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The Dallas Ebola Case: An Immigration-Related Process Conspiracy?

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To begin, consider that people like Dr. Sanjay Gupta keep saying that the Dallas Ebola patient Thomas Eric Duncan had "told the nurse" who attended to him upon his first arrival at the Texas Presbyterian Hospital Emergency Room that he had "traveled "to" Africa."

That's certainly a very odd thing for a Liberian national, having just arrived *from* Monrovia, Liberia *to* the United States *for the very first time in his life*, to have supposedly said, is it not? Of course, it fits the CDC Checklist used prior to, and including, Duncan's case, so that must have been exactly what Duncan said, right Sanjay?

Duncan's status as a Monrovian Liberian national has not exactly been blasted across the MSM news; in fact, the MSM news for the most part has been adhering studiously to the asinine "traveled to Africa" view even though it is grossly misleading.

So why adhere to the view? The chief contention of this article is that we might be observing the unfolding of a "process conspiracy" pertaining to Ebola and the highly contentious immigration issue. The phrase "process conspiracy" is operationalized here as a conspiracy rooted in a policy or policies consciously designed to shape practice in ways such that the output exacerbates the very problems the policy/policies was (were), on the surface, designed to contend with.

The specific object of the Globalist Ebola process conspiracy is here theorized to involve diminishing the linkage, in public consciousness, of Ebola with nationality status. Globalists have huge immigration plans for the U.S., and they do not want Ebola (or any other infectious disease, for that matter) getting in the way of those plans. That is why their Ebola policy protocols—as absurd as they are (discussed shortly)— read the way they do, that is why we have been exposed to a cloud of lies emanating from Dallas and dispersed through the MSM, and that is why Duncan was discharged with antibiotics soon after his first visit to the Emergency Room of Texas Presbyterian.

Because the theory is a process conspiracy theory and therefore rooted in subverted policy, it has application not just to Duncan, but to future Duncans as well. The argument proceeds as follows. First, a brief observation concerning risk is offered which, even though obvious, is necessary because without it the argument will make little sense. Second, the CDC's Ebola Screening and Isolation polices are examined, and, on the basis of the risk observation, shown to be not only wholly inadequate to the task they were allegedly crafted to meet, but quite likely to make the Ebola contagion problem even worse. Third, evidence is provided in support of the idea that the Ebola process conspiracy theory offers a simple, and very plausible explanation, of certain important *assertions* of fact, and inconsistencies, emanating from Dallas that are otherwise rather difficult to explain. Throughout, the

connection to the issue of nationality status will be obvious.

On the risk issue, people who are Liberian nationals and residents of the hot zone Monrovia clearly present much greater risk than randomly drawn "travelers to" Liberia, simply because the exposure time is likely to be much greater for the former set of people.

Now we turn to consideration of the CDC's policy guidance on screening and isolation of Ebola patients—and keep in mind that, astonishingly, these (click here and here) are purportedly *new* policy statements issued *in the wake* of the Duncan Dallas case, and yet they *still* do not meet the *very problem* Duncan-type cases present.

The screening/isolation problem presented by Duncan type cases is this: under CDC policy guidelines, what are hospitals supposed to do when they encounter potential Ebola cases that are asymptomatic, but which involve persons who have not merely "traveled to" certain countries in Africa, but in fact are also *nationals* of one of those countries who have *lived*, perhaps *even in outbreak areas*, at a minimum since the outbreak began?

Amazingly, as the above-linked policy recommendations show, national origin and indeed even residence in hot zones is in no way independently factored into risk assessments for purposes of screening and isolation! But let's pay especial attention to the second document just linked, which is the "Ebola Virus Disease" "algorithm" document, which is actually nothing more than a truly insidious flowchart of gruesome death. First, look at the subheading, which states "Algorithm for Evaluation of the Returned Traveler." Can you believe it? Where is the "Algorithm" for evaluation of *newly arrived hot zone nationals*? Second, don't be misled by the language in the "No Known Exposure" box. That language does state "Residence in or travel to affected areas** without HIGH- or LOW-risk exposure", but the critical fact is that Duncan-type cases are asymptomatic, and, as the "Algorithm" chart shows, with those types of cases there are *no arrows leading anywhere else*. And, in any event, the degree of exposure row only applies with respect to those people who have *already* been isolated. Indeed, the most that can happen with Duncan-type cases under the Algorithm document is, incredibly, a mere referral to "the Health Department."

The first CDC document linked above functions similarly; but at least specifies a few more symptoms. In the final analysis, though, it too talks only about travelers "to" hot zone countries, and so says nothing at all about how to contend with asymptomatic Duncan-type hot zone nationals.

So what is going on? Let's have a look at some Ebola charades at Texas Presbyterian Hospital, Dallas. Check out these weird accounts *via* CNN:

"Hospital officials have acknowledged that the patient's travel history wasn't "fully communicated" to doctors, but also said in a statement Wednesday that based on his symptoms, there was no reason to admit him when he first came to the emergency room last Thursday night.

"At that time, the patient presented with low-grade fever and abdominal pain. His condition did not warrant admission. He also was not exhibiting symptoms specific to Ebola," Texas Health Presbyterian Hospital Dallas said.

The patient, identified by his half-brother as Thomas Eric Duncan, told hospital staff that he was from Liberia, a friend who knows him well said.

A nurse asked the patient about his recent travels while he was in the emergency room, and the patient said he had been in Africa, said Dr. Mark Lester, executive vice president of Texas Health Resources. But that information was not "fully communicated" to the medical team, Lester said.

What on earth can it mean to say that the patient's travel history was not "fully communicated" to doctors? How hard is it to communicate "the patient is from Liberia"? Here is where we need to notice that, according to a friend, Duncan told hospital staff that he (Duncan) was *from* Liberia—not merely that he had "traveled" there. And how hard is it, really, to communicate these things to others? Add to this that, in all likelihood, Duncan's friend probably *did* tell CDC that Duncan was *from* Liberia (because the friend wanted to get Duncan help early).

But given that the hospital officials now say that "[h]is condition did not warrant admission at the time", *what difference* would it have made if Duncan's "travel history" *had* been fully communicated to doctors? It's not like CDC guidelines would have had the hospital behave in any way other than the way it did—and the hospital itself asserts that in any event Duncan was asymptomatic on his first visit.

To see what is at stake here, reflect on what would have happened if the hospital had flouted CDC policy guidelines and, of its own initiative, isolated Duncan on the basis of Liberian and Monrovian origin. People would certainly have asked why Duncan was being isolated, and what could the hospital have said? Under CDC standards, the hospital would have had to have said that Duncan *was* symptomatic (and can you imagine the chaos and panic that would have caused)—but he wasn't, according to the hospital. The alternative would have been to say that even though he was *not* symptomatic, he was being isolated anyway because his *status as a Liberian and Monrovian citizen amounted to a grave risk factor*.

So the hospital was in a bind, you see, because the U.S. Government doesn't want people to even think about Liberian and Monrovian citizenship as an Ebola risk factor because that could conceivably *completely destroy the One Party State's immigration reform goals*—especially given psychological associations with mystery viruses and other illnesses believed to have arrived from south of the border. These things are probably why we got a bunch of weasel-wording from the hospital, and that is probably why Duncan was sent home with antibiotics after his first visit. The hospital chose to follow the CDC, and so Duncan, now characterized, per the CDC, as a mere "traveler to" an affected country, was loosed on Dallas and therefore the entire world.

That, ladies and gentleman, is ObamaCare, and that is what "comprehensive immigration reform" means to the Global Elite.

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