Author’s response to reviews

Title: Global Health Ethics: Critical Reflections on an Emerging Field

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Dear Editorial Team,

We are grateful for the chance to further revise our manuscript in light of the reviewer’s comments. We had added the librarian in the acknowledgements as Reviewer 1 has suggested.

In response to Reviewer 2, we have made addressed the comments as follows below. For a more robust understanding, we suggest a re-read of the paper, but given that this is a second revision, we have attempted to summarize the changes we have made within this letter. But a fuller understanding would be gleaned from the paper itself.

1. We have revised the methodology of the paper to better reflect what was done. We are glad that we have been encouraged to reflect more on the process we undertook, and we hope that the revised description and justification will clarify our aims and thus assuage the reviewer’s concerns. While we suspect that we hold fundamentally different positions on the question of empirical data and ethics, we have not addressed this issue as the reviewer has said he will set aside this issue. So, while we are not subscribers to a “retroactive” selection of methodology, as this is not proper, we have decided that our paper is better characterized as a Critical Interpretive Review, as per McDougall R. Reviewing Literature in Bioethics Research: Increasing Rigour in Non-Systematic Reviews. Bioethics. 2015;29(7):523–8. We have indicated that our intent and method was in line with what McDougall calls a Critical Interpretive Review, and that the Arksey and O’Malley methodology was followed to a point, in order to provide some systematicity to the review process. However, the intent was not to review “evidence” but rather to ensure a thorough, methodical and transparent search strategy. The aim of the paper and thus the methodology has been revised (primarily on page 4):
The aim of this paper was to provide a Critical Interpretive Review of the literature. We chose this methodology because our goal was not to review ‘evidence,’ as is often the goal of systematic reviews or even some scoping reviews. A Critical Interpretive Review best describes the methodological process we undertook to go beyond description and include a degree of analysis and conceptual clarification. Such a review does not aim to provide ‘an answer’, but rather seeks to provide analysis and synthesis.(3) Given the diversity of views on what constitutes global health ethics, we felt this kind of review provides an opportunity to “take stock”(3) of the literature to date, and to provide a “launch pad” (3) for further conceptual debate and development on this important issue. We proceeded from the premise that discourse not only reflects ideas, but that it is productive and reproductive of things such as social arrangements and power dynamics, and is therefore of moral relevance to bioethical debate.(4) Questions such as “who can speak”; “where are the discursive fissures and tensions occurring and what can they tell us” are critical questions that we hope to attend to in this paper.

One of the main drawbacks of the methodology, however, is that it is often faulted for its lack of systematicity in its approach to reviewing literature.(3,5) In order to improve the methodological rigour, transparency and rationale for our search strategy, we (somewhat unusually) employed a modified version of Arksey & O’Malley’s six-stage methodological framework as expanded by Levac et al.(6,7) However, the scoping review methodology outlined below was a means to an end, rather than an end in itself.

2. These changes have led us to alter the title of the manuscript as well to reflect the methodology. This allows us to better clarify the aims of the paper. We understand that the previous version has led to confusion over the goal of the paper, and we hope this provides some insight into why we are not providing our own definition, but rather mapping the landscape of the global health ethics discursive terrain. So we are interested in both how the term itself has been deployed, and in a critical reflection on this landscape. Primarily, this entails an examination of how this term has been used, and within that data set, determining the levels of interaction captured within it. So we are NOT interested identifying the ethical issues that arise in context of global health, but rather how we can characterize the level of interaction being examined as subject of ethical reflection within papers which self-identify as being about “global health ethics”.

3. The justification for this leveled approach has been explicated within the body of the paper on page 8 at line 176:

These categories were created to aid in analysis and understand what level of interaction was being analyzed under the heading of ‘global health ethics’. This was a form of deductive, descriptive coding that was based on the notion that at its heart, ethics is about relationships and the obligations we have to one another. These codes are an attempt to categorize these data on the basis of who the moral actors are in the context of relationships being described and argued for in the data set. This is important because much of the global health ethics literature is an attempt to argue for particular sets of obligations by particular moral agents, whether they are medical students, researchers, NGOs, nation states, or inter supra-national actors. Being able to capture this information, and to map the contours of these moral relationships in the discourse on global health ethics was essential to our analysis. While some of the papers covered in this review would be coded as addressing more than one level, papers tended to be focused at one end of the spectrum of relationships (micro or macro level) than the other, i.e. it was very rare that authors would focus on both political economy and individual relations between actors in the context of a medical encounter. This becomes important as we begin to map the contours of the debate over what counts as a legitimate level of focus for the field of global health ethics. This fits with the methodological aim of the paper to view the literature “as an object of scrutiny in its own right”(9) with the aim of “identifying normative issues arising from the study” which entails additional critical scrutiny.(2)
So while the reviewer clearly feels that levels 3 and 4 are key to global health ethics (and we agree), we felt it important to present the data that shows that not all who claim to be engaged in global health ethics ‘work’ share this view. We feel it is actually very interesting in that it shows that there is a large range of views about what the term “global health ethics” entails, that it is still a contested term. Providing some clarity about how the term is being used, and then providing some critical reflections on this in the Discussion seemed important as a means of moving the discussion forward. Our aim, again, is not to come up with the best definition, but to take stock and reflect on this body of work in order to provide the impetus to move the conceptual work of defining global health ethics forward.

4. The point of the section on Ethical Frameworks (pg. 13) is to present the range of disciplines and types of frameworks being employed. Again, there is no one dominant framework being employed, which is reflective of the broad range of scholarship that purports to being engaged in global health ethics. It also shows how there is a correlation to some extent about the levels of engagement, and the kinds of ethical frameworks being employed by people writing about global health ethics. Presumably, if we want to move towards building consensus around a particular definition of global health ethics, we need to know what kinds of frameworks are being used to address what kinds of moral questions.

5. We have attempted to connect the Discussion to the Findings in a manner that makes it clearer that the Findings are being used as a jumping off point for our critical reflections. To this end, we have added a section called “Who can speak?” (line 362) which addresses the issues around the lack of voices in this data set from the global south. We have also made it clearer (pg. 17) that we believe that the lack of consensus around the scope of “global health ethics” stems from the lack of consensus around the term global health itself. We make the argument that these terms matter in that they reflect deeper scholarly disputes about our moral obligations, and our willingness to depart from the historical bioethics preoccupation with micro-level interactions and issues that are framed as issues pertaining to individuals and their self-determination.

We hope that these revisions will satisfy in a more robust way the helpful comments provided by Reviewer 2. We think that we clarified the aims of the paper, which should go some way to assuage his concerns, even though we have fundamental differences in our views on the value of examining the discursive landscape and what we can say about ethics based on the findings.