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From the Editors

“It is easier now,” our colleague says. He refers to doing thought experiments in teaching or, more specifically, getting students to accept imagined cases that involve moral tradeoffs. That seems easier after experiencing a pandemic. Other colleagues around the table are starting to agree; however, not only is this true for students taking ethics courses, but attitudes seem to have changed among people on several levels in health care and various academic environments.

The pandemic uncovered the preconditions for healthcare priority setting in a viciously transparent way. In situations with limited ventilators, beds in the intensive care unit, or vaccines, it is difficult for people to deny the moral importance of choices that can be made. Decision-makers on different levels need to decide who should get the resource and, by implication, who should not. In the context of COVID-19, many such decisions were made in the clinical context putting pressure on healthcare professionals. In this issue, **Nowak et al.** explore moral distress and medical decision-making in such situations. They argue that the pandemic has brought a problematic social atmosphere detrimental to ethical decision-making in a clinical context. This, in turn, leads to intensified moral stress among clinicians. Based on an empirical study of moral stress conducted in Poland and Lithuania, Nowak et al. propose strengthening the conditions for resilient medical decision-making.

Irrespective of the extent to which the speculating professors around the table are right, ethical reflection and discussion about priority setting have, over the last two years, found their way from seminar rooms to various levels in health care systems as well as the public debate. Ethicists worldwide were now formulating ethical standpoints in guidelines that would make a real difference for the people affected by them rather than formulating these standpoints in journal papers. Furthermore, some questions that primarily attracted the interest of scholarly discussion are now contentious topics in public debate. One such pressing question in Scandinavia has been whether healthcare professionals should be prioritized for COVID-19 vaccines. In this issue, **Jølstad & Solberg** discuss this question with a particular focus on the notion of reciprocity. They argue that reciprocity-centered arguments in the context of healthcare priority setting may be problematic, especially concerning vaccines. According to their analysis, a plausible argument from reciprocity may be that since healthcare professionals incur risks, they should have priority to vaccines. However, many other essential workers may be justified in making the same claim. Therefore, it would be difficult to devise an argument from reciprocity to the effect that healthcare professionals are unique in this sense and, therefore, should get such a priority. Moreover, they point to reasons for utility maximization, the situation of the worst off, and equality that may have more normative weight than reciprocity reasons.

The question about the distribution of vaccines for COVID-19 also has a pressing dimension of global justice. The contribution by **Hicks & Gürtler** focuses on this question and discusses the obligations that higher-income countries may have toward lower and middle-income countries during a global pandemic. They find that the global inequality concerning medical resources during the pandemic cannot be justified. They argue that such resources should be distributed according to a global needs-based sufficiency principle. Higher-income countries have reason to accept this principle based on a duty to

rectify historical injustice and a duty to refrain from upholding present unjust institutions, according to Hicks & Gürtler. In practice, this would mean that excess medical resources in higher-income countries should be redistributed to lower-income countries rather than being left to waste, that patents could be suspended during a pandemic, and that there should be an investment in global medical infrastructure.

Finally, **Hol & Solberg** invite us to consider pandemic priority setting from a different perspective: that of the ancient philosophy of Epicureanism. This school of philosophy holds that death cannot be bad or good for the person who dies. There may, however, be other-regarding effects on, *e.g.,* friends and family that make death bad. Taking Epicureanism as a starting point, Hol & Solberg take justifications of the response to the pandemic as having been overly preoccupied with the number of deaths while overlooking other sufferings that occur in lives as well as other societal effects. The badness of such effects may well outweigh the badness of death. An epicurean change of perspective on pandemic strategy may not support a different set of policies and practices. Still, it would give us a more sophisticated philosophical approach to this pressing issue of public concern.

The motivation behind this special issue has been that the specific characteristics of COVID-19 put pressure on questions previously discussed in the literature on distributive justice in general and that of health care priority setting in particular. Furthermore, issues that were not previously the focus of the discussion in priority-setting ethics are now on that agenda. For example, how the regional and global perspectives cannot reasonably be discussed in isolation from each other. Whereas the papers published in this issue draw on experiences from working on ethical questions in relation to COVID-19, each paper approaches the complexities of the pandemic from its own unique perspective. Which are the lessons learned?

Erik Gustavsson, guest editor, and Lars Lindblom, executive editor