Despite – or perhaps because of – their limited evidence base, herbal medicines should not be forgotten during consultations

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The development of modern medicine has led to an increasing life expectancy of our population. At the same time, the global epidemics of certain chronic conditions, including diabetes, lead to a resultant life-time polypharmacy regimen for many.

Poor concordance is often multifactorial in origin. One of the main contributing factors can be adverse drug reactions. A fear of adverse effects and uncertainties regarding the long-term effects of drugs can influence the increasing use of herbal medicine in our population. Indeed, among people with diabetes the use of herbal medicine is increasing (DiNardo et al, 2012). Furthermore, people with diabetes are 1.6 times more likely to use herbal medicine (Egede et al, 2002).

The regulations required to license herbal medicines were not implemented in the UK until fairly recently. Thus, testing herbal medicines has not been as stringent as it might have and pharmacokinetic and pharmacodynamic data are often limited.

The paper in this issue by Virani et al (starting on page 193) describes the growing industry of herbal medicine and potential drug interactions with conventional medicine, with a focus on antidiabetes agents.

The use of herbal medicines can be viewed as safe and without risk of side effects by some individuals, while "allopathic" medicines are seen as being the opposite. This is not only a simplistic view but an inaccurate one; indeed, there are some widely established medicines used in practice today that have a plant origin (e.g. digoxin and morphine).

In my experience, the use of complementary and alternative medicine varies among different population groups. In certain ethnic minority groups, herbal medicine intake may be more prevalent. This can be influenced by cultural practices and beliefs about perception of health, illness and prescribed treatment.

Factors contributing to medicine-related problems among ethnic minority groups include fear of side effects and dependency (Alhomoud et al, 2012). Moreover, while data do not exist that reliably quantify herbal medicine use in individuals from ethnic minority groups, research has shown that such individuals may have more medicine-related problems compared with the non-ethnic minority population (Alhomoud et al, 2012). One study found that South Asian people had a greater harm score relating to beliefs about medicines compared with white British individuals (Kumar et al, 2008).

It is also important to note that language and communication difficulties can influence the intake of medicines in relation to the understanding of treatments (Scheppers et al, 2006).

There are data to suggest that the majority of people using herbal medicines do not mention this during contact with healthcare professionals (American Diabetes Association, 2004). Equally, it could be said that not all healthcare professionals probe patients to accurately gauge their herbal medicine use.

Although data for herbal medicine drug interactions and side effects are limited, I believe that healthcare professionals should be more proactive in obtaining information on their patients' herbal medicine usage. This may provide an opportunity to promote concordance, to discuss the role of herbal medicines and to dispel some myths. ■

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