

In early 2020, I served as Director of Medical Services for Paralyzed Veterans of America. In that capacity I was responsible for quality of care, access to care, and benefits for catastrophically injured veterans living with spinal cord injury. I worked with VA medical centers nationwide on care that is highly specialized and, for this population, available almost exclusively inside the Department of Veterans Affairs.

The American people support Veterans receiving the finest care, especially veterans with catastrophic injuries connected to their service. The COVID-19 shutdown and vaccine protocols disproportionately robbed these veterans of the care they desperately needed and caused incalculable damage to this vulnerable population.

When COVID-19 arrived, the Department chose to follow the public-health recommendations associated with Dr. Anthony Fauci and to restrict access to care. The risk of an unknown, laboratory-associated virus was judged too great for this high-risk veteran population.

Leadership later described the cuts as limited to elective surgery. That description does not match what veterans and staff experienced. Urgent procedures became harder to schedule. Routine appointments were postponed. Community-based outpatient clinics—the local access points many veterans depend on—were closed to in-person visits. Of 1,031 such clinics operating before the pandemic, 173 discontinued face-to-face care after February 2020.

Specialty referrals inside the VA fell more than 70 percent in April 2020. Wait times, already a documented problem, lengthened. Community-care referrals under the MISSION Act, intended to guarantee timely treatment outside VA walls, were delayed as private capacity contracted and VA authorization slowed.

Staffing shortages, already chronic, grew worse. Nurses and medical officers were the positions most frequently reported short. Facilities cited COVID-related requirements as a leading cause. A joint inspector-general review found reduced patient access as a result.

When COVID-19 vaccines began to roll out in early 2021, the Department faced a second choice: preserve medical freedom for its workforce, or remove nurses and support staff who declined an injection that many clinicians regarded as an experimental gene-based product labeled a “vaccine.”

At the direction of HHS policy and the prevailing medical consensus of that period, the VA chose the latter. Employees who declined were terminated. Nurses were not treated as licensed professionals with individual judgment. They were treated as interchangeable inventory. Work previously called essential was treated as disposable.

Nurses in Spinal Cord Injury Centers are not easily replaced. They deliver a narrow, high-skill form of care. They were placed in an impossible position: accept a forced medical intervention, or leave posts that veterans with paralysis depend on.

Religious and medical exemption requests were submitted in large numbers. Almost all were denied. The Department reports that it ultimately obtained compliance from 98.8 percent of its staff. The full cost to those nurses will never be fully measured. The cost to veterans who lost timely, specialized care is incalculable.

The first duty of medicine is to do no harm. That duty is not confined to the patient in the bed. It extends to the nurse at the bedside and to the veteran waiting for a clinic that no longer opens its door.

In this episode, restriction of care and coercion of staff were presented as protection. For the veterans I was charged with serving, and for the nurses who served them, the cure was worse than the disease.

If Congress does not examine these decisions—how access was shut, how exemptions were denied, and how specialized units were stripped of irreplaceable staff—the same pattern will be available the next time an emergency is declared.