Bioethical Inquiry (2014) 11:405–411
DOI 10.1007/s11673-014-9589-1

EDITORIAL

Art, (In)Visibility, and Ebola

"What Are the Consequences of a Digitally-Created Society in the Psyche of the Global Community?"

Leigh E. Rich · Michael A. Ashby · David M. Shaw

Received: 30 October 2014 / Accepted: 6 November 2014 / Published online: 23 November 2014

> [V]isibility is central to the shaping of political, medical, and socioeconomic decisions. Who will be treated—how and where—are the central questions whose answers are often entwined with issues of (in)visibility … [and] the effects that media visibility has on the perception of particular bodies (Pietrzak-Franger and Stoddard Holmes 2014, ¶1–¶2).

In a documentary entitled *Paris: The Luminous Years* (Adato 2010), writer Janet Flanner (who wrote for *The New Yorker* under the penname Genêt) describes the intense friendship of Pablo Picasso and Georges Braque. Both were inspired by Paul Cézanne and his retrospective at the 1907 Salon d'Automne—which, according to *Paris: The Luminous Years*, marked in Janus-like fashion the end of the 19th and the beginning of the 20th centuries in art. Flanner tells of the frequent visits between the two painters, where they "talked and talked … two or three months that they just spent gabbling, gabbling." And from their camaraderie and gabble emerged something new, something hinted at in the earlier work of Cézanne. "[B]ack and forth it went," Flanner says of Picasso and Braque's dialogue. "And they hammered out between them the beginnings of Cubism."

At the time, their revelatory work wasn't particularly well received. The jury of the 1908 Salon d'Automne rejected Braque's landscape paintings of the French village of L'Estaque (though "two jurors voted to save one of his pictures"), and it was Henri Matisse, a friend and member of the jury, "who famously described Braque's pictures as having been composed '*avec les petits cubes*'—a phrase that the French art critic Louis Vauxcelles promptly picked up and published" (McAuliffe 2014, 180).

Vauxcelles had intended the term "Cubism," as Mary McAuliffe explains in *Twilight of the Belle Epoque*, "as an epithet" (2014, 180), much in the same way he had scorned Matisse's own *Femme au chapeau* (1905) and similar boldly colored works by André Derain, Maurice de Vlaminck, and others at the 1905 Salon d'Automne—dubbing these painters "les fauves" (wild beasts).

What perhaps seemed shocking at the time, whether in response to Fauvism, Cubism, or the other 20th-century Post-Impressionist movements, was these

L. E. Rich (✉)
Department of Health Sciences (Public Health), Armstrong State University,
11935 Abercorn Street, University Hall 154F, Savannah, GA 31419, USA
e-mail: leigh.rich@armstrong.edu

M. A. Ashby
Palliative Care Service, Royal Hobart Hospital, Southern Tasmania Area Health Service, and School of Medicine, Faculty of Health Sciences, University of Tasmania,
1st Floor, Peacock Building, Repatriation Centre, 90 Davey Street, Hobart, TAS 7000, Australia
e-mail: michael.ashby@dhhs.tas.gov.au

D. M. Shaw
Institute for Biomedical Ethics, University of Basel,
Bernoullistrasse 28, CH-4056 Basel, Switzerland
e-mail: david.shaw@unibas.ch

artists' straying from realistic representations of their subjects (and even the painting of surreal subjects). Like Claude Monet's loose brush strokes captured in *Impression, Sunrise* (*Impression, soleil levant* 1872) or Vincent van Gogh's late-19th century "freeing of color from a simple descriptive function" to an expression of "more subjective, emotional states" (Dreishpoon 2014–2015), Cubism was "a very occult, new way of regarding what you could not see," Flanner explains. "After all," she adds, quoting Gertrude Stein, "you paint what you know is there. Not what you can see" (Adato 2010).

In this way "Cubism is a kind of Realism," Beth Gersh-Nesic says. "It is a conceptual approach to realism in art, which aims to depict the world as it is and not as it seems" (Gersh-Nesic n.d., ¶2):

> For example, pick up any ordinary cup. Chances are the mouth of the cup is round. Close your eyes and imagine the cup. The mouth is round. It is always round—whether you are looking at the cup or remembering the cup. To depict the mouth as an oval is a falsehood, a mere device to create an optical illusion. The mouth of a glass is not an oval; it is a circle. This circular form is its truth, its reality" (Gersh-Nesic n.d., ¶2).

Thus, earlier art that seemingly recreated reality was actually concealing the truth (and, as Futurists and Surrealists later depicted, concealing other forms of knowing).

The perspective of the Cubists and other Post-Impressionists is particularly poignant for illness and suffering. How can we understand someone else's pain or convey our own to others? How do we make sense of the nonsensical, whether the chaos of life-as-lived or the inscrutability of dying? How do we answer the questions "Why me?" and "Why now?" when we are diagnosed with disease? How do we paint what we know is there but cannot see? Modern medicine, like much pre-Impressionistic art, tried to square this circle by instituting a technical and professional gaze that filters out the ephemera of the individual in order to identify and name what is hidden by opaque bodies (see, of course, Foucault 1994). But this was not Cubism's aim; it was not a reductive attempt to discover the building blocks common to all landscapes or buildings or humans or musical instruments. It was to uncover the essence of a thing, that particular thing, in order to reveal more.

Our representations of dis-ease may actually conceal even as they seek to reveal. Nowhere is this more evident than the media coverage of the current Ebola epidemic, particularly in the United States. Since the first case of Ebola was diagnosed on U.S. soil on September 30, the American media, with the complicity of politicians and public health professionals, have turned the individual identified as "patient zero" into an oval and believe this depiction of him is real.

Thanks to 24–7 news coverage, most probably know this patient's name (which we will not repeat here), though few know much about Ebola or anything about the man. And no thanks to 24–7 news coverage—which could offer through its technological reach and skilled personnel in-depth, nuanced exploration on a wide range of issues—we know nothing of this person's narrative, who he was as a unique irreducible and irreproducible being. Nor have we asked whether naming him was appropriate or necessary. His image has been displayed countless times, his name invoked in professional and casual conversations. He likely will be remembered—by a mediated society of onlookers—in relation to a handful of "facts" in his last days of life. In another case, an American doctor from New York was the subject of headlines that not only revealed his identity but also his detailed movements across the city, thanks to highly developed contact tracing (Hartocollis 2014). This type of hysterically specific information was inevitably broadcast and reported repeatedly, increasing the misplaced sense of panic while also turning a human being into a mere vector of disease (although the risk of transmission was virtually nil).

Identifying these patients within and by the media trampled principles of privacy, dignity, confidentiality, and nonmaleficence. Public health practices to prevent further spread of the disease did not require or justify the release of their names. While, according to CNN, "[n]either the hospital nor government officials … identified [the first patient] by name" (Shoichet, Fantz, and Yan 2014, ¶5 under "Friend: I called the CDC with concerns"), few, if any, have emphasized these basic ethical standards in the aftermath. The media have used the patients as a means to a self-serving end (in the guise of informing the public), and it seems as though health care and government professionals see the media's coverage as something distinct from their own roles and ethical and legal responsibilities.

But health care, government, and the media are intertwined, perhaps more so today, and the Ebola coverage may be one more reminder of the difficulties and weaknesses in how identifiable public health

information (e.g., notifiable diseases) is protected and used. As Fairchild et al. note:

> Contemporary decisions about whether to reveal the identity of those with disease who posed a public health threat have turned on assessments of the risk to the community. In Texas, in response to a 1993 investigation of a case of fatal hantavirus, state health officials refused to disclose the name of an infected individual to the local media. A 1999 case of meningitis in a Maryland school was not sufficient for the County's Director of Community and Environmental Health to identify the student by name. The official, however, suggested that had more people been at risk for contracting the disease, it may have been deemed appropriate to identify the infected student by name, even over the objections of her parents. Such criteria were met in the case of SARS. In the 2003 outbreak in Toronto, the names of the first two cases, a mother and son, were released to the press for the purpose of identifying and advising people who might have had contact with them (Fairchild et al. 2007, 10).

New technologies also pose new challenges in this context. In a recent case in Britain, a friend of a student with meningitis posted this information on the patient's Facebook timeline and warned possible contacts of the potential risk. When this came to the attention of the local Health Protection Unit, health officials surprisingly edited and endorsed the Facebook post rather than deleting it and contacting at-risk individuals through other means (Shaw 2014).

There of course can be a power to being named, to being recognized. In a *Dallas Morning News* article, Mark Wingfield, an associate pastor of the church where the family of the first U.S. Ebola patient are members, stated that if the patient "had not been able to get on that airplane to come to the United States, none of us would have ever known his name. … He would have died of Ebola in Liberia and been another nameless person dying of a disease we think of being someone else's problem" (Staff Reports 2014b, ¶16). The caveats here, however, are that the patient did not seek to be a public figure or a counter to our global health and human rights myopia. Now deceased, he also cannot ask, like the U.S. nurses who subsequently contracted Ebola, that the media respect his and his family's privacy (Neuman 2014; Staff Reports 2014a).

The media also have highlighted "differences" between certain Ebola patients, such as "patient zero" and his nurses (and other health care professionals returning from Western Africa). The latter are being deemed "brave nurses and determined [hospital] administrators. A story of heroes, frankly," while the initial U.S. patient has been painted as "[w]hether intentionally or not … mis[leading] authorities about his exposure to Ebola" and not being "wholly honest," despite how he "bravely helped carry an Ebola-infected woman to a local hospital in Liberia" (Diamond 2014, ¶1, ¶5, and ¶8). Similarly, the doctor from New York was labeled a "liar" who misled authorities about his movements (Schram and Golding 2014).

These depictions in the media, whether from professional journalists or readers posting comments, have "other-ized" these individuals (not to mention those suffering in countries in Western Africa) and turned them into spectacles. As Prof. Karla F.C. Holloway (2014) emphasized in the opening plenary of the recent American Societies for Bioethics+Humanities conference, bioethics often has relied on spectacle (e.g., repeatedly highlighting the same egregious examples) in the name of educating and motivating students, policymakers, or the public, when many ethical issues within medicine and public health are rooted in the dull day-to-day (Komesaroff 2014). Holloway asks why we must prioritize the display rather than the action we wish to promote. In doing so, there is a "privilege in healthcare ethics," a "privilege of being the nominator—the one to do the naming—[that] effectively absents the nominator from inhabiting the category" (Holloway 2014, 27).

With regard to the first U.S. Ebola patient, Holloway also noted that his Liberian citizenship and African ethnicity can't be overlooked within the context and history of a Texas emergency department.

Playing into the media's coverage of infectious disease epidemics is the social psychology of infection. Be it leprosy, plague, or HIV/AIDS, it is the notion of contagion and attendant social exclusion that the media (and others) lock into and stoke. In Australia, one talks of the "dog whistle" to express the playback of peoples' prejudices and fears to them, and it is easy to do in today's media-saturated world and, in the process, shape public policy responses. No government can afford to be seen to have failed an epidemic test, and the press will ensure that any perceived lapse in surveillance and action, however unscientific or unfair or unreasonable to the leaders and technical advisers concerned, means

that there is one "rational" and one public side of each measure. Risk management not only has to be done but it must be seen to be done. The naïve modern obsession with safety and certainty guarantees that only hyper-cautious approaches are acceptable.

The sense of the untouchable nature of infected or potential carriers of disease provokes fear and alienation of "particular bodies." Witness the nurse from Maine (and volunteer with Doctors Without Borders who recently returned from treating patients in Sierra Leone) who clearly was not a danger to her community, but the state governor enforced a home quarantine to be seen as keeping his citizens safe (Malone and Zargham 2014; Alman 2014). This contentious approach even has been tentatively credited with helping him win reelection on November 4: Despite being "consistently underwater with his approval ratings" and one "of the most vulnerable incumbent governors in the country" (Woodard 2014, ¶1), "many supporters felt he was putting politics aside and acting like a leader" in his legal battle with the nurse (Paletta 2014, ¶9). Although both ultimately prevailed in their quests (the governor in terms of re-election, the nurse in getting the quarantine lifted), not everybody (every body) possesses the cultural, social, and/or financial capital to recapture their narrative in the media or fight political injustice.

Another interesting contrast that has made news is between human and non-human victims of Ebola. The Spanish nurse who contracted the virus while caring for Spain's "patient zero" (a priest who returned from Africa with the virus and then died) was treated with some sympathy, despite initial suggestions from her superiors (similar to the government's response in the United States) that she had deviated from protocol. However, her pet dog Excalibur received much greater expressions of sympathy and support, particularly when Excalibur was ultimately euthanized as a precautionary measure regardless of showing no symptoms of Ebola or scientists possessing much knowledge of canine susceptibility to the virus (Wilson 2014).

Also problematic has been the comparison the U.S. Centers for Disease Control and Prevention (CDC) director made between Ebola and HIV. In early October, Dr. Thomas Frieden said at a World Bank forum: "This is a fluid and heterogeneous epidemic. It's changing quickly, and it's going to be a long fight. … I will say that in the 30 years I've been working in public health, the only thing like this has been AIDS. We have to work now so this is not the world's next AIDS" (Westcott 2014, ¶3).[1]

While Frieden likely was attempting to underscore the potential scope of the epidemic, especially if (resource-rich) countries don't respond, he may have undermined his intention and obscured an accurate understanding of the risks and needs within and beyond Ebola-affected areas. Unfortunately, many today still see HIV/AIDS as a disease of an "other," rooted in Africa and/or homosexuality, and even "just desserts" for stigmatized behaviors. While Ebola was initially viewed (and also disregarded) in the same way—as an African phenomenon—this has very rapidly changed as individuals "closer to home" have become infected. Moreover, Ebola and HIV are different. Although both are viruses spread via bodily fluids (and neither is very durable outside the human body), "Ebola is transmitted when a person is sick, usually very sick, and you have to come into direct contact with bodily fluids. So it's difficult not to know you're exposed" (Anthony Fauci cited in Siegel 2014, ¶15). Those with HIV, on the other hand, may remain symptomless but infectious for years, making it much harder to identify and combat infection. Treatments also vary; where one is acute and relies on "good supportive care and the patient's immune response" (CDC 2014, ¶5), the other is ongoing and requires multiple, expensive antiretrovirals.

Where Frieden's comparison may be apt is in regards to the U.S. response to HIV in the 1980s as one of indifference and disdain (because it was seen primarily as infecting and affecting gay men), and even today many politicians and organizations in the United States support abstinence-only sex education, disapprove of needle exchanges, and never think about why condom advertisements are not seen on broadcast TV. The comparison Frieden failed to make clear was our complicity with allowing the epidemic to grow.

As Holloway noted in "Made Vulnerable: Notes on Privilege; or, How When You Say Their Names, the Bodies Go Missing," there is much concealed in public health terms such as "target population," "priority population," and "vulnerable population" or by prioritizing the needs of "our own" health care workers over local (i.e., "foreign") health care workers living within the most-affected regions. What structures do we ignore and

[1] The next paragraph notes: "Frieden did not make any further remarks on how the two health crises were similar" (Westcott 2014, ¶4).

who in power do we absolve by such phrasing? Isn't it more honest and more revealing to say "populations made vulnerable by …" (Holloway 2014)?

We know that socioeconomics and other social determinants (e.g., discrimination, exposure to violence, lack of education and social support, etc.) are tied to health and risk of illness and disease. We also know that socioeconomics and other social determinants affect prognosis and recovery. And we know that while the "exotic" like Ebola captures our attention (however fleetingly), in fact the greatest threat of incurable infection comes from the global overuse of antibiotics in medicine, veterinary practice, and agriculture. Resistant microorganisms are now challenging health systems worldwide on an unprecedented scale. Yet research and development into new antimicrobials have dwindled on the basis of profitability, and governments, industry, clinicians, and patients have been resistant to change current behaviors.

Although the media love to highlight the enemy on our borders threatening to disrupt our safe worlds insulated from many of the realities of danger and suffering, it is actually our capacity for self-destruction that constitutes our greatest foe: poverty, poor nutrition, lack of access to care, neglect of mental illness, climate change, and war, both declared and undeclared. But far easier to wind up a distant epidemic and see a remote danger to ourselves (while thousands die in a distant place) than address our real threats. Despite many genuine humanitarian responses from wealthier "first-world" countries, it is still clear that we have primitive protective responses (at home and abroad) that largely ignore the real wolves at the door.

Frieden and others in the United States (and elsewhere) have assured the public that "there is no doubt that … we will stop it [the spread of Ebola] here" (Frieden cited in St. James and Davis 2014, ¶5) and that "the United States has 'been prepared for this possibility for a long time. America has the best doctors and public health infrastructure in the world, so we're ready to deal with it'" (White House Senior Adviser Dan Pfeiffer cited in Hudson 2014, ¶5)—intimating, like others have stated more explicitly, that the shortcomings in African health care infrastructures don't exist in the Western world (see, e.g., Welsh and Jennings 2014; *The Daily Targum* 2014; Editorial Board 2014). But as the events that began on September 30 at the Texas Health Presbyterian Hospital in Dallas have illustrated, people in public health glass houses shouldn't throw (shepherd's crook-shaped) stones. Through political posturing and colonialist bravado, the United States has created a House of Mirrors optical illusion in representing its health care system as

> "the best in the world," "with the best health care professionals on Earth, the finest health care institutions, the best medical research, the most sophisticated technology," this despite the fact that U.S. morbidity and mortality rankings make the American health system "arguably the worst in the developed world" (Rich and Simmons 2011, 63–64).[2]

Amid the warped reflections then come calls for closing borders and the creation of vaccines (as if this were the first Ebola case or the first Ebola epidemic in the world). Such actions simultaneously prioritize the protection of the newly at risk (and at low risk) and prolong an indifference to the needs of those most affected.

In seeing the Ebola outbreak that began in December 2013 (Baize et al. 2014) through the eyes of the U.S. media, one is reminded of artist Margaret Noble's multimedia installation *Dorian's Gray* (2014), a series of six increasingly smaller wooden frames—from one larger than the human body to one the size of a small portrait—that resemble fractured mirrors (see http://www.margaretnoble.net/dorians_gray/). Light and sound from behind the viewer cast shadows and reflections of one's image, warped and twisted and appearing in multiple places simultaneously. One doesn't know where to look but at the same time can't look away.

The plaque accompanying the piece perhaps says it all:

> [*Dorian's Gray*] integrates physical materials, light, and sound to construct a reflective metaphor on identity in today's digital age. The work explores the complicated yet timeless questions of influence, superficiality, and entertainment as put forth in two books—*The Portrait of Dorian Gray* by Oscar Wilde and *The Narcissism Epidemic: Living in the Age of Entitlement* by Twenge and Campbell. If the digital world fosters isolation,

[2] One need also only look at how the United States handled Hurricane Katrina and its aftermath for a reality check on how well prepared the country's health care and public health infrastructures are, even with "non-exotic" and yearly occurring risks (Fink 2013).

what evokes empathy? Which of our personas do we believe in—our social media portraits or our reflections in the mirror? What are the consequences of a digitally-created society in the psyche of the global community?

References

Adato, P.M., writer, director, and producer. 2010. *Paris: The luminous years: Towards the making of the modern*. New York: Thirteen for WNET.org, The Elegant Image LLC, and Ina & Arte France.

Alman, A. 2014. Maine Gov. Paul LePage sends state police to enforce Ebola quarantine. *The Huffington Post*, October 29. http://www.huffingtonpost.com/2014/10/29/paul-lepage-ebola-quarantine_n_6069740.html.

Baize, S., D. Pannetier, L. Oestereich, et al. 2014. Emergence of Zaire Ebola virus disease in Guinea. *The New England Journal of Medicine* 371(15): 1418–1425.

CDC. 2014. Ebola (Ebola virus disease): Treatment. Centers for Disease Control and Prevention, October 3. http://www.cdc.gov/vhf/ebola/treatment/.

Diamond, D. 2014. "60 Minutes" just broke new details on the Dallas Ebola case. Here's what they revealed. *Forbes*, October 26. http://www.forbes.com/sites/dandiamond/2014/10/26/60-minutes-just-broke-new-details-on-the-dallas-ebola-case-heres-what-they-revealed/.

Dreishpoon, D., curator. 2014–2015. *Gauguin to Warhol: 20th century icons from the Albright-Knox Art Gallery*. Exhibition at The San Diego Museum of Art, October 4, 2014–January 27, 2015, in San Diego, California, U.S.A.

Editorial Board. 2014. West Africa can't manage the Ebola outbreak. *The Washington Post*, June 29. http://www.washingtonpost.com/opinions/west-africa-cant-manage-the-ebola-outbreak/2014/06/29/07f4c354-fee9-11e3-b1f4-8e77c632c07b_story.html.

Fairchild, A.L., L. Gable, L.O. Gostin, R. Bayer, P. Sweeney, and R.S. Janssen. 2007. Public goods, private data: HIV and the history, ethics, and uses of identifiable public health information. *Public Health Reports* 122(Suppl 1): 7–15.

Fink, S. 2013. *Five days at Memorial: Life and death in a storm-ravaged hospital*. New York: Crown Publishers.

Foucault, M. 1994. *The birth of the clinic: An archaeology of medical perception*. Translated by A.M. Sheridan Smith. New York: Vintage Books. Originally published as *Naissance de la clinique* (Paris: Presses Universitaires de France, 1963).

Gersh-Nesic, B. No date. Cubism—art history 101 basics: 1907–present. About Education. arthistory.about.com/od/modernarthistory/a/cubism_10one.htm.

Hartocollis, A. 2014. Tracking one man's contacts in a city of 8 million: Retracing Ebola patient's movements creates host of challenges for New York City. *The New York Times*, October 23. http://www.nytimes.com/2014/10/24/nyregion/tracing-patients-possible-contacts-creates-host-of-challenges-for-the-city.html?_r=0.

Holloway, K.F.C. 2014. Made vulnerable: Notes on privilege; or, how when you say their names, the bodies go missing. Opening plenary at the 16th annual meeting for the American Society for Bioethics+Humanities, October 16–19, in San Diego, California, U.S.A. See also http://www.asbh.org/uploads/files/meetings/annual/pdfs/asbh14_prbk.pdf.

Hudson, D. 2014. CDC confirms first case of Ebola diagnosed in the U.S. *The White House Blog*, September 30. http://www.whitehouse.gov/blog/2014/09/30/cdc-confirms-first-case-ebola-diagnosed-us.

Komesaroff, P. 2014. *Riding acrocodile: A physician's tale*. Austin: River Grove Books.

Malone, S., and M. Zargham. 2014. Maine governor vows to use full extent of authority on Ebola nurse. Reuters, October 30. http://www.reuters.com/article/2014/10/30/us-health-ebola-usa-maine-idUSKBN0IJ2F820141030.

McAuliffe, M. 2014. *Twilight of the Belle Epoque: The Paris of Picasso, Stravinsky, Proust, Renault, Marie Curie, Gertrude Stein, and their friends through the Great War*. Lanham, MD: Rowman & Littlefield.

Neuman, S. 2014. Dallas nurse Nina Pham, now "Ebola free," discharged by NIH. NPR, October 24. http://www.npr.org/blogs/thetwo-way/2014/10/24/358553648/dallas-nurse-nina-pham-now-ebola-free-to-be-discharged-today.

Noble, M. 2014. *Dorian's gray*. Multimedia installation at the San Diego Art Institute's "Beyond Limits: Postglobal Mediations, " curated by G. Shulick Porcella and D. Carvalho, October 4–November 16, in San Diego, California, U.S.A.

Paletta, D. 2014. Paul LePage projected to win governor's race in Maine. *The Wall Street Journal*, November 5. http://blogs.wsj.com/washwire/2014/11/05/paul-lepage-projected-to-win-governors-race-in-maine/.

Pietrzak-Franger, M., and M. Stoddard Holmes. 2014. Disease, communication, and the ethics of (in)visibility. *Journal of Bioethical Inquiry* 11(4). doi:10.1007/s11673-014-9588-2.

Rich, L.E., and J. Simmons. 2011. Heidegger and "House": The twofold task in working out the question of American medicine. *Film and Philosophy* 15: 49–69.

Schram, J., and B. Golding. 2014. Ebola doctor "lied" about NYC travels. *New York Post*, October 29. http://nypost.com/2014/10/29/ebola-doctor-lied-about-his-nyc-travels-police/.

Shaw, D. 2014. Communicating about communicable diseases using Facebook: Whisper, don't shout. *Public Health Ethics* 7(1): 61–63.

Shoichet, C.E., A. Fantz, and H. Yan. 2014. Hospital "dropped the ball" with Ebola patient's travel history, NIH official says. CNN, October 1. http://www.cnn.com/2014/10/01/health/ebola-us/.

Staff Reports. 2014a. Amber Joy Vinson's family releases statement thanking everyone for support, Nina Pham arrives in Maryland. *The Dallas Morning News*, October 16. http://thescoopblog.dallasnews.com/2014/10/cdc-director-frieden-we-do-not-yet-know-exactly-how-ebola-transmissions-occurred-at-texas-health-presbyterian.html/.

Staff Reports. 2014b. Ebola patient Thomas Eric Duncan dies at Dallas hospital. *The Dallas Morning News*, October 8. http://www.dallasnews.com/ebola/headlines/20141008-ebola-patient-thomas-eric-duncan-dies-at-dallas-hospital.ece.

Siegel, M. 2014. Ebola and AIDS: A tale of two viruses. *New York Post*, October 2. http://nypost.com/2014/10/02/ebola-and-aids-a-tale-of-two-viruses/.

St. James, J., and J. Davis. 2014. CDC: Ebola confirmed in Dallas patient. WFAA, September 30. http://www.wfaa.com/story/news/health/2014/09/29/dallas-presbyterian-hospital-ebola-patient-isolation/16460629/.

The Daily Targum. 2014. We got 99 problems, Ebola ain't one: Outbreak in U.S. unlikely, focus must remain in affected countries. *The Daily Targum*, October 5. http://www.dailytargum.com/article/2014/10/we-got-99-problems-ebola-aint-one.

Welsh, J., and K. Jennings. 2014. Here's why you shouldn't panic about the first US case of Ebola. *Business Insider*, September 30. http://www.businessinsider.com/ebola-virus-in-us-dallas-dont-panic-2014-9.

Westcott, L. 2014. CDC director draws parallels between Ebola outbreak and HIV/AIDS epidemic. *Newsweek*, October 9. http://www.newsweek.com/cdc-director-draws-parallels-between-ebola-outbreak-and-hivaids-epidemic-276466.

Wilson, J. 2014. "Save Excalibur" fails: Madrid euthanizes Ebola patient's dog. CNN, October 9. http://edition.cnn.com/2014/10/08/health/save-excalibur-ebola-dog.

Woodard, C. 2014. How did America's craziest governor get reelected? How the confounding victory of Maine's Paul LePage helps explain the national GOP wave. *Politico*, November 5. http://www.politico.com/magazine/story/2014/11/paul-lepage-craziest-governor-reelection-112583.html#.VFvPLvldUlI.