FCON COVID-19 Deployment
Oral History Interview
CAPT Ljuca Belsito, R.N.

FCON History Committee
FDA History Office
Collaborative Oral History Project
Edited Transcript
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Table of Contents

Oral History Abstract

The FDA History Office and members of the FCON History Committee interviewed Captain Ljuca Belsito as part of a collaborative oral history project to document the experiences of FDA commissioned officers in the COVID-19 emergency response. CAPT Belsito is a Public Health Service officer who is in the USPHS Commissioned Corps. She is a Registered Nurse who worked in the Division of Disclosure in CDRH until her retirement in May 2022 and was deployed as a member of the COVID Response Team in February 2020. She served as the deputy commander of the Service Assistant Teams. CAPT Belsito discussed her deployment to Tokyo to facilitate the care American citizens who had been quarantined on the Diamond Princess cruise ship and received treatment in Japan.

Keywords

Commissioned Corps; COVID-19; deployment; Diamond Princess; emergency response; Extracorporeal Membrane Oxygenation (ECMO); Japan; Minister of Health (Japan); nurse; patient; quarantine; Rapid Deployment Force (RDF); US Public Health Service

Citation Instructions

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Glossary

510(k)	Section of the Federal Food, Drug, and Cosmetic Act establishing a premarket notification requirement for medical devices that can demonstrate substantial equivalence to approved products
ACA	Affordable Care Act
ACF	Administration for Children and Families
ACS	Alternative Care Site
AEG	Agency Executive Group
AMSUS	Association of Military Surgeons of the United States
ASPR	Assistant Secretary for Preparedness and Response
ASPR TRACIE	Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange
BARDA	Biomedical Advanced Research and Development Authority
BOP	Bureau of Prisons
BSL Lab	Biological Safety Levels Laboratory
CAP Team	Capital Area Team, U.S. Public Health Service
CAPT	Captain, U.S. Public Health Service (O-6)
CBER	Center for Biologics Evaluation and Research, FDA
CBP	Customs and Border Protection Agency
CBTS	Community-Based Testing Site
CCHQ	Commissioned Corps Headquarters
CDC	Centers for Disease Control and Prevention
CDER	Center for Drug Evaluation and Research, FDA
CDR	Commander, U.S. Public Health Service (O-5)
CDRH	Center for Devices and Radiological Health, FDA
CFSAN	Center for Food Safety and Applied Nutrition, FDA
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CONOPS	Concept of Operations
CPR	Cardiopulmonary Resuscitation
CRAFT	COVID-19 Response Assistance Field Team
CTP	Center for Tobacco Products, FDA
CVM	Center for Veterinary Medicine, FDA
DART	Disaster Assistance Response Team
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DOD	Department of Defense
ECMO	Extracorporeal Membrane Oxygenation cardiovascular life support device
EHO	Environmental Health Officer
EMS	Emergency Medical Services
ER	Emergency Room
ESF	Emergency Support Function, FEMA

EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Shelter, FEMA
FOIA	Freedom of Information Act
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIS	Indian Health Services Agency
HRSA	Health Resources and Services Administration
HSIN	Homeland Security Information Network
HSO	Health and Safety Officer
HVAC	Heating, Ventilation and Air Conditioning
ICS	Incident Command System
ICU	Intensive Care Unit
IMG	Incident Management Group
IMT	Incident Management Team
JIC	Joint Information Center
LCDR	Lieutenant Commander, U.S. Public Health Service (O-4)
LT	Lieutenant, U.S. Public Health Service (O-3)
MCAS	Marine Corps Air Station
MD	Medical Doctor
MMU	Monrovia Medical Unit (Liberia Ebola Response)
N95	Particulate filtering facepiece respirator, NIOSH rated "not-resistant to oil" filtering 95% of airborne particles
NCTR	National Center for Toxicological Research, FDA
NDMS	National Disaster Management System
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NIST	National Institute of Standards and Technology
NP	Nurse Practitioner
NPI	National Provider Number
OASH	Office of the Assistant Secretary for Health
OC	Office of the Commissioner, FDA
OFDA	Office of U.S. Foreign Disaster Assistance
OLS	Office of Laboratory Safety, FDA
OMB	Office of Management and Budget
OPDIV	Operating Division
OPM	Office of Personnel Management
ORA	Office of Regulatory Affairs, FDA
OSHA	Occupational Safety and Health Administration
PA	Physician Assistant
PAPR	Powered Air Purifying Respirator
PCR	Polymerase Chain Reaction (test)
PHS	Public Health Service
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder

RDF	Rapid Deployment Force
RedDOG	Readiness and Deployment Operations Group
RIST	Rapid Incident Support Team, U.S. Public Health Service
RN	Registered Nurse
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SAMSHA	Substance Abuse and Mental Health Services Administration
SAT	Service Access Team/s, U.S. Public Health Service
Sitrep	Situation Reports
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOC	Security Operations Center
SOFR	Safety Officer
SOP	Standard Operating Procedure
TAT	Technical Assistance Team
TDY	Temporary Duty Assignment
TPN	Total Parenteral Nutrition
USACE	Army Corps of Engineers
VA	Veterans Administration

Index

Interview Transcript

VB: This interview is a contribution to the FDA Commissioned Officers Network and the FDA History Office collaborative oral history project to capture the deployment experiences of officers that served in the COVID-19 Public Health Emergency response. My name is Vanessa Burrows. I am from the FDA History Office.

JS: I'm John Swann, also from the FDA History Office.

LP: This is Captain Laura Pincock. I'm a Pharmacist Officer, and I'm working on behalf of the PharmPAC History Project.

OB: Good morning. My name is Lieutenant Commander Oumou Barry. I am a Health Service Officer. I am representing the FDA Commission Office in Etwa, FCON, and I am currently stationed in CDER.

LB: This is Captain Belsito. I am a Registered Nurse. I work in the Division of Disclosure in CDRH, and I was part of the COVID Response Team back in February 2020.

VB: Thank you all. Captain Belsito, could you tell us a little bit about your experience with the Public Health Service, when you joined, or any details that you think are pertinent to share?

LB: My career with the Public Health Service started June 1, 2001. This is my second career, and I was commissioned in New York on June 1, 2001. I worked for Immigration Health

Services and was on duty three months and ten days when 9/11 happened in New York, so I knew exactly why I took the oath. I had always wanted to go into the Service, but I did it in the reverse manner. I feel that my 21 years of nursing experience prior to coming into the Corps had given me a lot of clinical experience, leadership experience. I developed a case management team within one of the biggest hospital networks in New York back in 1996, and I helped start up a high-tech home care company in 1991 to 1996. Coming into the Commissioned Corps was something for me that opened my eyes to service before self, learning how to carry myself as an officer. I was fortunate to have a lot of prior military colleagues that worked in my detention center, a Marine, Army, Air Force, and felt that those experiences helped me to navigate my career within the Commissioned Corps.

From the deployment situation that happened in 9/11, I was then selected as one of the tip of the spear nurses for Hurricane Katrina, and was one of the 37 officers preselected to go out and set up - at that point we didn't have the deployment teams that we do now - but to set up a medical facility, which would house evacuees that required medical assistance. When we went through the hurricane, we woke up the day after Katrina; it was a beautiful sunny day, and we were in rounds, getting briefed by our leadership, and that's when the levees broke. We knew that we had two disasters, and at that point we were directed to go to the Peter Maravich Center down at LSU (Louisiana State) University, set up basically a big evacuation center, where our team became one of the first teams to set up a discharge planning, or case management model for disaster response I think that Commissioned Corps had ever experienced.

From there, I became part of RDF2, second to none, when they developed the deployment teams, and my role evolved into Deputy Director of the SAT teams, and so my career is built upon my 41 years of nursing experience, clinical skills and leadership experience. I have a master's degree

in Nursing Administration, and it's just been a whirlwind of good and challenging times, but I wouldn't change anything in my career.

VB: Thank you so much for sharing that. Before we get into any great detail into your participation in the COVID-19 response could you just give us a very brief overview of what you were deployed to do during COVID?

LB: Sure. We knew that there was something going on because we kept seeing media coverage of the cruise ship that was docked in Yokohama, Japan, and an email came through in probably the first or second week of February, case managers needed to deploy, to assist patients, American citizens with repatriation. I felt as though that email had my name written all over it, so I discussed it with my family, and I put my name forward, and within 48 hours I was selected and on a plane to Tokyo, Japan. I didn't really know what our mission was going to be when we were en route, but I did meet up with six other officers who were at the airport, some who had never deployed before, some who had been on teams with me before, and we talked a little bit about the fact that we didn't really know what we were going to be called to do, but that we would arrive and wait to discuss what plans were and what the mission would develop into.

When we arrived in Tokyo, there was already a team on the ground that had been deployed four or five days prior to us, and they had worked overnight, evacuating over 400 American citizens off the cruise ship, as we were en route to Japan. We then had to collaborate with ASPR and all the other response teams that were already on the ground to figure out how we were going to identify which of the American citizens were evacuated off the ship, and either in country or sent back to the United States to the evacuation centers, where our American

citizens were being screened and housed until we understood what was going on at that point it was not declared a pandemic yet. We landed on February 16th, and from February 16th to February 18th, the two teams came together, Team 1 and Team 2, and I was the lead for the small team 2 that came in.

Admiral Childs arrived on February 18th, and tried to gain the lay of the land as far as what was being done from the State Department, from ASPR and from all the other people who were already involved, CDC, CDC leadership, and we tried to navigate the communications that were taking place between the families who were back in the States, or the families who were still in Japan, to try to identify who we needed to really monitor and follow. What we realized after we received the manifest from the cruise ship staff that had been given to ASPR and some of the leadership of the other teams, we started to reach out to all of the families. There were a number of us who split up the 100 plus names that we knew were still in country or in hospitals across the United States, and that's where we realized that we were in a situation where our ability to communicate with other medical officers or other hospitals was not the same as here in the United States.

Being a case manager, we have that ability to ascertain information from hospitals over the phone once your credentials are identified and validated. But in Japan, they have a much different healthcare system. When Admiral Childs arrived, we quickly realized that we had to try to negotiate with the Minister of Health and the leadership on that higher level, to be able to access medical information on our patients, any patients that had been placed into a hospital, and find out their clinical status. Within the next three to four days, Admiral Childs had had some colleagues who had served as residents under him in NIH, who came to our Command Center and helped us to create intake pages of paper, because they liked to use fax. So, we had to create

intake screening tools in Japanese, find out who the patients' physicians were, and those physicians had to be given permission from the Minister of Health to be able to speak to any of us, or to give any clinical information. This all took place over a matter of 72 hours over a weekend, where we were able to get that permission, and once we were able to start sending faxes to the correct hospitals, we had one or two interpreters that were assigned to our Command Center from 8:00 am until 6:00 pm, and as we started to receive the clinical information back, we would have that information interpreted back to us.

We would create medical records or a file on each patient, and then we would have Admiral Childs have a conversation with the physicians who were taking care of these patients, and what we identified were 16 patients who were in the hospital in critical condition; 14 of those patients were American citizens. And the one that struck us as the clinical information started to come back was that all of these patients were on ECMO, which is a device that's used sometimes for open heart surgery, where you have a heart/lung machine breathing for you or oxygenating the blood, and when we asked why that was, the Japanese medical system basically told us that this is the way they care for a lot of their ICU patients who are in this type of situation where their lungs are basically in a position where they just can't function, and a lot of these patients were also being put in the prone position, which we also felt was something that none of us had experienced in our own clinical situations in working with patients.

Every patient was ventilated, every patient was on ECMO, and many of the patients had been given multiple types of antibiotics and treatments and IV fluids, and we really didn't know if any of these patients were going to survive. Admiral Childs, again, being involved in a lot of these higher-level deployments, was very involved in the Ebola response with the Commissioned Corps, and he had had some experience with the drug Remdesivir, and he knew that there was a

representative that was in country who was going to start a clinical trial through Gilead. He got some of the clinical information from the medical staff at the hospitals, and discussed some of the clinical situations, the type of virus, the diagnosis that were coming back, and he felt that this COVID, CoV2 virus, was something - or COVID-19 was something that was similar to Ebola, but not Ebola in regards to the fact that it might respond to this Remdesivir.

That began a whole conversation about if we could get permission from the families and the patients to use this drug as a compassionate use intervention, and if Gilead would release 20 doses, that Admiral Childs would work with the Minister of Health to get the drug to the facilities and to the patients, and see if this was an option. The clinical status of these patients from day to day, their needs for oxygen became more, if they were on high volume nasal cannula, they were being converted over to ventilation, full ventilation. There was a lot of behind the scenes negotiations going on with Admiral Childs, the Minister of Health and the State Department, and basically was put into a previous video that we did, brokered a deal that we were given 20 doses of the Remdesivir, and then put together a series of clinical criteria that these patients needed to meet in order to be offered the medication. That included any of the patients that we were looking at, meaning there were American citizens, there were some Japanese patients, some Chinese patients that were all triaged and reviewed to see if they could qualify to receive the medication.

The patients that did receive the medication, the American citizens that did receive the medication all started to show improvement, and over the course of their hospital stay, the 14 patients that we were following from American citizens, every one of them survived, and it was a long course. We were in Japan from February 16th, and we were stood down on March 6th, when the clinical situations for many of these patients started to show improvement.

Admiral Childs and some of our team members did make some visits to the hospitals to speak with the families that were still in country, and to speak to the medical staff that were providing care to a number of these patients. It became a mission that I don't think any of us could have imagined. We got on a plane, knowing that we were going to have to try to repatriate American citizens, which again most of Team 1 had done a really good job of evacuating. I think there were 417 American citizens removed from the cruise ship in a 24-hour period, getting them onto flights and buses, and from the cruise ship site to the airport, to California, to Texas, to wherever they needed to go to, and then the ones that were critically ill and removed from the ship were taken by ambulance to the hospitals in Japan.

[00:19:56]

We didn't want to leave. When they told us that we were being given orders to come back to the United States, that the case management of these patients was not going to stop, that Admiral Childs was going to set up another team back in the States at the NIH campus, where he worked with another group of nurses and other officers, to monitor all of these patients until every one of them came out of the ICU, went through rehab, and was able to be sent back home to be with their families. Some of them didn't come back home until June or July. We did have one patient who did expire in July, and this was a patient who originally did not meet the criteria for the compassionate use. It was a patient who had had chronic renal disease prior to this whole thing, but that was one of the criteria that would exclude them from compassionate use for this drug.

The Japanese government and the Japanese healthcare system were amazing. They seemed to be prepared for all of this, and when we asked them how did you know that you would need ventilators, you would need prone positioning, you would need possibly to use ECMO on this disease that we had no idea what it was, and basically they said that they've practiced for this. They were prepared for what could happen in the event of a pandemic, and that was kind of surreal when we heard them say that. But we were just very grateful that we were able to function in the roles that I think we all came together. There were three nurses on our team. There was an HSO, an epidemiologist, Admiral Childs of course, medical, and one social worker. There were seven of us, that managed all of these patients and made this come to fruition for these patients and families, and when we left, it was very emotional.

I personally, felt very responsible as the Chief Nurse for this team, and the Chief of the managed care program. I felt as though I had a connection with every one of these patients, and still do, and sometimes wonder if we will ever be able to have a Zoom call to see them again and tell them that we were so fortunate to be able to be there at a time. We have received numerous calls and cards and emails back through NIH from these families, thanking us for our efforts, thanking us for the communication outreach, because there was a period of time where none of these families knew where their family members were, what their medical condition was, who they could call, and we were sort of that conduit to help them find their loved ones in a situation where it seemed very confusing in the beginning. We helped to bring them back in touch with their family members at a critical time that they needed to know. Coming back to the States, we who served on this team, kept in touch. We did keep in touch with Admiral Childs. Of course we all had to do our quarantine because we came back to the States on March 6th, and we actually have a photograph of us sitting in the Command Center where we watched as the first

case was announced on CNN, when the first patient in the nursing home in Washington had passed. At that point, the Admiral just looked at us and said, "I think we're going to have a bigger issue on our hands now," and shortly thereafter it was declared a pandemic

You never know when you go into these missions, how big of a part you're going to play. You don't go into a deployment thinking that you're going to be part of something that could be a once in a lifetime, we hope, situation, but all of us feel a sense of honor, service, and I just feel grateful and blessed to know that I could have contributed to these families and these patients' survival, and getting them back in touch with their families, and helping them to navigate, which is kind of what I do as a case manager. It brought all of my clinical skills, all of my case management training and experience, not only to my deployment, but I think a lot of the other officers that I'd been deployed with, and of course with this, Admiral Childs and his Ex-O, CAPT Julie Herb Alvarez, realized how important that role is; patient advocacy, transitions of care, and I think that Japan, knowing how much they contributed to the success and the survival of these patients, and from what I understand, the Japanese government picked up the entire cost of all the medical care, all the rehab, and the transportation for these families and housing while they were there, waiting for their loved ones to be discharged and come back to the United States.

It's a story that we had been told by some higher levels, is a made for TV movie that needs to be told because no one knew of our mission. We were not allowed to speak about it until after probably December last year, when it was presented at the AMSUS conference. It feels good to tell the story from boots on the ground, and we understand that this doesn't undermine anything that went on in the States. Once the pandemic hit here, we all felt the pain and the suffering, but we feel as though our role, in the very beginning of what is a pandemic,

hopefully a once in a lifetime, I can say that we were part of something that will go down in history I think as probably one of the most successful deployment stories in our history of public health.

VB: I think you're surely right about that. It's such a remarkable mission, and I'm sure that the patients' families and the rest of us who are aware of the story now, are extremely grateful for your service, and the success that you guys were able to achieve in it. And thank you so much for recounting in such detail and breadth the great number of things that were entailed in your mission. I was wondering if you could bring us back to last February in Japan, and give us a sense of what the mood was like when you arrived. Certainly, they were in an earlier or closer relationship with the COVID pandemic than we were in the United States at that point, and I wonder what it was like when you landed, and the emotional atmosphere was?

LB: Well in Japan, they always seem to have had a history of wearing masks in Japan. And going into a completely different culture like this, that was something that is part of their day-to-day activity anyway. When we arrived at our hotel, which was in Yokohama, you could sense that there was something in the air, but this Japanese culture is very private, and very dignified I guess is the word I would use. The distance thing in a Japanese culture was something that you always respected from the time you hit the ground. But what I can say is that at the hotel, in the beginning, as you walked in the door, there were hand sanitizer stations, but I wasn't sure if that was something that was always there, or was something that was because of this cruise ship being in their town, so to speak, and the fact that at some point some of these cruise ship

passengers might get released into the community, not knowing if they were carrying or tested for the virus.

After we were there probably two or three days, and once I believe their government got news that some of the patients were being discharged off the cruise ship, the shift in the way hotels were managing was very clear. We were then told that we needed to wear masks all the time. We were not allowed to wear our uniforms because we did not want anyone who was in our hotel to be panicked by our presence. We were very discreet about things that we were doing, meaning our meetings, our briefings that we were having, and we started wearing masks all the time, probably from the 18th on. Because once we understood that this could be something that was in the air, but nobody really knew at that point. Before Team 1 could be stood down, all of the members needed to be tested before they could be sent home. So what started to happen was, some of the staff officers who were on Team 1, some of those officers started to exhibit signs of cold symptoms, some had fevers, and right away we flipped the switch and started going into isolation mode, where Team 1 and Team 2 were not allowed to be cohabitated anymore, we weren't allowed to be in the same room.

We wanted to really make sure that if there had been any exposures, that we weren't going to spread it amongst ourselves and possibly in the hotel that we were being housed at. Fortunately, every one of our team members, including those team members that went onto that cruise ship and evacuated and stood with those patients on the buses to make them understand that they were being transported and what was going on, none of our team members tested positive. That was a testament to our preparation, our safety officers, our use of PPE, even though at that point we were using the medical masks. We weren't in full garb, but they did have gowns and masks and goggles, so that was just a testament to their ability to protect

themselves, and most of them I think who did come down with a cold or a slight fever, I think it was just a matter of being in a situation where you were sleep deprived and exhausted, and sometimes we get compromised with our immune system. The fact that none of us, on any of the teams tested positive on a mission like that was amazing. We quickly noted that when we moved from our one hotel in Yokohama to a hotel down in downtown Tokyo, so we could be closer to the Command Center at the State Department, we noticed very quickly that everybody was wearing masks. Every hotel had masks in the lobby. Every hotel was making sure that there were hand-washing stations. At that point, they weren't really putting out those six-foot dots yet, but everybody was being very mindful and respectful of everyone's personal space. You could feel it, but there wasn't that level of high-level concern, but the concern was definitely there.

VB: So, I'm really struck by what you mentioned about how prepared the Japanese Health Service was in responding to the pandemic and I was wondering if you could tell us a little bit more about your interactions with Japanese officials or medical staff, and what their procedures were or in general, what was unique about their health system?

LB: They're socialized medicine, and the Japanese citizens are all taken care of, is what we're told. And because the healthcare system is set up the way that it is, the top-down approach, meaning that they're very private and tightlipped, and in order for them to function in their hospitals, everything comes from the Minister of Health down. In order for any of those people at any of the hospitals, and I'm talking about even the people who picked up the phone to say "hi, this is unit whatever", when we would say that this is the United States Public Health Service. We are here in country, trying to manage and find out more about the American

citizens' clinical condition, nobody would give any information. "I'm sorry," in Japanese they would say, "No, I can't talk to you. You'll have to talk to someone else," and they would hang up on us. That was something that we all got within the first day of trying to get clinical information. When we had the interpreter with us, she would help Admiral Childs, once we could speak to the Minister of Health, who actually did come to our Command Center, and their head of their healthcare system, to talk to us a little bit about their privacy issues, and that the only way that these medical doctors who were on the units would be able to give any clinical situation was if this letter that we created, with the medical staff that Admiral Childs knew, who worked in Japan could help us put together, would allow them to say, "Okay, this group of officers has the permission from the Minister of Health," so the letter had to come from him down to us, to be sent to every hospital that we needed to network with.

[00:39:52]

Once that happened, everything started to flow. When you talk about being prepared, the question that was asked, and it was actually asked in one of our face-to-face meetings, after we were starting to wind things down. Admiral Childs asked the physician, and I'm sorry, I'm drawing a blank on his name right now, but he said, "How did you know that you would need to have X amount of ventilators or X amount of ECMO machines?" because not every hospital has ECMO. And the response back to us was, "We prepare for this. We train for this because there's always a chance that there will be a pandemic," and fortunately or unfortunately, we had what we needed to provide the care to these patients when they needed it, and it saved lives.

JS: Captain Belsito, I'm curious, how many hospitals were involved here? And also, you mentioned there were maybe 100 patients that were disbursed among these hospitals. Were these all in Yokohama or were they in other areas? It must have been difficult reaching the hospitals themselves as you needed to.

LB: Yeah, I think originally we identified there were about 25 different hospitals that they could have been evacuated to, and the geography in Japan almost reminded me a little bit about when we deployed to Katrina, Hanna, Gustav, and Ike. Trying to let patients or evacuees go back to their homes in Louisiana. Louisiana has parishes, and I didn't know what a parish was, but apparently that's a county. You learn things. In this deployment, we had to find out where were these hospitals in Japan? And the biggest thing was trying to understand the names of the hospitals, because some of the names were very similar, and those were the main barriers with language and barriers with geography. Most of our patients were spread out, I believe we had 14 patients in the hospital, and I think they were probably in 10 different hospitals. So, it was navigating how far are they from us because Admiral Childs wanted to make visits to some of the families that were still in country, and possibly go and speak to those staff. That's what I remember from us trying to identify exactly how many hospitals. Originally, we were told that there's over a hundred hospitals that we could have had to reach out to, but then we narrowed it down with help from the interpreter and the other people who were on the ground with us to speak to some of these healthcare providers, to find out if these patients were in their hospital.

JS: And by the way, I know you had mentioned there was already a team that had arrived about a week or so before you did, right?

LB: Yes.

JS: At what point did they become aware of the situation? I'm trying to figure out what kind of communication you had with the other team, and how they must have then departed soon after you arrived, or did they stay around as well?

LB: When we arrived on February 16th, we blended the two teams. There was a Command set up for the first team, and then I was the lead for the second small group of us that came in, and two lead case managers. Commander Price was the Commander for that first team, CDR Dustin Price. We quickly got together and tried to figure out how we were going to collaborate to make sure that we understood what their mission was, and how we were going to move forward. We had the manifest. We knew that all of the patients that we had removed from the ship were either transported out, and again, it was a lot of collaboration between us, between ASPR, between the cruise ship staff, and understanding which patients were sent back to the United States that didn't need hospital care, and which patients had stayed back. So by process of elimination, we went through the manifest and then through the hundred patients, and identified the families of the 14, and started to reach back to those family members to find out if they were in state, in country, or if they were back in the United States,

That was kind of how we collaborated for probably the first week we were there, until probably the 1st of March. And I think the first team started to be stood down on I think - could have been February 23rd or February 24th. Again, it was making sure that everybody got tested

before they could go home, and then managing their travel plans to get them back to the United States.

OB: John are you done? This is Lieutenant Commander Barry.

JS: Yes, please go ahead.

OB: Captain, thank you for your service, and thank you so much for sharing your experience with this remarkable deployment. During this time there was very little known about this pandemic I am very impressed that you all were able to apply the universal precaution and protected yourself from contracting this virus. I was wondering, would you kindly tell us what your daily activity was like during this deployment? Meaning what did you do on a routine basis?

LB: The first few days we were trying to identify which patients we would need to be working with, and which families we needed to reach back to, and try to make some communication to let them know that we were here in the country, and that we were here to help them with navigating the healthcare system, trying to get them information on their family members. We would usually meet at 7:30 or 8 o'clock in the morning. We would do a round robin of which patients we had identified. We would check to see if we had received any updated clinical information on each patient, and believe it or not, because we were in a hotel in downtown Tokyo, there were many days that we had to shift our "Command Room," and our running joke was that we had big white boards on the wall, but we couldn't take that information

with us. So we would have to take a picture of what we had up on the wall, and then re-transcribe it onto a new white board in the new meeting room that we were given, until finally, we were able to commandeer a room, where we didn't have to move so many times, and we were able to get a few white boards that were on wheels so we could take them with us.

But on that white board, we would go through the list of patients. We would go through the different criteria that each patient was being monitored on, meaning were they on a ventilator? Were they on oxygen? Were they a candidate for receiving the compassionate use? Did the family get contacted? Was the hospital willing to accept the dose of Remdesivir? Because they had to receive ten doses which was the course of treatment. And was the family willing to participate? We really didn't know if it was going to help or not. But for some of the patients who had shown decline in their clinical status, all of them who could qualify for the criteria accepted the ability to receive the medication, and within probably 48 to 72 hours after receiving their first few doses, the patients started to show improvement in their decreasing oxygen needs, and being able to be weaned down off the high oxygen levels, off the high volume ventilators and off of ECMO.

We were monitoring the chest x-rays, which were being sent to us and reviewed again by Admiral Childs. Once he was given permission to communicate with a lot of these physicians, he was communicating with a lot of these physicians through electronic medical records being reviewed, x-rays being reviewed, and it would help us to understand what the clinical course of improvement or not improving for each of these patients was on a day-to-day basis. And sometimes we were in our Command Center until 10 or 11 o'clock at night. Admiral Childs is a very dedicated, intelligent, high-energy Admiral, and none of us wanted to leave him until we

made sure that he had everything that he needed to make sure that we were doing everything that we could for these patients. We did take breaks to get lunch.

As the Chief of this staff, I did oftentimes - for those who know who I am, I am very interested in health and fitness, and a competitive athlete. Every day I would make sure that my team ate well. I would make sure that my team did exercise, and I would run little PFT's in our Command Center. I would make sure that if people looked or sounded exhausted, I would send them back to their rooms to take a nap, and I personally at one point came down with an upper respiratory infection, and I wasn't sure what it was, and Admiral Childs said, "Captain, I'm hoping that you don't have COVID," so I went back to my room, I slept, I took care of myself for a day and a half, and it wound up just being exhaustion and I think allergies from a lot of the foliage there that I just wasn't used to. Many of our days were long. It was between 10 to15-hour days sometimes that we just felt that we needed to be available, not only for the patients but for the medical teams, and also for headquarters back here. Because remember, the time difference was 14 hours ahead of you or behind you, I don't even remember. But we were trying to keep Admiral Giroir and Admiral Orsega, and all of our leadership in the loop, so there were conversations and phone calls sometimes going on throughout the night, where many times we were called, or I was called in the middle of the night to get information to give to Captain Alvarez, to give to Admiral Childs so that he could get back to Headquarters to let them know and have an up-to-date SITREP. It was pretty intense.

JS: Just a quick follow up for that. Once the clearance was provided by the Minister of Health, was it your experience or your understanding that, in terms of the team's consultation

with the Japanese physicians and nurses and other healthcare providers, was there pretty much an openness and willingness to have your participation in the care of these patients?

LB: Absolutely. When these physicians from the Japanese hospitals realized that they were going to be part of a – again, it couldn't really be called a clinical trial because it was for compassionate use - they were I think very excited to be able to participate in something that I think they realized could be an opportunity for them to be part of articles, research, whatever it could be. So yeah, I think that once they were given that permission, they realized that this was bigger than any of us had realized. And I can only say from what I know from the physicians, hearing the conversations between them and the interpreter and Admiral Childs, and then speaking to the physicians that Admiral Childs was colleagues with or who had mentored as a resident back here at NIH, that these physicians understood that there was no communication at all, unless they got that permission. And it was very clear that that directive was taken very seriously. That's the difference I think between their healthcare system and our healthcare system, not to say that our healthcare system gives out information.

I think we all understand that we have our own HIPAA guidelines and things, but to not get any response at all and total hang-ups or no call backs, or no response to anything, and then to have open conversations within 72 hours of getting this permission and having faxes coming in with updated clinical information all day and all night, was something that I think was a great benefit to all, including mostly the patients.

[00:57:39]

VB: Captain Belsito, one of the things that I am really coming to appreciate deeply in doing this project, and I hope that others will really learn about the Public Health Service through this project, is that the depth of expertise and experience that the PHS sort of has on the bench, as well as the expert systems and protocols that it trains officers to be able to employ are of immeasurable value in actually being able to respond to crisis like these. One expression of that, of course, is just implementing that into the command structure, but it goes so much deeper than that. I'm really interested in learning more about how those systems work in an international setting, and what compromises or what alterations you need to make in the ICS, or just basic chain of command when you're interacting with foreign officials, or just in general, how that plays out in an international setting.

LB: Well, I think our experience as officers, nurses, physicians, case managers, our individual expertise was something that fortunately all came together for this mission, because I think that was part of why it was so successful. Regarding the collaboration with the command structure, there seemed to still be some difficulty, but many tiers of leadership that you have to learn how to navigate, who to communicate with, when to communicate with them, who needs to know what and when. And being in a foreign country, I think our experience over there, my experience over there, Admiral Childs had sent me to the State Department to set up a position where I could be right there with them, helping them to navigate the patient information, and they weren't so accepting.

I went up there two or three times and spoke to their leadership, and I went with our ASPR leadership to explain what our role would be, and basically was told that, "We got this.

We're good. We don't need your help." And so, when I came back to the Admiral and gave him the brief, he said, "Well, maybe they just didn't need you then. They needed you at a different time." I wound up going back three times, trying to assist not only the State Department, but the CDC, who had a Command Center set up there as well, and basically was just an extra staff member, listening to what was going on from the periphery, knowing that I could contribute and give information but was not asked to, so I really needed to just do as I was told, and when I went back to report back to the Admiral, that was when we decided to set up our own Command Center and work collaboratively with the in country physicians, and try to get in touch with the Minister of Health.

After I think two or three visits, the Admiral actually made a visit to the leadership at the State Department, and once that meeting took place, they were kind of enamored at how much we were able to accomplish in a 72-hour period, and communicate with the Minister of Health in making those relationships such a positive thing, so then they wound up wanting to collaborate in our Command Center on a day-to-day basis, to see how things were being handled for each of these patients who were in hospitals across Japan. My understanding was that some of these families who were trying to find out information were not feeling as though they were getting the information they needed, and they were very upset, very concerned, rightly so. And those of us who did have the opportunities to reach out to them prior to establishing our communication with the hospitals, the tears, the joy, the thanks that came to say you're the first ones who've communicated to us that know where our family members are, and it was very emotional. It was very taxing on that level to know that we were there trying to make a difference, to advocate for these people, and that our mission was becoming very clear as we were boots on the ground. So, I hope that answers your question.

LP: Hi, Vanessa. This is Laura. Could I ask a question right now please?

VB: Yes. Absolutely, go ahead.

LP: Great. Thank you so much, Captain Belsito, for talking a little bit about your challenges that you faced in this pandemic, and you've already talked about previous deployments that have helped you prepare for your role in Japan. What about your responsibilities in your day-to-day job at the Food and Drug Administration? Was there anything or any experiences you've had at FDA that helped develop you as an officer and who you are today, that have helped you in carrying out your responsibilities while on deployment in Japan?

LB: Well, the work I do with the FDA is kind of unique. I am a nurse. I am a Division of Disclosure, which is FOIA, if anybody knows what that is; Freedom of Information Officer, with Center of Devices and Radiological Health. This role with the FDA, I understand as a nurse and as a case manager, and as a customer service person, that this is all part of what I do anyway on a day-to-day basis in my day-to-day job. Helping requestors, helping sponsors, helping businesses and companies and the public navigate through FDA's processes and the regulations that we have to function under can be difficult sometimes. But knowing the regulations and understanding the work that I do, and understanding and having used a lot of the medical devices that I'm looking at on a day-to-day basis gives me the opportunity to help not only our internal customers, meaning FDA fellow colleagues and staff members who work in my division who are not medical, but also I have become someone in my division that the sponsors, the companies

will circle back to because they know that if I don't know the answer to something, I will try to find the answer for them, or I will do my best to respond to their request in the most timely fashion, within the regulations and within the workload volume that we are faced with every day.

I love what I do. I think that when you talk about public health, medical device review and medical device approval, and what I do for people who are looking to create new medical devices based off other 510(k)'s is very interesting because things have certainly evolved and improved, and I can see how the processes of FDA, under the guidance of Dr. Shuren and his leadership have improved certain processes to help bring things to market. And again, you talk about the compassionate use of the Remdesivir, we got to see that in action. We got to see that happen live, and that was so exciting, to look at Dr. Hahn, who was at the time our Commissioner, and Admiral Giroir and Admiral Childs, and all of those high level people that I've never met, but to be part of that is bigger than I could have ever imagined.

Most of my nursing career was clinical, and when I came to the FDA, it became more administrative, but it shows me, and I think it shows a lot of officers that your life experience, your professional experience can bring so much to the work that you do on a daily basis for the FDA, and it's just a matter of finding that position or that niche that you love. I love going back and forth with sponsors. I love going back and forth with requestors, and explaining to them what are the FOIA exemptions, what are the regulations, I thought this was free, all of these kinds of things that you try to help them navigate our internal processes and our website, which sometimes is not real intuitive. I think it's a great place to work, and like I've said to people, I don't know if I will ever leave. I love the work, but the deployment part of it, I believe that our leadership understands that as the Commissioned Corps evolves, that we are, at times, asked to deploy, and I know that those directives have changed. But I personally feel as though there are

certain missions, as a nurse, as a leader in the nursing category, and someone who has mentored a lot of junior officers, I want to be part of some of those missions that are life changing, and I think having great communication skills, having organization skills, leadership skills, all of those things don't just happen in one's career.

I'm still learning. I still look at leaders who I want to emulate. I still look at Admirals and Captains who have mentored me, and I just hope that as I've been taught in life by my family and upbringing, that you want to lead by example, and I've always felt that service is something that I've always wanted in my life, and this has sort of just been a culmination of everything that I've experienced in life, with education and life experience, nursing experience, Commissioned Corps experience, and it just keeps getting better.

JS: Captain Belsito, I wanted to ask a couple questions about the transitions that may have preceded your arrival, and some took place after your deployment ended. I'm curious, there's so many moving pieces here, and moving people here, and I know there were a large number of passengers on the Diamond Princess, many of whom were US citizens. Can you clarify a little bit how many of those were folks that could transition and go back to the US fairly promptly, and obviously a number had to remain and receive care. How were they transported from place to place, whether it's to clinics or to an airport or what have you, and was there sufficient PPE in use to protect these patients as far as you're aware?

LB: Well, from what I know from Team 1, in speaking to the patients that were evacuated, again, I don't know what the total roster or manifest was on the cruise ship, because sometimes cruise ships can hold 3,000 people. Our mission was to identify the 416 American citizens who

needed to be taken off that cruise ship. What we knew was all 416 patients or passengers were removed from the ship. Now that would be excluding the hundred or so who had been sent from the ship via ambulance to a hospital because they were experiencing shortness of breath, or fevers, or some other symptom.

The patients who were experiencing no symptoms were loaded from the ship onto buses, and then brought to the airport, and then I think there were either chartered flights or flights that brought them back to the US, to the evacuation centers that were set up on the west coast, and I think they were in multiple different military bases. As far as the patients who needed to be brought to the hospital, who were in, I don't want to say critical, but in a worse medical condition, there were ambulances that were taking patients off the cruise ship onto the ambulance, and brought to the hospitals throughout Japan.

The PPE that I know our staff was wearing were gowns, gloves, masks, goggles, shields. Some had the bouffant hats, and basically that was it. It was the N95 masks, which all of us had been fit tested for prior to arriving. We were all fit tested at the airport, either en route to Japan or upon arrival to Japan, but most of us were fit tested I think midway when we stopped in California. Most of us did our fit testing there, and then proceeded on to Tokyo from there.

OB: Captain Belsito, as a follow up to John's question, it was good to know that we were grateful to have a healthcare facility in Japan that took care of our sick patients until they felt better. I was wondering, was there any guidance for them to seek further treatment once the sick patients returned from Japan to the US?

LB: I'm sure that there was. What I do know is that a lot of these patients who were critically ill, many of those patients required rehabilitation because they needed to get their strength back, they needed to get their respiratory capacity back, they needed to get their ability to walk back. The Japanese healthcare system made all that available to all of these patients, and when they were discharged from rehabilitation, they were then transported back to the United States, and I believe that when they get back to the United States, that was when our other team at NIH would follow up with those families to make sure that they had all the information that they needed to follow up with their providers when they arrived back into the United States. I believe that the case management part of that was ongoing, once they were discharged from the hospital, discharged from rehabilitation, and able to get back to the United States.

One of the stories that I believe resonates with all of us was a case that I was involved with the family, and the patient was in his 60's, Asian descent, and the daughter kept calling me and telling me that her dad was in a bad way. And I tried to understand what she was talking about, and she said that he was in the hospital and he was on oxygen, but that he didn't understand anything that anybody was saying to him because of the language barriers, and the difference in maybe their pronunciation if they could speak English.

[01:20:08]

When I started to dig a little deeper, what was going on was this was a gentleman who, like many older people, are not very technologically savvy with cell phones. He had a flip phone, but he hated using it because he didn't really know how to text. The other thing with this patient was he was deaf, and he had hearing aids, but they weren't really working the way that

they should, and I think between the language barriers, the inability to hear and understand what was going on, he was alone, he couldn't communicate with is family, his wife, his daughter, and it was a very difficult situation. His daughter called me and sent a text to me, that "My father is making his funeral arrangements. My father is telling us that he is not coming home, and he's probably going to die," and wrote this to me. And there's a text with his funeral arrangements. When I heard that, I really had to, I don't want to say yell, but I had to call attention to Admiral Childs and say this is real. If we don't pay attention to this, this man is going to die, not from COVID, but he's going to die from failure to thrive, or inability to communicate with other people because he's alone.

This is a mental health issue that we need to get on this immediately, and I think he understood in the tone of my voice that I've dealt with patients like this before, and making sure that they can hear, that they can understand, that they can communicate with their family is huge, and so we made that happen. We made that happen for this patient through either a white board or communicating with his daughter, but this man survived. And to see this man being discharged from the hospital with a smile on his face, going back to his family was huge for all of us. It was again, a very emotional case, but every case had its own little unique mission that from day one, when we first started making those phone calls on February 18th, this family kept saying, "My dad is hard of hearing. He's not able to communicate, he doesn't understand what's happening. He's in the hospital but he can't really give me any information, and I'm very concerned that he's not going to make it." But he did, so these are the kinds of stories that we were part of it, and that's part of what we did on this mission.

VB: Captain Belsito, that is such a moving story, and I'm so glad that it had a happy ending. And it suggests to me in part that perhaps that those kinds of experiences helped to make sure that the mental health dimension of this crisis was on the PHS's radar from the beginning. I know that that was an important component of the response throughout, both for patients and for officers to the extent that they needed mental health support, and as you said, it certainly points to the need for personalized attention to each case. I wanted to ask, since you had close contact with these patients, particularly the evacuees from the cruise ship, did any of them share their stories from when they were on board? It sounds like such a harrowing experience, and something that maybe they needed to talk about, and I certainly wouldn't want you to compromise their privacy or any of those details, but if they did share stories that you could relate to us, we'd be grateful to hear about them.

LB: Well, most of our patients were non-communicative and pretty much ventilated, so there wasn't a lot of communication with them specifically. Some of the family members who were on board, like wives or husbands or friends who had accompanied them on the ship – I did not have any personal conversations with them, but from what I know from the stories that were told to us from the team that took them off the ship was that nobody had any idea what was going on. They were pretty much quarantined to their rooms and not able to leave the rooms, but yet, they were being given food and nutrition and everything that the cruise ship has to offer, but I think a lot of them were in a state of I guess disbelief and fear to some point, because nobody really knew what this was, or what was happening, and how it was going to all turn out. And of course, once families knew that certain patients were sicker than others and some critical, all they

wanted to know was that they were going to get to talk to or see or understand what their family members were going through.

We had another couple where the wife told us that she didn't get sick, her husband got very sick, and when Admiral Childs met with her at the hospital, this is a couple who had been together since high school, and they considered themselves a peanut butter and jelly sandwich and that they never went anywhere without each other. We have video of this patient, the husband, who at one point was starting to do better, and the nurses brought an iPad into the room when he was starting to wake up, and they were video chatting his wife through the iPad, and when you see him turn to the iPad and reach for the face of his wife, it just like - you can hear my voice now, it destroys you. These two are so connected, and to see him responding to her, and knowing that he's hopefully on the way out of that critical condition, but to let him hear his wife's voice and see her face – there's another picture that we have in our presentation where he's awake, he's sitting up in his bed. He is still ventilated and he writes on a white board, "I love you, I owe you," and that was sent to us.

These are moments that I don't even know who these people are, and it still today brings tears to my eyes. You would hope that all of us never have to be in that situation, and I think as someone who has been a nurse for so many years in different settings, from neonatal ICU to critical care, to high tech home care, to home hospice, as I said in my interview when they did the video for our presentation, you realize how precious life is, and nobody is promised tomorrow, and if you can make a difference in one person's life, one day of your life, then you've done your job. And I just feel like we were called to do this. For some reason we were put in the right position at the right time for the right reasons, and luckily, all of our patients that we cared for survived. Again, I just feel honored and blessed to be a part of this team.

VB: It's just so moving to listen to these stories, and frankly, it brings a tear to my eye, too. I'm really grateful that you all were there for these people, and that so many of the stories turned out well. I want to return to the point I raised earlier about the mental health dimension of this crisis for officers. It seems to me that this is a really emotionally taxing and I imagine emotionally rewarding too in some ways. There's a spiritual element and an emotional element that really takes a lot of energy, and I was wondering what you and the rest of your team did to provide or to find emotional support, or to provide an outlet? You had these extraordinarily long days and really, really heavy issues you were dealing with. How did you offset the tension?

LB: Well, as I said, there were times where some of us would take breaks and rotate in and out of the Command Center to take a nap or go to the gym. There was great food over there, and there were great opportunities, so we would send different people out to get different types of food for us. And after the day was over, there were quite a few nights that we all sat around and just talked about the day, and really got to know each other. There were a couple of nights where each of us went around the table and said, "Just tell me who you are, tell me why did you get selected for this mission?" I think in this situation we were able to create a bond amongst our small group that to this day, we text each other every day, we have our own little WhatsApp chat group. But there were times where many of us had our meltdowns.

When people would call home and talk to their families, their children, and for myself, I was missing something that I'm very involved with, I am the head coach for the Wounded Warrior Program for the United States Marine Corps, and that's part of what I do outside of the Commissioned Corps as part of my collateral outside activities. In 2020, I was not able to go to

the Marine Corps trials that I've been part of for the past six years as the head coach. But I was able to put athletes that I've worked with and trained in place to do that for me, and that was hard. But I knew that I was in a place where I needed to be. They are all military, they're all Marines, they understand the call to duty. They respect me for my leadership and my role in the Commissioned Corps, as a Captain, and even to this day, we as a group, we long for getting back together again, because when we came home on March 6th, that was the last we've seen each other, and it's been almost a year, and aside from a Zoom call and a couple of texts, and trying to meet up to say Happy Holidays and things like that, we haven't seen each other, and that's hard.

Some of us I know, have engaged in counseling because there are a lot of things that we have experienced in not just this, but other deployments that trigger some PTSD feelings and situations, and you have to be able to deal with them in a healthy way, and we tried to do that while we were boots on the ground. One night, actually two nights, Admiral Childs said, "Okay. We're going to end early tonight. We're going to stop at 8 o'clock, and I'm going to take you all out, and we're going to go touring, and we're going to go to the Tokyo Tower, and we're going to see a little bit of Japan with our own eyes and experience it, except not from a hotel room." So, we did, and those two nights that we did get out of the hotel and do those things with him were fun. They were exhausting because I think we walked five or six miles with him, at a very fast pace because that's just who he is. To see a lot of different things and to experience Japanese culture, and that was refreshing.

He got it. He understood. He knew that we were all doing above and beyond, and I don't think he slept more than one or two hours a day, but we were all there for each other, and had to have that comfort level with saying to one of the other team members, "you know what, I've had enough", or a team member saying to another one, "you know what, you're a little distracting

and I need you to go lay down for a little while, and come back when you feel better", and that's okay. It's not a punitive thing, it's take care of yourself, but do it in a healthy way.

One night we were able to go out and get a nice Mexican dinner, even though we were in Japan, but it gave us an opportunity to see the Japanese culture also likes Mexican food. It was kind of a fun twist. We danced a few little dances to the music that was on, and then we came home. We tried to keep ourselves healthy, but again, being so tired we had to make sure that we got our rest because we knew that the next day was going to be - we didn't know what it was going to hold, but we knew it was going to be a long day.

VB: So when your deployment came to an end and you had to transition back into your role at FDA, it was just before we all went to full time telework, and just before the pandemic was declared. How did you move from this total experience of your deployment in Japan back to your normal life and normal tour of duty, and have to confront the way the pandemic was escalating in the US at the same time?

LB: It was tough. I think the biggest ah-hah moment was when Commander McBride and I flew back on one of the same flights from Tokyo, once we left the other team members at the hotel and went our separate ways. We left Tokyo to come back to the States, at that point Tokyo was already doing whatever it does to protect its citizens. We were familiar with what was happening here, and we knew what was happening from where we stood. What hit both of us the hardest was when we landed in the United States, and we and the Japanese coming off this aircraft were the only people in the airport wearing masks. And people were looking at us like why are you wearing a mask? And the two of us just kept looking at each other, and it was

almost like you know the tsunami is coming, but you can't say anything about it, or you think something bad is going to happen, but you're not allowed to talk about anything that just occurred in the past three and a half weeks of your life.

[01:39:51]

So, we proceeded to get on our aircrafts, kept ourselves protected, got back home, and it was kind of surreal because I think when you come back, you have this adrenaline shift, and you try to relax but you can't. And when we got back, of course we were quarantined for two weeks, so we were home. I think I slept for three days when I got home. I mean I did wake up obviously to eat and shower and stuff, but I was emotionally and physically exhausted. We did come back to work, I think it was only one week, and then we went complete telework.

I had only been in the office maybe once or twice during that time to get things to bring home, but it's hard because my leadership is all civilian, and as much as they try to understand what we experience on these deployments, I really don't think they have any idea how hard it is. I couldn't just flip a switch. There were nights where I cried. There were days where I didn't sleep because you were worrying about what was going to happen, and then when we saw what happened, and saw how the wave hit the United States, even to today, it's very concerning and very sad.

We lost a lot of lives. Would it have been different? Could it have been different? I don't know. I'm sad, you're feeling like you want to do more but you can't. You want to be there and you want to help, but you don't know how. And even if I did, there's no telling that it would make a difference, and in a way I kind of think that if they wanted to send me out again,

which they did call me three weeks after I was home, and I asked them if they were kidding, that I was not ready. It just becomes something that - we're not bulletproof. We're still human, and when you see all the pain and suffering that's going on, and you are one of those people that wants to help, but you can't, it's rough.

This deployment, Katrina, and a couple of the other deployments I've been on, they've left their marks. I have had other experiences in my career where before I came into the Corps, I responded to the Avianca plane crash in Long Island, back in 1996, and was on duty receiving patients from that. There are a lot of things in my life that I've been exposed to that other people haven't. You always want to be there front and center, but you have to understand that sometimes it's time to pull back and take care of yourself, and I've been trying to do that, and it's been tough.

JS: Captain, when you started your quarantine or even soon after, did you reach out to any of the teammates that you served with in Japan?

LB: Yeah, we did. We would either talk or we would do a Zoom call with the Admiral. We did a couple of distance calls and emails and things like that, but as far as the being in person, I haven't seen anyone in person except for one of my officers who actually stopped by the gym that I own and wanted to get a workout in to just do some stress management. So that was it. We do talk to each other a lot. We have WhatsApp that we keep in touch almost every day, but it's not the same. Every time we do a Zoom call, everybody gets emotional. Everybody understands that you were a little unit, a family for a very short period of time, and now you're back out on your own, but you have a bond and you can't really explain it.

VB: So Captain Belsito, given the fact that you served in I'm assuming the first, if not one of the first deployments in this response, and you have this very unique perspective from that experience, and of course have experienced and witnessed how the pandemic has progressed since then. Considering your deployments, both for 9/11 and for Katrina, and any others that have had formative impact on PHS, do you foresee any particular aspects of this pandemic having significant lessons that can help PHS improve practices going forward for future responses?

LB: Absolutely. I think every deployment, every mission since 9/11 has given the Commissioned Corps an opportunity to try to prepare its officers and teams for the "what if's" in our careers. I remember 9/11, there really wasn't a readiness force that was called Commissioned Corps Readiness Force, and there wasn't really any rhyme or reason to anything. I remember people just running into the pile. Admiral Babb at the time was the leader of the Commissioned Corps Readiness Force, and I know that there were a lot of officers who went to the pile, not knowing what they were being exposed to, not knowing that their shoes were going to melt because of the heat, because officers were showing up in khakis and regular Bates shoes.

Then Katrina, that deployment, where we thought we would only need to set up evacuation sites, and of course, all of this, excluding 9/11 because nobody would have ever imagined that that could or would happen, but it did. Preparing for hurricanes and disasters and things like that, it's something that on a local, state, and regional level, many are prepared for. The reason I say that is because as a nurse who did home care and also high-tech home care for home hospice patients, and patients who were very ill, oncology patients and such, who were

home on pain management pumps and TPN and other things. Our first call to action in caring for those patients is to make sure they know how to care for themselves or have someone to step in to care for themselves for them in the event of a disaster, a snowstorm, a power outage, whatever it is. As much as that seems simple, those are the little plans that we, as the home care nurses, and division, and company, would make sure that everybody understood.

There was a call-down list, there was a roster, there was this. I think that in a lot of ways the PHS has tried to respond to all of these different disasters, and each one is unique and requires a different skill set maybe or a different type of response, but with this current one, it turned into a public health disaster I would call it I guess, or pandemic, and you've got your infrastructure I guess you would say, of Public Health experts who were trying to sound the alarms and create a situation that might have helped in the response, but again, there's so many deep levels to how this evolved, and how the response could have been better.

I don't know. I think it has opened up the eyes again, from our leadership, and meaning top down from our President all the way down to how do we prepare our Commissioned officers for going out the door, and the issue seems to be that sometimes you have groups that are trained. I think in this situation you certainly are using your epidemiology teams, your scientists, your doctors, your nurses, your CDC employees and stuff, but the models that I think we try to implement sometimes try to mimic what the DOD has as an integral part of their infrastructure, that they plan, they train, they go. They have teams, they have commands, they have troops who are trained up and educated, and trained to do X, Y, and Z.

Sometimes our deployment teams aren't as well organized as they need to be, and again, we are augmenting other State and local and Federal authorities. I'm hoping and from what I understand, we have been given the funding to do what needs to be done. I know that years ago

they had talked about creating hammer teams, which were going to be teams of 150 officers who were civilians, or possibly Commissioned officers, who were stationed to certain assignments within the Commissioned Corps while they were not deployed, but at the assignment notification that there was a mission, these officers would then be pulled from wherever they were and sent out, and that was really their assignment category, was to be an emergency response officer. That was it.

I don't know whether that ever came to fruition. I know they tried by creating RDF1, RDF2, and then the RDF's all the way down to 5, but again, remember, we're a different type of agency organization, where each of us is assigned to a certain agency for a specific position. That's sometimes where the difficulties come in, with having officers being out on a mission for extended periods of time. I don't think there's any officer who doesn't want to serve. But I think as we go on, what you're hearing is people are physically and emotionally exhausted. And I don't know how long that can be maintained, but I hope that the leadership hears the message, and ultimately, I don't know what the answer is to that, but maybe they will eventually through their Ready Reserve Corps, through their creation of these new Public Health Emergency Response Teams that they've started advertising for; the country still has DMAT teams, the country still has emergency response mechanisms on the local and State, and it really becomes our mission.

What I've learned through all of this is the difference between ESF8 activation and ESF6 activation, and when the President activates ESF8, that's when we go, and in some other missions such as the Repatriation after the Haiti tsunami there was ESF6, which is a mission that starts after the disaster, and you start to repatriate. It is more of a case management role, where you're helping the locals get their patients or citizens back to where they need to be in country,

or to the United States, or wherever they may reside. I know that after 9/11, myself and nine other nurses and ten other pharmacists were selected by the Admirals at that time to create national nurse response teams, and national pharmacy response teams. I remember being in my duty station because I was on the nightshift and working on this mission that I was assigned by the Admiral to create a nursing team of 200 for Region 2, and there were ten of us across the country that would have given us all those extra assets to Federalize in the event of an emergency. And I know I completed that mission, and I believe my other colleagues did too, but when you do all this work and you put all this effort into recruiting and screening, and creating and getting credentials for. I wonder where did all that go, and what happened to that?

I think sometimes we go through a lot of changes in leadership and changes in administrations, and I know we have to go through that, but that doesn't mean we always have to recreate the wheel every single time. I think we have to start looking back at our lessons learned, and listen to those of us who've been there, done that, seen that, and try to carry forward the positive lessons learned, so that we can make our responses better in the future.

[01:59:19]

I don't know if they're talking about that, how they're talking about that, but I would hope that all of those officers who have been so much part of our Rapid Deployment teams and SAT teams, and Patient Advocacy Teams that we developed years ago, would use their experiences and hopefully create a template for what could be for the future. But it all has to come down to training and support. Hopefully now we will get that, and maybe moving forward,

the Commissioned Corps will be more efficient and more effective in some of these high-level deployments that we're being asked to assist with.

VB: Thank you so much for sharing those insights. I thank you so much for sharing everything in our discussion this morning. I'm really grateful for the opportunity to learn about your experience and to learn from you. I really want to thank you for participating in this project. I don't know if anyone else has a question they'd like to raise before we close the interview, or Captain Belsito, if there's any other comments you'd like to include before we finish?

LB: No, I think the questions were pretty specific and pertinent. I hope that I've answered them the way that you needed them to be to get the information that you need. Again, these are my personal and professional experiences and opportunities that I've had with the Commissioned Corps, and as challenging as they have been, like I said in the beginning, I don't think I would change anything. I think that coming into the Corps gave me new opportunities to serve the nation, my country, my corps, and my patients on a whole different level that I never even knew existed. I feel like I have lived a full career and want to finish out my career in a respectful manner, and hopefully others will do the same.

VB: We're so grateful for your service, and that there are people like you that our country can depend on in a crisis. Thank you, Captain Belsito.

LB: You're welcome.

VB: I'm going to close the recording.

[END OF INTERVIEW]

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