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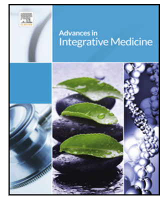
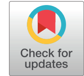


Maslow's hammer in integrative medicine: one size will never fit all



The editorial published at the outset of the COVID-19 outbreak – in which integrative medicine clinicians were cautioned about the role of integrative medicine in the pandemic [1] – has led to several inquiries from clinicians over the past few months. Many have questioned why an integrative medicine journal would suggest that integrative medicine should not be considered part of the toolbox in the global pandemic response. However, this was not a call to abandon integrative treatment options, but rather a call to remember the *integrative* nature of integrative medicine – *combining* the best of both conventional and complementary medicine worlds by *supporting* rather than *replacing* public health initiatives directed at COVID-19.

However, it was also an important reminder to make as there have been (and still are) elements of the integrative medicine community that have been making highly inappropriate claims about the potential of some treatments to treat or cure COVID-19. Many of these were often directly advocating use of ineffective, untested and sometimes dangerous treatments in place of public health treatments, even though the unprecedented global response on the frontline has been an effective tool for containing the virus SARS-CoV-2, and treating those acutely affected by its associated disease COVID-19. This is not a critique of the integrative medicine community as a whole – indeed, the integrative medicine community itself is often at the forefront of addressing these issues – examples of the naturopathic and Chinese medicine communities were provided in the last editorial, but similar leadership has been more recently observed from the chiropractic community in addressing misleading claims from some members of that chiropractic could boost immunity and protect patients from COVID-19 [2]. The integrative medicine community is also stepping up to this challenge – one integrative health organisation (the World Naturopathic Federation) has even taken leadership to address the issue of poor evidence on integrative medicine options by developing a collection of systematic evidence summaries which will be released shortly online and form the nexus of the next physical *Advances* issue.

But these issues also highlight the constant need for the integrative medicine professions to show leadership in advancing standards, to root out problematic elements, and to identify where they can play a role *as part of a broader health effort*, not just as a solo player. Formal recognition is not enough, and it is not automatically helpful to ensure appropriate treatments are integrated. Even when traditional treatments are officially endorsed by governments – for example AYUSH in India – unfounded or inflated claims that encourage a focus on using these treatments alone or making them the centre of treatment can discourage true integration and has actually hampered their incorporation into broader COVID-19 treatment regimes [3]. This can be particularly frustrating considering this approach often makes the inclusion of integrative approaches unnecessarily contentious [4], when in reality even a modest contribution from these therapies could provide is significant benefits to patients (as seen in Chinese medicine trials, where although Chinese medicine itself does not appear to shorten treatment duration or have antiviral effects, symptomatic relief provided by herbal medicines appears to have complemented conventional treatment well to result in improved outcomes) [5,6].

Part of this leadership is also acknowledging the role of other clinicians and other clinical tools, as well as acknowledging the limitations of our own. Clinicians naturally have their own clinical preferences in terms of treatments, and these preferences may dictate how they direct treatment. The cognitive bias known as Maslow's Hammer (also known as the Law of the Instrument: "if all you have is a hammer, everything looks like a nail") itself was drawn from such an example. Most people know this theory well, yet relatively few know that it was developed from within the field of medicine. Maslow developed this theory when describing the dangers of reductionism in psychiatry – at a time when antipsychotic drugs (such as *stelazine* and *thorazine*) were the only treatments available to psychiatrists, many patients with other mental illnesses were incorrectly diagnosed and treated as if they were psychoses [7]. Professional tensions may also impact decision-making – (e.g. referring to a physiotherapist rather than a chiropractor due to personal opinion rather than cost or effectiveness or refusing to prescribe an equally effective generic version of a pharmaceutical drug in place of a branded drug). Intra-professional tensions can be similarly detrimental – as last issue's guest editorial highlighted in relation to the difficulties to develop a nationally consistent guideline for Chinese medicine use in China's COVID-19 response [8].

In integrative medicine we often recognise this bias when it is all-too-commonly directed unfairly at integrative treatments [9], but we also need to recognise that we can sometimes exert this bias ourselves as we look for a way for our favoured components of integrative medicine to be *central* to the solution to everything, rather than focusing on true *integration* that offers the patient the best of all clinical worlds, *including* our favoured tools *where appropriate*. There are already numerous areas where evidence

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suggests integrative medicine can help in the COVID-19 response [10], a situation that is likely to increase as the long-term and chronic consequences of COVID-19 become better known. However, we need to be critical in our approach to integrative medicine treatment of COVID-19, and avoid the pitfall of fitting conditions and patients into our preferred treatment regimes, rather than developing a regime focusing on what is best for the patient in their individual circumstances. Just as you need a full toolbox and a team of builders because you can't build a house with a hammer and nails alone, clinicians of all persuasions will have to recognise (and sometimes work against) their own often unconscious biases to ensure that patients are getting the best of all worlds in the response to COVID-19 – or any other treatment. After all, integrative medicine is meant to be the best of both complementary and conventional treatment worlds, not just the parts clinicians like best.

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