Palliative Extubation

Withdrawal of ventilatory support · the goal is comfort, and the preparation matters more than the extubation itself

Treat distress
not the numbers

THE PRINCIPLE THAT GOVERNS EVERYTHING HERE

You are withdrawing an intervention that is no longer achieving the patient's goals, not withdrawing care, and not causing death. The underlying illness causes death; removing the ventilator allows it to take its course. **Medication is titrated to relieve observed distress, and doses adequate for that are appropriate even if they may hasten death as a foreseen but unintended effect.** Sedation given *in order* to cause death is a different act and is not what this is. **Document the indication for every dose as symptom relief**, and the distinction stays clear in the record.

BEFORE THE DAY *almost all of the work is here*

Step	Detail
Confirm the decision	Agreed with the family and the whole team, consistent with the patient's known wishes. **Ensure consultants and nursing staff are aligned first**, because a dissenting voice on the day is devastating for a family
Prepare the family explicitly	**Say what they will see:** breathing may become noisy or irregular, there may be gasping or agonal breaths, the color may change, and **the time to death is unpredictable**, from minutes to days. **Say clearly that noisy breathing does not mean suffering**. Ask who wants to be present, and whether children will attend
Time it deliberately	Allow family to arrive, and arrange **chaplaincy or cultural and religious rites beforehand**. Avoid handover times. A private room where possible, and relax visiting restrictions
Write the orders in advance	**PRN opioid and benzodiazepine with clear titration instructions, plus an antimuscarinic for secretions and an antiemetic. Have the drugs physically at the bedside before you start**, since a delay hunting for medication while a patient is distressed is the commonest avoidable failure
Stop what no longer serves comfort	**Discontinue monitors and alarms**, vasopressors, antibiotics, dialysis, blood draws, imaging and routine observations. **Turn the monitor off or out of view**: the family should watch the patient, not a screen. Consider deactivating an **ICD**, which is easily forgotten and can deliver shocks

THE PROCEDURE *pre-medicate, then withdraw*

Step	Detail
1. Pre-medicate	Give an **opioid with or without a benzodiazepine before touching the ventilator**, targeting a comfortable patient at the moment of withdrawal. Anticipate that requirements often rise sharply as support is removed
2. Stop neuromuscular blockade absolute	**Never extubate a patient with any residual paralysis.** It masks every sign of distress and prevents the patient from breathing at all, so the family witnesses apnea that is drug-induced. **Confirm full reversal with a train-of-four before proceeding**, and wait as long as it takes
3. Withdraw support	Two accepted approaches: **immediate extubation**, or a **terminal wean** reducing FiO2, PEEP and rate over minutes to hours. **Weaning gives more time to titrate comfort** and may suit an uncertain respiratory drive; immediate extubation removes the tube sooner and can feel more natural to families. Either is acceptable
4. Titrate to observed distress	**Assess with tachypnea, accessory muscle use, grimacing, restlessness and brow furrowing**, using a validated tool where available. **There is no maximum dose**: the correct dose is the one that relieves distress. **Do not titrate to blood pressure, respiratory rate or oxygen saturation**, and turn the pulse oximeter off
5. Stay	**Remain at the bedside for the first minutes**, then review frequently. Nursing presence continues throughout. **Leaving immediately after extubation is the thing families remember badly**

AFTERWARD *the part that is routinely rushed*

IF DEATH DOES NOT COME

Some patients survive hours or days, and a few survive to discharge. **Plan for this openly in advance** so the family is not left feeling the plan failed. Transfer to a ward or hospice as appropriate, and **ensure comfort orders travel with the patient**, since this is where symptom control is most often lost.

AT THE DEATH

Confirm and document death, allow the family unhurried time with the body, and explain what happens next. **Ask about organ and tissue donation and about autopsy where appropriate**, and check whether the case must be referred to the medical examiner before certification.

THE TEAM

Debrief the team, including nursing and trainees. These are among the most distressing events in critical care, and moral distress accumulates silently. **Bereavement follow-up for the family**, and a contact point for later questions.

VARIATIONS ON THE SAME PRINCIPLE *the reasoning transfers to every other withdrawal*

Situation	What changes
The awake, communicating patient	Rare and difficult, most often in high cervical injury or neuromuscular disease. **Confirm capacity and settled intent over time, ideally with psychiatric and ethics input**, and let the patient direct the timing and who is present. **Sedation before withdrawal is offered and titrated to their wishes**, not imposed
Vasopressors, dialysis, LVAD, ECMO	The same principle governs all of them: **an intervention no longer meeting the goals is stopped**. Decide explicitly what is being withdrawn and in what order. **Stopping vasopressors alone often leads to a quieter death than extubation**, and some teams withdraw them first. ECMO and LVAD withdrawal need the implanting team involved
Artificial nutrition and hydration	Medically and legally a treatment like any other, and it can be withdrawn. **Reducing fluids often reduces secretions, edema and breathlessness**. Expect this to be the hardest one for families, because feeding carries meaning that ventilation does not: **address the meaning, not just the physiology**
Organ donation after circulatory death	If donation is planned, the process changes: **the organ procurement organization must be involved before withdrawal**, and withdrawal may happen in or near theater with defined time limits. **Comfort care obligations do not change**, and the clinicians providing comfort remain separate from the transplant team

PEARLS & PITFALLS

- **Under-treatment is far more common than over-treatment.** Fear of hastening death leaves patients visibly distressed. If the patient looks uncomfortable, **the dose is too low**: titrate, do not wait.
- **Do not extubate while any neuromuscular blockade remains.** It removes the only signals you have to guide dosing, and is the hardest error to defend afterward.
- **Language shapes how families remember this.** Say **"withdrawing the breathing machine"** and **"allowing natural death"**. Avoid "there is nothing more we can do", and never use "being made comfortable" as a euphemism for something you have not explained.
- **Watch for the family member who arrives late and disagrees.** Pause and re-run the conversation. A few hours of delay costs little and prevents years of unresolved conflict.

References: Professional society and critical care consensus statements on withholding and withdrawing life-sustaining therapy · published guidance on palliative ventilator withdrawal and terminal weaning · validated respiratory distress observation tools.