peoples. Inspired by the work of Battiste in educational research, of Bourque-Bearskin, and Dion Stout in nursing, as well as nursing schools who have already begun the critical work of decolonizing nursing curricula, we have provided a tentative conceptual scaffold that outlines possibilities for integrating Indigenous perspectives. Schools that have successfully included Indigenous

perspectives can serve as examples to other nursing education programs interested in doing the same. Educators and administrators attempting to weave Indigenous perspectives and knowledge into nursing education may encounter several challenges. Research and prior experience have demonstrated that partnerships, collaboration, and commitment to local Indigenous communities are instrumental to the successful integration of Indigenous perspectives and knowledge into nursing curricula. Through our engagement with Indigenous perspectives we create openings, possibilities for critical questioning, relentless reflecting, shared meaning making and human flourishing. Perhaps the greatest possibility for Indigenous perspectives within the academy is that it contributes to developing citizens who are not more alike, or more entrenched, but citizens who are more human.

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CHAPTER 3: METHODS

Introduction

The research design including the procedures used in this study are discussed in this chapter. Given that arts-based research (ABR) as a methodology, along with the theoretical orientation and methods have been discussed in Chapter 1, and that descriptions of Theatre of the Oppressed (TO) and forum theatre (FT) permeate the dissertation (in Chapter 1 but also in papers 2, 3 & 4), the focus of this chapter is on the methodological procedures related to the design including sampling strategies, data collection methods and data analysis. In addition, ethical considerations, and notions of rigour and trustworthiness are reviewed. But first I begin by describing my own forum theatre training, workshop team, and workshop logistics.

Research Design

Forum theatre training

In November 2018, I attended a week-long forum theatre training at Cardboard Citizens Company in London, England. There, I met a group of theatre practitioners, scholars, community builders and activists, all seeking to learn more and apply forum theatre to their various disciplines and practices. The training was intensive and challenging but also what I would describe as the "most fun I have had in my adult life". Prior to attending the training, my knowledge of TO and FT was theoretical. I'd read Boal's books and numerous articles about TO and FT. However, through the immersive training, I begun to comprehend TO and FT's power in a much more visceral manner. The training was led by the notable Adrian Jackson, a protégé of Augusto Boal himself, and the one who translated Boal's text *Games for Actors and non-Actors* to English. Adrian is truly a master facilitator and to train under his tutelage was a privilege. I also had an opportunity to collaborate and perform alongside some of the brightest and most

accomplished theatre practitioners in London. While these theatre practitioners did not have a background in forum theatre and Theatre of the Oppressed, their ability to perform, engage and emote was awe-inspiring.

During the training at Cardboard Citizens, I participated in a myriad of theatrical exercises and games, as well as image theatre. However, we also crafted our own forum theatre plays in small groups during the last two days of training and performed our plays to an audience on the second afternoon. I knew then that it was possible to create a short forum theatre play in two days if group trust and cohesion was high. During my training at Cardboard Citizens, I also attended two different forum theatre performances in London. I had the opportunity to take on the role of the spect-actor and experience what it's like to be compelled to intervene, to try my hand at changing the outcome of the play. One of the forum theatre performances was done with professional actors, and another was done with non-professional actors, military veterans who struggle at reintegrating into society. While the former performers were wonderful, the latter were no less compelling. This really is *theatre for the people and by the people*. I came back to Winnipeg reinvigorated, with so many ideas in my head, and keen to seek out a workshop team to assist me with this project.

Fortuitously, I presented at the Indigenous Health Symposium a few weeks later in November 2018 and described my research to a small audience of approximately 15 people. Most attendees on that day attended a drum workshop in another room (I would have done the same had it not been my presentation)! Despite the small audience, three people at that presentation had a significant if not integral impact on my research journey. One of the other presenters was Dr. Julianne Sanguins from the Manitoba Métis Federation (MMF) who immediately saw the potential benefit of the research, and the link between FT and traditional

Métis storytelling approaches. Her belief in me and in the research as a representative of the MMF was crucial. Secondly, Daniel Thau-Eleff, a Winnipeg playwright, theatre director, 2018 Manitoba Human Rights Commitment Award winner for his work in addressing injustices through theatre and trained forum theatre facilitator attended the presentation simply to hear me talk about forum theatre as research. Mabel Horton, an Indigenous nurse-Elder involved in Indigenous health research and policy and nursing for over 30 years also attended the event. Mabel is also one of the founding members of the Canadian Indigenous Nurses Association (formerly the Aboriginal Nurses Association of Canada). Mabel and Daniel approached me after the presentation to discuss my research further, and given that I was looking to assemble a workshop team with a trained forum theatre facilitator and an Elder, I knew that somehow the universe had ensured that we would cross paths.

Workshop team

Besides my research advisor, both Daniel Thau-Eleff and Mabel Horton were interested and excited to collaborate with me in conducting the theatre workshop and contributing to this research. From January to April 2019, there were numerous emails, phone and in-person conversations between Daniel, Mabel, my advisor and myself to develop the workshop. While Daniel brought with him his theatrical experience, Mabel brought Indigenous and nursing knowledge. I brought forward the research lens. The workshop was conceived, developed and implemented in ways that would honour both TO and Indigenous approaches. The actual workshop events and activities are discussed at length in Paper 3.

Workshop logistics

The organization of the workshop was no small feat. I often worried if everything would come together in the end. The pragmatics of the research were nearly overwhelming…I had to

find a theatre studio, ensure meals and snacks for both days of the event, get approvals for smudging, hire a photographer and a videographer for the event, and attempt to coordinate a date that would work for Daniel and Mabel. This was on top of my significant recruitment efforts which proved problematic (more on that below). One of the things I have learned along the way is that TO and FT research requires a significant investment, not only of my time, but also financial and physical resources. I was gratefully supported by the Manitoba Centre for Nursing and Health Research and received a $5000 graduate student grant to conduct my research. However, the costs associated with conducting this research (including salaries for the workshop team, studio space rental, meals, professional video recording and photographs, transcriptionist services and honorariums) exceeded the grant despite being cautious and mindful about the budget.

Recruitment and Sampling

Purposive sampling of undergraduate and graduate nursing students in a baccalaureate nursing program at the University of Manitoba was utilized to recruit student participants. Participants were invited to participate in the study through online recruitment (um learn, email), and through in-person presentations in several nursing courses.

Health care providers including nurses, nurse educators and allied health professionals were recruited from the University of Manitoba through email and in-person recruitment. A process of snowball sampling or referral was employed to recruit further nursing educators and health care providers. Participants identified through snowball sampling were recruited via email and personal conversation.

The criteria for the nursing students included: current undergraduate or graduate nursing student at the University of Manitoba; willingness to participate in a FT play; and willingness to

be videotaped during the FT play. Inclusion criteria for the nursing educators and health care providers include current or former employment as a nursing educator, nurse or health care provider (included but not limited to midwife, physiotherapist, respiratory therapist, doctor, dentist, dental hygienist, pharmacist); willingness to participate in a theatre workshop; and a willingness to be videotaped during the FT play.

Before initiating recruitment, a letter was sent to the Dean of Nursing in the College of Nursing at the University of Manitoba requesting access to nursing students and educators, as well as requesting permission to contact nursing students and educators about their potential participation in the research study (Appendix A). To avoid coercion, I requested that the student and faculty members receive the recruitment email, including the attached student letter of introduction (Appendix B) and letter of invitation to nursing educators or health care providers (Appendix C) from the Manitoba Centre for Nursing and Health Research's (MCNHR) email. After access was formally granted from the Dean of the College of Nursing, the Clinical Director advised which classes I could attend to share information about the study, using a recruitment script (Appendix D). Presentations were made at two undergraduate classes to over 200 undergraduate students. Presentations were also made in two master of nursing classes to a group of approximately 25 students. Students in these classes were offered a nursing student interest form if they wished to be contacted about participating in the study (Appendix E), as well a paper copy of the nursing student participant information and consent form (Appendix F). A follow-up email was sent from the MCNHR to nursing students (Appendix G). Given that all graduate students were also nurses, they could choose to participate as either audience members or as health care providers in the workshop. A presentation was also made to 17 undergraduate nursing student researchers from the MCNHR. Graduate nursing students and HCPs interested in

participating in the workshop were also given a Health care provider information and consent form (Appendix H), which was also given to HCPs who were contacted through email.

While there is no suggested scientific sample size for TO and FT, Santoro et al. (2016) have successfully used forum theatre in the undergraduate classroom with as few as five participants. A sample of 5-15 nursing educators and health care providers was chosen for the workshop to ensure dialogue and enhance the plausibility and credibility of the created vignettes. We also anticipated that a larger sample of participants might prove unwieldy in terms of schedule coordination and thus creating lack of cohesiveness and trust within the group. While the inclusion criteria were general and did not specify a particular ethnicity or background, I was intentional in my efforts to reach out to Indigenous health care providers. From a forum theatre perspective, a homogeneous group is important in terms of trust and in terms of identifying common issues. From an Indigenous research lens, I wanted to ensure that the topic was framed from an Indigenous perspective. However, the theoretical orientation along with the aim of this research was to facilitate a dialogue between Indigenous and non-Indigenous people. Accordingly, I needed to have Indigenous and non-Indigenous HCPs in the workshop. Nine individuals expressed interested in participating. However, on the day before the workshop, one individual was in an accident and could not attend. The eight participants included: six nurses (4 of whom were also nurse educators) and two allied health professionals. Five of the participants were Indigenous, while the three other participants identified as White/Caucasian. Demographic information on the HCPs is found in Table 1. HCPs were offered $100 for each day of participation if they were not employed by the University of Manitoba to reimburse some costs associated with travel, parking and time off work.

I initially anticipated recruiting between 12-40 nursing students in order to maximize the likelihood of audience participation. However, there was very low interest in participating from nursing students. Despite conversations with the Clinical Director of the College of Nursing about having students attend in lieu of class or clinical time, there were very few classes offered during Spring term. Those that were offered had instructors unwilling or unable to allow students to attend in lieu of clinical time. To potentially increase nursing student participation, in consult with my research advisor, I applied to the Health Research Ethics Board- Bannatyne campus requesting an amendment to my ethics application in support of offering a draw for three 100$ cash prizes for student participation. Despite this honorarium, only five students volunteered to participate as audience members. Two nursing educators who were unavailable to participate in the workshop attended the forum theatre performance as well.

As a workshop adaptation to increase the dialogue and interventions from the audience, the workshop team discussed and decided that the two groups of HCPs would not see each other's vignettes until the forum theatre performance. While one group was presenting their vignette, the other sat in the audience as spect-actors. While not in the initial plan, HCPs were excited about watching the vignette created by the other group. Because each group was unaware of what the other was creating, there was also an element of surprise and anticipation. This resulted in an audience of 10 nursing educators, although two other people, from outside of nursing and health care, did attend the play as audience members as they were interested in forum theatre as a research approach.

Setting

To create an atmosphere of theatrical authenticity and also to remove participants from their traditional campus spaces, the workshop and forum performances were held at the Black

Hole Studio on the University of Manitoba campus. The Black Hole Studio is in the University

College building and is the historical home of the Black Hole Theatre Company, a combination

of a student group and an academic program. However, a theatre student group has taken

ownership of the name, and the academic program is now simply called the University of

Manitoba Theatre Program. Most plays performed by the theatre program are presented in the

new John J. Conklin Theatre in Taché Hall (University of Manitoba, n.d.). While some

performances are shown in the Black Hole Studio, it is a much smaller space. For the purposes of

this research and the small group of participants and audience, it allowed a much more intimate

venue for the workshop and the performances, one that might evoke as Barone suggests

"conspiratorial conversations" about possible and desirable worlds (as cited in Barone, 2008, p.

39).

Data Collection

As Kaptani & Yuval-Davis (2008) explain forum theatre as a research tool produces

"generative and local knowledge, starting with the use of the body, the container of memory,

emotions and culture" (section 3.17). Data was collected through multiple sources and included

all activities from the workshop including stories, discussions and dialogue during the sharing

circles, theatrical exercises and games, image theatre, vignette scripts and my field notes.

Photographs were taken during the theatrical exercises, games and image theatre by me and

Mabel. Select photographs are included herein. The entire workshop was audio-recorded. When

the HCPs divided into two groups to craft their vignettes, each group had a digital recorder to

record their dialogue and conversations. This ensured that data collection continued regardless of

which group I was with during the workshop. Demographic data was also collected through the

HCP demographic questionnaire (Appendix H).

Image 1: Mabel engaged in the theatrical game "modelling sequence"

Data collection included professional video recording of the forum theatre performance including audience interventions, dialogue, suggestions and post-play discussions. Prior to watching the play, the students filled out a student demographic questionnaire (Appendix I). The video recording was also transcribed to assist in further analysis. In June 2019, I also met with Daniel (Mabel was out-of-town) for a debriefing session where we discussed what emerged during the process of workshop, the forum theatre performance and post-play discussion, including our insights, and challenges. During this debriefing session, I took notes which were also included as data. The audio-recordings were professionally transcribed. This resulted in 9 transcripts, and over 18 hours of recordings (including the forum theatre performance). 122 photographs were taken during the workshop and forum theatre performance.

Image 2: Participants engaged in Image Theatre

Table 1: Health care provider demographics

Gender	
Male	n=0
Female	n=8
Age (range) years	
30-39	n=5
40-49	n=1
50-59	n=1
60 +	n=1

Population group

First Nations	n=2
Métis	n=2
White (Caucasian)	n=3
Other: mixed heritage Cree and British	n=1

Occupation

Nurse	n=2
Nurse educator	n=4 (also nurses)
Health care provider	n=2

Years as nurse or HCP

1-10	n=1
11-20	n=4
20-30	n=2
31-40	n=1

If applicable, how many years as a nursing

educator

1-5	n=3
6-10	n=1

Prior knowledge of MCIEB

Yes	n=0
No	n=8

Table 2: Student participant demographics

Gender

Female	n=4
Male	n=1

Age (range) years

20-29	n=4
30-39	n=0
40-49	n=1

Population Group

White (Caucasian)	n=3
Black	n=1
Métis	n=1

Years of post-secondary education prior to

starting nursing program (range)

1-5	n=4
No answer	n=1

Year in nursing program

3rd	n=2
4th	n=2
No answer	n=1

Prior knowledge of MCIEB

Yes	n=0
No	n=5

Data analysis

The data was analyzed using thematic analysis (Attride-Stirling, 2001). Thematic analysis is a foundational approach to data that can be used widely across of a range of epistemologies and research questions (Nowell et al., 2017). One of the initial tasks of analysis involved becoming very familiar with the data. The audio-recordings were professionally transcribed. However, the quality of the professional transcriptions was not as detailed as I would have liked due to background noise and the many voices in the recordings. I decided to re-transcribe the recordings and was able to carefully listen, extract and transcribe numerous sections missing from the professional transcriptionist's version. Certainly, my participation in the workshop helped me hear parts of the recording that may not have been as obvious to an outsider. The benefit of this was two-fold: 1) the transcription was more exact; 2) it increased my familiarity with the data. Every time I listened to the data, I relived the stories shared, laughed at the jokes and humour and felt emotionally connected to the data and to the participants. I returned to these recordings often throughout the writing stages of my dissertation in order to connect with the data again. However, I listened for more than just analytical purposes. I listened because of the limitations of the written text. As Kenneth Burke argued:

> The [written] record is usually but a fragment of the expression (as the written word omits all telltale record of gesture and tonality; and not only may our "literacy" keep us from missing the omissions, it may blunt us to the appreciation of tone and gesture, so that even when we witness the full expression, we note only those aspects of it that can be written down)(as cited in Conquergood, 2002, p. 147).

I also listened to privilege an oral storytelling tradition…I listened to resist hegemonic research and educational practices… I listened to remind myself for what and for whom I was doing this research…I listened for inspiration to forge ahead…

I had originally intended to use NVivo to help with the data analysis. However, given the volume of transcriptions, pictures and recordings, it was easier for me to proceed manually through analysis. In this way, when I was analyzing a certain theatrical game or activity, I could analyze the recording, the transcription and the image simultaneously, without toggling between different tabs or screens in NVivo. After several initial readings of the transcripts, I then dissected the material into initial codes. Abstract themes were then identified and refined from the coded material. From these abstract themes, a thematic network emerged with basic themes and organizing themes. Global themes were then deduced from this process. As Attride-Stirling (2001) notes "thematic networks are a tool in analysis, not the analysis itself; to take the researcher deeper into the meaning of the texts, the themes that emerged now have to be explored, identifying the patterns that underlie them" (p. 393). After the thematic network had been constructed, I returned to the data again and explored it through the lens of the basic, organizing and global themes. Subsequently, the patterns that emerged from the data were interpreted as they related to the research questions. I had initially analyzed the two groups of HCPs and the data they generated separately, which resulted in too many organizational and global themes. Upon discussions with my research advisor, I returned to the data again, looking for patterns from a more global perspective which resulted in a much better analysis that honoured the data and the stories in a more authentic manner.

It is important to note that the above approach is qualitative in nature. This approach was used to analyze the data post-performance. However, data analysis was iterative throughout the

workshop, running parallel with data generation. Participants dialogued, shared stories and from these stories, they identified themes from which they used as inspiration to write their vignette scripts. With feedback from Daniel, Mabel and me, there was additional and ongoing analysis. Donmoyer and Yennie-Donmoyer (1995) describe that scripting, in this case the crafting of the vignette by participants, draws parallels to analysis in qualitative research. Furthermore, through the engagement of the spect-actors and Daniel's questions as the Joker to the audience during the FT interventions, further data generation and analysis emerged. Thus, all participants, as well as Daniel and Mabel contributed insights that informed the analysis which were also shared and discussed with my research advisor. Cho and Trent (2009) refer to this as coreflexive member checking. Accordingly, my analysis post-workshop is simply illuminating and broadening the analysis that began with the participants and the workshop team.

Image 3: Student spect-actor intervention

Validity and Trustworthiness

There is often a belief that ABR lacks systematic rigour and is less valid than other forms of scientific inquiry. However, O'Connor and Anderson (2015) argue that the arts are indeed highly rigorous and disciplined processes that strive to be "rigorous in the pursuit of knowledge that is hard to discover" (p. 65). In ABR, we are not striving for generalizability. Rather, data analysis in arts-based research is marked by a commitment to credibility and authenticity. One of the ways to achieve credibility and authenticity is to craft characters and scenarios that resonate and captivate the audience. As Sommerfeldt (2014) argues "resonance is not generalizability, but an awareness of commonness and credibility" (p. 49). To demonstrate trustworthiness, I have been deliberate in documenting and explaining the processes involved in the research and have been explicit about what aspects of the work are grounded in observations or dialogue, and what is derived from fictional accounts. Furthermore, by using thick descriptions including many participants' quotes as well as the vignette scripts in the presentation of the findings, I hope to have achieved transparency, an important evaluative criterion for arts-based research (Rolling, 2013). Lastly, at each stage of analysis, I shared my findings and interpretations with my advisor, thus further ensuring the credibility and trustworthiness of the study.

In the context of applied theatre, O'Connor and Anderson (2015) concur that ABR should depart from traditional definitions of rigour and work to develop and define standards that suit the needs of the communities we work with rather than the research industry. They argue the work must reflect multiple perspectives in the data-generating and in the analysis. While triangulation is the use of multiple data sources in study, O'Connor and Anderson prefer the term crystallization as it allows a greater scope to validate the data. This term is inspired by Richardson who asserts that the:

…central image for "validity" for post-modernist texts is not the triangle- a rigid, fixed,

two-dimensional object. Rather, the central image is the crystal, which combines

symmetry and substance with an infinite variety of shapes, substances, transmutations,

multidimensionalities, and angles of approach. Crystals grow change, alter but are not

amorphous (as cited in O'Connor and Anderson, p. 67).

Through the concept of "crystallizing" rather than "triangulating" data, I ensured that the

authentic voices of the participants emerged, safeguarding against my voice overwhelming those

of the participants. The multiple facets of the data including the activities, sharing circles, video

and audio-recordings, the scripts and the photographs are also suggestive of crystallization.

Ethical considerations

Approval from the University of Manitoba's Health Research Ethics Board was received

prior to conducting the study (H2019:090). Aligned with an Indigenous ethical approach, the 4

R's of research – **respect, reciprocity, relevance, and responsibility** – originally described by

Kirkness and Barnhardt (1991), guided this research. Unlike mainstream research in which

participants are viewed as "human subjects" and the ethical review is seen as a process to "get

through" before starting the research, I considered the ethical dimensions of research work in

every aspect and each stage of the research process. Thus, relationships were fostered and

dialogue was sought with nursing educators and health care providers before the workshop,

during and after the workshop. While I had a prior collegial relationship with many of the HCPs

that participated in the study, these relationships expanded as a result of the research. In the final

sharing circle, I offered this reflection to the participants:

…thank so much, all of you, for being here. I think one of the most important reminders

I've had is that at the core of everything I do is this idea of relationships. I have emerging

relationships with some of you and more longstanding relationships with others but to show up and to do this work I'm so grateful for that…relationships are so important. They're at the core of my Métis way of being and how I was raised, you know, a large extended family. I now consider you part of my family, so there's good and bad with that (laughter).

The principle of respect is now considered a cornerstone of mainstream research. However, respect from an Indigenous perspective moves beyond mainstream notions of informed consent and protecting the confidentiality of private information required by research ethics boards. Respect for persons and communities implies an obligation: An obligation on the behalf of the researcher to respect and abide by the values of the people and communities with whom they intend to work. Respect in research also involves recognizing the knowledge people and communities already possess. In this research, I respectfully considered and included appropriate protocol with engaging in Indigenous ceremony. By involving Mabel with this research, we integrated appropriate protocols for prayer, smudging, feasts and sharing circles that respected and recognized Indigenous knowledge. Respect also means understanding how knowledge is created and legitimized and included conversations, listening and mutual negotiations regarding meaning with participants. The very basis of TO and FT engages with participants respectfully, listening and creating space for participants' voices to be heard.

Image 4: Symbols of Indigenous ceremony

Relevance is an important ethical issue as irrelevant research squanders valuable resources and harms participants because even minimal risks are unacceptable if no good can come from the research study (Shaw & Elger, 2013). As such, research has to be responsive to the needs of those for whom the research is intended. Relevance requires asking: Does the research address problems or challenges of concern to people and their communities? Does the research produce knowledge and offer possible solutions that may be utilized by people? Relevance was a critical issue in this research project. I wanted to ensure that the project held significance for the participants. The intent of the research was to explore priorities # 2, 3 and 6 of the MCIEB during the workshop. However, Mabel along with the Indigenous participants stressed that priority # 6 "Building school and campus communities that are free of racism, value diversity and foster cultural safety" was primordial (University of Manitoba, 2015). As Mabel emphasized, "racism is the foundation for everything else. We can't explore the other priorities without addressing racism first". This required a pivot on my part as I had originally thought all three would be equally discussed and if anything, the inclusion of Indigenous knowledges and approaches might take precedence. By respecting the tenet of "relevance", I acknowledged that my place as a researcher was to ensure participants find meaning and value from the research

project. This resulted in an emergent research agenda that explicitly explored various activities as symbols for participants' struggles with racism in health care and health care education. From a theatrical perspective, Daniel added that the struggle, with one person pushing against something, "is the centre of storytelling across cultures". While integrating Indigenous knowledge and approaches is crucial, the story that needed to be told was the struggle with racism in health care and health care education, as from this story the other stories emerge.

Reciprocity in research involves being reciprocal in the research relationship. It is no longer acceptable to simply propose the benefits and risks of the research, and ask for informed consent from participants, nor to disseminate the research with little after thought. Reciprocity in relationships with research partners (including the people and communities we engage in research) involves building relationships. Baumbusch et al. (2008) describe reciprocity as the mutual negotiation of meaning and power. However, in my estimate, mutual negotiations of meaning in power reflect respect and relevance but not necessarily reciprocity. Reciprocity requires more from researchers and research relationships. Reciprocity means asking: "What can I do for you?".

Reciprocity, as Kovach (2009) reminds us, begins at the preparation phase (not completion) and it is here where there can be discussions of how the research (and researcher) will give back to the community. There are many possibilities for how reciprocity may be enacted in the research relationship. One way I have engaged in reciprocity is to offer my gifts to the participants. As a spoken word artist, I have been asked to perform spoken words and facilitate spoken word workshops. Through my commitment to reciprocity, I was asked by one participant to facilitate a spoken word workshop to a group of undergraduate research assistants. Another participant, who had attended a spoken word workshop I conducted in March 2019 for

Indigenous Awareness month at the University of Manitoba, requested my PowerPoint

presentation which described my technique for writing spoken words. I shared this information

not with the intent I would receive anything in return. However, this participant, an Indigenous

scholar, embodies reciprocity and relationship building. Her commitment to reciprocity and

relationships in the academic space reaffirmed my own and will guide me along my path as a

scholar. I have also performed at the request of Dr. Sanguins for the MMF to give back to my

own community. Through these gifts, and other future opportunities, I hope to have revealed my

commitment to the notion of reciprocity.

While Norris (2009) maintains that working with human subjects is sensitive work at the

best of times, the process of TO and FT is far more complex than traditional qualitative research

studies, because the roles of the participants differ. With TO and FT, the data sources are

primarily actors and spect-actors and is much more participatory. Aligned with Kirkness and

Barnhardt's (2001) above principles, consent was viewed as an ongoing negotiation rather than a

single moment of consent, illustrating the importance of relationship at the core of this research.

Participants had a right to withdraw from the research at any point in the process, and the audio

recording from the workshop will not be released publicly. Given the intensive participation

required of nursing educators and health care providers, HCPs had the option to consent to being

acknowledged on publications that emerge from the workshop and forum theatre performance.

Participants were specifically asked on the consent form if they wished to be acknowledged, and

these wishes will be respected in any publications emerging from the research. However,

participants were still required to have an ethical relationship to one another and a "non-

disclosure" rule applied during the entire workshop process. Educators and health care providers

were asked to keep one another's stories and opinions shared during the workshop as

confidential to ensure that trust is maintained within the group. Secondly, though the script and vignettes created were based on experiences and had a strong empirical basis, they were presented under a "thin veil of fiction" (Norris, 2009, p. 37) and they represent collaborative fictional stories. However, it was acknowledged that anonymity was not possible within the workshop and the performance.

Telephone number, email address and name were only collected for the purposes of contacting participants and were collected separately from the demographic questionnaire (Appendix J). Demographic information such as age and type of health care provider, were collected through a demographic questionnaire and were only included in the analysis as aggregate data. The demographic questionnaire was kept separate from the contact information, or other direct identifiers.

Photographs from the forum play were taken to help with the analysis of the play and for knowledge dissemination. Participants were able to consent or decline consent to the use of photographs for dissemination on their consent form. The forum performance was video-recorded and this recording may be used for educational purposes within the Rady Faculty of Health Sciences at a future date. Participants were asked to consent to video-recording and the release of the video for the above educational purposes. If consent is revoked in the future, faces will be blurred or pixelated to de-identify the participant. Workshop members (nursing educators and health care providers) were required to consent to direct quotations and had the option to be identified by name, to be quoted anonymously or through a pseudonym. Nursing students were advised that they would be quoted anonymously in any publication or report that emerges from the forum play. Research personnel were required to sign a confidentiality agreement (Appendix K).

Participants in the workshop and in the play were made aware that the research explored sensitive issues. Participants were encouraged to discuss their concerns with me or Mabel, and seek professional help as needed. The names and phone numbers of professional resources were provided within the consent form package.

Chapter Summary

This chapter provided an outline of the workshop planning and preparation and also explored the study's research design including sampling, setting, participants and data collection and analysis. Issues relating to validity and trustworthiness along with and the ethical principles of respect, relevance, reciprocity and relationships were also reviewed.

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CHAPTER 4: INTRODUCTION TO FINDINGS

In this chapter, the findings that resulted from this research study are presented. The research methods described in the previous chapter were employed to answer the three research objectives. Each research objective was analyzed and is described separately below.

Findings Relating to Research Objective #1

The aim of this research as it relates to research objective #1 was to explore several priorities of the Manitoba Collaborative Indigenous Education Blueprint with nursing educators, students and health care providers. Through this exploration the theme of *colonialism is ongoing* emerged. The three sub-themes that relate to this main theme are: 1) the multiple faces of racism; 2) challenges in negotiating identity; 3) struggles in finding safe spaces and people.

Figure 1: Visual depiction of the themes relating to research objective #1
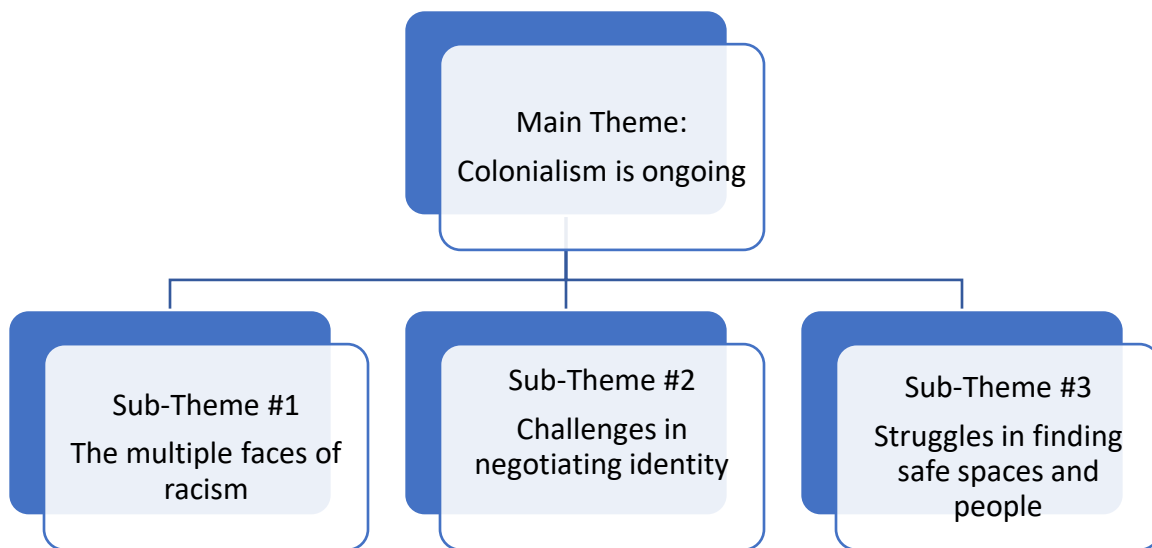
Main Theme: Colonialism is ongoing

Colonialism is ongoing was the main theme that emerged from the exploration of several priorities of the Manitoba Collaborative Indigenous Education Blueprint with health care

providers and students through forum theatre (research objective #1). Through discussions, image making and sharing stories, participants crafted vignettes (Appendices L and M) that demonstrated several ways in which health care, social services and education continue to reproduce colonialism. For example, in the second vignette, birth alerts, a policy in hospitals across several provinces in Canada, in which "high risk" expectant women are flagged by social services for assessment once they present to hospital for delivery is a crucial theme in the vignette. This theme represents one example of ongoing colonialism in nursing and health care. Participants also shared numerous other stories that demonstrated ongoing colonialism in health care and crafted characters representative of this reality as well. Participants expressed that nurses often reproduce colonialism through their complicity in upholding colonial practices and policies. Worse yet, while colonial policies such as the birth alerts exist, the procedures around these policies are often manipulated to further oppress and colonize Indigenous people. For example, in creating the character of Jody, a non-Indigenous participant drew from conversations and dialogue she had overheard in her many years as a labour and delivery nurse. This nurse, also a nurse educator, identified that birth alert practices are normalized in labour and delivery and visibly Indigenous women are subjected to unfair targeting and surveillance.

> …I've heard people (nurses) say all the time when we get Indigenous people (expectant mothers), "You're going to want to make sure you check the birth alert binder", because we have a binder where we keep all the notices of apprehension in and I find nurses always racially profile before they check that. We're supposed to check it for every patient, but they only check it for certain ones…It's something that nurses say a lot and not even in a mean way…it's just matter of fact.

Participants also described nurses' and health care providers' dispositions and attitudes towards Indigenous knowledge and perspectives as deeply problematic and contributing to ongoing colonialism in the health care milieu. While discussing the locked door policy on labour and delivery wards in some Manitoba hospitals, a participant brought forward that colonialism exists on a deeper level. "Yes, there are closed door policies. But this is also about how we actively push away Indigenous knowledge with our current education" Another participant agreed adding:

They're still pretty bad (referencing a particular hospital) and they have locked doors so people can't come in (to labour and delivery). But another one too is around honouring Indigenous knowledge and traditions. I think of keeping the placenta, that's one I hear a lot (from nurses). Because a lot of Indigenous people like to take their placenta home and they might bury it or they have different rituals around it and people (nurses) roll their eyes at that sometimes- actually, quite a lot.

While the theatrical games helped open a dialogue around racism in health care and nursing education, many games were also physical metaphors for ongoing colonialism. For example, in the game Columbia hypnosis, participants paired up and one participant (A) was asked to hold their open hand, fingers upward, about 20-40 cm from their partner`s (B) face. (A) then started a series of movements with their hand (up, down, right, left…), while (B) tried to contort their body to keep their face at exactly the same distance from (A's) hand engaging in ridiculous, grotesque and uncomfortable positions using forgotten muscles in the body. Participants then switched roles and partners after a couple of minutes (Boal, 2002, p. 51). Many participants expressed that the game of following another person, without knowing where one is going and being contorted into grotesque shapes embodied the hierarchical and colonial nature of

health care. Mabel, the Indigenous nurse-Elder stated "There's something similar (between the game and health care), whether it's a policy, or whatever, you have to follow it. You have no choice. You can't go the other way. And you're sort of dizzy at times, trying to follow the whole system". One of the Indigenous participants described that the game reminded her of hospitals:

> … where they have those lines. Follow the yellow lines on the floor. Follow this, follow that. You just have to go where they tell you, even though you don't feel comfortable, you feel awkward and like "Am I going in the right place?" And then you stop and ask people for directions they and they keep telling you to follow the lines. And then you know at the end, even if you follow the line, you may or may not get service…Or maybe you get to that place and then they tell you to follow more lines where you have to go. Or just sit there and wait.

Another Indigenous participant added "That's a good one…How many times have we (Indigenous people) followed the lines and then not gotten good service?".

An exchange between two participants, a White nurse educator and an Indigenous health care provider, also revealed how deeply entrenched colonialism is within the language used in nursing and nursing education. The nurse educator recounted the story of an Indigenous student who was asked by a clinical instructor "I don't want to offend you but do you think residential schools were as bad as they make them out to be?". While discussing this incident as an example of the microaggressions that Indigenous students face in nursing education, the following exchange between the White nurse educator and an Indigenous health care provider transpired highlighting the deeply engrained nature of colonialism, even amongst the most informed nurse educators and allies. The White nurse educator stated: "Here's the Indigenous student, I'm going to ask them every question I've ever had about residential schools, and they were really terrible

questions. But I don't think that's unusual even…and I think our Indigenous students are really used to it…" An Indigenous health care provider interrupted stating "Can you say *the* Indigenous student not *our* Indigenous students because we're not yours".

This exchange resulted in a conversation about language in nursing and health care amongst all the participants in the group, myself included. Reflecting on my own use of language in the past, I admitted: "I think we've (in nursing) colonized all our students. We teach them as though they are ours, but in this context, there's a whole other layer of complexity I didn't recognize". The Indigenous health care provider added "I don't say our students or my students because I don't have ownership of them". Another Indigenous nurse added that it reflected the maternal nature of nursing. "We call them our patients…our physicians. I guess because we care for people and are maternal".

Other discussions during the workshop also revealed the powerful colonial force of the English language and of Eurocentric approaches to health research. An Indigenous participant stressed that with Indigenous research "I hate fill-in sheets and questionnaires and stuff like that because you're already setting it up so it's not Indigenous knowledge because it's in the English language, it's in a format that's very Western. A Western Paradigm…". Another Indigenous participant agreed adding that because of the Eurocentric and Western education she received, her own thinking has been "institutionalized". When pondering the possibility of integrating Indigenous knowledge or perspectives in nursing education, she expressed "What can really be shared within the current structures that we already have, or is this just an excuse to maintain the status quo with a smile?". Another Indigenous participant added that even when Indigenous knowledge or perspectives are inserted into the curriculum, the integration is fundamentally disconnected from an Indigenous perspectives or approaches, in particular in terms of evaluation.

…That's where the disconnect happens…it's all these forms and check logs in nursing practice. People will see it and say "we should talk about the medicine wheel, check" or "we should talk about traditional medicines, check" and what is missing is not just the teachings themselves but the way in which the teaching are given and why. Because when I think of any teaching, it wasn't ever part of our curriculum, it's because everything else that was happening and the Elder that I was speaking to, or my friend, or whoever was holding the knowledge that wanted to be shared. There was something that happened in that moment that made it pertinent…It's not the same as how you teach microbiology, you know what I mean? Or how you teach about how antibiotics work. That's typically how we (in nursing) teach most things. So, when I see that (attempts to integrate Indigenous perspectives in nursing), I'm like, "how is this going to be played out and who is that for, and to what benefit and why".

Participants also identified that colonialism is ongoing through the deviant and deficit discourses about Indigenous peoples and Indigenous knowledge that pervades health care and nursing education. For example, while an exaggerated moment for theatrical purpose, the character of the professor who stands at the front of the class, generalizing the conditions on First Nations reserves and presenting a deficit perspective of Indigenous peoples (Vignette #1) is rooted in real experiences many of the Indigenous participants endured during their years of higher education. Participants also extensively discussed and shared stories of how nursing education characterizes Indigenous peoples from a deficit perspective, as problems to be solved or corrected, with scant attention given to the strengths and contributions of Indigenous peoples in Canada and to Canada. One nursing educator explained "We do cover Indigenous history (in nursing education) but we get stuck talking about Sixties Scoop, residential schools, forced

sterilization…and then it gets summed up as all these negative outcomes. We have a hard time incorporating strength-based pieces". Another nurse educator added "We get stuck in trauma outcomes" when discussing Indigenous peoples and Indigenous history.

The participants who created the second vignette, also shared stories, dialogued and created a scenario in which Indigenous peoples and Indigenous knowledge in the clinical milieu are viewed at best as a nuisance and at worse, as potentially dangerous. For example, the character of Madison asking "Is that legal?…Sounds like a biohazard" in relation to taking the placenta home highlights the notion of Indigenous practices as potentially dangerous and illegal. The instructor's response also reinforces that despite policies supporting Indigenous practices in health care, these practices, devoid from their teachings, are viewed problematically. This scenario vividly demonstrates that Indigenous knowledge in nursing and health care is filtered through colonial structures and frameworks that are resistant to change and continue to centre a colonial, Eurocentric worldview. As one participant stated "our system is still racist and still one of the biggest colonizing entities. We need to start talking about the health system as actively continuing to colonize Indigenous peoples. We're not doing that".

Furthermore, the vignettes demonstrate that the mere presence of Indigenous bodies is viewed as a challenge in nursing education and health care. In the second vignette, the character of Madison asks if she will have an opportunity to take care of an Indigenous patient and the instructor responds with "Eventually, but not today. There's like a lot of cultural, traditional things involved, that you probably won't know enough about, and Shavon will know all about that…". In the crafting of the vignette, participants discussed that nurse educators commonly assign student nurses to patients with a similar cultural or ethnic background under the notion

this might increase patient comfort or safety. However, participants asserted these practices contribute to othering Indigenous peoples.

Sub-Theme #1: The multiple faces of racism

  The multiple faces of racism represents an important theme in this research and supports the primary theme of colonialism is ongoing. As it did when settlers first arrived to Canada, racism continues to play an important role in ongoing colonialism. Many colonial practices, policies and beliefs are rooted in racism. While overt racism fueled colonialism initially, the stories, dialogue and vignettes created by the participants revealed that racism in contemporary health care and nursing education is generally insidious, subtle and covert. As one participant shared "a lot of time we're (nurses) looking for racism and we don't really see it- we're looking out of ourselves but the fact is it's so prevalent within a system…there's systemic racism but we individually perpetuate it". According to participants, this "invisible racism" in health care often presents itself through dog whistles[2], offensive innuendos, microaggressions, stereotypes and misinformation. Furthermore, participants identified that challenging racism is a difficult and complex task due to the its insidious presentation and due to power imbalances and fatigue.

  Based on the sharing of stories and dialogue, both of the vignettes created by the Indigenous and non-Indigenous workshop participants depicted numerous instances of dog whistles and innuendos. In the first vignette, the professor refers to Indigenous people as "these people". In the second vignette, the instructor mentions that "St. Mary's is right next to Point Douglas and is also the high-risk referral center for Northern Manitoba. And those population

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[2] A dog whistle is a "a coded message communicated through words or phrases commonly understood by a particular group of people, but not by others" (Merriam-Webster, 2017).

groups have a high number of apprehensions and child welfare system involvement". In the development and rehearsing of the script, an exchange between Daniel and the participants crafting the vignette revealed how dog whistles are used to communicate in nursing. Daniel requested that the participant playing the character of Jody be "a little more specific about who they (nurses) look for in the binders…either state or suggest that it's the Indigenous families they look in the binder for". One of the participants responded with "well that's what we're talking about, like they (nurses) don't usually say Indigenous, they say people that are in the north and Point Douglas.". Another participant added another dog whistle "They say high-risk". Another participant agreed stating "They wouldn't come out and say it right away. We're getting at it in a more subtle way than explicit". When Daniel mentioned "I think it's too subtle for me", one participant maintained "I've met nurses like that blatantly racist before but I think a lot of them are a lot more subtle and feel that they are doing a pretty good job but they're actually not". Rather than present an overtly racist depiction of Jody, participants added the line "I think you know what I mean" with a knowing look towards Shavon, the Indigenous student. However, participants refused to be more explicit as they felt this would be an inauthentic representation of how racism operates in nursing and health care.

Dog whistles and innuendos are frequently used in nursing and health care and they send a message about select patients, usually racialized minorities and Indigenous people, that operate inaudibly on one level but communicate clearly on another. For Daniel, a White theatre practitioner with no background in health or social services, the dog whistle was inaudible when initially presented, yet for everyone else in the room, Indigenous and non-Indigenous health care providers alike, the message was received. When the vignette was performed to the audience of nursing students and educators, Daniel asked the audience "Does everyone know what Jody is

implying? What the implications of what Jody is saying about the binder", an audience member yelled out "You only need to check the Indigenous people. If they look Indigenous, check the binder".

Microaggressions also represent another face of racism in health care and nursing education. Both vignettes highlight numerous examples of microaggressions. In the first vignette, the professor jokingly refers to Stacy as "Native…an Aboriginal. What is the PC term these days anyhow? Who really knows, right?", while Madison asks Shavon questions about keeping the placenta and residential schools. Both Indigenous and non-Indigenous participants shared numerous stories that revealed the frequency and pervasiveness of Indigenous microaggressions in nursing and in health care. One Indigenous participant revealed that she had been approached while in graduate school and asked by her classmate "I don't want to offend you or anything, but are you Indigenous?". Another, non-Indigenous nurse educator revealed that the inspiration for the residential school question emerged from a real question a clinical instructor had asked an Indigenous student. An Indigenous participant then added "I used to hear those things a lot…Or people will say *but you're so different.*" The non-Indigenous nurse educator added that these questions and comments often come "from a place of sincerity, which is the scariest part". Similarly, the participants in the other group also brought that racism is not as flagrant, rather "it's the microaggressions". Another participant added "the well-intentioned…the paternalistic".

Participants also brought forward that stereotypes are also pervasive in higher education and these stereotypes represent another form of racism. During the crafting of the first vignette, participants dialogued extensively about the stereotypes they had endured or heard in nursing and higher education. Participants listed the following stereotypes as commonplace occurrences for Indigenous students: "you can get a whole bunch of scholarships"; "you get a free ride"; "you

have a lower GPA"; "she doesn't seem that smart…she probably got in as a special consideration". Participants also related stories where Indigenous people are called "lazy" by other students. One nurse educator shared that she had witnessed several nursing instructors questioning the purpose of an Indigenous access program in nursing, overhearing "they don't even bother showing up to class".

In discussing the multiple faces of racism, participants also described the challenges they experienced in contesting racism. For example, power and hierarchy revealed themselves to be dominant inhibitors to challenging racism in nursing and higher education. In both vignettes, the nursing professor or instructor are acting in racist ways and microaggressing the Indigenous students. In non-hierarchical situations, some participants described using humour to challenge racism and stereotypes. However, in situations where they had less power, as demonstrated in the vignettes, most participants described simply enduring the stereotypes, racism and microaggressions. For example, one participant added that "I've had a guest speaker in a class use the terms like apple, or say really derogatory things and I would like to shut them down, like I know I can, but I felt too uncomfortable to do it". Another Indigenous nursing educator added that very few students feel comfortable reporting racist behaviours to administrators and most students "feel like they are pretty powerless" and that there's a "power dynamic with the educators above them".

Because microaggressions and dog whistles present themselves in less overt ways, participants maintain that they are harder to challenge and contest. One participant recalled being microaggressed by a peer in the classroom, while the instructor stood by and allowed the microaggressions to continue. Given the instructor's unwillingness to intervene, the participant, a student at the time, did not feel comfortable or empowered to address it herself. A further

problem in dealing with microaggressions is that because they are subtle, non-Indigenous people seldom view these behaviours and comments as racist or problematic. Rather, participants noted that if they do challenge microaggressions, they are often labeled as "overly sensitive or defensive". Several participants stated that they tried to deal with these situations without anger, as the repercussions for being viewed as angry as an Indigenous person are often great.

Some Indigenous participants also noted as health care providers and educators they often experienced inappropriate acts of student or colleague opposition. These microaggressions in the classroom and in the clinical setting are difficult to challenge due to exhaustion or surprise. One participant revealed:

> it's also the exhaustion (of dealing with microaggressions). At what point do you just stop trying to fight it? Does it become our job to teach?...I had an awful committee experience earlier this year and I felt like I was supposed to be teaching people but it was too much. These are my colleagues and they're acting horribly and so I have to say something but I don't, you know- because they don't want to hear it.

In response to this story, another Indigenous participant added "My whole doctorate was like that…My whole career was." Another participant added that "it's very hard to challenge things that happen in the moment. There have been times when I can't believe this is actually happening…sometimes I've been taken by surprise, like a phone call at work where I didn't know that I was going to be dealing with this (racism) right now". Several Indigenous nurses referred to microaggressions in the clinical setting as "blindsides" or "dumbfounding" and then you're "pissed off at the world" and "you could kick yourself…with what I should have said or how I would have handled that situation differently".

Sub-Theme #2: Challenges in negotiating identity

One of the salient themes that emerged from the research participants is the challenges that Indigenous people experience in negotiating their identity in nursing and higher education and in health care more broadly. This theme supports the overarching theme of *colonialism is ongoing* as the negotiation of identity for Indigenous people has long been a complicated, racist and colonial process. Several Indigenous participants described experiences of lateral violence such as having their Indigenous identity challenged or being purposefully excluded due to perceptions of inauthenticity based on skin colour or lived experiences. Other participants described a conflicted sense of identity and a feeling of apprehensiveness regarding identifying as Indigenous due to the pervasiveness of negative and debasing stereotypes about Indigenous people in nursing and health care. This theme is discussed at greater length in the manuscript in Chapter 5.

Sub-Theme #3: Struggles in finding safe spaces and people

Indigenous workshop participants expressed feelings of isolation in nursing and higher education and articulated that they struggled to find safe spaces and safe people on campus. Several participants mentioned that Indigenous people struggle on campus and in health care settings due to their limited inclusion and tokenism. This theme supports the overarching theme of *colonialism is ongoing* as colonial spaces such as university and hospital campuses are spaces where deficit discourses of Indigenous peoples continue, along with tokenism and limited representation from Indigenous people at the faculty, administrative and student level. The struggle in academic spaces is also the struggle to challenge Eurocentrism and to create space within the curriculum for Indigenous knowledge and perspectives. This theme is discussed in greater detail in the manuscript in Chapter 5.

Findings relating to research objective #2

The second research objective of this study was to explore how the priorities of the MCIEB could be integrated within nursing education. One of the most significant ways this research contributes to the second objective is by developing the hybrid Indigenous and Theatre of the Oppressed influenced workshop. The critical elements of the workshop are discussed in the manuscript in Chapter 6. However, through a post-performance discussion with the workshop participants and the audience, four other possibilities were also suggested as ways to integrate the priorities of the MCIEB within the College of Nursing. The following categories of findings emerged from this research objective:

1) Scaffolded learning: Several nursing students identified that Indigenous content should be scaffolded through the nursing curriculum and have relevant clinical application. One nursing student expressed that Indigenous content needs to be:

   …threaded through. Beginning, like an introduction, then you kind of build up on the knowledge people gain as they go through nursing, cause I think if you throw things at people, they just shut it out. But if you just do it softly and gently and just ease them into it…it's a difficult topic.

2) Increase Indigenous faculty representation: Participants suggested that the lack of Indigenous faculty representation was problematic in terms of teaching Indigenous content. Many instructors and professors rely on Indigenous guest speakers to teach this content but they rarely have a nursing background. The College of Nursing must be more intentional about recruiting and creating pathways for Indigenous nurses to become faculty. One participant brought forward that the graduate program should offer flexible

delivery options and pay for tuition and salary, with a commitment of service to the
university in exchange.

3) Create an advisory group of Indigenous people who guide the curriculum in terms of
what content and who can teach this content within nursing education.

4) Hire an Elder as an advisor for both students and faculty in the College of Nursing. While
there was a position for an Elder within the College of Nursing , the role was
discontinued. Several participants suggested that a lack of perceived benefit and
understanding about the role of an Elder may have contributed to suspending the position.
As one participant stated "There's a lot of mysticism about what an Elder can do and
what the role might look like". As such, the Elder must have the creativity and the
freedom in terms of determining what their role looks like within the faculty.

Findings relating to research objective #3

The findings relating to research objective #3 (To explore nursing educators, health care
providers', and nursing students' experiences of Theatre of the Oppressed and Forum Theatre as
a pedagogical approach) affirmed the response and receptivity to Theatre of the Oppressed and
forum theatre as pedagogical approaches in nursing education. The themes that emerged from
health care providers' responses to Theatre of the Oppressed and forum theatre included an
opportunity for: 1) reflection and growth; 2) strengthening relationships, 3) expressing
vulnerability. Given that students only participated as audience members, their ability to describe
how forum theatre might be useful was limited to the theme of "practical applications". The
findings relating to this research objective are presented in the manuscript in Chapter 7.

Chapter Summary

In this chapter, an overview of all the research findings was presented and a detailed description of several findings was provided. The first research objective elicited one main theme of *colonialism is ongoing* and three sub-themes: 1) the multiple faces of racism; 2) the challenges in negotiation identity; 3) and the struggle to find safe spaces and people.

The second research objective was realized through developing an Indigenous and Theatre of the Oppressed influenced workshop in which an anti-racist framework emerged. In a post-play discussion, actors and audience members also identified that scaffolding learning; increasing Indigenous faculty representation; creating an Indigenous advisory committee; and hiring an Elder were also possibilities for integrating some of the priorities of the MCIEB within nursing education.

Finally, in relation the research objective #3, the findings of this research revealed that nurses, nurse educators and health care providers were receptive to Theatre of the Oppressed and forum theatre in nursing education and that the above pedagogical methods provided opportunities for reflection and growth, strengthening relationships and expressing vulnerability. The findings emerging from the nursing students revealed that forum theatre has practical applications.

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CHAPTER 5: PAPER 2

Illuminating Indigenous Health Care Provider Stories through Forum Theatre

The manuscript presented in this chapter specifically addresses research objective #1 of this study (to explore several priorities of the MCIEB through Theatre of the Oppressed and Forum Theatre with nursing educators, students and health care providers) and links to priority #3 of the MCIEB (promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples). This manuscript illuminates the contemporary context of Indigenous health care provider lives revealing several notable themes. The two themes discussed in this manuscript include the challenges in negotiating identity for Indigenous health care providers including lateral violence. The second theme discussed is the struggle in finding safe spaces and people in nursing and higher education related to limited Indigenous inclusion and tokenism. This manuscript brings to light an under-explored topic, and promotes a decolonizing and participatory approach. The approach within this manuscript may also serve as a model for future "holding spaces", wherein Indigenous and non-Indigenous people come together in a respectful manner to explore boundaries and tensions that exist between both parties.

Abstract

Learning about the historical and current context of Indigenous peoples' lives and building campus communities that value cultural safety remains at the heart of the Canadian educational agenda and have been enacted as priorities in the Manitoba Collaborative Indigenous Education Blueprint. A participatory approach informed by forum theatre and Indigenous sharing circles involving collaboration between Indigenous and non-Indigenous health care professionals (n=8) was employed to explore the above priorities. Through the workshop activities, vignettes were created and performed to an audience of students and educators (n=7). The findings emerging from the workshop illuminated that Indigenous people in nursing and higher education face challenges with negotiating their identity, lateral violence and struggle to find safe spaces and people due to tokenism and a paucity of physical spaces dedicated to Indigenous students. This study contributed to provoking a greater understanding of Indigenous experiences in higher education and advancing reconciliation.

Introduction

The inequity in the health and wellbeing of Indigenous peoples (including First Nations, Métis and Inuit) in Canada is well documented (Martens et al., 2012; Reading & Wiens, 2009). There is overwhelming evidence that the experience of colonization has had deleterious effects on Indigenous people in Canada (Greenwood & de Leeuw, 2012; MacDonald & Steenbeek, 2015). Colonization is now recognized as a determinant of health in Canada (Czyzewski, 2011; Manitowabi & Maar, 2018). In an effort to redress these inequities, the Canadian Nurses Association (CNA), along with Canadian Association of Schools of Nursing (CASN) and the Aboriginal Nurses Association of Canada (ANAC)[3] have strongly advocated for changes to the nursing curriculum including the need to increase Indigenous content in schools of nursing and increase the cultural safety of nursing students (Aboriginal Nurses Association, 2009; Canadian Nurses Association & Aboriginal Nurses Association of Canada, 2014). Supporting nurses and nursing students to develop as culturally safe practitioners who are knowledgeable about the history of colonization, racism and oppression of Indigenous Peoples in Canada is a priority. Indeed, in their Calls to Action, the Truth and Reconciliation Commission of Canada (TRC) has specifically appealed to medical and nursing schools in Canada to:

> Require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (TRC, 2015, Calls to Action, p.3).

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[3] The Aboriginal Nurses Association of Canada is now renamed the Canadian Indigenous Nurses Association

In response to these Calls to Action, commitments to increasing Indigenous perspectives and cultural safety in educational institutions are also being affirmed and implemented across Canada. For example, in the province of Manitoba, educational institutions from the primary to the post-secondary, have signed on to the Manitoba Collaborative Indigenous Education Blueprint (MCIEB) which outlines ten priorities for educational institutions to implement as steps towards reconciliation with Indigenous peoples in Canada. Two of the priorities: "Promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples" and "Building school and campus communities that value diversity, foster cultural safety and are free of racism" (University of Manitoba, 2015, p. 1) are especially important for schools of nursing. These priorities are important for schools of nursing to enact in order to redress health inequities because nurses are key players in Indigenous health. Nurses are the largest health care professional group in Canada (Canadian Institute for Health Information, 2017), and also the predominant primary health care professionals in remote First Nations and Inuit communities (CNA & ANAC, 2014). Furthermore, these priorities are also crucial because most non-Indigenous nurses are unfamiliar with Indigenous perspectives given they were educated in academic and clinical environments that barely included Indigenous content within their programming and curriculum (McGibbon et al., 2014).

More recently, Indigenous nurses have begun generating health care scholarship intended to help enhance critical reflection on the effects of colonization, and to document their experiences within nursing education and/or clinical practice (Bearskin et al., 2016; Etowa et al., 2011; Vukic et al., 2012). However, non-Indigenous nurse educators often remain uninformed about these perspectives or cautious about how to incorporate Indigenous content in their curriculum and in their classroom, for fear of being viewed as insensitive or culturally unsafe

(Varcoe & McCormick, 2007). Lane and Petrovic's (2018) review of Indigenous cultural competency amongst nursing educators revealed a significant gap in the literature pertaining to how to address or evaluate the cultural competency of nursing educators. Rather, most of the literature continues to address the supports needed for Indigenous students to succeed and the strategies needed to recruit and retain Indigenous students in nursing education (Lane & Petrovic, 2018). While increasing Indigenous representation in nursing is important, if experiences of discrimination, racism and othering continue to plague Indigenous nurses (Vukic et al., 2012) and the culture of nursing which is steeped in Euro-centrism and whiteness remains unchanged (McGibbon et al., 2014), this strategy alone is unlikely to lead to redressing educational and health inequities. These efforts are referred to as remedial or "band-aid" strategies and reflect nurse educators' tendency to ignore broader systemic issues (CNA & ANAC, 2014; Pijl-Zieber & Hagen, 2011). More troubling, St. Denis (2002) cautions that increasing Indigenous representation in education, while leaving the structure of education unchanged may result in Indigenous students and educators witnessing racial violence, and even participating in practices that uphold dominant colonial models and minimize oppression (as cited in Cote-Meek, 2014).

Undoubtedly, Indigenous representation in nursing education is crucial. However, all nurses and nurse educators must engage with knowledge about the history and contemporary context of Indigenous peoples' lives in order to change the structure of nursing and higher education. CASN (2013) maintains that one of the key approaches to obtaining such knowledge is to bring society, history, culture and context alive through the nursing program and to support faculty development to teach this content. However, for faculty and students to gain such knowledge, conversations and discussions between Indigenous and non-Indigenous people must

occur for genuine understanding to occur. To engage in such a dialogue is neither an easy, nor straightforward process. Cote-Meek (2014) refers to the knowledge of Indigenous historical and contemporary experiences as "difficult knowledge". To engage in difficult knowledge without retraumatizing the colonizer-colonized relationship, transformative pedagogies are needed as are research methodologies that can adequately capture this nuanced and complex dialogue.

Transformative pedagogies require a shift in worldview and a "more fully developed (more functional) frame of reference…one that is more a) inclusive, b) differentiating, c) permeable, d) critically reflective and e) integrative of experience (Mezirow, 1996, p. 163). Arts-based work can function in service of the goals of transformative education in: engendering an aesthetic experience for participants; developing empathy; establishing relationships and connections to the content; altering perceptions; and disturbing equilibrium (Barone, 2008, p. 39). It is in this context that we propose forum theatre as a transformative pedagogy and research methodology that can foster dialogue and challenge and decolonize traditional research methods.

Forum theatre was pioneered by the Brazilian educator Augusto Boal (2002) as a form of participatory theatre between actors and the audience, called "spect-actors". Within forum theatre, spect-actors are invited to watch a play in which the struggle between an oppressed protagonist and his or her antagonist(s) is depicted. The play unfolds once, without interruptions, until it reaches some kind of calamity. The second time the play is shown it follows the same course until a spect-actor intervenes, yelling 'Stop!'. The spect-actor then takes replaces a character on stage and tries to defeat the oppressor(s). The game is a challenge between spect-actors trying to break the cycle of oppression and actors attempting to bring the play to its original end (where the oppressors are unchanged and victorious) (Boal, 1995). The play is mediated by a facilitator whose function is to ensure the smooth running of the game and teach

the audience the rules. Many different scenarios are enacted in the course of a single forum. The merging of knowledge, approaches and experience is referred to by Boal as a "rehearsal for life" (Boal, 1995, p. xxi).

The purpose of this study was to explore the priorities of the MCIEB with Indigenous and non-Indigenous health care professionals and students through forum theatre as well as explore possibilities for integrating the priorities of the MCIEB in nursing education. However, the focus of this article is on the former objective.

Method

Theoretical framework

This research is grounded in a Two-Eyed Seeing (Bartlett et al., 2012) as a theoretical framework. Without privileging one perspective over another, Bartlett et al. (2012) contend that within Two-Eyed Seeing both "eyes", the Western (Euro-centric) eye and the Indigenous one, contribute to our understanding of the world; and learning from both eyes results in greater benefit for all. In this research project, Two-Eyed Seeing supports a mutual understanding between Indigenous and non-Indigenous participants as it relates to their experiences of health care and nursing education and it also was also the basis for respectful collaboration for the workshop team that included the PI, a theatre facilitator and an Indigenous nurse-Elder who were navigating multiple knowledge systems (i.e. nursing, artistic, Indigenous).

Setting, Recruitment and Participant Demographics

Ethical approval for this study was obtained through the university's health research ethics board. Using snowball and purposeful sampling, we recruited nurses, nurse educators and health care professionals from the university. Signed informed consents were obtained from all participants along with a demographic questionnaire. Eight participants, excluding the nurse-

Elder and theatre facilitator (n=8) were recruited for this study. All of the participants were female. Most of the participants had been practicing as health care professionals between 15 to 40 years. In total, six nurses and two other non-nursing health care professionals were recruited. Among the nurses, four worked as nursing educators. Two participants identified as First Nations, two as Métis, one as mixed Cree and British and three as Caucasian. For clarity, we refer to the above participants as "participants" in the body of the article while the audience members, described below are referred to as "audience members".

Audience members were recruited via purposeful and snowball sampling and included undergraduate and graduate students and educators on the university campus (n=7). Signed informed consents were obtained from the audience members. While confidentiality and anonymity could not be observed during the workshop and performance, participants were advised to treat the personal stories shared during the workshop as confidential. Echoing the sentiments of Ward and Shortt (2020), our primary considerations were not anonymity or confidentiality given the participatory nature of this project, but of respect and care. However, when presenting the data within this article, we employed pseudonyms to protect the identity of the participants.

Procedure and Data Collection

Forum theatre workshop

Prior to the workshop, a transdisciplinary team which included a forum theatre facilitator and an Indigenous nurse-Elder were recruited to plan and facilitate the workshop along with the principal investigator (PI). Over the course of several months, the team designed the workshop collaboratively, to include both Indigenous knowledge and approaches (including prayer, smudge ceremony and sharing circles), and traditional forum theatre techniques. The workshop

preparation also helped establish rapport between the team members, who had never worked together before and introduced the theatre facilitator to Indigenous approaches and the Indigenous nurse-Elder to forum theatre and theatrical techniques.

A two-day forum theatre workshop was held in May 2019 in a theatre studio on a central Canadian university campus. On the morning of the first day of the workshop, participants engaged in sharing circles and forum theatre games and activities. On the afternoon of the first day of the workshop, the participants separated into two groups of four to craft a vignette based on one priority of the MCIEB. Through a process of discussion, analysis and experimentation, two collective vignettes (one from each group) were created with several scenes of identifiable conflict and struggle relating to their chosen MCIEB priority. A sharing circle at the end of the day was a necessary transition in order to debrief about the work done during the day, but also as closure for two of the participants who, due to prior commitments could not attend the second day of the workshop. The dialogue in the sharing circle opened the space for collective analysis, and for generating new understandings and possibilities.

On the second day of the workshop, the six remaining participants returned to participate as actors in the forum theatre vignettes. Once again, the day was opened with a sharing circle and participants expressed new ideas and insights that had emerged. The participants then spent the morning of the second day further refining, rehearsing and receiving feedback on their vignettes from the PI, the theatre facilitator and the Indigenous nurse-Elder. The afternoon of the second day culminated with a performance of the vignettes by the participants to the audience of educators and students. The data generated from the workshop included sharing circles, theatrical games, vignettes, discussions and photographs of the workshop activities along with audio and video recordings of the above data.

Data Analysis

The data from the forum theatre workshop were analyzed using thematic analysis (Attride-Stirling, 2001). Audio and video recordings of the workshop and the forum theatre performance were professionally transcribed. The transcript data was coded by the PI, and then organized into basic, organizing and global themes. To ensure rigor in the analytical process, the PI discussed and reviewed her analysis with the second author multiple times until consensus regarding the themes was reached. Trustworthiness was also established throughout the forum theatre process, and through member checking (Lincoln & Guba, 1985) as confirmation of the findings. By describing the forum theatre workshop in detail, and including one vignette crafted by the participants to illustrate the study's themes, we hope to have achieved transparency, an important evaluative criterion for arts-based research (Rolling, 2013).

Through the process of creating their vignettes, participants focused on a range of experiences and conversations which they considered, made manifest these priorities of the MCIEB: Promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples; and building campus communities that value diversity, foster cultural safety and are free of racism. In foregrounding and accentuating Indigenous experiences and discriminatory practices in nursing and health care, the following themes emerged: challenges in negotiating identity complicated by lateral violence; and struggles in finding safe spaces and people due to tokenism and a paucity of physical spaces for Indigenous people on campus. While only one vignette is included in the following section, the findings emerged from the data as a whole.

Vignette script

The scene begins with two nursing students sitting side by side in a classroom waiting for their teacher to start the class. Stacy is visibly Indigenous, while the other student, Carrie, is White in appearance. Stacy and Carrie have a relatively new relationship with each other, and Carrie has never revealed that she is Indigenous.

Stacy: Hey, Carrie, what's with those beaded earrings?

Carrie: What do you mean?

Stacy: I mean, they're beautiful, but, as a Cree woman, I feel like I really need to explain to you as a non-Indigenous person how that can be really offensive to be wearing those, because there is lots of significance behind...For instance the colors of those beads, they represent the four directions, which are actually the colors that were gifted to me when I received my spirit name, so I feel like, if you're going to wear those, at least you should wear earrings that were made by Indigenous artists.

Carrie: Stacy- I am Métis.

Stacy: Like, are you claiming that now just because you want to get in with a lower GPA, or…?

Carrie: I am Métis, I'm from Peguis, I was born and raised there.

Stacy: Well, I see blonde, blue eyes, I just don't get this.

Carrie: I just want to…nevermind.

Teacher: *(Teacher stands)* Let's begin. Good afternoon. And it being a Friday afternoon, let's keep it brief. I know we all want to go home and get out of here and start our weekend, right? Okay, today's topic, nutrition, specifically childhood nutrition. With an addition. Okay, since the TRC, we, as a very culturally aware and sensitive university,

are going to be introducing this topic about childhood nutrition on the reserves. Let's be

progressive, shall we? I have an idea, instead of listening to me drone on and on and on

about this subject, why don't we invite a native person who clearly was raised on a

reserve…an Aboriginal. What is the PC term these days anyhow? Who really knows,

right? *(Teacher chuckles and then motions for Stacy to come to the front of the class).*

Come on up. Right here. It's terrible what's happened to these people, isn't it? No

drinkable water on their reserves. Forced with Coca Cola in their baby bottles. Virtually

raised on junk food. *(Teacher turns to Stacy who is uncomfortably standing at the front of*

the class). Can you speak about that?

Stacy: I don't really know what you want me to...

Teacher: No, no, no, no. You are a voice for your people. You wanted this chance.

Continue.

Stacy: *(Turning to the audience)* I just want to disappear.

Findings

Challenges in negotiating identity

One of the prevalent experiences in this study was the challenge Indigenous people

experienced associated with negotiating their identity or their self-presentation as Indigenous

students and health care professionals. While the participants often expressed their own

challenges in nursing and higher education, some participants also related stories they had heard

from Indigenous students that highlighted this issue as well. Participants described a conflicted

sense of identity and a feeling of apprehensiveness regarding identifying as Indigenous for

several reasons. For example, Jane, a First Nations participant, described that during her

undergraduate degree she did not identify as Indigenous as she felt "that would put a target on

me". When people mistakenly assumed she was Portuguese or Mexican, Jane mentioned that she sometimes agreed because she felt shame in her Indigenous identity. Jane also described negotiating her identity as a "no win" situation. When she did disclose her identity, Jane expressed "I did have people ask me inappropriate questions and I had these negative experiences (from Indigenous people as well) and I was like, wow, I can't win for hiding and I can't win for disclosing"

Anne, a participant of Métis heritage and blonde and blue-eyed, described that she has felt uncomfortable identifying as Indigenous due to her White privilege but also fearing not being viewed as "legitimate" as an Indigenous person. Anne, a nursing educator, also revealed that Indigenous nursing students had shared similar stories with her, expressing embarrassment with their Indigenous identity and choosing to not self-identify to the larger nursing academic community. Anne disclosed that she had only truly become comfortable with identifying as Indigenous after she started working with Indigenous students on campus and recognized their shared struggle to self-identify. While listening to Anne's story, Barbara, a non-Indigenous nurse educator described the situation as a "balancing act…trying to figure out who you are". Barbara added that all students are already contending with multiple identities in nursing education. "I feel like students have multiple identities…you're a student in clinical, you're a student in class, you're a student on the committee, you're in simulation lab." Barbara acknowledged that "there are so many different pieces that need support" and that this is made more complex for Indigenous nursing students.

Drawing attention and making visible the challenge of negotiating identity was important to the participants. The vignette depicts the inner struggle that many light-skinned Indigenous people experience regarding their identity. The vignette also highlights the common but harmful

perception that light-skinned Indigenous people only choose to self-identify to garner some advantage or benefit (such as preferential admission to university or funding). Although special consideration and access programs are designed to increase Indigenous representation and redress historical inequities in access to education, these programs can actually stigmatize Indigenous students. Several participants working in higher education noted that non-Indigenous faculty and students often view Indigenous students admitted under special consideration or through an access program as circumventing the "fair" system through which all other students must apply or as "taking the spot from a deserving candidate". These assumptions create an added layer of complexity for Indigenous students as they negotiate their identity in higher education and damages the self-concept of many Indigenous people who have internalized these debasing stereotypes.

Lateral violence

Many participants described that negotiating identity in nursing and higher education as an Indigenous person is often made more challenging because of the prevalence of lateral violence within and between Indigenous communities. Participants emphasized lateral violence as a major theme in the script. Lateral violence is described as "the way people in positions of powerlessness, covertly or overtly direct their dissatisfaction inward toward each other, toward themselves, and toward those less powerful than themselves" (Korff, 2019, para. 1). Lateral violence within Indigenous communities is the result of colonization, oppression, intergenerational trauma, racism and discrimination (Native Women's Association of Canada, 2015). Jane described how lateral violence affects Indigenous identity: "lateral violence kind of happens…who can be seen as legitimate, and I've internalized that, and you've internalized that…". These negotiations of identity are complicated by factors such as rediscovered

Indigenous heritage, often with regards to Métis individuals. For example, Sally, a First Nations participant described there is now a Métis citizenship bus that comes to campus to assist individuals of Métis heritage in obtaining their Métis citizenship. While the purpose of the Métis citizenship bus is intended to increase access to membership, Sally noted that some cynicism from other Indigenous people has emerged from such an initiative: "I've heard things like *Did you see that Métis bus? And now they're Indigenous*?"

As another example of lateral violence, Jane described an experience during a classroom discussion, wherein another Indigenous student spoke up and authoritatively said "I'm the only Indigenous person in this class". The student then pointed to Jane and said "Well, the only visibly Indigenous person". While this event occurred many years ago, Jane still felt the shame of being singled out and viewed as not legitimately Indigenous. This event reinforced some of her earlier decisions to not identify as Indigenous or to claim an alternate ethnicity and exemplifies some of the challenges that exist for Indigenous students in negotiating their identity.

Struggles in finding safe spaces and people

Indigenous workshop participants expressed feelings of isolation in nursing and higher education and articulated that they struggled to find safe spaces and safe people on campus. To demonstrate this isolation and struggle, the script was crafted to depict Carrie and Stacy in a struggle with each other along with Stacy struggling with her nursing professor and with an approach to curriculum that trivializes and pathologizes (views as abnormal) Indigenous perspectives and content.

For example, Anne, a nursing educator, noted that there is currently no dedicated physical space for Indigenous nursing students to gather and study in the faculty of nursing. "We (nursing faculty) don't have a lounge or an area where our (Indigenous) students can go. We're working

on it, it's a priority, or it's been identified as a priority, we're in the process…but I've been working here two years now…". While there is a building specifically for Indigenous people on campus, several of the participants identified that the high course load in nursing education as well as the clinical placements off campus preclude Indigenous nursing students from fully utilizing that space. While engaged in an image theatre exercise, Anne specifically chose a pose (or image) in which she was hiding herself with her hair and trying to make herself as small as possible. When asked to describe her image by the forum theatre facilitator Anne expressed that her pose was:

> reflective of this space and the racism but also about the building of space because a lot of our (Indigenous nursing) students come do their class and leave, they don't feel comfortable in our building or on campus…so my pose was about hiding while you're here (on campus) to get the job done and retreating to safety.

Tokenism

According to many participants, one of the oft mentioned reasons that Indigenous people struggle on campus and in health care settings is due to their limited inclusion and tokenism. The vignette script above addresses tokenism as one of the main themes. While the nursing professor calling upon an Indigenous student to come to the front of the class to speak about nutrition is intentionally dramatic for theatrical purposes, many Indigenous participants described being singled out and called upon to speak from an Indigenous perspective in higher education and in the clinical setting. As a commonplace example, Kathy, an Indigenous nurse, described an instance of having lunch across from the hospital with nursing colleagues, where an Indigenous man is seen panhandling outside the restaurant. A fellow nurse turned to Kathy and said "Look at that man, he could easily hold down a job, he looks able-bodied. How do you explain that

Kathy?" Kathy noted that her colleagues all turned and looked to her to provide an answer as though she was a representative or a voice for all Indigenous people.

During the crafting of the vignette, the forum theatre facilitator "hot seated" Kathy, the participant playing the nursing professor. "Hot seating" is a theatrical technique in which the actor playing a character is interrogated to flesh out the character. This requires the actor playing the character to think about what she is doing, feeling and the motivations behind the character portrayal. The theatre facilitator specifically asked if the character planned on putting the student on the spot in asking her to come to the front of the classroom to discussion nutrition on First Nations reserves. Drawing on her numerous experiences of tokenism, Kathy expressed that she did not think most non-Indigenous people recognized their actions as tokenistic, culturally unsafe, or as actions that contributed to the ongoing struggle for Indigenous people:

> I didn't think I was putting her on the spot. I was just meeting my own ends. I realize my limitations… I'm not that prepared really (to teach this class). I should have given more thought to it but now I figure I can just get the students to do the work, then you know…isn't this innovating of me? I'm proud of myself actually because look at what I've figure out. I can get the (Indigenous) students to talk. Blah-blah-blah. Go through it, meet all the criteria and boom, now I get credit because how sensitive of me to actually ask one of them…give them a voice.

During the performance of the vignette to the audience, one of the audience members identified that as an educator there is often an expectation to be "all-knowing". The audience member expressed that there should be no shame in not having all the answers and taking the time to learn unfamiliar content. In replacing the character of the nursing professor on stage, the

audience member's intervention modeled a powerful way to be respectful and inclusive towards Indigenous students without singling them out:

> We actually have new directions to incorporate the Truth and Reconciliation
> Commission, the directives of it. And since I'm not super familiar right now, I'm going to
> take some time to think about it. I don't want to just throw this in like this and it can wait
> a day. But, if anyone wants to come talk to me who has experiences or ideas, I'm open to
> that.

Indigenous workshop participants identified that lack of Indigenous representation at the faculty and administrative level also contributed to the struggle of Indigenous students in nursing and higher education. Several participants stressed that mentorship is important for Indigenous students and can contribute to Indigenous well-being and flourishing. For example, Jane shared that she had received support through an Indigenous mentorship program during her undergraduate studies.

> I flourished because I had these mentors established from that program, and so I started
> building these networks and building these relationships that I can still go to, these really
> strong Indigenous mentors that I have in my life…They helped me realize my gifts.

Discussion

To our knowledge, this is the first study to use an innovative approach to explore key priorities of the MCIEB. The findings of this study revealed that Indigenous nurses and health care professionals struggle to negotiate their identity in higher education. Several participants expressed feeling shame in their Indigenous identity and finding ways to assimilate or deny their heritage which has also been mentioned in other studies (Henschke, 2017; Nielsen et al., 2014; Slatyer et al., 2016). In the Australian context, Henschke (2017) found that Indigenous nursing

students endured similar stereotypes and often chose to deny their Indigenous identity, or not willingly share their identity if they were light-skinned. Indigenous registered nurses in Australia described "acting white" in order to fit in and be considered worthy of achievement in the field of nursing (Nielsen et al., 2014). The experiences of lateral violence identified in this study are similar to those experienced by students as well as health and social services professionals in other studies (Bailey, 2020; Monchalin et al., 2020). In Bailey's (2020) study, Indigenous students identified lateral violence including questioning and judgement regarding Indigenous authenticity as a major concern on campus. Similarly, Métis women working in Indigenous-specific health and social services in Monchalin et al.'s (2020) study described feeling unwelcomed in Indigenous-specific spaces due to doubts regarding their Indigenous identity, bullying and gossiping based on their Métis rather than First Nations status. The findings of Slatyer et al.'s (2016) study noted that Indigenous nursing students in Australia experienced shame in their identity as a result of a legacy of colonialization which contributes to a sense of vulnerability and lower self-concept for Indigenous students. Slater et al's findings confirm those in this study and highlight that while Indigenous groups in colonized countries are not heterogeneous, they do share similar experiences of living with the divisive legacy of colonization.

The experiences of tokenism and its contribution to the struggles of Indigenous people builds on the research of others (Henry, 2012; Henry et al., 2017; Settles et al., 2019; Vukic et al., 2012). While the descriptions and the depiction of tokenism in our study are undeniably negative, other studies have noted that tokenism can also take on a more insidious form. For example, Indigenous Canadian nurses in Vukic et al.'s (2012) study identified tokenism as a hiring practice that had some positive benefits. However, at least one participant in that study

remarked that it did lead to a questioning about her own professional capabilities and merits. Similarly, with regards to Canadian faculty, Henry et al. (2017) describe that administrators often highlight Indigenous faculty, by placing them "front and centre" on faculty websites and university brochures. While these acts are viewed as "well-meaning", they are nonetheless perceived as tokenistic because they essentialize Indigenous people and contribute to their othering. Likewise, American faculty of colour (including Black, Hispanic/Latinx, Asian and American Indian faculty members) describe being treated as "tokens" to represent diversity within academic institutions and experienced sentiments of hypervisibility through heightened scrutiny and invisibility through a lack of belonging (Settles et al., 2019). These diverse experiences of tokenism emphasize the need for administrators to treat diversity as more than just a performance metric or as a superficial equity measure. It also highlights the need for further intergroup dialogue to generate greater understanding about Indigenous experiences of tokenism.

Kirkness and Barnhardt (1991) have long advocated for the need to create safe spaces in post-secondary institutions for Indigenous students by offering programs and services that connect Indigenous students with their cultural dispositions and values. While there is a dedicated space on campus for Indigenous students, many participants in this study felt that a safe space within the faculty of nursing was critical to fostering a sense of cultural safety. The need for dedicated physical spaces for Indigenous students on campus has also been mentioned in other studies (Minthorn & Marsh, 2016; Ottmann, 2017; Smith & Varghese, 2016). Smith and Varghese (2016) noted that dedicated space for Indigenous Canadian students may not only provide a safe space for Indigenous students free from racism and microaggressions but may also enhance Indigenous students' identities and knowledge about their culture. While the complexity

of the university campus being on Indigenous land was not broached by participants in this study, other scholars have stressed the importance of space in higher education for Indigenous students, not only because Indigenous cultures are deeply connected to human relationships and to place, but also because all North American colleges and universities are located on Indigenous lands (Minthorn & Marsh, 2016). This line of inquiry should be further explored in the context of health professions education given that hospital campuses and clinical settings in North America are also contested spaces located on Indigenous lands.

Echoing the findings of this study, previous research has recommended that initiatives and strategies such as mentorship programs, increasing student support, and culturally inclusive curricula and programming are important for Indigenous students and faculty (Canel-Çınarbaş & Yohani, 2019; Elston et al., 2013; Hutchings et al., 2019). Like the participants in this study, Indigenous Australian scholars in Elston's study (2019) identified a dedicated space for Indigenous peoples as important. This space is referred to as a 'third space", an Indigenous-only gathering space that challenges the oppressive nature of the academic model. However, Elston et al. (2013) also identified the need for "holding spaces" where Indigenous and non-Indigenous people could come together in a respectful manner to explore boundaries and tensions that exist between both parties. While there are no dedicated "holding spaces" on campus, this research may serve as a model for future "holding spaces" for Indigenous and non-Indigenous people.

There are limitations in this study in terms of the small sample size and only female representation. Given that nursing is still predominately female, this is not unusual. The authors acknowledge that this is an exploratory study facilitating a dialogue between Indigenous and non-Indigenous people through forum theatre. While the purpose of this research is not transferability, the aforementioned may be enhanced through a larger scale study that would

include broader participation from Indigenous and non-Indigenous people in health professions education and across the university.

Conclusion

Promoting research and learning that illuminates the history and the contemporary context of Indigenous peoples' lives is critically important if universities are truly committed to the Calls to Action of the TRCC and the priorities of the MCIEB. However, it is obvious from our research findings, that the contemporary context of Indigenous peoples' lives in nursing and higher education is made challenging. The issues experienced by Indigenous nurses and health care professionals are often under-explored and unacknowledged in the academic milieu. As such, capturing and dialoguing about the experiences of Indigenous health care professionals in higher education is an important strength of this study. By facilitating an embodied and experiential dialogue between Indigenous and non-Indigenous people in higher education we have created opportunities for knowledge acquisition and for knowledge application in a safe and respectful "holding space". Grounding this research in a Two-Eyed Seeing theoretical approach, and using forum theatre along with Indigenous sharing circles, we offer a unique method for understanding and dialoguing about Indigenous issues in higher education. Through this research, we hope to have shone a light and facilitated a dialogue about the experiences of Indigenous peoples but also contributed to advancing an Indigenous research agenda that promotes decolonization, reconciliation and transformation within nursing, higher education and beyond.

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CHAPTER 6: PAPER 3

An Indigenous and arts-influenced framework for anti-racist praxis in nursing education

   The manuscript in this chapter addresses research objective #1 of the study by exploring one priority of the Manitoba Collaborative Indigenous Education Blueprint (to create campus spaces that value diversity and are free of racism). The aim of this article is to introduce Theatre of the Oppressed along with Indigenous sharing circles as a framework to facilitate a discussion on race and racism in health care and in nursing education. The framework also offers an example of how Indigenous approaches, models and knowledge may be integrated within nursing education, linking to research objective #2 of this study. This framework is decolonizing, relational and promotes an embodied dialogue as well as opportunities to practice change.

The manuscript included in this chapter is a pre-print of an article accepted for publication in the *Journal of Professional Nursing*. Per the *Journal of Professional Nursing* webpage on November 25, 2020, authors can share their pre-print anywhere at anytime. The accepted article was published as Van Bewer, V; Woodgate, R.L.; Martin, D.; Deer, F. (2020). The accepted article is titled: An Indigenous and arts-influenced framework for anti-racist practice in nursing education. The DOI for the accepted publication is https://doi.org/10.1016/j.profnurs.2020.11.002

Abstract

In this article, we share observations and outcomes from using Augusto Boal's Theatre of the Oppressed along with Indigenous sharing circles as an innovative framework to explore racism with nurses, nurse educators and allied health professionals. Theatre of the Oppressed is an umbrella term that encompasses a variety of participatory and improvisational theatre techniques and games to facilitate dialogue about the problems and oppression that people face in their own lives and to rehearse solutions for acting on these problems (Boal, 2002). The purpose of this article is to detail the Indigenous and arts-influenced framework and our methodology. Then, using select findings from the study, we illustrate how Theatre of the Oppressed, along with Indigenous sharing circles have the potential to raise consciousness regarding racism and provide nurses, nurse educators and allied health professionals with ways to reimagine race and confront racism within their own practices.

Key words: anti-racism; Arts-based methodologies; health professional education; Indigenous, racism

Setting the stage

Most nursing professional organizations endorse social justice and the protection of

human rights as values within their codes of ethics (American Nurses Association, 2015;

Australian Nursing and Midwifery Council & Nurses Board of South Australia, 2008; Canadian

Nurses Association, 2017). However, longstanding patterns of racism in health care and nursing

education in Canada continue to challenge the enactment of these values (Boyer, 2017). Over the

past few years in Canada, cross-cultural training and anti-racist teaching for medical and nursing

students has gained attention (Diffey & Mignone, 2017; Truth and Reconciliation Commission

of Canada, 2015). However, while cross-cultural training such as cultural competency and

cultural sensitivity have been adopted by many schools of nursing as curricular inclusions, anti-

Indigenous racism in health care persists (Allan & Smylie, 2015; Browne, 2017; Denison et al.,

2014), as it does in nursing practice in Canada (Vukic et al., 2012) and abroad (Huria et al.,

2014; Power et al., 2018; Stuart & Gorman, 2015).

Racism is considered a social determinant of health and has known health consequences

(Allan & Smylie, 2015; McGibbon, 2012; McGibbon & Etowa, 2009). In Canada, Indigenous

peoples (including First Nations, Métis and Inuit peoples) have lower life expectancy than non-

Indigenous Canadians, along with higher morbidity and disease burden, including higher rates of

heart disease, cancer, diabetes, and mental health issues (Public Health Agency of Canada &

Pan-Canadian Public Health Network, 2018). Furthermore, Indigenous people in Canada also

face significant structural barriers to accessing health care and receive poorer health services

(Horrill et al., 2019).

More recently, nurse educators have begun to consider race and racism in teaching and

student learning (Blanchet Garneau et al., 2018; McGibbon & Etowa, 2009). In Canada, much of

the focus on racism relates to Indigenous peoples, given the legacy of colonization, oppression and violence that has resulted in widespread inequitable health and social outcomes experienced by Indigenous peoples (Canadian Nurses Association & Aboriginal Nurses Association of Canada, 2014; Vukic et al., 2012). While institutional and ethical commitments to teach about race and racism are ever growing (Truth and Reconciliation Commission of Canada, 2015; University of Manitoba, 2015), the reality is that most nursing educators lack the experience, resources and pedagogical training to teach about race and racism (Holland, 2015). In the context of higher education, racism is often perpetuated by well-intentioned faculty who lack awareness of their offensive actions or respond to racism in the classroom with silence (Sue et al., 2010). Complicating the issue, is the lack of diversity amongst nursing faculty, with very little representation from Indigenous and minority scholars within nursing education (Rowan et al., 2013).

There is scant literature on the best methods or approaches for teaching race and racism in the nursing or health professions education classroom. Rather, several different approaches have been proposed, rooted in critical race theory (Bennett et al., 2019), social justice (Blanchet Garneau et al., 2018; Hatchett et al., 2015), or cultural safety (Papps & Ramsden, 1996; Ramsden, 2002). These approaches all highlight race and racism, and the need for students to gain certain attitudes, knowledge and skills. However, they do not explain how an educator might develop the attitudes, knowledge or skills to teach this content. For such a complex issue, nursing educators must tend to their own development and have opportunities to broaden their understanding of race and racism. According to DiAngelo (2018), a deliberate effort by White faculty is needed to develop the cognitive abilities and resilience to engage in constructive dialogue about race and racism in the classroom. Faculty must also have opportunities to

critically analyze the experiences of oppression and prejudice that Indigenous people encounter in health care and in nursing education. This type of professional development and education must acknowledge schools of nursing and health care settings as sites where racism and stereotypes may be learned and provoked. We argue that schools of nursing must become sites where racism is unlearned.

Pedagogy and Theatre of the Oppressed

Educators have often relied on traditional instructional strategies that increase student knowledge through the correction of misinformation when teaching about race and racism in the classroom. However, these traditional pedagogical approaches are often insufficient in provoking deeper reflection, insights and transformation as they do not address the affective ways that racism is construed and experienced (Harbin et al., 2019). Student resistance to learning about racial injustice may also result in educators feeling "unmoored…incompetent…and on the verge of losing control" (Smith et al., 2017, p. 655). This may lead to an educator's disinclination to engage in race-related dialogues in the classroom or reverting to didactic, inactive, paternalistic and/or unengaged approaches to teaching (Lichty & Palamaro-Munsell, 2017; Smith et al., 2017). Approaches to teaching about race and racism must foster dialogue, encourage reflexivity (on both the students' and the instructor's part), and welcome discomfort and difficulty (Harbin et al., 2019).

Freire (2000), a Brazilian educator, scholar and social theorist advanced a dialogical model of education wherein educator and student are partners in learning. Through Freire's approach, the educator and students become critical co-investigators and fully engage in dialogue and critical thinking about real-life problems. Beyond dialogue, Freire was concerned with *praxis*- action informed by critical reflection and *conscientization*, the process of developing

critical awareness of one's social reality through reflection and action. Boal (2008), inspired by his compatriot Freire's model of transformative education, developed Theatre of the Oppressed, which mirrors the dialogical and transformational aspects of Freire's critical pedagogy (Ferreira & Devine, 2012). As in Freire's model, Theatre of the Oppressed empowers people to critically analyze and examine systems of power as well and encourages people to act in service of social change. Importantly, Theatre of the Oppressed engages the affective and the embodied dimensions of learning that are critically important for teaching and learning about race and racism (Harbin et al., 2019). Theatre of the Oppressed has been used previously as a medium to foster increased awareness about Indigenous experiences of oppression and racism and has created opportunities for students and faculty to understand the rights of Indigenous peoples and to expand their human rights and social justice work (Ferreira & Devine, 2012). Furthermore, in their work addressing Indigenous youth's health issues, Goulet et al., (2011) assert that TO techniques created space for decolonization and for future action.

This article stems from a larger research project that aimed to facilitate a dialogue about integrating Indigenous knowledge and approaches in education along with creating campus spaces that value diversity and are free of racism. The secondary aims of the larger study were to explore possibilities for integrating Indigenous knowledges in nursing education and explore nursing educators' and students' experiences of Theatre of the Oppressed as a pedagogical approach. Not all research objectives will be addressed in this article. Rather, the aim of this article is to introduce Theatre of the Oppressed along with Indigenous sharing circles as a framework to facilitate a discussion on race and racism in health care and in nursing education. The framework also offers an example of how Indigenous and non-Indigenous approaches to education may be woven together, linking to the broader study's secondary objective. This

framework is decolonizing, relational and promotes an embodied dialogue as well as opportunities to practice change. We begin by describing the methodology of the TO workshop. We then identify how different components of the workshop supported conscientization and an anti-racist praxis. We also discuss some of the strengths and challenges that emerged during our project.

TO workshop methodology (Critical elements of TO process)

Prior to the workshop, a transdisciplinary team that included a trained Theatre of the Oppressed facilitator as well as an Indigenous nurse-Elder were recruited to plan and facilitate the workshop along with the principal investigator (PI). For this project, the methods used were critically important as we wanted to challenge and decolonize traditional research methods. The workshop was intentionally designed to include both Theatre of the Oppressed and Indigenous approaches to learning. As a workshop team, we all sought to locate ourselves: PI as Franco-Métis, the TO facilitator as White and Jewish and the Indigenous nurse-Elder as Cree. Due to our backgrounds, we have faced in varying degrees and contexts experiences relating to prejudice, discrimination, stereotype and racism. We shared these experiences with the workshop participants which helped establish rapport and understanding.

Ethical approval was obtained for this study from the Health Research Ethics Board and written consent was obtained from all participants. Eight women participated in this workshop. Six were nurses, while two were allied health professionals. Of the six nurses, four were also nurse educators. Five participants identified as Indigenous, while three identified as Caucasian (White). The participants were not a pre-existing group, though some participants had worked together or knew each other previously. The vignettes created from the TO workshop activities were performed to a small audience of other nursing educators and students in higher education.

The workshop was held over two days in a theatre studio on the campus of Western Canadian university. On the first day of the workshop, the Indigenous nurse-Elder led an opening prayer first in her native Cree language, then in English, followed by a smudge. The inclusion of Indigenous protocol and ceremony was important as a way to start the workshop in a "good way" but also served as an initiation to Indigenous practices for participants who had never participated in a smudge before. The burning of medicinal plants creating sacred smoke is a common practice to cultures and religions all over the world. In Canada, it is commonly referred to as smudging. Different ceremonies and protocols for smudging exist, but it is often used for releasing negative thoughts of a person or place and involves burning one or more of the four sacred medicines including tobacco, sage, cedar, and sweetgrass (Robinson, 2018). While several participants had assisted in a smudge before, including the smudge was particularly important to cleanse the university space of its negative energy given its position as a colonial structure. The smudge was also particularly important to one participant, an Indigenous woman, the daughter of a residential school survivor, who due to banning of spiritual practices and the suppression of her culture, had never participated in a smudge before. Indeed, during the following sharing circle, this participant revealed that she had not even known her parent had attended residential school until she (the participant) was an adult. The participant shared that the smudge, along with the sharing circles did indeed provide some healing and a reconnection with her culture.

After the smudge, an opening circle led by the Indigenous nurse-Elder was employed to discuss each participant's concerns, apprehensions and aspirations for the day. Within the circle, a feather or stone (or other sacred element) is passed from person to person, and only one person speaks at a time, while the remainder listen in a non-judgmental way (Lavallée, 2009). It is acceptable for a person to pass the stone along and not contribute and there is no judgment

attached to this. However, everyone must feel invited to participate. Unlike a focus group, the sharing circle does have a mechanism built-in to avoid the domination of one or more speakers, as one can only speak once they have the stone and a person can only speak twice once the stone has gone around the circle once (Lane, 2012). The prayer, smudge and opening circle set the stage for the workshop and a spirit of respect, of reciprocity and of relationship, values central to Indigenous ways of being (Kirkness & Barnhardt, 1991).

After the opening circle, the forum theatre facilitator then engaged participants, along with the nurse-Elder and PI in theatrical games. These games were intended to evoke memory, emotion and imagination and were selected to emphasize movement and trust activities aimed at getting participants comfortable and aware of their bodies. These games also allowed participants to experiment, build community, and created an atmosphere of experimentation and creativity. After each theatrical game, the entire group debriefed and participants were asked "could this be a symbol for racism in general or racism in health care and health care education?".

The sharing circles and theatrical games were conducted with the entire group. However, through Boal's Image Theatre (further described on page 13), participants created personal images of their struggles in health care and health care education. Participants were then asked to group themselves with other images that appeared similar. This resulted in two groups of four participants. Each group spent considerable time sharing their own experiences and struggles in health care education and listening to others' stories of the same. The vignettes crafted were not one individual participant's story, but rather a collaborative, co-created story. Once the vignette was preliminarily developed, the scene was then acted out for the facilitator, the PI and the

nurse-Elder who shared input, thus creating an additional collaborative feedback loop, which provided an extra layer of analysis. Participant/actors integrated changes as they saw fit.

The first day ended with a sharing circle. Each participant discussed their experiences and concerns. On the morning of workshop day 2, an opening sharing circle led by the nurse-Elder started the day along with a warm-up theatrical exercise. Due to prior commitments, two participants from Day 1 of the workshop could not attend the second day. Thus, the remaining six participants continued to refine their scripts with assistance from the theatre facilitator, nurse-Elder and the PI. The workshop then culminated with the performance of the forum theatre vignettes to an audience of other educators and students in higher education. After watching the vignettes a first time, audience members were invited to then test "interventions" on stage in attempts to alter the outcome of the vignettes. Participants and the audience also engaged in a post-play discussion. After the audience members had left, a final sharing circle was conducted with participants sharing their experiences of the workshop, their thoughts and their hopes for the future.

Theatre of the Oppressed: A method for critical analysis of race and racism in health care and nursing education

In this section, we review select activities from the workshop and highlight how these activities facilitated a dialogue about race, racism and oppression in health care and nursing education.

Theatrical Exercises and Games:

According to Boal (2002), theatrical exercises refer to all physical and muscular movement (respiratory, motor and vocal) which helps the participant have better understanding of their body. The goal of theatrical exercises is enhanced awareness of the body and its

mechanisms. Each theatrical exercise is a physical reflection or an introversion. On the other

hand, theatrical games refer to the expressivity of the body as a sender and receiver of messages.

While theatrical exercises are a monologue, a gaze inwards, games are a dialogue and are an

extroversion (p. 48). During the two-day workshop, several theatrical exercises and games were

employed (Table 3). All theatrical exercises and games were decided upon jointly by the

workshop team and served their purpose in building trust and rapport amongst participants, and

to initiate participants to movement, exercise and theatre.

Table 3: Theatre of the Oppressed Games and Activities

Theatre of the Oppressed Activities	For full description refer to Games for Actors and non-Actors (Boal, 2002).
Colombian hypnosis	Played in pairs. One player (A) holds their open hand, fingers upward, about 20-40 cm from their partner`s (B) face. (A) then starts a series of movements with their hand (up, down, right, left…), while (B) tries to contort their body to keep their face at exactly the same distance from (A's) hand engaging in ridiculous and uncomfortable positions using forgotten muscles in the body. Switch sides and partners after a couple of minutes. (p. 51)
Modelling Sequence	Played in pairs. One participant will start as the sculptor, the other as clay. The sculptor can sculpt by touching the "clay" using their hands to move their partner into place or by mirroring and showing them the position they should take. There is no dialogue during the sculpting. After the sculptors have sculpted, they can walk around and look at others sculptors' images. There should be a range of

	responses to the sculpted images. The sculptors then bring their statues together, so they form a single, multi-person sculpture which the sculptors give meaning to. Participants then switch roles. (p. 136)
The clapping series	Players are sitting in a circle and one person (A) sends a single clap towards the person on their right (B), who claps with (A) at the same. (B) then turns to (C) and claps with them and so on. Once the group is in tune, increase the clapping speed. Then the clap can be sent anywhere in the group and everyone has to watch to know where the claps are directed. (p. 97)
One person we fear, one person is our protector	All players are scattered around the room. Saying nothing, each person chooses one person in the room whom they fear and one person who is their protector. Players then move about the room trying to keep their protector between them and the person they fear. (p. 141)
Pushing against each other	Described in the text below. (p. 58)

Pushing against each other

"Pushing against each other" is an important exercise because it is a physical manifestation of a spect-actor intervention during forum theatre (Boal, 2002). In pushing against each other, two partners face each other. With their hands on their partner's shoulders, participants push against each other. If a person increases their efforts, the partner attempts to

respond in kind. Boal's (2002) version involves participants pushing with all their strength, attempting to cross an imaginary line on the ground. However, given the varying ages and physical abilities in this workshop, the exercise was modified so participants pushed equally against each other and respected their partner. The exercise was played several times with variations such as back-to-back or bottom-to-bottom. Participants also had opportunities to practice the exercise with different partners. The exercises and games were always foregrounded by an ethic of care and respect for each other. Participants were aware that some members of the group had physical limitations. For example, one participant used a walker but was able to stand for periods of time. Participants were repeatedly advised by the theatre facilitator to care and respect for their bodies and their partner's as well.

This exercise served as an overt and graphic way to physically illustrate the power relationships inherent in nursing education and health care, in particular as it relates to marginalized and vulnerable people and nurses. For example, participants recognized how much more powerful they were than some of their partners and modified their actions in kind. Some participants described the exercise as metaphor for pushing against a wall or a system, such as education and health care that upholds models of hegemony, oppression and discrimination. Through this exercise, one participant, a White nursing educator, expressed that her struggle in the game mirrored her struggle within the classroom especially when teaching on racism, oppression or privilege:

> my struggle within the classroom is always having to protect my students and also call out students on certain things, like you know, when it comes to having difficult conversations about race or privilege. And this is a bit of a weird struggle, having to call people out without shaming them, having to create safety for all. Especially in nursing,

they're large classes and it's very diverse. I could feel that struggle (in the exercise), like

that balancing piece. And any movement we make forward is probably pretty minute and

it's going to have a lot of pushback.

Image Theatre

After the participants had cycled through a series of theatrical games and exercises and

been introduced to the basics of movement and acting through these activities, the theatre

facilitator then guided the participants in constructing images and symbols relating to racism in

health care and nursing. Through several rounds of image theatre, at first using only their bodies

and then using the bodies of others to create their tableau, participants presented their images to

the larger group. After presenting each image, the participants selected one image that resonated

with them the most as a collective: the image of a person sitting and another person standing

with her back to the person sitting. In order to co-create this image of racism in health care,

participants were then invited to step into the image and create a pose surrounding the initial

image. The final tableau of the image is seen in the photograph below (Image 5). Through the

use of "I want" sentences, participants were asked to vocalize their internal monologue and

identify what their character was thinking or feeling or their struggle at the moment. Various "I

want" sentences emerged from the participants:

I want to reach out

I want tolerance

I want everyone to be seen the same way

I want to learn

I want power

I want to be brave

I want to be understood

I want to be heard

Image 5: Image Theatre

Participants then debriefed in a circle and reflected on what the image represented for them. "What's going on in this image?" the theatre facilitator asked. Participants then began a process of storytelling, and developing characters and motivations. Most of the interpretations given by the participants related to power, exclusion, discrimination and racism. All participants agreed that the characters standing had power and privilege. One of the participants explained how she interpreted the image: "I definitely felt it was an Indigenous person behind me. I thought that we (standing characters) were White and able-bodied and have lots of privilege. And that's why my internal monologue was more like I don't see colour. Everyone is equal. Like what's their problem?" One of the sitting participants expressed that "I was very aware of the blondes standing, and of course, us sitting, and then it hit me, we are two different tribes, different peoples". Another participant expressed that she sensed the division between those standing and those sitting and wanted to reach out but did not know how: "I tilted my head to

show I was trying to reach out. But there's a structural barrier between us and I felt there were alliances and anger".

By exploring racism and oppression in health care and nursing through group images, participants experienced exclusion and marginalization viscerally and sensorially. One participant stated: "I felt alone…and 'Laura' came and gave me a hug afterwards because I really did feel excluded, left out, marginalized…I felt all of it". The image theatre process allowed for a reflexive look inward, an unearthing of attitudes, biases and behaviours that may promote or sustain racist and discriminatory practices in nursing and health care. It also allowed for communication without the constraints of the verbal language and without interruption. Resembling the sharing circle, image theatre engages participants democratically: every person is "heard" and has the opportunity to contribute.

Furthermore, through observing an image and then listening to the multiple interpretations of that image, an opening is generated. There is possibility to see the world differently, to get a glimpse into the world of others and to realize our own complicity and agency in the world. Seeing images through this process facilitates critical consciousness thus aligning with Freire's (2000) notion of conscientization.

Forum Theatre – The Curtain Rises

Two forum theatre vignettes were created through a process of collaborative storytelling and analysis. While participants were encouraged to begin by sharing stories and discussing possible ideas for their vignettes, both groups initially got "stuck" in verbal dialogue without a strong narrative for their vignettes. While storytelling and sharing are important, it also demonstrated the strong reliance participants had on verbal communication and the difficulties participants had in transitioning to non-verbal dialogue. To re-engage the body and the senses,

participants were encouraged to return to physical image making in silence to move the process along. Through imaginary play, image making and drawing on the collection of stories shared, participants focused more meaningfully on narratives that rendered visible a multitude of perspectives: the dominant, the defeated, the impervious as well as other perspectives. At first, the participants were wary about creating and playing characters who acted in racist ways or held racist beliefs. White participants in particular felt very uncomfortable saying or acting in racist ways while in character. The theatre facilitator reminded the participants that to play a character who might behave in a racist way is actually a form of generosity:

> Those problems (racism and discrimination) do exist and if you can portray it in an accurate and authentic way and make us (the spect-actors) feel all the things that we feel when someone is behaving in a racist way, then we have to do something about it and it allows it to come to life. Also, maybe not always, but in most cases, people who are being racist are probably doing it from a legitimate place. If you touched them on the shoulder and asked them an "I want" sentence, there's probably something they want. And it's probably not to be mean to anyone but it might be coming from a legitimate place of fear, of unknown, however hurtful and oppressive and however much we disagree with their actions.

It was important for White educators to see themselves in the role of the oppressor, and not see themselves as neutral, as bystanders or as saviours. While these positions may be more comfortable for the White educators, they only serve to maintain and perpetuate the status quo, and systems of racism and oppression. Indigenous participants on the other hand were particularly adept at vocalizing numerous racial insults, micro aggressions and stereotypes about Indigenous people emerging from their own lived experiences. One Indigenous participant called

it a "delicious irony" to play a White educator who demonstrates racist behaviours and attitudes. Indeed, despite the seriousness of the subject we were broaching, the workshop included numerous moments of humour, laughter, and irreverence. As Copage (2019) argues, Indigenous people use humour:

> As a tool for (re-) education, to reclaim our histories, teachings, and ultimately identities as Indigenous people. Humour provides a revolutionary platform to have difficult but necessary conversations reaching towards achieving any kind of genuine reconciliation. Humour brings us closer to one another through the shared experience of laughing (p. 187).

In the crafting of the forum theatre vignettes, the two groups of participants were primarily focused on various aspects of racism in health care and nursing education. We present and briefly deconstruct one of the vignettes and demonstrate how the vignette helped facilitate a dialogue on racism and support the conscientization and praxis of the participants.

Vignette Script:

The scene begins with two nursing students, one Indigenous (Shavon,) and the other White (Madison), sitting in a room waiting for their clinical instructor (Jody) to start their first clinical rotation on a maternity ward.

Madison:	So, good morning.
Shavon:	Good morning.
Madison:	Hi, actually, I've seen you in class before, but we've never actually met. I'm Madison.
Shavon:	Shavon.
Madison:	Shavon, nice to meet you Shavon.
Shavon:	Thank you.
Madison:	So, Shavon, where are you from?

Shavon:	Oh, I'm from up north.
Madison:	Oh my God, we're both rural! I'm from Niverville *(a town 30 minutes from the city with a predominately White, middle-class population)*.
Madison:	So, hey Shavon, I haven't seen you at some of our Nursing Student Association events. I'm on the executive, so I just wanted to let you know that every Friday at 4:00 we meet at the Hub to eat and drink. And, so, just wanted to put that out there in case you wanted to join us sometime.
Shavon:	Oh, no, I wouldn't have time. I have to rush home after.
Madison:	Oh, do you live in the dorms?
Shavon:	No, no, I live with my auntie. We have an apartment.
Madison:	Oh. Oh, okay. Okay. Well, do you think you could join us sometime?
Shavon:	No, no, I have to rush home.
Madison:	Oh, why do you have to get home so fast?
Shavon:	Oh, I have to get home for my aunt. My aunt takes care of…*(pauses and reluctantly continues)*. I have a son, he's about a year old.
Madison:	Oh, my God, well how old are you?
Shavon:	I'm 22.
Madison:	Really, I'm 22 too. I can't even imagine being a parent. How are you doing with that?
Shavon:	I'm okay.
Madison:	You're okay? Well, that's good. *(Madison is struggling to keep the conversation going).* Um, so, I'm trying to keep up with my stream on Instagram and Snapchat and Facebook and all that, and so, I was wondering if you wouldn't mind if we could do a selfie together and I could post that on the Facebook page so that everybody sees that we're starting our labour and delivery rotation. Is that okay?
Shavon:	*(Shavon is clearly uncomfortable but agrees)* Mmm…yeah.
Madison:	Okay, all right so, let's say, 1, 2, 3, labour and delivery rocks! Okay, here we go.
Shavon:	(Shavon mumbles). Labour and delivery rocks.

Jody, the clinical instructor enters the room.

Jody:	Hi there, I'm Jody, I'm your clinical instructor for this rotation. *(Looking at Madison).* What's your name?
Madison:	I'm Madison.
Jody:	Okay Madison, nice to meet you. *(Turns to Shavon).* And you must be Shavon. So, I'm very excited about this rotation, I love labor and delivery and I love the St. Mary's General Hospital. This is a really great hospital. You're going to learn things here that you just would not learn at any of the other hospitals. So, hopefully this will be a really great term for all of us.
Jody:	So, before we go to the unit, I thought we'd spend a little bit of time talking about the process for families when they come to the hospital. So, the first place that families go when they come to the hospital is to triage and that's where they're assessed and we figure out from there where they need to go. A really important thing about triage is the birth alert binder. All right, so you're going to want to have a look at the birth alert binder. This is where we keep all of the notes and referrals for child and family services about which babies are going to be apprehended, and which ones require further assessment after delivery. So, with certain families, you want to make sure that you're looking at the birth alert binder. And this is St. Mary's so we get a lot of birth alerts.
	(Shavon raises her hand to ask a question).
Jody:	Yes, Shavon.
Shavon:	Do you have to look at the binder for all of the families?
Jody:	Well, I guess technically you should look at the binder for all the families, but you'll start to figure out pretty quickly which families you really need to look at the binder for. St. Mary's is right next to Point McKay and is also the high-risk referral center for the North. And those population groups have a high number of apprehensions and child welfare system involvement. So, you'll start to get an idea of which families you really need to look at. I think you know what I mean (*Jody looks at Shavon knowingly).*
Madison:	*(whispering to Shavon)* What do you think she means by that?
Shavon:	*(speaking quietly)* I'll talk to you later.

Jody: So, I had a chance to go to the unit and I picked out patients for both of you. There is an indigenous family on the unit, so we're all really happy you're here Shavon because you'll be able to take care of them.

Madison: Jody, am I going to be assigned an aboriginal family as well?

Jody: Eventually, but not today. There's like a lot of cultural, traditional things involved, that you probably won't know enough about, and Shavon will know all about that. You know, they want to take the placenta home, things like that.

Madison: What, wait a minute, is that legal? Can you take the placenta home?

Jody: Yeah, it is legal. Don't even get me started about that *(Jody rolls her eyes)*. There's a whole policy.

Madison: Oh my gosh, that sounds like a biohazard. *(Turning to Shavon)* Hey, Shavon, when you had a baby, did you take the placenta home?

Shavon: Um…I'll talk to you later.

Madison: Okay.

Jody: Okay, so I just need to talk to your charge nurse about one more thing and then I'll come back and grab you both and we'll head in there. *(Jody leaves the room)*.

Madison: Awesome, I'm so excited. I'm so excited to see the babies. So, Shavon, I've never actually had the opportunity to talk to someone who is indigenous before. And so, I'm wondering if you could answer some questions for me? And, so, my first question is about residential schools[4], and I'm just wondering like, from your perspective, was it really as bad as they said it was? Because I've heard that people who went to residential schools got an amazing education.

Shavon: *(Shavon appears very uncomfortable and stammers)*. Well, um, well, um, I'll talk to you later about this. *(Turning to the audience)*. Can you believe this?

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[4] "The term *residential schools* refers to an extensive school system set up by the Canadian government and administered by churches that had the nominal objective of educating Aboriginal children but also the more damaging and equally explicit objectives of indoctrinating them into Euro-Canadian and Christian ways of living and assimilating them into mainstream Canadian society. The residential school system operated from the 1880s into the closing decades of the 20th century. The system forcibly separated children from their families for extended periods of time and forbade them to acknowledge their Aboriginal heritage and culture or to speak their own languages. Children were severely punished if these, among other, strict rules were broken."(Indigenousfoundations.arts.ubc.ca, n.d, The Residential School System, para 2).

Through the forum theatre vignette, participants were able to succinctly craft a scene that demonstrated racism on several levels including epistemological, individual and structural. The audience is keenly aware of the derision the clinical educator is demonstrating towards Indigenous knowledge and Indigenous protocol. The audience is able to see the individual racism that Shavon experiences through her exchanges with Jody and Madison. Furthermore, the vignette makes visible the overlapping matrix of racism, power and inequity that renders Shavon vulnerable and oppressed.

Aligning itself with Indigenous methodologies, forum theatre adjusts to and reflects the local context and experience. We use the example of the birth alert in our vignette to demonstrate this adaptation. While the birth alert binder is not employed universally across Canada, it is a critical issue in several provinces, disproportionally affecting Indigenous women and children (Ridgen, 2020). Children are often apprehended due to maternal poverty, homelessness or domestic violence. In this vignette, participants were able to demonstrate how Indigenous expectant women continue to be colonized, oppressed and discriminated against by approaches to their social and medical care. The vignette also highlighted that rather than supporting Indigenous women in these precarious circumstances, nurses are actually complicit in these colonial practices.

By broaching a structural issue such as the birth alert in the vignette, it allowed participants in the workshop and in the audience to understand, and critique these processes. For instance, despite all workshop participants having an educational background in health or social services, only the participants who had worked in labour and delivery were aware of the birth alert practice, the remainder expressed shock that this system existed. When the vignette was performed to an audience of nursing students and educators, none of the nursing students had

been taught about birth alerts during their nursing education. Exposing a powerful critique of the system and of nurses' roles in that system, an audience member, a nursing educator and administrator, replaced the character of Jody (the clinical instructor) on stage during an intervention decoding what the birth alert binder thinly conceals:

> We point our fingers at people who are poor, people who don't speak English, who don't understand health care systems. We point our fingers at people who have less power and privilege so it's not an equal playing field…We target people… This is the racist binder and 90% of people in it will be Indigenous.

By acknowledging her professional complicity and personal responsibility, the intervention supported this educator's conscientization and praxis. But beyond this, the goals of anti-racist education were also met. As Dei (1996) maintains, anti-racism education must address not only racism but interlocking systems of oppression. It must explicitly name issues of race and social differences as issues of power and equity, rather than as matters of cultural and ethnic variety (p. 252).

Strengths and challenges of the framework

This framework has numerous strengths. By building a transdisciplinary workshop team, varied and nuanced perspectives were considered. The inclusion of Indigenous, nursing and artistic knowledge demonstrated the ability of the methodology to support epistemological and ontological pluralism. Furthermore, throughout the project, there was an ethic of equity, diversity and inclusiveness. Whether through sharing circles, image or forum theatre, we attempted to ensure that all participants had the opportunity to express their views, articulate a perspective and identify their real and imagined worlds. However, there were also moments of tension during the workshop and the unintended silencing of voices. Participants in one group expressed that the

dialogue they crafted was reduced by the theatre facilitator as he felt this dialogue did not contribute meaningfully to the narrative. Given that the PI and the Indigenous nurse-Elder were working with the other group during this exchange, they were unaware of this issue until it was brought to their attention later. For one participant in particular, the act of reducing her dialogue contributed to a feeling of being silenced, an experience that resonated with her as an Indigenous person. However, the participant was able to express this sentiment during our final sharing circle, allowing her voice to be heard and providing an opportunity for reflection, acknowledgment and growth for the theatre facilitator and the rest of the workshop team as well. Accordingly, we must continue to engage in our own personal reflection as TO practitioners and on our own power within the group. We must ensure that our voices, aesthetic and directorial choices do not supplant the voices of those we most wish to hear. In failing to reflect on our own positionality, we run the risk of reifying a culture of silence and oppression. However, the silver lining was that through the sharing circles, we were able to have this issue come to light and the pain of the experience be shared. Had we not employed our hybrid framework, this issue may have simply remained as a painful solitary experience. Thus, while unintended, this incident validated the importance of both the TO and Indigenous methods employed in this project.

Some might view the methods in this workshop as an opportunity for self-healing or some form of therapy for those who have experienced racism, discrimination or oppression. We are deliberate in identifying that the goals of this workshop were not to alleviate the pain and trauma of racism or colonization. While some participants did indeed express a sentiment of healing through the workshop, this was corollary to the research. Rather, the goal of this workshop was to facilitate a dialogue on race and racism and demonstrate the possibility of integrating Indigenous as well as artistic knowledge in nursing education. Through this project,

we sought to implore others, those with privilege, power and authority (including nurses, nurse educators and administrators) to reflect on their own practices, and the systems within which they work and live.

The curtain closes

As Fine (2018) argues, "universities have an obligation to interrupt the social anesthesia; to provoke a wide-awakeness…to awaken a sense of injustice…to do the work of subversion, contestation, and cultivation" (p. 117). We argue that faculties of nursing and health have to work in service of those obligations as well. In this article, we presented an anti-racist framework that is infused with Indigenous, artistic and participatory sensibilities that enabled critical dialogue, collective analysis, contemplation, consent and dissent. Using findings from the study, we illustrated how this framework has the potential to raise consciousness regarding racism and provide nurses, nurse educators and allied health professionals with ways to reimagine race and confront racism within their own practices. This framework may provide inspiration for educational administrators and leaders of health care professionals as they consider anti-racism education as a crucial curricular inclusion. The focus of the workshop was to create a space, however liminal, through which our participants might see the world differently and realize an alternative to hegemonic nursing and health care practices. MacNeill (2018) refers to these spaces as fissures, and are akin to the margins that hooks (2009) identified as a space of radical openness. And so, we leave you with hooks' vision. We hope you join us in this liminal space:

> This is an intervention. A message from that space in the margin that is site of creativity and power, that inclusive space where we recover ourselves, where we move in solidarity to erase the category colonized/colonizer. Marginality as site of resistance. Enter that space. Let us meet there. Enter that space. We greet you as liberators (p. 85).

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CHAPTER 7: PAPER 4

Theatre of the Oppressed and Forum Theatre: An Arts-based Approach to Fostering Reflection, Relationships and Vulnerability in Nursing Education

The content in this manuscript addresses research objective #3 of this study and describes health care providers' and nursing students' responses to Theatre of Oppressed and forum theatre as pedagogies in nursing education. The findings in this manuscript underscore that Theatre of the Oppressed may promote self-reflection, vulnerability and enhance relationships, thus connecting nurses to their professional values and ethics. For students, forum theatre and Theatre of the Oppressed may be beneficial for emphasizing content and enhancing current teaching strategies used in nursing.

Abstract

Background: Nurse educators must find ways to educate nurses that are able to challenge and contest oppression and reflect on their own practices, biases and attitudes. Arts-based pedagogies and in particular Theatre of the Oppressed which includes forum theatre, may offer opportunities for critical reflection, action and transformation.

Objectives: The aim of this study was to explore health care providers' (including nurses, nurse educators and allied health professionals) and nursing students' response towards Theatre of the Oppressed and forum theatre as pedagogical initiatives.

Design: This arts-based participatory study was conducted at a university in Canada. Two groups participated: one that included health care providers (n=8) and the second that included an audience of nursing educators and students (n=7). The data were drawn from sharing circles and group discussions and were analyzed using thematic analysis.

Results: The themes that emerged from health care providers' responses revealed that Theatre of the Oppressed represents an opportunity for reflection and growth; strengthening relationships; and expressing vulnerability. Given that students only participated as audience members, their ability to describe how forum theatre might be useful was limited to the theme of "practical applications".

Conclusion: The study demonstrates that health care providers and nursing students are receptive to Theatre of the Oppressed and forum theatre as pedagogical approaches. In particular, Theatre of the Oppressed supports professional nursing formation and practice through critical reflection, fostering relationships and expressing vulnerability.

Background

This pedagogical initiative is located within the context of an increasing Indigenous population in Canada (Statistics Canada, 2017), and an understanding that Indigenous peoples bear the burden of the worst health outcomes in Canada (Frohlich et al., 2016). Indigenous peoples in Canada (including First Nations, Métis and Inuit peoples) have a lower life expectancy, higher morbidity than non-Indigenous Canadians (Allan & Smylie, 2015). These disparities in Indigenous and non-Indigenous health outcomes are noted around the globe. Indigenous peoples worldwide suffer from poorer health and gaps in life expectancies up to 20 years lower than non-Indigenous people (United Nations, n.d). A growing body of literature demonstrates that negative attitudes, including stigma, stereotypes and discrimination by health care providers (HCP) towards Indigenous peoples are linked as contributing factors in poor health care delivery, substandard quality of care and barriers to access (Allan & Smylie, 2015; Browne, 2017; Browne et al., 2016; Nelson & Wilson, 2018).

Given the core values of human dignity, social justice and advocacy to the profession of nursing, nurses have an ethical and moral mandate to challenge and contest oppression and reflect on their own practices, biases and attitudes (Canadian Nurses Association, 2017; International Council of Nurses, 2012; New Zealand Nurses Organization, 2019). To fulfill the above aims, nursing educators are tasked with helping students understand and translate difficult concepts such as oppression, racism, privilege, power and discrimination to their professional practice. However, traditional teaching practices in the nursing classroom have focused on didactic approaches to learning, wherein students passively absorb information (McClimens & Scott, 2006). Freire (2000) referred to this traditional approach to teaching as the banking model

of education wherein students are simply vessels to be filled with knowledge by an omniscient instructor, thus undermining a learner's capability to critically think and reflect.

While pedagogical content shapes students, nursing education has generally downplayed the significance of pedagogical practices in influencing and socializing students. However, attention to pedagogical practices is vitally important as they can also perpetuate and reproduce inequalities. Pedagogies can be "…thinner (educating and training for a job) or thicker (for wider flourishing)…thinned out pedagogical spaces are reproductive of inequalities of power and opportunities" (Walker & Wilson-Strydom, 2017, p. 12). There is an urgency to advancing "thicker" pedagogical practices. Thicker pedagogical practices can address inequalities through dialogic listening, fostering respect and responsibility and create spaces for creativity, hope and human flourishing (San Pedro & Kinloch, 2017). However, all participants in the learning environment, including the educator must participate in this process of growth and learning (hooks, 1994).

Arts-based pedagogies can potentially "excavate the recurrent patterns of inequity and oppression as well as the acts of transformation and activism" (Villaverde, 2008, p. 123) as well as help learners explore their professional identities, develop deeper understandings of a multitude of issues and nurture a spirit of inquiry (Carroll, 2018). Theatre of the Oppressed (TO) is particularly noted for its dialogical, critical and transformative potential (Boal, 2000; Duffy & Powers, 2018; Garcia, 2019). TO is a type of participatory and community-based education that uses theatre as a method to develop critical consciousness and as an instrument for social change. Boal (2000) invented TO, which includes a repertoire of theatrical games and exercises (i.e. Image Theatre, Rainbow of Desire, Forum Theatre, etc.), as a search for dialogical forms of theatre through which a possibility for dialogue about and on social activity, pedagogy,

psychotherapy and politics occurs. Though all of TO's techniques have found expression around the world, forum theatre (FT) in particular has become popularized as a pedagogical strategy and as a research method.

In FT, a group of people drawing on their own personal experiences and problems from within their community, devise a scene where power is exerted over an oppressed individual (Garcia et al., 2019). The scene or play is then shown once to an audience, without interruptions. The second time the play is shown, audience members, referred to as "spect-actors", are encouraged to stop the action, replace a character on stage and attempt to overcome the oppression and rediscover their own power in the situation (Boal, 2002). By inviting the audience into the scene, they can attempt to create new narratives that are emancipatory and transformative (Premaratna, 2020). Boal (2002) describes FT as pedagogical in the sense that "we all learn together, actors and audience" (p. 242), and as a radical opportunity for social change.

In various post-secondary classrooms, FT has been used to cultivate agency and challenge oppressive scripts (Duffy & Powers, 2018; Garcia et al., 2019; Thomson & Wood, 2001). FT also inspires dialogue, encourages people to explore choices and help citizens practice community development within a safe space (Mitchell & Freitag, 2011). Within nursing education, FT has been used to promote interdisciplinary teamwork (Lundén et al., 2017); address horizontal violence (Fehr & Seibel, 2016); encourage reflective practice and professional identity formation (Arveklev et al., 2015); improve person-centred care (Dingwall et al., 2017) and communication skills (Middlewick et al., 2012). Despite this growing body of literature on FT in nursing education, scant research has explored the response and receptivity to FT as an educational strategy in nursing.

Aim

The findings presented in this article are part of a larger study that was designed to: facilitate a dialogue with HCPs and nursing students about Indigenous perspectives and racism and oppression in health care and nursing education through TO; find solutions for addressing Indigenous perspectives and redressing racism and discrimination in nursing education; and explore the response and experience of HCPs and nursing students to TO and FT as nursing pedagogies. However, the aim of this article is to present the findings related to the last objective above.

Methodology

Study design and approach

This study was designed using a participatory arts-based methodology. Savin-Baden & Wimpenny (2014) describe arts-based research (ABR) as "research that used the arts, in the broadest sense, to explore, understand, represent and even challenge human action and experience (p. 1). ABR practices are grounded in more holistic conceptions of knowing that engage the body, mind, and spirit in shared creations (Barnt, 2004).

Participants and ethical considerations

Ethics approval was gained through the university's research ethics board. The participants for this study included health care providers (HCPs) (nurses, nurse educators and allied health professionals) and nursing students. Five of the HCPs identified as Indigenous, while three of the HCPs identified as White. Six of the HCPs were nurses (four of whom were nurse educators) and two were allied health professionals. The participants recruited for the audience included two nursing educators and five students (n=7). Participants were recruited via snowball and purposive sampling and informed consent was obtained from all.

Data collection and analysis

The pedagogical initiative took place on the campus of a Canadian university in May 2019. Sharing circles and dialogue during the workshop were used to collect data from the HCPs. A post-play discussion was employed to elicit responses from the audience. Participants were asked to describe their experiences about engaging in forum theatre as a pedagogical approach. However, no other main questions were asked. During the sharing circles, all HCPs had an opportunity to reflect and provide responses without interruption or time limitations. HCPs reflections during the workshop activities were unprovoked and spontaneous. During the post-play discussion, all students volunteered feedback, and follow-up questions were asked only to deepen understanding and reflection. Data obtained from the sharing circles, workshop dialogue and the post-play discussion were professionally transcribed verbatim. Data were analyzed using thematic analysis (Attride-Stirling, 2001) to identify the main themes. The data were analyzed by the first author (VVB). To enhance trustworthiness, the analysis was reviewed by the second author (RW).

Pedagogical Initiative

The pedagogical initiative included two distinct components: 1) a two-day TO workshop; 2) a FT performance. HCPs participated in the TO workshop and then presented the FT vignettes they created to the audience of nursing educators and students. The workshop included components of TO including theatrical games, image theatre and FT to facilitate dialogue and reflect on oppression in health care and nursing education. Through the workshop, HCPs demonstrated their worldviews, explored their experiences of health care and nursing education and created characters and scenarios reflective of these experiences. This process was particularly useful for illuminating Indigenous HCPs tensions and experiences. The workshop

was led by a trained TO facilitator, along with VVB and an Indigenous nurse-Elder. However, the HCPs made decisions about the content of their vignettes, while the theatre facilitator, VVB and the Indigenous nurse-Elder gave feedback creating an added layer of dialogue, reflection and analysis. The workshop culminated on the afternoon of the second day with a forum performance of the vignettes to the audience. Both vignettes reflected scenarios with epistemological, interpersonal and systemic racism. After watching the play once without interruptions, audience members were then encouraged to replace any character on stage and attempt to resolve the conflict and oppression in the scene and bring the play to a different ending.

Findings

Health care providers

Three key themes emerged from health care providers regarding their experiences of the Theatre of the Oppressed workshop as a pedagogical approach including: 1) reflection and growth; 2) strengthening relationships; 3) expressing vulnerability.

Reflection and growth.

In this theme, several statements made by HCPs highlighted that the pedagogical initiative allowed for reflection and growth. All HCPs responded positively to the pedagogical initiative. Through the TO activities, participants engaged in inter-and intragroup dialogue which promoted awareness and understanding of Indigenous perspectives and experiences of racism in health care and nursing education as well as supported personal and professional reflection and growth. Participants evocatively described their experiences of the initiative as a "journey", an opportunity for "outside the box" thinking, and expressed that the embodied and emotional style of communication led to personal and professional growth which countered the more usual intellectual and cerebral approaches to learning. For example, HCPs responded:

- *I loved the whole journey because I was learning new knowledge that I could contribute to this institution…This has been really eye-opening.*

- *These exercises…I thought would be cerebral and passive. So opposite…They got me feeling so much and these stories will stay with me…I have to process this long after the workshop.*

- *Thank you for all the stories you shared…there's so much to reflect upon. I'm actually looking forward to growing professionally but more importantly personally from this.*

Strengthening relationships.

The pedagogical initiative fostered and strengthened the relationships between HCPs. HCPs expressed feeling more connected to each other. There were numerous moments of laughter, humour and fun during the pedagogical initiative which helped facilitate the connection between group members leading to higher group trust and cohesion. HCPs worked in various roles and some had different disciplinary backgrounds, but the initiative fostered a deep connection through the sharing of personal stories and experiences. For example, two had previously worked in hospital together, one as a ward nurse and the other as a hospital supervisor. During the workshop, the ward nurse expressed that she had been apprehensive of the hospital supervisor, acknowledging a tension and hierarchy that often exists between ward nurses and hospital supervisors. Through the workshop, there was an opportunity for participants to engage with each other differently and more equitably leading to a mutual feeling of support and understanding. Examples of HCP statements supporting this theme are found below.

- *You get to know people so well. I think there's such value in that and how it can be brought into a curriculum. So we can talk about how we create these spaces that*

celebrate diversity, that have diversity. I think it all starts with relationships. I feel so

connected to all of you because of this.

- *This is community building…I could feel us coming together and it's just incredible. Everyone had different backgrounds but we came together for this common good.*

- *It's nice to have these opportunities where we have a different way of connecting. I'm grateful for meeting all of you and for the gift of your stories.*

Expressing vulnerability.

Most HCPs admitted that the initiative required significant vulnerability. HCPs acknowledged an element of vulnerability inherent in sharing very personal and sometimes difficult stories, as well as engaging in uncertain theatrical activities. Some participants expressed that this vulnerability was also linked to feelings of authenticity and the notion of the "gift" they received in hearing other people's stories and sharing in their vulnerability. However, vulnerability was only made possible through the safety the HCPs felt in the workshop space and amongst each other. While vulnerability was viewed positively by most HCPs, it also led to feelings of exhaustion. Examples of HCPs' responses in support of this theme are reflected below.

- *So I'm exhausted…I learned new things, I've made new friends and new relationships. It was a place of trust and respect. It wasn't sure what roads we were going to walk down so for me to walk down that road again and relay the experience that happened to me like 10 years ago, that was good. We need to talk about these things. This is a safe place to talk.*

- *I'm also exhausted…but grateful for the gift of the day. I'm grateful for the gift of your stories and being vulnerable…it's great to spend such an intimate day exploring something that's so close to my heart, that we need to address.*

- *You have to be vulnerable, you have to bring yourself in. This is a different way of examining your experience and your knowledge. I think it's really a gift that you gave us all to have this time together. It's never going to be the same, right? What's so cool about this kind of experience it that it all depends on who's here and what they're bringing in.*

Student responses

Practical applications.

The key theme emerging from student responses was that FT has practical applications. For students who participated solely as audience members (spect-actors) in the play, their responses to FT as a pedagogical approach reflected more applied applications rather than more transformative experiences. Students responded that it would be a valuable way to learn, in particular in simulation training, or for teaching content such as diversity and multiculturalism in theoretical courses. However, one student expressed reluctance to taking the stage during FT given their novice status as a nursing student. This student also expressed that FT would be more useful if students participated in creating the vignettes with their classmates. Examples of participant responses supporting this theme are reflected below.

- *In simulation we do a lot of acting. In class, it's more of a learning thing, I think if we did this in class it might show different options and work through scenarios. It might be beneficial. As opposed to right now all we do is just simulate actual health care in a health care setting, we don't actually do this kind of Indigenous health care interaction.*

- *I think it would be good in simulation too. Right now we just do simulation with a mannequin.*

- *I feel like this would not just be for simulations…this could be done in the Human Diversity class…it would drive a lot of points home…I feel like something interactive would have really helped that class. I definitely think this is something that would work there.*

- *I could see it as a really valuable way for faculty to learn.*

Discussion

While arts-based pedagogical initiatives using TO and FT are slowly gaining ground in nursing, there is a dearth of studies that have explored the responses of nurses, educators and students to these initiatives and how these pedagogies might support nursing practice. The findings of this study revealed that the use of TO allowed opportunities for reflection and growth, to strengthen relationships and to express vulnerability amongst HCPs. While the FT initiative was well received by students, their reflection on FT as a pedagogy was linked to more practical applications.

Reflective practice is recognized as a critical component of professional nursing practice. The Canadian Nurses Association (2004) identifies that nurses must demonstrate a "commitment to continuing competence through lifelong learning, reflective practice and integrating learning into nursing practice" (p. 1). Past research has noted that critical reflection allows nurses to explore personal biases and leads to transformed understandings and practices (Miraglia & Asselin, 2015). Freire (2000) advanced the notion of praxis which stresses action linked to deeper understanding and reflection. By connecting movement, dialogue, observation, reflection and action, HCPs had a deeper understanding of various situations and scenarios, and an

opportunity to reflect on their own actions and the actions of others. Through this deep engagement and reflection, personal and professional growth was realized.

There are numerous benefits to well-functioning professional relationships. High quality professional relationships in the nursing milieu results in higher job commitment and lower level of job stress (Michaloupoulos & Michaloupoulos, 2006; Tran et al, 2018). Contrastingly, poor professional relationships, including lack of collaboration and communication between HCPs has a negative impact on care delivery as well as patient outcomes (Martin et al., 2010). This pedagogical initiative strengthened the relationships between HCPs, fostered a sense of belonging and facilitated collaboration. The opportunity to share stories, work conjointly in crafting vignettes, and perform together allowed HCPs to understand other perspectives, compromise and confront a novel experience together. Taken together, these activities helped foster supportive and trusting relationships based on mutuality and respect. Given that learning is enhanced in supportive and trusting relationships (Raider-Roth, 2005), the importance of TO as a method to foster and strengthen relationships is valuable for educators in all disciplines as well as for nurses in the clinical setting.

Vulnerability is often viewed as a weakness in nursing, or used to describe marginalized patients and populations (Nichiata et al., 2008; Parrish, 2008). Little has been written about the importance of vulnerability as a nursing practice in the classroom or in the health care milieu. However, leadership in the classroom and in health care requires vulnerability (Hewson, 2007; Younie, 2016). In the context of teacher education, Hewson (2007) advances that "spontaneous leadership in the classroom setting requires openness and vulnerability on the part of the teacher" (p.12). From a medical educator perspective, Younie (2016) maintains that through engaging with their own vulnerability, HCPs are demonstrating strength and courage, liberating others to

do the same. By engaging with one's vulnerability there is also the possibility to "draw closer to those forced into vulnerable situations through situations beyond their control" (p. 37).

However, theatre practitioners have long known that the "theatre is a safe place to do unsafe things that need to be done" (Shanley, 1991, p.5). By engaging with TO and FT, HCPs and nursing students have an opportunity to practice vulnerability in a safe space. Through the pedagogical initiative, HCPs shared their own stories, participated in uncertain theatrical activities, and performed in front of an audience. By engaging in these activities, HCPs demonstrated courage and a willingness to engage in vulnerability with each other and with the audience. Given that vulnerability may indeed be considered a curricular need in education (Clement, 2014) as well as for leadership in health care (Younie, 2016), the opportunity afforded to HCPs through the pedagogical initiative may be revelatory.

One of the questions we must ask ourselves is related to power relationships while using FT with HCPs and nursing students. In particular, we have to consider whether nursing students could engage equitably in FT with nursing educators present. While nursing students were able to identify applied benefits related to using FT as a pedagogical strategy in nursing education, their responses to the initiative did not reveal more transformative benefits. One of the reasons is likely related to the more limited engagement and time nursing students were involved in the pedagogical initiative. Given that HCPs engaged in a two-day TO workshop, they had opportunities to sequence through various strategies and activities that enhanced trust, fostered relationships and vulnerability. The nursing students on the other hand, only participated as spect-actors on the afternoon of the second day and did not have an opportunity to engage with the initiative in the same capacity. However, since one of the nursing students expressed feeling uncomfortable participating as a spect-actor due to her status as a student, we must consider how

to use TO and FT so equity can be achieved between all participants. One suggestion made by nursing students was to have opportunities to engage in the TO workshop activities along with their own peers and to devise their own scenarios. This would enable greater participation from nursing students, and if shown to an audience of other nursing students, might allow for greater participation from the spect-actors. Future research should focus on engaging nursing students in TO to determine if the pedagogy does indeed foster greater reflection, relationships and vulnerability as it did for HCPs.

Conclusion

The findings of this study highlight that TO and FT may be beneficial as pedagogical strategies to enhance reflection and growth, strengthen relationships and as a conduit for expressing vulnerability amongst HCPs. Nurses are expected to engage in reflective practice and foster supportive relationships as outlined in their code of ethics. Thus, TO and FT might support professional development and uphold the values and ethics that the profession holds dear. Through the sharing of stories along with the dialogue, collaboration, compromise and action inherent in TO and FT, HCPs were able to able to gain a deeper understanding of Indigenous perspectives and racism. While student nurses identified more applied applications for FT, they also had an opportunity for participatory and experiential interactions that may indeed support their future practice.

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CHAPTER 8: DISCUSSION

This arts-based study aimed to: 1) explore several priorities of the Manitoba Collaborative Indigenous Education Blueprint (MCIEB) with health care providers (including nurses, nurse educators and allied health professionals) and nursing students through Theatre of the Oppressed and forum theatre; 2) explore how the priorities could be integrated within nursing education through Theatre of the Oppressed and forum theatre; 3) and explore nursing educators, health care providers', and nursing students' experiences of Theatre of the Oppressed and Forum Theatre as pedagogical approaches. A paper-based thesis was employed to focus on these three aforementioned objectives. This multi-pronged inquiry illuminated the contemporary context of Indigenous health care providers' and students' lives. This study also supported the development of an arts and Indigenous influenced anti-racist framework for nursing education and a resulting methodological manuscript. Moreover, the study also determined the response of health care providers and nursing students to Theatre of the Oppressed and forum theatre as pedagogical methods in nursing.

This chapter presents a discussion of several findings emerging from research objectives #1 and #2 and relates these findings to the literature. Given that several findings pertaining to research objective #1, #2 and #3 have already been discussed in the manuscripts in Chapters 5-7, the focus of this chapter is on the findings that have yet to be discussed and contextualized.

Research Objective #1

To explore several priorities of the MCIEB (priorities #2, 3 & 6) through Theatre of the Oppressed and Forum Theatre with nursing educators, students and health care providers.

Main theme: Colonialism is ongoing

The theme of *colonialism is ongoing* was revealed through an exploration of the priorities of the MCIEB. According to the participants in this study, some of the key ways in which colonialism manifests itself in nursing and health care is through policies and practices, as well as through deviant and deficit-based discourses surrounding Indigenous peoples and Indigenous knowledge.

Participants dialogued and presented the birth alerts[5] as one prominent example of ongoing colonialism in health care policy and practices. While birth alerts are purportedly used to flag "high risk" expectant women for assessment by social services, they disproportionately affect Indigenous women and children. In Manitoba, 90% of apprehended children are Indigenous and the province has more children in care per capita than any other in Canada. Furthermore, evidence supports that birth alerts do not increase the safety of children (Bergen, 2020). Rather, the birth alerts confirm that colonialism is ongoing through policy and practice. Like the residential schools and the Sixties Scoop before them, birth alerts and the child welfare system more broadly, seek to remove Indigenous children from their families and communities, severing Indigenous children's connection to their families, their cultures and their identities (Allan & Smylie, 2015). The emphasis on birth alerts in the vignette highlights that colonial policies are not simply historical events, but ongoing attempts to assimilate and destroy Indigenous families and communities. While child welfare systems and social workers are assuredly implicated in the removal of Indigenous children, nurses' sustained complicity in enacting these policies by contacting social services once flagged women present to labour and

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[5] Manitoba abandoned the birth alert policy on June 30th, 2020. British Colombia abandoned the practice in late 2019. Despite being under review, the practice continues in other provinces such as Saskatchewan.

delivery is rarely acknowledged or challenged. Although the experiences of Indigenous women

accessing health care when child apprehension is threatened has been explored previously

(Denison et al., 2014), there remains scant scholarly literature illuminating birth alert practices in

nursing and how these practices continue to reproduce colonialism. The participants in this study

wanted to render such practices visible. Thus, this study represents an important contribution to

unearthing harmful colonial nursing practices.

Health care is a "pernicious colonizing force" (McGibbon, 2012, p. 19) and the root

cause of the health, social and healthcare inequities experienced by Indigenous people (Stout,

2012). In this study, participants emphasized that colonialism in health care is ongoing and must

be discussed in nursing education. As one participant stressed: "We need to start talking about

the health system as actively continuing to colonize Indigenous peoples". While ongoing

colonialism is rarely or inadequately broached in nursing education, the vignettes and the stories

shared by participants revealed that colonialism is not "a thing of the past" (McGibbon et al.,

2014, p. 183) and students must "recognize that colonialism is not over" (Beavis et al., 2015, p.

5). These findings suggest the importance of educating nurses to recognize historical and

contemporary forms of colonialism in health care, as well as develop nurses' understanding of

colonialism as a determinant of health.

The vignettes in this study demonstrate that colonial thinking and actions are pervasive in

health care and nursing education, and that nurses actively contribute to colonialism. As

McGibbon et al. (2014) suggests, one of the most important ways colonialism and oppression

flourishes in nursing is because nurses actively participate in it; deny or ignore it; witness it but

refuse to speak up with the belief that "it is none of our business or that it is someone else's

responsibility to speak up" (p.187). However, Indigenous nurses may choose not to speak up for

lack of conflict resolution skills (Vukic et al., 2012) or due to exhaustion and fatigue as identified by the participants in this study. Taken together, these findings further emphasize the importance of equitable and transformative pedagogical practices like forum theatre and Theatre of the Oppressed. Such pedagogical approaches create opportunities for students and nurses to identify and reflect on oppression, racism and discrimination in health care, thus developing the conflict resolution skills necessary to challenge, intervene and act upon these situations in their professional lives. As Wright (2000) asserts, drama education is "first and foremost an education in negotiation" which is fundamental to conflict resolution (p. 28).

Participants in this study described how nurses actively push away Indigenous knowledge and provide little support for traditional practices. Vignette #2 demonstrates the disdain the clinical instructor has for the traditional practice of keeping the placenta. However, participants also identified numerous other practices such as smudging, drumming and chanting that are often denied entirely or allowed but met with demonstrable displeasure from nurses and other health care professionals. Scant literature has explored how non-Indigenous nurses engage with Indigenous knowledge and traditional practices in the clinical setting. However, past research on improving access to Indigenous medicine and healers in hospital-based settings in the Northwest Territories has revealed that barriers to developing Indigenous wellness services persist (Redvers et al., 2019). These barriers and constraints are often rooted in trying to understand Indigenous models from Western methodological approaches, governance structures, and policies. These findings add weight to those of this study, demonstrating that despite nursing scholarship advancing the importance of traditional medicines and ceremony to the health and wellbeing of Indigenous peoples (Bearskin et al., 2016; Etowa et al., 2011; Minore, 2013), Indigenous healing practices continue to exist outside the margins of mainstream nursing and health care settings.

These findings also affirm the need for policies that acknowledge and legitimize traditional medicine and ceremony in nursing and health care.

The findings of this study exposed that research, education and policy in health professions education continue to privilege Western knowledge, epistemologies and languages. Indigenous health care providers described their struggle in trying to negotiate Western epistemological policies and procedures in academic studies and in the work place. Saliently, several participants shared stories describing their experiences of graduate studies wherein they had to continuously challenge established academic conventions and advisory committee members' opposition to Indigenous approaches and methodologies. Participants described it as a "fight" with one participant admitting that she nearly did not graduate because of this opposition. The omission of Indigenous peoples' epistemologies, knowledge and methodologies from policy and educational discourses is "a form of epistemological colonialism, whereby Indigenous epistemologies are subjugated via the dominance of Western epistemologies." (Fridkin, 2012). This forces Indigenous people to adopt colonial discourses which Fridkin (2012) refers to as the "ultimate form of assimilation" (p. 115). The stories shared by Indigenous participants reveals the limits of Western knowledge and its lack of capacity to engage with Indigenous knowledge and ontological pluralism more broadly.

The aforementioned findings reinforce the complex terrain (from assimilation to contestation while risking failure) that Indigenous students must negotiate in academia and stress the importance of further decolonial training within post-secondary settings, in particular for administrators, educators and scholars. This study also affirms the importance of arts-based and Indigenous research, scholarship and pedagogical practices such as those employed in this study, in order to counter the supremacy and universality of Western knowledge. As Barone (2008)

advances, arts-based research is epistemologically humble research that takes on the master narrative and its monolithic view of the world, avoiding epistemic violence or "terrorism" (p. 39).

Participants in this study also expressed concern about the ways in which Indigenous knowledge or perspectives might be integrated or shared within nursing and higher education, stressing incompatibilities between Indigenous and Western knowledge systems. Indigenous knowledge is not generalizable, immutable knowledge that can be easily categorized (Canadian Nurses Association & Aboriginal Nurses Association of Canada, 2014). Rather, Indigenous knowledge is sacred and holistic knowledge that should not be fragmented or dislocated from its local meaning or context (Hill, 2003; Nakata, 2007). However, as the participants in this study brought forth, nursing content and skills are often fragmented into discrete categories of information (i.e. the cardiac system; the circulatory system, etc.) which represents a challenge to integrating Indigenous knowledge within the current pedagogical structure of nursing education. Indigenous participants also advanced that the differences in approaches to teaching nursing versus Indigenous knowledge are significant. The description of an Elder's teachings provided by one of the participants in this study stands in opposition to the goals of modern education and its "technocratic zeal towards individualism and progress" (Marker, 1998, p. 497). These findings further highlight the need to engage Indigenous knowledge holders, Elders and communities for guidance in developing, implementing and teaching Indigenous knowledge within nursing education (Van Bewer et al., 2020).

Past research has noted that discourses of Indigenous deficiency are prevalent in health care (Beavis et al., 2015; Browne, 2009; de Leeuw et al., 2010; Tang & Browne, 2008). Indigenous people are often viewed as poor, urban dwellers with problems such as addiction,

homelessness, or unable to care for their children (de Leeuw et al., 2010; Tang & Browne, 2008). The findings of this study also revealed that deviant discourses about Indigenous peoples within nursing education and health care are prevalent and affect how nurses teach Indigenous health or provide care to Indigenous patients. Nurse educators in this study recognized that they taught Indigenous health from a deficit perspective, with little reference to the strengths and resilience of Indigenous peoples and communities. As one participant lamented "We get stuck in trauma outcomes". The vignettes presented in this study also uncovered abundant narratives of Indigenous deficiency and deviancy (i.e. checking the birth alert binder for all Indigenous women; Indigenous people on reserves are living in poverty without potable water; Indigenous people are feeding babies Coca-Cola in their baby bottles). Furthermore, the cynical manner that nurses approach Indigenous patients was also theatrically depicted. This cynicism emerges from prevalent discourses that powerfully socialize nurses and colours "the perception of what to expect from 'them' (e.g., 'unpleasant dealings') and how 'they' should be dealt with by 'us' (e.g., 'more guarded')" (Tang & Browne, 2008, p. 119).

These deviant discourses are not only present in nursing and health care, but also in child welfare policies, as exemplified by the birth alert practices described earlier in this chapter. Contemporary child welfare policies and practices emerged from ideas and assumptions about Indigenous deviance and inferiority which continue to justify the surveillance and intervention into the lives of Indigenous peoples (de Leeuw et al., 2010). These deviant and deficit patterns of discourses often ignore or under-represent the role that historical and political forces play in producing and reproducing inequities in health and well-being (Browne, 2005; Manhire-Heath et al., 2019). Furthermore, discourses of Indigeneity not only transmit a message of Indigenous deficiencies but also curtail or prevent authentic engagement with the lived experiences of

Indigenous peoples (Slater, 2010). However, through the Theatre of the Oppressed workshop and forum theatre performance, participants were able to create and recreate themselves and to step across an imaginary divide between "us" and "them". Through these embodied and sensorial experiences, participants were able to apprehend the effects of these deviant discourses and also begin to understand how these discourses can be challenged and even replaced with alternate discourses. Furthermore, by illuminating the context of Indigenous health care provider lives, this research seeks to affirm Indigenous experiences of strength, resilience and success, thus challenging deficit and deviant discourses.

Sub-Theme #1: The Multiple Faces of Racism

An emergent finding exposed through this research was the multiple, insidious and varied ways that racism continues to manifest itself in nursing and health care more broadly. Participants elucidated that dog whistles, offensive innuendos and microaggressions are all commonplace examples of racism encountered in nursing and health care. Microaggressions are described as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue et al., 2007, p. 271). In this study, one of the primary manifestations of racism was through racial dog whistles. Stewart (2016) describes dog whistles as hiding a message in a relatively uncontroversial statement. Participants in this study communicated typical examples of dog whistles for Indigenous people in the health care context. As demonstrated in vignette #2 and in the conversations during the crafting of the script, nurses typically use geographic terms such as patients "from up North", "from Point Douglas", "from the inner-city", "from downtown". Alternately, participants described that they might use the terms "high-risk" or "vulnerable" linking back to deficit discourse previously described in this

chapter. The findings herein demonstrate that while overt forms of racism are eschewed by health care providers, "moderate expressions of discrimination can easily fall under the radar as long as they are in concordance with the status quo" and may be "concealed under the pretext of political correctness" (Ly & Crowshoe, 2015, p. 615).

Previous studies in higher education in Canada have reported that Indigenous students and faculty are subjected to microaggressions (Bailey, 2016; Canel-Çınarbaş & Yohani, 2019; Clark et al., 2014). However, the findings of this study represent an important contribution to the scholarship on microaggressions in nursing education and in clinical practice specifically. Furthermore, this study also revealed the presence of new racism in nursing and health care education. New racism is the perception that another racial group is demanding, receiving special treatment and undeserving of any specific recognition or government policy or programming (Banks & Valentino, 2012). Participants in this study identified numerous manifestations of new racism in nursing education from comments such as "you get a free ride" or "she doesn't seem that smart…she probably got in as a special consideration". Participants in this study described encountering new racism and microaggressions as "blindsides" and being angry, "dumbfounded", confused and uncertain about how to respond to these comments, even if they were in positions of authority. Thus, this research demonstrates how microaggressions and new forms of racism are powerful and difficult to challenge. By rendering such behaviours explicit, this research aims to make visible how the multiple faces of racism operate in nursing and health care.

The finding of lateral violence has been discussed in the manuscript in Chapter 5 under the sub-theme of *challenges in negotiating identity.* However, reporting on the themes discretely presents a challenge because of the interconnectedness of the themes. Lateral violence and its

relational association with the other themes of racism, identity, struggles in finding safe spaces and colonialism renders a discussion on these themes as discrete categories impossible. For instance, while lateral violence is identified as a salient example of the challenges in negotiating identity, it also represents one of the *multiple faces of racism* and is discussed below.

In contrast with Sue's (2010) assertion that only White individuals can perpetuate microaggressions, the stories shared by Indigenous participants in this study would suggest otherwise. Several participants in this study described being the target of microaggressions from other Indigenous people based on the lightness of their skin, their particular Indigenous identity (i.e. Métis versus First Nations or Inuit), or their lived experiences (growing up in an urban environment versus on reserve). One participant noted that colonization is the root contributor to lateral violence: "there's even an attack about who is (Indigenous) and who isn't… it's colonization that's impacting that person and they feel they have to be protective of who is and who isn't. And then there are other people (non-Indigenous) also doing that to us (Indigenous people)".

These stories of lateral violence are not unique to the Indigenous participants in this study either (Bennett, 2014; Clark et al., 2016; Monchalin et al., 2020). Métis women identified being the target of lateral violence and microaggressions such as bullying, gossiping and shaming from their First Nations peers (Monchalin et al., 2020). Similarly, Aboriginal and Torres Strait Island people in Clark et al.'s (2016) have also noted experiences of lateral violence which they described as primarily covert and similar to microaggressions. Furthermore, these latter participants identified that the most common experience of lateral violence was related to questioning of Indigenous authenticity via blood quantum (Clark et al., 2016). The questioning of one's identity based on skin colour is a common feature within and between Indigenous

peoples (Bennett, 2014). Lateral violence and racism stem from divisive colonial strategies implemented by imperial governments to exert control and power over Indigenous peoples (Bennett, 2014; Clark et al., 2016; Monchalin et al., 2020). These divisive tactics are still evident in racist policies and practices today which Clark et al. described as "fertile ground for the internal denigration and division of Aboriginal people" (p. 49). The findings of this study affirm what I have poetically illustrated elsewhere…

while we battle with ourselves

the colonizer's story gets retold (Van Bewer, 2020, p. 9).

Research Objective #2

To explore possibilities for integrating the priorities of the MCIEB within nursing education through Theatre of the Oppressed and Forum Theatre.

The most significant way this research contributes to research objective #2 is through the development of the hybrid Indigenous and Theatre of the Oppressed workshop and subsequent framework. Through the integration of Indigenous models and knowledge (i.e. sharing circles, prayer, smudging, presence of an Elder) throughout the workshop, this research demonstrated one way that Indigenous knowledge, languages, intellectual traditions and models may be brought into curriculum and pedagogy (MCIEB priority #2). By illuminating Indigenous history and the contemporary context of Indigenous health care providers' lives, this research links to priority #3 of the MCIEB (Promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples). Finally, the anti-racist framework that emerged from this research also represents one of the ways in which the work of creating campus communities that are free of racism, value diversity and foster cultural safety (MCIEB priority #6) can continue. However, during a post-play discussion with the audience and the workshop

participants, several other possibilities for integrating the priorities of the MCIEB within nursing education were also brought forward.

Scaffolded learning

Participants in this study identified that scaffolding learning related to Indigenous knowledge (including Indigenous history, perspectives and lived experiences) is crucial. Students characterized the content as overwhelming especially given the volume of knowledge that students are expected to learn in nursing education. Participants suggested that scaffolding the learning of such content would enable students to "build up" their knowledge. Scaffolding knowledge is a process through which an educator provides a framework for learning new ideas and new tasks. The framework then supports students to develop their own initiative, motivation and resourcefulness, allowing them to become independent learners (Chambers et al., 2013). Scaffolding is an inherent aspect of Freire's (2000) Pedagogy of the Oppressed and Boal's (2000) Theater of the Oppressed. As Sleeter et al. (2004) noted in the context of teacher education, Freire's process of conscientization (including awakening, reflecting and learning from each other and about issues of oppression) can be particularly sensitive and challenging for largely White preservice teachers. This can result in student denial and frustration, challenges similar to those identified by participants in this study. Conscientization is "rarely a one-time awakening, but rather it is a process with multiple avenues of insightful moments as well as difficult times of denial and pain" (Sleeter et al., p. 83). In learning for conscientization, the educator must engage students in meaningful learning through scaffolding and then step back to give the necessary power over to the students to construct knowledge (Sleeter et al.).

An ongoing process of scaffolding student experiences is necessary to expand student consciousness and self-reflection, to link student personal experiences to social issues, and to

encourage activism and citizenship (Waite & Brooks, 2014). In this research, Theatre of the

Oppressed activities, including games, image theatre and forum theatre, along with Indigenous

sharing circles were used to scaffold learning by facilitating a participatory dialogue, by

identifying oppressive circumstances, by contextualizing these circumstances within a broader

historical, ethical and socio-cultural context, though reflection and finally action. In this way,

Theatre of the Oppressed can be seen as a pedagogical map or framework to guide faculty and

students through a learning process. By scaffolding learning in such a way, students are less

likely to experience "critique fatigue", which Boodman (2019) describes as:

> the discouragement, demoralization and disempowerment that groups of students may
>
> collectively experience where there is too much "critical content" (that is, content aiming
>
> to reveal and explain the patterns and mechanisms of oppression) and not enough
>
> structured skill-building to allow students to respond creatively, emotionally, practically,
>
> and politically/institutionally to the information they are being asked to take in –even if,
>
> and especially if, it relates to their own experience (p. 28).

Increasing Indigenous faculty representation

Participants in this study maintained that increasing Indigenous faculty representation

was crucial to enacting the priorities of the MCIEB, in particular with regards to teaching

Indigenous content. According to participants, there are no tenured academic faculty members

identifying as Indigenous within the College of Nursing. This has resulted in very little content

taught from an authentic Indigenous perspective or relying on the generosity of Indigenous guest

speakers to fill that gap. Furthermore, the current lack of Indigenous tenured faculty and

administrators may transmit a powerful message to Indigenous students about their lack of

belonging within the institution. These findings have been echoed by other scholars as well.

Rohatinsky et al. (2018) have acknowledged a paucity of Indigenous nurses and an even lower representation of Indigenous nurse educators within schools of nursing in Canada. To date, most scholarship has focused on increasing access and retention of Indigenous students and Indigenous nurses (Lane & Petrovic, 2018; Minore, 2013; Rowan et al., 2013). This is a vital aspect in creating a pathway to encourage and promote Indigenous nurses into academic and administrative positions. However, as mentioned in the manuscript in Chapter 5, increasing Indigenous representation in nursing education, without changing the structures of the institution, may result in Indigenous faculty witnessing racial violence, and complying with practices that further entrench and sustain colonial models and oppression (St-Denis as cited in Cote-Meek, 2014). Therefore, increasing Indigenous representation must also occur within a context of decolonizing nursing curriculum and academic spaces.

Creating an Indigenous advisory group to guide curriculum

Participants in this study suggested the creation of an Indigenous advisory group to guide nursing curriculum in terms of content and with regards to who can teach this content. This has also been suggested by Stansfield and Browne (2013) and Beavis et al. (2015) who have proposed the creation of Indigenous advisory committee or the need for Indigenous educators to be directly involved in the design, review and teaching of curriculum related to Indigenous knowledge and content. The Rady Faculty of Health Sciences at the University of Manitoba currently has an Indigenous advisory planning committee that consists of Indigenous and non-Indigenous academics, staff and students, and the College of Nursing has recently created an advisory council as well. However, as Bullen and Flavell (2017) have cautioned, Indigenous scholars, staff and students working in this space may be further overburdened by the extreme workloads of such unacknowledged and underappreciated tasks. These workloads may limit

opportunities to progress in higher graduate studies, limit career progression and impact personal relationships and well-being. Accordingly, Indigenous people engaged in this work must have their contributions acknowledged and recognized, and their workloads adjusted accordingly.

Hiring an Elder as an advisor for students and faculty

Participants in this study identified that hiring an Elder is crucial to integrating the priorities of the MCIEB within the College of Nursing. Participants perceived that an Elder may provide guidance and counselling to students and faculty as well as help guide the inclusion of Indigenous content within the curriculum. As discussed in the manuscript in Chapter 2, including Elders within schools of nursing has been identified as crucial to integrating Indigenous knowledge and perspectives (Van Bewer et al., 2020). These findings are in accordance with those of prior research (Edgecombe & Robertson, 2016; Moffitt, 2016; Zeran, 2016). In this research, the presence of an Elder was crucial to ensuring authentic integration of Cree ceremony, prayer and sharing circles, for guidance and for support. Through this process, several participants were exposed and sensitized to Indigenous ceremony and practices for the first time and apprehended the power and benefit of Indigenous knowledge and ceremony.

Chapter Summary

This chapter explored several findings that emerged from this research study regarding research objectives #1 and #2. Relating to research objective #1, a discussion of the themes of *colonialism is ongoing* and *the multiple faces of racism* was broached and related to the findings of other scholars. The findings relating to research objective #2 were also explored and contextualized within the existing body of research. The final chapter will illustrate how the goals of the research have been met, as well as discuss the limitations of the study. Future

directions for practice, education and research will be identified. Lastly, concluding thoughts will

be offered.

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CHAPTER 9: REFLECTIONS, LIMITATIONS AND IMPLICATIONS

In this final chapter, I offer my reflections on this study in the current context and discuss my own growth and transformation as well as my aspirations for nursing education and health care more broadly. I also present some of the knowledge translation (KT) activities associated with this research. Based on the study findings, I offer recommendations for practice, education and research.

Reflections

When I initially began my PhD program, I had no idea how far the research would take me. In this process, I have been pushed to exhilarating heights as well as woeful lows. In those moments of desolation, I contemplated leaving the PhD program entirely. While some challenges were necessary to my growth as a scholar, others impeded my progress and muted my voice (for a period of time at least). There are certainly things I learned during the coursework stage of the PhD program. However, the critical and decolonial lens compels me to acknowledge that the content taught during this coursework stage privileged Eurocentric ontologies, methodologies, approaches and scholarship. Borrowing from Marie Battiste (2002), I was marinating in Eurocentric thought. However, through this research, I wanted to disrupt and challenge hegemonic, taken for granted knowledge and structures. Yet, I had none of the tools to do so. But as Audra Lorde (1984) contends, "For the master's tools will never dismantle the master's house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change" (p. 111).

I looked beyond the master's tools… As Boal (2002) asserts "The theatre is a weapon, and it is the people who should wield it" (p. 120). I found tools to dismantle the master's house in forum theatre training in England. However, I also found tools elsewhere… in coffee and

telephone meetings with my advisor, mentors, supporters, Elders and knowledge keepers closer to home; through a research assistantship in decolonial and Indigenous methodologies; and through the endless reading and listening to Indigenous, decolonizing and arts-based scholars, activists and advocates that have come before me. I tilled the soil of my creativity. I re-cultivated my own gifts of storytelling and spoken word. Gifts I had long ago cast aside, replacing them with paler representations.

One of the biggest challenges I experienced throughout this research was related to uncertainty. To lay in the unknowingness was a difficult task as a graduate student. To give up control was a difficult task as a nurse and former educator. However, uncertainty is expected and even relished in arts-based research. As Savin-Baden and Wimpenny (2014) assert, it may not be initially clear what knowledge might be generated through art. However, in the uncertainty resides limitless possibilities. For example, while the decision to explore the priorities of the MCIEB was mine (based on discussions and experiences), the participants/collaborators decided for themselves the focus of their vignettes. This uncertainty fostered wider and more authentic engagement and public scholarship that raised "the voices of practitioners as co-generators of knowledge" (Giles as cited in Chilton & Leavy, 2014, p. 408).

To say the experience of the Theatre of the Oppressed workshop and the forum theatre performance was transformative would be an understatement. How often do we get to play as adults? How often do we get to take on the role of someone else, to transform ourselves, to speak power to truth? How often do several Indigenous health care providers get to share a space with each other and with allies? How often do we get to share in the power of ceremony or share our knowledge and perspectives? How often are university spaces places where we feast, or laugh so hard our stomachs hurt? Some people participating in the workshop had previously worked

together or previously worked on issues relating to increasing Indigenous content and representation in nursing. However, through the workshop, "we found new ways of working, acting and hoping together" (Rahnema, 2009, p. 145).

Knowledge Translation and Dissemination

In Canada, knowledge translation has become a priority issue that has been included as an objective in the Canadian Institutes for Health Research (CIHR) act and requires all researchers, including nurse researchers, to explicitly advance how they will translate the findings of their research to the appropriate audience (Government of Canada, 2016). Research continues to demonstrate that failures to translate research findings into practice or policy persist across contexts (Grimshaw et al., 2012). However, this situation has been magnified with research with Indigenous peoples and communities. Smylie et al. (2009) propose that within Indigenous communities, differing ways of knowing and being contribute to difficulties with translation. Effective translation in Indigenous contexts requires understanding these ways of knowing and being. Knowledge translation in Indigenous communities encompasses a wide range of activities both formal and informal, and that that knowledge translation is a pre-existing integration of Indigenous *knowing* and *doing* that Indigenous people have always done (Kaplan-Myrth, 2006). Estey et al. (2010) have suggested that appropriate Indigenous knowledge translation is about sharing locally developed and contextualized knowledge. The knowledge generated from this study was not translated specifically for Indigenous peoples. However, the philosophy of Indigenous knowledge translation as described above is at the heart of this study and is inseparable from knowledge generation.

As demonstrated by the vignettes in this study, the knowledge generated through Theatre of the Oppressed and forum theatre is local and contextualized knowledge. However, viewed

through a Two-Eyed Seeing lens, there is space in this research for both local and more universal

knowledge. For example, the vignettes represent the particular, the local, the contextualized

knowledge, while the themes that emerged from this research represent something more

universal or more widely applicable (Norris, 2009). Conquergood (2002) evokes Michel de

Certeau's adage "what the map cuts up, the story cuts across", to denote that arts-based research

transgressively travels across a boundary that separates two different domains of knowledge:

"the map" which represents the objective and abstract, and the "story" which represents the

practical and the embodied (p. 145). In this research, there is both the "map" and the "story".

Importantly, both forum theatre and Indigenous storytelling traditions favour orality and

performance, which is often a secondary aspect of traditional knowledge translation. Through the

performance of the vignettes, the research is shared with an audience of stakeholders including

students, educators and administrators in language accessible to a wide audience. Thus,

knowledge dissemination is an inherent aspect of forum theatre. However, the audience members

are not merely passive observers in receiving knowledge through the performance, rather, they

engage in a process of knowledge generation and translation as well. Furthermore, while

translating knowledge through art is likely to be more evocative and compelling, by privileging

the oral voice, this research also challenges the ethnocentrism of textualism, remembering that

countercultures of dispossessed peoples have been forcibly excluded from acquiring literacy

(Conquergood, 2002).

Since completing the TO workshop in 2019, there have also been opportunities for more

traditional knowledge translation. The three findings manuscripts included in this dissertation

have been submitted to academic journals in order to disseminate the findings in a more

conventional manner. I have also presented a poster at the Sigma Theta Tau International

Nursing Congress in Calgary in July 2019. In October 2019, I presented the research at the Qualitative Health Conference in Vancouver. A Reader's Theatre approach was used to present one vignette. Two faculty members, Dr. Donna Martin and Dr. Kendra Rieger, along with a graduate nursing student, performed vignette #2 to the audience. The purpose of employing Reader's Theatre was to evocatively and creatively communicate the research findings to a wider audience of academics and scholars. By inviting other nurse scholars to participate in disseminating this work through Reader's Theatre, the research is constantly renewed, never clinging to a definitive or immutable meaning.

Limitations

One of the limitations of this research was securing the participation of students as audience members and spect-actors. The plan was to recruit between 12-40 students. Unfortunately, only five students and two faculty members participated as audience members. Attempts to increase participation by offering a draw for cash prizes were also unsuccessful. Some of the nursing educators participating in the workshop shared that engaging students outside of formal class time is very difficult at the undergraduate level. This may indicate that students feel saturated with formal theoretical and clinical coursework, thus precluding attendance at additional, voluntary activities. However, this may also suggest that nursing students have yet to link professional development to personal responsibility. Nonetheless, wider participation from students would have likely resulted in a greater number of spect-actor interventions, and more opportunities to dialogue, reflect and act.

Another challenge of this research was securing the participation of people with real decision-making power. While Mabel and I reached out to many different people in positions of authority and power, we overestimated the solidarity of our social and relational network. As

mentioned previously, this research is best lived and experienced rather than discussed theoretically. By participating in the workshop, key players would have heard the stories of Indigenous health care providers, gained a greater understanding of the issues that persist in nursing education and contributed to imagining new possibilities for nursing education. While several nurse educators participated in the workshop, it would be interesting to develop a study that consisted exclusively of tenured faculty and administrators.

One of the obstacles of this study emerged from the different trainings the theatre facilitator, Daniel and I received. Daniel is first and foremost a trained and acclaimed playwright and director, who has also attended David Diamond's training in Theatre for Living (an adaptation of Boal's Theatre of the Oppressed). On the other hand, I received training from Adrian Jackson at Cardboard Citizens Theatre Company. Adrian follows Boal's approach without modifications. As mentioned in Chapter 1, in Boal's approach, a spect-actor can only replace the protagonist on stage. However, Diamond (2007) maintains that "the binary poles of oppressor and oppressed are actually part of the same large organism living in some kind of dysfunction" (p. 38). Thus, a spect-actor can replace any character on stage. The argument made for the poly-protagonist scenario, is that a single protagonist may limit the choices the audience can make and may constrain the dialogue. Paterson (2011) on the other hand, contends that the poly-protagonist approach muddies the subject. Given Daniel's background and his training as a student of Diamond's Theatre for Living, a multiple protagonist approach was employed during the forum theatre interventions.

However, this poly-protagonist approach may have indeed "muddied" the vignette and created some uncertainty for the audience. In particular, vignette #1 had two oppressed individuals (Carrie and Stacy) which resulted in some confusion and may have limited the

audience interventions. While there was a spect-actor intervention for the character of Stacy in vignette #1, no audience member volunteered to replace Carrie, the blonde and blue-eyed Métis student in the vignette. Rather than viewing Carrie as oppressed, audience members dialogued about cultural appropriation determining that Carrie may have been appropriating Stacy's culture, resulting in a justified response from Stacy. Audience members also wondered whether an Indigenous person could oppress another, harkening to Sue's (2010) claim that only White individuals can microaggress people of colour. Unfortunately, the participants who crafted the vignette wanted to highlight lateral violence, as this was important aspect of their Indigenous lived experiences. By having a multiple protagonist approach, the audience may not have deciphered who was oppressed in the scene and were unable or reluctant to intervene in such a way to change these circumstances. Vignette #2 had much more defined oppressors, and only one oppressed protagonist, and this resulted in wider audience interventions, even if some interventions may have bordered on magical or naïve thinking, which Boal (1995) eschews. In particular, the spect-actor intervention with Jody, the clinical instructor in the second vignette, may represent naïve thinking (the intervention is described in the manuscript in Chapter 6). However, the intervention was powerful nonetheless. The spect-actor that intervened to replace the character of Jody was a nursing administrator, the only administrator in attendance in the audience that day. To hear her acknowledge the birth alert binder as racist, and to acknowledge that nurses target people who are poor, who are Indigenous, who don't speak English, was a powerful statement and action for students and health care providers to witness and an important step towards reconciliation.

While not a limitation per se, I must also acknowledge this research may have benefitted from the voice of an Indigenous forum theatre facilitator. However, there are few forum theatre

facilitators in Winnipeg, and I was unable to locate an Indigenous forum theatre facilitator. This is not to discount Daniel's considerable talents and skills, but there were moments of tension that may have been approached differently by the theatre facilitator and perceived differently by the participants had the theatre facilitator been an Indigenous female. One moment of tension has already been discussed in the manuscript in Chapter 6. In this manuscript, I describe that several participants' dialogue was reduced by the theatre facilitator which contributed to feeling silenced, an experience that resonated with one of the participants as an Indigenous woman. Another moment of tension occurred during the crafting of the vignettes. Daniel acknowledged that he was frustrated that Mabel and I were also giving feedback to the participants about their vignettes and that our feedback differed from his. At one point he expressed this frustration to one group while Mabel and I were not present, stating "How many directors are there?". Some of this frustration likely emerges from the differences in our training. I am not a trained forum theatre facilitator, and not a traditional director. Daniel is formally trained in both of those roles. However, I drew from Adrian Jackson's approach to forum theatre, providing feedback, but ultimately allowing participants to make their own decisions about what to include in their vignette. To his credit, Daniel brought this to my attention at the end of the workshop and we also discussed this during our debriefing meeting the following month. However, conflicts, and unanticipated struggles in research should be expected. I stress that as an emerging scholar and Theatre of the Oppressed practitioner, I too am not beyond critique. These aforementioned experiences reinforced the benefit of the sharing circle to share in these struggles as well as learn and grow from these experiences. These moments of tensions further affirmed the important conflict resolution skills that can be gained through an education in forum theatre. In future research and work in this area, I will pay greater attention to the dynamics of the workshop team

as it is unfolding, and will aim to be clearer about my expectations for the team, ensuring that our voices as Theatre of the Oppressed practitioners do not displace the voices of the participants and others on the workshop team, including the Elder.

Lastly, the vignettes may have been more refined and lengthier had the workshop lasted several days longer. In designing the workshop, I was sensitive to the time commitments required of the participants and the constraints of my budget. I balanced the time needed to participate in the workshop, to collectively dialogue, share stories and craft a forum theatre performance with what I could realistically ask of participants and of my workshop team. However, one of the strengths of the format proposed in this study is that it lends itself to be more easily reproduced, thus creating fewer barriers about engaging in such work.

<div align="center">Implications for Practice, Education and Research</div>

Implications for Practice

Through an exploration of the priorities of the Manitoba Collaborative Indigenous Education Blueprint with nurses, nurse educators and health care providers, this study identified that colonialism is ongoing in health care, as is racism. These findings reveal that health care providers need anti-racist and decolonial training and education to have the disposition, attitudes and skills to reflect, challenge and act against oppression, racism, hegemony and Eurocentrism. The College of Registered Nurses of Manitoba (CRNM) requires all registered nurses to engage and demonstrate proof of continuing competence every year. The CRNM advances that nurses "maintain and enhance their competence through self-reflection, lifelong learning and integrating learning into their practice" (n.d, para. 2). This study did indeed promote self-reflection, lifelong learning and allowed nurses to rehearse and practice skills to integrate within their practice.

Thus, this research supports continuing competence and may represent an innovative way to approach professional development.

The importance of reflecting on ethical and moral responsibilities is also promulgated in the Canadian Nurses Association's (2017) code of ethics. The latest version of the code of ethics for nurses includes the duty for nurses to engage with the legacies of colonialism and the history of Indigenous Peoples, as well as working towards addressing "organizational, social, economic and political factors that influence health and well-being within the context of nurses' roles in the delivery of care" (p. 18). Translating historical and ethical knowledge through the approaches used in this study may allow nurses to more effectively link to the ethical and professional values they are mandated to represent and uphold. Through forum theatre, nurses may be enticed into dialogues that explore and connect nursing ethical values and responsibilities to the historical and sociopolitical matrix of health care and education. Future research should extend this research to the clinical setting to develop clinical nurses' understanding within a local and context-specific setting.

While nursing scholarship relating to nurses as the victims of oppression (at the hands of physicians or through lateral violence) abounds, there remains a tendency to myopically ignore nurses' and the profession's contribution to oppressing others. Bringing to the fore harmful nursing practices that continue to oppress Indigenous people is an important contribution of this study. Rather than sanitizing or turning a "blind eye" to these oppressive practices, attitudes and behaviours, this inquiry documents some of these practices, evocatively depicting them through the vignettes, thus creating enhanced awareness. This study contributes to more accurate, honest and reflective nursing scholarship. By shining a light on unjust and harmful values and practices that nurses endorsed, this study serves not only as a reminder of the cruelty that can be dispensed

under the notion of some social good but as Edmund Burke famously noted "those who don't know history are destined to repeat it" (as cited in Johnson, 2012, para. 1).

Implications for Education

The findings of this study suggest the need to further enhance the knowledge, training and skills of student nurses regarding historical and ongoing colonialism, as well as racism and Indigenous lived experiences. If a commitment to the priorities of the MCIEB and the Truth and Reconciliation Commission of Canada's Calls to Action is truly important to the University of Manitoba and the College of Nursing, then nurse educators must communicate this knowledge to students more effectively. As a starting point, students must learn of oppression and colonialism as ongoing, and then explore colonialism, oppression and racism as structural and individual (Curry-Stevens, 2007).

Nurse educators should not ask themselves "What do we want students to know?" but rather "Who do we want them to be?". To educate for transformation is not simply adding more content, or more readings, or more didactic teaching. Rather, educators must disrupt the pedagogical status quo and develop students' critical consciousness, knowledge, leadership and practical skills. Through the pedagogical strategies proposed in this research, students may gain a better understanding of their own attitudes, biases and perspectives and may feel more prepared to identify and challenge oppression, injustice and inequity within their professional and personal lives.

However, it is not only nursing students that need to develop critical thinking, cultural safety and an anti-racist orientation. Academia must also foster the development of critical, anti-racist oriented educators who are able to step out of the rigidity of curricular standardization and take a leap of faith in which the teaching for anti-oppression becomes a principal instructional

goal (Coffey et al., 2015). Such a leap of faith requires training for academics, including clinical instructors, professors and administrators as well. However, there remains a serious gap in education, wherein nursing educators, scholars and administrators are beginning to pay attention to issues of racism, colonialism and oppression on a macro level (i.e. What occurs out in the world), as opposed to the practices, virtues and ethics of the individual educator or administrator (i.e. What occurs in the classroom) (Hytten, 2015). Given this study sought to implicate nurse educators foremost, it represents a step toward transforming nursing educators, as well as pedagogical practices in nursing education.

In view of the pervasiveness of deficit discourses in nursing education and health care revealed through this study, there is an urgent need to address, challenge and transform these discourses. In order to counter these narratives of deficiencies, participants advocated for the use and creation of strengths-based and empowering discourses of Indigeneity. By virtue of their success and accomplishments, the Indigenous participants in this study challenged deficit narratives. However, future inquiries should aim to explore how discourses of Indigenous strength and resilience can be incorporated into nursing education while still acknowledging issues of inequities. Arts-based approaches may prove particularly useful in unsettling stereotypes, dominant ideologies and in promoting marginalized voices and perspectives (Leavy, 2015).

This research also affirmed the need for administrators to hire, mentor and educate Indigenous nurses into administrative and faculty positions. Indigenous administrators and faculty members, along with Indigenous communities, Elders and knowledge holders must collaborate on strategies and policies to integrate Indigenous perspectives and knowledge as well as address racism within academia and the healthcare milieu. This must not merely be token

representation, but authentic partnerships that empower Indigenous nurses and communities and promote the appropriate inclusion of Indigenous knowledge and perspectives.

While this research provided possibilities for integrating the priorities of the MCIEB in nursing education, these remains a need to document and explore such possibilities in greater detail. Future research should also explore the benefits of engaging in such research from a longitudinal perspective. While benefits in the short-term have been documented, this does not necessarily imply sustained transformation.

Implications for Research

One of the most important contributions of this research was methodological. Although Theatre of the Oppressed along with Indigenous sharing circles have been used with Indigenous youth in Saskatchewan (Goulet et al., 2011), it is not an approach widely employed in any discipline including nursing and health care. This methodology allowed a unique approach to research that allowed for participatory and collaborative knowledge generation and dissemination that challenged the status quo and hegemonic research practices. This research supported epistemological and ontological pluralism, and well as affirmed Indigenous ethical values and a Two-Eyed Seeing approach. Given this research is not merely didactic, nor represented only through print on the page, but through an interactive and embodied process, this research may represent "the next frontier" (Norris, 2009, p. 203) and may offer one example of decolonizing nursing research. Future inquiries should aim to further explore "the next frontier" with a broader sample that includes wider participation from administrators, educators and students both within and beyond the walls of nursing education.

While the anti-racist framework that developed from this research represents a significant contribution to nursing scholarship, this was not a predetermined goal or expectation but an

unexpected emergence. Thus, this research advances flexibility and uncertainty, rather than a set of methodological rules. May we continue to "ask the trenchant questions rather than provide the easy answers, with no desire to replace a master narrative with a totalizing alternative, let alone one that is preconceived" (Barone, 2008, p. 45). While the framework in this research may be useful to others, it represents but a starting point. Future researchers, collaborators, activists and theatre practitioners may reconstruct or revise the framework and assert their own influence over the work. Relinquishing control of the research is a "profound and necessary gesture of epistemological generosity" (Barone, 2008, p. 44). However, we (researchers, theater facilitator, Elder, participants/collaborators) should not attempt to detach ourselves from this work or refuse to imprint it with our own visions, hopes and aspirations.

Concluding Thoughts

In this final chapter, I have considered the implications and limitations arising from this research. In adopting an arts and Indigenous influenced methodology, an exploration of the priorities of the MCIEB was facilitated amongst health care providers and students, and possibilities for integrating the priorities of the MCIEB were ascertained. Each manuscript presented within this dissertation contributed to the research objectives in Chapter 1. The manuscript in Chapter 2 lay a foundation for the dissertation and advanced the importance and relevance of affirming Indigenous perspectives and knowledge in nursing education. The manuscript in Chapter 5 illuminated the experiences of Indigenous health care providers. The framework in the manuscript in Chapter 6 presented an innovative approach to anti-racist education in nursing. Finally, the manuscript in Chapter 7 determined the receptivity of nurse educators and nurses to Theatre of the Oppressed and forum theatre as pedagogical methods in nursing.

While the work represented in this dissertation is considered research, this is only part of its intent. Boal and Freire were radical grassroots activists and revolutionaries. The aim of this work is not for it to reside inside the walls of academia, or to reside in my hands alone. This research is not meant to be read, it is meant to be lived and re-lived, created and re-created and most importantly, acted upon.

I express my most sincere gratitude to the intrepid participants/collaborators who were willing to walk this journey with me and explore arts and Indigenous influenced approaches in nursing education and in research. But this is not an ending. As Mabel reminded us in our final sharing circle "It's never down, it's always up here…There's always new ways of doing things, something else to explore…It's a beginning…".

To be continued…

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APPENDIX A: LETTER TO DEAN OF COLLEGE OF NURSING

Dean of Nursing, College of Nursing, Rady Faculty of Health Sciences, University of Manitoba

I am a doctoral student in the College of Nursing at the University of Manitoba. I am requesting access to nursing students and nursing educators at the University of Manitoba for research purposes. My doctoral research will focus on the use of forum theatre, a type of participatory theatre as a way in which to engage nursing educators and students with several of the priorities outlined in the Manitoba Indigenous Collaborative Indigenous Education Blueprint (MCIEB). My research supervisor is Dr. Roberta Woodgate, and my committee members are Dr. Donna Martin and Dr. Frank Deer. The purpose of my study is to explore through forum theatre the priorities of the MCIEB process with nursing educators and students; to identify possibilities for integrating several of the priorities within nursing education; and to determine the suitability of forum theatre as a pedagogical approach in nursing education. This study is part of my doctoral thesis, and will fulfill a partial requirement for a doctoral degree in nursing.

I am requesting permission to contact nursing students as well as nursing educators to discuss their potential participation in my research study. I would like to conduct email and in-person contact with nursing students and email contact with nursing educators. For in-person recruitment, I would like the opportunity to briefly present my research to nursing students during course or clinical time. For email recruitment, I am requesting that you would send the attached letter of invitation to nursing students and educators. Could you please send this email from your administrative assistant's email account, instead of from your own email address, in order to avoid any perceived coercion to participate in the study?

The nursing educators would be invited to participate in a full-day (8 hours) *playbuilding* workshop as well as a forum theatre rehearsal that would last approximately 4-5 hours, and a performance that would last approximately 2-3 hours. The nursing students would participate as audience members in a forum theatre play and post-play discussion that would last approximately 2-3 hours.

The workshop with nursing educators will be audio-recorded and transcribed. While anonymity cannot be assured, nursing educators will consent to a non-disclosure rule during the workshop. The nursing educators and students will be videotaped during the forum theatre play, and the footage from the videotape will be used for transcription, to assist with data analysis and may be released for educational purposes only. Photographs of the nursing educators and students may also be taken during the forum play to help with data analysis and knowledge translation.

Given that *playbuilding* is a participatory collaboration, nursing educators will be acknowledged on any publications that emerge from the workshop and forum theatre performance. The workshop data (audio-recordings and transcriptions) will be stored on an encrypted USB flash drive and will not contain the participant's name. The University of Manitoba Health Research Ethics Board- Bannatyne Campus has approved the study. The research ethics submission and a copy of their approval is attached.

I believe that the embodied understanding developed in this project will: provide insights into how nursing educators and students understand the priorities outlined in the MCIEB; may help in identifying solutions or ideas for integrating Indigenous content in nursing education; and will help determine the receptivity to forum theatre as a pedagogical approach in the nursing classroom. On completion of this project, I plan to share my findings with other nursing educators and researchers. I would be happy to provide any additional information about my work. Could you please email me to let me know if you are willing to grant my request to recruit nursing educators and students from the College of Nursing? Thank you for considering my request.

Sincerely,

Vanessa Van Bewer, RN, MN, PhD (c)

APPENDIX B: LETTER OF INTRODUCTION TO STUDENTS

Hello, my name is Vanessa Van Bewer and I am a doctoral student in nursing at the University of Manitoba.

I would like to let you know about an upcoming study called: *Rehearsing for the revolution: Using forum theatre to engage nursing educators, students and health care providers with the priorities of the Manitoba Collaborative Indigenous Education Blueprint*. The purpose of this research is to facilitate a dialogue with nursing educators' and students' regarding the priorities of the Manitoba Collaborative Indigenous Education Blueprint (MCIEB) through forum theatre. A secondary purpose is to contribute to the knowledge regarding teaching and learning approaches in nursing.

The MCIEB is a document that has been signed by most educational institutions across Manitoba including the University of Manitoba. The MCIEB is intended to take action on the Truth and Reconciliation Commission of Canada's Calls to Action pertaining to education. Though not all the priorities in the MCIEB are relevant to schools of nursing, several priorities should be explored within schools of nursing such as:
- Bringing Indigenous knowledge, languages and intellectual traditions, models and approaches into curriculum and pedagogy (Priority #2, MCIEB).
- Promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples (Priority #3, MCIEB).
- Building school and campus communities that are free of racism, value diversity and foster cultural safety (Priority # 6, MCIEB).

For this research, a form of participatory theatre called forum theatre will be used to collaboratively create a play with nursing educators and health care providers that explores the priorities of the MCIEB. This play will then be performed to an audience of students once without interruptions. The second time the play is shown, audience members can yell "stop" at a particular scene in the play and come up on stage and replace the main character and act out solutions to attempt to change the outcome of the play. In forum theatre, the audience is referred to as a "spect-actor", a combination of a spectator and actor. Many different spect-actors can come up on the stage and test an "intervention" and try to change the outcome of the play. However, you will not be forced to come up on stage and your participation as a spect-actor is completely voluntary.

I am inviting you to take part in this study by participating as an audience member for the forum theatre play. If you choose to participate in this study, your involvement would include attending the forum theatre play and post-play discussion that would last approximately 2 hours in total. The play will be at the Black Hole theatre on the University of Manitoba Fort Garry campus. After the play, there will also be a post-play discussion in which you will be asked questions about how the priorities of the MCIEB could be better integrated in health care education and your experience with forum theatre as a learning approach.

The forum theatre play and post-play discussion will be video-recorded and the video may be used for educational purposes. While you will not be named, there is the possibility that someone viewing the video for educational purposes might be able to identify you. If you do not want your image released on the video, we can blur your face in the video. You can withdraw from the study at any time, and there will be no repercussions for not participating.

If you are interested in participating, or would like more information, please email me at xxxxxx. Please remember that your participation is voluntary and you are under no obligation to participate. Thank you for considering my request.

Sincerely,
Vanessa Van Bewer, RN, MN, PhD (c) Doctoral Student, University of Manitoba

APPENDIX C: LETTER OF INTRODUCTION TO NURSING EDUCATORS AND

HEALTH CARE PROVIDERS

Dear nursing educator and or health care provider,

I am inviting you to participate in my research study entitled, *Rehearsing for the Revolution: Using forum theatre to engage nursing educators, students and health care providers with the priorities of the Manitoba Collaborative Indigenous Education Blueprint* (MCIEB). The purpose of my study is to explore the priorities of the MCIEB with nursing educators, students and health care providers; to explore possibilities for engaging with the MCIEB within schools of nursing; and to explore your thoughts on forum theatre as a pedagogical approach. This study is part of my doctoral thesis, and would fulfill a partial requirement for a doctoral degree in nursing at the University of Manitoba.

I am inviting you to participate because you are a nursing educator and/or health care provider and have clinical and/or educational experiences in health care. If you decide to participate in this study, your involvement would include a full-day *playbuilding* workshop (8 hours) in which you, along with other nursing educators, health care providers, an Indigenous nurse-Elder and a trained theatre facilitator would participate in theatrical activities, share stories of teaching and clinical practice and collaboratively create a short play based on the priorities of the MCIEB that would be presented to nursing students. A total of 5-15 nursing educators and health care providers will be recruited to participate in the workshop and 4-5 of the participants in the workshop would be recruited to perform the play to nursing students. The workshop will be held on Thursday May 2nd. Participation in the workshop does not require you to participate in the performance of the play. Participation is completely voluntary. Participation in the rehearsal, and performance of the play, along with a post-play discussion will take approximately 8 hours in addition to the workshop and will occur on Friday May 3rd. Both the workshop and the performance of the play will take place at the Black Hole Theatre on the campus of the University of Manitoba. You do not need any experience as an actor to participate in the performance.

If you are interested in participating, or would like more information, please email me at xxxxxx. Please remember that your participation is voluntary and you are under no obligation to participate. Thank you for considering my request.

Sincerely,

Vanessa Van Bewer, RN, MN, PhD (c) Doctoral Student, University of Manitoba

APPENDIX D: RECRUITMENT SCRIPT FOR NURSING STUDENTS

Hello, my name is Vanessa Van Bewer and I am a doctoral student in nursing at the University of Manitoba.

I would like to let you know about an upcoming study called: *Rehearsing for the revolution: Using forum theatre to engage nursing educators, students and health care providers with the priorities of the Manitoba Collaborative Indigenous Education Blueprint*. The purpose of this research is to facilitate a dialogue with nursing educators' and students' regarding the priorities of the Manitoba Collaborative Indigenous Education Blueprint (MCIEB) which are based on the Calls to Action of the Truth and Reconciliation Commission of Canada. A secondary purpose is to contribute to the knowledge regarding teaching and learning approaches in nursing.

For this research, a form of participatory theatre called forum theatre will be used to collaboratively create a play with nursing educators and health care providers that explores the priorities of the MCIEB. This play will then be performed to an audience of nursing students once without interruptions. The second time the play is shown, audience members can yell "stop" at a particular scene in the play and come up on stage and replace the main character and act out solutions to attempt to change the outcome of the play. In forum theatre, the audience is referred to as a "spect-actor", a combination of a spectator and actor. Many different spect-actors can come up on the stage and test an "intervention" and try to change the outcome of the play. However, you will not be forced to come up on stage and your participation as a spect-actor is completely voluntary.

I am inviting you to take part in this study by participating as an audience member for the forum theatre play. If you choose to participate in this study, your involvement would include attending the forum theatre play and post-play discussion that would last approximately 2 hours in total. The play will be at the Black Hole theatre on the University of Manitoba Fort Garry campus on Friday May 3rd at 1:30 pm. After the play, there will also be a post-play discussion in which you will be asked questions about how the priorities of the MCIEB could be better integrated in nursing education and your experience with forum theatre as a learning approach.

The forum theatre play and post-play discussion will be video-recorded and the video may be used for educational purposes. While you will not be named, there is the possibility that someone viewing the video for educational purposes might be able to identify you. If you do not want your image released on the video, we can blur your face in the video. You can withdraw from the study at any time, and there will be no repercussions for not participating.

In appreciation of your time, there will be a draw for three $100 cash prizes for nursing students attending the play.

If you are interested in participating, please complete the student interest form that is being distributed. If you would like more information, you can email me at xxxxxxPlease remember that your participation is voluntary and you are under no obligation to participate. Thank you for considering my request. Do you have any questions for me?

Sincerely,
Vanessa Van Bewer
Primary Investigator,
Doctoral Student,
College of Nursing, University of Manitoba
Research Supervisor: Roberta Woodgate, RN, PhD
College of Nursing, University of Manitoba
Roberta.Woodgate@umanitoba.ca

APPENDIX E: NURSING STUDENT INTEREST FORM

Please check the appropriate box below to indicate if you would like to participate in this study. Thank you.

 I would like to participate in Vanessa Van Bewer's study entitled:
"Rehearsing for the revolution: Using forum theatre to engage nursing educators, students and health care providers with the priorities of the Manitoba Collaborative Indigenous Education Blueprint".

YES _____

NO _____

If yes, please provide your name and phone number and/or email address.

My name is: _____

My signature: _____

My phone number is: _____

My email address is: _____

My preferred method of contact is:

_____

The researcher will first attempt to contact you at your preferred method of contact. If you provide alternate contact information, she may also use that information to contact you about your involvement in the study.

Thank-you for your time and consideration,
Vanessa Van Bewer
Primary Investigator, Doctoral Student,
College of Nursing, University of Manitoba

Research Supervisor: Roberta Woodgate, RN, PhD
College of Nursing, University of Manitoba
Roberta.Woodgate@umanitoba.ca

APPENDIX F: NURSING STUDENT PARTICIPANT INFORMATION AND CONSENT

FORM

Forum Theatre Play

Title of Study: Rehearsing for the revolution: Using forum theatre to engage nurses, nursing educators and nursing students with the priorities of the Manitoba Collaborative Indigenous Education Blueprint.
Principal Investigator: Vanessa Van Bewer, College of Nursing, University of Manitoba
Co-Investigators: Dr. Roberta Woodgate, College of Nursing University of Manitoba
Dr. Donna Martin, College of Nursing, University of Manitoba
Dr. Frank Deer, Faculty of Education, University of Manitoba
Sponsor: Manitoba Centre for Nursing and Health Research

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the principal investigator, your friends, colleagues, and/or family before you make your decision.

Purpose of this Study

The purpose of this research is to examine the use of forum theatre, a form of participatory theatre as a teaching approach to understand nursing educators', students' and health care providers' understanding of several priorities outlined in the Manitoba Collaborative Indigenous Education Blueprint (MCIEB).

The MCIEB is intended to take action on the Calls to Action of the Truth and Reconciliation Commission of Canada (2015) as they relate to education. The University of Manitoba is signatory to the MCIEB and while not all priorities outlined in the MCIEB are relevant to the College of Nursing, the following priorities are important for schools of nursing:

- Bringing Indigenous knowledge, languages and intellectual traditions, models and approaches into curriculum and pedagogy (Priority #2, MCIEB).
- Promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples (Priority #3, MCIEB).
- Building school and campus communities that are free of racism, value diversity and foster cultural safety (Priority # 6, MCIEB).

The objectives of the study are the following:
1) To explore through forum theatre several of the priorities outlined in the MCIEB (priorities #2, 3 & 6) with nursing educators, students and health care providers.
2) To explore possibilities for integrating the priorities of the MCIEB within nursing education.
3) To explore nursing educators, health care providers', and nursing students' experiences of FT as a pedagogical approach.

Participants Selection

You are being asked to participate in this study because the researcher would like to explore the priorities of the MCIEB with nursing students; students' thoughts on how the priorities of the MCIEB could be integrated within schools of nursing; and what students think about forum theatre as a learning strategy. A total of 12-40 nursing students be recruited to participate in the

project. In addition to nursing students, nursing educators and health care providers will also participate in this research.

Study procedures

- The method of data collection is a forum theatre play.
- If you agree to participate in this research, you will attend a forum theatre play as an audience member. The play will be created by nursing educators and health care providers who will also be the actors in the play.
- When you arrive to the play, you will complete a short demographic form (e.g. asking about age, gender, education, etc.). This form is expected to take between 5-10 minutes to complete.
- You will be invited to watch the forum theatre play at the Black Hole Theatre on the University of Manitoba campus.
- The play will be about the priorities of the MCIEB.
- You will watch the play once without interruptions. The play will last approximately 20 minutes.
- You will watch the play a second time and have the opportunity to stop the play, replace an actor on the stage and attempt to change the outcome of the play.
- Many different audience members can replace the actor(s) on the stage and attempt to change the outcome of the play.
- The audience will provide feedback regarding the effectiveness of the solution acted on stage.
- Participating as an audience member in this research does not mean that you must replace an actor on the stage. Choosing to replace an actor is completely voluntary and you will not be asked to do so by the theatre facilitator or the researcher.
- After the play, there will be a post-play discussion with the audience and the actors about the MCIEB and about forum theatre.
- Your participation in this study is as an audience member, along with 12-40 other nursing students and 5-15 nursing educators and health care providers as actors.
- Participation in the study will be last approximately 2-3 hours in one day.
- There will be a theatre facilitator present for the forum theatre play who will ask questions of the audience and facilitate the discussion during and after the play. The theatre facilitator will be an experienced forum theatre facilitator from Winnipeg's theatre community.
- The forum theatre play will be video-taped and photographs may be taken of scenes of the play. Students and educators will be video-taped during the forum theatre play and photographs may be taken.
- The video-tape will be transcribed by the company *Transcription Heroes* to ensure accurate reporting of the information that unfolds during the performance.
- Transcribers will sign a form stating that they will not discuss any item on the recording with anyone other than the researchers.
- The video-tape will be stored in on an encrypted USB flash drive before and after being transcribed. The transcription of the play will be destroyed within 7 years of completing the study. The video-recording may be retained longer for educational purposes.

- You will be provided with a summary report upon completion of the study. At your request, you will be provided with a copy of journal manuscripts emerging from the *playbuilding* workshop and forum theatre performance.

Risks and Discomforts
There are very few risks. However, you may find some of the content in the play to be upsetting or emotional. You do not have to answer any question that makes you feel uncomfortable or that you find too upsetting. You can also choose to leave the performance at any time. Please let the PI know if you have any concerns.
Should you need any additional help or support, we will refer you to the Student Counselling Centre at 474 UMSU University Centre (Fort Garry Campus) at (204) 474-8592.

Benefits
You may find that the information gained during the play and post-play discussion helps you in your clinical practice. In the future, other students, nursing educators and schools of nursing may benefit from what we learn in this study.

Costs
There are no costs associated with participating in the workshop.

Payment for participation
There will be no payment for participation in this study. However, you may receive credit for participation in this study in lieu of practicum or class time.

Confidentiality
Given the participatory and collaborative nature of this research project, confidentiality and anonymity are not possible. However, your contact information will be kept separate from the recording and the transcript of the play which will be coded. During the course of this research the PI will only retain your name and contact information for the purpose of contacting you. Your name and contact information will not be linked to the recordings or transcripts.
The findings of this study may be published in an academic journal and presentations will be given both locally and nationally. In any publications or presentations about the study findings, the researchers will ensure that your identity remains confidential. Your name will not be used. Care will be taken to ensure that any quotes used from the data to present the study findings contain no identifying information in order to protect your privacy.
During the course of the research and for 7 years following the conclusion of this study, the data and confidential materials will be stored on encrypted USB flash drives in a locked filing cabinet. These materials will only be accessible to the researchers listed above. The confidential materials will be destroyed in a secure manner after 7 years.
Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy. These people or groups are:
- ➢ The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability.
- ➢ Quality assurance staff of the University of Manitoba in the College of Nursing who ensure the study is being conducted properly.

Your personal information is being collected under the authority of The University of Manitoba Act. The information you provide will be used by the University for the purpose of research and education. Your personal information will not be used or disclosed for other purposes, unless

permitted by the Freedom of Information and Protection of Privacy Act (FIPPA). If you have any questions about the collection of your personal information, contact the Access & Privacy Office (tel. 204-474-9462), 233 Elizabeth Dafoe Library, University of Manitoba, Winnipeg, MB, R3T 2N2.

Permission to Quote, Record, Photograph

Due to the nature of this research, the PI will collect video recordings or photographs of participants during the forum theatre performance. The purpose of collecting the video recording during the research is for use in transcribing the play, in analyzing the play and for educational purposes. The recorded information is expected to include images and/or voices that may identify you. If you withdraw consent for the study after a video has already been released, we will blur your face in any video-recording released for educational purposes.

We may wish to quote your words directly in reports and publications resulting from this study. We will not reveal identifying information and your quotation would be anonymous. We may wish to include photographs of the workshop in reports or publications resulting of this study. Please check yes or no for each of the following statements:

Researchers may publish documents that contain the following information:	
☐ Yes ☐ No	I agree to be quoted directly if my name is not published (I remain anonymous).
☐ Yes ☐ No	I agree to be video-recorded.
☐ Yes ☐ No	I agree to be photographed.

<u>Voluntary Participation/Withdrawal from the Study</u>

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

Your participation or discontinuance in the study will not constitute an element of your student performance or evaluation.

<u>Questions</u>

If any questions come up during or after the study contact the principal investigator: Vanessa Van Bewer at xxxxxx or xxxxxx

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

Consent Signatures:
1. I have read all 5 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.

5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

Participant signature_____   **Date** _____

                                                                                                    (day/month/year)

Participant printed name: _____

APPENDIX G: FOLLOW-UP EMAIL FOR COLLEGE OF NURSING STUDENTS

Dear Student,

You may have already indicated your interest in participating in the study "Rehearsing for the revolution: Using forum theatre to engage nursing educators, students and health care providers with the priorities of the Manitoba Collaborative Indigenous Education Blueprint". If not, this message reminder is being sent to you to ask you to consider participating in this study. If you are interested in participating, please respond to this email.

Thank you for considering this request.

Vanessa Van Bewer, Principal Investigator, Doctoral Student, University of Manitoba

APPENDIX H: NURSING EDUCATOR AND HEALTH CARE PROVIDER

INFORMATION AND CONSENT FORM

Playbuilding Workshop and Forum Theatre Performance

Title of Study: Rehearsing for the revolution: Using forum theatre to engage nursing educators, students and health care providers with the priorities of the Manitoba Collaborative Indigenous Education Blueprint.

Principal Investigator: Vanessa Van Bewer, College of Nursing, University of Manitoba
Co-Investigators: Dr. Roberta Woodgate, College of Nursing, University of Manitoba
Dr. Donna Martin, College of Nursing, University of Manitoba
Dr. Frank Deer, Faculty of Education, University of Manitoba
Sponsor: Manitoba Centre for Nursing and Health Research

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the principal investigator, your friends, colleagues, and/or family before you make your decision.

Purpose of this Study

The purpose of this research is to examine the use of forum theatre, a form of participatory theatre, as a pedagogical approach to understand nursing educators' and health care providers' engagement with certain priorities outlined in the Manitoba Collaborative Indigenous Education Blueprint (MCIEB). The MCIEB is intended to take action on the Calls to Action of the Truth and Reconciliation Commission of Canada (2015) as it relates to education. The University of Manitoba is signatory to the MCIEB and while not all priorities outlined in the MCIEB are relevant to the College of Nursing, the following priorities are important for schools of nursing:

- Bringing Indigenous knowledge, languages and intellectual traditions, models and approaches into curriculum and pedagogy (Priority #2, MCIEB).
- Promoting research and learning that reflects the history and contemporary context of the lives of Indigenous peoples (Priority #3, MCIEB).
- Building school and campus communities that are free of racism, value diversity and foster cultural safety (Priority # 6, MCIEB).

The objectives of the study are the following:
1) To explore through forum theatre several of the priorities outlined in the MCIEB (priorities #2, 3 & 6) with nursing educators, students and health care providers.
2) To explore possibilities for integrating the priorities of the MCIEB within schools of nursing.
3) To explore nursing educators', students' and health care providers' experiences of FT as a pedagogical approach.

There are two phases to this research project:

Phase 1: The first phase involves a *playbuilding* workshop with nursing educators, and health care providers in which you will participate in theatrical activities/games; and discuss the priorities of the MCIEB as well as your past and current educational and clinical experiences with the content identified in the MCIEB. You, along with the other participants, a theatre facilitator, and Indigenous nurse-Elder and the PI will then collaboratively create a play from these discussions.

Phase 2: The second phase of the research project involves presenting the play created from the workshop to an audience of nursing students in the style of forum theatre. Forum theatre is a type of participatory theatre in which a play is shown once to an audience without interruption. The play ends in an unresolved fashion. The second time the play is shown, the participants in the audience yell "stop" during the play to intervene in an attempt to change the outcome of the play. Participants in the audience are referred to as "spect-actors" in forum theatre. For this research, the actors in the play will be some of the participants from Phase 1 (*playbuilding* workshop). Participants in phase 1 of the play will be asked if they would like to participate as actors presenting the play to nursing students. If you consent to participating in Phase 1 (*playbuilding* workshop), there is no obligation to participate in Phase 2 of the research. Consent for Phase 2 is separate from Phase 1.

Participants Selection

You are being asked to participate in this study because as a nurse, nursing educator or health care provider you have experience teaching and/or learning within a school of nursing or other health professional training. A total of 5-15 nursing educators and health care providers will be recruited to participate in the workshop and a total of 4-5 workshop participants will be recruited to participate in the forum theatre performance.

Study procedures

Phase 1:

- The method of data collection is a *playbuilding* workshop.
- Prior to the workshop, you will complete a short demographic form (e.g. asking about age, gender, education, etc.). This form is expected to take between 5-10 minutes to complete.
- You will be involved in a *playbuilding* workshop in which you will create a script based on the priorities of the MCIEB along with other nursing educators, health care providers, a theatre facilitator and an Indigenous nurse-Elder.
- The workshop will include 5-15 nursing educators and health care providers.
- The workshop will last 8 hours.
- There will be a theatre facilitator and an Indigenous nurse Elder present for the workshop who will help guide you through theatrical exercises, ask questions, facilitate the discussion and help create the script. The theatre facilitator will be an experienced forum theatre facilitator from Winnipeg's theatre community. The theatre facilitator and Indigenous nurse Elder will sign a form stating that they will not discuss information shared during the workshop with anyone other than the researchers.
- During the workshop, you will be asked some questions relating to your experiences with nursing education and/or clinical practice. These questions will help us to better understand how nursing educators and health care providers engage with the priorities

outlined in the MCIEB, and identify future possibilities for upholding the priorities outlined in the MCIEB.

- The workshop will be audio-taped and the audio-tape will be transcribed by the company *Transcription Heroes* to ensure accurate reporting of the information that you provide.
- The transcriber will sign a form stating that they will not discuss any item on the tape with anyone other than the researchers.
- At the start of the *playbuilding* workshop, everyone will be asked to respect the privacy of the other workshop members. All participants will be asked not to disclose anything said within the context of the discussion, but it is important to understand that other people in the workshop with you may not keep all information private and confidential.
- The audio-tape recording will be stored in an encrypted USB drive before and after being transcribed. Audio-recordings and transcriptions will be destroyed within 7 years of completing the study.
- Given that this is a collaborative project that aims to create a script based on the discussions in the workshop, you will be acknowledged in journal publications relating to the *playbuilding* workshop and performance to respect your creative contributions. If you do not wish to be acknowledged in any journal publications, you can decline.
- You will be provided with a summary report upon completion of the study. At your request, you will be provided with a copy of journal manuscripts emerging from the *playbuilding* workshop and forum theatre performance.

Phase 2:
- The method of data collection is a forum theatre performance and post-play discussion.
- 4-5 participants from Phase 1 (*playbuilding* workshop) will be recruited to participate as actors in the forum theatre performance.
- Participation as an actor is completely voluntary. If you participate in phase 1 of the research, there is no obligation to participate in phase 2.
- If you agree to participating in phase 2, you will be involved as an actor in a forum theatre performance of the script developed during the playbuilding workshop.
- The play will be presented to an audience of nursing students.
- You will present the play once without interruptions.
- After watching the play once, nursing students will then have an opportunity to replace an actor on the stage and try to change the outcome of the play.
- Your role as an actor on stage is to stay in character.
- Many students may take turns replacing an actor on the stage.
- At the end of the play, there will be a post-play discussion about the priorities of the MCIEB, and a discussion on forum theatre as a pedagogical approach.
- The play will be videotaped and photographs of scenes of the play may be taken.
- You do not need any formal or past experience as an actor to participate in the forum theatre performance.
- The rehearsal and performance of the play, along with the interventions provided by the nursing students and a post-play discussion will last approximately 4-8 hours.

Risks and Discomforts

There are very few risks. However, you may find talking about the priorities of the MCIEB or your experiences in clinical practice to be upsetting or emotional. You do not have to answer any question that makes you feel uncomfortable or that you find too upsetting.

For University of Manitoba employees

Should you need any additional help or support, we will refer you to the *Employee & Family Assistance Program* at 1-800-387-4765 (English) or 1-800-361-5676 (French) or help you find other counseling help.

For participants who are not University of Manitoba employees.

Should you need additional help or support, you will be referred to the following counselling services:

Klinic Crisis Line at (204) 786-8686 or 1-888-322-3019

First Nations and Inuit Hope for Wellness Help Line at 1-855-242-331

Benefits

As a member of the forum theatre performance and/or *playbuilding* workshop, you will be acknowledged on any publication(s) that emerge from the workshop and performance of this research (you can decline this acknowledgement). As a collaborator in the *playbuilding* workshop or the forum theatre performance, the information gained may help your professional practice and may help other nursing educators and health care providers with their professional practice in the future.

Costs

There may be costs relating to parking, travel and time off work you might incur as a result of participating in the workshop and performance.

Payment for participation

Lunch will be provided on the day of the workshop for all participants.

Participants who are not employees of the University of Manitoba will be given $100 for participation in the workshop in compensation for costs relating to parking, travel and time off work.

Participants who are not employees of the University of Manitoba will be given $100 for participation in the forum performance in compensation for costs relating to parking, travel and time off work.

Confidentiality

Information gathered in this research study may be published or presented in public forums. Given the collaborative nature of this study, if you agree, your name will be acknowledged in any publication that emerges from the workshop or forum theatre play. If you would prefer to not be acknowledged, your name and other identifying information will not be used or revealed. Your names will be replaced by code numbers so that no one will be able to identify you. Confidentiality and anonymity during the workshop and forum theatre performance are not possible. However, we ask that all participants respect and maintain the confidentially of the discussions during the workshop. However, it is not possible for the researchers to guarantee that everyone will do so. However, the script created during the workshop will present a fictional story, not one participant's particular story or experiences.

If you decide to withdraw consent after the play, your face will be blurred from any video recording released for educational purposes and your name will not be acknowledged in any publications emerging from the workshop or the forum theatre play.

Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy. These people or groups are:

- ➤ The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability
- ➤ Quality assurance staff of the University of Manitoba in the College of Nursing who ensure the study is being conducted properly

All records will be kept in an encrypted USB flash drive in a locked filing cabinet in the PI's home office. Only the PI and the PI's supervisor will have access to these records. If any of your research records need to be copied to any of the above, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

Your personal information is being collected under the authority of The University of Manitoba Act. The information you provide will be used by the University for the purpose of research and education. Your personal information will not be used or disclosed for other purposes, unless permitted by the Freedom of Information and Protection of Privacy Act (FIPPA). If you have any questions about the collection of your personal information, contact the Access & Privacy Office (tel. 204-474-9462), 233 Elizabeth Dafoe Library, University of Manitoba, Winnipeg, MB, R3T 2N2.

Permission to Quote, Record, Photograph and Permission for acknowledgement in publications:

We may wish to quote your words directly in reports and publications resulting from this. We wish to audio-record the workshop and take pictures during the workshop. We also wish to acknowledge you for your creative contributions on publications emerging from the workshop and play. Please check yes or no for each of the following statements:

Researchers may publish documents that contain the following information:		
☐ Yes ☐ No	I agree to be quoted directly (my name is used).	
☐ Yes ☐ No	I agree to be quoted directly if my name is not published (I remain anonymous).	
☐ Yes ☐ No	I agree to be quoted directly if a made-up name (pseudonym) is used.	
☐ Yes ☐ No	I agree to be audio-recorded.	
☐ Yes ☐ No	I agree to be photographed.	
☐ Yes ☐ No	I allow my name to be acknowledged in any publications resulting from this project.	

<u>Voluntary Participation/Withdrawal from the Study</u>
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

If you are an employee of the College of Nursing, or the University of Manitoba, your participation or discontinuance in the study will not constitute an element of your job performance or evaluation nor will it be part of your personnel record at the University of Manitoba.

Questions

If any questions come up during or after the study contact the principal investigator: Vanessa Van Bewer at xxxxxxx or xxxxxx

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

Consent Signatures for workshop (Phase 1):

8. I have read all 7 pages of the consent form.
9. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
10. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
11. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
12. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
13. I understand I will be provided with a copy of the consent form for my records.
14. I agree to participate in the study.

Participant signature_____   **Date** _____
                                                                            (day/month/year)

Participant printed name: _____

Consent Signatures for forum theatre performance (Phase 2):

1. I have read all 7 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

Participant signature_____   **Date** _____
                                                                            (day/month/year)

Participant printed name: _____

APPENDIX I: DEMOGRAPHIC QUESTIONNAIRE FOR NURSING EDUCATORS

AND HEALTH CARE PROVIDERS

1. Please tell me your age in years. _____

2. What do you identify as your gender? _____

3. Which of the following best describes your population group?
   ___ Arab/West Asian
   ___ Asian
   ___ Black
   ___ First Nations
   ___ Inuit
   ___ Métis
   ___ Latin American
   ___ White (Caucasian)
   ___ Other (please specify) _____

4. Which of the following best describes your current occupation?
   ___ Nursing educator
   ___ Nurse
   ___ Health care provider (please specify) _____

5. How many years have you been a nurse or health care provider? _____

6. If applicable, how many years have you been a nursing educator? _____

7. Had you heard of the Manitoba Collaborative Indigenous Education Blueprint before being approached for this study?

   Yes_____   No_____

   If yes, briefly describe what you know?

APPENDIX J: DEMOGRAPHIC QUESTIONNAIRE FOR NURSING STUDENTS

1. Please tell me your age in years. _____

2. What do you identify as your gender? _____

3. Which of the following best describes your population group?
   ___ Arab/West Asian
   ___ Asian
   ___ Black
   ___ First Nations
   ___ Inuit
   ___ Métis
   ___ Latin American
   ___ White (Caucasian)
   ___ Other (please specify) _____

4. How many years of post-secondary education did you have before starting the nursing program? _____

5. In what year of the nursing program are you? _____

6. Had you heard of the Manitoba Collaborative Indigenous Education Blueprint before being approached for this study?

   Yes_____   No_____

   If yes, briefly describe what you know?

APPENDIX K: CONFIDENTIALITY AGREEMENT FOR RESEARCH PERSONNEL

Project title – Rehearsing for the revolution: Using forum theatre to engage nursing educators, students and health care providers with the priorities of the Manitoba Collaborative Indigenous Education Blueprint

I, _____ , the _____ (specific job description, e.g., interpreter/translator) have been hired to _____

I agree to -

1. keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the *Researcher(s)*.

2. keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.

3. return all research information in any form or format (e.g., disks, tapes, transcripts) to the *Researcher(s)* when I have completed the research tasks.

4. after consulting with the *Researcher(s),* erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher(s)* (e.g., information stored on computer hard drive).

5. other (specify).

_____   _____   _____
(Print Name)   (Signature)   (Date)

Researcher(s)

_____   _____   _____
(Print Name)   (Signature)   (Date)

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Research Ethics Board at the University of Manitoba. For questions regarding participant rights and ethical conduct of research, contact the University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Agreement retrieved from the University of Alberta.

APPENDIX L: VIGNETTE #1

The scene begins with two nursing students sitting side by side in a classroom waiting for their teacher to start the class. Stacy is visibly Indigenous, while the other student, Carrie, is White in appearance. Stacy and Carrie have a relatively new relationship with each other, and Carrie has never revealed that she is Indigenous.

Stacy: Hey, Carrie, what's with those beaded earrings?

Carrie: What do you mean?

Stacy: I mean, they're beautiful, but, as a Cree woman, I feel like I really need to explain to you as a non-Indigenous person how that can be really offensive to be wearing those, because there is lots of significance behind...For instance the colors of those beads, they represent the four directions, which are actually the colors that were gifted to me when I received my spirit name, so I feel like, if you're going to wear those, at least you should wear earrings that were made by Indigenous artists.

Carrie: Stacy- I am Métis.

Stacy: Like, are you claiming that now just because you want to get in with a lower GPA, or…?

Carrie: I am Métis, I'm from Peguis, I was born and raised there.

Stacy: Well, I see blonde, blue eyes, I just don't get this.

Carrie: I just want to…nevermind.

Teacher: *(Teacher stands)* Let's begin. Good afternoon. And it being a Friday afternoon, let's keep it brief. I know we all want to go home and get out of here and start our weekend, right? Okay, today's topic, nutrition, specifically childhood nutrition. With an addition. Okay, since the TRC, we, as a very culturally aware and sensitive university,

are going to be introducing this topic about childhood nutrition on the reserves. Let's be

progressive, shall we? I have an idea, instead of listening to me drone on and on and on

about this subject, why don't we invite a native person who clearly was raised on a

reserve…an Aboriginal. What is the PC term these days anyhow? Who really knows,

right? *(Teacher chuckles and then motions for Stacy to come to the front of the class).*

Come on up. Right here. It's terrible what's happened to these people, isn't it? No

drinkable water on their reserves. Forced with Coca Cola in their baby bottles. Virtually

raised on junk food. *(Teacher turns to Stacy who is uncomfortably standing at the front of*

the class). Can you speak about that?

Stacy: I don't really know what you want me to...

Teacher: No, no, no, no. You are a voice for your people. You wanted this chance.

Continue.

Stacy: *(Turning to the audience)* I just want to disappear.

The End

APPENDIX M: VIGNETTE #2

The scene begins with two nursing students, one Indigenous (Shavon,) and the other White (Madison), sitting in a room waiting for their clinical instructor (Jody) to start their first clinical rotation on a maternity ward.

Madison:	So, good morning.
Shavon:	Good morning.
Madison:	Hi, actually, I've seen you in class before, but we've never actually met. I'm Madison.
Shavon:	Shavon.
Madison:	Shavon, nice to meet you Shavon.
Shavon:	Thank you.
Madison:	So, Shavon, where are you from?
Shavon:	Oh, I'm from up north.
Madison:	Oh my God, we're both rural! I'm from Niverville *(a town 30 minutes from the city with a predominately white, middle-class population).*
Madison:	So, hey Shavon, I haven't seen you at some of our Nursing Student Association events. I'm on the executive, so I just wanted to let you know that every Friday at 4:00 we meet at the Hub to eat and drink. And, so, just wanted to put that out there in case you wanted to join us sometime.
Shavon:	Oh, no, I wouldn't have time. I have to rush home after.
Madison:	Oh, do you live in the dorms?
Shavon:	No, no, I live with my auntie. We have an apartment.
Madison:	Oh. Oh, okay. Okay. Well, do you think you could join us sometime?
Shavon:	No, no, I have to rush home.
Madison:	Oh, why do you have to get home so fast?
Shavon:	Oh, I have to get home for my aunt. My aunt takes care of…*(pauses and reluctantly continues).* I have a son, he's about a year old.
Madison:	Oh, my God, well how old are you?

Shavon:	I'm 22.
Madison:	Really, I'm 22 too. I can't even imagine being a parent. How are you doing with that?
Shavon:	I'm okay.
Madison:	You're okay? Well, that's good. *(Madison is struggling to keep the conversation going).* Um, so, I'm trying to keep up with my stream on Instagram and Snapchat and Facebook and all that, and so, I was wondering if you wouldn't mind if we could do a selfie together and I could post that on the Facebook page so that everybody sees that we're starting our labour and delivery rotation. Is that okay?
Shavon:	*(Shavon is clearly uncomfortable but agrees)* Mmm…yeah.
Madison:	Okay, all right so, let's say, 1,2 3, labour and delivery rocks! Okay, here we go.
Shavon:	(Shavon mumbles). Labour and delivery rocks.

Jody, the clinical instructor enters the room.

Jody:	Hi there, I'm Jody, I'm your clinical instructor for this rotation. *(Looking at Madison).* What's your name?
Madison:	I'm Madison.
Jody:	Okay Madison, nice to meet you. *(Turns to Shavon).* And you must be Shavon. So, I'm very excited about this rotation, I love labor and delivery and I love the St. Mary's General Hospital. This is a really great hospital. You're going to learn things here that you just would not learn at any of the other hospitals. So, hopefully this will be a really great term for all of us.
Jody:	So, before we go to the unit, I thought we'd spend a little bit of time talking about the process for families when they come to the hospital. So, the first place that families go when they come to the hospital is to triage and that's where they're assessed and we figure out from there where they need to go. A really important thing about triage is the birth alert binder. All right, so you're going to want to have a look at the birth alert binder. This is where we keep all of the notes and referrals for child and family services about which babies are going to be apprehended, and which ones require further assessment after delivery. So, with certain families, you want to make sure that you're looking at the birth alert binder. And this is St. Mary's so we get a lot of birth alerts.

(Shavon raises her hand to ask a question).

Jody:	Yes, Shavon.
Shavon:	Do you have to look at the binder for all of the families?
Jody:	Well, I guess technically you should look at the binder for all the families, but you'll start to figure out pretty quickly which families you really need to look at the binder for. St. Mary's is right next to Point McKay and is also the high-risk referral center for the North. And those population groups have a high number of apprehensions and child welfare system involvement. So, you'll start to get an idea of which families you really need to look at. I think you know what I mean *(Jody looks at Shavon knowingly).*
Madison:	*(whispering to Shavon)* What do you think she means by that?
Shavon:	*(speaking quietly)* I'll talk to you later.
Jody:	So, I had a chance to go to the unit and I picked out patients for both of you. There is an indigenous family on the unit, so we're all really happy you're here Shavon because you'll be able to take care of them.
Madison:	Jody, am I going to be assigned an aboriginal family as well?
Jody:	Eventually, but not today. There's like a lot of cultural, traditional things involved, that you probably won't know enough about, and Shavon will know all about that. You know, they want to take the placenta home, things like that.
Madison:	What, wait a minute, is that legal? Can you take the placenta home?
Jody:	Yeah, it is legal. Don't even get me started about that *(Jody rolls her eyes).* There's a whole policy.
Madison:	Oh my gosh, that sounds like a biohazard. *(Turning to Shavon)* Hey, Shavon, when you had a baby, did you take the placenta home?
Shavon:	Um…I'll talk to you later.
Madison:	Okay.
Jody:	Okay, so I just need to talk to your charge nurse about one more thing and then I'll come back and grab you both and we'll head in there. *(Jody leaves the room).*
Madison:	Awesome, I'm so excited. I'm so excited to see the babies. So, Shavon, I've never actually had the opportunity to talk to someone who is indigenous

before. And so, I'm wondering if you could answer some questions for me? And, so, my first question is about residential schools[6], and I'm just wondering like, from your perspective, was it really as bad as they said it was? Because I've heard that people who went to residential schools got an amazing education.

Shavon: *(Shavon appears very uncomfortable and stammers).* Well, um, well, um, I'll talk to you later about this. *(Turning to the audience)*. Can you believe this?

The End