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Indigenizing The Outbreak Narrative: How Lee Maracle, Richard Van Camp, And Cherie Dimaline Critique Settler Colonialism And Medical Racism

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INDIGENIZING THE OUTBREAK NARRATIVE: HOW LEE MARACLE, RICHARD VAN CAMP, AND CHERIE DIMALINE CRITIQUE SETTLER COLONIALISM AND MEDICAL RACISM

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Deanne Sparks
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Table of Contents

Acknowledgments

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Introduction

For the purposes of this dissertation, I am attempting to bring into conversation two functionally disparate fields, medical humanities[1] and Native literary studies, that appear to feature little to no crossover in academic discourse. In order to make this endeavor and my arguments manageable within a limited space, I have opted to aggressively narrow the scope to outbreak narratives and how Indigenous outbreak tales disrupt current literary criticism of the subgenera in general. One of the reasons for focusing on outbreak narratives stems from how current critique features some of the same research biases and blind spots as medical humanities criticism overall, especially source selection (traditional canon over inclusive and diverse BIPOC voices) and narrative construction (a binary opposition that favors the microbe over miasma).

The Problem with the Literary Canon of Medical Humanities

Part of the modern nation-state's failure to uphold its treaty-based health obligations to Native communities can be traced back to its adherence to western medical epistemologies and the institutions that replicate, reinforce, and repackage those knowledges and cultural behaviors to the public at-large and itself. Both individual and structural racism within the fields of medicine and healthcare appear through the absence (or silencing) of multi-ethnic voices, whether as patients, clinicians, artists, or critics. For example, medical and health humanities journals devote very little space for research or the highlighting of texts related to an author of color, especially if that author is Native. In 2007, John M. Hoberman published "Medical

[1] For the duration of this project, I will be using the more well-known and popular term "medical humanities" instead of "health humanities" even though much of my research and argumentation includes health and care – key tenets of the health humanities movement. I chose to use medical humanities in order to link and focus my arguments to medical institutions and epistemologies that underwrite much of the debates and rhetoric related to nation-state health/care policies and Eurowestern ideas of caretaking and nursing.

Racism and the Rhetoric of Exculpation: How Do Physicians Think About Race?". While his research focused on African American patients and their relationships with their overwhelmingly white doctors, his usage of pain medicine differential studies highlighted a discriminatory system that interpreted patient pain levels differently across race.[2] Five years later, Hoberman published *Black and Blue: The Origins and Consequences of Medical Racism* (2012) where he observed that medical humanities journals, as a representation of a field seeking to increase empathy and improve bedside manner, failed to publish and confront issues of race within its pages.[3] Another four years later, Olivia Banner observed that not much had changed since Hoberman.[4] Furthermore, she argued that the field should shift away from empathy-building in individuals and instead move toward critical assessment of the structural racism within western medical institutions. Her stance sought a more holistic, radical approach than the previously advocated individual, personal approach to reforming medical education and its professional practices.

Both Hoberman and Banner highlight the existence of a medical humanities canon that harkens back to a more traditional composition of dead, white, and (for the most part) male-authored texts. Banner goes so far as to identify specific "foundational works" such as Howard Brody's *Stories of Sickness,* Arthur Kleinman's *The Illness Narratives*, Arthur Frank's *The Wounded Storyteller,* Anne Hawkin's *Reconstructing Illness*, and Rita Charon's *Narrative Medicine.* Nevertheless, she does acknowledge that scholars consider Audre Lorde's *The Cancer*

[2] John M. Hoberman, "Medical Racism and the Rhetoric of Exculpation: How Do Physicians Think About Race?" *New Literary History* 38 (Summer 2007): 505-525.

[3] John M. Hoberman, *Black and Blue: The Origins and Consequences of Medical Racism* (University of California Press, 2012) as qtd in Olivia Banner, "Structural Racism and Practices of Reading in the Medical Humanities," *Literature and Medicine* (Spring 2016) 25-52.

[4] Banner 28.

Journals and Anatole Broyard's *Intoxicated By My Illness* to be "more or less exemplary" in their representation of the patient and their desires.[5]

I argue that because this canon includes less than a handful of diverse BIPOC voices, the fields of medical humanities and medical education both utilize curriculum and reading strategies that avoid structural medical racism and community-wide disease narratives by narrowly focusing on the exceptionalism of a particular patient-doctor encounter. Even though anthologies like Richard Reynolds and et al.'s *On Doctoring*[6] include a handful texts written by Latin@[7] and Afro-Americans, more critical work and recovery needs to be done in order to incorporate Asian American and Native American perspectives, literatures, and histories into these fields. For example, the US government is responsible for the funding and management of not only the Bureau of Indian Affairs but also the Indian Health Service. Since many practitioners and researchers will cross paths with these institutions, their patients, or test subjects (thanks to DNA research studies) at some point in their careers, it is vitally important for medical humanities scholars to be more inclusive and to integrate indigenous voices into their research and teaching. Native literatures, fiction and non-fiction, shed a bright light on the complicated intersection where the state (as both a national and settler colonial agent), its healthcare system, and citizenship requirements converge in the body and clinical experience of the Native patient.

As both a literary scholar and historian, I situate my work alongside Olivia Banner and other scholars who seek to reorient and redesign the objectives and curriculum of medical humanities and medical education. In particular, I argue that by integrating Native (and other

[5] Banner 28 and 27.

[6] Richard Reynolds and et.al, *On Doctoring: Stories, Poems, Essays*. 3rd ed. (Simon & Schuster, 2001).

[7] In order to acknowledge both the masculine and feminine forms of the word, scholars and publications use either Latin@ or Latinx as a gender-neutral or spectrum-aware classification.

multi-ethnic) voices a more complicated, nuanced picture emerges of the embodied and clinical experiences of multi-ethnic individuals navigating contemporary North American settler colonialism and its influence on western medical epistemologies as well as clinical practice. Such a multifaceted, diverse reading has the potential to create new (and reconsider old) avenues of research and patient care. Considering the Native patient as an individual linked to a tribal community embedded within particular historical and present-day contexts can potentially alter or upset the so-called textbook procedures that follow an internalized state-supported medical science that either fails to acknowledge its blind spots or refuses to accept alternative worldviews as a viable option for research and medical practice. Ultimately, much can be learned by widening one's gaze to include more BIPOC perspectives, especially those connected to queer, feminist, and indigenous theories and scholarship.

Outbreak Narratives: Structure, Miasma, and Virgin-Soil Hypothesis of Medical Humanities

Even though I have chosen to aggressively narrow my focus to outbreak narratives, reading the subgenre through a crossover lens that includes both Medical Humanities and literary Native Studies reveals biases and blind spots that replicate the larger canonical issues previously noted.

All criticism of outbreak narratives and epidemic histories must start with the classic analysis established in Charles E. Rosenberg's 1989 article "What is an Epidemic?,"[8] in which he advocates for a dramaturgical approach to analyzing disease events to determine whether or not they can be classified as true epidemics. Using Albert Camus's *The Plague* as the core example of the dramaturgical structure of epidemics, he argues that epidemics feature a

[8] Charles E. Rosenberg, "What is an Epidemic? AIDS in Historical Perspective," *Daedalus* 118 (Spring 1989): 1-17.

prologue, three Acts, and an epilogue that mimics the dramaturg. The prologue contains a moral message that humankind exists within a web of biological relationships, and features communities who anticipate the arrival of the disease. The three Acts focus on society's engagement with the epidemic through revelatory recognition to managing random human susceptibility then finally initiating reactionary public rituals in response to its biomedical threats. The epilogue skirts a definitive conclusion by reflecting upon the outbreak's significance and long-term effects.

Not intended as an update of Rosenberg, but more of an expansion of his foundational points, in *Contagious: Cultures, Carriers, and the Outbreak Narrative* (2008), Priscilla Wald argues that these narratives contain a structural formula that corresponds with a traditional plot structure and linear temporality: emergence, contagion routes, and containment. She observes that these outbreak narratives present a self-contained, closed environmental event that features an identifiable starting point with documented transmission routes.[9] However, their denouements seek only or settle for containment instead of disappearance of the disease through a cure or eradication via vaccination. Like Rosenberg, her outbreak narratives do not fully take into consideration aftermath conditions and endemic futures.

In addition to establishing the formula of outbreak narratives, critics through their own citational process (un)intentionally crafted a canon for this subgenre. Typically, critical analyses of fictional outbreak narratives tend to utilize the usual suspects list found in Jill Lepore's 2020 New Yorker article on "contagion fables" in which Albert Camus's *The Plague* is situated alongside Daniel Defoe's *Plague Year,* Mary Shelley's *The Last Man,* Edgar Allan Poe's "The Masque of the Red Death," Jack London's *The Scarlet* Plague, and Jose Saramago's *Blindness.*

[9] Priscilla Wald, *Contagious: Cultures, Carriers, and The Outbreak Narrative* (Duke University Press, 2008), 2.

Furthermore, she identifies within this set of texts two distinct types of epidemic genres. For her, "The structure of the modern plague novel […] is a series of variations on 'A Journal of the Plague Year' (a story set within the walls of quarantine) and 'The Last Man' (a story set among a ragged band of survivors)."[10] These two classic examples of epidemic fiction, along with Albert Camus's *The Plague*, hold prime of place for critics discussing outbreak fiction because they easily divide the fictional outbreak landscape into quarantine tales or stories of apocalyptic-esque survivors and further subdivide the narrative plotting into easily accessible and knowable phases.

However, such simple literary categories and plot structures ignore or erase complex, nuanced outbreak experiences authored by marginalized voices across Turtle Island. Beyond the fact that this outbreak fiction canon, like the medical humanities canon, does not contain BIPOC voices, Rosenberg, Wald and Lepore's structural analyses fail to take into consideration (or simply ignore) those fictional outbreak narratives that reside in a textual world of active disease but without the possibility of quarantine or containment. In Indigenous outbreak narratives, the characters must live in, not through, a devastating biomedical catastrophe where traditional containment models cannot function.

In these tales, the disease appears within settler communities first and then becomes an invading, invisible force affecting Native communities who are ill-equipped to simultaneously stave off its debilitating effects and locate a cure. Because the individual stranger-carrier fails to make an identifiable appearance, the disease appears in multiple indigenous bodies at once leaving indigenous communities to valiantly manage their physical and mental health through as best they can. Furthermore, settler communities who (usually) contained their original carriers of the contagion shroud their knowledge of the carriers and the cure with misdirection or bad

[10] Jill Lepore, "What our contagion fables are really about," *The New Yorker* (23 March 2020).

science, thus exacerbating the outbreak environment for Native communities. In Indigenous outbreak fiction, Native groups locate solutions thanks to allies willing to actively disrupt medical racism by stealing its knowledges (and equipment) and indigenous characters excavating counter-epistemologies that prove successful against Eurowestern exploitative biomedical beliefs. For Indigenous outbreak fiction, quarantine, containment, and small-scale survival models fail to materialize as an option because those options only exist for those the settler-state deems as privileged.

These privileges run counter to the common observation across scholars that outbreaks and their narratives showcase a form of egalitarianism. Outbreaks function as a multifaceted shared experience marking its participants with a temporal divide that manifests in a set of experiences and (new, coping) behaviors that provide common touchstones for a sense of belonging. For example, as Jill Lepore notes, in American literature, epidemics take a significantly "democratic twist: contagion is the last leveler."[11] Contagion contains a democratic nature that no one can escape. In the words of Howard Markel, "The most egalitarian of living organisms, they cross national boundaries and every social class, attacking without prejudice."[12] For these American historians and literary critics, germs flatten social distinctions due to their ability to strike anyone and everyone.

However, this position does not fully take into account the intersection of contagion with settler colonialism and the Indigenous biomedical experience within a settler medicine. While on the surface outbreaks appear to flatten the field and strike everyone, the outbreak narratives of Wald, Rosenberg, and cultural critic Darla Schweitzer typically ignore how settler colonialism

[11] Ibid.

[12] Howard Markel, *How Germs Travel: Six Major Epidemics That Have Invaded America and The Fears They Have Unleashed* (Penguin Random House, 2005), 5.

enables contagion to spread at far faster rates and with devastating results thanks to medical and social systems of oppression and discrimination. Indigenous outbreak narratives present an environmental and embodied world that takes seriously medical complications arising from access to treatments and perceived common knowledge about illness and its care. These narratives demand that the so-called democratic, egalitarian nature of contagion be unpacked and reconsidered in light of holistic intersectional considerations of settler colonialism, environmental conditions, gender roles, and justice.

Furthermore, outbreak narratives spotlight how microbial contagions make visible the web (a common metaphor amongst academics) of relationships that typically go unnoticed or overlooked. Mainstream outbreak narratives highlight the web of bio-relationships that cross communities and nations emphasizing the global/local interweaving of relationships. Outbreaks make these previously invisible, interconnected and interdependent routes visible with their disruptive nature and fatal consequences. However, Indigenous outbreak narratives center the relationality of the local community and its land base with the nation-state and its responsibility to the local and indigenous. They do not take the stance of wall-building or borders being able to stop diseases. Instead, Turtle Island outbreak narratives view the 49th Parallel as a settler colonialist construction that must be viewed as a legal fiction and porous. The critique of the nation-state and racial discrimination of the local Indigenous communities emphasizes ongoing settler colonialism and its continuing efforts to withhold basic medical resources and its deliberate attempts to obfuscate Eurowestern knowledges of care and treatment while refusing Indigenous knowledge and rituals be practiced.

Thanks to the popularity of the magic bullet belief system, the microbe model of medical storytelling continues to hold prime-of-place within popular belief and the nation-state's drive to

tackle medical emergencies using military problem-solving. Whereas Wald, Schweitzer, and Markel focus on germs and how their contagious nature infects particular narrative structures as well as bodies, Sonia Shah advocates for a paradigm shift that seeks to return the miasma model to the center of medical storytelling and how it influences research and policy. For her, the centering of the microbe model at the expense of the miasma model created serious blind spots as well as the potential for medical catastrophes to run-amok with devastating consequences while the nation waits for the possibility of a magic bullet that may never appear. By uncritically accepting the microbial model of storytelling, outbreak narratives fail to consider a holistic view or how miasma and its varied environmental factors can play havoc with disease events. For this dissertation, like Sonia Shah, I resurrect the archaic word "miasma" to refer to environmental issues that can exacerbate disease and outbreaks.

Prior to the 20th century, Turtle Island settler societies explained contagious diseases through miasma – a biomedical narrative theory that rooted outbreaks to their environmental conditions, both geographical and demographic. Miasma was an invisible or foggy atmospheric force (sometimes known as "bad air") that could cause disease. However, with the revelation of the microbe in the 19th century, contagions found their origin narratives revised from miasmas to military-inflected microbial invasions that could be targeted and eliminated with singular focus while also being nearly divorced from their environmental moorings. As science journalist, Sonia Shah noted, thanks to germ theory, "instead of untangling the web of social relations, environmental factors, and human behaviors that promoted disease, scientists could blame a single microscopic speck […] The multifarious process of infection was reduced to its simplest components: a naïve victim, a foreign germ, an unwanted incursion."[13] Because the microbe

[13] Sonia Shah, "It's time to tell a new story about coronavirus – our lives depend on it," *The Atlantic* (15 July 2020).

model views contagions as an invading externalized force, outbreaks become combat actions against a foreign enemy where the end-goal is full eradication, preferably through a biomedical-based maneuver like vaccines or pills.

Miasma as a common term mostly disappears from popular and scientific discourse of medicine in the 20th and 21st centuries. It came to be replaced with environmental terminology, social justice phrases (e.g. environmental racism), or rebranding miasma-related public health policies as the work of a "sanitationist state".[14] Nevertheless, thanks to the Covid-19 pandemic, it reappeared, mostly as an alliterative pairing with microbe, in popular critical discourse when discussing historical paradigm shifts.[15] I deploy miasma as a marker for disease transmission related to environmental conditions in order to align myself with the current discourse that maintains a historic binary opposition between microbe and miasma. Furthermore, I view environmental contexts and conditions as intersecting and layered with settler colonialism and other systems of oppression. Miasma's inherent invisibility contains an incredible power that functionally damages communities inhabited by indigenous groups. Medical fiction like Indigenous outbreak narratives provide a unique opportunity to reveal insidiously miasmic web-like forces making them visible, knowable, and linguistically comprehensible.

In addition to my resurrection of miasma and decentering of the microbe model of storytelling, this dissertation includes engagement with the virgin-soil-epidemic hypothesis often found in Indigenous disease histories. Although a great many Indigenous histories related to disease and epidemics have been published within the frameworks of genocide studies and settler

[14] John Fabian Witt, *American Contagions: Epidemics and the Law from Smallpox to Covid-19* (Yale University Press), 2020.

[15] See Markel and Sonia Shah.

colonialism, recent historical criticism has shifted to (re)consider what I have been calling the miasma model of medical narratives. As the historian Jeffrey Ostler argued,

> Post-contact diseases were crippling not so much because indigenous people lacked immunity, but because the conditions created by European and U.S. colonialism made Native communities vulnerable. The virgin-soil-epidemic hypothesis was valuable in countering earlier theories that attributed Native American population decline to racial inferiority, but its singular emphasis on biological difference implied that population collapses were nothing more than historical accidents. By stressing the importance of social conditions created by human decisions and actions, the new scholarship provides a far more disturbing picture.[16]

The virgin-soil hypothesis fails to take into consideration the devastatingly repetitive nature of contagious diseases where tribal communities as well as their settler neighbors saw seasons of sickness and waves of epidemics with high mortality rates. Ostler argues that the Indigenous outbreak narrative can no longer be a simple explanation of the relationship between the microbe and immunity. These histories must take into account the greater miasmic conditions and the indifference of settler colonialism which exacerbated the outbreak to devastating proportions. The virgin-soil hypothesis does not live in the past, but its continued reiteration into the present influences public policy and perceptions of the affected and infected community in disastrous ways.

[16] Jeffrey Ostler, "Disease Has Never Been Just Disease for Native Americans," *The Atlantic* (29 April 2020). Note: Virgin-soil epidemics or decreased immunity outbreaks did occur but were based within very specific circumstances that did create a universal experience across indigenous communities and tribal nations. Some tribes caught the disease while their neighbors did not. Others became infected because of allyship during European wars making violence the carrier that created the conditions for outbreaks. In different circumstances, some saw outbreaks a century or more after post-contact due to malnutrition and other environmental deprivations exacerbated by colonialism.

As historians and critics work toward a more holistic and miasmic approach to Indigenous outbreak histories in the early 21st century, Indigenous authors have been utilizing this approach within their fiction critiquing the virgin-soil-epidemic hypothesis and Rosenberg's epidemic-as-event along the way. Because Indigenous literatures place high value on the land (and its miasma concerns), their outbreak stories explore environmental and community issues alongside, and in relationship to, the epidemic. The disease cannot be divorced from the social conditions, histories, and land of the specific plotting. While the disease exists, haunting everyone, indigenous characters fight to survive in the moment and in the mundane of the daily.

Because my analysis is conducted at the intersection of Native literary studies and medical humanities, I seek to explore how contemporary Indigenous fiction grapples with the complex relationship between Native characters, communities, and Eurowestern medical epistemologies and institutions as portrayed through outbreak narratives. For this dissertation, I intentionally chose contemporary Indigenous-authored texts situated in Canada[17] that feature writers typically identified within a Turtle Island canon, but not necessarily widely known within the United States. In making these decisions, I tried to uphold a "politics of citation". When speaking of this intentional academic behavior, Daniel Heath Justice argues, "Always citing the same small circle of voices is both harmful to the health of the field and disrespectful to the many fine scholars and writers whose work informs, enhances, challenges, and complicates our broader conversation. It's also a political choice that too often silences the less empowered and

[17] Gregory Younging, *Elements of Indigenous Style: A Guide for Writing By and About Indigenous Peoples* (Brush Education, 2018). Note: Younging's text is an essential style guide that began as the house style guide for Theytus Books, the first Indigenous publishing house in Canada. The guide stipulates prioritizing Indigenous through capitalization (in the same manner as capitalizing Native or First Nations) as well as placing it in a primary position that emphasizes sovereignty of the group over the settler nation-state.

enfranchised, who are often the ones with the most trenchant understandings."[18] By practicing a "politics of citation" that intentionally chose Indigenous-authored texts by Lee Maracle, Richard Van Camp, and Cherie Dimaline, my intent is to persuade medical humanities and literary Native Studies scholars working within the United States to consider incorporating these Indigenous authors and texts that have not been marketed as widely (or aggressively) in the US.[19]

In addition to this authorial selection process, I also intentionally chose to restrict textual temporality in order to uphold the ongoing mandate in Native Studies to teach and present material in a manner that systematically critiques the myth of the vanishing or always-already dying Indian. Within Indigenous literary criticism, Thomas King openly speculated that one of the reasons why there is so little historical fiction written by Native authors is because of the desire to present Native characters as alive, contemporary, and actively present.[20] To that end, this widespread strategy meant to combat settler colonialism's ongoing cultural project of erasure has created a literary landscape that appears to actively avoid a temporal setting situated prior to the nineteenth century or earlier.[21] Even though this avoidance eliminates many of the iconic outbreak histories experienced by Indigenous groups across Turtle Island, Indigenous authors

[18] Daniel Heath Justice, *Why Indigenous Literatures Matter* (Wilfrid Laurier University Press, 2018), 242. See also Justice's bibliographic essay "Citational Relations" in its entirety where he discusses the citational work advocated by Sarah Ahmed, "Making Feminist Points" feministkilljoys blog (11 September 2013) and the Citational Practices Challenge hosted online at criticalethnicstudiesjournal.org/citation-practices/

[19] While it is theoretically possible that these three authors may be known by Native Studies scholars in the US, I would argue that the knowing is not the same as accessible and teachable. Lee Maracle's *Ravensong* is out-of-print in the US, not all of Richard Van Camp's short stories are available, and Cherie Dimaline's popularity stems from *The Marrow Thieves* and appears to not have widened to include her other novels.

[20] Thomas King, *The Truth About Stories: A Native Narrative* (University of Minnesota Press, 2008), 106.

[21] Margaret Verble and Louise Erdrich may stray into the late 19th century but are ultimately deeply connected to a 20th and 21st century setting. As to medical humanities texts, Louise Erdrich has probably come the closest to exploring the health and disease narratives of Indigenous characters across the generations, but her novels tend to step very lightly into the late nineteenth century instead of zero-in as the central focus.

instead center contemporary disease narratives and tribal health concerns which allows them to simultaneously spotlight new or endemic health crises while amplifying the actively present, always-already living Indigenous communities. My dissertation seeks to uphold this literary position of visibility and recognition by working with texts that privilege contemporary and futuristic settings. To intentionally amplify this temporal choice, the dissertation is structured chronologically starting with the" living memory" recent past of Lee Maracle's *Ravensong* (1993) then moving onto the contemporary present of Richard Van Vamp's "I Am Filled with a Trembling Light" (2019) and ending with the dystopian speculative future of Cherie Dimaline's *The Marrow Thieves* (2017).[22]

In Chapter 1, Lee Maracle's novel *Ravensong* situates its Indigenous community in a 1950s historic outbreak past that ultimately functions as a collective reflective exercise to explain its psycho-social consequences on the late 1970s / early 1980s. Its narrative world navigates waves of disease events alongside the medical racism of the clinics and hospitals and the microbial-focused neighboring white town that fails to take into consideration the settler colonial and miasmic impacts that exacerbate the disease experience for the Native village. By reading *Ravensong* point-for-point through Charles E. Rosenberg's outbreak narrative model, I highlight its generic structures as well as its slight divergences from the traditional expectations. Furthermore, I argue that while *Ravensong* follows the model's linear stages for the most part, it complicates each phase by exploring and showcasing settler colonialism's disruptions and Eurowestern medical racism that (in this case) fails to effectively treat and contain the disease. Instead, settler colonialism allows it to run rampant until Indigenous female caregivers literally

[22] I acknowledge that using a chronologically linear structure for analytical purposes can be perceived as a Eurowestern imposition that potentially erases, misconstrues, or radically shifts traditional Indigenous storytelling protocols that prioritize circular and cyclical forms. I have sought to counteract this potential problem by highlighting specific features of the storytelling protocols embedded within each text within the chapters.

take the knowledge and treatments into their own hands. The epidemic ends not through heroic masculine Eurowestern action, but through the negotiated response and agency of these women. In addition, *Ravensong* refuses the discrete, closed structure of Rosenberg's epidemic event by repeatedly highlighting the historical and ongoing outbreak waves that occur within the Native community, microbial and psycho-social in nature. Reflective closure fails to occur during the direct aftermath of the epidemic and instead appears a generation later during a lengthy recounting of its history in an attempt to explain the current social epidemic. For *Ravensong*, and other Indigenous outbreak narratives, epidemics do not simply end but overlap, evolve, and wave across space and time.

From *Ravensong*'s historical microbial epidemic exacerbated by miasmic conditions and outbreaks that further evolves into a psycho-social epidemic, Chapter 2 reads Richard Van Camp's short story "I am Filled with a Trembling Light" alongside Priscilla Wald's carrier and outbreak narrative structures to further explore how Indigenous outbreak tales utilize epidemics and disease carriers to critically and creatively unpack social outbreaks that do not contain a singular microbe to fight. By centering Indigenous oral storytelling techniques that refuse the traditional linear narrative structures found in Eurowestern literatures, this short story circles repeatedly back to specific scenes experienced by the carrier protagonist who remains fully situated in a contemporary present. This carrier tale displaces the germ-centric outbreak narrative with the biopsychological outbreak of soul murder. By shifting from microbe to miasmic-based conditions, the tale draws the genre toward nuanced, layered understandings of epidemics, both its' language and social components, and the carriers who wander the socially diseased landscape.

Staying within the bounds of social epidemics with no known microbial source, Chapter 3 explores a post-apocalyptic future where the outbreak only affects settlers and the dominant society views Indigenous bodies as the cure. By reading Cherie Dimaline's *The Marrow Thieves* alongside both Rosenberg and Wald's outbreak narrative structures, I argue that the novel highlights the elasticity and transportable nature of settler colonialism across space and time with institutions and policies being repackaged to tackle new outbreaks for the greater good at the expense of marginalized bodies and communities.

Chapter 1: The Past, or How an Outbreak History Contains Past, Present, and Plurality

As a genre, outbreak narratives focus on one highly infectious disease that appears abruptly and with the potential to enact disastrous sociopolitical and medical complications if not contained or cured as quickly as possible. This disease event creates heightened tension and suspense due to its highly indiscriminate nature because traditional socio-economic status markers fail to provide protection. The nation-state and its elite classes create a medico-political drive that demands social stratification and discriminatory behavior based on an individual and/or group's relation to perceived risk and immunity. Those who reside close or within risk-prone conditions are demonized, scapegoated, and segregated, while those who navigate spaces at some social and physical distance from risk are protected and prioritized for the greater good.

Indigenous outbreak narratives push the genre to tackle settler colonialism and its discriminatory influence on Eurowestern biomedical epistemologies and policies in the name of the nation-state and its prioritized citizens. These tales confront epidemic histories featuring settler colonial policies that exacerbate these events and master narratives regarding Indigenous immune systems and their perceived propensity to not survive disease-based events. They center Indigenous characters as active agents inhabiting outbreak-ravaged environments who must also navigate settler colonial policies that further threaten their lives and communities. Indigenous outbreak narratives disrupt typical outbreak structures in order to emphasize Indigenous knowledges as a decolonizing alternative to death-dealing Eurowestern medical racism, sociopolitical indifference, and dehumanizing policies.

In this chapter, I argue that Lee Maracle's 1993 novel *Ravensong*[23] features the traditional outbreak narrative structure that follows the five-stage sequencing advanced by Charles E. Rosenberg: anticipation, progressive revelation, managing randomness, negotiating the public response, and reflection after the epidemic has passed.[24] While it may not seem particularly revelatory to note point-for-point how *Ravensong* acts like a typical outbreak tale, I say that identification is the first step to greater multi-ethnic representation within the genre and its inclusion in classrooms and criticism. As I stipulated in the introduction, one of my goals for this project is to practice a "politics of citation" to intentionally cite and analyze texts that have not previously been given space and critical privilege in the United States, specifically in Medical Humanities criticism and pedagogy.[25]

Beyond the point-for-point identification process arguing that *Ravensong* qualifies as outbreak fiction, I also argue that the novel complicates the standard outbreak narrative formulas by critically unpacking the intersections of Native health and settler society in ways that showcase the indifference of settler colonialism and systemic medical racism. Unlike the medical triumphalist outbreak narratives where a Western-backed medical organization saves a community from certain death, *Ravensong* contains no comparable medical rescue from the settler nation or the practitioners in the neighboring white town. By centering the Indigenous experience, *Ravensong* spotlights how a settler-colonial world rife with medical racism actively discriminates against infected Indigenous communities to the point of failing to provide basic

[23] Lee Maracle, *Ravensong: A Novel* (Press Gang Publishers, 1993).

[24] Charles E. Rosenberg, "What is an Epidemic? AIDS in Historical Perspective," *Daedulus* 118 (Spring 1989): 1-17.

[25] As *Ravensong* is currently out-of-print in the United States and its sequel continues to be only distributed in Canada, I would like to hope that such advocacy will bring Maracle's novels back into circulation south of the 49th Parallel.

knowledge and resources with widespread fatal consequences. Instead, all understanding of the disease, including treatment and containment, come from caregiving members of the Indigenous community because settler medical practitioners and hospitals refuse.

Even though *Ravensong* maintains Rosenberg's structure of an outbreak narrative, it also pushes the genre to explore how settler medicine's germ-centric drive and its attending virgin soil hypothesis fails to consider how racism (general and medical) as well as miasmic environmental conditions can drive up fatality rates within Indigenous communities. The microbe is not the only factor, nor is the culture of a community at sole fault for increased fatal cases. *Ravensong* refuses to link the aggressively virile outbreaks with poverty and so-called primitive practices, a structural feature common within outbreak narratives. Instead, the novel disrupts the implied bias of singular microbial infestation and Eurowestern medical authority by centering intersectional, miasmic considerations that magnify the outbreak experience alongside the care practices of the Indigenous female caregivers.

My argument for shifting from germ-centric to miasmic-inclusive analysis takes its inspiration from Jeffrey Ostler and Dine historian Jennifer Denetdale's arguments that historic settler-initiated removals and mass medical incidents should be considered as health crises instigated and exacerbated by settler colonialism which continue to influence and directly affect present-day conditions and decision-making within Indigenous communities.[26] In particular, like the editors of the collection *Beyond Germs*,[27] they argue against the virgin soil hypothesis which postulates that diseases spread throughout Indigenous communities with little influence or

[26] Jennifer Denetdale links the Dine forced removal known as the Long Walk to present-day health crises in the Dine nation. She argues, "severe poverty, addiction, suicide, and crime on reservations all have their roots in the Long Walk". See Jennifer Denetdale as qtd in Laurel Morales, "Legacy of Forced March Still Haunts Navajo Nation," NPR (27 January 2014).

[27] Alan C. Swedlund, Paul Kelton, and Catherine M. Cameron, *Beyond Germs: Native Depopulation in North America* (University of Arizona Press, 2015): 3-15.

engagement with other factors, like settler colonial policies, generational immunity or individual prior immunity, environmental conditions, or intentional decrease in fertility or disrupted reproduction. In essence, the bodies of Indigenous communities were perpetually 'virgin soil' for whatever outbreak of communicable disease came their way. However, as *Ravensong* explicitly notes on more than one occasion, outbreaks function in 'waves' and not as singular, isolated events. They also enact near-annual tolls on the Native village which further exacerbate their ability to recover at rates comparable to the neighboring white town.

Ravensong explores the historic 1954 Hong Kong 'flu epidemic through the eyes of Stacey, an Indigenous young adult female trying to complete her senior year of high school in the "white town" across the bridge from her village located north of Vancouver, British Columbia. While juggling her studies, she with a group of Indigenous female caregivers nurse the village through a series of tragedies over the course of a single year. While attending class, she learns of the approaching epidemic and immediately anticipates its fatal consequences upon her community and her future goals. Shortly thereafter, the disease enters the province of British Columbia and proceeds to ravage Stacey's village with mass infection, devastating deaths, and exhaustion. Because no doctor will help and no hospital will admit them, eventually the women responsible for nursing the community take the initiative to learn on their own how to administer intravenous treatment, but they must steal the equipment from Vancouver hospitals in order to do so. Within a year, the epidemic passes, but its consequences can still be felt some twenty-five years later. The epilogue reveals that four women, including Stacey, have been retelling the outbreak history in order to answer Stacey's son question as to why his cousin committed suicide. Through this recounting, the women link the epidemic and its devastating social disruptions to the suicide.

In Rosenberg's narrative structure, during the initial "emerging infection" phase, the disease slowly appears within a community. Likewise, in Indigenous outbreak narratives, the epidemic usually arrives with prior warning through communication networks, but it functions within a world grappling with waves of disease outbreaks that span decades. These anticipatory actions and Indigenous knowledges do not determine the speed with which an outbreak spreads. Rosenberg's "emerging infection" phase appears to underestimate the aggressiveness of epidemics occurring in colonial environments, both biomedical and psychological. In traditional outbreak narratives, 'emerging' tends to be read as an initially slow, but steady process of appearance that eventually gains speed as its finds more hosts to infect. However, in Indigenous outbreak narratives, the disease appears rather than emerges. It infects households and groups seemingly all at once rather than creeping through one individual at a time.

In *Ravensong*, the epidemic strikes a house and then proceeds to whip through the village at frightening speed instilling terror and horror at the aggressiveness of a disease. At the beginning of the novel, Stacey's white classmate Carol blithely announces the coming of disease and gives its name as "the Hong Kong 'flu." Stacey's immediate reaction to the news features a visceral response bordering on vomiting her breakfast. The social dissolution of the Native village is at-risk from the start due to the potentially high case and fatality rates. To combat this ever-present threat, Native communities and their individual members remain vigilant towards encroaching disease threats and attempt to provide near-immediate collective care to those who fall ill and seek help. Carol's casual inquiries of "whatsa matter?"[28] and "are you all right?"[29]

[28] Maracle 25.

[29] Maracle, 27.

during Stacey's initial panic foreshadow the racial divide of disease and death experiences between the white town and the Native village that will be explored throughout the novel.

This opening interracial exchange between two classmates spotlights the racial complexities sometimes overlooked in the social construction of disease, death, and healthcare. As Stacey tells her mother, "'The 'flu means illness to them. For us it means terror.'"[30] For white town, influenza is a medical term denoting an illness assumed to be a recoverable condition. However, the same word invokes the stark emotional response of terror for the Native community based on past experiences of its devastatingly fatal nature. Specifically, Carol views her announcement as just another bit of news to share. Its name, "Hong Kong 'flu", makes the disease a paradoxical known-unknown since it's an influenza but from a distant exotically foreign place. For Stacey, the news carries terror connected to past 'waves' of outbreaks but the name of the disease means very little beyond rampant disease and devastation to the Native village. To know its name is to still remain in the dark. Its name only identifies its existence in the world of medicine as a 'thing,' but that knowledge brings no solace or knowledge of care management to the Indigenous community and its members. To name the disease does not change the reality of the community's disease experience since knowing that it's the Hong Kong 'flu does not provide additional resources, knowledge, or care for the Native village.

After hearing Carol's news, Stacey's immediate cognitive response features dark visual memories of tuberculosis cases that slide into her understanding of the differing cultural value of disease between the white town and her village. Stacey sees "frame after frame of the tubercular deaths of some ten years earlier jumped into view. They crowded the present, rendering her momentarily powerless […] tubercular deaths which plagued her village for some thirty years

[30] Maracle, 178.

some time back. This was the first tuberculosis-free year the village had had."[31] Upon hearing that a new, different disease approaches, Stacey's mind immediately links it to the recent and personally experienced ravages of tuberculosis. Carol's jarring announcement sparks cognitive and temporal disruption for Stacey whose mind overlaps past fatal outbreak waves with the present's anticipation of another. The first TB-free year turns out to be the year of an influenza epidemic. Instead of achieving disease-free years like the neighboring white town, the Native village experiences waves upon waves with varying degrees of immunity as well as little to know access to settler-controlled resources and knowledge related to disease and care management.

After the epidemic arrives and making itself known through increasing cases of infections, Rosenberg argues that outbreak death must reach unavoidable levels in order to be officially recognized by powerholders and the elites. However, citing the epidemic histories and narratives of Africa, Guillaume Lachenal and Gaetan Thomas argue, "that it is always possible to ignore an epidemic, and that ignorance is socially and historically produced along specific, often racial, lines."[32] Furthermore, they disagree with Rosenberg that denial is a distinct phase that precedes recognition since politics holds responsibility for recognition, in/visibility, and de-recognition of a disease event. Along these lines, the politics of recognition determine how death

[31] Maracle, 25.

[32] Guillaume Lachenal and Gaetan Thomas, "Epidemics have lost the plot," *Bulletin of the History of Medicine* 94 (Winter 2020): 681.

is culturally valued and ignored - whose death counts and whose does not.[33] During her moment of initial panic, Stacey acknowledges that death functions differently in white town and the Native village. For her,

> Death does not count in white town the same as it does in the village. […] She could see the meaning of death to the village. She watched the numbers terrify everyone. The loss was total. […] Every single person served the community, each one becoming a wedge of the family circle around which good health and well-being revolved. A missing person became a missing piece of the circle which could not be replaced. White people didn't seem to live this way. No one individual was indispensable. Their parts didn't seem bonded to their whole. It wasn't that they didn't feel their people's losses, it was that their losses didn't seem to have much value. Carol couldn't seem to conceive of the threat an epidemic posed. Stacey just shook her head, frightened by how inessential the others were to one another. No wonder they can blithely watch us die.[34]

Stacey fears the epidemic and marks it as a terror because each member of the community holds a unique position filled with deep knowledge and support that is irreplaceable (or extremely difficult to do so). To her, each death stands as an infinite collective loss because that person's services and aid are lost. Death experienced in white town, however, holds the event to be an individual emotional loss, not a community loss of knowledge and support. Even though members hold emotional connections to each other, they are replaceable as they are not welded

[33] While Rosenberg notes that epidemics end with "a whimper" and a not a bang, he opts to not closely interrogate how recognition politics and denial reappear at this final stage when officially determining and designating the end of an epidemic event. Thanks to ongoing discussions surrounding the end of Covid-19 at the time of writing, several historians and critics such as Lachenal, Thomas, Vargas, and Downs sought to tackle the complexities of when epidemics actually end and how denial and devaluation play a role. For one example of this ongoing debate, see Jim Downs, "Pandemics End When We Stop Caring About Their Victims," *The Atlantic* (9 June 2021).

[34] Maracle 25-26.

to the functional structure of the community. Such a loss of knowledge and support can potentially be easily replaced by other individuals. Thus, Carol fails to understand the terror felt by Stacey because Carol's concept of death and community individualizes the experience into separate parts that play interchangeable roles.

The differing cultural values of death alongside the differing connotative views of influenza intersect to facilitate the white town's stark judgment of the Native village's disease experience. While visiting Carol's family, the Snowdens, Stacey's mind wanders to the coming epidemic and how its presence will be interpreted by the people living in white town. She muses, "It would rip through her whole community barely noticed by the Snowdens or anyone else in white town. People would pinch out, 'It's a shame,' qualified by absolving remarks like, 'Well, look at how they live. Three generations under one roof. It can't be healthy. Please pass the salt.'"[35] Her predictions function as both foreshadowing as well as commentary on historical settler-colonial experiences and expectations of disease outbreaks. White town inhabitants "barely notice" when the disease does not directly affect and infect their towns and lives. If they do, their (re)actions are deeply rooted in a settler-colonial belief system that passes damning judgments upon Indigenous cultural practices and living conditions that reinforce indifference and victim-blaming. They care more about the epidemic's disruptions on commercial labor ("lost man-days") and the failure to create a magic bullet vaccine. In the eyes of Stacey, the epidemic is viewed as a mere inconvenience to those living in white town, while it is a devastating death-dealer to her own village.

After the emerging infection phase and recognition of the outbreak, Rosenberg moves into managing randomness. In particular, communities "seek rational understanding of the

[35] Maracle 40.

phenomenon in terms that promise control, often by minimizing their own sense of vulnerability." He goes on to argue that epidemic response management has the potential to "serve as a vehicle for social criticism as well as a rationale for social control."[36] This phase opts to find its stride in blame, stigma, and direct actions of othering that place the disease as a fault or feature of a group. One community's attempts to decrease their risk factors or social vulnerabilities provides them with the opportunity for socio-environmental criticism of others around them.

Such social criticism ignores the underlying miasmic environmental factors that make the disease a death-dealer rather than a recoverable inconvenience. Because of knowledge barriers and medical racism, the Native village anticipates the coming epidemic but cannot adequately prepare for it, nor can they count on resources and knowledge from the local community or nation-state. They can only watch in terror as it enters their village with an aggression unseen in white town. It is at this point that the microbe intersects with a miasmic environment and population group already contending with multiple deprivations including outbreak waves. Stacey notes, "Year after year, day after day, the entire village barely managed to survive the endless prohibitions the government kept coming up with which seemed to be designed to starve them. […] Employers so rarely hired them that most of the villagers were convinced white people wanted them to die."[37] These settler policies and politics lay the foundation for high co-morbidity rates that pale in comparison to neighboring towns and the settler society at-large. Yet, Carol's family, the Snowdens, and others in white town and nearby Vancouver skim the surface

[36] Rosenberg 5-6.

[37] Maracle 53.

of their simplistically shallow criticism not willing to look underneath as to why and how these environmental impacts came to be.

Beyond the socio-economic and racist machinations that drove the Native community into poverty, its members cannot access Eurowestern medical resources, either the clinic or the hospital. Shortly after Carol's announcement, Stacey begins to reorient her expectations and goals for her senior year of high school in light of the coming epidemic. This action serves to manage the potential randomness of the incoming outbreak and provide a sense of (temporary) control over uncertain and vulnerable circumstances. She begins by mentally cataloging her village

> trying to determine who were the frailest, the most likely to succumb, who might survive, which of the younger women could be counted on to help. She measured her grades, calculated the likelihood of passing despite the crisis. The 'flu could not possibly last as long as the worst tuberculosis epidemic; besides, there are hospitals that we can all go to now. She breathed relief. It would not likely be as bad as the other epidemics.[38]

Stacey actively anticipates what can happen, who will be affected, and possible outcomes, both personal and communal. However, her anticipatory reaction is oddly and overly optimistic. Considering the Indigenous history of tuberculosis in Canada and the rampant racial segregation of medicine (both clinical and hospital), her belief that settler-administered hospitals will admit Indigenous patients afflicted with influenza seems incredibly naive, which may be the point.[39] Her early anticipatory naïveté and optimism makes the later devastation and frustration with

[38] Maracle 27-28

[39] Maureen K. Lux, "Care for the 'racially careless': Indian Hospitals in the Canadian West 1920-1950s," *The Canadian Historical Review* 91 (September 2010): 407-434. See also Lux's *Separate Beds* (2016) and *Medicine that Walks* (2001).

Eurowestern medical care all the more disheartening while reinforcing the theme of settler-colonial indifference toward influenza-ravaged Native communities.

Throughout the novel, this history of medical racism in hospitals resides in the background only coming to the forefront as a reminder as to why no one in the Native village receives clinical treatment. Prior to the epidemic, Indigenous communities and hospitals maintained a fraught relationship that was exacerbated by racism, public health policing, and residential schools. While nursing one of the first afflicted with influenza, the female caregivers bandy about why Stacey would not want to become a trained nurse after her experiences as an outbreak caretaker. Stacey

> knew they [the women] had no idea what went on in a hospital. So far, few who went there had ever returned. As a result, the whole village was convinced that hospitals were there to finish them off. Stacey thought this was a little unfair. She knew the villagers never sent anyone there unless there was nothing more they could do. Only the near-dead showed up on the doorsteps of the place. It annoyed the hospital staff no end. They tried to explain that the villagers should have come earlier, but no one was convinced. Since the hospital was going to kill them anyway.[40]

This contention between white hospital staff and ill Natives seeking only end-of-life (palliative) care stems in part from histories of public health officers in Canada permanently removing tubercular Natives from their homes to hospitals where they would later die. The Native belief that a hospital is where people go to die instead of receiving treatment with the intent of returning home appears often across its medical histories. The historical lack of informed consent and appropriate cross-cultural communication regarding Eurowestern clinical care exacerbates

[40] Maracle 51.

the medical professional view of the non-compliance of Native patients and their worthiness to access care. Such clinical views further result in delayed, damaging (error-prone), or denied care.[41]

Moving from managing randomness to negotiating public response, Rosenberg argues that once recognition has been given the collective community swings into action providing an open, visible response in the form of rituals that promote social values and solidarity. However, *Ravensong* complicates this phase by spotlighting the fraught intersection of settler colonialism, Indigenous health, and medical racism found in Eurowestern clinical experiences. The rituals and collective actions split into segregated spheres with white town maintaining its solidarity against medically resourcing the Native village. The public actions of medical professionals cordon off access to care for Natives who must then resort to methods that prove to be less than effective. These settler decisions to not act, to not provide care, are still public actions in themselves that reinforce existing racial distinctions and socio-cultural beliefs as to who is deemed worthy of care within the nation-state.

Negotiating the public response means prioritizing resources and patients when care is limited or restricted, yet those decisions feature racial prejudice leading to unethical or near-genocidal consequences. Very early in the epidemic, a scandal breaks out regarding care management across the province, specifically in Vancouver, British Columbia. Hospitals, the vast majority being located in urban areas significantly distant from the Native village and white town, experience overcrowding and white doctors are unwilling to treat Native patients on the

[41] For similar views of care attached to other marginalized patient groups, see Harriet A. Washington's *Medical Apartheid*, Linda Villarosa's *Under the Skin*, John Hoberman's *Black & Blue*. Caroline Criado Perez's *Invisible Women: Data Bias in a World Designed for Men* and Kate Manne's *Entitled* also touch upon the medical biases that appear when patients are female, either white or BIPOC.

reserves.[42] Through her reading of the newspapers, Stacey comes to the conclusion, "Under the shabby arguments about hospitals being full and doctors already overworked lay an unspoken assumption: white folks were more deserving of medical care. There was a hierarchy to care."[43] These arguments prioritize care along racial lines which fails to take into consideration that the Indigenous disease experience is rooted in environmental factors exacerbated by settler colonialism, medical racism, and 'waves' of disease events. The negotiated distribution of medical resources and knowledge holds within it a racial hierarchy of care that replicates the racism and racial hierarchy of the society at-large. However, the medical field deflects and covers over this perspective with arguments related to workload and available beds.

In care work, doctors give direction and patients follow that direction or are deemed in norm violation and non-compliance. Historically, (male) doctors working within environments that enable and sustain medical racism may refuse to provide their knowledge or deprioritize care to certain patients or marginalized communities. Broadly, these doctors hold to a series of entitlements and expectations deeply embedded within a settler-colonial heteropatriarchical world. They view their medical knowledge and treatments as a precious, limited resource that must be prioritized to those actively and successfully fulfilling the patient role as grateful and compliant. If a community is deemed to be not worthy, fully compliant, or a squanderer of the opportunity of care (they will not take, or receive, in a manner the giver feels they are entitled), the giver opts to not give at all.[44]

[42] Maracle 65.

[43] Maracle 69.

[44] For additional discussion related to the giver/taker dynamic, see Kate Manne's *Entitled* and *Down Girl.*

Near the end of the novel, *Ravensong* confronts the realities of such medical racism head-on during another interracial exchange with Stacey. This narrative delay of confronting local doctors mimics the near-impossibility of confronting medical racism while simultaneously working tirelessly to care for a community in need. Eventually, in moments of reflection and aftermath, such confrontations can take place. At the end of the epidemic, after working side-by-side with the Native female caregivers to the point of exhaustion and deep unreleased grief, Stacey confronts Steve, her white male friend and the son of a white town doctor. "'How did it feel to watch us die, Steve?' She asked. It was mean. She didn't care much that it was mean. Steve blushed. His father was one of the white doctors who could not possibly be expected to cross the river to treat 'those' people. He had so easily persuaded his son of the interests of his patients, his workload."[45] Yet, Stacey forces Steve to dig deeper and consider the motivations and ramifications of his father's arguments and decisions to not treat her community.[46] Under the good doctor's liberal views stood a darker reason that circled back to the cultural value of life and the racist capitalist value associated with it. She notes,

> the good Owenite doctor, Steve's father, could argue against his own oath to humanity and not come to the village. Despite his sociological radicalism, his intellectual

[45] Maracle 186.

[46] Steve continues to struggle with this intersectional conflict that includes an Indigenous love interest, the traditional male medical model, and Indigenous female care. In *Celia's Song*, the direct sequel to *Ravensong*, Stacey will force the now middle-aged Steve to once again confront the medical racism of their youth, the ongoing racism embedded in medical education programs that privilege Caucasian applicants and knowledges, and the inappropriateness of Eurowestern masculine medicine in specific Indigenous cases involving female patients recovering from violence.

> recognition of racial equality, he could translate patients into cash income — sustenance without conscience. He could translate her village into a squalid hopeless condition in his mind. He had patients he had to treat. He could save them.[47]

The doctor calculated the risks, the costs, and tallied up the socio-medical criticisms to create a rationalization that excuses his actions to prioritize his white patients while removing the possible taint of racism.[48] His targeted refusal to treat Native cases afflicted with the disease leads to devastating and damaging ends for the Native community, but not for the medical field and his professional status. No professional repercussions occur for practitioners. Only trauma, continued distrust, and perceived (or misunderstood) medical non-compliance for the Indigenous survivors.

By not caring, by not valuing the embodied experience and full life of the individual, people die from preventable disease. This indifference and its resulting violence begin with how a person is seen in the sense that their personhood is 'read' through an interpretative lens based on a host of assumptions and misreadings of the individual. This process can prove fatal in this case of medical professionals, especially those who fail to critically unpack their own scripts and readings of patients.[49] Steve's father purportedly holds liberal beliefs, but they function as a sort of ideological shield that removes the guilt for not helping patients who are dying of a treatable,

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[47] Maracle 187.

[48] I am not arguing that medical practitioners are not overworked and hospitals are not overcrowded during outbreak events. Nevertheless, as *Ravensong* highlights, there is a potential for racist behavior to run rampant when rationing of care is uncritically assessed and distributed. In the case of this novel, as a targeted group, Natives seeking care and treatment were refused admittance to hospitals and doctors denied them care. The limited nature and rationing of medical resources necessitates a hierarchy of care. However, within that rationing, uncritically sits the potential for racist decisions and distributions if not critically considered within the bounds of medical ethics and the history of medical stereotyping and racist behaviors.

[49] For additional arguments and analysis regarding the uncritical nature of Western medicine, see Hoberman (right to privacy and personal beliefs that may run counter to medicine and best practice) and Tanya Talaga, *All Our Relations: Finding The Path Forward*, CBC Massey Lectures (House of Anansi Press, 2018).

survivable illness. The indifference (that also appears to have an economic rationale attached to it) proves violent in the sense that his unresponsiveness to the desperate medical needs of the village leads to their deaths. To not act or to not make a decision is itself a decision — in this case, to act against his own oath creates deadly harm.

To combat this indifference mixed with medical racism, the Indigenous female caregivers negotiate their own public response outside the parameters of normative settler behavior. In order to create an ending to the epidemic based on medical treatment and care and not fatal exhaustion, these women act outside expected settler norms of (il)legal behavior. This public action showcases and postulates an Indigenous necessity of working outside the settler medical establishment in order to achieve health in the Native community. By quite literally taking matters into their own hands, they procure the knowledge and steal the equipment from those who refuse to provide it. Thanks to her reading and learning, Stacey suggests the option of intravenous drips to the caregiving group. However, the village does not have access to the equipment or even the knowledge of how to conduct the procedure. Her mother offers to observe influenza patients at the local hospital and the sons of other female caregivers volunteer to steal the equipment and plasma from hospitals in Vancouver. As the narrator recounts, "German Judy drove them. They came back with loads of glucose, saline solution and the necessary instructions. Stacey had to go to the library with German Judy to figure out what the instructions meant. They hooked up the sickest to the three intravenous apparatuses. Like a miracle it worked."[50] A second successful theft at a Vancouver hospital acquires more equipment and fluids allowing more to recover. Stacey notes, "Within days those treated with intravenous recovered. It made the women furious that they would be left in total ignorance about how easily

[50] Maracle 82.

the disease could be treated."[51] Through their public actions and agency, the female caregivers create the means to end the outbreak in the Native village. In this act of negotiated response, they refuse the neglect and negligence of settler medicine and the society at-large. Using their collaborative agency alongside the help of some of their neighbors, they take from the dominant society and settler medical establishment in order to give the care their community requires.

After moving from managing randomness to negotiating public response, Rosenberg's model shifts to latter phases that actively seek to shore up solidarity and communal cohesion through rituals and reflection. Because he situates the acute fear of social dissolution during the emerging infection and recognition phase, these later phases focus on maintaining community and connection. However, in Indigenous outbreak narratives, the core drive to simply survive the disease significantly delays the social dissolution to the aftermath period thus disrupting Rosenberg's progressive linear structure. When influenza appears in the village, Stacey's mental response demands that she "stay with the present. We have to try."[52] The epidemic forces the village to inhabit a temporality that is myopically focused on the present moment and its drive to tackle only its immediate complications for the sake of survival. The time for communal reflection and future-planning cannot take place until (hopefully) the epidemiological catastrophe has passed.

However, a disease event does not exist in total isolation from its historical context and miasmic environmental factors. The world with all its complications, successes, and losses holds the same temporal space as the epidemic and any overlapping outbreak waves. For the Native village, tragedies occur alongside the disease. During a gathering with her peers where they are

[51] Maracle 83.

[52] Maracle 45.

canning berries, Stacey notes, "'The drought […] The epidemic … the fire … natural catastrophe and just plain poverty disrupting our lives again.' The air heaved. No one liked hearing it all strung together like that."[53] To return to the "name and claim" idea of recognition which seeks to provide psychological comfort through linguistic identification, Stacey's voicing of these miasmic events in succession does not bring collective comfort but a deeper, visceral sense of the devastation amassed through a cumulative series of horrific events. The relentless timing of the events creates a myopic focus on the present moment which fails to provide a sense of balance, psychologically and socially. This temporal demand unifies the community only temporarily in the short-term.

Even when the epidemic and its attendant travesties have passed, collective and individual reflection and proper grieving fails to occur because then the social dissolution of the community takes place, which is exacerbated by the sheer exhaustion felt by its members. As Priscilla Wald notes, "the psychological numbing attendant on disasters of great magnitude compounds the dissolution of social organization."[54] The exhausting quality of disease events appears not only in the bodies of the survivors, but also in their emotional state. For the women and their village, the inability to properly grieve and reflect on the events happening around them creates a collective psychological state filled with its own indifference and apathy. As Stacey observed, "They [the village] were tired, not the easy tired of a long day's work, but overcome with the deep fatigue of losing battle after battle on the trail to clan survival."[55] Later, when she herself leaves for college in Vancouver, Stacey notes that her family does not exhibit the

[53] Maracle 143. The ellipsis that occur on their own (not inside brackets) is a direct copy of the punctuation in the text.

[54] Wald 11.

[55] Maracle 181.

traditional forms of emotionality for the goodbye. “No tears were shed. It was odd. It was as though the epidemic had created a drought in their hearts. They had been bled dry of tears. A distance small and almost invisible stood between each one of them. They were an exhausted raggedy family now.”[56] The epidemic had drained them and her town of demonstrative emotion. Not until nearly a generation later will four of the women from the caregiving group be provided the necessary time and space to reflect on this epidemic and then express and expel their grief completely.

In the aftermath of the epidemic, Rosenberg’s model moves to the reflection phase where the survivors critically consider the event and its ramifications. Once cases decline and the epidemic as a biological event fade into the distance, the disease event elicits the opportunity for reflection and critical analysis. He notes, “Epidemics have always provided occasion for retrospective moral judgment.”[57] The epilogue allows for the construction of meaning and learning that can possibly be applied to future epidemics.

Ravensong’s epilogue reveals that all previous chapters were part of a season-long storytelling session crafted by four female characters (Stacey, Celia, Momma[58], and Rena) in an attempt to provide an answer to a contemporary question related to their community’s social problems. The epilogue’s linking of the influenza epidemic with other waves of outbreaks emphasizes the destructive onslaught of multiple disease ‘waves’ across generations that eventually shift away from the biological into a solely social epidemic. In retrospect, as Jeremy Greene and Dora Vargha note, these “epidemics can be harbingers of significant political

[56] Maracle 196.

[57] Rosenberg 9.

[58] The character of Momma is Stacey’s mother and her official birth name is also Momma.

changes that go well beyond their ending, significantly reshaping a new 'normal' after the threat passes."[59] *Ravensong*'s epilogue provides a chronologically layered reading of historic epidemics that prove to be harbingers of contemporary multi-generational trauma and community socio-environmental conditions. It is only in the present 'now' some twenty-five years later (a full generation later) that the group of Indigenous female caregivers find themselves with the time and opportunity needed to reflect on that devastating past. With the questions posed by Stacey's adolescent son and the act of storytelling, these women grapple toward an understanding of the epidemic (both social and biomedical) and its consequences that are still felt and seen after so many years.

Furthermore, the epilogue emphasizes the local Native history of repetitive disease outbreaks that put a striking death knell to the virgin soil hypothesis. These recurring disease outbreaks feature devastating generational outcomes as seen in the itemized accounting of the mortality rates of Native children for smallpox (1840), diphtheria (1885), measles (1905), influenza (1918), tuberculosis (1920-1940). This list with its horrendous fatalities increases the grief of the women to such an extent that they join in a grieving song in order to release it. This list stands as a reminder that the virgin-soil hypothesis and its attendant microbe model fail to accurately explain and portray indigenous disease histories. Because the miasmic environmental model treats disease as a social phenomenon, it demands a cross-generational accounting of the socio-environmental conditions of the outbreak, thus making visible the intersections and interconnections of the past with the present and its waves of disease.

This reflective session draws a line connecting the older outbreak experience with the ongoing social problems of the contemporary period. As Stacey explains to her nephew, "'The

[59] Jeremy Greene and Dora Vargha, "How Epidemics End," *Boston Review* (30 June 2020).

world floated in, covering us in paralyzing silence and over the next decade the village fell apart.'"[60] The aftermath exhibits transformational loss in its social dissolution that included the mass out-migration of women and a loss of social cohesion and safety that has led to the current "'epidemic of their own making.'"[61] The novel features a direct acknowledgement that no gains, no positive transformation occurred during or after the outbreak. It was an event with long-term social consequences filled with even more deprivations and struggles.

Furthermore, this recounting of the epidemic serves to document and explicate a historical epidemic in order to provide answers to a contemporary question posed by a querying young adolescent. To understand the present-day circumstances that enabled the suicide, one must unpack and critically consider the community's past encounters with death, both microbe and miasma. By linking death across a generation, the women juxtapose microbe with miasma deaths highlighting the cultural components and intersections across Native and settler understandings of community life and human value.

Indigenous outbreak narratives prioritize the overlapping and cyclical nature of disease events by decentering the singular microbe, foregrounding the history of disease waves, while anchoring the storytelling to miasmic environmental conditions that include (medical) racism and settler colonialism. Furthermore, microbial epidemic waves roll into psycho-social epidemics that roll into microbe outbreaks that potentially cycle violently for generations. Because these waves (in conjunction with parallel travesties) force a myopic focus on the immediate present, upon their initial arrival, Indigenous outbreak narratives disrupt expectations of a linear progressive structure like Rosenberg's where disease events contain easily delineated

[60] Maracle 197.

[61] Ibid.

phases that mark out a closed, discrete event with a definitive ending. Instead, Indigenous outbreak narratives like *Ravensong* contain explicit, direct links between past and present that refuse closure.

While *Ravensong* contained all the pieces of Rosenberg's model, including presenting a linear narrative that moves progressively forward in time chronologically detailing one event after another, many Indigenous outbreak narratives break the traditional linear storytelling structure of outbreak narratives by utilizing Indigenous storytelling protocols that center the oral tradition and its cyclical style. The next two chapters tackle texts that foreground noted Indigenous narratives techniques that move away from linearity and feature a forward moving cycling structure that centers oral storytelling practices. Furthermore, following *Ravensong*'s movement from microbial epidemic(s) to a psycho-social epidemic, so too will I now be moving from the analysis of microbial epidemic(s) in *Ravensong* into the next chapter that tackles the psycho-social outbreak narrative of Richard Van Camp's short story "I Am Filled with a Trembling Light" featuring carriers both diseased and asymptomatic.

Chapter 2: The Present, or When Disease Carriers Wander into Indigenous Outbreak Tales

Typical outbreak narratives tend to quickly identify the emerging infection through its physical symptoms in the human body. This plotting imperative creates a germ-centered narrative myopically focused on containment and eradication, usually through magic bullet science. However, the microbe-obsessed structure has not always been so popular. Since the 18th and 19th centuries, miasma-centered narratives explored the environmental conditions that facilitated rampant disease, specifically bad air, fog, or an impure, contaminating atmosphere that is responsible for outbreaks of respiratory disease. For my argument, miasma includes a wide array of environmental conditions such as nature itself (animal-human crossover, disease carrying insects, stagnant water), industrial pollutions, socioeconomic concerns (housing, work, and family planning), and the social health consequences related to heteropatriarchy and racism. By broadening the parameters of miasma, it has the capability to more easily unpack how environmental conditions heavily affect healthcare and disease, individual and outbreak.

In the twentieth century, the narrative shift away from miasma towards a narrow focus on the microbe enabled unintentional and unconscious biases to flourish when tackling disease prevention and management plans. Centering the microbe narrows the medical options to pharmaceutical 'magic bullets' that seek to eliminate the germ or enact a cure for the disease but fail to grapple with the environmental miasma that birthed the microbe in the first place. The 'magic bullets' perspective plays whack-a-mole one disease at a time instead of considering the holistic, collective environmental circumstances of disease landscapes and how to mitigate or eliminate their harmful effects upon the community. Indigenous outbreak narratives seek to reorient this paradigmatic pendulum back into the middle ground by either (re)considering the

intersections of miasma and microbe or prioritizing miasmic environmental factors with a critical focus on how settler colonialism enables opportunities for disease.

I argue that outbreaks do not function as isolated, discrete events. Instead, outbreaks operate within a historical space of recurring 'waves' with some diseases becoming endemic and others cycling through generations. In Indigenous outbreak narratives, these waves construct an outbreak history where one disease event medically and socially influences others. As seen in Lee Maracle's *Ravensong*, the socio-political consequences of one epidemic can lead into a socially disruptive, biopsychological outbreak such as community-wide suicides. The seriousness of overlapping disease events highlight the importance of considering the so-called "social epidemic" happening within an outbreak, specifically prioritizing the community's miasmic conditions and how they relate to the mind/body as a whole and not its segregated parts.

However, not all Indigenous outbreak narratives utilize a known microbial disease as the basis for their disease events. Instead, some feature biopsychological diseases that deploy the language of epidemics while eschewing common names or known diagnostic labels in order to discuss biopsychological disorders that Eurowestern medicine traditionally does not identify as either a contagious phenomenon or a biomedical epidemic event because they tend to be viewed as individualized conditions and not treated as community-wide disease events. Furthermore, Indigenous outbreak narratives explore how settler colonialism instigates opportunities for both disease and dis/ease as well as how to best negotiate that dis/ease through Indigenous methods and knowledges.

In this chapter, I look at how Indigenous outbreak narratives tackle carrier narratives featuring biopsychological outbreaks that do not utilize germ-centric plotting, such as Rosenberg's emerging infection phase found in traditional outbreak narratives. I argue that

Priscilla Wald's usage of the carrier-as-stranger archetype and slimmed three-stage formula for outbreak narratives needs to be reoriented to include the politics of settler colonialism. In particular, Richard Van Camp's 2019 short story "I am Filled with a Trembling Light" (abbreviated to "Trembling") features two carriers: an Indigenous carrier with cancer and a physically healthy settler carrier-as-stranger. Unlike Wald's transformative bordering on rejuvenating carrier-as-stranger, in Indigenous outbreak narratives, the settler carrier-as-stranger tends to be a destructive and damaging force to the Indigenous community and the bodies of its individual members. Furthermore, Wald's stranger-carrier posits their incorporation into the community as a positive for the sake of biodiversity and transformation. However, in Indigenous outbreak narratives, stranger-carriers fail to fully incorporate themselves and thus function as negatively transformative characters who cause damage and devastation to the community. The Indigenous carrier, on the other hand, collectivizes this traditionally individualized archetype by working within the community and facilitating social cohesion.

Furthermore, I read "Trembling" as a carrier narrative that complicates the formulaic plotting of outbreak narratives by critically unpacking the stranger-carrier archetype while broadening the definition of epidemic to include biopsychological manifestations of disease, such as soul murder and other conditions connecting mental health with presentations of physical disease. By focusing on a biopsychological epidemic attached to the community's social problems, "Trembling" initially appears to walk through each of the phases of Priscilla Wald's formula in order: emerging infection, mapping transmission networks, and containment. The narrative begins by identifying the protagonist's, Simon, malignant diseased (cancerous) state and the soul murder outbreak occurring in the community. Then it quickly moves into a detailed exploration of the journey Simon takes to gain restitution for his family and the community at-

large. This process makes visible all the usually invisible web-like relationships or transmission networks that facilitate dis/ease locally as well as across the province. Finally, it concludes with a multi-pronged containment of all the settler-based contaminating elements causing harm to the community by asserting Indigenous creative agency.

Like many of the short stories in Richard Van Camp's collection *Moccasin Square Gardens*, "Trembling" explores the intersection of masculinity, settler-colonialism, power and authority, and Indigeneity within Indigenous communities and spaces using the techniques and structures of oral Indigenous storytelling.[62] The short story is structured as a present-day recorded audio transcript of a police investigation. I say investigation and not interrogation because the text contains only one narrative voice with less than a handful of noise-related transcription tags (e.g. [laughter]). Simon, the first-person narrator and protagonist, does make references to an unnamed RCMP officer using the pronoun "you", thus indicating that his speech is directed at another, yet silent person inhabiting the same space. However, Simon completely controls the recording of testimony with no questions or comments from the RCMP officer included. Unlike *Ravensong*'s collective voice of women who speak as one in order to recount Stacey's, and by extension the village's, outbreak history, "Trembling" narrowly focuses on a single, individualized Indigenous speaker who holds prime of place and total control over the telling of the tale. He operates as the chief storyteller in real-time and "Trembling" seeks to craft a carrier narrative that replicates Indigenous cyclical storytelling protocols that disrupt the progressive linear structures of traditional outbreak narratives.

Within the space of a criminal investigation, the narrative follows a forward-moving cyclical structure. Simon immediately begins the recording with the possibility that he is guilty

[62] Richard Van Camp, *Gather: Richard Van Camp on the Joy of Storytelling.* Regina: University of Regina Press, 2021.

of a crime of vandalism ("maybe I threw that rock") and then proceeds to verbally wander into historical family tales, community gossip, and a personal story. At the narrative's core, Simon, a man experiencing late-stage spinal cancer, negotiates a deal with a local kingpin to temporarily keep his house after his father loses it with a bad hand of poker. The deal requires that Simon travel to the city to help a female elder identify a tampered slot machine in one of the kingpin's casinos. Inside the slot machine contains a powerful Indigenous artifact in the shape of a black-beaded spider, which Simon is supposed to bury deep within the earth. When he returns to his hometown, he instigates a community-wide reckoning against the kingpin and the RCMP officer thanks to the information the elder shared with him. While a community posse proceeds to wreck physical justice on the kingpin, Simon finds himself inside the police station. After giving the investigating RCMP officer the black-beaded spider, which has now been infused with Simon's spinal cancer, Simon reveals that he knows the officer has committed widespread child molestation across several Indigenous communities. He likens the catatonic adolescent victims of drug abuse seen around town to the disease of 'soul murder,' whose various symptoms also appear in the victims of the RCMP's sexual assaults.

Unlike the typical outbreak narratives that start with early-alert indicators and emerging cases, Indigenous outbreak narratives tend to begin either *in medias res* or in flashback. Through this reflective process, these texts highlight the early warnings either ignored or overlooked by settler society and its authorities. In "Trembling," Simon identifies various instances of 'soul murder' early in the narrative and then links back to those same instances in the conclusion. 'Soul murder' is an outbreak whose victims present with impaired mobility, cognitive dysfunction, and motor impairment that points to a social problem manifesting as a biopsychological condition. Initially, Simon uses the term for those who become catatonic after

taking “dope”. He states, “There’s something wrong with them. You’ll probably try and tell me that you’re building a case against Steve [the dealer], but this is soul murder. Those boys will never be the same.” Now that he has named the disease, he describes the affliction as: “He was shuffling in his yard, walking towards the fire that was going. His hair was long. He looked dead. Dead and walking.”[63] Later when directly confronting the actions of the RCMP officer, Simon links this initial soul murder experience by the boys who took dope with the “kids you murdered inside […] As the tumor takes hold and your face twists, thank of every young boy you ever stole. We’ve all been shuffling towards the fire because of you”.[64] Like variants of a disease, the biopsychological symptoms of soul murder appear in similar forms but arise from different environmental origin points: dope or predatory sexual abuse. This framing spotlights the variants that inhabit the same biospychological outbreak while also emphasizing that the settler authorities ignore what the Indigenous community recognizes.

This biopsychological outbreak of soul murder has its links to historic sexual predation and contemporary suicide within the Indigenous community in Canada, specifically in the Far North. Several documented cases have occurred where settler colonial authority figures act as a sexual predator upon the Indigenous community who then present the consequences of such abuse through a soul murder outbreak or suicide clusters. Historically, medical and national discussions of sexual predation and suicide do not utilize the language of outbreaks and epidemics. However, that rhetorical choice appears to be changing. For example, Hugh Brody, a white British anthropologist, argues that a link exists between past outbreaks of sexual abuse against Inuit children at the hands of white authorities and the current epidemic of suicide in

[63] Van Camp 109.

[64] Van Camp 125.

those same communities. Utilizing the language of epidemics and disease in reference to the suicide crisis, he argues that one outbreak of violation lays the foundation for a much later outbreak of death noting that initially the Inuit themselves made the connection explicitly. For them, "[the sexual predator] is pointed to as the direct cause of many deaths in each of the places where he was a teacher, and as a prime example of those responsible for the terrible and continuing epidemic in which abuse has laid the foundation for suicide among the young."[65] Brody and Indigenous advocates deploy the language of epidemic and disease in order to shift the Indigenous suicides away from the Eurowestern perception of suicide and mental illness as an individualized biopsychological act usually conducted in isolation. By using the vocabulary of outbreaks, specifically their contagious viral nature, these suicides become a connected series of cases rapidly spreading within communities like outbreak clusters that are attached to a specific source. Like an infection that does not release its mortal consequences until years later, to borrow from Brody, the "virus of anguish" later evolves into outbreaks of fatality that communities find difficult to understand, contain, or counteract.

Brody's analysis has a fictional mirror image in "Trembling" which features a sexual predator in a position of settler authority. Whereas *Ravensong* links a historic disease event to the community experience of suicide in order to make explicit connections between how one type of epidemic creates another, "Trembling" focuses solely on the present-day biopsychological epidemic rooted in trauma, exploitative settler actions, and environmental conditions occurring in the Far North. In a similar manner to Brody grappling with being unable to see and identify ongoing sexual assault during his initial fieldwork, "Trembling" argues that outbreaks of sexual assault occur because of a pervasive culture within settler colonialism that enables local-level

[65] Hugh Brody, "'The deepest silences': what lies behind the Arctic's Indigenous suicide crisis." *The Guardian* (21 July 2022).

settler behavior to invisibly exploit Indigenous bodies within distanced circumstances. The settler characters enact damage within Indigenous communities because of settler colonialism's failure to police its own society and legal institutions and contain its violating agents.

Murdering the Soul: Diagnostic and Creative Terminology

Unlike the "emerging infection" phase of traditional narratives where mounting corpses refuse to be ignored, "Trembling" does not contain any deaths or unavoidable corpses. Like *Ravensong* and other Indigenous outbreak narratives, the soul murder disease does not emerge over time but appears simultaneously among many. It features living individuals who appear like the undead, as zombies shuffling towards destruction. They "looked dead. Dead and walking."[66] To Simon, soul murder as a term carries both scientific authority and literary creativity that highlights the blurry nature and authority of medical terminology. On first encounter, soul murder reads as a non-medical term because it does not feature the traditional construction and grammar commonly found within biomedical science. However, as cancer scholar Siddhartha Mukherjee notes, "To name an illness is to describe a certain condition of suffering."[67] For literary purposes, naming a community-wide disease, an illness in and of the social environment, demands a sense of urgency and emotional depth in the body politic. It highlights the psycho-spiritual destruction of the individual and by extension evokes a threatening, existential terror for the community. Speaking of street drugs and criminal behavior as having the ability to destroy another's individual humanity, to murder their soul, heightens the emotional impact and belief in the urgent need to create solutions. These external, traumatic acts of kingpins and sexual

[66] Van Camp 109.

[67] Siddhartha Mukherjee, *The Emperor of All Maladies: A Biography of Cancer* (New York: Scribner, 2011), 46.

predators kill the internal life of the individual while leaving their physical body to shuffle listlessly towards premature death.

Soul murder also carries scientific authority and diagnostic history. In *The Body Keeps The Score*, itself an exploration of how psychological trauma manifests as biomedical conditions and disease, Bessel Van der Kolk notes, "we must observe what we see around us and label it correctly; we must also be able to trust our memories and be able to tell them apart from our imagination. Losing the ability to make these distinctions is one sign of what psychoanalyst William Niederland called 'soul murder.'"[68] In Simon's community, the shuffling undead fail to observe and correctly label the world around them. Tracing soul murder to the work of Henrik Ibsen, Leonard Shengold observes, "Ibsen defines it as the destruction of the love of life in another human being. […] part of Ibsen's definition … is killing the capacity for joy."[69] Even when a family member attempt to steer them away from the fire, they are determined to walk into it. As Simon notes, "Those boys will never be the same. Their parents don't work anymore. They tend to their sons all day."[70] Their reading of the world around them remains permanently skewed toward fatalistic endeavors causing them to become permanently dependent on their families to care for them. The victim's body is transformed into a hollow shell seeking self-destruction through fire in order to cleanse itself of the violations and violence committed upon it.

[68] Bessel Van Der Kolk, *The Body Keeps The Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2014), 136.

[69] Leonard Shengold, "Excerpt: Chapter One: Soul Murder Revisited: Thought about Therapy, Hate, Love, and Memory by Leonard Shengold – Yale University Press (1999)," *New York Times* (17 October 1999). archive.nytimes.com. Accessed 2022.

[70] Van Camp 109.

Like the power of diagnosis to provide public and private recognition of a biomedical problem, the naming of a crime is socially constructed and thus must be recognized and labeled as a socially destructive behavior that is deemed unacceptable to the community and its collective health. "Trembling" showcases the problematic nature of diagnostic labeling, because more than one community must agree that a problem is a problem, that an illness is an illness. Shengold argues that the willful and intentional nature of soul murder makes it "a crime, not a diagnosis."[71] I argue that it is both, and its capacity to be both resides in the power of recognition. As Simon implies in his testimony, the power to determine and recognize what is socially unacceptable resides solely in the hands of settler authorities whether or not the Indigenous community has labeled acts and disease events as such. Highlighting the damaging wait times for recognition, Simon issues a direct accusation of "how the hell long does it take a build a case?"[72] Simon interprets the slowness of the police in building a case as indifference, as apathy towards the crimes becoming committed within the town. Since the officers are biding their time waiting to be reassigned, they are in no hurry to police the visible soul murder happening in the community. For him, both criminals and law enforcement together are enacting and enabling soul murder upon the community through their actions of indifference and direct predatory behavior. They consume souls and steal resources through gambling, drugs, and molesting bodies. Returning to Hugh Brody, such actions thrive in settler colonial systems which then create community-wide devastation. However, "Trembling" offers hope through the use of creative Indigenous solutions that effectively combat the community's disease with retribution and restoration based in Indigenous knowledges and circumventing settler norms.

[71] Shengold.

[72] Van Camp 109.

The power of 'naming and claiming' indicates social (and by extension scientific) acceptance that the problem exists, thus making it a visible phenomenon that may potentially receive sociopolitical priority and resources. A disease does not exist until it has been socially constructed and recognized as such by the society at-large and its stakeholders. However, such social construction does not mean that the symptoms and the condition simply do not physically exist. Instead, the community contends with it the best they can. Without recognition, an unofficial disease lives on at the margins until the powerholders speak it into an official (settler) existence that demands funding, resources, and manpower. As seen in *Ravensong* and now in "Trembling", naming does not bridge the chasm created by settler colonialism. Instead, it fails to secure resources to the community that medically benefit the ill and combat miasmic dis/ease instigated by settler colonialism. This textual naming of soul murder may be Van Camp's attempt to provide the psychological effect of diagnosing ongoing epidemics in Indian Country by using a known psychological term in a literary manner. Nevertheless, "Trembling" only names the biopsychological disease outbreak happening within at least two Indigenous communities in its textual world and the naming is enacted by only its protagonist and no one else. Thus, the power of this recognition sits with the reader's acceptance of the term - an interaction that is beyond the scope of this chapter.

Carriers: Diseased and Asymptomatic

In "Trembling," the settler indifference, exploitation, and violence appears in the experiences of its two carriers. Priscilla Wald argues that carriers in outbreak narratives are "the archetypal stranger, both embodying the danger of microbial invasion […] and transforming it into the possibility for rejuvenation and growth […] This figure embodies not only the forbidden

intrusions, the deep connections, and the most essential bonds of human communion but also the transformative power of communicable disease."[73] The stranger inhabits a space of fear based on the potentially contaminating body and transformative incorporation through genetic reproduction. Within these outbreak narratives, the stranger-carrier may be contained by authorities and "domesticated through the practices of social responsibility (manners, ethics, rituals) that register the internalization of state mechanisms of surveillance and discipline."[74] The stranger-carrier finds their place within the community, either through sacrifice and integration that allows them to be domesticated and disciplined. In "Trembling," none of this applies to the RCMP officer and his stranger-carrier status.

The RCMP officer functions as a non-local, non-Native antagonist who inhabits and works at the geographic margins of the nation-state, far away from the expected oversight typically found in urban centers and headquartered stations. The RCMP officer stands as a settler stranger, unnamed and thus unknowable, enacting sexually predatory behavior that contaminates the community he is supposed to be policing. He is a man with a mobile position of authority unattached to his assigned frontier community. Hugh Brody observes that "the authority at the colonial frontier is exaggerated by geography and politics: the sheer distance from administrative centres delivers to representatives of education and God, when they appear in remote, vulnerable Indigenous communities, an almost magical esteem and charisma. The places they work are isolated, and their lives are further hidden within the isolation."[75] Simon criticizes the officer and the entire RCMP department as being temporary, unrooted occupants who rotate through

[73] Wald 10.

[74] Wald 57.

[75] Brody, "The deepest silences".

communities “biding your time”. As Simon notes, “You all rotate out the first chance you get”.[76] In conjunction with Wald’s analysis of fear and infection, the RCMP officer functions as a strange rotational intruding body that acts upon and damages the bodies inhabiting the communities he is tasked to protect and serve. Again, Hugh Brody notes, “The preconditions for abuse are in place. The victims and their families are intimidated and driven into silence.”[77] These destructive interactions prove to be socially invisible due to the shame and stigma attached to such acts, thus allowing the RCMP stranger-carrier to act at-will with little-to-no repercussions. Since the officers are biding their time waiting to be reassigned, they are in no hurry to investigate the criminal and dis/ease occurring within their territories. The failure to apprehend the RCMP officer’s widespread, soul murdering behavior further highlights the nation-state's inability to identify and police sexual predators who hold settler-colonial normative identity.

As a contaminating carrier of soul murder, the RCMP officer damages those he touches through violation and invasion. Using language previously linked to gambling and punishment, Simon notes, “Already feeding your hunger […] Like my dad, you can’t stop yourself. They should have taken off all of your fingers when you were in Rae so you could never grab a boy again.”[78] The RCMP officer behaves as a voracious addict, a consuming dis/ease agent, who consumes indigenous souls by stealing their bodies through a transformative touch. The sexual predation becomes an act of soul murder that alters one body at a time creating an outbreak of sexual assault within a single community (or more). The victim’s body is transformed into a

[76] Van Camp, 114.

[77] Brody, “The deepest silences”.

[78] Van Camp 125.

hollow shell seeking self-destruction through fire in order to cleanse itself of the violations and violence committed upon it.

Unlike the stranger-carrier of the RCMP officer, Simon's carrier status does fulfill much of Wald's description with the exception that he functions as a marginalized member and not a stranger. Whereas the RCMP officer is an asymptomatic healthy stranger-carrier spreading soul murder throughout the Indigenous youth, Simon presents as a collector-carrier (my term, more on this later) whose body contains cancerous tumors wrapped around his upper spinal column. He is a known resident in the community, but his diseased state physically marks his body in a stigmatizing manner that allows the community to push him further into the margins.

Simon's marginalized status stems from his status as a dying man whose body reads like a near-personification of death. Simon describes himself as carrying "a hot, bloating sweet stench of mange bubbling up through my clothes"[79] and "a dusty monster all humped up."[80] However, Simon's perceptions are a tad incomplete and unreliable as "I couldn't tell you how rough I looked. I stopped looking in mirrors a long time ago."[81] His body is externally marked as diseased by its smell, temperature, and deformity. His state has progressed to a point where he refuses to confront his appearance in mirrors.

Furthermore, Simon knows and openly acknowledges that his embodiment is read by others as a stigmatized body that is a carrier of disease and death. When Simon tries to talk to the local crime boss, Benny refuses him entrance, saying "I don't want death in the house"[82] and

[79] Van Camp 111.

[80] Van Camp 115.

[81] Van Camp 116.

[82] Van Camp 111.

later Benny "remember[s] that death was standing on his doorstep."[83] Simon's diseased and dying state turns him into an exploitable human being that can be used for good or ill. His body contains terminality as a present state. He acknowledges that Benny sees him as expendable because of his dying state. To Benny, the kingpin, Simon's life only had value "because I was already gone."[84] Later, Simon explains, "I was disposable. That's why I was there. If anything medicine touches you, you're done, but I was done anyway. This was Benny's strategy. Even I could see it."[85] This imposed fatalism reinforces his outsider status which he then uses to enact retribution for his family and restoration for the indigenous community.

In addition to being a carrier of cancer, Simon functions as a carrier who collects stories, or as a collector-carrier. Unlike the stranger-carrier who acts as a depersonalized, unknowable invader that contaminates the community, Simon invisibly collects the stories of trauma into his body and holds space for them in the form of cancerous tumors. During his work as a janitor at the Friendship Center, he overhears the stories of young adult members seeking counseling for sexual assault. These stories then appear to manifest as cancerous malignant tumors wrapped around the upper spinal column creating a visible mass in his neck. As a collector, Simon amasses approximately a hundred tales, including his own as a survivor of the RCMP officer's earlier assaults in another town. His body carries that narrative burden as a literalized cancer aggressively altering his physique and visually marking him as a dying man. The biopsychological outbreak of soul murder running rampant in the community is made fully visible through the physically altering cancerous disease in Simon's body. As a collector-carrier,

[83] Van Camp 112.

[84] Van Camp 113.

[85] Van Camp 118.

he acts as a (temporary) container until the cancerous narratives migrate from his body into the black-beaded spider. To borrow from Bessel Van der Kolk, Simon's body keeps the communal score of trauma and then returns that trauma to the original source of violation and trauma.[86]

In "Trembling," during the transference of the cancer from Simon to the spider, the cancer becomes momentarily sentient "realizing I [Simon] was the wrong meat."[87] In this brief moment, the cancer recognizes that Simon's body is the wrong host and that it needs to be in a different body. Furthermore, Simon (and, by extension the black-beaded spider) uses the language of cancer during his conversation with the officer. He speaks of the cancer as a consuming disease that views its host body as "meat". Then, he gives the cancerous spider to the officer "so it could take you"[88] emphasizing how the cancer takes the holistic body in a totalizing manner that creates systemic disruption.

After identifying the emerging disease and its carriers, traditional outbreak narratives move onto the task of mapping the weblike networks that facilitate disease transmission through intricate and intimate relationships. According to Wald, this process of mapping makes visible the interactions, intersections, and transportation routes typically overlooked or intentionally made invisible during non-outbreak periods. Mapping thus serves as a revelatory act that throws a spotlight on interactions previously excused, effaced, or erased, but are now seen as points of utmost vulnerability. In "Trembling", Simon's journey to retrieve and then deliver the spider

[86] Van der Kolk. This reading gains further validity when compared against Richard Van Camp's and Thomas King's position regarding the interactive relationship between storytellers and their audiences, specifically they argue that the reader/audience holds a sense of responsibility upon receiving a story and they carry within themselves. In Van Camp's short story "Birthmark," the story inhabits and physically scars the body of the receiver. See Van Camp's *Gather,* King's *The Truth About Stories*, and Van Camp's "Birthmark" in Daniel DAvid Moses and Terry Goldie, eds. An Anthology of Canadian Literatures in English (Toronto: Oxford University Press, 1992).

[87] Van Camp 124.

[88] Ibid.

artifact manifests the web-like connections and circular story structures being created through Simon's storytelling. Usually, the mapping process reveals the relationships between the metropolis, the outlying towns, and the rural land spotlighting the movement of products to market and the interactions of people. This mapping includes commentary concerning the links between the primitive and poverty and the modern with the military but avoids making strong argumentative statements about the connections between criminality, gambling (vice), and settler colonialism.

In Indigenous outbreak narratives, settler colonialism become a feature not a bug of the mapping attempting to be made. In Simon's recounting the triangulation is unavoidable. The black-beaded spider functions as the vehicle that links the RCMP officer with the local drug dealers and the town's criminal kingpin. The narrative web attached to the spider reveals that both criminals and law enforcement network to exploit the community of its resources and infect it with soul murder. Initially, the spider is found at the center of a slot machine within an urban casino. After its supposed burial at Simon's hand, the spider ends up in the hands of the RCMP officer during the investigation. The mapping of the spider's journey from casino to Simon's hometown makes visible multiple points of vulnerability to soul murder.

The spider object serves as a metaphorical and literal container for the cancerous soul murder, the social devastation and psychological damage enacted on the community by the RCMP officer. After becoming an embodied carrier of these cancerous tales, Simon is given the opportunity by the black-beaded spider to transfer the cancer into the artifact. When Simon holds the spider, it speaks in a grammar that runs its words together,

"Thespiderspoketomeincoldlittlewhispers:Giveittohimgiveustohimgiveusgiveusgieusgiveustohim

."[89] The spider, a singular object, speaks first of "it" - of Simon's cancer, which the spider demands be given to the officer. Simon validates this reading when he tells the officer, "It wanted me to bring it to you so it could take you. With it comes my tumor. I'm cured, see?"[90] Then, the spider also refers to itself using the plural "us". This personal plural pronoun coincides with Simon's reference to nearly a hundred black glass beads covering the spider. Early in his testimony, Simon observes, "They say in the Cree way, every bead is a prayer. Think of all the beads that went into that. Think of all the prayers."[91] Through a literalizing of the spiritual ritual of prayer, the community invests within the spider's foundational construction a desire for justice Furthermore, the number of beads reinforces the long-game nature of the endeavor ("we have a long memory in the North"[92]) as well as the sheer number of individuals affected by the soul murder caused by the RCMP officer.

Once the emerging infection and carriers are identified and the mapping web turns invisible relationships into visible vulnerabilities, Wald's final process of disease containment can begin. Because not all diseases and medical catastrophes can be thoroughly eradicated and cured, they are contained in order to control transmission and hopefully starve the disease into submission or elimination. In Indigenous outbreak narratives, containment functions as a layered process that features more than just quarantine and enclosure. In "Trembling," the RCMP officer is already holding the spider at the beginning of the recording. In essence, his threat has been contained before Simon even gets past his opening anecdotes about family members. However,

[89] Van Camp 124.

[90] Ibid.

[91] Van Camp 109.

[92] Van Camp 125.

this containment of the RCMP officer is not enough. Ultimately, it is the story that matters, as the story speaks containment into existence.

Unlike *Ravensong*'s predominantly linear structure with a flashforward epilogue, "Trembling""s usage of Indigenous oral storytelling that features a cyclical technique serves to provide containment in three ways. The tale begins and ends with the containment of the two carriers in the same physical space trying to determine if Simon committed a crime of vandalism or was an innocent bystander who witnessed it. Due to the nature of police investigations, the narrative implies that the audio recording is being conducted within an interrogation space that leads to a closed case. Yet, "Trembling" refuses the Western linear structure that chronicles one event after the other with progressive intent. Instead, it invokes a conversational, testimonial tone that uses its framing to further contain the tale itself as it circles back to its original starting point – the audio recording as documentation of criminal behavior.

At the start of the story, Simon proclaims a desire for official documentation of his community's story, which appears in the form of an audio transcript of a police investigation. As Simon elucidates, "The reason I wanted you to take this is I have a story the world needs to know. If they put the tube in tomorrow, well, this is my chance to have something written down forever in our name, amen. [*Laughter*]."[93] This demand for documentation initially reinforces his position as a collector-carrier. Simon plays the easy-going, in full compliance witness who simply wants the story he carries to be written down in the name of the community, preserved for eternity and sanctified. Even though the RCMP apprehended his body, Simon exploits the protocols of the investigation process, and the audio transcript makes comprehensible the circumstances of the community, the soul murdering disease infecting its inhabitants, and the

[93] Van Camp 107.

web-like relationships that enable its spread. The audio recording serves to officially document the networks of criminality and the criminals who are meant to police the system. The consequences of this recording turn the predators into prey while unburdening Simon of the collective disease of soul murder.

Simon's recounting of the disease story serves to make knowable the suffering and the disease burden within individual and collective Indigenous contexts. As Siddhartha Mukherjee argues, "A patient, long before he becomes the subject of medical scrutiny, is, at first, simply a storyteller, a narrator of suffering — a traveler who had visited the kingdom of the ill. To relieve an illness, one must begin, then, by unburdening its story."[94] For Simon, he must unburden his own personal experience with cancer in his community before he can unburden the cancerous, soul murdering stories he collected.[95] Simon carries a cancerous mass of tumors that functions as a biophysical manifestation of the psychological traumas and soul murder in his community. He carries sexual predation stories that contain significant social stigma which wrap them in social invisibility making them particularly difficult to detect. As the centering voice, he speaks those stories into greater visibility in order to contain (and stop) their traumatic, cancerous growth from continuing to hurt the community. In this fashion, "Trembling" moves the tales from perceived individualized, isolated incidents to a collective outbreak. Simon's storytelling makes visible the bigger picture containing nuance and complexity that includes intersectional overlaps of miasmic environment, settler colonialism, and disease.

Instead of presenting concluding emotions of exhaustion and loss, "Trembling" opts to deploy cancer as both an element of containment and as a form of supernatural collective

[94] Mukherjee 46.

[95] Historically, Mukherjee notes, "cancer was imagined as a burden carried by the body" (47).

punishment. Simon gifting cancer to the officer performs a closing of the circle in an act of retribution. The officer's cancerous behavior is returned to him in the form of literal cancer. Through the spider, Simon gives the cancer to the officer. This usage of disease as (divine or collective) punishment harkens back to pre-20th century Eurowestern fiction that viewed disease as an act of the divine upon a people or a person acting outside the accordance of the particular spiritual mandates. By transferring the community's cancerous horror into the spider, Simon contains and returns the terror-inducing soul murder back to the RCMP officer. As Simon reminds the officer, "What you're holding now is for them and the terror you brought their way."[96] As a collector-carrier, Simon's physical body holds space for this terror and, at the appropriate moment, he gives it to its rightful recipient.

In conclusion, Van Camp's "I Am Filled with a Trembling Light" constructs an outbreak/carrier narrative that features Wald's formula but disrupts it using Indigenous storytelling protocols and settler colonialism. The removal of the microbe prioritizes and explores the miasmic environmental conditions and the carriers, both diseased and terror-filled asymptomatic. In the drive to eradicate the germ, Western medicine and its medical tales of discovery myopically focus on the microscopic world to the near erasure and silencing of the environmental miasma and its carriers. Indigenous outbreak narratives like Van Camp's refuse to take their eye off the miasma and its layered, intersecting connections across history into the contemporary moment. These tales center the environmental and psycho-social disease infecting and influencing the community as an epidemic that contains a violence upon contemporary Indigenous bodies.

[96] Van Camp 125.

From *Ravensong*'s outbreak waves evolving into psycho-social epidemics of violence and suicide to "Trembling's" centering of biopsychological outbreaks in order to highlight the intersection between settler colonialism's policies that manifest and enable damaging miasmic conditions including destructive stranger-carriers, Indigenous outbreak narratives put to the lie that virgin soil hypothesis and germs hold the blame for increased cases and devastating fatalities. In line with the devastating histories by Ian Mosby, Maureen Lux, James Daschuk, and others, these Indigenous outbreak narratives place the blame at the feet of the nation-state for its fatal indifference, negligence, and refusal to own up to its responsibility to provide care and clinical resources to Indigenous groups as well as manage the miasmic consequences of its own settler policies. Nevertheless, these narratives refuse to inhabit a passive state of agency. Instead, they feature Indigenous agents crafting creative solutions that function outside settler norms and preserve sovereignty and Indigenous knowledges. Furthermore, as *Ravensong* and "Trembling" seek to indigenize the genre of outbreak narrative by incorporating and centering engagement with settler colonialism and medical racism while using Indigenous storytelling protocols to disrupt traditional progressive linear structures, other Indigenous outbreak tales are pushing the genre's dystopian plagues to not only include Indigenous representation but to explore how the past is never really gone but recycled in new and dangerous forms.

In Chapter 3, Cherie Dimaline's *The Marrow Thieves* explores how Indigenous bodies become exploitable and how historic carceral systems like residential schooling are recycled for the greater good during times of contemporary medical emergencies. In particular, *The Marrow Thieves* disrupts Rosenberg's and Wald's formula with its own sense of temporality and cyclical narrative structures that center Indigenous knowledges, the culturally necessary act of storytelling ritual, and the body-as-carrier.

Chapter 3: The Future, or What Plagues Teach About Indigenous Storytelling and Time

Cherie Dimaline's 2017 novel *The Marrow Thieves*[97] takes the outbreak narrative and places it within the world of speculative fiction, specifically a post-apocalyptic Canada ravaged by climate change and a biopyschological disease. Upon first glance, the text falls into one of the two outbreak subgenres identified by Jill Lepore as it is "a story set among a ragged band of survivors" on a journey of survival within a world beset by dangers and deprivations.[98] Such outbreak narratives provide social commentary on the nature of humanity, the necessity of collective or coupling collaboration in order to survive, and the quest to locate a haven of safety and resource security. While these post-apocalyptic tales traverse a world grappling with and trying to contain a singular disease, they maintain a structural linearity that holds true to the genre expectations where epidemic events are presented as a series of phases that operate within the ravaged dystopian landscape the characters travel. Yet, the ragged band of survivors negotiate their circumstances divided from a pre-outbreak past viewed as a distant, foreign place[99] irrelevant or even unknowable to the present. These outbreak narratives narrowly restrict their characters to a survival mode rooted to a present that fails to imaginatively craft a futurity beyond settler colonial and late capitalist modes of behavior and nationhood.

However, as a piece of Indigenous outbreak fiction, *The Marrow Thieves* refuses this demarcation of time that severs the Before Times of a pre-outbreak past and the all-

[97] Cherie Dimaline, *The Marrow Thieves* (Cormorant Books, 2017).

[98] Jill Lepore, "What our contagion fables are really about," *The New Yorker* (23 March 2020). Web.

[99] To borrow from historian David Lowenthal, post-apocalyptic outbreak narratives view the Before Times like "the past is foreign country". Life before the catastrophe and its attendant outbreak(s) becomes the place that exists in a distant time and foreign location with its own distinct manners, expectations, and resources. David Lowenthal, *The Past is a Foreign Country* (Cambridge University Press, 1999).

encompassing Now while still maintaining a progressive linearity. From its very beginning, the novel utilizes cycling Indigenous storytelling protocols to create a temporal structure that intricately intertwines past with present. The ragged band of survivors regularly attends and participates in storytelling sessions, known simply as Story, either as hosting storytellers or active listeners. These sessions provide the opportunity for all in the band to learn and apply Indigenous knowledges and experiential information in ways that imaginatively problem-solve and ultimately craft a futurity that confronts and combats the settler drive to capture, exploit, and annihilate Indigenous bodies for the health of the settler nation.

This structural feature of regular Story sessions disrupts and complicates the progressive linear formulas of outbreak narratives identified by critics such as Priscilla Wald, Charles E. Rosenberg, and Darla Schweitzer. Typically, these formulas stem from sample texts created through Eurowestern literary and cultural traditions that prioritize linear time as a marker of social progress, national exceptionalism, or medical triumphalism. The last marker comes from narratives focused on the drive to create magic bullet, singular cures meant to contain and eradicate the biomedical problem. Such linearity in typical outbreak narratives craft a germ-centric plot featuring a single disease that initiates a sequential determinist structure of events. While this formula is not necessarily wrongheaded in how to tackle a microbial outbreak, it fails to take into consideration that disease outbreaks may be features of (not a single bug inhabiting) miasmic environmental conditions that include damaging settler politics and recurring instances of disease, biopsychological or biomedical.

In this chapter, I read *The Marrow Thieves* through and alongside specific phases and features of the formulas of typical outbreak narratives identified by Wald, Rosenberg, and Schweitzer. As an Indigenous outbreak narrative, *The Marrow Thieves* contains specific

elements of the formulas, such as Rosenberg's negotiating the public response, Schweitzer's social cohesion via the construction of a 'found family,' and Wald's carriers. However, the novel makes the genre its own through its usage of Indigenous storytelling techniques and its direct engagement with settler colonialism's history of carceral systems and blood quantum policies, including the capturing and annihilating of the Indigenous body for the health of the settler nation. By centering the histories of Indigenous disease and residential schooling, *The Marrow Thieves* critically unpacks how historic settler colonial policies can be recycled during a biomedical emergency that is perceived as a direct threat to settler society. Through the collective strength of storytelling sessions and found families, Indigenous communities maintain social cohesion and actively negotiate successful creative responses to the outbreak's settler-based social forces that seek to exploit and extinguish those deemed expendable for the greater good of the nation.

Is it an outbreak narrative?

Set in a post-apocalyptic epidemic-ravaged Canada where the white population is afflicted with dreamlessness, the novel follows Frenchie, an adolescent Indigenous male protagonist, on his journey from being slowly separated from his blood kin to joining a small mixed-age, multi-tribal Indigenous group of migrants heading into the Far North. The group is led by Miigwans, a middle-age homosexual Elder, responsible for initiating and mentoring new members as well as hosting and facilitating the weekly ritual of Story when Indigenous histories, knowledges, and personal stories are shared. During the group's travels they encounter Natives working for the government as Recruiters, individuals tasked with capturing Indigenous bodies who are believed to carry the cure within their bone marrow. These Recruiters take the captured

Natives to the new "schools," old residential schools sites refashioned into medical holding facilities, where all their bone marrow will be extracted and their body itself annihilated. In the midst of direct confrontations with state-sanctioned violence where they unsuccessfully attempt negotiation and rescue, the group lose two of their female members. Eventually, their quest to locate a hidden self-sustaining Native community leads to the reunion of Frenchie with his biological father and Miigwans with his believed-to-be-deceased husband, Isaac.

Because the novel deploys the language of disease and epidemics when describing the outbreak that drives the settler nation to seek out human extractive cures found in dreaming Indigenous bodies, I read the sleeplessness and dreamlessness of the settler population as a biopsychological outbreak disease stemming from a series of miasmic conditions that diversify its points of origin: climate change, a mass dying event, and a drive for normality. However, some critics tend to read the outbreak as metaphorical and thus a symbolic vehicle for reconciliation and settler economics. For example, Paul Heubener[100] argues that the loss of dreams and sleep by the settler population serves as a metaphor for the commodification and economization of sleep as well as how sleep relates to settler colonialism. Insomnia and the loss of dreams function as externalized physical manifestations of settler guilt linked to how the residential schools were state-sanctioned actions of dream-killing. Patricia Zanella[101] reads *The Marrow Thieves* through the lens of reconciliation discourse and its assumptions of linear progress. She argues that the novel reveals the hidden traces of settler colonialism and its attempts to preserve white futurity at the expense of Indigenous futures. Both readings focus on

[100] Paul Huebener, "Stealing Sleep: Expanding the Conversation on the Literary Politics of Sleep and Insomnia," *ESC* 44.3 (September 2018): 68.

[101] Patrizia Zanella, "Witnessing Story and Creating Kinship in a New Era of Residential Schools: Cherie Dimaline's *The Marrow Thieves*," *SAIL* 32 (Fall-Winter 2020): 176-200.

the metaphorical thus leaving the biomedical considerations and the outbreak nature of the core disease event untouched (and taken for granted). While I do concur that *The Marrow Thieves* can be read metaphorically to reveal intriguing arguments related to the social construction of sleep and the politics of reconciliation, I argue that the settler population tackles the epidemic of dreamlessness as a biomedical crisis that requires a cure through magic bullet technologies. Furthermore, the novel directly positions the outbreak of white dreamlessness as one in a series of consequential catastrophic events for the settlers and the Natives, not as an abstract metaphor.

A metaphorical reading of a text that includes a plague or epidemic is not enough to label a text an outbreak narrative. For Charles E. Rosenberg[102], an epidemic must be a discrete, closed event that features a progressively linear narrative structure that moves sequentially through a series of phases: progressive revelation, managing randomness, and negotiating public response. These phases are framed with a prologue that spotlights the interactive web of human-animal relations and the community's anticipation of the disease's arrival by following its spread through its communication networks and an epilogue that contains a period of reflection for the community and individual. Priscilla Wald[103], on the other hand, simplifies the plotting to three phases: the identification of the emerging infection, the mapping of transmission routes through epidemiological work, and containment the disease.

At first glance, *The Marrow Thieves* features many of the components of a typical outbreak narrative, such as the state's management and negotiating of the experience, the drive to maintain social cohesion, and attempts at containment. The novel details how the widespread

[102] Charles E. Rosenberg, "What is an epidemic?" AIDS in Historical Perspective," Daedalus 118 (Spring 1989): 1-17.

[103] Priscilla Wald, *Contagious: Cultures, Carriers, and The Outbreak Narrative* (Duke University Press, 2008).

appearance (but not slow, anticipatory emergence) of white dreamlessness necessitates an aggressive official public response that seeks to minimize the settler perceived randomness of white affliction by exploiting and regulating the bodies of non-whites. The state's attempts at extracting a magic bullet cure believed to reside in the bone marrow of Indigenous individuals woefully fails to contain the epidemic. By seeking to contain Indigenous bodies within a carceral system, itself based on historically destructive policies of containment, the state's negotiated response fails to eradicate the disease. However, upon closer examination, the novel rearranges the plotting, upends expectations of containment, and critiques the genre's own canon. In many ways, it indigenizes a Eurowestern genre for its own purposes by reinforcing some elements (social cohesion and collective storytelling) while disrupting others (linear bias and Eurowestern medical triumphalism).

Living in and through: Cycling Temporality

Because the novel begins *in medias res* of the epidemic, it immediately constructs an unsettled, unstable textual world where its characters attempt to connect their lived experiences with the disease stories told by others in order to piece together some sense of understanding of the situation. Using Rosenberg's three phases for reference, the novel's *in medias res* sits within the stages of managing randomness and negotiating public response. This structural instability and uncertainty center the in-real-time emotional state of those navigating a catastrophic biomedical and refuses the genre's traditional linear timeline of anticipating the emergence of the disease. In such cases, Priscilla Wald observes the existence of a "psychological numbing attendant on disasters of great magnitude."[104] Early in *The Marrow Thieves,* Miigwans

[104] Wald 11.

rhetorically enacts such psychological coping during a recounting of the early catastrophes. He notes, “Half the population was lost in the disaster and from disease that spread from too many corpses and not enough graves.”[105] In order to narratively manage this recurrence of catastrophes including outbreak waves, Miigwans lumps five environmental catastrophes together under the singular phrase “the disaster”. By flattening the recounting, Miigwans manages its overwhelming qualities whose aftermath remains the same: a mass death so socially unmanageable that proper burial rites fail to be conducted.

From the onset, the novel’s temporality complicates the linear chronological structure commonly found in typical outbreak narratives. Instead of simply following one phase after another with clues and revelations laid out in a straight linear form, *The Marrow Thieves* prioritizes the cyclical, yet forward-moving Indigenous oral tradition often found in Turtle Island literatures. Utilizing the ritual of Story, the overall plot contains multiple flashbacks interspersed with forward-moving action sequences that provide additional characterization and development through a process of ongoing reflection facilitated by the act of storytelling. Reflection becomes an ongoing present phenomenon, instead of Rosenberg’s delayed reaction conducted at the perceived end of the epidemic. Frenchie’s found family inhabit a temporality that overlaps past with present while constantly seeking knowledge to locate a new future. The members function within a present that demands strict adherence to a survival mode where they must always already be mindful and alert to possible attacks and deprivations. However, they each carry within themselves a past filled with traumas, tragedies, and bittersweet memories that influence their behavior and affects daily decision-making. The present cannot be divorced from the past

[105] Dimaline 26.

because the two overlap, nest, contradict, and conflict with each other in the daytime and in the dreaming.

To reinforce this narrative argument, the past and present coexist and intersect within Indigenous lives, literatures, and histories, *The Marrow* Thieves complicates Rosenberg and Wald's initial phase of identifying an emerging infection by presenting a narrative that contains paralleling catastrophic events and outbreak waves making recognition and anticipatory efforts difficult. Disease outbreaks can occur as aftermaths of each other or proliferate as simultaneous medical events that can be effaced or magnified by environmental conditions like climate change and exacerbating socio-economic factors.

In particular, the novel directly confronts and complicates the virgin soil hypothesis and replaces it with a reoccurrence model containing 'waves' of catastrophes, biomedical and miasmic. Developed at the cross-section of Indigenous history, anthropology, and archaeology, the virgin soil hypothesis postulates that the high fatality rates amongst Indigenous groups experiencing disease events stems from their bodies being "virgin soil" for microbes and diseases traveling from Europe and via the transcontinental routes seen in the Columbia Exchange. However, recent revisionary work[106] from these fields counter-argue that the fatalities stem from miasmic factors (e.g. settler colonialism) as well as 'waves' or concurrent of disease events that disrupted recovery efforts through generational immunity, fertility, and reproduction. This recurrence model argues that a community may experience multiple waves of disease, either the same disease multiple times or one disease leading to another to another over any length of time.

[106] See Alan C. Swedlund, Paul Kelton, and Catherine M. Cameron, *Beyond Germs: Native Depopulation in North America* (University of Arizona Press, 2015): 3-15; Guillaume Lachenal and Gaetan Thomas, "Epidemics Have Lost The Plot," *Bulletin of the History of Medicine* 94.4 (Winter 2020): 678-684; Jeffrey Ostler, "Disease Has Never Been Just Disease for Native Americans," *The Atlantic* (29 April 2020).

Indigenous outbreak narratives like *The Marrow Thieves* deploy the recurrence model to argue that Native communities experience multiple disease outbreaks over time. Thus, they cannot be microbial virgin soil every year and every generation. Immunity alone cannot be the only explanation for high fatality rates within Native communities.[107] For example, in *The Marrow Thieves*, Miigwans positions the present epidemic of dreamlessness within a deeper outbreak history connected to and exacerbated by settler colonial institutions and policies. When recounting early colonialism, Miigwans notes, "Mostly because we got sick with new germs. And then when we were on our knees with fever and pukes, they decided they liked us there, on our knees. And that's when they opened the first schools. We suffered there."[108] Even though Miigwans initially acknowledges the virgin soil hypothesis at the beginning of early contact between Natives and settlers, he then connects these initial outbreaks with residential schooling. For Miigwans, the "new germs" lay the foundation for the history of colonial policies meant to induce physical and cultural suffering including more outbreak waves.

Within Indigenous outbreak narratives, the recurrence model acknowledges that the microbial intersects and interacts with the miasmic for devastating effects. However, these Indigenous tales avoid connecting environmental conditions with the primitive and its association with poverty – a common feature of traditional outbreak narratives.[109] Shortly after spotlighting the recurrence model, Miigwans overlays it with a series of environmental catastrophes connected to the exploitation of natural resources to devastating ends. The Water

[107] See Ostler and Guillaume Lachenal and Gaetan Thomas, "Epidemics Have Lost The Plot," *Bulletin of the History of Medicine* 94.4 (Winter 2020): 678-684.

[108] Dimaline 23.

[109] Wald 8.

Wars[110] between the United States and Canada pollute the rivers and the Great Lakes as well as destroy settler communities and reserve lands. Then, The Melt[111] and the destruction of pipelines simultaneously drown and pollute whole regions necessitating mass migrations. As Miigwans notes, "People died in the millions when that happened. The ones that were left had to migrate inward. It was like the second coming of the boats, so many sick people and not enough time to organize peacefully."[112] Here Miigwans interprets these migrations as a new first contact that recycles historic colonial interactions where settlers seek land and resources while bringing sickness and violence to Indigenous inhabitants. These environmental travesties are products of climate change and late capitalist extraction practices, not the supposed primitiveness and poverty of a people.

Denial, Drive, and Devastation: Negotiating Responses

In addition to prioritizing the experience of living with and through a recurrence model of catastrophes and disease events, Indigenous outbreak narratives like *The Marrow Thieves* prominently situate the nation-state's politics of recognition and negotiation of the public response. In Miigwans' retelling, the displacement and mass dying event fails to elicit any public acknowledgement or identification of a biomedical problem. As the history of AIDS and other epidemics have shown, Guillaume Lachenal and Thomas Gaetan argue, "it is always possible to ignore an epidemic, and that ignorance is socially and historically produced along specific, often racial, lines. […] denial is not a phase preceding 'inevitable' acknowledgement … but an always

[110] Dimaline 24.

[111] Dimaline 25.

[112] Dimaline 87.

available option, even when bodies pile up. […] There is a politics of visibility, concern, and ignorance."[113] While Rosenberg and Wald tend to engage the politics of denial and recognition at the beginning of the epidemic, Lachenal and Thomas highlight the need to consider these issues throughout all phases of the event, especially since outbreaks contain a temporality that blurs the nature of endings and beginnings, sometimes refusing closure altogether.

In keeping with a recurrence model featuring a state of official public denial mixed with an exhausted citizenry, this initial disease outbreak chronologically precedes the epidemic of dreamlessness that sits at the center of the novel. Miigwans simply states, "The ones that were left were no better off, really. They worked longer hours, they stopped reproducing without the doctors, and worst of all, they stopped dreaming."[114] Life after the disease outbreak contains drudgery manifesting in infertility[115] and dreamlessness. The mind stops creating innovative futures, and the body refuses to reproduce itself. Miigwans provides a deeper and darker explanation of the days between the initial disease outbreak and the dreamless epidemic. He states:

> But the powers that be still refused to change and bent the already stooped under the whips of a schedule made for a population twice its size and inflated by the need to rebuild. Those that were left worked longer, worked harder […] The suburban structure of their lives had been upended. And so they got sicker, this time in the head. They

[113] Lachenal and Thomas 681.

[114] Dimaline 26.

[115] See early 20th century arguments regarding 'race suicide' related to the health of the nation. As Priscilla Wald notes, "it was commonly argued that the nation had a biological as well as social basis in the family and the institution of marriage safeguarded the reproduction of both" (86).

> stopped dreaming. And a man without dreams is just a meaty machine with a broken gauge.[116]

For Miigwans, the refusal of the nation-state to recognize the changes that the initial outbreak and mass dying event had wrought leads directly to the next epidemic. While the first outbreak struck the body, the second is psychologically destructive for the individual white settler-citizen. Like traditional outbreak narratives that link the horror of a disease with its dehumanizing effects upon the body, Miigwans describes the dreamlessness as a disease externally manifesting itself by transforming a man into a "meaty machine."[117] The dreamless disease leaves the body as a broken mechanical husk stripped of its personhood. It is this last grotesque symptom that forces the nation-state into official recognition of the disease and a negotiation of the public response.

Transmission Threats, Carriers, and the Damages of the Magic Bullet

Unlike traditional outbreak narratives, the novel inverts the typical unidirectional flow of contagion by making the Native healthy and the settler diseased. As Priscilla Wald notes, in the geography of disease, some outbreak narratives "implicitly constitute disease outbreaks as the incarnations of a timeless and diseased 'Third World' leaking, through the microbes, into the metropolises of the 'First World'."[118] Such rhetorical maneuvering postulates racially marginalized communities as always already vectors for disease in need of invasive health regulations, surveillance, and policing in order to protect the health of a mainstream, settler society. *The Marrow Thieves* reverses this direction by having healthy Native communities

[116] Dimaline 88.

[117] Wald 35.

[118] Wald 45. In Indigenous outbreak narratives, the Indigenous so-called Third World does not "leak" onto the urban settler community. Instead, the First World "leaks" and contaminants all over Indigenous land and peoples.

living in marginalized spaces be exploited and consumed as a pharmaceutical resource by the diseased settler community.

The epidemic of dreamlessness functions as a targeted disease that affects only a distinct demographic of white settler-citizens or members of the original settler community who are rooted to late capitalist belief systems. As privileged members of society whose diseased state poses a threat to sociopolitical identity and the power of the settler nation, these carriers place incredible pressure on their political and medical communities that the inability to dream becomes a national medical emergency that demands a magic bullet cure. As Miigwans notes, "They needed answers, solutions. So, up here, the Governors turned to the Church and the scientists to find a cure for the missing dreams."[119] The settler carriers hold a deep faith in medicine's ability to craft urgent treatments on short timetables so that normality can be restored. As Paul Heubener argues, "This sense of trust in science and technology to solve what is really an ethical or spiritual problem — a notion that reflects the sociological link between the medicalization of sleep and its commodification —- foreshadows the monstrous technology that will be used to steal indigenous dreams."[120] The nation-state prioritizes their belief that the situation is temporary, changeable, and ultimately solvable. All they need is the experts, "the Church and the scientists," to locate a solution for the disease to provide a biomedical answer to a perceived bio-national threat.

The deployment of this diseased/healthy binary by the settler state reinforces longstanding medical paradigms that myopically prioritizes the microbe inhabiting the body over other innovative, creative thinking associated with miasma. As Priscilla Wald notes, "much of

[119] Dimaline 88.

[120] Huebener 82.

the outbreak narratives feature a tale of conquest where the disease or germ must be eliminated, not just cured."[121] *The Marrow Thieves* complicates this tale of biomedical conquest with ethics by asking what would happen if the cure required a totalizing extraction from a human body. In order to eradicate the disease, the nation-state opts to completely annihilate Indigenous bodies for their supposedly curative bone marrow. The sick settler demands that the healthy Other serve as their cure. This drive for the singular simple cure at all costs ultimately fails all its citizens and simultaneously highlights the nation's devastating blind spots and biases related to settler colonialism and its attending medical racism. Rather than acknowledge and confront the new reality post-catastrophe, the settler social order crafts an extractive treatment that kills the captured nonconsensual Native donor, but cures no one of the disease.

If outbreak narratives feature tales of conquest, then Indigenous outbreak narratives invert the expectations. The cure itself, in this case the Indigenous body and its linguistic community, is annihilated, not the disease or the conditions responsible for emergence and transmission. Microbial-biased medical policies and their settler agents capture and conquer the wrong thing by continuing to look in the wrong direction. Prior to his position as Elder of the kinship group, Miigwans discovers residential school crates filled with "frosted test tube with the shadow of liquid inside, a thick, viscous liquid that was neither cool nor warm"[122] with labels that provide a serial number, age, sex designation, and tribal identity. Considering the specimen tubes, He states, "I couldn't live with the people being served up like a club sandwich to the dreamless."[123] Because the nation-state believes that Native bone marrow contains the dreaming

[121] Wald 45.

[122] Dimaline 144.

[123] Dimaline 145.

qualities necessary for a cure, they seek to capture it in a vial that will then be administered into a non-Native patient suffering from the disease. Ultimately, this capture process requires killing the nonconsensual Native carrier because their entire supply of bone marrow is required. By annihilating the body with its dreams and then distilling it down into a syringe to be mechanically inserted into others, this process transforms the Native carrier into a dehumanized, disposable, and transferable medical object. The Native carrier becomes an anonymous pharmaceutical commodity to be consumed and incorporated into the bodies of others. Instead, the entire process enacts genocidal violence against healthy Native carriers whose bodies end up contained in test tubes, while the sick carriers remain unrestrained and uncontained.

Identifying and Containing the Native Carrier

By the logic of settler colonialism, Indigenous carriers of health can be determined using the longstanding colonial categories of blood quantum. However, the Native carrier's ability to dream appears not to be linked to blood quantum. Members of Miigwans kinship group are identified as Indigenous, but not tribe-specific. Only Clarence is explicitly noted to be Cree due to his knowledge of that language. The detailed blood or DNA status of its members remains unknown, which implicitly reinforces blood quantum's usage as a settler measure and not an Indigenous marker of status.[124] To explore contemporary problems of the settler state demanding a strict adherence to blood quantum to determine Indigeneity, the novel directly confronts blood quantum's failure as a testable quality.

[124] Blood quantum is a historically complicated and fraught topic that has only become more complex with the advent of over-the-counter DNA tests. For the purposes of this project, I will only briefly explore how the novel quickly dispatches with blood quantum and how its failure is just one among many committed by the settler nation in the name of seeking a magic bullet cure. For a detailed analysis of DNA tests, blood quantum, and tribal sovereignty politics, see Kim Tallbear, *Native American DNA: Tribal Belonging and the False Promise of Genetic Science* (University of Minnesota Press, 2013).

Because settler society view Indigenous groups through a narrowly biomedical lens that fractures the body into fluids and matter, the blood tests and quantum categories fail to reveal markers of Indigenous values and knowledges. For example, near the end of novel, the kinship group encounters Isaac, Miigwans partner, who was thought to have died after being taken by Recruiters. In his brief retelling of his journey, he notes, "I was brought in to their hospital for blood work to determine my eligibility […] To make sure my blood wasn't too mixed. Can't catch a break for being a half-breed, any way you look at it."[125] Holding half, full, or other divisions of blood quantum does not determine socio-cultural knowledge, linguistic fluency, and kinship identity. As the novel notes time and time again, the blood tests, as a settler measure, do little more than turn Indigenous carriers into an exploitable, harvestable resource. Blood and bone do not create and support the ability to dream, especially when that ability is intimately wrapped up in linguistic and cultural fluency. The state's continued usage of blood blinds them to Indigenous bio-cultural solutions that center the holistic embodied experience as both physical and cultural.

Once the blood quantum process of verifying Native carriers of health is established, the settler state must then locate enough carriers to harvest the cure for all those seeking treatment. From one settler measure of failed surveillance to others utilizing existing or historic carceral systems that capture and contain the Indigenous bodies with devastating results. As Miigwans explains, initially the health authorities "asked for volunteers first … for medical trials"[126] and offer all the typical incentives that come with this phase: honorarium, room and board, etc. However, due to the longstanding antagonistic relationship within Anglo-Native clinical

[125] Dimaline 229.

[126] Dimaline 89.

experiences, not enough volunteers participate. This failure prompts a shift to using incarcerated Indigenous donors – an always already contained population. Miigwans notes, "The prisons were always full of our people. Whether or not the prisoners went voluntarily, who knows? There weren't enough people worried about the well-being of prisoners to really make sure."[127] A classic understanding of the incarcerated holds that their bodies exist under the protection and supervision of the state, and by extension their bodies are not quite their own because their crimes have deprived them of full physical autonomy. An incarcerated population is a literal "captive audience" who can be used at the will of the state, within reason and legal statutes.

When these options are exhausted and more Native carriers are demanded, history becomes the basis for the next stage of identification and containment. In the words of Miigwans, "Soon, they needed too many bodies, and they turned to history to show them how to best keep us warehoused, how to best position the culling. That's when the new residential schools started growing up from the dirt like poisonous brick mushrooms."[128] Native carriers are given no choice, no option to refuse in the face of the Recruiters, the agents representing the nation-state. Like the children of previous generations, their bodies become state objects viewed as violable, inherently expendable, and exploitable since their humanity and bodily autonomy are refused and erased by settler colonialism's urgent drive for magic bullet solutions. By repackaging the historical genocidal practices of Canadian[129] boarding schools, the past never

[127] Dimaline 89.

[128] Ibid.

[129] These schools have a documented history of conducting unethical, at times nonconsensual, starvation and malnutrition studies on Indigenous human test subjects as well as being sites of fatal disease outbreaks, specifically tuberculosis. See Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1952," *Social History* 46.91 (May 2013): 145-172 and Ashifa Kassam, "Canada sued over years of alleged experimentation on indigenous people," *The Guardian* (11 May 2018). Web.

truly dies or was never fully buried, because the past maintains its power through systemic ideas. People may forget, but the institutions do not. In times of emergency, historic systems rise again for the sake of expediency and efficiency while basic human rights are ignored, overlooked, or suspended for the greater good.

The Marrow Thieves exposes the historical links between schools and medicine that once drove medical progress for the nation-state. Specifically, the novel uses the history of compulsory education laws that removed Natives from family and communities, enabling educational institutions to cause deformity and death with impudence for the greater good of medical research and national health because what little oversight that prevailed functioned with indifference. The act of re-purposing one colonial institution (the schools) into another (harvesting sites) highlights the historical intertwining of school and medicine in the service of the nation-state.[130]

Found Families and Story: Creating Social Cohesion in a Survival Mode

A community-wide experience of shared suffering unifies its members while simultaneously reinforcing divisions where those same communities establish and police borders against the "Other". As Dahlia Schweitzer notes, "contagious disease can also bring us together" and facilitate the "formation of shared human bonds."[131] In *The Marrow Thieves,* 'found families' are key to individual survival as well as establishing kinship bonds, conducting healthy

[130] Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1952," *Social History* 46.91 (May 2013): 145-172. See also, Ashifa Kassam, "Canada sued over years of alleged experimentation on indigenous people" *The Guardian* (11 May 2018). Web.

[131] Dahlia Schweitzer, *Going Viral: Zombies, Viruses, and The End of the World* (Rutgers University Press, 2018), 49.

socialization, and distributing generational knowledges. Schweitzer notes, "outbreaks create new kinds of families, survivors banding together in groups to form new types of social structures."[132] Miigwans identifies the members of his kinship group as a "my family,"[133] a "motley group"[134] of individuals who "seemed to all be Native". The group constitutes a "found family" as none are related by blood (with the exception of one set of twins) and features no common connections across its members. They all carry a unique "coming-to" origin story, an initiation tale that explains how they came to be a part of the family. Their pre-outbreak affiliations appear to span all the regions of Canada.

Like the temporal split found in outbreaks and catastrophe, being found by Miigwans and then included into the family group creates an individual temporal split for its members. For Frenchie, he physically enacts a transformation that replicates a rebirth. After Miigwans confirms that they are heading north and suggests that Frenchie travel with them, Frenchie proceeds to cry to the point that his body curls into the fetal position. He notes, "I was embarrassed to be so broken in front of all these new Indians … They just let me be broken, because soon I wouldn't be anymore."[135] The meeting with Miigwans group moves Frenchie from a state of isolated survival as a singular individual to a member of a collaborative, relational, caretaking group. He is no longer alone but an active member of a 'found family' containing a male-female Elder pairing and siblings that span the life stages of young adult, teen, and childhood.

[132] Schweitzer 50.

[133] Dimaline 16.

[134] Dimaline 18.

[135] Dimaline 17.

Returning to Rosenberg's model, after progressive revelation and managing randomness, outbreak narratives turn to negotiating public response through rituals and rites that seek to tackle the complexities of social cohesion and control. To establish and maintain bonds within the found family as well as provide its members with vital cultural knowledge to sustain their health, *The Marrow Thieves* features the ritual of Story, a regular storytelling session facilitated by the Elder Miigwans. During Story, members of the found family recount their individual "coming-to" stories or origin tales that trace their lives prior to their arrival in the family group. In this manner, no single story[136] of an emerging infection or catastrophic event stands supreme. Instead, many stories present multiple perspectives of these early days. These stories attempt to make visible and known the varied lived experiences of grappling with an unseen, unknown, yet destructive biomedical event. The members of the family piece together a collective knowledge about the catastrophe while simultaneously living through it.

Structurally, Story holds prime of place in its importance for social cohesion, intergenerational transference of knowledges and histories, and individual care. Importantly, it does not function on a receiver-model where the audience passively receives the message and then forgets it. As Frenchie states, "We needed to remember Story. It was his [Miigwans] job to set the memory in perpetuity. He spoke to us every week."[137] Miigwans hosts the weekly event as a gathering where the storyteller passes stories and cultural information from themselves to the audience, who must then internalize its narrative and embody its message. Its content ranges across regions, cultural events, and political concepts and histories.

[136] See TED, "Chimamanda Ngozi Adiche: The Danger of the Single Story," YouTube (9 October 2009).

[137] Dimaline 25.

The ritual's name of "Story" highlights the narrative quality of these gatherings and how the teller and the audience hold to a particular set of ethics and responsibilities. Story does not divide fact from fiction, myth from history. All texts, events, and narratives hold equal importance and must be remembered as well as passed from one generation to the next. As French notes, "But every week we spoke, because it was imperative we know. He said it was the only way to make the kinds of changes that were necessary to really survive."[138] Story is passed down and across generations as it contains both oral histories, cultural knowledges, and individual tales. Following Indigenous storytelling protocols like those advanced by Richard Van Camp and Thomas King, the orality and campfire ritual of the storytelling sessions dictate that the listener must carry those stories within themselves.[139] Through the transference of story from speaker to listener, the story holds space within the body of the listener where it functions as a resource for decision-making and cultural understanding. Through the ritual of Story, the members maintain a state of health and balance that is reinforced through weekly sessions that provide the opportunity for members to share and exchange knowledges as well as internalize the relational care embedded within storytelling protocols and actions.

The storyteller is still a human being with their own psychological and physiological complexities. They take care of their audience while also monitoring themselves and what they can and cannot handle at particular points of time. During an early session of Story, Miigwans stops and Frenchie notes, "He couldn't continue. Couldn't walk us into the darker parts of Story,

[138] Dimaline 25.

[139] See Richard Van Camp, *Gather: Richard Van Camp on the Joy of Storytelling* (Regina: University of Regina Press, 2021); Thomas King, *The Truth About Stories: A Native Narrative* (Minneapolis: University of Minnesota Press, 2008).

not now."[140] Frenchie's use of the phrase "walk us into" highlights the guiding position of Miigwans, while also noting that at this particular point as a storyteller he could not continue. Miigwans knows that he needs to walk his family into the darkness, guide them into the depths of their world so that they can protect themselves with that knowledge. That night Story ends with only the exposition because at that moment, the storyteller was not yet ready to lead the group into "the darker parts".

Knowledge gaps, silenced or erased stories, create a significant problem when dealing with current issues and assessing their risk levels. If the stories do not exist or do not pass from one generation to another, individuals may not have the skills and information necessary to survive. Miigwans notes:

> Isaac didn't have memories in his family of the original schools, the ones that pulled themselves up like wooden monsters coming to attention across the land back in the 1800s – monsters who stayed there, ingesting our children, like sweet berries, one after the other for over a hundred years. Isaac didn't have grandparents who'd told residential school stories like campfire tales to scare you into acting right … stories about a book that was like a vacuum, used to suck the language right out of your lungs. And I didn't have time to share them, not now.[141]

The stories act as pedagogical devices and protection against physical and intellectual damage. Unfortunately, their loss of an individual's knowledge can lead to tragic ends and devastating social disruption.

[140] Dimaline 26.

[141] Dimaline 106-107.

Regular Acts of Reflective Practice

In addition to the social cohesive ritual of Story, the novel features multiple scenes of discussion and reflection in the midst of the epidemic. Unlike typical outbreak narratives where individual acts or collective phases of reflection occur after the epidemic ends, *The Marrow Thieves* utilizes an ongoing reflective practice where group members critically question and unpack immediate experiences in light of collective knowledge. In the chapter entitled "A Plague of Madness," the main protagonist, Frenchie, and his found family discuss not only the plague but the human drive to survive and how that drive can create disastrous consequences for personal identity, community cohesiveness, and ethics.

By connecting *The Marrow Thieves* with *The Plague*, Dimaline directly situates her novel within the genre of outbreak narratives and outbreak fiction. However, Miigwans's truncated summary of *The Plague* begins with him not identifying the novel by title but remembering that its author was named Camus and that he was from Algeria. At no point does the title of the book officially appear either in dialogue or narration. In fact, the narrator Frenchie observes, "I've never heard the story before. But I knew what a plague was. That's what they were calling the dreamlessness when it started, a plague of madness."[142] *The Marrow Thieves* uses Camus's *The Plague* as a point of reference, a philosophical guide, and positions it as connective literary tissue to other plague narratives. It does not directly "speak to" *The Plague* by adjusting or criticizing its interpretation and narrative construction. Instead, *The Marrow Thieves* reorients *The Plague'*s privileging of colonialist experiences under strict geographic quarantine by including Indigenous voices who have been forcibly displaced, put under surveillance, and whose bodies become objects of the state.

[142] Dimaline 53.

For Rosenberg, the reflective act (epilogue) is when the historians and the policymakers construct objective reflections and craft historical narratives that make meaning of the epidemic event. Outbreak narratives typically fail to consider the reflective process outside settler colonial paradigms where reflection and history function along linear structures potentially revealing socio-militaristic progress or problems to the heteronormative capitalist drive of civilization. However, while such intentional post-event reflection does take place, its isolated timing and specialized experts are a luxury that many communities can ill-afford.

The Marrow Thieves takes the reflective stage and places it inside an ongoing outbreak, thus reinforcing the act of living with and living through a disease event. In particular, the act of reflection through Story becomes a regularized in-person, oral-based activity that creates and sustains community cohesion through opportunities for cultural sustainability of its knowledges and languages. It is an on-going and socio-psychologically necessary function of community survival. It cannot wait until the event-as-event appears to be at its ending stages or has passed out of existence, because to delay reflection is to court cultural disaster in the loss of elders or knowledge keepers who die without passing knowledges to others. Like its predecessor *Ravensong*, *The Marrow Thieves* spotlights the necessity of ongoing reflection within a community in order to maintain tribal knowledges and languages while also safeguarding the transfer of knowledge across generations. Knowledge maintenance and reflection must be a continuous process of renewal and review in order for the community and its individual members to survive and thrive whether the circumstances be benign or catastrophic.

Containment and Closure: Living With and Living Through

The Marrow Thieves refuses the last component of outbreak narratives: total containment and full closure. Instead, the narrative slowly reveals an Indigenous-based alternative where an embodied linguistic-cultural ideal provides the means for a solution to the plague. The "key" to the epidemic turns out not to be microbial but linguistic and psychological. The novel does not use the word "cure", but instead wields the noun "key".[143] Prior to the capture of the Elder Minerva by the Recruiters, Frenchie comes realize that the ability to dream is related not to Indigenous blood, but to the knowledge of Indigenous language(s). During Frenchie's recounting of the disastrous extraction process of Minerva's bone marrow, he states, "every dream Minerva ever had dreamed was in the language. It was her gift, her secret, her plan. She'd collected the dreams like bright beads on a string of nights that wound around her each day, every day until this one."[144] Minerva's linguistic ability proves to be a shield that protects her against the loss of dreams and the very extractive process meant to kill her. Through her use of Indigenous language, she literally short-circuits the machinery and frees herself from medical incarceration. This scene explores how the survival of language, and the ability to dream in that language, resides within the body and it is this embodiment of language that proves to be an effective antidote to the biopsychological outbreak. The cultural act of learning, maintaining, and using the Indigenous language within the individual body and its community creates opportunities for healing and health. Storytelling and language preservation act as the healing "key" that can unlock the mind and provide alternative decolonizing solutions to a colonial problem. The body holds the language, and the language balances the health of the body. Language cannot be accessed through bodily fluids or DNA since language is a learned experience requiring initial

[143] Dimaline 227.

[144] Dimaline 172-173.

cognitive acquisition and regular maintenance over one's lifetime. By embedding the power of language within physical embodiment, the novel appears to demand that language fluency be considered a key component of Native intersectional identity.

Furthermore, linguistic fluency levels do not seem to increase or diminish dreaming ability. Frenchie and his youthful kin group seem to know only a smattering of words and phrases in Cree, yet they appear to dream in English. While the elder generations speak and interact with more advanced and sophisticated levels of fluency, they too seem to dream across languages. The significance seems to lean on having some knowledge of an Indigenous language (particularly Cree) in order to maintain the ability to dream. With the return of Isaac to the group, the linguist serves as both a cultural hero and potential healer who can revitalize Indigenous languages within Native communities and beyond.

Even though the novel ends with the revelation that Miigwaans's partner lives and holds the solution to the epidemic thanks to his position as a linguist, the novel simply ends. The epidemic still ravages, Indigenous individuals and groups are still being rounded up for harvesting, post-apocalyptic life remains unchanged with only a bit more hope. The novel refuses to provide the closure and resolutions of those typically found in Rosenberg's and Wald's outbreak narratives. Instead, *The Marrow Thieves* offers up the presence of a "key" with all its possibilities and potential. It refuses to enact how or if the "key" will solve a national crisis, nor does it even allude to a plausible direction. In this way, *The Marrow Thieves* reinforces the messiness of crafting solutions to epidemics and the need to acknowledge the complicated, nuanced outbreak experiences of marginalized groups where endings may never arrive.

The Marrow Thieves functions as an Indigenous outbreak narrative that disrupts and rearranges Rosenberg's and Wald's plotting formulas while creatively pushing the genre to

tackle nuanced notions of temporality, the recyclable nature of settler colonialism, and the ritual of oral storytelling to craft social cohesion and cultural knowledges. By centering Indigenous experiences living with and through an outbreak being managed by settler authorities with devastating results, the novel reorients the canonical interpretation and structures of the genre established Albert Camus's *The Plague.* Whereas *The Plague* privileges colonial authorities while criticizing their protocols and misreading of the disease event, in both social and medical terms, *The Marrow Thieves* verbally silences the settler society while amplifying the Indigenous voices directly affected by settler colonial decisions that uncritically revisit and repackage historic colonial policies and systems. By putting itself in direct conversation with its own genre, *The Marrow Thieves* acknowledges its colonial antecedents with its colonial blindspots. It also pushes the genre to critically engage with its own canon and reorient itself to (re)consider and include how marginalized voices speak and experience outbreak events.

Whereas *Ravensong* maintains a sense of progressive linearity and "Trembling" circles its way through a singular storytelling session, *The Marrow Thieves* opted to include multiple storytelling sessions that featured several different speakers while also crafting a cycling journey that still moved forward in time. One could potentially chalk up this difference in style to one of literary history moving from the Eurowestern inflected styles of the 80s and 90s to the more Indigenous-centric structures of the early 21st century. While this may be a factor, I tend to see it as more of unintentional bias in text selection. Progressive linearity has not gone out of style, considering the recent Covid-19 outbreak narratives of Louise Erdrich's *The Sentence* (2022) and Thomas King's *Deep House* (2022). Instead, I highlight the structural differences across these texts to point out that Indigenous outbreak narratives play with and against the formulas and expectations of the genre for their own devices and agendas. In particular, the tackling of historic

outbreak waves lends itself more easily to the linear structure of history while an outbreak in a dystopian future may demand more narrative instability (or techniques outside settler mainstream craft) in order to push the genre to engage with diverse storytelling cultures.

A surface reading of the texts may appear to mark them as hyper-focused on the outbreak present, upon further analysis they instead overlap the past with the present in a reflective mode meant to creatively craft a better future. Whether the reflection mode appears in *Ravensong*'s epilogue, "Trembling"'s foregrounded interrogation space, or the ritual of Story in *The Marrow Thieves* the past and present coexist, cycle across each other, or creatively construct new ways of knowing and decision-making. In Indigenous outbreak narratives, the importance of the work of reflection cannot be overstated as it provides critical psychological and emotional release in *Ravensong,* lays the foundation for community retribution in "Trembling", and enacts social cohesion in the found family while inoculating individuals with cultural and linguistic knowledge in *The Marrow Thieves*. In a way, reflection acts as a vital mode of care, both for self-care and cross-community health, and without it the potential for communal damage occurs. Without proper time and space for reflection, grief remains unburdened for nearly a generation as seen in *Ravensong,* individuals uncritically and repeatably make decisions and social judgments that lead to devastating community problems in "Trembling", and a reactionary series of settler state decisions that lead to more catastrophes and an epidemic uncritically negotiated using past protocols in *The Marrow Thieves.*

Hopefully, my analysis of these three texts have shown that Indigenous-authored outbreak narratives not only exist within the traditional formulas and structures of the genre, but they also bring disruptions and innovations that push the genre to critically consider its own canon and its (settler) colonial biases like linear plotting, the virgin-soil hypothesis, and medical

racism and triumphalism. Whether working strictly within its structures or disrupting it altogether, Indigenous outbreak narratives interweave their own histories and knowledges in order to further explore notions of temporality, language, and the continuing existence of settler colonialism.

Conclusion: Now What?

Throughout this dissertation, I have sought to identify and establish the presence of Indigenous outbreak narratives within the genre of outbreak narratives in order to showcase how Indigenous authors work with and against established formulas and expectations. Depending on how one would want to delineate the boundaries, Indigenous outbreak fiction has been around since at least Lee Maracle's *Ravensong* (1993). However, it can be argued, using Wald's broader definition that includes non-fiction as well as fiction, that Indigenous outbreak narratives go back to the colonial period of the fifteenth century.[145] Yet, these historic texts as well as the fiction produced influenced by the Covid-19 pandemic have not sufficiently received critical focus as either a separate and unique genre or as texts read through the critical lens and frameworks found within medical humanities. In the case of this significant gap in the research, I believe it would be beneficial to continue to seek out additional nuance and complexity driving the subgenre of Indigenous outbreak narratives across history, especially in light of the Covid-19 pandemic.

Digging deeper into the aftermath phase of epidemics, a stage ignored by most critics until recently thanks to Covid-19 and one that Rosenberg relegates to a period of post-epidemic reflection conducted by social authorities and elites, Indigenous outbreak narratives like Lee Maracle's 2014 novel *Celia's Song* (a sequel to *Ravensong*) and Thomas King's 2022 novel *Deep House* argue that the long-term consequences of the so-called social epidemic needs just as much attention as the declared ending and aftermath of a medical outbreak. For example, Thomas King's most recent addition to his DreadfulWater mystery series, *Deep House*, navigates a world where the Covid-19 outbreak is believed to have come and gone. Written during the early stages of Covid-19, the novel postulates an outbreak whipping through the community as a

[145] As may be implied, the discussion of what qualifies as Indigenous outbreak narrative coincides with a similar debate in Indigenous literary studies as to what and who qualifies as Indigenous literature.

discrete medical event that still leaves its traces in the bodies of its Indigenous residents and then explores how those traces can create crime scenes. In Lee Maracle's *Celia's Song*, the novel picks up at the point where *Ravensong* ends allowing a deeper exploration of the miasmic fatalities that take place in response to the consequences of the 1954 epidemic. By placing these texts under critical scrutiny meant to decenter the microbial medical triumphalist narrative, the simple view of the traditional aftermath period, and its attached notion of epidemic endings, becomes complicated with miasmic forces that feature long-term disability, delayed biopsychological trauma response and suicide events, and an increased drive to assert Indigenous holistic care in the face of destructive medical and judicial racism.

Another possible track would be to explore how Indigenous outbreak narratives grapple with Eurowestern judicial and carceral systems, especially in light of the current wave of Indigenous publications that either work directly within the crime fiction genre or utilize its techniques and structures for its own purposes.[146] For example, in Lee Maracle's *Celia's Song*, the social epidemic rages across the Native village. At the hands of a Native man, brutal violence occurs against two women that necessitates the usage of the medical equipment stolen a generation ago for the 1954 epidemic. In this cycling of the past with the present, the novel argues, to borrow from James Baldwin, "History is not the past. It is the present. We carry our history with us." However, instead of negligent indifference, the white town doctor (and Stacey's lover) opts to learn from Indigenous care practices and intentionally allies himself against the white judicial system so that the Native village can enact their own culturally appropriate and sovereign justice. Across the 49th Parallel, in the tradition of Daniel Defoe's *A*

[146] For a few examples of the ongoing plethora of Indigenous fiction featuring crime scenes, David Heska Wanbli Weiden, *Winter Counts* (HarperCollins, 2021), Eden Robinson's Trickster trilogy (2017, 2018, 2021), Louise Erdrich's Justice trilogy (2008, 2012, 2016), and Stephen Graham Jones.

Journal of the Plague Year, Louise Erdrich's *The Sentence* documents the plague year of November 2019-November 2020 through the eyes of its urban Indigenous characters working at a Native-owned bookstore in Minneapolis. Starting with the incarceration of its protagonist, the novel works through the crises of lockdown, ghost hauntings, George Floyd, and critical care hospitalization. Like *Marrow Thieves*, it fails to provide full closure as the epidemic (both medical and social) remains an active menace. Instead, it offers up a sense of hope that living with and through these social ruptures offer the possibility of significant social change. These two publications speak to an engagement with the complex social disruptions and transformations inherent to plague events, whether ongoing or in the aftermath. They choose to disrupt or refuse components of the traditional outbreak narrative formula in order to showcase indigenous knowledges that focus on holistic, miasmic conditions, which then can lead to imaginative and effective problem-solving.

Looking beyond new directions of literary critical research and returning to my desire to diversify the medical humanities canon in the classroom, I believe that another next step should be a critical interrogation and expansion of the curriculum and pedagogies used when teaching outbreak narratives. As seen in my earlier discussion using the work of John Hoberman, Olivia Banner, and others, currently the medical humanities canon on the whole contains very little BIPOC-authored texts whether they be fiction or non-fiction.[147] The inclusion of texts that contain marginalized voices and experiences helps to increase student engagement with the material as well as expand their knowledge of and skills related to bias, empathy, and diverse

[147] See John Hoberman, *Black & Blue: The Origins and Consequences of Medical Racism* (Berkeley: University of California Press, 2012); Olivia Banner, "Structural Racism and Practices of Reading in the Medical Humanities," *Literature and Medicine* (Spring 2016): 25-52; Richard Reynolds, John Stone, Lois LaCivita Nixon, and Delese Wear, eds. *On Doctoring: Stories, Poems, Essays.* 3rd ed. (New York: Simon & Schuster, 2001).

clinical experiences. Considering the widespread expansion of medical humanities programs in the United States over the past two decades,[148] intentionally teaching and writing about texts that feature outbreaks, disabilities, and clinical experiences should be an active component of the professional development experience within the field and its interdisciplinary allies. Preferably, such a practice should include seeking out texts, possibly conducting recovery work on historic out-of-print or archival texts, in order to create a curriculum that critically interrogates Eurowestern and settler medicine as an epistemology and practice, especially through the eyes and experiences of both white and non-white patients and practitioners.

[148] Erin Gentry Lamb, Sarah L. Berry and Therese Jones. *Health Humanities Baccalaureate Programs in the United States and Canada*. Cleveland, (Ohio: Case Western Reserve University School of Medicine. July 2022). The report notes, "At a time when Liberal Arts education, and humanities programs in particular, are under fire in many public quarters, programs in the Health Humanities are experiencing dramatic growth. Since the turn of the century alone (from 2000 to July 2022) the number of Health Humanities programs has increased nearly twelvefold from 12 to 140, with another 7 known programs currently in development" (6).

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