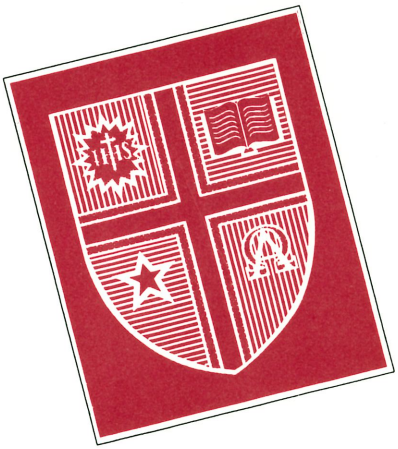
WESTON SCHOOL
OF THEOLOGY
Cambridge, Massachusetts

Presents

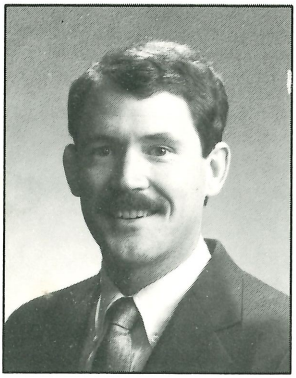
AIDS and the Church: A Stimulus to Our Theologizing



Jon D. Fuller, S.J., M.D.
Margaret E. Pyne
Professor of Pastoral Studies

PUBLIC LECTURE
March 12, 1991

JON D. FULLER, S.J., M.D.



Weston School of Theology is honored to announce the appointment of Jon Fuller, S.J., M.D., a distinguished alumnus, as the first Margaret E. Pyne Professor of Pastoral Studies. Dr. Fuller, a Jesuit priest, is Assistant Clinical Professor of Medicine at Boston University School of Medicine and Assistant Director of the Clinical AIDS Program at Boston City Hospital. He is also president of the Board of Directors of the National Catholic AIDS Network.

Since graduating from the University of California Medical School (San Diego) in 1983, Dr. Fuller has been involved in the diagnosis and treatment of persons with HIV disease. He was an intern and resident in the Department of Family and Community Medicine at the University of California (San Francisco) from 1983–86. San Francisco General Hospital was the site of the earliest diagnoses of AIDS cases in the U.S., and was a pioneer in developing treatment and outreach programs for persons living with AIDS.

The author of numerous scientific papers on clinical management of AIDS-related disease, Dr. Fuller is recognized as a significant medical educator. At UCSF, he was the recipient of the *Julius Krevans Prize for Clinical Excellence,* and was the recipient in 1985 of the *Excellence in Teaching Award* from UCSF Medical School. In 1989, he was honored by the AIDS Action Committee of Boston with their *Mass Recognition Award* for service to his patients in the Clinical AIDS Program at Boston City Hospital, and for his major contributions to AIDS Prevention Education in the greater Boston area.

A diplomate of the American Board of Family Practice, Dr. Fuller is a member of the American Academy of Family Physicians, the Massachusetts Academy of Family Physicians, and Massachusetts Medical Society.

Professor Pyne, in whose memory this professorship is named, was a lifelong advocate for disabled persons. A former Associate Dean of Special Education at Lesley College, Margaret Pyne had a particular vision of the need to educate theological students about ministry for and with persons with special needs. Through the Endowment Trust established by her estate for this purpose, students at Weston School of Theology and other students of the Boston Theological Institute will be assisted to expand their ministerial formation by pursuing courses and attending public lectures related to these special ministries.

AIDS and the Church: A Stimulus to Our Theologizing

Jon D. Fuller, S.J., M.D.

March 12, 1991

I would like to express my gratitude to the Weston School of Theology for the invitation to teach in the department of pastoral theology this semester, and also to share some thoughts with you this evening.

As many of you are aware, with her vast experience in preparing students from many disciplines to work with the physically handicapped, Margaret Pyne also wanted to make sure that pastoral students were among those whose professional training would focus particular attention on the needs of special populations. And certainly, the care of persons infected by HIV falls into this category. Just as we could not expect a physician without adequate preparation to provide proper care in this setting, so does the pastoral minister need focused training to be prepared to face the particular challenges and unique issues of the epidemic. And thus, the academic course sponsored by the Margaret Pyne endowment has been dedicated to developing such skills not only through reading, discussion, and didactic presentations, but especially by interacting with HIV-infected persons, and by learning from them what the needs of this population are. As I think many who are taking the course can tell you, these weekly encounters have taught us as much about ourselves and our own faith as they have about the history and particular needs of those who have come to share their stories.

But providing direct, pastoral service is only part of what it means for us to respond comprehensively to the AIDS phenomenon. Because Weston, as an academic center, undertakes the study of theological issues from both pastoral and systematic perspectives, we also need to stand back from the level of one-to-one contact and look at the challenges that the HIV epidemic brings to our wider, systematic approach to the theology that underlies our pastoral practice. I would hope to at least tentatively begin such a reflection as a project for this evening.

You may quite reasonably be asking yourself by now, who in the world am I to be presenting this reflection at a place like Weston? If I've ever thought I was bringing coals to Newcastle, this is certainly it. Having earned Masters of Divinity and Theology degrees at this institution, I at least have learned enough to know that an M.Div. and a Th.M. do not a theologian make. But given a combination of historical circumstances that lead me to begin my graduate medical training in one of the major epicenter hospitals as the epidemic began to gain momentum, and given the opportunity I had to continue in AIDS clinical care at Boston City Hospital during my years of study at Weston, I feel that I can at least claim the descriptor of being a privileged observer. And since I will try to develop the thesis that observations from pastoral contact can contribute to our systematic ethical analysis, this is perhaps not such a bad position in which to be.

During last summer's National Catholic AIDS Ministry Conference at the University of Notre Dame, I was deeply moved as I listened to a woman from Texas describe the details of her last several years. She narrated the story of learning that her husband, a prominent journalist, had contracted HIV; of his struggle with the medical and social consequences of the infection; and of his eventually succumbing to AIDS-related disease. She spoke of how much the experience had transformed and radicalized her own life. But I was startled by the request she made at the end of her presentation. To this group of Roman Catholic ministers who were together specifically because of their shared AIDS ministry in the context of the Catholic tradition, her final remark was an earnest entreaty to members of the audience *not* to speak about her flesh and bones experience in theological language. She begged us not to do her the injustice of transforming her hard-fought battle into meaninglessness by describing it in language that would lift it out of the world of the concrete into one in which—in her anticipation—it would only be able to relate to other ideas.

I tried to appreciate how her personal experience with theology—or more likely, with theobabble—could make her so fearful of such a transformation. But at the same time, my own insides were shouting just the opposite. I heard myself saying: "Don't you see, that is precisely what we *have* to do, what we have not yet adequately succeeded in doing." As I sat in an auditorium with nearly 200 ministers who had travelled the length and breadth of the country to reflect on our work,

I realized how much I felt the need to put our experience into theological language—perhaps as much as I needed the physical presence and emotional support of my peers. We need to speak of this experience in the language of our faith because God meets us in this crisis, is present at the heart of the human dramas that are played out again and again. God is in the midst of the spiritual battles that occur as men and women, too young to die, learn that they are, in fact, dying; as they learn that their lives and their families' lives have been turned upside down and exploded from within. God is *in* the sustaining of caregivers from every discipline who find in this work the place where they must bring their skills to application, the place where their rubber best meets the road. We must speak about the experience theologically, because as a human crisis of dramatic proportions, God is in it.

But more than this, I would also suggest that the experience of the HIV/AIDS epidemic challenges our understanding of certain aspects of human sexuality, of sexual development, and of our role in developing public policy. Just as the church has always had to develop its tradition in the face of new challenges, so do we need to evaluate the experience in the light of our tradition as we develop our response to a new and apparently permanent part of the human landscape.

But as I hope you will appreciate, I think the issues that are difficult for us are not specific to AIDS; rather, the crisis has been yet another in a series of historical developments that serve to reveal differences in theological perspective because of the varying impact that each approach makes when it is played out to its conclusion in real life. The epidemic is simply one of many events which reveal the sensitive areas, the areas of transition and stress, the areas in which models are being remolded.

Having suggested that the issue is not AIDS itself, there are nevertheless unique aspects about HIV's impact on the human community which have contributed to the particular challenge that AIDS presents to us. The virus strikes individuals and communities in ways that distort our expectations about longevity and that force us all to consider our frail mortality. The epidemic represents a major challenge to global progress and economic development, and has the frightening capacity to dramatically widen the gap between the rich and the poor, and between first and third world nations. Unlike the great plagues of

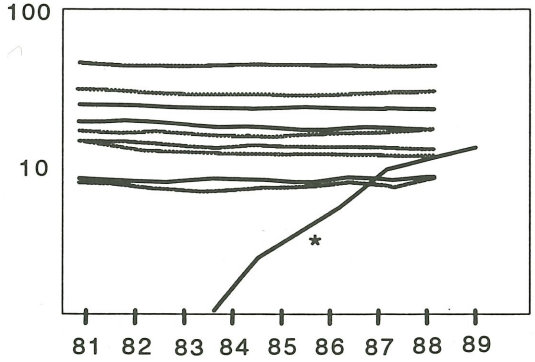
the past which burned themselves out over time, HIV appears to have become part of the human landscape in an irrevocable way. We are looking not just at an epidemic, but at a new *endemic* disease that we will have to learn to live with for the foreseeable future. And unlike most of the plagues of the past, HIV infection is preventable by education and behavior change.

We recognize that the AIDS pandemic has reached frightening levels at the present time. Because knowledge of the pace and scale of the epidemic are pertinent to our analysis of the problem, allow me to briefly present some information on the current status of AIDS, as well as some projections for Africa in the next 25 years.

As you know, the epidemic was first recognized in this country in 1981. By 1988, at a time when women accounted for just 9% of all U.S. cases, AIDS had become the nation's eighth leading cause of death among women aged 25–44, and in New Jersey (not seen in this slide) it was the leading cause of death in this age group, exceeding causes #2 and 3 combined.[1] By 1990 AIDS had become the leading cause of death among young black women in New York State, and it is anticipated that in 1991, with women representing at least 11% of all cases, AIDS will become the fifth leading cause of death among all young women in this country. Between 1988 and 1989, when AIDS cases increased by 18% among men, they jumped by 29% in women.[2]

Leading causes of death: Women 25-44

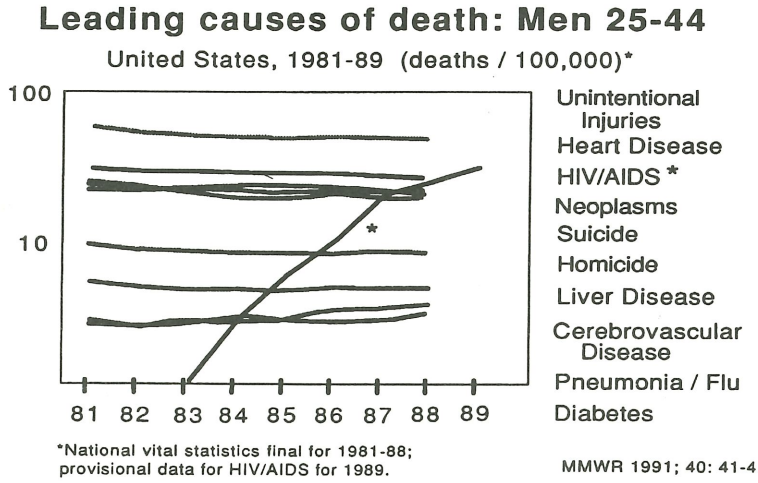
United States, 1981-89 (deaths / 100,000)*



*National vital statistics final for 1981-88; provisional data for HIV/AIDS for 1989.

MMWR 1991; 40: 41-4

Among young men aged 25 to 44, by 1988 AIDS had become the 3rd leading cause of death, and by 1989 had risen to the number two position. In 1990 AIDS was the leading cause of death among young men in Los Angeles, San Francisco and New York City.

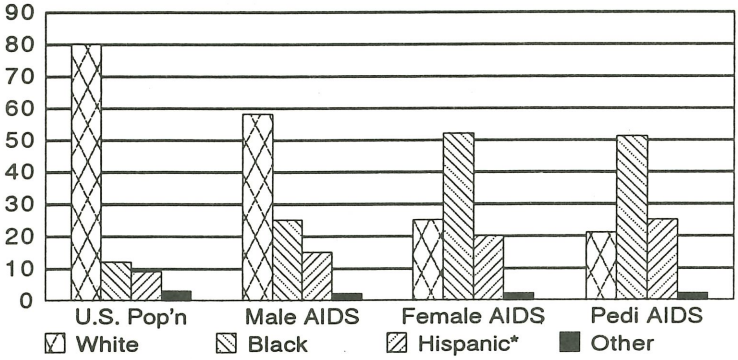


It is also critical to our analysis to recognize the differential impact of HIV upon persons of color. In this slide you see on the left the distribution of whites, African American and Latinos in the U.S. population[3]; next you begin to see a skewing of this distribution among men with AIDS, but especially do we see a disproportionate share of the burden being born by women of color—especially by black women—and by their children.[4] By 1988, among children aged 1–4 in New York and New Jersey, AIDS was the number one cause of death among Hispanic children and number two among black children. We have seen more than 100,000 deaths from AIDS in this country in the last decade; 1/3 of them occurred during 1990 alone.

The U.S. certainly has grave problems to contend with, but as we look to the third world, even a brief survey reveals the devastation that is being wrought. While there are currently believed to be one million HIV-infected persons in the U.S., this number rises to 10 million in the world at large, with 30% of infections occurring in women.[5] The vast majority of these are in Africa where up to 40% of women of childbearing age in certain urban areas are infected, and where 1 million

Race/Ethnicity Comparisons: 1990

Source: U.S. Census Bureau; CDC HIV/AIDS Surveillance

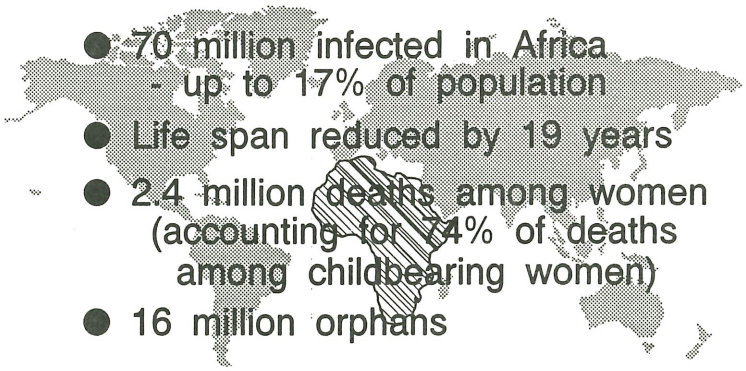


*Note: Hispanic origin can be any race

children have already become AIDS orphans. By the year 2015, some 70 million persons are expected to be infected in Africa, accounting for 17% of the continent's population.[6] African life expectancy will be reduced by 19 years, and AIDS will account for nearly 80% of the deaths of women in childbearing years, leaving some 16 million children orphaned.

I would argue that AIDS presents us, by virtue of its scale and by its anticipated permanence, with a new part of the human landscape

HIV/AIDS Projections for Africa in 2015



Source: U.S. Census Bureau (Boston Globe 2/17/91)

that requires innovative responses from all sectors of the human community. And to the same degree that we as a church have had to respond to the challenges of the industrial revolution, Marxism, capitalism, biogenetic engineering, the women's movement, and the nuclear age, so will we need to completely and compassionately ask about the ways that AIDS requires new responses from our tradition.

However, as I have hinted, AIDS is just one of a number of stressors on the theological horizon that press upon us. But this is not just a crisis of content; it is also a crisis of method; of switching, in Lonergan's words, from a classicist understanding to one that is more historical and dialogic. As Yves Congar has put it:

> If the church wishes to deal with the real questions of the modern world and to attempt to respond to them...it must open as it were a new chapter of thelogico-pastoral epistemology. Instead of using only revelation and tradition as starting points, as classical theology has generally done, it must start with facts and questions derived from the world and from history.[7]

With this as an introduction, allow me to propose that one challenge of the epidemic focuses attention on the understanding we have of the relationship between moral theology and pastoral theology.

I believe it is fair to say that pastoral theology has classically been seen as the child of moral theology. Pastoral theology is the concrete application of the pre-existing, overarching theory of moral theology. As a deductive approach, the relationship between these two disciplines suggests that the response to historically novel situations requires only that perennial truths be skillfully applied to changing circumstances.

The deductive model which has helped to define our applied moral theology begins with our understanding of human sexuality. Scripture and tradition are the source of principles in this framework. Pastoral theology, on the other hand, has been the locus of application of these principles in individual cases, the place where the pastoral provider, with an understanding of the tradition's ideals and principles, meets the individual who seeks guidance and help in a situation that is colored by personal history, by unique wounds and gifts, by individual capacity and moral development, as well as by the convictions of conscience. And in each complex, partly unique and partly archetypical situation, the pastoral provider, with an understanding of the

tradition's principles and its capacity for compassion, helps each one to progress further along the way, a little better than the day before, one step at a time.

I would argue that we are now observing that there is perhaps a complementary model as well. If we hold that an apprehension of the natural law requires our reflection on experience; and if we believe that history does provide truly novel events that test us in unprecedented ways; then I would suggest that there needs also to be an inductive component to moral theology. Such an approach would hold that a systematic look at pastoral experience can provide data for doing moral analyses, can become a source of premises for ethical analysis as much as it has been an end-user of previously developed moral and ethical principles. This, if you will, is an "ascending" model for relating pastoral to moral theology.

The impact of AIDS helps us to see, as Lonergan has previously suggested, that theology is moving from being a purely deductive science to being an empirical endeavor. As he writes,

> It was a deductive science in the sense that its theses were conclusions to be proven from the premises provided by Scripture and Tradition. It has become an empirical science in the sense that Scripture and Tradition now supply not premises, but data. The data has to be viewed in its historical perspective. It has to be interpreted in the light of contemporary techniques and procedures. Where before the step from premises to conclusions was brief, simple, and certain, today the steps from data to interpretation are long, arduous, and, at best, probable. An empirical science does not demonstrate. It accumulates information, develops understanding, masters ever more of its materials, but it does not preclude the uncovering of further relevant data, the emergence of new insights, the attainment of a more comprehensive view.[8]

Vatican II would perhaps agree with this, as in its Pastoral Constitution on the Church in the Modern World it describes the fact that "the human race has passed from a rather static concept of reality to a more dynamic, evolutionary one. In consequence, there has arisen a new series of problems, a series as important as can be, calling for new efforts of analysis and synthesis."[9]

We must let this experience of HIV/AIDS ask questions of us. It speaks loudly about central issues of human striving, at whose center

we believe God dwells. Therefore, this experience must not be conceived simply as another of many varied situations to which moral principles are applied, but must be allowed also to become a *source of content* for our ethical reflection. We must *listen* to it.

Having described how the epidemic might stimulate the development of our response to certain issues, I would like to test this approach by discussing the possible impact such an epistemology might shed on three specific areas. First: what can be said about methodologic differences surrounding the question of condom education? Second, what might data from the epidemic add to this analysis, and how might this bear on the church's role in influencing public policy? And finally, I would like to explore whether the intense contact with the gay community which the epidemic has afforded us provides input to our developing understanding of the phenomenon of homosexuality.

First: Our approach to education on condoms.

Because the prevention of HIV/AIDS involves behaviors related to sexual intercourse, and because there are different approaches to the issue even among members of the hierarchy, we currently have the unusual situation in which two current episcopal letters on AIDS disagree on a key point. And what is that point? I would suggest it is the framework used to analyze the implications of condom education.

What did the first letter say? Entitled *"The Many Faces of AIDS: A Gospel Response,"* the first letter was issued in December, 1987, by the fifty bishops of the Administrative Board of the United States Catholic Conference. This document upheld the Catholic tradition regarding human sexuality; it recognized the functional limitations of condoms; and it did not espouse or encourage condom use. Nevertheless, acknowledging the responsibility of competent authority to protect the public health; recognizing that persons do not always behave as the bishops might desire; and acknowledging that the U.S. is a pluralistic society, it observed that public educational programs "could include accurate information about prophylactic devices or other practices proposed by some medical experts as potential means of preventing AIDS. We are not promoting the use of prophylactics, but merely providing information that is part of the factual picture."[10]

The second letter, *"Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis,"* was issued in December, 1989, by

the larger membership of the USCC. It differed significantly, I think, only in its approach to this question of condom education. After affirming that the use of prophylactics to prevent the spread of HIV is technically unreliable, it goes on to state that "Advocating this approach means in effect promoting behavior which is morally unacceptable."[11]

While the topic over which the two letters differ regards condom education, the deeper issue is not so much about condoms, I think, as about the framework that one brings to the condom question.

Neither letter believes condoms are 100% reliable; neither sees them as goods in themselves. But the first letter, in weighing the consequences of becoming infected by a life-threatening virus, judges that condoms are the lesser of two evils. It has essentially made a proportionalist argument based on the relative weight it gives to two bad outcomes: HIV infection, vs. condom use. This method *weighs evils* and finds it ethically appropriate to support the lesser one in order to avoid the greater.

The second letter rejects condom education because this is morally unacceptable. No mention is made of a weighing of two potential evils. While the second letter does not specifically phrase its position in these technical terms, it seems to me that its opposition is based on an intrinsic evil analysis. Using a condom is intrinsically evil because it interferes with the procreative function over which humans have no authority; nothing can justify its use.

The obvious difference between the two letters can quite understandably be seen as a standoff between philosophical approaches to judging moral actions: intrinsic evil vs. the lesser of two evils, or proportionalism. These obviously have different philosophical starting points, and since it is difficult if not impossible to argue starting points, it can appear that we have found ourselves at an impasse.

I would propose that there is a potential alternative, one that leads to the same conclusion as the first bishops letter, but which is developed from what I would suggest is the same internal logic which can lead to a possible finding of intrinsic evil.

To argue the case, I will try to show that an intrinsic evils analysis is ultimately a judgment about significant goods, and that we now have competing sets of significant goods confronting one another.

The conclusion that a particular action is intrinsically evil is a reflection of the prior value established for certain human capacities and actions. That is, an action could only be judged to be intrinsically evil because it violates so highly cherished a good that actions which put the good at risk could never be justified. Since *by their nature* such actions contradict an important principle, they are judged to be *intrinsically* evil. Because of the sanctity with which we regard the human capacity for procreation, and because of the respect we have for what we understand to be the proper use of the procreative faculty, any interference with the potentially fertile nature of the sexual act has been judged to be intrinsically evil. Since condoms so interfere, their use, or education about their use, cannot be condoned.

However, it may no longer be possible to view the moral significance of condoms simply as contraceptives, or even as barriers to treatable sexually transmitted disease. For the first time in history, and for the foreseeable future, unprotected sexual contact now has the capacity to threaten human life, indeed to threaten some of the most vulnerable sectors of society. As Bishop William Hughes of Covington, Kentucky, wrote in response to *The Many Faces of AIDS*: "AIDS is a fatal disease, a fact that puts it into a category very different from other sexually transmitted diseases."[12]

The issue is no longer simply that condoms interfere with conception, or even that they prevent disease. They have become a means to protect human life by preventing an infection that has a high chance of leading to death. If we take account of this difference as we develop our response, it would appear that preserving the sanctity of sexual acts as a cherished good might now be seen to be in competition with an even more fundamental good: the preservation of human life.

Although the bishops in the first letter justified their approach by appealing to the principle of the lesser of two evils, there is precedent in the Jewish ethical tradition for making this argument positively, of saying that the preservation of human life has a special claim upon us. The Jewish principle of *Pkuach nefesh* holds that when a human life is at stake, all prohibitions except those against murder, rape and incest may be abrogated to save a life.[13]

If one can conceive that the duty to preserve life may take precedence over the prohibition against interfering with intercourse,

there may be a role, at this period in our history, for allowing condom education in certain circumstances. This approach simply acknowledges, as do both of the bishops' letters, that the developmental capacity and psychological freedom to internalize our Catholic approach are not necessarily fully developed at the time that sexual maturity is reached, that in fact sexual encounters of questionable moral quality do occur. This perspective acknowledges that human beings in general, and adolescents in particular, exist along a continuum in their capacity to respond with maturity and commitment to the possibility of a sexual relationship. For example, the U.S. Department of Education reports that 60% of high school girls, and nearly 80% of high school boys, have had at least one episode of intercourse before graduating from high school.[14] One out of seven adolescents has a sexually transmitted disease, and 25% of all the gonorrhea and syphilis in this country occurs in young people between the ages of 10 and 19. We know that poverty, alcohol, drug use—especially the use of crack cocaine, as well as threats of physical abuse or abandonment all contribute to a lack of freedom in the negotiation of sexual activities. But at the same time that we are redoubling our efforts to more efficaciously communicate to young people the values we cherish regarding human sexuality, and as we try to approach the complex issues of poverty, racism and drug use which play so large a role in the diminishment of human freedom, is it not appropriate to offer a safety net to help keep those who are admittedly acting irresponsibly alive long enough to grow into their capacity to make the mature decisions we hope for?

What of the issue of *public policy* regarding condom education? This is obviously an extension of this same issue, but here we must also look to the relationship between law and practice in the church.

If we were to briefly describe the Roman attitude to law and pastoral practice, I don't think it would be unfair to say that we could be characterized as having strict principles that are often applied with understanding in extenuating, individual circumstances. This distinction is often exasperating to North Americans who, because of our democratic principles, feel uncomfortable with what can sometimes appear to be two sets of discipline, a public and a private ethics. Though we may bridle at the seeming discontinuity between regulation and pastoral practice, we have also appreciated that mechanisms for individual relief do exist—for example, in the confessional, and in

confidential conversation that has technically been referred to as the *internal forum.*

But now we are discussing not church law but public policy. We must anticipate the impact of such policy not only on individuals, but on communities and nations as well. While individual relief can sometimes be worked out confidentially with church law, not so with public policy. And yet the policy we influence—especially with regard to the prevention of new HIV infections—will have grave consequences for the common good, for the preservation of individual life, and even for the conservation of local populations.

The big difference between approaches to public policy in the two bishops' documents is that the first, while holding the church's principles, allows that not all human behavior will be informed by the values that are important to us. Given this fact, those charged with the care of the public health may reasonably try to prevent infection by prophylactics, even given the plain acknowledgement that latex barriers are not always effective.

Without explicitly forbidding such an approach, the second letter clearly withdraws the understanding that public health authorities may ever have our approval for educating about condoms. And as has been seen across the country, Catholic opinion plays a major role in the dialogue regarding public health and school-based education.

I would propose that the same argument that has been made for the possible allowance of condom use to save an individual human life should also be "writ large" for public policy, given the data we have reviewed describing the catastrophic consequences that are befalling minority and third world communities as a result of HIV infection, and given the fact that a great deal of risky behavior is occurring, especially among adolescents. Despite the fact that condoms are by no means *the* solution to the world-wide ravages of the epidemic, data support their efficacy in reducing viral spread. Surely we must consider the responsibility we bear if we would make it harder for populations at risk to be educated about all the means available to decrease transmission of this life-threatening virus.

Finally, I would like to offer a few reflections about our developing response to the phenomenon of homosexuality, about the impact

that the experience of working with the gay community during this epidemic can teach us.

Before the 1980's, data regarding the gay community in this country were largely limited to surveys of persons in psychotherapy—which showed that people in therapy have problems—and to population-based surveys which were unable to discern any necessary psychological or social pathology associated with being homosexual. Since the onset of this epidemic, many health care and pastoral professionals have had an unprecedented degree of contact with the gay community. After so many tens of thousands of encounters, the quality of this experience has for many posed a basic question regarding the principles which have traditionally guided our moral evaluation of homosexuality. The question which arises is essentially this: are we sure our position is adequately based on facts? Do we not have something to be taught by observing and working with well-balanced, spiritually integrated, faithful, loving, generous gay men and women, who have forged what is frequently a painful path to self acceptance within the church? Does the witness of hundreds and thousands of gay men and women, caring faithfully and heroically for their loved ones and friends until death, sometimes despite the rejection of natural families—does this not have something to teach us about the true quality of this love and affection which we have deemed intrinsically disordered? We have witnessed a community that has not only poured out care for its own in hundreds of thousands of hours of voluntary service, but one which has also used its power effectively to champion the rights of those with less capacity to gain equal access to drugs and to clinical research trials.

We profess that our understanding of human sexuality is a reflection of the natural law—of *a way of being* given to us by the creator in our very essence. The law reflects not only the will of the creator for our good, but is also an anthropological reflection; it is also a description of who we are. Following the natural law should lead to a sense of integrity and solidity.

In the case of our moral understanding of the phenomenon of homosexuality, it would seem that the judgment we have made is not an argument based on data gleaned from experience with homosexual persons. It is, rather, based on the principle that the only legitimate use of the sexual faculty is in a heterosexual marital relationship that is open

to childbearing. Thus our basic judgment about homosexuality is a conclusion deduced from *a priori* principle. But the question is, are the premises of this principle valid?

The principle, which can be traced to the earliest verses of genesis, developed out of a worldview which presumed that all persons were heterosexual. But the twentieth century has brought with it a virtual consensus among medical and behavioral scientists that some persons are constitutionally and healthily homosexual. If this is so, the challenge to us is not to strike down the values that we have traditionally cherished. It is rather to understand how these principles might require further development as we reflect on data that we continue to incorporate from the sciences. As Vatican II reflects,

> If methodological investigation within every branch of learning is carried out in a genuinely scientific manner and in accord with moral norms, it never truly conflicts with faith. For earthly matters and the concerns of faith derive from the same God. Indeed, whoever labors to penetrate the secrets of reality with a humble and steady mind, is even unawares, being led by the hand of God, who holds all things in existence, and gives them their identity.[15]

To summarize these reflections, in contrast to a method which views moral theology as the sole source of principles to be applied in the pastoral encounter, I have suggested that pastoral encounters can also be the source of data to be taken back to the level of fundamental reflection. We can conceive of an ascending pastoral theology that takes as one of its starting points reflection on the experience of the human community. Such an approach, taking into account the personal and global implications of the HIV pandemic and, believing that the obligation to preserve life is one of our most highly cherished principles, might place in a new light our approach to the use of condoms as a means of preserving life. Likewise can we reflect on our encounters with the realities of homosexual affection and love. As we appreciate the fact that our moral evaluation of homosexuality has derived from a world view which has presumed that heterosexuality is universal, we are given the opportunity to develop more broadly our moral understanding of homosexuality based upon the realities of the relationships and affections which are the heart of the matter.

Since the method I have described is very similar to that of many liberation theologians, it is perhaps appropriate to close with a reflection of Gustavo Gutierrez as he discusses the relationship between theory and praxis. In *A Theology of Liberation*, he writes:

> What Hegel used to say about philosophy can likewise be applied to theology: it rises only at sundown. The pastoral activity of the Church does not flow as a conclusion from theological premises. Theology does not produce pastoral activity; rather it reflects upon it. Theology must be able to find in pastoral activity the presence of the Spirit inspiring the action of the Christian community.[16]

1. Centers for Disease Control. Mortality attributable to HIV infection/AIDS—United States, 1981–1990. *Morbidity and Mortality Weekly Report* 1991; 40:41-44.

2. Centers for Disease Control. AIDS in Women—United States. *Morbidity and Mortality Weekly Report* 1990;39:845-846(6711).

3. Felicity Barringer. Census shows profound change in racial makeup of the nation. *New York Times* March 11, 1991, p.1.

4. Centers for Disease Control. *HIV/AIDS Surveillance*, January 1991.

5. James Chin. Current and Future dimensions of the HIV/AIDS pandemic in women and children. *The Lancet* 1991;336:221-224(7044).

6. Richard Saltus. AIDS seen taking a huge toll in Africa. *Boston Globe* February 17, 1991, p. 2. (7135)

7. Yves Congar. *Situation et taches presentes de la theologies* (Paris: Les Editions du Cerf, 1967), quoted in Gustavo Gutierrez, *A Theology of Liberation* (Orbis Books, New York, 1973, p12).

8. Bernard Lonergan, "Theology in Its New Context," in *A Second Collection* (Darton, Longman & Tod, London, 1974; p.58-59).

9. Gaudium et Spes #5.

10. *Origins* 1987;17:486.

11. *Origins* 1989;19:429.

12. Reaction to AIDS Statement. *Origins* 1987;17:490.

13. Immanuel Jakobovits, *Jewish Medical Ethics* (Block Publishing Company, New York, 1959; p. 45-58).

14. United States Department of Education. *AIDS and the Education of Our Children: A Guide for Parents and Teachers* (U.S. Government Printing Office, October, 1987)

15. Gaudium et Spes, #36.

16. Gustavo Gutierrez, *op. cit.*, p 11-12