TABLE 1: Typology of Clinical Moral Orientations Among ICU Physicians

Moral Orientations	Personal clinical moral beliefs	Perceived power over moral decision-making	Clinical moral decision-making	Level of moral distress	Perceived rewards from clinical moral decision-making	Perceived by others as… (from quotes)
Virtuous type	Strong beliefs about what is right or wrong	High	Based on own beliefs about what is 'just' for the society and/or for the patient	Low	Moral satisfaction of doing 'what they believe is right'	Paternalistic, dogmatic, lacking empathy
Additional Quote	"*But I spent two hours with* [the patient's family] *explaining, and I basically gave them a physiology lesson about why we can't do this and why we can't do that and what's going to happen if we put the breathing tube in. And putting the breathing tube in itself might, in fact, actually hasten his death and will take away his ability to interact with them to whatever extent he was able to. And at the end of it, they said: "well we don't agree, we think he* [the patient] *should be put on life support but we can't make you do it, so I guess that's okay". And I took that as the family saying that they were not willing to say that they don't want him to be on life support but they're willing to accept that it's maybe not the right thing to do. And so, he didn't end up being put on life support, he did go to the ward and eventually died there.*" [P14] "*It can also lead to difficulty among the intensivists, handover to handover. Sometimes you get other intensivists who are a little bit more militant about pushing their agenda. They're a bit more directive with families. But my approach is one of, I won't say surrendering or capitulating to the family, but we know medically/legally there's no support for paternalism. We know from recent legal cases that when push comes to shove, the law sides on the side of the family. For better or for worse, that's how it is. So, if you're handing over a case where you're continuing wanting to proceed with that futile care, to a colleague who maybe would be a bit more directive, sometimes they question you. And that leads to a little bit of friction sometimes between colleagues.*" [P3]					
Resigned type	Strong beliefs about what is right or wrong	Low	Based on fear of negative consequences (e.g., legal or inter-personal conflicts)	High	Limited	Avoidant, not able to cope
Additional Quote	"*I'd be handing over a case where I didn't necessarily feel that dialysis was in the patient's best interest. I didn't feel that it would change their outcome. But nephrology is involved, the family wants to move ahead, and we're stuck*." [P3] "I would say some colleagues, earlier on [in their career], they will express frustration and sometimes the only way you can make banging your head against a wall not hurt is to stop banging your head against the wall. And they're continuing to bang their head against the wall. I think it's just that not figuring out a way to accept it or, yeah, not figuring out a way to continue doing what you don't think is right without going crazy." [P9] "*… [I feel] mostly disappointment in my colleagues and I guess frustration as well. I think that in medicine there is often no objective answer and the training is very long. We kind of have this prolonged adolescence where if your staff doctor is happy with you, then you're a good boy, and there's no objective standard that you're held to other than making your staff doctor happy. And then I think that carries on where many of my colleagues just seem to be wanting to know what the*					

	rule is so they can follow it, wanting either the College or the CMPA or the courts to tell them what to do. I think you robbed yourself of a meaningful life if you delegate moral decision-making to these committees of people who are much like you, perhaps morally stunted as you are. I got very frustrated with them." [P7]					
Deferring type	Tolerance & open-mindedness about what is right or wrong AND Think personal beliefs are irrelevant to DM	Low	Based on perceived societal priorities and values, not on personal beliefs	Low	Moral satisfaction of doing 'what they perceive others believe is right'	Avoidant, not team player
Additional Quote	"*I do believe in individual autonomy and if you believe in autonomy then autonomy has to include the option to make poor choices. I actually believe that fairly strongly. And there's all kinds of stupid things in the world. So I think inappropriate end of life care, when you look at it in the big picture, is a small issue. Once again, ultimately, it's people choosing to do that to themselves and who am I to say, oh, I don't think you should do this. I mean there's a small distributive justice issue perhaps in that it's expensive to take care of these people, maybe, but not really, and to the extent we waste money, we waste a lot more money doing other dumb things. So yeah, it's just not an issue for me at any level.*" [P16] "*But nevertheless, with this patient, one of our colleagues recently put them on continuous renal replacement therapy, which I have to say was distressing. This patient has no chance of any what most people, I think, would consider to be a valuable outcome. And it was distressing not to just myself but to a number of physicians in my group. It really sat outside the boundaries of what most of us thought were the boundaries, so we were kind of shocked and surprised even though this person would certainly be the most conservative among us, which we all really respect. It felt that it put us in a tough position because that means that the next time one of us is taking care of that patient, if they become unstable on dialysis, then we felt like we would be forced to make that same decision.*" [P11] "*The idea is that [the nurses] are carrying out a plan that maybe they're not invested in, a plan that they really think is wrong in some of the cases; we talk about multi-organ failure, patients in a vegetative status that we know are not waking up. Certainly, there can be conflicts. The nurses will ask on rounds: "why are we doing this?". Medically/legally, we may not agree with this, but it's not our call to make, and we have to pretty well proceed as the family directs us. So, that can lead to difficulties.*" [P3]					
Empathic type	Open-mindedness about what is right or wrong AND Think all beliefs are relevant to DM	Moderate	Based on consensus between own, healthcare team, patient, family beliefs and values	Moderate	Empathic, altruistic rewards	Supportive, ally

Additional Quotes	"*A kind of horror, just horror. I would go and do rounds. The patient had been avoided by all the doctors so I would be on call at night. I would get there on my night-time rounds, and there would be this room where the patient was lying inert on a ventilator, and there was a family member in continuous attendance. So I would make it a point of going in and actually seeing what was going on in [the room]. I would see the family member, they would stand up, and I would introduce myself. I would examine the patient. I would see some of the involuntary movements that she would make that were distressing, and I would notice that this patient's family had a bible on their bedside. It would be open to different verses so I would read the verse, and I'd ask them what is this about?*" [P2] "[…] *so I'm going to introduce the difficult situation to the family and I'm going to see how they respond. If the initial response from the family is one of portraying a patient who is very aggressive in terms of their goals of care, who would undertake most risks for even a marginal improvement in the quality of life or length of life, well that's going to come through pretty quickly. And then I'm going to be able to take a step back and reassess and probably move the goal posts a little bit. I readjust my plan for that patient's care, right and so, maybe it is, instead of withholding life-sustaining therapy right at that moment, because ultimately, I think it's futile, maybe we say okay we'll do a short trial. And these are the new parameters, these are the new rules of engagement, this is the new set of goal posts.*" [P19] "*What I was trying to do is to express that the family is really hurting and acknowledge that it is, and understandably, frustrating but was trying to sort of take the high road and say things like, well we'll just try to do the best we can to care for the patient and the family. And their perspective is very different than many members of the healthcare team but let's remember to be as compassionate as we can be, do what we can, continue to give messaging about what we expect to happen, be realistic when we're anticipating the future and then try to stay calm and be non-judgmental.*" [P20] "*It's mostly how to make sure that the patient's spouse is able to express all the emotions that she's feeling, because there is grief, there is anger, there is guilt. Just to make sure that she feels safe saying those things and expressing those things if she needs to and make sure that she has support. That was the main thing. […] but I still have a really, really sick patient on the other hand. The other thing is to make sure that she has the support system that she needs, because I cannot be there for 24 hours non-stop. So, that's the goal: we need to make sure that we are there but taking care of her spouse at the same time.*" [P6] "*I think we've got an ethos in our ICU. Humanism is important and we try to be very patient and family centred. We try to have perspective about things that are frustrating in the workplace and try to find workarounds or acknowledging when they exist and trying to deal with them on our own. I think we talk to each other about what's going on and how we're thinking and feeling a fair bit. We're fairly open with that. And try to spare each other off if we're feeling exhausted or tired.*" [P20]