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Review Article

Palliative Withdrawal of Mechanical Ventilation in Critically Ill Patients: A Narrative Review

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Abstract

Background: Palliative withdrawal of mechanical ventilation is an important component of end-of-life care for critically ill patients when life-sustaining treatment no longer provides meaningful clinical benefit or is no longer consistent with the patient's goals of care. Its application in end-of-life care remains challenging because it involves clinical, ethical, communication, and multidisciplinary considerations.
Objective: This review aimed to map recent evidence on palliative withdrawal of mechanical ventilation in critically ill patients and to examine practice-relevant themes and implications for nursing care.
Methods: A structured narrative search of PubMed, ScienceDirect, and Google Scholar mapped literature published between 2023 and 2025. The Population, Concept, and Context framework guided eligibility. The evidence map contained two primary withdrawal-specific studies and three contextual reviews. Sources were interpreted according to study design and directness; the synthesis did not estimate comparative effects.
Results: Among five mapped publications, two primary studies examined clinician perspectives on withdrawal and three review-level sources provided contextual information. Six a priori domains organized the narrative synthesis: therapeutic communication, shared decision-making, advance care planning, symptom management, family support, and multidisciplinary collaboration. Direct evidence was concentrated on communication, withdrawal processes, symptom management, and teamwork.
Conclusion: Palliative ventilator withdrawal is a planned, comfort-focused care process requiring continued nursing assessment, team coordination, and support for relatives. Because the evidence base was small, heterogeneous, and predominantly descriptive, the six domains should be understood as provisional practice considerations rather than a validated withdrawal protocol.

Keywords: End-of-life care; intensive care unit; mechanical ventilation; palliative extubation; palliative withdrawal of mechanical ventilation.

INTRODUCTION

Mechanical ventilation is a life-sustaining intervention used for critically ill patients with respiratory failure and other severe conditions. When recovery becomes unlikely or continued ventilatory support no longer aligns with the patient's goals of care, clinicians may need to consider the benefits and burdens of ongoing treatment. Such decisions require clinical assessment as well as attention to the patient's values, communication needs, and comfort.

Decisions to limit life-sustaining treatment should be distinguished from abandonment of care. Even when ventilatory support is withdrawn, the obligation to relieve suffering, provide emotional support, and preserve dignity continues. This principle is central to end-of-life care, in which symptom relief and goal-concordant treatment guide practice (1).

The need for palliative care is substantial. The World Health Organization has estimated that 56.8 million people require palliative care each year, including 25.7 million during their last year of life (2). Yet access to palliative services remains uneven, making the integration of palliative principles into acute and critical care particularly important.

In Indonesia, this integration also presents practical challenges. Astuti et al. described dilemmas encountered by critical care professionals when recognizing palliative needs while treatment remains directed toward maximal physiological support (3). These tensions suggest a need for clear processes to discuss goals of care before decisions about treatment limitation are implemented.

Implementation of palliative care in the ICU is influenced by healthcare system readiness, interprofessional communication, and the involvement of patients and families in decision-making. Successful implementation is not determined solely by clinical interventions but also by comprehensive assessment and systematic documentation to ensure that treatment goals, patient needs, and family involvement are appropriately documented (4).

Zamharira et al. reported that palliative care in the ICU should not focus exclusively on symptom control but should integrate communication, family support, and multidisciplinary collaboration to achieve appropriate goals of care (5). From the perspective of patients and families, advance care planning in Indonesia continues to encounter barriers, particularly limited communication regarding disease conditions, a cultural tendency to delegate decisions to family members, and limited familiarity with discussions regarding end-of-life treatment (6). These findings primarily reflect broader palliative and end-of-life care rather than withdrawal-specific practice. However, they provide important contextual considerations for communication, family involvement, and decision-making when withdrawal of mechanical ventilation is considered.

Similarly, Eng et al. found that Indonesian communities generally preferred end-of-life care discussions to be conducted sensitively and gradually, with family involvement as an important component of decision-making (7). These findings suggest that the application of palliative and end-of-life care in Indonesia is influenced not only by patients' clinical conditions but also by communication, cultural factors, healthcare professionals' preparedness, and the availability of patient- and family-centered care systems. These contextual considerations may also be relevant when decisions regarding withdrawal of mechanical ventilation are made.

Palliative withdrawal of mechanical ventilation refers to planned reduction or discontinuation of ventilatory support when continued treatment is inconsistent with agreed goals of care. The intention is to avoid burdensome, non-beneficial treatment while maintaining active comfort-focused care, not to hasten death. For nurses, the process entails anticipatory assessment of distress, communication, family support, accurate documentation, and coordination with the ICU team (1).

Withdrawal-specific publications address different parts of the process. Ortega-Chen et al. reviewed practical considerations in palliative extubation (8), whereas Bryan et al. investigated clinicians' perceptions of communication and symptom management during withdrawal in two ICUs (9). Elverson et al. discussed advance care planning, caregiver support, and withdrawal in neuromuscular disorders, a related but clinically distinct population (10).

Efstathiou et al. explored clinicians' experiences of palliative ventilator withdrawal, including communication, the choice of withdrawal

approach, teamwork, and emotional effects (11). In contrast, the umbrella review by Salins et al. examined broader ICU palliative-care practices rather than ventilator withdrawal as its primary question (12). The differing scopes of these publications require their findings to be interpreted according to design and directness.

Although ICU palliative-care reviews identify important elements of high-quality end-of-life care, they do not necessarily explain how those elements interact during a planned withdrawal of ventilation. In particular, findings from studies of general advance care planning or family support should not be presented as direct evidence of better outcomes after extubation (8–12).

The available publications also differ in population, clinical setting, methodology, and outcome definition. A focused nursing synthesis can clarify which observations arise directly from ventilator-withdrawal studies and which are contextual inferences from the broader palliative-care literature.

A narrative approach was selected to organize these heterogeneous findings into practice-relevant themes. The purpose was descriptive and interpretive; it was not to estimate pooled effects, compare withdrawal techniques quantitatively, or establish the effectiveness of a standardized nursing protocol.

The specific knowledge gap addressed here is the fragmented presentation of nursing-relevant actions before, during, and after withdrawal of mechanical ventilation. The review therefore distinguishes withdrawal-specific evidence from supporting literature and identifies areas in which the current evidence remains insufficient.

This review aimed to synthesize recent literature relevant to palliative withdrawal of mechanical ventilation in critically ill adults, distinguish direct from contextual evidence, and examine implications for critical care nursing. The contribution of this review is an explicitly nursing-oriented synthesis of communication, shared decision-making, advance care planning, symptom management, family support, and multidisciplinary teamwork. The six domains are used as an organizing framework for the literature, not proposed as a validated clinical pathway.

METHODS

Search Strategy

Literature was identified through PubMed, ScienceDirect, and Google Scholar. The first two sources were used to locate clinical and health-science publications; Google Scholar served as a supplementary search source. The review concerned literature published from 2023 through 2025. Because the exact search dates and complete database-specific search logs were not documented in the available record, the search should be regarded as a structured narrative search rather than a fully reproducible systematic search.

The Population, Concept, and Context (PCC) framework defined the scope. The population comprised mechanically ventilated critically ill adults, their families, and clinicians participating in end-of-life decisions. The concept was palliative withdrawal of ventilatory support, including terminal weaning and palliative extubation. The context was adult intensive and critical care.

Free-text terms were combined across the three PCC concepts with OR within concept groups and AND between groups. Terms reflecting communication, decision-making, family support, symptom assessment, and nursing care supplemented the core search when necessary. The core terms are presented below to make the search logic transparent.

Search terms and filters

The core search strategy included the following terms:

("critically ill" OR "critical illness" OR "intensive care patient*") AND ("palliative withdrawal" OR "withdrawal of mechanical ventilation" OR "withdrawal of ventilatory support" OR "palliative extubation" OR "terminal extubation" OR "withdrawal of life-sustaining treatment") AND ("intensive care unit" OR ICU OR "critical care").

Additional terms related to nursing practice, communication, decision-making, symptom management, family support, and multidisciplinary collaboration were used in supplementary searches when necessary.

The mapping focused on the 2023–2025 publication period. Older guidance and Indonesian contextual publications were cited in the introduction or discussion when relevant,

but were not counted among the five articles in the core evidence map. The publication window limits recency, but it does not ensure that every eligible withdrawal study was captured.

Table 1. PCC framework

Component	Description
Population	Critically ill adult patients receiving mechanical ventilation in intensive care settings, their families, and healthcare professionals involved in end-of-life care.
Concept	Palliative withdrawal of mechanical ventilation, including communication, shared decision-making, advance care planning, symptom management, family support, and multidisciplinary collaboration.
Context	Intensive Care Units and other critical care settings in which mechanical ventilation is withdrawn as part of end-of-life or palliative care.

Inclusion Criteria

The review distinguished two evidence strata. Primary empirical studies of adult ICU ventilator withdrawal were regarded as direct evidence; selected review publications were retained only when they clarified withdrawal procedures or relevant palliative-care principles. This distinction was maintained during extraction, synthesis, and interpretation. Sources had to be available in English full text and fall within the 2023–2025 mapping period.

- Addressed withdrawal of mechanical ventilation, palliative extubation, or closely related end-of-life processes relevant to the review question;
- Involved critically ill adults, family members, or healthcare professionals in critical or end-of-life care;
- Described communication, decision-making, symptom control, family support, team processes, or nursing implications;
- Reported an empirical primary study or a review publication that could be explicitly categorized as contextual evidence;
- Were published between 2023 and 2025;

Selection Criteria

The PCC framework was used to define the scope of the review.

- Were published in English; and
- Were available in full text.

Narrative, systematic, and umbrella reviews were not interpreted as primary studies. Review-level findings were identified as secondary syntheses and used only to place the withdrawal-specific observations in context.

Exclusion criteria

Articles were excluded when they:

- Discussed mechanical ventilation without a relationship to palliative or end-of-life care.
- Were editorials, commentaries, letters to editors, or conference proceedings.
- Did not provide sufficient information relevant to the review objective.
- Were not available in full text.

Screening and Selection Process

Records were merged and screened for duplicates, followed by title/abstract review and full-text assessment against the stated scope. Reasons for exclusion were summarized in the existing flow diagram. The distinction between primary and review-level sources was retained throughout the process.

One reviewer performed the initial screening and full-text assessment; uncertain decisions were discussed with a second reviewer. Because duplicate independent screening was not conducted, some selection bias is possible. Figure 1 reports the record counts supplied for this narrative search.

Two primary studies formed the direct empirical evidence layer. Three review-level publications were mapped as contextual sources and were not treated as additional independent patient-level observations.

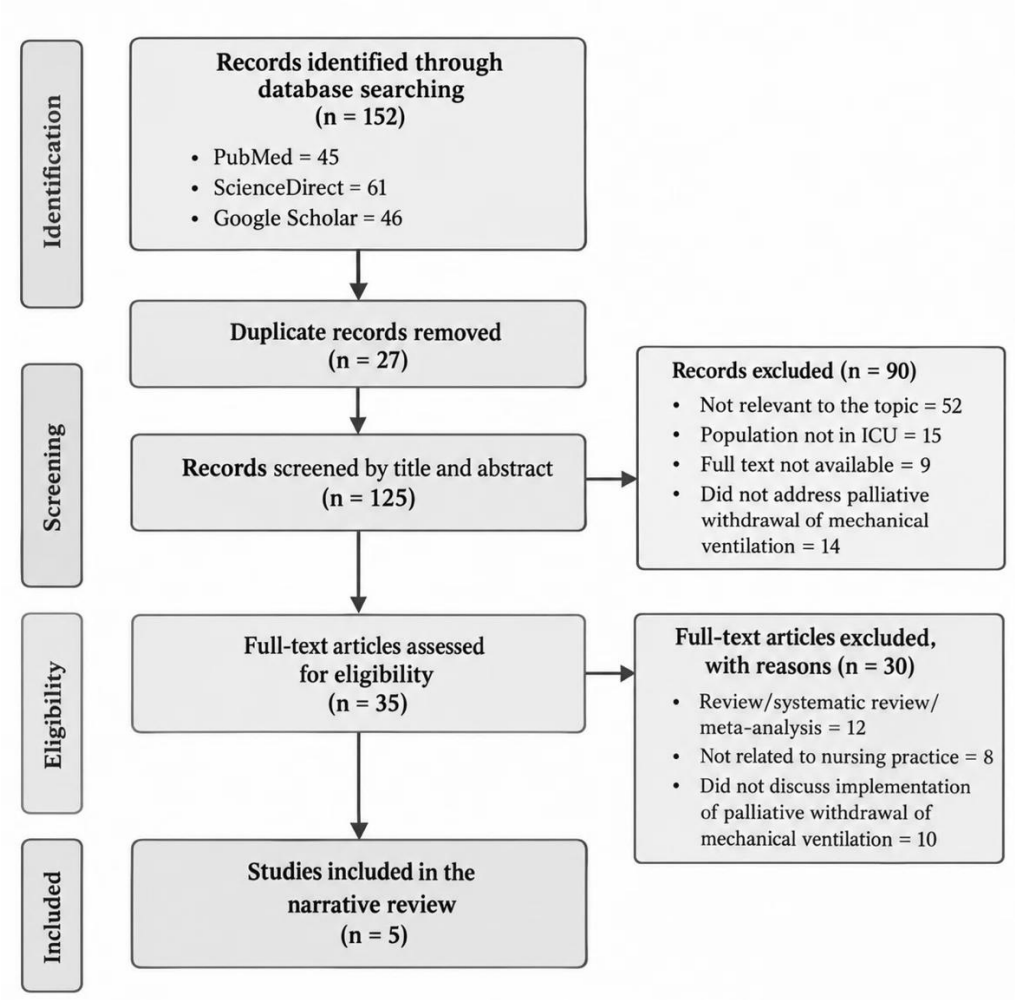


Figure 1. PRISMA flow diagram of the literature search and study selection process

Data Extraction

A structured extraction form captured author and year, publication type, population or focus, study setting, withdrawal-relevant findings, and relevance to nursing practice. The extraction distinguished participant-level observations from recommendations, interpretations, and review-level conclusions.

Table 2. Characteristics and Findings of Included Studies

Source and design	Population or scope	Evidence relevant to withdrawal	Interpretation for this review
(8) Narrative review	Palliative extubation in ICU patients; families and clinicians	Describes preparation, communication, symptom relief, extubation practice, and team support.	Direct topic but review-level evidence; recommendations are not observed effect estimates.
(9) Two-center prospective observational study	Clinicians caring for 152 ICU patients undergoing withdrawal; 312	Clinicians prioritized team and family communication and patient symptom control in judging process quality.	Direct primary evidence; clinician perceptions cannot establish causal effects.

Source and design	Population or scope	Evidence relevant to withdrawal	Interpretation for this review
	clinician surveys		
(10) Narrative review	Ventilation withdrawal in neuromuscular conditions	Discusses advance care planning, symptoms, coordination, and caregiver support.	Partially direct; disease context and ventilation modality may differ from adult ICU extubation.
(11) Qualitative study	22 clinicians at two UK hospitals	Themes covered communication, withdrawal methods, multidisciplinary teamwork, and effects on clinicians.	Direct primary qualitative evidence; transferability requires contextual assessment.
(12) Umbrella review	40 reviews of ICU palliative and end-of-life care	Provides broader themes of decision-making, family support, communication, and care planning.	Indirect contextual synthesis; not evidence of a specific ventilator-withdrawal pathway.

Quality Assessment

The two primary studies were considered against their respective design-specific appraisal domains, including participant selection, data collection, analysis, and consistency of interpretation. Item-level checklist judgments and a reproducible appraisal record were not available for reporting in this manuscript. Consequently, no formal risk-of-bias rating or quality-weighted estimate is presented; interpretation emphasizes study design and relevance to ventilator withdrawal.

The two narrative reviews and one umbrella review were considered separately. Their conclusions were not counted as independent primary-study outcomes, and their broader recommendations were not taken as proof of a particular withdrawal protocol.

Potential selection bias, non-equivalence of populations, and the distinction between clinical observations and expert recommendations were considered when comparing the sources. These judgments inform the limitations of the synthesis, rather than a numerical evidence-quality score.

Data analysis

Each source was summarized with attention to the setting and the distinction between directly observed outcomes and authors' recommendations. Extraction focused on information relevant to symptom assessment, communication, family support, and the clinical sequence of withdrawal.

A narrative matrix was organized under six a priori domains: therapeutic communication, shared decision-making, advance care planning, symptom management, family support, and multidisciplinary collaboration. Direct primary-study findings were described first; review-level publications supplied context where the direct evidence was incomplete.

Synthesis considered convergence, differences in study scope, and the temporal sequence of nursing actions before, during, and after withdrawal. The six domains were an interpretive structure rather than six independently validated components of an intervention.

Initial coding and mapping were performed by one reviewer, then discussed with a second reviewer. This process could reduce but not eliminate subjective interpretation because independent duplicate coding and a full audit trail were not reported.

RESULTS

Study Selection

The search yielded 152 records (PubMed, 45; ScienceDirect, 61; Google Scholar, 46). After removal of 27 duplicates, 125 records remained; 90 were excluded at screening and 35 full texts were assessed. A further 30 full texts were excluded, leaving five publications for the narrative map: two primary studies and three review-level sources. The counts correspond to Figure 1; missing search-date details and

limitations of the screening process are acknowledged below.

Study Characteristics

Of the five mapped sources, Bryan et al. and Efstathiou et al. were the two primary studies directly addressing ventilator withdrawal in critical care (9,11). The other three were literature reviews: Ortega-Chen et al. directly concerned palliative extubation; Elverson et al. addressed ventilation withdrawal mainly in neuromuscular disease; and Salins et al. synthesized broader ICU palliative care (8,10,12).

The evidence therefore differs along two axes: study design (primary versus review-level) and proximity to the review question (direct, partially direct, or contextual). These differences matter because a review recommendation or observation from neuromuscular care cannot establish clinical effects in adult ICU extubation.

The primary studies chiefly explored clinician-reported process quality, communication, symptom management, withdrawal methods, team functioning, and emotional experiences. They did not test whether the six organizing domains, considered as a package, improved patient or family outcomes.

Table 2 summarizes the five publications; Table 3 provides an explicit appraisal of their directness to the review question. Findings are discussed as practice themes, with observational associations and qualitative accounts distinguished from causal evidence.

Table 3. Directness to review question

Study	Design	Directness
Ortega-Chen et al. (2023)	Narrative review	Direct – specifically addresses palliative extubation, but review-level evidence
Bryan et al. (2024)	Prospective observational study	**Direct**
Elverson et al. (2023)	Narrative review	**Partially direct** – ventilation withdrawal but neuromuscular population
Efstathiou et al. (2025)	Qualitative study	**Direct**
Salins et al. (2024)	Umbrella review	**Indirect/contextual** – broad ICU palliative care

Findings

Therapeutic communication

Across the two direct primary studies, communication was repeatedly described as central to preparing patients, families, and clinical teams for withdrawal. The literature focuses on the clarity, timing, and consistency of discussions rather than measuring the effect of a specific nursing communication intervention.

Ortega-Chen et al. recommended preparatory conversations as part of palliative extubation (8). In the observational work of Bryan et al., clinicians emphasized team-family communication and symptom management when judging the quality of withdrawal (9). These findings support deliberate planning, but do not demonstrate a causal reduction in distress.

Shared decision-making and advance care planning

Advance care planning can record patient values and preferences before loss of decisional capacity. Elverson et al. discussed its role in neuromuscular conditions requiring ventilatory support; this evidence is relevant conceptually, but is not derived from withdrawal of invasive ventilation in an adult ICU cohort (10).

Indonesian studies of end-of-life discussions show that the family may play a central role and that communication often needs to be gradual and culturally sensitive (6,7). These findings guide contextual adaptation only; they should not be taken as direct evidence that a particular approach changes withdrawal outcomes in Indonesian ICUs.

Symptom management

Withdrawal of ventilatory support can be accompanied by respiratory distress, pain, anxiety, or agitation. Planning should include assessment before treatment changes, reassessment during withdrawal, and continued relief after ventilation stops. Available sources do not establish a single optimal medication regimen.

The palliative extubation review emphasized anticipatory symptom control and proportionate use of analgesic and sedative treatment (8). The wider umbrella review likewise placed symptom assessment within ICU palliative care, although it did not quantify effects of specific ventilator-withdrawal regimens (12).

Family support

Families need an explanation of the treatment decision, what the withdrawal process may involve, and how comfort will be assessed. Supportive communication and opportunities to express concerns may reduce uncertainty, although the five mapped publications did not yield a pooled estimate of benefit.

Cultural considerations are especially relevant to application in Indonesia, where family participation and preferences concerning disclosure vary between individuals (6,7). The patient's own expressed wishes and the applicable decision-making process should remain central.

Multidisciplinary collaboration and nursing role

Withdrawal requires coordination among the responsible physician, bedside nurse, respiratory-care personnel, and palliative-care or other support services when available. Communication of the agreed treatment goal, division of responsibilities, and continuity of symptom assessment may prevent inconsistent bedside care.

Efstathiou et al. found that clinicians described teamwork, withdrawal methods, communication, and emotional consequences as salient aspects of their experiences (11). Nurses contribute through repeated assessment, documentation, communication facilitation, advocacy, and support for relatives; the impact of each role on measured outcomes remains to be evaluated.

DISCUSSION

This synthesis maps six interconnected domains of palliative ventilator withdrawal, but the interpretation is constrained by its small evidence base. The two direct primary studies provide insight into clinician perspectives and processes; the three review-level articles add context. The mapping cannot determine the comparative effectiveness of immediate extubation, terminal weaning, or a multicomponent nursing protocol.

The distinction between withdrawing ventilation and withdrawing care is fundamental. Once life-sustaining treatment is no longer aligned with agreed goals, responsibility for managing symptoms, supporting family members, and documenting decisions remains (2). These obligations are consistent with contemporary end-of-life guidance but require implementation under local institutional and legal procedures.

The findings highlight communication as an important aspect of palliative withdrawal of mechanical ventilation. Effective communication helps healthcare professionals establish a shared understanding with patients and families regarding the goals of care and the planned withdrawal process.

Misunderstandings can arise if the family sees ventilation withdrawal as abandonment. The reviewed withdrawal-specific literature describes the value of advance explanation, a consistent team message, and anticipatory planning (8,9). The available studies chiefly report clinician perceptions or offer recommendations; they do not independently establish that a particular conversation format improves bereavement outcomes.

The Indonesian studies by Martina et al. and Eng et al. emphasize family-mediated decision-making, uncertainty surrounding prognostic disclosure, and the need for sensitive conversations (6,7). Indonesian ICU nursing literature also reports communication and organizational barriers to end-of-life care (16,17). These findings support culturally responsive assessment of each family's preferences, without assuming that all Indonesian families make decisions in the same way. A local review of therapeutic communication interventions describes possible educational approaches but does not establish withdrawal-specific effects (18).

Shared decision-making is another important component. Withdrawal of mechanical ventilation involves both clinical and ethical considerations. Decisions should involve the patient when they retain decision-making capacity and, when appropriate, an authorized surrogate or family member together with the healthcare team. The patient's previously expressed preferences, values, and goals of care should guide decision-making when the patient is unable to participate directly. Clear communication among the relevant decision-makers is important to maintain consistency in the agreed plan.

When patients can participate, their own goals and preferences should guide discussion. Otherwise, an appropriately identified surrogate and the team should consider previously expressed values and the patient's best interests under the applicable framework. Studies from Indonesia and international syntheses indicate that religious concerns, family roles, time constraints, and inconsistent records can complicate advance care planning (6,7,19,20). Thus, the nurse's role includes identifying misunderstandings and ensuring that decisions and preferences are handed over accurately.

Withholding means choosing not to initiate a life-sustaining treatment; withdrawal means discontinuing support already in use. In both situations, active care continues through symptom relief, psychosocial support, and attention to patient dignity. The recent Society of Critical Care Medicine guidance recommends documented surrogate identification, structured decision-making, and protocols for treatment withdrawal and symptom assessment (13).

Terminal weaning generally reduces ventilator assistance stepwise, whereas terminal extubation discontinues mechanical ventilation and removes the endotracheal tube. Neither approach should be presented as universally preferable: selection depends on patient needs, anticipated respiratory distress, the goals of care, and available expertise (8,14). The European Society of Intensive Care Medicine similarly emphasizes patient-centered decisions and individualized end-of-life care (14).

Symptom assessment is particularly important because distress may be difficult to identify in patients who cannot communicate. A review by Mazzu et al. identified validated observational scales but also important gaps concerning withdrawal processes, dosing, and team support (15). Analgesia and sedation should be titrated to observed or anticipated symptoms according to clinical orders and local guidance (8,15).

The aim of symptom-relieving medication is comfort, not deliberate acceleration of death. Opioids and sedatives may be appropriate when clinically indicated, with ongoing assessment and proportional titration; refractory symptoms may require specialist palliative input (8,13,15). A stepped-wedge cluster randomized trial published in 2024 reported improved respiratory comfort with a structured ventilator-withdrawal algorithm compared with usual care, although that trial was not among the five publications included in the present mapping (21). This reinforces the need for transparent inclusion procedures in future syntheses.

Clear documentation should include patient preferences and decision-making capacity, the surrogate where relevant, participants in family discussions, the agreed limitation of treatment, the selected withdrawal approach, symptom-management orders, and reassessment. Standardized documentation may improve continuity between shifts and disciplines (13,19). However, the present narrative map provides no direct estimate of its effects on patient comfort.

Family support must continue during and after the procedure, including explanation of possible changes in breathing and opportunities for presence or spiritual support as desired. Evidence about family-support strategies in broader ICU populations is informative but heterogeneous; benefits cannot automatically be extrapolated to families of patients undergoing palliative extubation (14,22).

Nursing responsibilities can be organized temporally: before withdrawal, assess comfort and communication needs, confirm the plan, and prepare family members; during withdrawal, monitor for distress and coordinate prescribed symptom relief; afterward, continue comfort measures, documentation, and family support. These are practice considerations informed by the mapped literature rather than an evaluated intervention bundle (8,9,11). Qualitative ICU nursing studies support the relevance of communication and emotional labor at the end of life (17,23,24).

Clinicians also require consistent role allocation and opportunities for team reflection. Efstathiou et al. reported emotional consequences of

withdrawal and highlighted multidisciplinary teamwork (11). Additional critical care nursing evidence describes uncertainty about roles and information gaps during end-of-life situations (25). Organizational support should therefore be considered alongside bedside symptom management.

Implementation in Indonesia cannot be inferred directly from UK and US withdrawal studies. Decisions must comply with applicable Indonesian law, hospital policy, ethical review processes, and professional standards. The national palliative-care literature identifies broader service and workforce gaps (26), but this review does not provide a legal analysis or demonstrate which withdrawal protocols are currently feasible in Indonesian ICUs.

Taken together, the most defensible interpretation is a staged nursing process—preparation and goal clarification, planned withdrawal with continuing symptom assessment, and follow-up support for relatives and staff. Communication and comfort are common threads across these stages. The six domains are neither exhaustive nor independently validated and should not substitute for multidisciplinary decisions or local protocols.

Implications for nursing practice

The findings suggest practical checkpoints for nurses: confirm that goals of care and the decision-making process are documented; identify communication and cultural needs; prepare a symptom-assessment and response plan; clarify responsibilities across disciplines; and provide family support throughout the withdrawal (8,9,11,13). These checkpoints require adaptation and formal evaluation before adoption as a standardized pathway.

The mapped primary evidence is strongest for describing clinician experiences and perceptions, whereas evidence about advance care planning, family support, and culturally sensitive communication is often indirect (6,7,10,12). Quality indicators for future studies could include documented goals-of-care discussions, validated distress assessment, family experience, and adherence to planned symptom management.

Future research should include adequately described prospective studies and implementation evaluations in Indonesian adult ICUs. Useful questions include how nurses monitor nonverbal respiratory distress, how culturally responsive family conferences are conducted, and whether a standardized documentation and symptom-response process improves patient comfort or family-reported outcomes.

Limitations

This review is limited by a three-source search, incomplete search-date and strategy reporting, English-only retrieval, a short publication window, and primarily single-reviewer screening and coding. Only two of five mapped publications were primary withdrawal-specific studies; the remainder were reviews with different populations and scopes. Item-level critical-appraisal results were unavailable, and the flow counts were not independently verified. The non-exhaustive selection is illustrated by relevant primary intervention research discussed outside the five-source corpus (21). No quantitative synthesis or certainty-of-evidence rating was possible; the six domains should not be interpreted as an evidence-based clinical protocol.

CONCLUSION

Palliative withdrawal of mechanical ventilation is a planned transition to comfort-focused care that calls for clear communication, documented shared decisions, anticipatory symptom assessment, family support, and interdisciplinary coordination. Nurses can contribute before, during, and after withdrawal through assessment, advocacy, communication, and continuity of care. Because this narrative map contained only two direct primary studies and three contextual reviews, its six domains are provisional practice considerations rather than a validated framework. More transparent evidence syntheses and prospective studies, especially in Indonesian ICUs, are required.

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Conflict of Interest

The authors declare no financial, professional, or personal conflicts of interest related to this study.

Author Contributions

FNA, SBNP, and TAM contributed to the literature search, data extraction, evidence synthesis, and initial manuscript drafting. FNR provided academic supervision, methodological guidance, critical revision of the manuscript, and oversight of the review process. All authors reviewed and approved the final version of the manuscript.

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