“We Usually Don’t Vote on Intubation.”

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“I’m worried we’re going to need a breathing tube again.”

Ms A’s respiratory status had been deteriorating all evening; now in the early morning hours, our discussion turned to next steps. To this point, Ms A had been hospitalized in our ICU for more than a week with a large right-sided empyema. A woman in her thirties, she’d dealt with asthma but had never before faced such a serious illness.

In the days leading up to her admission, she experienced fever, cough, and dyspnea. She grew wary that she might have contracted coronavirus disease 2019 and sought medical attention. Coronavirus disease testing was negative, but she was hypoxic with a rapidly escalating oxygen requirement. Her chest radiograph demonstrated a right pleural effusion. She was admitted to the ICU and treated with antibiotics and chest tube placement, with pleural fluid studies consistent with an empyema. She continued to deteriorate despite treatment and required intubation and initiation of dialysis due to progressive renal failure. After several days, Ms A seemed to improve. Ventilatory support was weaned, and 2 days before our current conversation, she underwent extubation. Despite her ongoing critical illness and need for dialysis, Ms A remained upbeat. She and our team were optimistic about her prospects for ongoing recovery.

This improvement was unfortunately transient, and Ms A’s respiratory status began to decline once again. During the day before our conversation, she had required escalation back to high-flow nasal canula, and her care had been signed out to the night team with a plan for aggressive volume removal via ultrafiltration to stave off further respiratory deterioration. Despite these measures, Ms A was now desaturating with minimal exertion and required conversion to noninvasive positive pressure ventilation. In the early morning hours, repeat blood gases demonstrated falling arterial oxygen saturations despite 100% supplemental oxygen, and her breathing was progressively more labored.

After summarizing the aforementioned events, one of the authors (Dr Despotes) drew from a practiced repertoire of scripts in breaking bad news: “I’m worried we’re going to need a breathing tube again.” Ms A had trouble speaking over and around her positive pressure mask. She had remained mentally clear throughout her decline, and she nodded in agreement. “Okay, I’ll call anesthesia.”

Ms A’s oxygen saturation had fallen precipitously on her last attempt to remove her mask to talk, so she shook her head and reached for her nearby cell phone. Her breathing too labored to speak around the mask, she instead typed: “I need to vote first.”

Initially thought to be a protest regarding the plan of care, Dr Despotes rapidly clarified that Ms A meant voting in the upcoming election. Via responses to a series of yes/no questions, Ms A indicated that she had a previously requested absentee ballot at home and that her fiancé knew where it was. Given Ms A’s urgent, but not yet emergent, respiratory status, we called her fiancé once again to update him. The call was placed on speaker phone with Ms A, and Dr Despotes discussed the imminent need for intubation and Ms A’s desire to cast her vote first. He left home immediately. While he was en route, the ICU team prepped the room for intubation, acquired a ventilator, mobilized support staff, and summoned anesthesia.

At this juncture, the daytime ICU team began to arrive. When they learned that Ms A was planning to vote prior to being intubated, the oncoming intern had the same initial confusion, musing “We usually don’t vote on intubation.”
As we clarified that Ms A was focused on the election, both the anesthesia team and her fiancé arrived, with the latter bearing an absentee ballot and Ms A’s previous notes on the candidates. Remaining on her positive pressure mask, Ms A pointed at the ballot to indicate her preferred candidates, which her fiancé then “bubbled” in. He signed the ballot as Ms A’s assistant, and Dr Despotes signed as the witness required by North Carolina state law for mailed ballots. Her fiancé then exited the room. The anesthesia resident and attending physician entered and proceeded with rapid sequence intubation. With ongoing supportive care, Ms A’s condition stabilized, with gradual improvement over the ensuing days, and she underwent extubation again.

In the days that followed, over the ongoing drumbeat of campaign ads and news coverage, we discussed these events repeatedly among the care team. Ms A’s palpable determination to avoid disenfranchisement due to her illness struck those present, and many were not sure they would make the same choice when faced with a risk to their own lives. Several of us expressed embarrassment that, in past elections, we had failed to register, considered abstaining due to logistics, or didn’t vote—citing the complexity of our lives as trainees or health-care providers. These seemed especially hollow excuses compared to Ms A’s experience. Moreover, despite living in a “battleground” state and discussing plans for voting among ourselves, the majority of us realized that illness-related disenfranchisement was not an issue that we usually consider during a patient’s critical illness or hospitalization or in our experiences as outpatient care providers. Perhaps this inclination stems from a belief that we should not discuss politics with patients in a health-care setting, although the simple logistics of voting should not be a political issue.

Chronic medical conditions have been recognized as a barrier to participation in elections, and the literature that is related to the intersection of health and voting has been reviewed recently. In a study of 30 European countries, subjective perceived poor health was associated with as much as a 10% absolute reduction in probability of voting. Due to the transient and variable nature of acute medical illnesses, the impact of acute illness on electoral participation has been more challenging to study, although data from Europe may again be illustrative. In one study of hospitalized patients in France, voter turnout was approximately 25% compared with 84% in the general citizen population. Although several of the nonvoting patients had acute mental status derangements or other medical barriers to participation, more than one-half of registered voters who abstained had no such barriers and instead cited the complexity of voting by proxy while hospitalized as the reason for their not voting. In other European studies, the availability of proxy voting has been associated with improved turnout among ill voters.

Flexible voting options are key tools in preventing disenfranchisement due to medical illnesses, both acute and chronic. Only the broad availability of absentee ballots in North Carolina allowed Ms A to vote. Physicians and other health-care providers can serve as critical advocates for patients in this regard. Our frequent contact with vulnerable patients who may face barriers to voter registration or electoral participation presents us with a unique opportunity, and perhaps a duty, to support patients in this arena. Results from a voter registration effort at two university-affiliated federally qualified health centers in the New York are striking. Among 304 screened patients, 128 were found to be eligible to vote but were unregistered. Among this group, 89% registered to vote through this project. More generally, given the <60% voter turnout typical of US elections, all citizens should be inspired by Ms A’s determination to participate. She could barely breathe, but she could still make herself heard.

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References