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By Electronic Mail
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Carolyn Martorana
U.S. Office of Special Counsel
1730 M St. N.W., Suite 218
Washington, D.C., 20036-4505

Re: Dr. Rick Bright

Ms. Martorana:

As detailed in the Second Addendum to Dr. Rick Bright's complaint of Prohibited Personal Practice, filed on June 25, 2020, the scope of Dr. Bright's role at NIH was extremely limited. Despite the Administration's public explanation about the importance of this role at the time it involuntarily transferred Dr. Bright, this was a significant demotion for Dr. Bright who was essentially relegated to the role of a project officer. At NIH, Dr. Bright was given a single assignment to support production of existing diagnostic platforms, which he promptly completed, even working at a time he was also managing serious health concerns. Dr. Bright also made a series of recommendations to fix the Administration's ineffective approach for COVID-19 testing, which NIH Director Francis Collins declined to support because of political considerations.

Dr. Bright has been assigned no meaningful work since September 4, 2020, when he completed the one assignment given to him at NIH. He has been idle for weeks. Dr. Bright informed his supervisors, Drs. Collins and Tabak, that he had no work, and requested opportunities to contribute his talents to the federal government's response to COVID-19. Neither assigned him new work.

The federal government is paying Dr. Bright, one of the nation's leading experts in pandemic preparedness and response, and an internationally recognized expert in vaccine and diagnostic development, to sit on his hands during a global pandemic that has, to date, killed one million people globally and over 210,000 people within the United States. HHS is denying Dr. Bright the opportunity to perform his life's work. And by sidelining him and harming his reputation, HHS is also making it harder for Dr. Bright to be able to return to his work in the future.

The public health crisis is worsening; there is too much at stake now for Dr. Bright to continue to stay silent, and these latest efforts to stifle his work and force him to sit idle have further harmed him and this nation as a whole. Dr. Bright had no choice but to tender his

resignation, which he did this morning. Because this resignation is involuntary, Dr. Bright has been constructively discharged by HHS.

Sincerely,

Debra S. Katz
Attorney for Dr. Rick Bright

THIRD ADDENDUM TO
THE COMPLAINT OF PROHIBITED PERSONNEL PRACTICE
AND OTHER PROHIBITED ACTIVITY
BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBMITTED BY DR. RICK BRIGHT

I. Introduction

Dr. Rick Bright, one of the nation's leading experts in pandemic preparedness and response, and an internationally recognized expert in the fields of immunology, therapeutic intervention, and vaccine and diagnostic development, was abruptly removed from his position as Director of the Biomedical Advanced Research and Development Authority ("BARDA") and transferred to a limited position at the National Institutes of Health ("NIH") in retaliation for his whistleblowing activity under 5 U.S.C. § 2302(b)(8)(A). Specifically, and as detailed in his initial Complaint of Prohibited Personnel Practice filed with the Office of Special Counsel ("OSC") on May 5, 2020, Secretary of Health and Human Services, Alex Azar, and other HHS political leaders engaged in an overtly hostile and career-derailing campaign of retaliation against Dr. Bright because he raised concerns about the Trump administration's chaotic and reckless response to the COVID-19 pandemic. Shortly after cases of COVID-19 were identified in the United States, Dr. Bright sounded the alarm about the shortage of critical supplies, such as masks, respirators, swabs, and syringes that were necessary to combat COVID-19. In response, HHS political leadership leveled baseless criticisms against him and sidelined him because of his insistence that the Trump administration address these shortages and invest in vaccine development as well. Dr. Bright continued to speak out about the inevitable devastation that would be wrought by this virus at a time President Trump and his administration were intentionally lying to the American people about the serious threat posed by COVID-19 to the public health and safety.[1]

Dr. Bright refused to be silenced by the retaliation to which he was subjected and continued to be an outspoken critic of the Administration's response to the pandemic. He vociferously objected to the Administration's insistence that BARDA fund chloroquine and hydroxychloroquine, potentially dangerous drugs that were recklessly promoted as a panacea by those with political connections and by President Trump himself. Within days of Dr. Bright opposing the broad use of these drugs because they lack scientific merit, and within days of objecting to the Trump administration's plan to "flood" New York and New Jersey with these drugs, Secretary Azar removed Dr. Bright as BARDA Director and transferred him to a more

[1] *See e.g.* Robert Costa & Phillip Rucker, *Woodward Book: Trump Says He Knew Coronavirus was 'Deadly' and Worse Than the Flu While Intentionally Misleading Americans*, WASH. POST (Sept. 9, 2020), available at https://www.washingtonpost.com/politics/bob-woodward-rage-book-trump/2020/09/09/0368fe3c-efd2-11ea-b4bc-3a2098fc73d4_story.html. Even as the United States exceeded 200,000 deaths from the virus, President Trump continued to claim that that his Administration has handled the virus "exactly right" and that the virus will "go away," even without a vaccine. *Trump's ABC News Town Hall: Full Transcript*, ABC NEWS (Sept. 15, 2020), available at https://abcnews.go.com/Politics/trumps-abc-news-town-hall-full-transcript/story?id=73035489.

limited position within NIH, to serve as a member of NIH's Rapid Acceleration of Diagnostics ("RADx") program leadership team.[2]

As detailed in the Second Addendum to Dr. Rick Bright's complaint of Prohibited Personal Practice, filed with the OSC on June 25, 2020, the scope of his role at NIH was extremely limited. Dr. Bright was given a single assignment – to lead the RADx-Advanced Technology Platforms ("RADx-ATP") project, which is responsible for making contracts with experienced diagnostics companies to scale up their production of existing diagnostic platforms. In other words, his team was tasked with working with companies that had already developed a COVID-19 diagnostic and had already obtained FDA authorization for the test and to contract with them to produce more tests within an established period of time. Despite the Administration's public explanation about the importance of this role at the time it involuntarily transferred Dr. Bright, this was a significant demotion for Dr. Bright who was essentially relegated to the role of a project officer.

Dr. Bright promptly completed the only assignment given to him, and made a series of recommendations to fix the Administration's ineffective approach for COVID-19 testing by devising a plan to better identify those infected with the virus and to trace and isolate contagious individuals. Specifically, he detailed the need to develop a robust testing infrastructure, which requires a combination of high-volume diagnostic laboratory-based tests with 24-hour turnaround, rapid point-of-care tests in traditional and non-traditional health care settings (e.g., schools, prisons, factories, nursing homes, homeless shelters), and rapid, high-frequency, low-cost home-based screening tests. He emphasized the critical need to provide screening tests for asymptomatic individuals and to provide services to underserved populations disproportionately impacted by COVID-19. In his proposed plan, Dr. Bright noted, "[w]ith as many as 40% or more of infections resulting from pre-symptomatic or asymptomatic transmissions, the ability to rapidly and cost-effectively screen large number of individuals frequently remains an important strategy for successful locating and containing the virus."

Dr. Bright's recommendations for development of a robust national testing infrastructure were based on best practices for pandemic response and provided a commonsense approach to better manage the pandemic by breaking the chains of transmission and reducing community transmission. Instead of embracing these recommendations and working towards implementation, NIH Director Dr. Francis Collins declined to support Dr. Bright's recommendations because of political considerations. He told Dr. Bright that he feared that the Trump Administration would not approve a plan that called for broad-based testing of asymptomatic people and also shared his concern that greenlighting this work could potentially step on the toes of other teams within HHS, such as the Office of the Assistant Secretary for Health ("OASH"), Admiral Brett Giroir. Dr. Collins's response was not surprising, given the current environment within HHS, and the immense pressure that the Administration has put on

[2] NIH Director Francis Collins and Dr. Lawrence Tabak, Dr. Collins's Principal Deputy Director, are also members of this team and Dr. Bright reports directly to Dr. Collins.

other HHS agencies to withhold, or even rescind, public health measures involving testing of asymptomatic people.[3]

Dr. Bright has been assigned no meaningful work since September 4, 2020, when he completed the one assignment given to him at NIH, and has been idle for weeks. His supervisors, Drs. Collins and Tabak, were well aware of this. Indeed, on September 25, 2020, Dr. Bright wrote them reiterating that he had been given no assignments and specifically requested that he be allowed to help lead the Operation Warp Speed vaccine and drug development teams. Dr. Collins did not respond to these requests and Dr. Tabak attempted to placate Dr. Bright by telling him that he needed a few days to consider the request, but then he too failed to respond.

Accordingly, having exhausted all efforts, on October 6, 2020, Dr. Bright submitted his involuntary resignation.

II. Even in the diminished role to which he was assigned, Dr. Bright's work was thwarted by political considerations that continue to harm public health and safety, and his efforts to take on additional responsibilities were rejected.

As detailed in Dr. Bright's initial OSC complaint, he objected to his involuntary removal as Director of BARDA and to his transfer into a diminished role at NIH – a role that did not make the best use of his talents and expertise. Despite these objections, he performed his work at NIH to the best of his ability and in a highly conscientious manner even after receiving a cancer diagnosis during this period and undergoing surgery and treatment.[4] In fewer than four months, he successfully launched a program to expand COVID-19 diagnostic testing. He developed a strategy, recruited staff, formulated a budget, conducted market research, reviewed proposals, and awarded eight contracts to companies with the goal of expanding capacity by one million tests per day by the end of December 2020. His team obligated the entire budget for RADx-ATP. The scope, size and number of contracts Dr. Bright's team was able to award was significantly limited by this budget. With additional resources, Dr. Bright could have supported expansion of testing capacity for more technologies and facilities. Moreover, with additional funding the program could support pilot studies to generate critical data to inform testing

[3] *See, e.g.*, Apoorva Mandavilli, *C.D.C. Testing Guidance Was Published Against Scientists' Objections*, N.Y. TIMES (Sept. 17, 2020), available at https://www.nytimes.com/2020/09/17/health/coronavirus-testing-cdc.html (reporting that political leadership and the White House Task Force posted guidelines on CDC websites, over objections of CDC scientists, discouraging testing for asymptomatic people); Brianna Abbott and Stephanie Armour, *CDC Reverses Relaxation of Covid-19 Testing Recommendations*, WALL ST. J. (Sept. 18, 2020), available at https://www.wsj.com/articles/cdc-reverses-controversial-guidance-on-covid-19-testing-11600452908) (same).

[4] In mid-July 2020, Dr. Bright was diagnosed with an aggressive skin cancer and had a series of surgeries on his scalp. Again in mid-August, he was diagnosed with additional sites of skin cancer that required eight weeks of local chemotherapy treatment. He did not let these health issues delay his work and did not take a full day off from work even when confronted with this serious health challenge.

strategies to assist K-12 schools, nursing homes, universities and workplaces. Data from these studies would be critically helpful to optimize plans to re-open our nation safely.

After months of analyzing available data regarding COVID-19 testing practices, Dr. Bright and a colleague co-wrote a paper recommending further development of a robust national testing infrastructure. As the paper explains, testing is "the cornerstone of a successful public health response" to the COVID-19 pandemic. *See* Draft Viewpoint on Testing (Sept. 4, 2020), *attached hereto as* Exhibit 1. Dr. Bright emphasized the urgent need to implement a coordinated national testing plan that incorporates different types of tests for different use-case scenarios, equitable access to testing, frequency of testing, and payment or reimbursement to ensure access to testing to achieve public health and economic goals for everyone. Dr. Bright's colleague sent the draft to Dr. Collins on September 4, 2020. *See* email to F. Collins (Sept. 4, 2020), *attached hereto as* 2.

Now, nine months after the COVID-19 first appeared in the United States and after over 210,000 people have died in the United States and over 7.44 million have been infected, the federal government still does not have a national testing strategy. While Dr. Collins praised Dr. Bright for developing a "thoughtful" plan that "includes a lot of good points about what optimal testing needs to look like" he declined to support it based on purely political considerations. Dr. Collins declined to move forward with Dr. Bright's proposal for implementation of a robust national testing strategy because of his conclusion that the Administration was unlikely to be receptive to this kind of push at this time and likely because of his fear of further reprisal.[5]

While Dr. Collins's timidity to push Dr. Bright's plan forward is understandable given the pervasive fear within HHS and among career scientists, Dr. Bright was aghast that Dr. Collins refused to support the implementation of an aggressive and coherent national testing strategy because of political considerations and fear of the Administration's response. This Administration has consistently discarded scientists and denigrated the opinions of scientists who speak out or challenge its approach of minimizing the threat of COVID-19. Public health guidance on testing, drafted by career scientists at the CDC, has been repeatedly overruled by political staff.[6] This hesitancy throughout HHS to implement the best scientific practices when it runs counter to the Trump Administration's unreasonably optimistic pronouncements has greatly harmed the public health and safety and has undoubtedly led to tens of thousands of preventable deaths.

[5] Recently, the White House scolded Dr. Collins when he opposed the Administration's efforts to obtain emergency authorization for convalescent plasma as a treatment for Covid-19 based on a lack of scientific support. *See* Laurie McGinley, Yasmeen Abutaleb, Josh Dawsey and Carolyn Y. Johnson, *Inside Trump's Pressure Campaign on Federal Scientists Over a Covid-19 Treatment*, WASH. POST (Aug. 30, 2020), available at https://www.washingtonpost.com/health/convalescent-plasma-treatment-covid19-fda/2020/08/29/e39a75ec-e935-11ea-bc79-834454439a44_story.html.

[6] Multiple career scientists within HHS have thanked Dr. Bright for speaking out, but these same scientists express a fear of rocking the boat themselves. People are terrified of losing their jobs if they speak up about the misinformation disseminated by the Administration.

Dr. Bright was disturbed that Dr. Collins appeared willing to bow to political pressure rather than advocate for implementation of a robust national testing infrastructure. Accordingly, Dr. Bright pushed back in response to Dr. Collins's refusal to advance his recommendations. On September 24, 2020, Dr. Bright asked Dr. Collins to reconsider Dr. Bright's request to support the testing recommendations in his paper. Dr. Bright emphasized that COVID-19 cases are continuing to increase, and the situation is getting worse. He wrote:

> I honestly think this viewpoint is timely and critical to advance critical discussions important to save lives. We are in desperate need of a national testing infrastructure (framework, strategy, plan, etc.). We are making progress on technologies. We should be pushing hard now to shape the infrastructure on how the various pieces come together to help stop the pandemic.

See email from R. Bright to F. Collins (Sept. 24, 2020), *attached hereto as* Exhibit 2.

Dr. Collins responded by email on September 28, 2020, once again declining to support Dr. Bright's recommendations. He did not deny that this kind of proposal was necessary to save lives, but explained that he was not sure how other agencies within HHS would view these recommendations. He concluded, however, that they should revisit the paper after an upcoming workshop. More delay – more lives lost. *See id*.

Dr. Bright remains very concerned about the lack of leadership at HHS and the failure of this Administration to articulate a coordinated national plan to address the pandemic with respect to diagnostics. For testing, there is significant confusion stemming from mixed messages – CDC guidance that is retracted, reversed, or contradictory from other healthcare guidance. There is confusion at the state, local and territorial level about testing protocols, technologies, and public health strategies about who to test, when to test, and with what type of test, and even what to do with the information that comes from testing. Though there is progress being made on the technical front for testing and testing capacity is expanding, there is still no guidance to optimize the use of these new technologies and there is no plan for fitting them into a coordinated national strategy. To further complicate things, as winter approaches it will become increasingly important to combine testing for SARS-CoV-2 with testing for influenza. This will be critical to ensure that patients are diagnosed correctly and treated quickly for the appropriate virus. A national testing strategy to safely re-open America was needed months ago. However, the U.S. government is only now initiating discussions to address critical questions and determine which types of research or pilot studies would be informative to support the development of a national testing strategy. Dr. Bright is acutely aware that without this strategy in place today, the country is truly "flying blind" into a very challenging winter for public health – a winter when we will undoubtedly see millions more Americans infected with COVID-19 and influenza and hundreds of thousands more deaths across our country. Now, more than ever before, the public needs to be able to rely heavily on non-politicized, un-manipulated public health guidance from career scientists with the expertise to prepare a plan to end the pandemic. However, in this Administration, the work of scientists is ignored or denigrated to meet political goals and to advance President Trump's re-election aspirations.

Most recently, the White House recruited Dr. Scott Atlas, a neuro-radiologist and fellow at Stanford University's conservative Hoover Institution, as a White House pandemic adviser. His arrival to the White House Task Force has added to confusion and consternation among senior public health officials about who makes decisions and guides the planning for the pandemic response. On several occasions, senior HHS officials, including Admiral Giroir, have complained about the confusing and sometimes disruptive role Dr. Atlas has played and continues to play. It is becoming increasingly unclear to Dr. Bright who is in charge of making final decisions for COVID-19 testing efforts. Dr. Bright learned that Admiral Giroir must approve all plans for investment of NIH funds into diagnostics. In addition, it has been extensively discussed that both Secretary of the Treasury and the White House Chief of Staff were making decisions and giving directives for sole source procurements of specific diagnostics, ignoring the doubts and concerns expressed by NIH diagnostic subject matter experts.

Dr. Bright has heard in meetings, including in his weekly meeting with Admiral Giroir, that Dr. Atlas, who lacks a background in infectious diseases, is now "calling the shots" at the White House. This is of significant concern to Dr. Bright and to other career scientists. Dr. Atlas has advocated for prematurely reopening schools and businesses and for an approach achieving herd immunity that is not supported by experienced public health experts. These positions have created high-profile clashes between Dr. Atlas and respected immunologists such as National Institute of Allergy and Infectious Diseases ("NIAID") Director Anthony Fauci and the White House coronavirus response coordinator Deborah Birx.[7] It also explains why Dr. Collins has been unwilling to support Dr. Bright's recommendations to implement a robust testing program, to increase testing of at-risk asymptomatic people, or to assign him to more meaningful work. For this reason too, the work environment has become intolerable for Dr. Bright.

III. Dr. Bright has now been idle for a month as NIH Leadership rejects his efforts to contribute further.

Since submitting his paper to Dr. Collins on September 4, 2020, Dr. Bright has not been assigned further substantive work at NIH and has been idle. This has been very demoralizing for him. On September 25, 2020, Dr. Bright wrote to Dr. Collins and Dr. Tabak request that he be given meaningful work. He stated:

> At this point, there is little for me to do on the RADx-ATP project. It is in project management mode in the hands of excellent project managers and contracting officers. My schedule is largely open and on many days, completely empty.

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[7] *See, e.g.*, Yasmeen Abutaleb and Josh Dawsey, *New Trump Pandemic Adviser Pushes Controversial 'Herd Immunity' Strategy, Worrying Public Health Officials*, WASH. POST. (Aug. 31, 2020), available at https://www.washingtonpost.com/politics/trump-coronavirus-scott-atlas-herd-immunity/2020/08/30/925e68fe-e93b-11ea-970a-64c73a1c2392_story.html; Lucien Bruggeman and Libby Cathey, *Former Stanford Colleagues Warn Dr. Scott Atlas Fosters 'Falsehoods and Misrepresentations Of Science'*, ABC (Sept. 10, 2020), available at https://abcnews.go.com/Politics/stanford-colleagues-warn-dr-scott-atlas-fosters-falsehoods/story?id=72926212.

See email from R. Bright to F. Collins and L. Tabak (Sept. 25, 2020), *attached hereto as* Exhibit 3.

Dr. Bright is an internationally recognized expert in the fields of immunology, therapeutic intervention, diagnostic development, and vaccines. He is one of the nation's leading experts in pandemic preparedness and response. Yet now, in the midst of a global pandemic that has, to date, killed one million people globally and over 210,000 people within the United States, the federal government has Dr. Bright sitting on his hands, with nothing to do. Desperate to contribute his talents to the nation's pandemic response, Dr. Bright requested that he be allowed to contribute to the work being done within his areas of expertise. He stated:

> As I look toward the future, I would like to help lead the OWS vaccine and drug development teams. I have 25 years of vaccine development and 12 years of drug development experience that is under-utilized and could help accelerate the development, production, deployment and delivery of vaccines and therapeutics. For now, I am not being fully utilized for the breadth of my experience as the pandemic rages and Americans die. **In short, I long to serve the American people by using my skills to fight this pandemic. The taxpayers who pay my salary deserve no less**.
>
> As soon as possible, I would like to join the technical working groups and leadership calls for the various vaccine and therapeutic development programs for the pandemic response. Do you foresee any issues or have any reservations about me getting more involved in these areas where I have expertise? I am happy to stay involved in the senior leadership group for the RADx program as well to offer guidance and assistance to ensure continued success.

See id. (emphasis added).

Dr. Tabak responded the next day. He expressed neither surprise, nor concern, that Dr. Bright had no further work and a nearly "completely empty" schedule. Instead, his entire response was: "Thanks for your note. I will need a few days to consider. And, please note that I will be off-line all day Monday." *Id.* Dr. Collins did not respond at all.

Since he joined NIH in May, Dr. Bright has requested the opportunity to contribute to the federal government's vaccine development efforts, his area of expertise. *See* Second Addendum, 5 (June 25, 2020). His requests were denied then, and are still being denied four months later. Dr. Bright feels an urgency to utilize his skills to save lives. HHS leadership apparently does not share his sense of urgency.

IV. Being side-lined has become unbearable for Dr. Bright, as HHS is not only denying him the opportunity to perform his life's work, but is also making it harder for Dr. Bright to be able to return to this work in the future.

Dr. Bright has devoted his career to pandemic preparedness. Now, the world is experiencing a global pandemic that has impacted millions of people in this country, and the United States government is paying Dr. Bright to sit on his hands. HHS's sidelining of Dr. Bright and its failure to give him meaningful work has significantly impacted his reputation and career. Until his involuntary transfer in April 2020, he led BARDA to great success, was respected by his peers, and had positive professional relationships with members of Congress and senior industry executives. Political and industry leaders came to Dr. Bright for strategy, guidance, and solutions. Now, he is excluded from significant industry events and he is forced to tell industry leaders who have continued to reach out to him for help navigating the government's pandemic response, that he is unable to help them because he is not currently working on these issues. Other industry leaders have avoided Dr. Bright because they know of his demotion and exclusion following his high-profile case and treatment by the Administration. One industry executive even wrote to him: "You may be a little (what's the word . . . 'hot', 'radioactive') until after the election."

Dr. Bright has tried to work within the Administration. After being involuntarily transferred to NIH, he put his nose to the grindstone, and even worked during a period he was undergoing cancer treatment to try to contribute where he could – with development of a national testing strategy. He has done all the work that NIH has allowed him to do and in so doing, has continued to serve his country ably despite retaliation, disparagement and impugning of his character by senior HHS and White House officials, including the President who called him disgruntled, a deserter, and unfit for government service.[8] But now, given the soaring number of deaths and infections in the United States, sitting idle is not an option for him. The public health crisis is worsening; there is too much at stake now for Dr. Bright to continue to stay silent, and these latest efforts to stifle his work and force him to sit idle have further harmed him and this nation as a whole.

Especially now, as the Administration continues to censor and sideline its scientists, and this country approaches the darkest winter in our nation's history, Dr. Bright had no choice but to resign. On October 6, 2020, Dr. Bright submitted a letter of resignation to Dr. Collins, effective immediately, in which he stated, in relevant part:

<REDACTED>

See Letter of Resignation from R. Bright (October 6, 2020), attached hereto as Exhibit 4.

[8] As detailed in the Second Addendum to Dr. Bright's complaint of Prohibited Personal Practice, Part I, President Donald Trump, Secretary Alex Azar, White House Senior Trade Advisor Peter Navarro, Congressman Markwayne Mullin, and an HHS spokesperson have all publicly disparaged Dr. Bright in this manner in media publications or on national television.

V. The totality of the circumstances supports the conclusion that HHS has constructively discharged Dr. Bright.

The Merit Systems Protection Board ("the Board") recognizes constructive discharge where a federal agency takes actions that make working conditions so intolerable that the employee is driven to an involuntary resignation. *See Heining v. General Servs. Admin.*, 68 M.S.P.R. 513, 519 (1995). In finding constructive discharge due to intolerable working conditions, the ultimate question is "whether under all the circumstances working conditions were made so difficult by the agency that a reasonable person in the employee's position would have felt compelled to resign." *Id.* at 520. *See also Lentz v. Merit Sys. Prot. Bd.*, 876 F.3d 1380, 1386 (Fed. Cir. 2017) (articulating "totality of events" standard). Under this standard, courts recognize that a resignation may be involuntary even when there has been no threat of an adverse action. *See Cano v. U.S. Postal Serv.*, 107 M.S.P.R. 284, 287 (2007) ("[W]hen there has been no threat of an adverse action, the appropriate test is whether, under all of the circumstances, working conditions were made so difficult by the agency that a reasonable person in the appellant's position would have felt compelled to retire.").

The Board has found constructive discharge based on intolerable working conditions where a whistleblower was subjected to consistent and enduring retaliation. In *Heining v. General Services Administration*, an auditor within the General Services Administration ("GSA") blew the whistle on internal audit practices, and was thereafter denied a promotion, placed under the supervision of a supervisor about whom she had previously complained, was singled out for inequitable treatment, received her first unsatisfactory performance rating, and "her formal complaint of whistleblowing and her many grievances were either ignored or investigated in an unfair and meaningless manner." 68 M.S.P.R. 513, 516–523. GSA argued that the employee's resignation was voluntary because she was not presented with a choice between resignation and removal. *Id*. at 521. The Board rejected this argument, explaining that even though there was "no adverse action currently pending," the totality of the circumstances amounted to intolerable working conditions, such that "the reasonable employee in [the employee-whistleblower's] position would have had no choice but to resign." *Id.* at 521. *See also Bates v. Dep't of Justice*, 70 M.S.P.R. 659, 672 (1996) (finding constructive discharge despite no pending adverse action where "the continuous and unredressed pattern of harassment" made it impossible for federal employee to effectively perform her job); *McCray v. Dep't of Navy*, 80 M.S.P.R. 154, 160 (1998) (finding that a pattern of reprisal including denial of promotions, training, and assignments; a hostile work environment; and defamation of character could be sufficient to establish constructive discharge).

Here, the totality of the circumstances around Dr. Bright's involuntary transfer and exclusion amount to intolerable working conditions, such that a reasonable employee in Dr. Bright's position would have no choice but to resign. Dr. Bright was involuntarily removed from an influential leadership position as Director of BARDA, and was repeatedly disparaged and smeared by the Administration in the process, including by the President of the United States. He was then given a single assignment, and insufficient resources to accomplish it, even though other and better-funded teams within HHS were working to advance the same goal. Once he fully obligated his team's budget, Dr. Bright sat idle for weeks. *See Bravo v. Dep't of Veterans Affairs*, 83 M.S.P.R. 653, 659 (evidence that agency transferred federal employee to a

new position "unnecessary to the agency," "created for the sole purpose of forcing him to quit his job," and in which supervisor was aware that employee "had virtually no duties to perform" may support finding of constructive discharge).

Dr. Bright raised all of these concerns to HHS leadership and his supervisors have for months either denied or punted his requests for more meaningful work or work more aligned with his expertise and experience. Dr. Bright raised his concerns to the OSC, which on May 7, 2020, requested that HHS stay Dr. Bright's removal as Director of BARDA. Now, 152 days later, HHS has yet to even respond to this request. *See Heining*, 68 M.S.P.R. at 523 (agency's inequitable handling of employee's complaints and grievances constituted aggravating factors contributing to the conclusion that her working conditions were intolerable); *Bravo*, 83 M.S.P.R. at 659 (finding potential grounds for constructive discharge after noting that the employee "brought these concerns to the agency's attention prior to his resignation, thereby giving the agency an opportunity to ameliorate the conditions which he claims forced his resignation")

HHS's failure to assign Dr. Bright meaningful work, and its indifference to his idleness, support a finding of constructive discharge. As in *Shoaf v. Dep't of Agriculture*, it appears that "the agency deliberately 'idled' [him] in an effort to persuade him to resign." 260 F.3d 1336, 1340 (Fed. Cir. 2001) (reversing administrative judge's decision that resignation was not involuntary). "A reasonable person in [Dr. Bright's] position would not 'stand pat and fight' any longer." *Heining*, 68 M.S.P.R. at 523. A reasonable person with Dr. Bright's expertise, experience, and ability to prevent illness and death from COVID-19 would not sit on his hands as the United States reports over 50,000 new COVID-19 cases every day. Dr. Bright was therefore forced to resign from his position.

Because this resignation is involuntary, Dr. Bright has been constructively discharged by HHS.