the duration of the training and collected open-text comments.

Results 37 adults (18 patients/citizens, 17 researchers/health professionals, 1 patient/researcher and 1 other) completed the questionnaire, of which 29 women, 34 university graduates and 19 persons without participatory research experience. Results showed positive perceptions of usability, credibility, and overall quality. Those new to participatory research found it highly valuable, participants with experience found it less valuable (mean 8.2 vs 5.4/9, $p<0.01$). The latter tended to suggest more improvements (content addition and clarification).

Discussion We did not collect perceptions regarding training patients and researchers together. Experienced participants highlighted gaps in content rather than formatting, indicating a need to adapt content to participants' level of experience.

Conclusion(s) Our module performed well on relevant criteria. Despite differences in the perceived value of the training between participants with more or less experience, the observed benefits support a joint training model. Flexible training content could meet the learning needs of participants with different experience levels, for example by accessing additional information through dropdown menus.

REFERENCES

1. Formation en ligne. www.forces-sante.ch/formation (Accessed 15 Dec 2023)
2. User Experience Design.https://semanticstudios.com/user_experience_design/ (Accessed 15 Dec 2023).

204 TOP 10 LEGAL DEVELOPMENTS IN SDM: LAW AND POLICY UPDATE ON IMPLEMENTING SDM INTO CLINICAL PRACTICE

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Introduction Real-world use of SDM and PDAs remains persistently and distressingly sparse. While most ISDM sessions and posters rightly explore the latest tools and strategies for improving patient oriented SDM, we must also explore ways to increase clinician uptake outside the research laboratory.

Methods This is a comprehensive and up-to-date status report on legal and policy incentives for SDM implementation. Because more work has been done on SDM in the USA, the authors reviewed statutes and regulations at both the state and federal level in the United States.

Results Three different types of new legal and policy incentives are pushing SDM implementation.

Payment incentives link PDA use to insurance/payor reimbursement.

Liability incentives link PDA use to legal protection from liability.

Mandate incentives require PDA use categorically.

In this highly graphic session, an attorney/bioethicist describes recent examples of each of these three types of legal incentives. He explains how these incentives push clinicians to use PDAs and engage in SDM. And he assesses how effectively these incentives are working.

Discussion Law cannot solve the implementation challenge by itself. Guidance documents identify multiple, overlapping strategies for implementing SDM and increasing clinician uptake. Still, law remains one important piece of the implementation puzzle. This session offers a succinct, yet comprehensive, review of recent law and policy related to SDM and PDAs.

Conclusion It is not enough to design communication materials and best practices. To ensure patient safety and protect patient rights, we must also ensure that they get adopted and assimilated into clinician-patient encounters.

205 MOTIVATE CLINICIANS TO USE PATIENT DECISION AIDS BY SHOWING HOW THEY REDUCE MEDICAL LIABILITY RISK

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Introduction Legal doctrines of medical malpractice and informed consent have failed to assure that patients understand the risks, benefits, and alternatives to the healthcare they receive. Most patients lack an adequate understanding of their treatment options. But clinicians' profound of dread liability claims can motivate them to use PDAs.

Methods The authors conducted systematic reviews on both (1) research on the benefits of PDA use and (2) research on medical liability risk. They then correlated PDA benefits with types of legal risk.

Results PDAs reduce liability risk from negligent nondisclosure (informed consent) in three ways.

First, using PDAs sometimes earns clinicians a 'shield' from liability.

Second, failing to use PDAs will increasingly be used as a 'sword' to find clinicians liable.

Third, PDAs lower risk through better documentation.

While PDAs can most obviously mitigate liability from negligent nondisclosure, they also mitigate liability from other types of medical malpractice claims unrelated to negligent nondisclosure (informed consent). They do this in three ways.

First, PDAs result in better outcomes (e.g., from better adherence), and patients with better outcomes bring fewer claims.

Second, PDAs result in more satisfied patients, and satisfied patients bring fewer claims.

Third, even when patients have adverse outcomes, they are less likely to have the surprise and anger that motivates them to bring claims.

Discussion PDAs not only benefit patients, but they also benefit clinicians and healthcare entities. PDAs materially reduce the risk of liability both from negligent non-disclosure and from other types of medical malpractice claims. This should help design implementation incentives. For example, professional liability insurance carriers can nudge clinicians to use PDAs with their patient by offering the monetary incentive of insurance premium reductions.

Conclusion Using PDAs improves patient safety and reduces medical liability risk.