EDITORIAL

It is fallacious to believe that aggression and violence are features peculiar to the 1980s or even to the 20th century. Aggressive behaviour is a characteristic human trait and is sometimes even encouraged. However, it may progress to violence, although this is usually discouraged, since another trait of human beings is control. This may be from without or within, but most human interaction allows for some aggression, assumes it will be controlled, and breaks down when violence ensues. By its very nature an accident and emergency department is exposed to both aggression and violence. The staff of these departments witness the effects and treat the victims of physical violence in its most obvious form. In addition, however, the patients themselves may be aggressive, as may their relatives. The staff assume that most of this aggression will be controlled but often it isn't. Aggressive verbal outbursts are serious for they may often herald physical abuse. After a physical attack has been made the matter is usually one for the police. However, there are steps which can be taken to prevent this final outburst.

People feel most threatened when they are frightened and seem unable to influence events. This frustration may be expressed as violence to others or to themselves. When directed inwards it may end in attempted suicide. It is known that when control is already impaired, for example by alcohol or mental illness, such attempts are more common (Kessel, 1965). Similarly, when unemployment is prolonged, and therefore influence is impaired, attempts at suicide are again increased (Platt & Kreitman, 1984). Mental illness and subsequent loss of control and influence tend not surprisingly to increase acts of aggression directed both inwardly and outwardly to others (Yesavage, 1983).

An accident and emergency department may prevent some of the violence directed towards it by removing the frustration and lack of influence often felt by patients and relatives. Some departments have installed videos which both entertain and educate those waiting for treatment. The current waiting time should be displayed and people given regular updates on the reason for any serious delays. Specific and remedial causes of patients' fear and lack of control must be sought. The more obvious causes are diabetic hypoglycaemia, head injury, mental illness and epilepsy. Drugs such as alcohol are commonly used and often predispose to accidents (Wechsler *et al.*, 1969). Alcohol is often abused by the pathologically aggressive (Nylander, 1979) and in otherwise normal people it impairs control and behaviour. Perhaps as important as its direct toxic effects on the central nervous system may be the neurological effects of its associated hypoglycaemia. This may occur after prolonged drinking and little intake of food (Freingel *et al.*, 1963), or within a few hours when alcohol is taken with sugar (O'Keefe & Marks, 1977). The latter stimulates insulin which lowers the blood glucose. The former then potentiates the insulin and prevents release of glucose from the liver. Symptomatic hypoglycaemia can ensue and the subsequent aggression is well recognized. Not so well recognized is that taking alcohol with glucose is common, e.g. gin and tonic, rum and coke. If alcohol is consumed with starch, as in beer, this effect is not seen (Jaffe *et al.*, 1982).

Aggression and violence are associated with injury and distress and so accident and emergency departments are invariably faced with them daily. Most departments cope most of the time. However, neither the scale of the problem nor, more importantly, its trend have been established. There are lots of horror stories but few facts. The British Medical Association is currently collecting information on violence against doctors in the United Kingdom and welcomes any information you may have. Not only doctors are at risk, of course, and the problem is worldwide. This does, however, represent an attempt to establish if there is a problem and what its dimensions might be.

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