ently high incidence of backache before pregnancy detected by Loughnan and colleagues serves to emphasise the difficulty of studying new postpartum backache. We believe, however, that backache during pregnancy is a potentially more important factor.

We agree that it is vital to take account of potentially confounding variables. The best way to do this is to carry out a multivariate analysis such as the logistic regression we performed. Unfortunately, randomisation will not overcome the problem that many women attribute backache to pregnancy, childbirth, or epidural analgesia; rather, it may compound the problem if women receive a treatment they did not directly choose.

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Reasons for stopping drugs are monitored in New Zealand

EDITOR,—The New Zealand intensive medicines monitoring programme is a system for monitoring adverse events in the early postmarketing period of selected new drugs. Each drug is monitored for four to five years usually, and cohorts of identifiable patients are established from prescription information sent in from virtually all pharmacies throughout the country, with a population base of 3.6 million. The average size of each cohort is 10 228. Each dispensing episode is recorded throughout the monitoring period; the data include date, daily dose, quantity dispensed, date of birth, sex, and name and address of the prescriber. When prescription records for individual patients stop coming in it is assumed that treatment has stopped.

Richard Martin and colleagues describe studies of the reasons for the withdrawal of treatment as a new method of monitoring.¹ In the New Zealand monitoring programme we have found this a useful part of our routine monitoring procedures since 1979; our results were first published in 1981.² Our methodology, which has been adapted with advancing technology, has been further described.^{3,4}

Over the past 12 years we have been using automated prescription follow up inquiries throughout the period of monitoring until a patient stops treatment, when a questionnaire asking the reason for stopping treatment is sent to the doctor. Our brand of prescription event monitoring covers a 25% segment of the population and involves about 700 general practitioners plus hospital doctors and private specialists. The questionnaire asks the doctor to confirm that treatment has stopped and to give the specific indication for the drug and the reason for stopping it. The following choices are given: lost to follow up; poor compliance; inadequate therapy;

peutic response; treatment no longer necessary; treatment changed for reasons unrelated to the drug (for example, changed diagnosis); death (date and cause should be stated); and possible adverse reaction(s), which should be described.

The results give a good picture of outcome, including efficacy, and can be related to any of the variables collected. Our experience has shown that doctors are unlikely to report death as an event even when actively encouraged to do so. Our follow up has been successful at capturing this important information. This method allows comparisons of the safety and efficacy of different drugs. Table 1 gives an example. The compliance rate for returning the computer generated questionnaires is consistently around 80%.

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Patients might be encouraged to become more ill in community psychiatry

EDITOR,—The various examples that have been given of the ways in which accountability systems in the NHS work against the better interests of patients' care have, I fear, only scratched the surface of the problem. In community psychiatry the current system for measuring our efficiency index acts as an incentive to encourage patients to become more seriously ill.

As the vast majority of people referred for specialist psychiatric assessment are treated on an outpatient basis by a psychiatrist or another member of the community mental health team, those patients who are admitted to hospital mainly represent the failure of treatment, by definition. Because the cost of a hospital admission is usually 30 to 50 times higher than the cost of an outpatient assessment, however, the easiest way to increase our efficiency index by the necessary target percentage is to treat more inpatients. The only alternative is to try to find time to treat massively increased numbers of outpatients.

As a large proportion of acute psychiatric units run at 100% bed occupancy or higher, the best option for providing the system with the statistics it likes to see is to discharge patients earlier than might be desirable. This not only leads to faster throughput and increased numbers but also

helps considerably in generating candidates for readmission. The alternative is to find a group of patients who can be admitted for even shorter periods, and there is certainly potential for this among less seriously ill patients. This group have the advantage of getting better quicker, which proves our efficiency even more effectively.

Many of the younger generation of community psychiatrists are motivated by a desire to fight the madness of the institution. To do so more effectively, it seems that we might need help from the government's advisers on accounting policy.

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Herbal stimulant containing ephedrine has also caused psychosis

EDITOR,—In her news article Deb Josefson reports that several deaths in the United States have been attributed to use of the Chinese herb Ma Huang, which contains ephedrine.¹ We report on a patient who developed a psychosis due to the same preparation.

A 34 year old man was brought to the accident and emergency department after jumping out of an upstairs window. He had sustained only minor bruising and explained that he had been frightened and had thought that he had to jump as he feared that he would be killed by supposed attackers. On mental state examination he was agitated and restless and showed paranoid delusions, with visual hallucinations. During assessment it became apparent that he had consumed Ma Huang over the previous 10 days. He had no history of mental illness, and results of routine investigations were normal. After admission his symptoms resolved rapidly, and he was discharged after two weeks; no treatment was prescribed. Follow up in the outpatient department confirmed that he remained well.

A search of the English language literature in Medline showed only a single reported case of psychiatric illness (mania) induced by Ma Huang,² though ephedrine has been reported to induce psychosis.³ Our patient had been attracted to this preparation by a magazine advertisement, which extolled its virtues as an energy tonic that calms the mind and stimulates the body while inducing weight loss. He bought the preparation by mail order, and the leaflet accompanying it made no reference to the fact that it contained ephedrine or to possible side effects. We wrote to the company and received a reply to the effect that it had not heard of any side effects. It was unable to tell us the amount of ephedrine in each tablet.

Given the increased marketing of such substances and their portrayal as a "herbal ecstasy," further such cases will probably occur. We wish to emphasise the need to consider the use of herbal supplements in the differential diagnosis of acute psychiatric illness. We would also urge the introduction of more stringent regulation of these potentially fatal preparations.

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Table 1—Reasons for stopping treatment with simvastatin, bezafibrate, and gemfibrozil. Figures are numbers of withdrawals (rates per 1000 patients)

	Simvastatin (n = 1094)	Bezafibrate (n = 2273)	Gemfibrozil (n = 1447)
Lost to follow up	30 (27.4)	98 (43.1)	70 (48.4)
Poor compliance	12 (11.0)	63 (27.7)	49 (33.9)
Inadequate therapeutic response	8 (7.3)	80 (35.2)	86 (59.4)
Patient died	7 (6.4)	16 (7.0)	15 (10.4)
Adverse reaction	14 (12.8)	69 (30.8)	37 (25.6)