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BACKGROUNDER

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Ebola: Dallas and New York City Experiences Drive Governments to Change Practices

David S. Addington

Abstract

Federal and state public health officials have adjusted their practices in light of the Dallas and New York City cases of Ebola. At the federal level, government officials adjusted their practices in light of the difficulties the Dallas hospital had in handling an Ebola case and of the plain need for restrictions on travelers from West Africa to the United States. At the state level, government officials began to recognize that they cannot simply rely on the federal government to address the Ebola situation and must step up to meet their public health responsibilities. At all levels of government, the Dallas and New York City cases of Ebola administered the general lesson that government must anticipate, and not simply react to, Ebola developments. Government needs to get ahead and stay ahead of Ebola and communicate more effectively to the American people about the decisions it makes on their behalf.

The federal government and several state governments have changed a number of practices since a Liberian citizen infected with Ebola virus disease in West Africa traveled to Dallas, Texas, where two nurses who provided medical services to him contracted the disease, and a U.S. citizen infected with Ebola in West Africa traveled to New York City. The Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) has (1) recognized that not every major hospital is fully ready to handle Ebola identification, biocontainment, and treatment requirements, (2) facilitated priority use of specially qualified medical facilities, (3) established CDC response teams to assist private sector medical facilities, (4) strengthened the medical screening of travelers flying into the United States who have recently visited West

Key Points

- The Ebola cases in Dallas and New York City tested the performance of the federal government and found it wanting.
- Since the Dallas and New York City cases, the federal government has changed its practices to provide more on-the-scene assistance to those caring for Ebola patients and tightened restrictions on travelers arriving in the U.S. from West Africa.
- A number of state governments have stepped up to their principal responsibility for public health and have implemented procedures to monitor, isolate, and quarantine travelers from West Africa according to the public health risk they present.
- Although responding promptly to events as they occur is important, federal and state officials need to get ahead of events, identifying potential risks and developments before they occur and establishing effective capabilities to address them, and keep the American people fully informed.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2974**

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

Africa, and (5) issued interim guidance to assist state and local public authorities in protecting their populations from the spread of Ebola by travelers arriving from West Africa. Also, the Department of Homeland Security (DHS) has strictly limited which airports of entry in the United States individuals may use if they have traveled within the preceding three weeks to a West African country with Ebola cases. Further, a number of state governments have imposed monitoring, isolation, and quarantine regimes designed to protect their citizens from Ebola.

Ebola Virus Disease

According to the CDC, the symptoms of Ebola include (1) fever, (2) severe headache, (3) muscle pain, (4) weakness, (5) diarrhea, (6) vomiting, (7) abdominal pain, and (8) unexplained bleeding. The CDC reports that those who contract Ebola exhibit symptoms, on average, eight to 10 days after exposure to Ebola, but notes that symptoms may first appear as early as two days or as late as 21 days after exposure. The CDC advises that Ebola transmission to a human occurs through direct contact with (1) blood or body fluids such as saliva, sweat, semen, urine, feces, vomit, and breast milk, (2) virus-contaminated objects such as needles and syringes, or (3) infected animals. Also, the CDC notes that those who recover from Ebola can no longer spread the virus (except that Ebola virus has been found in semen for up to three months after recovery) and have antibodies in their immune system that help resist Ebola for at least 10 years thereafter.[1]

The Three Dallas Ebola Cases

On September 15, 2014, Thomas Eric Duncan, then in the West African country of Liberia, of which he was a citizen, carried his landlord's ill daughter to a hospital, where she later died. On September 19, he departed Liberia by air transportation, traveling, via connecting flights at Brussels and Washington Dulles airports, to Dallas, Texas. On September 20, he arrived in Dallas to visit family. On September 24, he began to exhibit symptoms consistent with Ebola. On September 26, he sought treatment at Texas Presbyterian Hospital in Dallas, the emergency department of which evaluated him but did not admit him.[2] On September 28, he was admitted to the Texas Presbyterian Hospital, isolated, and tested for Ebola.[3]

The Texas Department of State Health Services (DSHS) confirmed that Mr. Duncan had Ebola virus disease on September 30.[4] Two days later, to help monitor those exposed to Ebola and prevent its further spread, the DSHS and Dallas County Health and Human Services (DCHHS) authorities issued orders to four members of Mr. Duncan's immediate family to observe control measures that required the family to stay at home, without having any visitors for several weeks, unless state or local health authorities approved the visits.[5] Mr. Duncan died on October 8 and his remains were cremated.[6]

On October 12, the DSHS disclosed that a health care worker at the hospital (Nurse Nina Pham), who had provided care for Mr. Duncan, tested positive for Ebola virus disease.[7] On October 15, the DSHS confirmed that a second such health care worker (Nurse Amber Vinson) tested positive for Ebola.[8] Later that same day, Nurse Vinson was airlifted to Atlanta, Georgia, for admission to the medical biocontainment facility at Emory University Hospital.[9] On October 16, Nurse Pham was airlifted to Washington, D.C., to enter the medical biocontainment facility known as the Special Clinical Studies Unit at the National Institutes of Health (NIH) in Bethesda, Maryland, for treatment.

On October 16, the Commissioner of DSHS instructed all health care workers who had entered Mr. Duncan's hospital room to refrain from using commercial transportation or appearing in places where the public gathers (such as restaurants, grocery stores, or theaters) and to submit to twice-per-day medical monitoring for signs of Ebola symptoms, until 21 days had elapsed since their exposure to Mr. Duncan's hospital room.[10] The Commissioner followed up with instructions for travel restrictions and medical monitoring for lab personnel, health care workers who treated the two nurses who contracted Ebola, and for airline passengers who had sat within three feet of Mr. Duncan on an aircraft.[11]

On October 24, the NIH pronounced Nurse Pham free of the Ebola virus, stated that she posed no public health threat, and released her from the biocontainment unit.[12] On October 28, Emory University Hospital pronounced Nurse Vinson free of the Ebola virus, stated that she posed no public health threat, and discharged her from the hospital.[13]

As a result of Mr. Duncan's contracting Ebola virus disease in West Africa, one person (Mr. Duncan) died, and two people (Nurse Pham and Nurse Vinson) were infected with the disease, but have survived.

The New York City Ebola Case

On October 14, 2014, a U.S. citizen and physician (Craig Spencer) with the non-governmental organization Médecins Sans Frontières (MSF) (tr. "Doctors Without Borders"), who had been treating Ebola patients in the West African country of Guinea, departed Guinea to travel via Brussels to the U.S., arriving on October 17 at John F. Kennedy Airport near New York City. He monitored his own temperature twice a day to watch for Ebola symptoms and, during the period when he detected no symptoms, he used public transportation, went to a bowling alley, and went to a restaurant. On October 23, when he detected that he had a fever (a potential Ebola symptom), he notified MSF, which in turn notified the New York City Department of Health and Mental Hygiene. A specially trained emergency medical response team of the Fire Department of New York transported Dr. Spencer to Bellevue Hospital in New York City, one of eight hospitals in New York state specially designated to handle Ebola patients.[14] The City of New York also established a regime to monitor the health of three other people (a fiancée and two friends) who had close contact with Dr. Spencer.

Federal Government Changes After Dallas and New York City Cases of Ebola

The federal government has the responsibility, principally through the CDC, to develop and share information concerning disease outbreaks and advises officials responsible for making decisions about responses to outbreaks. As is consistent with the traditional role of the states in the American federal system, state, local, territorial, tribal, and private sector medical personnel constitute the first responders to a serious communicable disease outbreak when it occurs in the United States.

Use of Specially Qualified Medical Facilities for the Health Care Workers Infected. When two nurses providing care for Ebola patient Thomas Eric Duncan in Texas Presbyterian Hospital in Dallas contracted Ebola disease, the CDC recognized that, for whatever reason (to be determined by investigation), the procedures followed in the hospital had not sufficiently protected the hospital's staff from Ebola. Given the shortcomings of Ebola care at Texas Presbyterian Hospital, CDC needed to advise how best to ensure prompt care for the two nurses and to end any risk of the nurses further spreading the disease. The result was the transport of the nurses to two of the tightest biocontainment medical facilities in the country: Emory University Hospital (Nurse Vinson) and the National Institutes of Health (Nurse Pham).[15]

CDC Response Teams for Assistance to Hospitals. On October 1, 2014, CDC sent to Dallas a response team of three experts in public health investigations and infection control, a communications officer, five Epidemic Intelligence Service officers ("disease detectives"), and a public health advisor, to assist in tracing Mr. Duncan's contact with people.[16] As events unfolded in Dallas and two nurses caring for Mr. Duncan contracted Ebola, CDC found it necessary to send a second team to Dallas on October 14, with experts focused on infection control, Ebola virus control and infectious diseases, laboratory science, personal protective equipment, hospital epidemiology, and workplace safety. CDC then announced its new policy that it would dispatch a CDC response team to any hospital within a few hours of the hospital's receiving a confirmed case of Ebola, to provide expertise on infection control, health care safety, medical treatment, contact tracing, waste and decontamination, and public education.[17] Dispatch of the second team to Dallas for Ebola treatment–focused assistance, and establishment of a standing policy to dispatch an Ebola response team for treatment-focused assistance to any hospital with an Ebola case, reflected CDC's dawning understanding that its assumption that major hospitals could handle Ebola cases in accordance with CDC published protocols was, at least in some cases, misplaced. When CDC learned that Bellevue Hospital in New York City had received an Ebola patient, the CDC immediately dispatched a response team for treatment-focused assistance to Bellevue Hospital.[18]

Federal Screening and Medical Monitoring of Inbound Airline Passengers from West Africa. In three successive steps, the federal government finally arrived at a tighter system for the screening and medical monitoring of travelers arriving in the U.S. who had traveled recently to West Africa. In the first step, CDC set up a regime to screen for Ebola symptoms passengers arriving at five major U.S. airports who indicated in response to questioning that they had recently visited West Africa. In the second step, CDC added a system to monitor such passengers who arrive without symptoms, but may develop symptoms later, after they pass through the

airport screening. In the third step, the government required all such passengers to arrive at one of the five airports covered by the screening and monitoring system.

On October 8, 2014, the date of Mr. Duncan's death in Dallas, the CDC and the U.S. Department of Homeland Security's (DHS) Bureau of Customs and Border Protection (CBP) announced that the CBP and CDC would begin to screen airline passengers arriving at five major airports that account for 94 percent of the arrivals of individuals traveling to the U.S. from West Africa. The airports are John F. Kennedy Airport in New York City, Newark Liberty Airport in New Jersey, Chicago O'Hare Airport in Illinois, Atlanta Hartsfield Airport in Georgia, and Washington Dulles Airport in Virginia. The screening arrangements provide for CBP to escort travelers from Guinea, Liberia, and Sierra Leone to a screening area at the airport, observe them for signs of illness, ask health and exposure questions, remind them to monitor themselves for symptoms, and take their temperature with a non-contact thermometer. If travelers have any symptoms that may indicate Ebola or the answers to health and exposure questions reveal possible Ebola exposure, a CDC quarantine station public health officer at the airport evaluates the traveler and, if so indicated, alerts the appropriate public health authorities.[19] This screening arrangement was designed to stop at the airport anyone presenting symptoms consistent with Ebola, but did little with respect to individuals who did not present symptoms as of the time of arrival at the airport but who might subsequently develop them. Moreover, the arrangement did not apply to the estimated 6 percent of passengers from West Africa who arrived at airports in the U.S. other than the five to which the screening arrangement applied.

On October 22, 2014, two weeks after Mr. Duncan's death in Dallas and the day before Dr. Spencer in New York City determined that he might be Ebola-symptomatic, the CDC announced that it would initiate active post-arrival monitoring of all travelers coming into the five monitored U.S. airports from West African nations affected by Ebola. Under the new, additional monitoring scheme, the CDC informs state and local health departments of such travelers, and the state and local health officials follow up daily with the traveler for the remainder of the 21-day period following their departure from West Africa, to see if they develop any symptoms of Ebola.[20] The new CDC arrangement provided an additional layer of protection with respect to individuals who present no symptoms of Ebola upon arrival at the airport in the U.S., but who develop symptoms after leaving the airport. The effectiveness of the new layer depends upon the cooperation of state and local authorities, upon whom the federal government depends to provide the medical monitoring for travelers after they pass through the airport into the U.S.

On October 23, 2014, the DHS closed the loophole that allowed approximately 6 percent of air travelers from West Africa to avoid the screening and monitoring regime by arriving in the U.S. at an airport other than the five airports covered by the regime. A federal statute that vests authority in the Secretary of Homeland Security provides that "The pilot of any aircraft arriving in the United States or the Virgin Islands from any foreign airport or place shall comply with such advance notification, arrival reporting, and landing requirements as the Secretary may by regulation prescribe."[21] Pursuant to that statute, CBP issued the following order: "To ensure that all travelers with recent travel to, from, or through the affected countries are screened, CBP directs all flights to the U.S. carrying such persons to arrive at the five airports where the enhanced screening procedures are being implemented."[22]

CDC Interim Guidance for Public Health Authorities in Dealing with Travelers from West Africa Presenting Different Levels of Risk. On October 27, the CDC published "Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure," to provide a framework for decisions by state, local, territorial, and tribal public health authorities, including on monitoring and restrictions of movement, with respect to individuals who may have been exposed to Ebola but have not (or not yet) presented symptoms and present low, some, or high risk.[23]

The Supreme Court of the United States has long recognized the power of states to enact and enforce laws that provide for quarantine of persons infected with disease to protect the people of the states from the spread of the disease, unless Congress has enacted a law displacing such state law, for example in the exercise of the congressional power to regulate interstate, foreign, or tribal commerce.[24] Congress has vested in the Secretary of Health and Human Services broad authority to fight disease that would

permit the Secretary to impose isolation or quarantine, providing that the Secretary may "develop (and may take such action as may be necessary to implement) a plan under which personnel, equipment, medical supplies, and other resources of the [Public Health] Service and other agencies under the jurisdiction of the Secretary may be effectively used to control epidemics of any disease or condition and to meet other health emergencies or problems." Congress also has vested in the Secretary's subordinate, the Surgeon General of the United States, power to issue with the Secretary's approval "such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession," regulations which may go so far in certain circumstances as to involve apprehension and detention of individuals.[25] However, Congress also has by law directed the Secretary to "cooperate with and aid State and local authorities in the enforcement of their quarantine and other health regulations."[26]

The CDC Interim Guidance issued on October 27 recognized the respective roles of the various levels of government in addressing Ebola:

> This guidance provides public health authorities and other partners with a framework for determining the appropriate public health actions based on risk factors and clinical presentation. It also includes criteria for monitoring exposed people and for when movement restrictions may be indicated.
>
> Federal communicable disease regulations, including those applicable to isolation and other public health orders, apply principally to arriving international travelers and in the setting of interstate movement. State and local authorities have primary jurisdiction for isolation and other public health orders within their borders. Thus, CDC recognizes that state and local jurisdictions may make decisions about isolation, other public health orders, and active (or direct active) monitoring that impose a greater level of restriction than what is recommended by federal guidance, and that decisions and criteria to use such public health measures may differ by jurisdiction.[27]

In the wake of the Dallas and New York City Ebola cases, governments of several states have taken action to deal with potential public health risks posed by travelers arriving in the state who recently have traveled to West Africa.

State Governments' Monitoring, Isolation, and Quarantine Procedures after Dallas and New York City Cases of Ebola

Under the American federal system, principal responsibility for public health services rests with state, local, territorial, tribal, and private sector public health and medical personnel, with the federal government providing information, expertise, advice, coordination, and, in some situations, funding. The task is simple to state, but difficult to execute:

> Since there is no vaccine against or cure for the disease caused by Ebola virus, the only way to stop it is to break the chains of infection. Health workers must identify people who are infected and isolate them, then monitor everybody with whom those people have come in contact, to make sure the virus doesn't jump to somebody else and start a new chain.[28]

Customarily, public health officials refer to "isolation" when separating from others an individual who has the symptoms of a communicable disease and refer to "quarantine" when separating from others an individual who has been exposed to, but does not present the symptoms of, a communicable disease.[29] Following the occurrences of Ebola in Dallas and New York City, a number of states, including those that have within their borders the only five airports at which aircraft may land with individuals who have recently visited West Africa, have established public health rules affecting such individuals, which may involve isolation or quarantine.

New York and New Jersey. On October 24, 2014, at a joint press conference, the Governors of New York and New Jersey, the homes of the John F. Kennedy and the Newark Liberty international airports, respectively, at which air passengers who have recently traveled to West Africa may arrive, announced that their states will proceed as follows:

> Each State Department of Health at John F. Kennedy Airport and Newark Liberty Airport will, as permitted under applicable law, make its own determinations as to hospitalization, quarantine, and other public health interventions. Number one, any individual while in one of the three West African nations who had direct contact with infected people or people who could have been infected with the Ebola virus and including any medical personnel having performed medical services to infected patients will be automatically quarantined. Number two, all individuals with travel history to the affected regions of West Africa with no direct contact to Ebola patients will be actively monitored by public health officials and if necessary quarantined. This will be depending on the facts and the circumstances of the particular situation. This has already been put into effect, as you have heard and will move forward from this point forward.[30]

On October 26, the Governor of New York issued a more detailed explanation of how the policy would apply at John F. Kennedy International Airport:

> Screening is first conducted by the U.S. Customs and Border Patrol [sic: Protection] (CBP). If a passenger has a recent travel history for any of the three affected countries, a secondary screening of the passenger will be conducted by CBP. If a person coming from any of the three affected countries has a fever or reports exposure to Ebola, the Center [sic: Centers] for Disease Control (CDC) reviews.
>
> An additional screening will now be performed by New York State Department of Health and New York City Department of Health and Mental Hygiene personnel.
>
> Scenario 1: If a person arrives and has symptoms of the Ebola virus, they will be transported, via medical transportation (in protective gear), to one of the New York City hospitals designated by the State to treat Ebola patients for further evaluation and treatment.
>
> Scenario 2: If a person arrives and had direct contact with people infected with the Ebola virus but is asymptomatic, they will be transported by private vehicle (arranged by the New York State Department of Health or local health department) to their homes where they will be quarantined for 21 days. (For those without homes, other accommodations will be made.) Under quarantine, at least two unannounced visits by local officials (in coordination with state health officials) will be made each day to check the individual's condition as well as ensure that the individual is complying with the quarantine order.
>
> The New York State Department of Health or local health department will, if needed, coordinate care services such as food and medicine.
>
> Any health care worker returning from one of the affected countries who had been treating patients with the Ebola virus and is sponsored by Doctors Without Borders, typically has their wages paid for three weeks by Doctors Without Borders. For any health care worker whose sponsoring organization does not do this or something similar for their workers, as well as adults who meet New York's criteria for quarantine, they would be provided financial assistance for 21 days by the state (e.g., cover their rent/mortgage and standard per diem).
>
> Family members would be allowed to stay with the person being quarantined. Friends would also be allowed to visit with the approval of the local health department.
>
> Scenario 3: If a person arrives from one of the affected areas with no symptoms and had no direct contact with anyone infected with the Ebola virus, such cases would be treated on a case-by-case basis. At the minimum the New York State Department of Health or local health department will monitor these individuals twice a day for temperature and other symptoms until the 21 day incubation period is over, but these individuals would not automatically be subject to quarantine.[31]

Illinois. On October 24, 2014, the Governor of Illinois "ordered the Illinois Department of Public Health to require a mandatory 21-day home quarantine for high-risk individuals who have had direct contact with an individual infected with the Ebola

virus while in Liberia, Sierra Leone or Guinea" and noted that the order "includes any high-risk medical personnel who have performed medical services to individuals infected with the Ebola virus."[32] The Illinois Department of Public Health subsequently made clear that, for purposes of the Governor's order, "high-risk individuals" are those who (1) had unprotected contact with infectious blood or body fluids of an Ebola patient, (2) made direct skin contact with blood or body fluids of an Ebola patient without appropriate personal protective equipment (PPE), (3) processed blood or body fluids of an Ebola patient without appropriate equipment or standard biosafety precautions, (4) made direct contact with the dead body of an Ebola patient without appropriate PPE, or (5) lived with or shared a household with an Ebola patient in an outbreak affected country.[33]

Florida. On October 25, the Governor of Florida issued an executive order on Ebola virus disease (EVD) directing as follows:

> Section 1. The Florida Department of Health will actively monitor all asymptomatic travelers with no known exposure to EVD who are identified by the CDC as being located in Florida for a period of 21 days after leaving the EVD-affected country. Active monitoring by the Florida Department of Health will include at least the following:
>
> A. An in-person risk assessment within 12 hours of the traveler's arrival in Florida.
>
> B. Twice daily, in-person temperature checks of the traveler.
>
> Section 2. The Florida Department of Health, pursuant to its authority in section 381.00315(4), Florida Statutes, will quarantine all high-risk travelers from EVD-affected countries in West Africa who are identified by the CDC as being located in Florida for a period of 21 days following last known EVD exposure.
>
> Section 3. I hereby direct the Florida Department of Health to make its own determinations as to quarantine and other necessary public health interventions as permitted under Florida law.[34]

Connecticut. On October 27, 2014, the Governor of Connecticut described new protocols under which the Connecticut Department of Public Health (DPH) would address Ebola:

> Under these protocols, DPH is working with federal authorities and is being notified of travelers arriving in Connecticut from the three West African countries impacted by the Ebola virus: Guinea, Liberia and Sierra Leone. All such travelers will be subject to 21 days of active mandatory monitoring, and Connecticut's DPH will review each case and determine if additional steps beyond monitoring are necessary based upon a review of the person's travel history and potential exposure. Under active monitoring, local health directors contact individuals daily to obtain their temperatures and determine whether they have developed any symptoms of illness.[35]

Minnesota. On October 27, 2014, the Governor of Minnesota announced that the Minnesota Department of Health (MDH) plans to proceed as follows:

> Based on guidance from CDC, Minnesota's plan covers four types of returning travelers:
>
> - Those who were not providing health care in an affected country.
> - Those who were providing health care to an Ebola patient in an affected country but have no known exposure.
> - Those who are contacts of a known Ebola patient (but not a health care worker) and have a known exposure.
> - Those who provided health care to an Ebola patient and have a known exposure.
>
> According to the framework:
>
> - All identified travelers will receive active case management that will include twice daily monitoring by MDH staff.
> - None of the individuals being monitored will be allowed to use public transportation for trips lasting longer than three hours, regardless of exposure history.

- Only those with a known exposure will be restricted from using local public transit or attending mass gatherings.

- All travelers will be allowed to have family members in their home.

- Only those travelers who treated an Ebola patient and have been exposed will be required to be restricted in their home (have no physical contact with others).

- All travelers will be required to keep a log of all activities and a log of close contacts during the 21 days.

Any situation involving children or adults who work with children will be evaluated on a case-by-case basis.[36]

Virginia. On October 27, the Commissioner of the Virginia Department of Health (VDH) announced that Virginia, the home of the Washington Dulles airport at which air passengers who have recently traveled to West Africa may arrive, will implement screening, isolation, and quarantine procedures as follows:

> On Monday October 27, 2014[,] VDH began post-arrival daily monitoring of all international travelers with a final destination in Virginia whose travel originated in Guinea, Liberia or Sierra Leone. The protocol includes a 21-day monitoring program requiring twice daily temperature recording by all travelers and at least one daily contact with a local health department monitor. Airport personnel provide travelers with thermometers, log books, and information on the signs/symptoms of EVD, and contact information for public health. During the initial public health interview, the traveler will be asked about all potential exposures to a person with EVD while in these countries. Depending on an individual traveler's level of exposure, some of the traveler's activities may be restricted, including but not limited to use of mass transit, attendance at large social gatherings, and direct patient care activities. During the initial and subsequent monitoring by VDH personnel, travelers will also receive information on the actions to take if they become ill. The monitoring activities for and any restrictions on travelers in the post-arrival monitoring program will be spelled out in voluntary agreements. As Commissioner, however, I have the authority to issue an involuntary order of quarantine if a traveler is noncompliant with an agreement and I determine that the individual's actions are a threat to public health. In Virginia, Ebola is considered a communicable disease of public health threat and, if indicated, I will not hesitate to issue an order to protect the people of Virginia. The goal of the post-arrival active monitoring program is to provide an additional strategy that can help in the early identification of anyone ill with EVD, so that appropriate and swift public health and clinical action may be initiated as soon as possible. Our ultimate goal is to prevent any transmission of EVD, while also minimizing disruption to an individual's life upon return to Virginia.[37]

Maryland. On October 27, 2014, the Governor of Maryland announced that Maryland will execute a plan for protecting the people of the state from Ebola:

> Under the plan, screeners at the airports of entry will provide the names and contact information for all travelers from the affected countries with destinations in Maryland. The Maryland Department of Health and Mental Hygiene will make contact through a new outbound call center and provide specific guidance, information, and 24-hour numbers for assistance.
>
> The state will coordinate daily contact with the travelers during the 21 days following the last possible exposure when illness might develop. The state will work with local health departments to conduct direct outreach as needed. Should a traveler need medical attention, health officials will provide advance direction to the emergency management system for transport and the local hospital for evaluation. Maryland's public health laboratory is available 24 hours a day for Ebola testing....
>
> The policy includes specific provisions for health care workers who are returning from caring for Ebola patients.

> Individuals at high or some risk of infection will sign agreements outlining certain restrictions, and other travelers will receive daily monitoring and will be alert for signs and symptoms of possible infection. At any time—in case of noncompliance, or if necessary for the public health—the state may issue a specific public health order.
>
> The level of monitoring and restrictions, including planned and unannounced home visits, will be based on the potential risk. Specifically:
>
> - Home restriction for individuals at "high risk." Individuals with a known exposure to Ebola virus, such as through a splash of body fluid on exposed skin or a needle-stick injury will remain at home for the 21-day period and will be closely monitored.
>
> - Activity restriction for individuals at "some risk." Health care workers who were wearing personal protective equipment during care for patients with Ebola virus are at "some risk." They will refrain from attending mass gatherings and using public transportation, will refrain from traveling long distances without approval from health department officials, and will also be closely monitored by state and local health officials.[38]

Georgia. On October 27, the Governor of Georgia announced that Georgia, the home of the Atlanta-Hartsfield airport at which air passengers who have recently traveled to West Africa may arrive, will implement isolation and quarantine procedures as follows:

> If travelers show symptoms, they will be isolated immediately and transferred to a designated hospital for evaluation. If the travelers show no symptoms, they will be divided into three categories for monitoring. Categories and associated procedures detailed below:
>
> Category 1, high risk—Travelers with known direct exposure to an Ebola patient. Travelers in this category will be subject to quarantine at a designated facility.
>
> Category 2, low risk—Travelers from affected area with no known exposure to an Ebola patient. Travelers in this category will sign a monitoring agreement with the Georgia Department of Public Health. This agreement requires travelers to conduct temperature and symptom self-checks twice per day and report results to Public Health once per day (electronic, email or phone contact acceptable). Travelers who fail to report during the 21-day incubation period will be contacted by Public Health and issued a mandatory quarantine order if necessary.
>
> Category 3 – Medical personnel actively involved in treating Ebola patients returning to the United States. Individuals in this category will be issued a 21-day active monitoring order and will be visually monitored (video communications or home visit) by Public Health twice per day. Public Health will assess for the development of symptoms and adjust restrictions as necessary. Noncompliance will result in quarantine at a state-designated facility.[39]

Maine. On October 28, the Department of Health and Human Services Commissioner of Maine described new protocols under which the Department will address Ebola:

> Any traveler from West Africa who comes to Maine will be monitored for at least 21 days after the last possible exposure to Ebola. This is consistent with federal guidelines. This monitoring includes daily check-ins with a state epidemiologist for any signs of a fever or other Ebola related symptoms. If any symptoms develop, they will receive immediate medical care.
>
> We have instituted additional protocols for ensuring that those individuals with a higher level of risk do not unnecessarily make contact with the public. These protocols include voluntary, in-home quarantine for someone who was known to have had direct contact with an Ebola patient.
>
> I want to be sure everyone understands what quarantine means in this case. Stating it plainly, what we are asking for is that individuals who had direct contact with Ebola patients stay in their home and avoid public contact until the 21 days for potential incubation has passed.

> We acknowledge that this protocol may go slightly beyond the federal guidelines, although the recent changes are very much more in line with Maine's approach. We have made the determination that out of an abundance of caution, this is a reasonable, common-sense approach to remove additional risk and guard against a public health crisis in Maine.
>
> If an individual who came in direct contact with Ebola patients has returned to Maine and is not willing to avoid public contact and stay in their home voluntarily during the period they are at some risk, we will take additional measures and pursue appropriate authority to ensure they make no public contact.
>
> Our true desire is for a voluntary separation from the public. We do not want to have to legally enforce an in-home quarantine. We are confident that the selfless health workers, who were brave enough to care for Ebola patients in a foreign country, will be willing to take reasonable steps to protect the residents of their own country. However, we are willing to pursue legal authority if necessary to ensure risk is minimized for Mainers.
>
> For any individual who must stay at home for a period of time for this reason, we will do all that we can to make sure that the person has everything necessary to be comfortable and receive the care that is needed.[40]

Conclusion: Federal and State Governments Need to Get Ahead and Stay Ahead of Ebola Developments.

The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services has the central role for detecting and advising on communicable disease threats to the United States from abroad. The federal government determined too late that protection of the American people required strict screening and monitoring, and if necessary isolation or quarantine, of people entering the United States who recently had traveled to West Africa. By the time the federal government took its first step to screen passengers at the five major airports through which most such travelers enter, Mr. Duncan, who had entered the country through one of those airports, was on his deathbed in Dallas and two nurses had contracted the disease from him. With the middle-of-the-night press conference by authorities in New York to reveal that a doctor in New York City, who had recently served in West Africa and traveled openly in recent days in the City, had Ebola, the federal government and state governments now understood that they needed effective procedures to deal not only with those who display Ebola symptoms on arrival at an airport in the U.S., but also those who had exposure to Ebola and may develop the symptoms after they have arrived and passed through the airport into the U.S.

Federal and state officials dealing with Ebola appear to have improved their performance after the Dallas and New York City cases of Ebola, but better-late-than-never can hardly be the governmental performance standard in dealing with the risk to public health that Ebola poses. Those officials must focus on the full range of potential risks the Ebola situation poses for the American public and anticipate (not react to) potential developments. Moreover, federal officials in particular need to explain effectively to the American people the basis for their decisions, such as the decision to continue to allow non-U.S. citizens from Ebola-affected areas to obtain visas and travel to the U.S., and not merely intone *ad nauseam* that "the science" dictates their decisions.[41] To be sure, sound science must fully inform the decisions of elected and appointed officials dealing with Ebola, but those decisions often involve application of social values and judgments about what levels of risk to accept, matters that "the science" alone does not dictate. The American people will have confidence in their government's ability to deal with Ebola when the government both acts competently and communicates effectively.

*—**David S. Addington** is the Group Vice President for Research at The Heritage Foundation.*

Endnotes

1. *See* sources cited in David S. Addington, "Ebola: The Basics," Heritage Foundation *Issue Brief* No. 4282 (Oct. 15, 2014) (citing CDC documents), *available at* http://thf_media.s3.amazonaws.com/2014/pdf/IB4282.pdf (visited Oct. 24, 2014).
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14. Transcript of Press Conference of Governor of New York, Mayor of New York City, and New York City Health Officials (October 23, 2014), *available at* http://www1.nyc.gov/office-of-the-mayor/news/886-14/mayor-de-blasio-governor-cuomo-new-york-city-health-officials-host-press-conference-at (visited Oct. 27, 2014). The eight hospitals specially designated to handle Ebola patients in New York are Bellevue, Mt. Sinai, and New York Presbyterian in Manhattan; Montefiore in the Bronx; North Shore/LIJ Health System in Nassau County; Upstate University Hospital in Syracuse; University of Rochester Medical Center in Rochester; and Stony Brook University Hospital on Long Island. See, Andrew M. Cuomo, "Governor Cuomo Outlines State Response to Positive Test for Ebola in Patient in New York City" (Oct. 23, 2014), *available at* http://www.governor.ny.gov/press/10232014-ebola-response (visited Oct. 27, 2014).
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21. Section 433(c) of the Tariff Act of 1930 (19 U.S.C. 1433(c)).
22. 79 *Fed. Reg.* 633130-1, 2014 WL 5361885 (October 23, 2014).
23. CDC, HHS, "Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure" (Oct. 27, 2014), available at http://www.cdc.gov/vhf/ebola/pdf/monitoring-and-movement.pdf (visited Oct. 28, 2014). Also, on October 29, 2014, the Secretary of Defense "signed an order that validated a recommendation from the Joint Chiefs of Staff to place all U.S. military service members returning from Ebola response efforts in West Africa into a 21-day controlled monitoring regimen," which will "apply to all military services that are contributing personnel to the fight against Ebola at its source." U.S. Department of Defense, "Statement from Pentagon Press Secretary Rear Admiral John Kirby on Controlled Monitoring for Personnel Returning from Operation United Assistance" (Release No. NR-547-14, Oct. 29, 2014), *available at* http://www.defense.gov/Releases/Release.aspx?ReleaseID=17007 (visited Oct. 29, 2014).
24. *Compagnie Francaise de Navigation a Vapeur v. State Board of Health, Louisiana*, 186 U.S. 380, 388 (1902) ("That from an early day the power of the states to enact and enforce quarantine laws for the safety and the protection of the health of their inhabitants has been recognized by Congress, is beyond question. That until Congress has exercised its power on the subject, such state quarantine laws and state laws for the purpose of preventing, eradicating, or controlling the spread of contagious or infectious diseases, are not repugnant to the Constitution of the United States, although their operation affects interstate or foreign commerce, is not an open question."); *State of Louisiana v. State of Texas*, 176 U.S. 1, 21 (1900) ("While it is true that the power vested in Congress to regulate commerce among the states is a power complete in itself, acknowledging no limitations other than those prescribed in the Constitution, and that where the action of the states in the exercise of their reserved powers comes into collision with it, the latter must give way, yet it is also true that quarantine laws belong to that class of state legislation which is valid until displaced by Congress, and that such legislation has been expressly recognized by the laws of the United States almost from the beginning of the government."); *Morgan's Louisiana & T.R. & S.S. Co. v. Board of Health of the State of Louisiana*, 118 U.S. 455, 465 (1886) ("... [Q]uarantine laws belong to that class of state legislation which, whether passed with intent to regulate commerce or not, must be admitted to have that effect, and which are valid until displaced or contravened by some legislation of congress."). See *Ex parte Fowler*, 85 Okla. Crim. 64, 73-74, 184 P. 2d 814, 819 (Okla. Crim. App. 1947) ("The adoption of laws for the protection of public health is universally considered to be a valid exercise of the police power of the State as to which the Legislature is necessarily vested with large discretion, not only in determining what are contagious and infectious diseases, but also in adopting means for preventing the spread thereof.")
25. Section 311(c)(1) of the Public Health Service Act, 42 U.S.C. 243(c)(1) (Secretary of HHS authority to develop and implement plan); Section 361(a) of the Public Health Service Act (42 U.S.C. 264) (Surgeon General's authority to issue rules).
26. Section 311(a) of the Public Health Service Act, 42 U.S.C. 243(a). Congress also has granted by law to the Secretary of the Interior authority to quarantine a member of an Indian tribe who has a communicable disease. Section 1 of the Act of August 1, 1914, 25 U.S.C. 198.
27. CDC, HHS, "Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure" (Oct. 27, 2014), p. 4, *available at* http://www.cdc.gov/vhf/ebola/pdf/monitoring-and-movement.pdf (visited Oct. 28, 2014).
28. Richard Preston, "The Ebola Wars," *The New Yorker* (Oct. 27, 2014), p. 42.
29. See, CDC, HHS, "Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure" (Oct. 27, 2014), *available at* http://www.cdc.gov/vhf/ebola/pdf/monitoring-and-movement.pdf (visited Oct. 28, 2014) ("Isolation means the separation of an individual or group who is reasonably believed to be infected with a quarantinable communicable disease from those who are not infected to prevent spread of the quarantinable communicable disease. An individual could be reasonably believed to be infected if he or she displays the signs and symptoms of the quarantinable communicable disease of concern and there is some reason to believe that an exposure had occurred.") ("Quarantine in general means the separation of an individual or group reasonably believed to have been exposed to a quarantinable communicable disease, but who is not yet ill (not presenting signs or symptoms), from others who have not been so exposed, to prevent the possible spread of the quarantinable communicable disease.").
30. Office of the Governor, State of New Jersey, "Gov. Christie With Gov. Cuomo: Mandatory Quarantine Is To Protect People Of NY & NJ" (Oct. 24, 2014), *available at* http://www.state.nj.us/governor/news/news/552014/approved/20141024c.html (visited Oct 28, 2014) (Dr. Howard Zucker, Acting Commissioner of Public Health, New York City, speaking).
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32. Office of the Governor, State of Illinois, " Governor Quinn Directs Illinois Department of Public Health to Require Quarantine to Protect Against Ebola" (Oct. 24, 2014), *available at* http://www.idph.state.il.us/public/press14/10.24.14_Governor_Directs_IDPH_to_Require_Quarantine_to_Protect_Against_Ebola.htm (visited Oct. 28, 2014).
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37. Commissioner of Health, Virginia Department of Health, Commonwealth of Virginia, "Ebola Virus Update #3," (Oct. 27, 2014), *available at* http://www.vdh.virginia.gov/clinicians/pdf/EbolaVirusUpdate3.pdf (visited Oct. 28, 2014).
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41. *See,* for example the television appearances on October 26, 2014, of Dr. Anthony S. Fauci, Director of the National Institute of Allergy and Infectious Diseases, National Institutes of Health, HHS. *Meet the Press*, NBC, *available at* http://www.nbcnews.com/meet-the-press/meet-press-transcript-october-26-2014-n234236 (visited Oct. 29, 2014) ("Go with the science. That's what we're trying to do here in our government. Go with the science."); *State of the Union with Candy Crowley*, CNN, *available at* http://transcripts.cnn.com/TRANSCRIPTS/1410/26/sotu.02.html (visited Oct. 29, 2014) ("You have got to make your decisions and your policies based on the scientific data."); *Face the Nation with Bob Schieffer*, CBS, *available at* http://www.cbsnews.com/news/face-the-nation-transcripts-october-26-2014-fauci-rogers-manchin/ (visited Oct. 29, 2014) ("Well, first of all, the most important thing is to protect the American people. And, as you said, you got to base your decision and your policy on scientific evidence and scientific principles."); and *Fox News Sunday with Chris Wallace*, Fox, *available at* http://www.foxnews.com/on-air/fox-news-sunday-chris-wallace/2014/10/26/dr-anthony-fauci-updates-fight-against-ebola-america-gov-chris-christie-talks-midterms#p//v/3859705267001 (visited Oct. 29, 2014) ("First principle, protect the American people. Second principle, make a decision based on the science."). *See also* the statements of Press Secretary to the President Josh Earnest, The White House, Office of the Press Secretary, Transcript of Press Briefing (Oct. 28, 2014), *available at* http://www.whitehouse.gov/the-press-office/2014/10/28/press-briefing-press-secretary-josh-earnest-102814 (visited Oct. 29, 2014) ("It would be wrong to suggest that it would make the American people safer to apply this military policy in a civilian context. The science would not back up—back that up. In fact, implementing this military policy in a civilian context would only have the effect of hindering our Ebola response by dissuading civilian doctors and nurses from traveling to West Africa to stop the outbreak in its tracks. And you've also heard me say many times the only way that we can entirely eliminate the Ebola risk to the American people is to stop this outbreak in its tracks in West Africa.") ("And we continue to be pleased that we're putting in place the policies that are driven by science, that are motivated to protect the American public, and are geared towards stopping this outbreak at the source.").