To the Editor:

We generally agree with Gilligan and Raffin's thoughtful defense of the rapid withdrawal of life support (CHEST 1995; 108:1405-08). However, we strongly favor terminating mechanical ventilation by extubation. We have never witnessed the "marked respiratory struggle and distress" cited by the authors when adequate morphine was given. Rather, it is unclear to us why gradually decreasing mechanical support would be more comfortable than extubation. If anything, the resistance imposed by the ventilator circuit and the endotracheal tube increases discomfort. Agonal breathing, though disturbing, occurs both on and off the ventilator. Appropriate counseling of family members before preterminal respiration begins will, with rare exceptions, prevent undue distress.

Removing the endotracheal tube (and other tubes) offers several advantages: the more "normal" appearance of extubated patients is more comforting to loved ones. If morphine can be titrated to keep the patient conscious, extubation may allow speaking and even possible sips of water. If patients survive long enough, they can be transferred out of the ICU to a private room.

Comfort care can be provided in a variety of ways and must be crafted individually for each terminally ill patient. Occasionally, the method suggested by the authors may be optimal. Extubation, applied with proper skill, however, is far more comfortable overall.

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To the Editor:

Terminal weaning remains a painful process for all caregivers and families of the terminally ill. All the ethical and practical issues are addressed sufficiently by Drs. Gianakos (CHEST 1995; 108:1405-06), Gilligan, and Raffin (CHEST 1995; 108:1407-08), except one: what is the preference of the terminally ill patient?

Both essays seem to address the issue from the perspective of what is least painful to the key decision makers, who essentially appear to be the physician and family members. I was troubled that while both sets of authors truly express a desire to alleviate pain and suffering for their patients in a manner that is just and compassionate, each seems to relegate the patient's role in the decision-making process to the back burner; neither essay mentioned the patient's desire until the second page.

I suggest that neither approach to terminal weaning is the correct method. Rather, each end-of-life process involving discontinuation of mechanical ventilation is a unique circumstance that must be remedied specifically to provide the optimal comfort for each and every patient.

Extubation, weaning over days, the middle-ground (indecisive) approach, or rapid weaning each has a role once the wishes, expectations, fears, and other needs of the individual patient are sought and considered. The proper technique can only be ascertained after open and honest dialogue with all involved in the dying process—families, doctors, nurses, clergy, other caregivers—with primacy given to the patient, when possible.

There is no single correct process of withdrawing life support; rather, physicians should focus on being correct in the manner in which the decision to terminate ventilatory support is reached.

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To the Editor:

The recent "Debate in Print" on terminal weaning was provocative and helped frame the issues surrounding this topic which is receiving increasing attention. Both Gianakos (CHEST 1995; 108:1405-06) and Gilligan and Raffin (CHEST 1995; 108:1407-08) make a number of interesting points. Both articles cite data from our experience with the Comprehensive Supportive Care Team (CSCT) at the Detroit Receiving Hospital.1,2 We therefore address our comments to the authors of both articles, to clarify the approach and methodology for terminal weaning by the CSCT.

We agree with both articles that a method of "terminal extubation" causes distress to the patient, attendant family, and caregivers. Furthermore, our experience has shown that distress from airway obstruction cannot be easily reduced with analgesia/sedation. Therefore, the method used by the CSCT at Detroit Receiving Hospital is "terminal weaning" with a gradual reduction of minute volume, by reducing the respiratory rate, over a period of minutes to hours.

We agree with Gianakos (CHEST 1995; 108:1405-06) that terminal weaning allows for precise titration of medications and careful adjustment of the process itself to ensure patient comfort. We do not agree with Gianakos' statements about the ability, with a prolonged wean, to maintain a "positive uncertainty" about patient outcome. While some (very few) patients may survive to hospital discharge, this is not the expected outcome, and giving patient and family false hope during weaning could be confusing and lead to family mistrust regarding the physician's prognosis predictions that led to the option of ventilation withdrawal in the first place.

Weans by our team are typically completed in a period of minutes to hours. The duration of the wean is directly related to the patient's consciousness at the beginning of the process. Patients who are deeply sedated or comatose can be comfortably weaned in 20 to 30 min. Patients who are more responsive, or awake, are usually weaned more gradually, over a few hours. We reduce respiratory rate, rather than oxygen, theoretically causing a hypercapnia and its associated narcotic effect. If there is no distress after the patient is in a spontaneous mode, then we reduce the oxygen. A reduction in oxygen, as proposed by Gilligan and Raffin (CHEST 1995; 108:1407-08) will theoretically lead to hypoxemia and the resulting symptomatic response of distress.

We agree with Gilligan and Raffin about the unlikelihood of patient survival after weaning. The CSCT experience to date of 340 weans over a 10-year period shows a survival-to-discharge of 11%