Supplemental Information

KEY ELEMENTS OF THE STANDARDIZED ACTORS' GUIDELINES

The standardized actors played the role of the mother and the father.

They were trained by an investigator specialized in medical simulation (A.M.).

They acted in a homogeneous fashion with all research participants, using the following guidelines:

Mother

- Say the name of your infant if and when asked (Beatrice).
- Cry and remain silent until ~5 minutes into the resuscitation, when you ask, "What is happening? "
- Remain silent.
- After the death, after the clinician speaks to you, ask, "Why did my baby die?"

Father

- Approach the bed where the infant is resuscitated.
- Stay standing up at the bedside unless told not to.
- Ask, "What is happening?"
- Continue asking questions, unless you are told not to or until you have an answer. Examples include the following: "Why isn't she crying?"; "It isn't going well, is it?"; "Can somebody tell me what is happening?"
- After the death, after the clinician speaks to you, ask, "What is happening now?"; "What will happen to her?"

PARENT EVALUATOR RECRUITMENT AND SUPPORT

The nonparent investigators initially wanted to involve nonbereaved parent evaluators and were not in favor of recruiting bereaved parents to evaluate videos of unsuccessful resuscitations. On the other hand, the parent collaborator disagreed (M.S.) as well as the other bereaved "veteran" resource parents (n = 8) who partner with us in clinical, teaching, and research initiatives.[13] We approached the institutional review board of our research center, and together, with the help of the NICU psychologist, we worked on a careful plan to approach bereaved parents.

The following stepwise approach was considered essential and accepted by all investigators, the bereaved resource parents, and the institutional review board.

We all agreed that

1. significant risks existed for potential bereaved parent participants;
2. despite their vulnerabilities as bereaved parents, some parents could safely participate with rigorous recruitment and additional support, if needed;
3. careful follow-up and a stepwise approach was essential;
4. some parents may estimate they can safely participate, but may only realize, when visualizing the videos, that this is harder than they thought or not realistic;
5. systematically excluding vulnerable populations from research only further increases our knowledge gap and our ability to improve care for this population; and
6. it could be possible that for some parents, participation could also be beneficial and may provide something constructive (meaning-making).

For this study, we wanted approximately one-third of evaluators to be parents, which translated in 6 to 7 parents. We also wanted the opinion of 1 to 2 parents whose child was alive but had survived several resuscitations and had regular discussions regarding level of interventions.

To recruit parent participants, it was decided that only bereaved parents who satisfied the following criteria could be contacted in writing:

- Their child had died at least 18 months before the start of the study.
- They had to have been evaluated by the clinical NICU psychologist while their infant was in the NICU. This is current NICU practice, but some parents refuse to meet the psychologist and were therefore excluded from consideration.
- The NICU psychologist recommended the names of parents to be contacted. Any parents with previous psychopathology or who developed any psychopathology after the

death of their infant would not be considered. The recommendations were based on her knowledge of the parents and their grieving process.

- Parents were contacted by mail with a request to respond by e-mail, telephone, or letter if they were interested. They could not be contacted a second time.
- Parents who reported any psychopathology were excluded from the research (depression, anxiety, posttraumatic stress disorder).
- Parents were given detailed information about the study in the way they wanted: phone, e-mail, or in person (some parents, after an NICU experience, do not wish to come back to the hospital). They were informed orally that as a bereaved parent, viewing videos of unsuccessful resuscitations, even when simulated, had a real potential risk to trigger traumatic symptoms as well as create undue distress. They were all informed that their participation was voluntary and that they could stop evaluating videos at any moment.
- They were informed of the length of time of each video and the number of videos.
- Parents who consented to participate were asked to view 1 video (or start viewing one) before confirming their ongoing consent in writing.
- After confirming their consent, they were reminded they could stop evaluating the videos at any moment and could contact us by phone, Internet, or in person anytime during or after the research process if they had concerns or questions.
- After their participation, parents were offered $500 compensation for their time.

Analysis of Open-Ended Questions

We also recruited 2 parents at a time and obtained their feedback before recruiting more, in case the protocol needed to be adapted after further parental input (the protocol was not amended).

Thirty-one participants were each evaluated by all 21 evaluators, which gave us 651 evaluations, each with up to 3 positive and 3 negative interactions.

To analyze 651 evaluations, each with 6 potential remarks (up to 3 positive examples and 3 negative examples), 1 investigator read all the evaluations (M.-H.L.) and another 2 investigators (A.J. and T.P.) read a total of 250 evaluations that were randomly selected. Using a thematic qualitative content analysis approach, themes and coding definitions were independently developed on the basis of these analyses. Then, themes and subthemes were discussed between the investigators, and each theme and subtheme (node and subnode) was rigorously defined. Then, the 3 evaluators randomly selected 50 evaluations and independently coded the open-ended questions in them, aiming for 85% agreement between all 3 coders before finalizing the themes and subthemes. Because agreement was >85%, the themes, nodes, and subnodes were finalized, and the remaining 601 evaluations were coded by 1 investigator (M.-H.L.).