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What makes a medical intervention invasive: a reply to commentaries

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We are grateful to the commentators for their close reading of our article [1] and for their challenging and interesting responses to it. We do not have space to respond to all of the objections that they raise, so in this reply, we address only a selection of them.

Some commentaries question the usefulness of developing an account of the sort we provide [2], or of revising the Standard Account (SA) in doing so [3-5]. Our schema is intended to provide a framework for developing a full account of invasiveness that captures existing uses of the term. On the assumption that the term is used somewhat reliably and consistently—and we are inclined to agree with some of our commentators [e.g. 3,4] that people are not terribly confused or mistaken in how they employ the term—an account that captures these uses will have a claim to being considered a good account of invasiveness.

Of course, it may well be that we should prefer an account—like the SA—that does not capture *all* uses of the term. We suggested—and would like to re-emphasise—that we are open to the possibility that some existing uses of ‘invasive’ should be rejected as confused or mistaken. We suspect, for example, that there might be good grounds to deny that whether an intervention is invasive or not should be sensitive to alternatives considered. However, in order to have these theoretical discussions, and argue for these claims, it will be useful to have a general account of invasiveness that can make sense of existing usage. For one thing, such an account will allow us to precisely specify *which* existing uses of ‘invasive’ ought to be rejected.

These discussions are especially important ones if, as it seems to us, considerations of invasiveness are taken to be useful in guiding our deliberations about interventions in clinical and policymaking contexts. All of our commentators seem to agree that invasiveness has, or is taken to have, such relevance [2-6]. If invasiveness is playing this practical role, then it is important to get it right.

Affleck and colleagues engage in such discussion [3]. They suggest that, whereas we attempted to “define invasiveness by potential harm”, in normal usage, “invasive” just picks out a *subset* of potential harms; presumably those brought about by incision or insertion.

It was not our intention to define invasiveness in terms of potential harm; though we did mention that one determinant of invasiveness may be harm-based (see p. 5, esp. n. XI) [1]. In fact, we are sympathetic to the view that one function of the concept of invasiveness may be to pick out interventions that can be problematic—for example, because they can constitute a form of bodily or mental trespass—even when they impose no significant risk of harm.

In any case, we do not think that existing usage can be understood as picking out only the sorts of potential harms associated with incision or insertion. We cited cases—and Bluhm and colleagues [7] cite others—in which ‘invasive’ is used in reference to interventions that do not risk such harms, such as psychological therapies. We suggested that some such uses could be understood as referring to what we call *mental*, as opposed to *physical*, invasiveness. Moreover, it is not clear to us why such uses must be rejected as mistaken, confused or practically irrelevant. The idea of mental invasiveness is particularly useful in certain contexts, like psychiatry [6].

A further conceptual question picked up in the commentaries is whether invasiveness is value-laden [5]. Perhaps it is, and perhaps patient preferences affect invasiveness. Yet we are not convinced. It is one thing to say that patients differ in their preferences concerning various features of interventions—features that are relevant to invasiveness, or perhaps preferences regarding mental and physical invasiveness. It is another to say that differences in such preferences affect *whether* an intervention is invasive, or *the extent to which* it is. We are inclined to accept the former but are not convinced of the latter.

We have just given some reasons for thinking that there is a point to offering an account of invasiveness, and we argued in our paper that our schema lays the foundation for an account that is an improvement over the SA. But our suggestions point to the usefulness of such an account as related to theoretical discussions. Yet some commentators have questioned the usefulness of this account in clinical settings, especially since it seems complex [4,5].

As Slack and Higgins [5] point out, it would be taxing and time-consuming to explicitly and deliberately go through the various steps they outline in order to determine the invasiveness of an intervention. This is particularly problematic in the clinical setting. We do not, however, suggest that any parties to a clinical encounter need to do this. If the term is useful in the clinical context, it may be best to simply apply the concept and term intuitively. We already reliably and consistently do this, with relatively little effort, with the somewhat analogous terms we mentioned in our article—e.g., “length,” “long,” “tall,” “health,” etc. The semantics for these terms may be just as complex as those for ‘invasive’, yet most of us find it relatively easy to apply these terms (see, for example, D’Ambrosio and Hedden [8]).

We do, however, wholeheartedly support Slack and Higgins’s suggestion that clinicians engage in clarificatory dialogue by, for instance, asking the patient to elaborate on their understanding of the term [5]. Regardless of what the best account of invasiveness is, such

dialogue can significantly improve communication, in recognition of the fact that individuals can differ on how they understand invasiveness, or how they apply the term. And if Slack and Higgins are right in thinking that patients' understandings of invasiveness are fairly subjective and idiosyncratic, it may be most useful to avoid using the term in clinical contexts, since this is a recipe for miscommunication.

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