



**FCON COVID-19 Deployment
Oral History Interview
CDR Deborah Belsky, MD, MPH
and
CDR Lei Xu, MD, PhD**

**FCON History Committee
FDA History Office
Collaborative Oral History Project
Edited Transcript
Date of Interview: June 4, 2021**

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Oral History Abstract

In this interview, CDR Deborah Belsky and CDR Lei Xu discuss their deployments as Public Health Service officers who are in the USPHS Commissioned Corps in response to the COVID-19 emergency. CDR Belsky is a Medical Regulatory Reviewer in the Center for Biologics Evaluation and Research (CBER) at FDA. During her deployment she served as the second Chief Medical Officer for the newly formed command center at CCHQ. Her responsibilities included policy development and implementation, medical oversight of deployed teams, including potential exposure or illness with SARS-CoV-2. She conducted risk assessments for returning officers to determine safe to return vs. quarantine period, and COVID-19 testing for officers. Lei Xu is a Medical Officer at the FDA. She also serves as a medical officer in CBER at FDA. During her deployment she screened international passengers at the CDC quarantine station at San Francisco International Airport for possible COVID-19 infection. She also worked with FDA's COVID-19 Contact Tracing Programs as a medical officer in the Risk Assessment Unit to assess FDA employers nationwide who were infected with COVID-19 or had close contact with people who had COVID-19.

Keywords

Commissioned Corps; contact tracing; COVID-19; deployment; medical officer; quarantine; personal protective equipment (PPE); San Francisco; SARS-CoV-2; screening; testing

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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 |

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Interview Transcript

VB: This interview is a contribution to the FDA Commissioned Officers Network and the FDA History Office and PharmPAC Collaborative Oral History Project to capture the experiences of Commissioned Officers in the COVID-19 emergency response. I am Vanessa Burrows from the FDA History Office.

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

VB: And we are conducting this interview via phone on June 4th, 2021. We are joined by Jen Eng from the FDA Commissioned Officers Network. Jen, would you please introduce yourself?

JE: Sure. Hello everyone. My name is Lieutenant Commander, Jen Eng. I am with the Office of Regulatory Affairs with the District of Northeast Imports. I am a Consumer Safety Officer located in Baltimore, Maryland. I am also with the Food and Drug Administration's Historical Commissioned Officers Network Committee. Thank you for having me.

VB: Thank you so much. And today we are going to be interviewing Commander Deborah Belsky and Commander Lei Xu. Commander Belsky, would you introduce yourself, please?

DB: Sure. I'm Commander Deborah Belsky. I am a family physician by training and I work in the Center for Biologics Evaluation and Research, in the office of Tissues and Advanced Therapies in the General Medical Branch 1. I have experience with being in the Air Force for a little over seven years prior to my joining the U.S. Public Health Service.

I had separated but had other government experience namely a fellowship at the U.S. State Department through the American Association for the Advancement of Science. That

gave me familiarity with the State Department processes. Also, many years ago I worked [as a staff assistant for] the House Armed Services Committee at the U.S. House of Representatives.

I have experience understanding the legislative process and I came into the Commissioned Corps of the U.S. Public Health Service initially at the Bureau of Primary Healthcare and the Health Resources and Services Administration as a senior clinical advisor for the Health Center Program.

VB: Thank you so much. Commander Xu, would you please introduce yourself

LX: Hi everybody. This is Commander Lei Xu. I'm also with the FDA's Center for Biologics Evaluation and Research, also known as CBER, Office of Tissues and Advanced Therapies, OTAT. I'm a Branch Chief of one of the clinical branches within the Office. I'm a neurologist by training. I have been with the PHS Commissioned Corps for seven years.

VB: Wonderful. Thank you both very much. And before we dive into any details about your deployments, it would be great if we could clarify the dates of your deployments, where you went and the role you played. Can we start with you Commander Xu?

LX: I was deployed twice. The first one was between February 19 and March 18th, 2020, and I was deployed to San Francisco International Airport, the CDC quarantine station. I served as a Medical Officer conducting the screening of international passengers who came from the area where COVID-19 was in pandemic.

My second deployment was a virtual one and it lasted a month. It started on December 21st, 2020, and ended on January 19th, 2021. It was an FDA wide remote

deployment for the FDA's COVID-19 Contact Tracing Program. And again, I worked as a medical officer in the Risk Assessment Unit and to assess FDA employees nationwide, who were either infected with COVID or had close contact with people who had COVID.

VB: Thank you very much. Commander Belsky, would you please briefly tell us about your deployment?

DB: I was deployed to the Commissioned Corps Headquarters Command Center as a Chief Medical Officer during the period, June 9th through July 10th, 2020. I did go to the headquarters to work and on weekends I worked from home during that period of operations. So, I wasn't deployed far away from home. I was fortunate to come home at night, but still carried on my duties as needed.

VB: Great, thank you very much. So now I'd like to dive a little deeper into your deployment experiences. Let's start at the beginning, how were you contacted and how much warning you were given that you were going to be deployed? How much information you were given about your assignment and do you have any insight into how your assignment was determined. Let's start with you Commander Belsky.

DB: I was contacted, I think it might have been as many as three weeks ahead for this particular deployment. It was two or three weeks, it's hard to recall now. I was contacted by the first Chief Medical Officer of this newly established Command Cell at Commissioned Corps Headquarters.

Commander Erica Radden reached out to me to find out, first of all, if I was interested in the position and whether I would be available. I'm going to back up for a second because

now it's reminding me that I think I had received an email generally about my being potentially deployed at some period of time. I might have received one of those first emails. So, I think I was somewhat expecting something to come down, but we had gotten emails that sometimes didn't yield a deployment.

When I got that phone call, I was really very flattered to be asked to be the second Chief Medical Officer of a newly established Command Center Headquarters. The purpose of it was to oversee the officers who were deployed and there were a number of responsibilities associated with that. So, I had a little bit more lead time to get clearance and to prepare myself for the fact that I could be deployed.

VB: Thank you so much. Commander Xu would you please tell us about how you first learned about both of your assignments and just what that experience was like?

LX: For the first deployment I remember I was notified toward the end of January, first via email and then via a phone call. In the first e-mail I was told we may leave pretty soon, but it took some time to finalize the date of the departure. I knew I would go to one of the 11 airports, but I didn't know where exactly until a few days prior to the deployment. For the second one, I think it was clearer. We were first contacted by email to [identify people who would be] interested in volunteering, and they gave us options of dates to choose from, and I think a few weeks later they just honored our choices.

JS: Thank you very much. I wanted to follow up with both of you briefly. I know it must help to have a little more advanced notice, but in terms of the workload that you had at FDA at the time you left, do you know how that was accommodated by the agency during the time

you left? If arrangements were had already been made in anticipation of your deployment or were some other arrangements made? Could we start with Commander Belsky please?

DB: I'm trying to remember, because I had a number of different occasions where I was nearly deployed, and so they came at different times. I had quite a workload. We always do in our group, it's a tremendous workload. And because I had a few weeks my team lead and branch chief, knowing that I would deploy, reassigned work to other members of our team.

Of course the workload increased on an already high workload for my team members, but I worked very diligently to clear just about every aspect of what would be due in the days that I work, either ahead of time, or that would be due during the deployment period so that it was easier for anyone covering for me to take over because these are complex files.

We review cell gene therapies and many, in this instance of the pandemic, I had COVID-19 files – that whole range of work. So, I think we also had reached out already for detail assistance from other centers. So, we had some support from outside our group for a period of time, which I think may have helped. Honestly, I can't remember exactly who might have been there or added on in my absence or whether they were coming anyway.

It was never easy. It was always a burden for others to take on my work. But I was able to, in this instance, clear a great deal of deadlines so that it would be as easy as possible to cover what was already assigned to me.

JS: Thank you very much that's helpful to know. Obviously, you must have been working very long hours in advance. Commander Xu how was it handled when you had to leave? I know it must have had a huge workload.

LX: Thank you, John. For me, I think it is hard. For the first one it was the start of the COVID pandemic. So back then we had not gotten a lot of files related to COVID. But even with the usual workload and with nine people under me, it's just a lot. So, I have to let my Team Lead know, and let my Division Director know that I'm leaving, but that I would try to cover as much as I could.

Because of the three-hour difference between San Francisco and east coast I was able to do some work in the morning before the hour starts which is 7:00am Pacific time. And then I will have to wrap up some work after I'm done there. But still over that one-month period, because of the miscommunication that occurred, at some point, I still lost one of the reviewers to the other center.

With the second deployment I was placed on the exemption list to not be deployed. So, I promised my Division Director, I will continue doing all the responsibilities for the [Division]. At meantime I will do the contact tracing because I really want to contribute to the COVID – basically for that second 30-day period, I worked almost double the usual time to have both responsibilities completed.

VB: That sounds incredibly demanding. And especially with the time difference I can't imagine how you juggled it all. Thank you for sharing. Lieutenant Commander Eng, would you like to ask the next question?

JE: Sure. Good afternoon again, everyone. My name is Lieutenant Commander, Jen Eng, I will be asking the next couple of questions. First of all, I would like to thank both of you for your service on these deployments during the pandemic. I'm sure they're really demanding. But you're both very skillful so you're service was needed.

Before we get into some of the details of the deployments, Commander Belsky as a second Chief Medical Officer for the new Commissioned Corps Headquarters Command Center, could you briefly describe the formation and function of this organization? Was it based on previous organizations assembled by the Public Health Service to deal with public health emergencies?

DB: That's a very good question. The Command Cell was set up with a Command Structure with a Commander, a Deputy Commander, an Operations Chief a Chief Nurse, a Chief Medical Officer, Safety Officer, and an Administrative Officer. So, it was set up as one would imagine a command structure would be set up. I personally had not worked in an Incident Command although I've learned about it, so I can't speak to if it like something else I'd done with the Public Health Service, but it was set up as I believe many of the prior Rapid Deployment Force Team structures were in that you'd have these different roles and responsibilities.

So, it was set up as any Command Structure might be set up. I think you asked about my responsibilities as the second Chief Medical Officer and I would say that when I did have two days of onboarding with the first Chief Medical Officer, and maybe it was a week, I can't even remember, it was so busy, but I think it was two days, anyway it was a very busy environment. There were constantly mission requests. There were mission changes. There were possible missions, and if you can imagine that all of this is going on, the staffing of missions, the oversight of missions, it's newly set up. When I came in, there were teams that had been sent out under some rules of engagement that then changed midstream.

We can get into that a little bit later, but my overall responsibilities included addressing any medical or health concerns during deployment, that is these teams of people, and if someone got sick, whether it was suspected COVID or other things, they might contact

me about it. I also provided pre-deployment medical and safety briefings to officers to establish a safety culture on deployment, in the setting of the SARS COV-2 pandemic to determine, and this was a very important part of my work, to determine COVID-19 risk exposure, prior to demobilization home. I established processes and operating procedures, maintained current guidelines that they were up to date and in place to support deployment operations and even create those guidelines.

I also coordinated SARS COV-2 testing prior to demobilization, which was actually no small task. And I collaborated of course, with the Commissioned Corps Headquarter Command Center staff, other stakeholders, like Corps Care for folks, and ASPR, I forget the acronym, but the preparedness and response folks who usually would be responsible for deploying people.

What I want to say about why – I think an important part of this is why was this command cell stood up? What was the reason? In the Commissioned Corps it's a limited number of staffing to do command and control over deployment and ASPR if we can look up what that stands for. I'm sorry, it's just escaped me, deploys our officers and they're usually responsible for us. They just send us out in the field, but it can be quite difficult to have communication back to and advice from the Commissioned Corps Headquarters or leadership in Commissioned Corps Headquarters should there be questions.

With the number of deployments and officers that were sent down it was felt that we really needed to have some administrative control and some kind of oversight to ensure that missions were carried out safely, that the execution of the mission was done, that we ensured the safety of our officers when they came back that they would not be a risk to their families when they came home, and all of those added pieces that would otherwise not be present.

It would just be you deploy and then you come back, and you didn't have this kind of space to debrief to prepare you and all of that in between. And so that was the real why for it. And I thought that was a really great decision by Headquarters to set up this Command Cell

JE: Wow, what you did during your deployment was very impressive. And two days of onboarding –

DB: It might have been longer, I can't even remember. I feel like it was two days. Maybe it was more, maybe it was a week, but I don't think it was a week. I really don't remember. I have to think about it. It's been awhile, it was a whirlwind.

JE: Yeah, I bet. And the way you're able to – the ever-changing response again, thanks for your hard work. And I can help with the acronym of ASPR. It is for the Administration for Strategic Preparedness and Response.

DB: That's right. Yes.

JE: Thank you. Commander Belsky, I'd like to move on to the next question. Put yourself back in the time when you first deployed, Can you tell us about what your knowledge, awareness, and impressions were of this public health emergency at the time. What concerns did you have about deploying at that point in time and tell us your first day on duty there, and this is for you Commander Belsky.

[00:19:51]

DB: Okay. You're asking about my impression of the pandemic generally? Let's see we were in June at this point, and we had locked down here locally around March. Kids were home from school, people were out of work. I had a lot of concerns about how people would feed their families. How would they pay their rent? I was very concerned about all of those things that many people were concerned about. And just general living concerns when people could not go out and work. And also, about the safety of our family and community and the general safety of people around and how we could protect ourselves.

I think at that time, we were just realizing that masks were good and it wasn't too long before that, that masks weren't recommended. It was just for people who were doing healthcare. It was a changing paradigm of what we were learning about transmission, about whether it was contact transmission, whether it was aerosol, whether it was droplets and there were a lot of unknowns and it was important just generally to be cautious and it was kind of a changing world and environment, especially here in the family with the children, and how we all interact with each other. So those thoughts were going through my head of course.

And then I think at that point, we weren't even in the point of thinking about variants, we were really just thinking about how do we deal with what we have and how do we prevent surges like in New York and other places around the world.

I was still prepared to go and work wherever they would send me, whether I was to do clinical work or however that might be, and we would do what was necessary to protect ourselves with N95 masking and personal protective equipment. But of course, there's a background concern of no one wants to get this. I think everyone pretty much felt similarly, but that didn't really stop my willingness to serve. It was very important what was going on.

So when I was asked to deploy to headquarters, it was the first time really going in person with a group of people, in a work environment where we all wore masks. At that time, we were still doing temperature screenings and those kinds of health checks. We were very

careful at headquarters. Every surface that we touched, we wiped down. We couldn't really practice full, appropriate social distancing, but we wore masks, they were cloth masks.

The only space that we had maybe a little bit more risk of exposure to each other was in the break area, and even then, one of the things that I often would do is give a signal like, let's spread apart a little more here. We tried to maintain safety in our work environment and there were occasionally some scares or concerns.

I think it was in the first week of my being there or the end of the first week I actually worked from home because I felt like I had a sore throat. So, I got myself tested and stayed home and worked and I was fine, but we were very careful for the safety of each other if that answers the question. Maybe there's more to the question, but that's what I remember.

JE: Great. Thanks for that Commander Belsky. Do you recall how your first day on duty went?

DB: My first day on duty, I was with the first CMO who was actually there for, I think, seven weeks. It was a very long deployment and a very intense deployment. You can imagine setting up for the first time a Command Center, that's going to oversee missions.

There were a number of missions that went out with one paradigm about return that then changed, and that was challenging to work through. And there were needs that could not be fulfilled at the time with the first CMO that were pending that I would have to somehow understand, pick up and create and do. So, it was very hectic. It was busy and it was very hard for my onboarding really, because the CMO was very busy from moment to moment, it was a very busy position. And that was not really what one might think, like people were sick in the field, it wasn't like that. It was just so many policy questions and testing questions and just a lot going on to get this newly established Command Cell functioning to create the right

operational procedures discussions about safety and just learning so much about the CDC protocols and how to interpret what they had written in the environment where our officers were working.

There was a lot going on. It was extremely busy. I was really very honored to be selected and to be there. And of course, my intent was to do the very best I could and work as hard as I could to ensure the safety of my fellow officers and make the smooth functioning command operation. That was paramount. I wanted to do the best I possibly could do.

JE: Great. Thank you so much again for your service and thank you for answering the questions, Commander Belsky. Back to you, Vanessa.

VB: Thank you Lieutenant Commander Eng. Commander Xu, can we turn to your deployments now? And could you please tell us about – bring us back in time to February 2020, when you were about to leave for San Francisco, what was going through your mind, what you were your impressions of the emergency response at that time, and then what was your first day like when you arrived for your deployment?

LX: First of all, there was a lot of confusion because there was a lot of email communications between myself and the CDC quarantine station at the airport and also the people who were there as Logistic Officers. And so, there is a lot of things to make sense of. For example, I had to get a special ID to get into the airport at the international passenger area. And before that, I had to go through a two-hour training at the airport and pass a test. So, I had to figure out which, and what do I need to do and before I can even start my first day.

And after that, I think my first day was a little bit confusing to people over there as well, because they didn't even know what my category was. So, they did not know what my duty was supposed to be, and I had to tell them I'm a physician by training, so I will be happy to be the Medical Officer.

In the meantime, Mandarin is my primary language, so I could be an interpreter because back then there were a lot of passengers who flew back from China to the U.S. because they knew the border was going to be closed soon. So, I had to basically establish my own role for my first deployment.

The first day went fine after everybody was clear about the role I was playing, but I think over those 30 days, because it was really early in the pandemic, things were really changing on a constant basis. For example, initially, almost all the passengers we screened came from China and [a small number] of them had a connection flight going through mainland. But over time there were passengers from Japan and Korea. And then during the last week we were overwhelmed with passengers from the EU countries because of the announcement that all those flights need to be screened because of the situation over there.

Also, in addition to screening the passengers, [as one of the] three or four medical officers within the 20-person deployment team,. most of them from the CDC, I had to take care of our fellow officers. I don't think back then, the headquarters really had an established system about what to do if an officer, who is on deployment, became sick, and we did have two officers who developed flu-like symptoms. So we had to use our own medical knowledge to help them to go through the process regarding the isolation, whether to go to the ER, and how long do they need to be in the isolation before they can come back to the station, et cetera.

VB: Commander Xu, this was so early in the pandemic, and as you said, like the screening procedures even broadened while you were there. What mitigation strategies were used while you were there? Were all of the deployed personnel wearing masks? Were there enough masks? Were the passengers wearing masks?

LX: No, when we were interacting with the passengers we were asked to wear the regular surgical masks and also wearing gloves. But for the medical officers, because we are usually the ones who would screen the people who have some symptoms, back then it was mostly fever, shortness of breath, and coughing. So if they have any of those symptoms we would gown up which means we would put on the surgical gowns, the N95, and the face shield or goggles. And we had a separate room to interview those people who have some kind of suspicious COVID symptoms.

But for the majority of the deployed officers, they are interacting with passengers who are not symptomatic. Surgical masks and gloves are the only things they would wear initially. Over time they started to put on the face shield. The quarantine station is next to the DHS, the Border Patrol Officers area where they – when you came in from outside of the US, you had to go through that. The line where the officers from the DHS, the Border Patrol officers ask you all the questions and they will stamp your passport [if cleared]. So we have to be careful not to scare them because if we all put on N95 masks or the gowns, they will be really scared. They were like, what's going on here? Do we need to put on everything like what they are doing?

So, it's a delicate balance between protecting yourself and not to overwhelm other people. But within the office, we tried to wipe the desks and the floor as frequently as we could. But usually, we did not wear the masks when we were among ourselves.

VB: Wow. That's really wild to hear about having to be concerned about your own health and safety, but also not alarming other people nearby like you say, a very delicate balance. I wonder if either of you can give us a sense of what an average day was like on any of your deployments. Is there a basic flow to the day or were there routine things you generally did every day? What was a day in the life for each of the deployments you served and let's turn to Commander Belsky to start with for this.

DB: There actually was a what we called the battle rhythm, and the battle rhythm was a set of times for different things. So, when we started first thing in the morning, there was a briefing we'd run through what the tasks for the day were and each person would have – any lead person would go through what their plans were for their team or for the day. There were some meetings that were established every day, like a briefing with the head of readiness, now Admiral Guyton would come in, or Admiral Trent-Adams might come in at some point in the afternoon, and we'd debrief where we are with the teams. The commander of the cell would go through that briefing with the deputy.

And we had briefings, or a set meeting with our Operations Chief. We'd have meetings established, if there was a team going out or team coming back, whether it was a debrief, or a briefing for them to understand what to expect. And we'd do a safety briefing with them. We'd have reports come in from various teams and we might meet with them. So, there was a rhythm of what meetings happened throughout the day. So, you were very busy just with that alone, and then in between was all the work.

Sometimes it would be, “Hey doc, do you know any officers that we could deploy?” from the admin person or doing a risk evaluation of officers who were due to come back. Or, it was trying to arrange testing because at the time the CMO was arranging for post COVID-

19 [indiscernible] RT-PCR testing and I would reach out to various military bases in the area and we would try to arrange for testing. There were a lot of things like that.

And then the risk evaluation was a very critical piece and that took a lot of time as well. When you say, was there a rhythm, yes, it was chaotic and busy, but we did have a battle rhythm. We did have specific times for various actions and then we just had to work through in between and after to get all the work done.

VB: Thank you. That the metaphor of the battle rhythm really sounds appropriate.

Commander Xu, can you tell us on each of your deployments, what was a day in the life?

LX: For the San Francisco one, I think I mentioned earlier, first thing in the morning, before the day started I would go through the FDA emails and make sure there's nothing urgent or burning. And then after getting to the airport, we would have a briefing just to update everybody about how many flights were coming in that day and which flights were expected to be busy, [so that we can appropriately allocate officers]. And then I think later when the European passengers had to be screened, the briefing became very brief because there were just so many flights coming.

So, we had to get to all the terminals and wait for those passengers to come because they're not supposed to get off the flights until they got the passes from us. And then I think after eight hours, we have a debriefing for the next shift to notify them of anything in particular that they needed to pay special attention to. I think that's pretty much what that 30-day period was like. Also, I think the CDC quarantine station – they still had to maintain their regular activities, so we had to take care of the phone calls from the general public related to COVID, and related to their travel.

For the FDA risk mitigation deployment, I think it was more structured. We had either a morning shift or afternoon shift. I had to go through all the new emails that came in during that time period and call each individual and go from there. And then at three o'clock in the afternoon, [physicians at the FDA's Occupational Health Office] that is in charge of contract tracing will go through the cases of interest from previous day and update us] about the CDC guidelines so that our recommendations to the affected employees would change based on the updates of the CDC guidelines.

VB: Thank you so much. I imagine that as a responder, you frequently draw upon past experiences in order to be able to be adaptable in the moment and respond to whatever comes up and is needed. Could either of you share a little bit about, if you had deployed prior to COVID, what skills or experiences from your past deployments you drew on during this emergency response? What from your role at the FDA, did you draw on during your deployments, Commander Xu, could we start with you?

LX: Because I was with this Capital Area Provider Team, my past deployments were short. The longest one I had was a four-day deployment for the inauguration in 2016, so I had never had any of this kind of two-week, let alone four-week deployment. But I think it is important to be flexible, especially when you don't know what your assignment will be, just try to be flexible, but whenever you feel there's something that doesn't sound right speak up. Because when you are in a team everybody is expected to contribute, and we need to help our fellow officers and to protect each other while doing the public duties that we were assigned to.

VB: Thank you. That's very interesting to hear, Commander Belsky, could you share any ways in which you drew on past deployment experiences in this particular emergency response?

[00:40:08]

DB: I've had a number of deployments, but like Commander Xu. I was on Capital Area Provider Team. I was the team lead for a CAP Team and these teams would go out to the U.S. Capitol for gold medal ceremonies. We deployed for a Police Officer Memorial event or Inauguration or a State of the Union, and they were relatively short deployments, but I, as the Team Lead, was responsible for coordinating and ensuring that we had members of our teams ready to deploy and fulfill the mission. So, in that role, I knew some people up at headquarters. So, it helped me to understand the dynamic at headquarters. So, I think that gave me some familiarity that was helpful.

I've also deployed for a mission for the unaccompanied – the Custom Border Patrol mission before the recent unaccompanied minor mission, which was a two-week mission. And I had the understanding that you go out there and you learn on the job, what your job is going to be, and we worked that out and it was a pretty understandable mission, but I think what Commander Xu said about flexibility is always critical. You need to be able to be flexible because your role and responsibilities might change from minute to minute, they might be expanded or even minimized depending on what the needs are.

We also have the attitude that we look out for our team members. So, we always look out for each other when we are deployed. And certainly, even in this Command Cell it was hard work. There were a lot of hours and there were a lot of close quarters and a lot of demands. And we all were really under a high-level – in a high-level space that could be

stressful. So, we looked out for each other, and I think mostly we just did fine and, we need to work well together. So, I think that helped.

I also have prior Air Force experience, so I have that understanding of rank and those protocols that maybe come a little bit easier to me than someone who just joined the Commissioned Corps, where we work in a civilian environment quite a bit and are not as exposed to that. So, I was very familiar with those types of circumstances.

I had also deployed when I was in the Air Force for three months with an expeditionary team to Saudi Arabia where you had to figure out what the flow was. It was a medical mission, so it was, doing medicine which wasn't too out of the ordinary for me. But I think one always draws upon what you've learned from the past. And sometimes you don't even realize how it's helping you. So I think the many deployments I had in the Commissioned Corps prior to going to headquarters really did help. And that Team Lead position really set me up to understand better what it's like and the dynamic of the headquarters. I would say it was very helpful.

VB: Commander Belsky given that you've had so much experience deploying, from that perspective, what was so different or unique about the COVID emergency response? You already discussed the uniqueness of standing up the Command Center, but is there anything else that particularly stands out to you given this perspective you have?

DB: I would say yes. This was an environment that was revealing itself – on a daily basis we were learning more, and we had set out with – we had to work within the CDC guidance.

I needed to come up with a way, and I needed to do this by a certain date, of how were we going to assess these many numbers of people to see who needed to be screened more intensely than others. So, for example, the CDC guidance talked about if you're so

many minutes in a room with someone, or what distance from someone, or what kind of exposure, so we had officers who worked in hospitals in the Indian Health Centers. We had officers who were training on how to use PPE to nursing home staff, we had officers deployed alone not as part of a group to remote sites to provide behavioral health counseling.

We had many different kinds of missions, and in each of those missions, the environment in which those individuals worked was different and their exposure was different. So, I had to come up with some kind of a method and to ask certain questions that reflected what the CDC guidance was saying was high risk versus not high risk to determine do I need to talk to this person one on one and really understand their risk? And does that person need to be in quarantine before they go home? So, when I took over as CMO, there were teams out that were told they were all going to come back to Maryland no matter where they lived, and they were going to be in a hotel room for 14 days before they went back to their families. The guidance changed or the operation decision changed and now they were going to go back to their families, and they were going to get a COVID test right before, and they were going to get a COVID test without necessarily knowing the result, and go home.

That was a very complicated paradigm to work in because I may believe that it should be done a different way. I may not completely agree, but I had to work with that environment and figure out the best way to assess people. And there were times where I made recommendations that an officer needed to be in quarantine for two weeks because of whatever reason. I won't expound on the specific cases. Or I believed that, or my recommendation was that, getting a test and then not having the answer – I didn't quite like that. But that was what we were doing. And I had to figure out how to provide guidance so that during travel officers were safe as possible, depending on the risk that they had from their experience, whether they should mingle or whether they should stay apart from their family members and how to do that.

There were a lot of difficult decisions and questions that needed to be answered and there weren't really absolutely right answers and there weren't absolutely wrong answers, but they were nuanced. And I was responsible for really trying to do our best to mitigate any risk to our officers or their return home to their family members. For example, if a family member had some underlying, risk that would make them more likely to get sick with COVID, that might change what the answer might be. And so that was, I think, a very complex piece of the work that I was responsible for.

VB: Sounds like you really you had to be very shrewd in how you determined the protocols and guidelines you developed and keeping pace with changing guidance and changing information about the pandemic. It must have been quite difficult.

I don't want to ask you to share any stories that would compromise anyone's privacy or security or anything but were there any examples of officers – they're so varied these stories and the roles that officers played. I wasn't aware until you just mentioned it that any officers were deployed alone. That sounds like a really harrowing experience in the middle of this pandemic that has been scary and stressful. Were there any experiences of officers that you assessed in returning home that particularly stand out to you, not their names or any personal details, but something that you really had to grapple with in your role, or that really speaks to the difficulty in making these decisions?

DB: There's a number of those. I could say that one example of changing knowledge about COVID-19, the duration of illness, how we clear someone from once they've been infected until they're no longer infectious was changing while I was there. For example, if an officer did come down with COVID but was not so sick, they might isolate in a hotel room for

example, and we'd have, a buddy check with PPE and that sort of thing. But the timeframe for how to clear someone and how you did it was changing.

Our requirements were to, and this was for a long period of time, it was two negative RT-PCR nasal swab tests 48 hours apart. And while that was going on, others weren't doing that anymore. Once they were at such a day where their symptoms had improved, they were clear to go, but we were staying with that paradigm. So that was a frustrating thing an officer in that position who was really well but couldn't be cleared until we were able to obtain those two tests. That's a frustrating experience, but that's the way we had to do it, and that's what our requirements were at the time.

Of course, I'm sure that may have shifted over subsequent CMOs, but that was what our guidelines were at the time, so that was a difficult one. Another type of example that was challenging is – being deployed is a very stressful experience. Some deployments are easier than others. Some are more routine, but some are very challenging. People work long hours, or they face other challenges, even outside of the pandemic. Challenges that are very exhausting, and sometimes the amount of time you get for respite is very little when you come back. And on occasion – I always worked with our Corps Care people if there were situations where we felt concerned that a person might need a little more time to reintegrate. I always tried to advocate for our officers in the field and advocate up the chain to the best of my ability if I felt what we were giving wasn't really enough.

I didn't always succeed, but I tried very hard to recognize that we have rules of deployment and rules for respite and rules around that, that we have to follow, but wherever possible and where I thought appropriate, I would advocate as a physician to leadership, to give them what they needed in the best possible way. So, there were on multitudes of different kinds of circumstances that really needed listening skills, flexibility, and then a way of really communicating, this is the way it is, was challenging, but that's what the role was.

I would say that from the perspective of my deployment, I felt the most important yet also perhaps the hardest part, the multitasking and all that is one thing, but looking out for your fellow officer's well-being is really, I think, the most critical and important job I could possibly do.

VB: Absolutely. You mentioned early on and in the overview of your work that you are coordinating with Corps Care for returning officers. Could you tell us a little bit about how you did that? Or just the little brief snapshot of what role Corps Care played once officers returned from their deployment?

DB: Corps Care's role and our role was evolving in how we worked together and what they would take on over time as this pandemic has taken shape. But at the time that I was CMO, Corps Care did have a representative that would come to our battle rhythm meetings and sometimes our safety briefing meeting. And there were times when an officer could reach out to Corps Care and I wouldn't know that the officer reached out to Corps Care we tried to maintain confidentiality, but if I felt like there was an issue or concern I might reach out to the Corps Care representative and discuss the circumstances so that we could be sure there would be appropriate follow up following return and that there would be ongoing engagement to ensure the well-being of any of our officers. So, it was a conversation, they weren't far away, and we worked very closely when we needed to, but also with respect to confidentiality and those kinds of issues.

VB: Thank you. I feel like Corps Care has played a really important role, especially in this response, and it's really enlightening to learn more about it from different perspectives. So, thank you for that.

Commander Xu, could you tell us a little bit more about what the screening procedures for COVID were like in your deployment to San Francisco? I'm thinking back to February 2020 and how focused we were, at that point in time, on cleaning surfaces as opposed to respiratory mitigations. I'm curious what the protocol was for screening while you were on this deployment how passengers reacted to it? If you can share any information about that, if they were scared or oppositional in any way? Also you had mentioned that there were a large number of passengers coming back from China and I was wondering, particularly given your primary language of Mandarin, if you could tell us about their experiences in particular just to get a glimpse into that perspective.

LX: When you are asking about the screening, you are talking about the screening of the passengers, right?

VB: Sorry, I didn't say that specifically, but yes.

LX: Basically, in the first two weeks of my deployment, most of the passengers we screened were from China, and those passengers were used to that kind of screening because China has done the same thing even before they were able to get on board the flight. And so, they were taking temperatures, they were asked all the questions. And so back then there was no testing for COVID but they had gone through all the screening questions so when they came over here, I believe before they got off the flight, the flight attendants had already told them that they had to go through this questionnaire and if they had any symptoms, there would be further screened. So they were pretty receptive regarding the questions and the recommendation of the two week quarantine period after they leave the airport, and also about whom they should contact if they develop any symptoms.

But later when the passengers came back from Europe, a lot of them were students, like those students who take half a year or three months of their college time to study in Europe. So, they had to rush back, and I think many of those passengers were very confused. They didn't know what to do because the policy was implemented within one or two days. I don't know whether you remember, I think there were some pictures, or some reports of the Chicago O'Hare Airport where the passenger line was two or three hours or even longer to go through the customer service was miles long.

In San Francisco, we had been trying to do a much better job by going to the terminal where the flight and the airport connects. So, we did not allow anybody to get into the airport until we had screened them. So, after we screened them, they could go through the customs, which is much more efficient. But I think overall because of the large number of people coming back [after a short notice, it] was pretty chaotic in a way. They had all the questions about what to do if they develop any symptoms whom they should contact. Although we had gone through those with them, I don't think they really registered with what we just told them. I think I answer your question. Did I miss anything?

VB: No, that was wonderful, thank you. When you identified a passenger that was exhibiting COVID symptoms, what was the procedure? I remember you said earlier that you had to be very careful just in terms of dawning, PPE to not cause fear. How did you handle a passenger that might be symptomatic?

LX: The general screening was done outside of that CDC quarantine office which the Border Patrol Officers can see what we're doing. But once we identify somebody with symptom such as fever, cough, or shortness of breath, that person would be given a mask, and then the initial screener would take that person to the quarantine office. And within the office,

there is a designated room and then the Medical Officer who was on duty during that shift would be called, gown up with all the PPE and start to ask more detailed questions relevant to COVID. [Anything occurred within the CDC office was not visible to the outside.]

[01:00:05]

If we had any questions or concerns, we can call a CDC hotline, where a physician who is more familiar with all the COVID-19 related issues and other medical issues [is available]. Basically, it is like a remote consultant. [After talking to the CDC hotline physician, we would] come to an agreement [about disposition of the passenger.] Then we would talk to the manager or the person in charge [of the CDC quarantine station in the San Francisco airport to] make them aware of what's going on. If we determined this person needed to go to the ER, we would call the fire station that would have the appropriate arrangement in place. If we determined this person can go home and follow up with their primary care physician, we would give appropriate instructions.

VB: Thank you. So, you have this unique perspective as well, given your one deployment was very early on in the pandemic. And then your next one was right after or coinciding with the first EUA authorization for a vaccine and the beginning of people actually getting vaccinated. But I imagine it was quite emotional to be involved in your second deployment dealing with FDA personnel that may have been infected and so forth. Could just tell us more about that deployment and in particular about what the protocol was for contact tracing at that point. And without compromising privacy or security, are there any examples you could provide that would really help to educate us about contact tracing?

LX: I will try because I'm more in the risk mitigate/risk management part, the contact tracing is a separate team. But I think everything started from my end. You are perfectly right with the San Francisco deployment, 99% of the people we screened were normal. And then with the FDA deployment, most of them were either in close contact with somebody with COVID or they were infected with COVID.

Also, they were our colleagues so I think emotionally it was more closely attached with the FDA deployment. I think the goal [of FDA contact tracing] is first to protect the person who either had COVID contact or had an infection, and also to protect their coworkers. The screening process usually starts after we got an email from the person's supervisor saying my employee contacted me reporting they either had a close contact or had a positive test for COVID or had symptoms, and this person was at the lab or at the workstation yesterday and potentially had some contact with their colleagues. Based on the information they provided, I will either email the person or call the person and go through all the questions to get more details. For example, quite often one of their family members were infected with the disease and then they had close contact with them, but they were asymptomatic. In that situation, I have to tell them that they have to wait until your family member has finished 10 days of isolation, and then their 14-day quarantine will start from that point in time.

If it was just close contact, I don't have to worry about the cleaning of the workstation and the contact this person had. But if it's somebody who had COVID or had symptoms very suggestive of the infection, for example, loss of smell, then I have to ask the person when was the last day they went to the workplace, whether they had close contact, which means within six feet for over 20 minutes. If they do, I have to put down all the information of all the contacts this person had at work. And then I have to submit all the basic information of the people this person had contact with and put that into a spreadsheet in SharePoint.

Then the contact tracing team would contact all those people who had close contact with somebody with COVID and instruct them to quarantine for 14 days. They were also instructed that if they develop any symptoms, they have to email the FDA contact tracing email box which was constantly monitored by the occupational health nurses or by us. So that was generally the flow.

Most of those people who had close contact with someone with COVID-19 didn't develop symptoms so they could be released after 14 days [of quarantine]. Some of them did develop symptoms, then we have to start the isolation procedure. For people who were infected, most of them recover within that 10-day isolation period. But I did encounter a few of them who didn't get better after 10 days. I have to tell them to continue with the isolation and check back on them within three to five days. Some of them got better after three to five days. Some of them were the same. Then I just have to continue the process until they are really feeling better and without any fever for 24 hours to meet the criteria of ending the isolation. I think they were really appreciative of what we were doing. So it was a really a rewarding experience.

JS: Commander Xu could share with us, or give us some idea of how extensively the FDA workforce was affected by COVID at least during the time that you were doing this for the agency. I'm not sure that there's a sense of this. I certainly don't have a sense of it, and it seems to me that it's an important thing, is that some information you could share?

LX: I think it's difficult to estimate, but because I worked at headquarters and most people, including myself at headquarters were working remotely during the pandemic. There were only a small number of people who had to go into the lab because they worked at the lab and those other people who are more likely to get infected and go through the contact tracing.

And, but I didn't realize, throughout the country, there are so many offices where our colleagues are stationed at.

I just read that there are over 300 stations throughout the country. The majority of the cases are from those stations. I think most of them belong to the ORA, the Office of Regulatory Affairs. Because they have to conduct all the inspections even during that time period. I think the inspection related to the new drugs had been pretty much suspended, but the inspections for food were still ongoing. So, when they went to those facilities, they could easily be in close contact with people who have COVID. And so, most of the cases from there, on average, I would say we had encountered at least five or six cases each day.

I think over that one-month time period it was over 100, it's not a really big number, but it's really dependent on your working situation. I don't think I had many people who worked remotely got infected. It was more because they had to go to the lab or they had to go to the inspection sites, that's how they got infected.

VB: Thank you. 100 a month is still eye-opening. Maybe I'm muddled on this, but were most of the cases you were managing with people working in the field?

LX: Yeah, I think most of them, are the ones working on the field –

VB: Thank you.

LX: Some of them were working on the lab but more are on the field.

JS: Also, in, in the international offices as well or not?

LX: No, I didn't get any international ones. At least personally, I didn't get any.

VB: I'd like to learn a little bit, and this is a question for both of you, about the team that you worked with. It seems like it's a really important part of the deployment experiences, the people that you work alongside and in these three different examples, you're drawing on other officers that are in different areas and of course sometimes working with people directly in ASPR or CDC or FEMA or a number of different agencies. We'd be really interested to learn about your team the dynamics, who you most frequently had contact with and the rapport of your team. I guess let's start with Commander Belsky this time.

DB: I would say the team environment's very important because we're all on the same mission. We're all working together, but in any deployment, sometimes you work with some people more than others, or some people you click more than with others. I had a fantastic experience working with some of the chief nurses whether they were the chief nurse on the deployment team and remote to me and I just communicated, or whether they were the chief nurse at the Command Cell, we worked very closely together and I also worked very closely with the Safety Officers at the Command Cell, that was a fabulous relationship.

We worked hand in hand on so many issues, so I would say the team support and how we helped each other to get the work done and make decisions and communicate with members in the field was excellent. I don't know what else to say about that. We all worked hard and did what was necessary. This is a group of people that are very committed to the mission, and to keeping our fellow officers safe in the field so that the missions that they're executing are done correctly and well. And that all of us, as a team, at the Command Cell succeeded in doing a good job.

There wasn't ever a question of working together as a team. Sometimes we had different opinions or different ways we might approach things, but we, always worked through that, so I think that it worked very well.

VB: That's great to hear, thank you. Commander Xu, could we hear a little bit about the team dynamics on each of your deployments?

LX: Yes, I will start with the San Francisco mission because that one is more complicated, and it involves more than one Federal agency. Within the deployment team, most of them were from the CDC and even at the San Francisco Airport quarantine station and the people who regularly work there are from CDC. They are our sister agency, so I think it is relatively easy to get harmonized.

We do have Customs and Border Protection, CBP, which is part of the DHS and was just outside the quarantine station. We had to interact with them on a regular basis – very closely to keep them updated about the CDC's new guidelines and our screening policies and to make them aware of why we're doing what we're doing.

We also had to provide some guidance for their leadership to protect their own workforce. But I think we had to refer to the CDC guidelines because sometimes what we are doing – for example, the PPE wearing back then, I don't think the CDC had clear guidelines about what's supposed to be worn. It's a delicate and difficult line to draw because this is the way we were wearing it, but we cannot recommend what we're wearing to them because there wasn't a CDC guideline out there for us to refer to. We could only tell them based on our medical knowledge, from a physician perspective, this is what we think is good to protect your officers, but we're not recommending anything, it's just our suggestion.

For the second one, the FDA contact tracing deployment, I think it's more collegial because everybody within the deployment team is from FDA. And so, when we needed each other, we sent messages through Skype just to make sure every case was taken care of in a timely manner. But I think that kind of collegial relationship and the respect for each other is critical. Overall, it's much simpler and straightforward.

VB: Commander XU, on each of your deployments, did the reporting structure follow the Incident Command Structure?

LX: The first one followed somewhat. We did have a Safety Officer and a Logistic Officer. We had a Medical Officer and we have everybody else – the primary screeners. I don't think the second one really followed the ICS. The second one was led by the FDA's Occupational Health Office. So, the physicians there pretty much took charge for all the operational activities. We were pretty vocal regarding how to improve or modify that [operation]. They were very open to any recommendations or suggestions as long as you had very good rationale behind them.

VB: That's good to hear, and good to know that you had strong team dynamics to support you. I recognize that's a really important factor when you're on a deployment, knowing that everybody knows how to be a productive member of the team and can be counted on. I'm sure it's also helpful knowing that you have someone you can rely on and turn to if you're feeling particularly stressed. I can only imagine that these deployments were extraordinarily stressful. What sort of opportunities did you have to take a step back or to download or share your feelings or just de-stress with your fellow officers during the deployment? Commander Xu, could we start with you?

LX: Sure. For the San Francisco one, we did have the opportunity to hang out together, especially initially when people were not so afraid of COVID. I do have some friends in that area and so I was able to visit them and have some good times with them and tour the city, which was a nice experience. Toward the end I didn't feel like they would be comfortable with me going to their house because of what I was doing, and because of fear of this virus started to escalate. Overall, within the deployment team we try to really take care of each other to de-stress ourselves.

For the FDA one because it was remote, other than the workload, I don't feel like it was stressful. And plus, we can always ask for help from the occupational health nurses and physicians. Also, we usually were paired up within the deployment team. One is doing the morning shift, and the other is doing the afternoon shift. But if one person is overwhelmed with the cases during their shift, the other person is always willing to step up to take over some of those cases.

VB: Thank you. In hearing you talk about walking around San Francisco last spring or late winter I can't help but wonder, given the really upsetting experiences with anti-Asian violence our country has seen in the last year, did you get a sense of the bigotry in San Francisco being inflicted on Asian people?

LX: Back then, I didn't feel that much. I think San Francisco is a city with a lot of Asian people to begin with and also back then, I don't think people had realized that this virus is scary, at least during the first three weeks when I was there. The lockdown started two or three days before I left, so back then, I didn't really feel much resentment against Asians.

VB: That's good to hear. Thank you. Thank you for sharing that. I wanted to turn to Commander Belsky, what did your team do to alleviate stress? What was the rapport on your team like?

DB: As I had mentioned, we had what we called the battle rhythm and part of the battle rhythm, first thing in the mornings, we did some kind of exercise together. So that was always fun. And it was a light way of, "here's our PT together" even if it was not in the biggest of spaces, we did some things, so that was nice. Sometimes there were lunches that were carefully served and doled out by a few people, and that was another way to sort of promote camaraderie and have a little bit of a lighter feel so that was nice.

Then just among us, those I work closest with, sometimes we'd be able to discuss our frustration or how we felt privately with each other, whether it was in another room or by phone. And about certain circumstances that we were hoping to work through or deal with which I think are normal ways that people relate to each other. It was always very respectful. I think maybe early on, I called the first CMO for questions a couple of times because she had some experience that I might not have had, I might have had a question or something.

[01:21:16]

It definitely had its amount of stress because it was an intense period. And I came home, at the end of the day, sometimes late, sometimes I was the last one there. I had quite a lot to do as the CMO, and then I'd come home and I'd continue working or I'd make phone calls to people in the field – there are different time zones. And I still have my family, so my husband and my children were very good. They understood that I had to work, and they would do what they had to do, so I got out of some of the household duties at times. Or at

times I was working, and they were doing something with the neighbors, I was on deployment.

It was really understood that I was 30 days working at headquarters, and even though I was home, I had these responsibilities. So, they were very supportive, and I really appreciated that because it took a lot of time. I easily worked 12 hours every day of the week for those 30 days. We all work a lot already at FDA, some people pull those kinds of hours daily, but it was 12 hours at least if that so it was a good amount of work.

VB: That's why it's so important to have your family there and supporting you in the midst of what must have been an absolutely exhausting and stressful deployment. When it ended and you returned to your normal tour of duty at FDA, I imagine your desk was piled high with everything you missed while you were gone. Can you tell us a little bit about the transition out of your deployment role and back to your normal tour of duty and how you took one hat off and put another on? Commander Belsky, if we could stay with you for this.

DB: Sure. That's an interesting question because, at the end of my tour, like I said, I had many responsibilities and things happen and there are decisions made that changed the way operations and processes occur. And so, the third CMO coming in did not have arranging the testing and coordinating the testing on their plate. It was switched to Corps Care because it was something that was happening not during the deployment, but really at the end when they were coming home so they felt that it would be better for testing and arrangements and follow up to occur in Corps Care.

I had been working all that time and did quite a lot related to this coordination and it was, at times, a bit complicated and suddenly, as I was leaving – maybe it was right, maybe it wasn't, but it was a really abrupt cutoff. You have the new CMO and now that CMO is doing

your work and you're supposed to stay out of it. So, it was like, get your head away from your deployment and get your head back to your other life. It was an interesting experience because I'd never really experienced that kind of forced transition in that way, and at times it was hard because you're so involved. How can you be so involved, still be present on your last one or two days and not want to give input.

So, it was an interesting transition, maybe it was strategic and for the best to get me done and moving on and someone else has got to take over. Maybe that was the way they had experienced transitions so that's the way leadership made it for me. I'm still not sure if it was good or bad or helpful or the right thing, but it certainly defined where my time ended. And I guess that was an important aspect to transitioning back to the life that I had before.

When I got back to FDA, of course, it's hard to explain what a deployment month is like. When we were asked to do this history project – we have to get clearance because you're really not supposed to talk about what happens at headquarters and in the Command Cell. So, there wasn't a lot that I would share except very broad brush sort of things because that was confidential stuff. So, it stayed where it needed to stay. And then I talked about it, but not in the in depth that I'm talking to you, about some of the experiences.

So far as work, as I said, the way our work is, we do have ongoing work that keeps coming in, but we also have deadline work. So much of my deadline work was dealt with without getting new deadline work. So of course, as soon as I came back, I was given many more assignments and I had to pick up some things, but it wasn't as intense as it could have been because I didn't have ongoing new assignments that were being given to me, other people took up that work. And so, I didn't have an immediate deadline.

I had some things of course, and I did get some work assigned in the last two weeks of my deployment but it wouldn't be due for another two to three weeks. It wasn't a horrific transition from the mountain of work, as I recall. We went on vacation right after I was done,

because we were going to take a vacation anyway. And so, I think I went on vacation right after that for the week. I can't remember exactly, but I think so because swim season was not happening that year, so my daughter wasn't occupied with that. It's amazing how time has gone by, I can't remember what we did and it's now we're here at the same period as we were, when I did this deployment a year ago, it's just been folding into itself.

All in all, I feel like it was nice to have a break from FDA and it was a really wonderful experience to contribute to the pandemic response and to have such an important position in that response. So, I feel very privileged about that.

VB: I hope you did get to take a vacation on your return from your deployment, cause you've more than deserve it. Commanders Xu, can you tell us what your experience transitioning out of your immersive deployment role and back to your normal tour of duty was like?

LX: I just felt relief because with both deployments I had been continuing working on the FDAs duties. So, when I'm done with both deployments, especially the second one, I just felt now basically my burden was cut by half. That was my feeling.

With the first one, I had to go through the 14-day quarantine period which was a little bit of a strange experience, because we were within the same household, my husband and my two daughters. The three of them were on one side of the house, and I was in the other part of the house. We tried to separate for the meals, the baths, and a lot of other things so it was an interesting experience.

VB: I can only imagine how difficult it is to try and make that work when you're obviously not used to putting up false barriers between your family members.

I think we all have a sense that this experience has affected the Corps on such a broad scale and that it's going to have an impact for years and years to come. I wanted to ask both of you if you have any insights or takeaways of lessons that we can learn from this experience. Things that can help officers on future deployments or maybe help the Corps in general in terms of strategizing for emergency responses. What can we take from this experience with the COVID-19 emergency and apply to future responses? Commanders Xu I'll ask that to you first.

LX: Overall this is a very unique experience that I really treasure, and I feel appreciative of. I don't think I would have ever expected to have such experiences within one year time period. To me, especially with the first one, I would hope that the Corps would have more control regarding the deployment of the officers. Because I was mobilized at the end of January, and I was told to leave within a few days. My husband works in Chicago, so I told him to come over right away, but he had to wait here for more than two weeks before I actually left. He is employed at Northwestern University, which has been very supportive for what he has to do, but on the other hand, I feel bad for him and for Northwestern, because basically he was unable to do anything for those two or three weeks and he could have left much later. So, I would hope the Corps has more control of our deployment so that when they tell us you are leaving within the next 48 hours, we can actually leave.

I had multiple interactions with the personnel who are in charge of the deployment arrangement. They are marvelous, but they just don't have that much control because they are trying to coordinate with all the other agencies for the deployment. I think that's the only thing I feel could improve for the future deployments.

VB: Thank you for sharing that. It's good to hear that wisdom, and I'm sure you're not the only officer who would suggest that. Commander Belsky, do you have any takeaways or lessons or final thoughts you'd like to share about your deployments and the emergency response?

DB: I think that the Commissioned Corps Headquarters Command Cell – stepping that up was in response to exactly what Commander Xu experienced, which was where was the command and control? Where was the administrative oversight? We had all these officers going out by ASPR, sent by ASPR, and they ask for orders and travel comes out of there. We don't have orders being issued. We're being told, there's a mission and this kind of coordination was necessary.

I applaud the leadership at the Commissioned Corps Headquarters for doing this. I think it was really helpful, it wasn't perfect. It was being built on the fly. It was like building the ship as it sails as all of this response has been we've learned along the way we've had to readjust our guidance. We've had to readjust yet again, and we are continually dealing with new experiences and new requirements.

First it was, meeting travelers then it was response to surges of sick people. Then it was, convalescent plasma and helping with that. Then it was vaccines. We have to all learn how to handle vaccines and be deployed to do mass vaccination sites. There's just so many different parts that we've played in it. And I think that the challenges that Commander Xu mentioned that we aren't like the military, headquarters doesn't have control, even if they've activated the whole Corps.

Even if now, they don't have to ask permission. We are paid employees from the agency that we work with, and they need us to do work. As well as the Commissioned Corps needs us to deploy. And that balance is very challenging. So, I don't know how we

completely fix that balance, but they're trying to set up a different kind of team structure to be more responsive to these kinds of deployments and long-term deployments.

I think headquarters is working on various ways to overcome the way that we are structured to meet the needs of the deployment missions. I know that there was improvement. There was a quality improvement process going on with all the feedback about notifications. So, at the beginning, people were notified that they were going to be deployed so they'd have their bag packed. It'd be packed and packed and packed, and you might never hear anything. And you don't know, and supervisors stopped assigning work because they don't know what to do. I know, because I was at headquarters, we made sure that once a mission would come down and sometimes, we think we needed to roster for it, and then it would be canceled, but the cancellation wasn't sent to the officer, oh, you don't need to worry or been stood down.

That quality improvement process was now we're sending an email and we're going to let them know that they're off the hook for probably another 30 days or so. It's been a work in progress, and I think it still needs refinement, and I think headquarters is working on that.

As far as advice to officers, sometimes we don't fully understand the picture as to why it is so hard to just say, okay, you're going out the door and you're actually going to go out in 48 hours like we thought you might. So, I would say, have an open mind and try to stay as flexible as possible, even if they're very difficult circumstances like Commander Xu's husband having to leave work prematurely. I've heard of someone flying in their mother from somewhere, then a whole month goes by, and the person never deploys or hiring a nanny or a babysitter or something to deal with childcare and then they never leave.

So, there are expenses and there are consequences to the difficult circumstances of missions and meeting the demands in a not necessarily fully staffed or staffed to the level that would be nice to help officers know when to stand down. I think those circumstances are understood and known by headquarters, and I think they're continuing to work on them. We,

at the Commissioned Corps, don't have the database systems that would be helpful to handle that. And I know that's a work in progress. So, I would say just keep an open mind and try to be as flexible and understanding as possible as things move forward. But I think tremendous lessons were learned through this pandemic and the operational tempo.

VB: Thank you both so much for sharing those insights. It's really illuminating for us who've been fortunate to get to speak with many officers who have deployed just to hear your takeaways from the experience. And before we close the interview, I want to thank you both sincerely for your service. Thank you for taking the time to help us capture a little bit about how the Corps has played a role in the COVID-19 emergency response. I'm going to close the recording.

[END OF INTERVIEW]



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