consultant responsibility to diagnose dying and/or withdraw treatments. Both juniors and seniors described being less inclined to diagnose dying if the patient is young and/or has young children.

Conclusions This study has revealed challenges in recognition of dying perceived by Scottish doctors. The findings suggest this area of patient care is complex and uncertain, even for experienced practitioners. Comparing perceptions of senior and junior doctors gives insights for potential means of improved medical education. Recommendations include clearly defining the responsibilities of junior and senior team members, being explicit with learners about the often uncertain nature of recognising dying, and improved organisational factors to facilitate continuity of care.

20 NEGATIVE PERSONAL EMOTIONAL IMPACT OF CARING FOR THE DYING – EXPECTATIONS OF FUTURE DOCTORS. A MULTICENTRE STUDY

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Background End of life care (EOLC) is a large part of junior doctors' workload. Negative attitudes may impact on care provided and may be shaped during undergraduate medical training.

Aims We investigated:

- whether medical students expect EOLC to have a negative emotional impact on themselves
- demographic and psychological factors associated with such expectations.

Methods Multicentre cross-sectional online study of 1520 first and 954 final year medical students from 18 universities, (16 UK, 1 New Zealand, 1 Ireland). We assessed attitudes towards EOLC (Sullivan's statements), age, gender, course year, course type (standard or graduate), spirituality and experience of bereavement as well as psychological variables: death anxiety (Collett Lester Fear of Death Scale, COLFD), empathy (Davis's Interpersonal Reactivity Index, IRI) and depression (Hospital Depression Scale HADS-D). Factor analysis suggested 3 Sullivan statements formed a 'negative personal emotional impact score' (Impact Score, −6 to +6). Students with low/neutral (−6 to +3) and high (+3 to+6) Impact Score were compared (Ï‡2-tests and ANOVA) and regression analyses undertaken.

Results Respondents were neutral overall (mean Impact Score=0.3), although with substantial variations. Participants with high Impact Score were likely to be younger, standard course, first-year students, and to have higher depression and distress scores (HADS-D and IRI-Personal-Distress-scale), lower cognitive empathy scores (IRI-Perspective-Taking) and to score more highly on all COLFD sub-scales. Regression analysis showed psychological factors were strongly associated with the Impact Score: COLFD others-dying (1.29;CI: 1.08 to 1.50; p=0.001), IRI-Personal-Distress-scale (0.97;CI: 0.77 to 1.17; p=0.001), HADS-D (0.45;CI: 0.17 to 0.74;p=0.002), and COLFD others-death (0.31;CI: 0.09 to 0.54;p=0.006) scales were the strongest predictors.

Conclusions Medical students worry about the possible negative personal emotional impact of EOLC when doctors. While medical education may mitigate such concerns, negative expectations appear related to distress, death anxiety and depression. Measures to improve and support psychological well-being may have a positive impact on medical students' attitudes toward EOLC.

21 REAL TALK – A NOVEL EVIDENCE-BASED, VIDEO-BASED COMMUNICATION SKILLS TRAINING RESOURCE

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Background Much palliative care communication training draws on sparse evidence about practice. Yet training's effectiveness depends on the strength of its underpinning evidence. An empirical, observational science of language and social interaction – 'Conversation Analysis' holds great promise because:

- it is generating copious evidence on communication, and healthcare–communication specifically;
- shows role–played interactions differ from authentic ones in fundamentally important ways;
- recent quantitative evaluations of interventions based on conversation analytic findings have shown effectiveness.

Within a research and training development programme, we designed novel training resources – 'Real Talk' incorporating research findings and clips from video-recorded hospice consultations. We designed Real Talk to complement rather than replace existing resources. We report a preliminary evaluation of Real Talk's strengths and weaknesses.

Method Mixed-methods, qualitative evaluation entailing observations, interviews, and participant-completed feedback questionnaires.

Results We collected data from 11 events, 10 trainers across England, and 150 trainees.

Conclusions Trainees and trainers alike appreciated the video clips and their authentic nature. Observations and reports indicated Real Talk was particularly effective for encouraging participants to both emotionally engage with the nature of palliative care, and actively engage in discussion and overall learning about communication practices. Trainers used the video clips more than they did the research findings components; with a similar pattern seen in most trainees' feedback. Our decision to design Real Talk for trainers to use without initial intensive training meant we could rapidly and widely distribute the resources and evaluate their use. However, this also meant heavy reliance on trainers' existing facilitation skills, and on their allocation of adequate time to familiarise themselves with the materials. We argue that this is also why the research findings-based components were not put to full use by trainers. We are revising Real Talk and its delivery on the basis of our evaluation.