

training, suggesting that doctors learn best through applied 'leadership learning' as opposed to theory-driven programmes. **Conclusions** Drawing on Self-Determination Theory this study provides a theoretical framework for engaging doctors in Medical Leadership; assessing their leadership competency and learning needs and setting up reliable leadership training programmes. Doctors' ability to reliably determine their learning needs and the invaluable role of hands-on leadership/management experience in boosting doctors' leadership confidence, calls for more personalised and relevant learning plan that can build on their previous experience and expertise.

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WARNING BELL AGAINST THE RISE OF VIOLENCE WITH REGARD TO HEALTH PROFESSIONALS IN THE EMERGENCY DEPARTMENT

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Introduction The violence is strongly present in the current hospital context, where the violence in the hospital is increasing, in particular with regard to harm to persons. The emergency department, as the hospital's multidisciplinary gateway, is now the most widespread hospital service with the highest number of acts of violence.

Methods This is a cross-sectional study conducted with the emergency department staff at a prefectural hospital in Casablanca using a self-administered questionnaire. The aim is to evaluate the violence in the emergency department and to define the methods of prevention.

Result Only 30 people (37.5%) participated in the survey, with a female predominance (66.6%). The average age was 35 years. 90% of our respondents feel exposed to violence in the performance of their duties. Nurses are the most exposed occupational category (34.6%). Visitors and accompanying persons were the main perpetrators of the violence (66.6%). Violence occurs more at night (39%). 69% of violence is harmful to people. Only 33.3% of the violence was reported to the administration.

Discussion Several studies, including ours, show a female predominance, this could be explained by the feminization of health personnel. In our study, visitors or accompanying persons were the most responsible for the violence (66.6%), which is in line with several Moroccan studies. However, the 2014 annual report of the national observatory of violence in the health sector shows that in 72% of the perpetrators of the violence were patients. Personal injury is the most frequent, which is in accordance with the literature. On the other hand, the reporting rate remains relatively low compared to the literature.

Conclusion Violence against health personnel has become a daily reality. Its continuous rise has sounded the alarm calling to control this risk. Efforts should be pursued towards evaluation and prevention in order to optimise exercise safety.

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APPLYING PRACTICE GUIDELINES IN OCCUPATIONAL MEDICINE

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Systematic critical appraisal and clinical epidemiology as represented by the Cochrane Collaboration have provided the methodology for the formulation of clinical 'practice guidelines' in many specialties and in primary care. Practice guidelines are valuable in establishing the standard of care, controlling costs, and improving consistency of outcomes. Critics charge that practice guidelines suppress innovation, constrain the practice of medicine, ignores differences in patient population, and are overly rigid given individual patient characteristics. The application of clinical guidelines to occupational medicine in the United States was pioneered by the American College of Occupational and Environmental Medicine (ACOEM), which developed and maintains the *ACOEM Practice Guidelines* (APG) using a Cochrane-like system of expert panels reviewing peer-reviewed evidence. The APG has become a widely accepted authoritative reference used especially workers' compensation systems to establish the standard of care. Problems include: Uneven evidentiary base (abundant and uninformative in the case of back pain, scanty and largely irrelevant for elbow and other issues); absence of clinical trials for occupationally-relevant outcomes; obstacles to performing outcomes studies and workplace intervention trials for injuries; characteristics of occupational disease such as latency, infrequency, and certainty of diagnosis; opposition by practitioners, mostly outside of occupational medicine; rigidity in application, not taking into account co-morbidity, patient characteristics, and complications; over-reliance on meta-analysis (which could be corrected by Bayesian analysis). Effectiveness of practice guidelines in occupational medicine has not been systematically studied except for cost, however. Performance assessment has been anecdotal. After having overseen the early APG program, the author's view was that practice guidelines for were a beneficial but partial solution, addressing different issues than in general medicine. The opinions expressed here are those of the authors and do not reflect a position of ACOEM.

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AVIATION MEDICINE: THE GLOBAL CHALLENGES TO REGULATORS AND AIRLINES

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Aim of special session An overview about contemporary global challenges to aviation regulators and airlines

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Regulatory aviation medicine/aeromedicine, a subsection of occupational medicine, aims to determine whether pilots are medically fit to fly either routinely or in response to a decrease in medical fitness. Traditionally, change occurs very slowly in aviation medicine, new treatments and technologies must be evidence based and well established before the standards will change. The role of the aviation medical regulator ('medical assessor') has become more demanding in the past 20 years as many complex ongoing clinical conditions have now been deemed compatible with safe flight. Therefore, many pilots are now deemed fit to fly where formerly their careers would have ended. In addition, regulators (competent authorities) around the world determine the medical standard