"THE PLAGUE OF BLOOD": HIV/AIDS AND ETHICS OF THE GLOBAL HEALTH-CARE CHALLENGE

by Barbara Ann Strassberg

Abstract. In this essay I explore the heuristic value of the concept of *ethics of complexity, chaos, and contingency* by applying its framework to the analysis of the HIV/AIDS pandemic. Everyday human moral choices are outcomes of a moral impulse, and such an impulse is grounded in moral competence shaped by moral literacy. This literacy is constructed on the basis of a body of knowledge of culture, social context, environment, and the universe. It also includes the knowledge of religions and religious and secular ethical codes. I also distinguish between the social and cultural aspects of ethical systems. Both societies and cultures provide resources and constraints for the development of literacy and competence. An intentionally developed multifaith and multidisciplinary coalition may help us move away from various forms of social speciation and toward sociological mindfulness. This could help us remake the world into one that has more courage to care.

Keywords: ethics; HIV/AIDS; moral competence; moral impulse; moral literacy; morality; pandemic; social speciation; sociological mindfulness.

I present herein an example of practical application of the concept of *ethics of contingency, chaos, and complexity* (see Strassberg 2001) to the analysis of ethical challenges faced by humanity as a result of the HIV/AIDS pandemic. I define *ethics* as a form of social construction of the theoretical foundations—in terms of right and wrong—for interactions between persons, social groups, and societies and between human beings and other

Barbara Ann Strassberg is Professor of Sociology at Aurora University, 327 S. Gladstone, Aurora, IL 60506; e-mail bstrass@aurora.edu. A version of this article was presented at the symposium "The Possibility of a Global Ethic: The Potential of a Religion-Science Dialogue on HIV/AIDS" organized by the Zygon Center for Religion and Science, 29–30 September 2001.

[*Zygon*, vol. 38, no. 1 (March 2003).]
© 2003 by the Joint Publication Board of Zygon. ISSN 0591-2385

components of the universe. It is a system of socially constructed complex systems of coded information that shape behavior toward people, other forms of life, and all that is.

On September 11, 2001, the flow of global events was interrupted by a defining moment so powerful and out of the ordinary that we know it is going to mark and separate in our consciousness the *before* and *after* for quite a long time. The terrorist attacks that took place on the territory of our country strengthened my belief in the heuristic value of the concept of an ethic of contingency, chaos, and complexity. One afternoon I heard on the news that among hundreds of donors who rushed to give blood for the victims of the attack were some who were infected with HIV, hepatitis B, and other infectious diseases and were unaware of it. They all had to be notified of their health status and referred to doctors for necessary medical care. For those who tested HIV-positive, terror evoked by the attack on the World Trade Center unexpectedly became very personal, individual, and private. It turned into terror of facing life with a deadly disease. These persons became live manifestations in time and space of the embodiment of two processes threatening today the very survival of humanity and maybe even the planet itself: the spreading terror of a medical pandemic threatening the lives of many in consequence of moral (biomedical) decisions of a few, paralleled by and intertwined with the spreading pandemic of political terror threatening the lives of many in consequence of moral (political) decisions of a few.

ETHICS OF CONTINGENCY, CHAOS, AND COMPLEXITY

In my interpretation, ethical systems are socially constructed complex systems characterized by paradoxes embedded in processuality, reflexivity intertwined with contingency, and plurality leading to centerlessness, and by wholeness—that is, an understanding of the interconnectedness and the interdependence of all that is. These systems unfold in moral choices of human agents who live according to ethical values and norms negotiated by the communities to which they belong and regulated by the political powers that rule in those communities.

The ethics of contingency, chaos, and complexity that I propose is an ethics that develops parallel to the evolution of our interpretations of nature, societies, and cultures. I agree with Zygmunt Bauman (1998) that, for instance, the collapse of the Communist bloc contributed to the unveiling of the contingent and erratic nature of global affairs. Globalization and fragmentation, polarization of world population into globals who are free to move and locals who have to stay put, and all other processes accompanying globalization seem to bring a new world order, a "new chaos." The September 11 attacks and the dominolike chain of events, followed by processes that suddenly started to unfold in front of our eyes, can be

viewed as more current examples of contingency, chaos, and complexity in our social life with profound consequences for now and the future.

In regard to HIV/AIDS, a moment that turned order into chaos for gay men in America was a short article by Lawrence K. Altman published in *The New York Times.* The author reported, “Doctors in New York and California have diagnosed among homosexual men 41 cases of a rare and often rapidly fatal form of cancer. Eight of the victims died less than 24 months after the diagnosis was made” (Altman 1981). This passage was quoted by one of my students in a paper he wrote for my class:

> I can remember with a clarity that takes my breath away the events of that morning as well as so much else of what would follow. Twenty years have passed. The disease that would come to be known as AIDS has swept across this country, and around the globe, and it has left in its devastating wake a place on the page that is recognized not just by myself, or others like myself, but by the entire community of mankind. Still, the mind reels when twenty years later, on another July morning, reading the same newspaper, in an article written by the same reporter, it is revealed that “a small but sharp rise in new infections has been detected among gay men in San Francisco . . . the estimated number of new infections in San Francisco nearly doubled . . . health officials linked the rise to a trend towards riskier sexual behavior.” A trend towards riskier sexual behavior? How could this be? (Funk 2001)

During the field-study portion of his research, my student interviewed several gay men on Chicago’s North Side in order to find the answer to his question, “How could this be?” The respondents informed him that they “had once seen AIDS as a deadly disease, but no longer viewed it as necessarily fatal.” Moreover, more than half of those who were HIV-positive stated that they would not tell a partner their status unless asked. Of those who were HIV-negative, almost exactly the same number said that they did not regularly inquire of their sexual partners their HIV status. Still, most men answered that they were “not likely” to die of an AIDS-related condition. “I just don’t see it as that great a possibility any more,” they kept saying (Funk 2001).

If we agree that ethics becomes embodied in everyday human moral choices, we might ask ourselves how these choices are contextualized. I agree with Bauman that moral phenomena are inherently “nonrational” and that people follow their *moral impulse*, their moral self, when they are making choices and take responsibility for those choices. Under the postmodern condition, we as “agents are constantly faced with moral issues and obliged to choose between equally founded (or equally unfounded) ethical precepts. The choice always means the assumption of responsibility, and for that reason bears the character of a moral act. . . . The performance of life-functions demands also that the agent be a *morally competent subject*” (Bauman 1993, 203). Thus, we might assume that even if we agree that a moral act is the outcome of a moral impulse, such an impulse has to be grounded in the moral competence of the acting subject.

I argue that moral competence is shaped by the dissemination of information gradually accumulated by people rather than by exposing people only to specific ethical codes. This competence stems from *moral literacy* constructed on the basis of the ever-changing and challenged body of knowledge of culture (cultural literacy), of the social context (socioliteracy), of the environment (ecoliteracy), and of the universe (cosmoliteracy). Cultural literacy includes the knowledge of religions (religioliteracy) and of ethical codes enforced by either sacred or secular authorities. Obviously the scope of this knowledge, the level of literacy in all of the foregoing dimensions, differs from individual to individual and from society to society. However, to be morally literate means—to paraphrase Fritjof Capra's definition of ecological literacy—knowing and understanding the principles of organization of all that is, from cosmic systems through ecosystems to social systems. *Moral competence*, on the other hand, means using those principles effectively for creating human communities that are sustainable and that provide favorable conditions for the full development of human potential. Such competence manifests itself in specific choices that people make on the basis of moral literacy, emotional responses to the information they have accumulated on a given topic, and predispositions for actions shaped by both coded information and emotional responses to that information. The higher the level of moral literacy, the larger the pool of resources available for the construction of moral competence.

Morally literate people know that HIV/AIDS is not a "gay disease," that it attacks without regard to age, sex, sexual orientation, social class, race, ethnic origin, level of education, and place on Earth. But because in the Western culture it was initially identified as a gay disease, the whole world today pays the price. If we agree that people's actual behavioral choices, their moral impulses, are founded in their moral competence, we realize the power of beliefs and patterns of behavior that are rooted in the lack of scientific information, or in misinformation, in "knowing" things that are not actually true. Often the lack of correct scientific information is intertwined with powerful religious beliefs that stem either from a rather narrow interpretation of sacred texts or even from intentional misinterpretation of such texts. Strong emotional responses, both overt and covert, to homosexuals and HIV/AIDS patients by members of certain social groups often lead to the development of emotional roadblocks in the processes of communication. Some people have internalized the traditional religious teachings that promote the interpretation of homosexuality as the bad or sinful personal choice of a specific lifestyle. As a result, such individuals tend to view the AIDS pandemic as a "plague of blood," a penalty imposed by God on selected human groups, or even whole societies, for their involvement in the homosexual lifestyle.

As individuals we are all members of numerous social entities that promote varying and often contradictory ethical systems. For the purpose of

my argument here, I focus only on the relationship between two such systems, one stemming from the "traditional-static" interpretation of Christian religious teaching and another from the secular "scientific-dynamic" interpretation of sexual orientation. This relationship can be either confrontational (a more frequent occurrence in actual social experience) or nonconfrontational (McGrath 1999, 44–50). If it becomes intensely confrontational on the social level, it may lead to the development or persistence of *social speciation,* a belief in the superiority of a specific category of people over all others (Erickson 1966, 51). If the relationship between ethical systems becomes intensely confrontational on the level of an individual worldview, it may lead to the development of a morally disintegrated pluralistic personality, of a self experiencing a continuous internal strain that results from a struggle between oppositional values and norms (Chrobot 1975). When the confrontational relationship occurs between a traditional interpretation of Christian ethics and everyday manifestations of sexual conduct judged as misconduct by those who adhere to such an interpretation, favorable conditions are constructed for the perception of any major health issue (such as leprosy, smallpox, or HIV/AIDS) as an expression of God's wrath.

The interaction between the two ethical systems discussed here also can be approached from the perspective of the four basic ways in which science and religion can be related to each other (Haught 1995, 9–25): (1) *conflict*, manifested in the opposition between key values and norms of the two systems and in their negative impact on each other, for example a group of Roman Catholic gays and lesbians being expelled from their parish because of their sexual orientation; (2) *contact*, expressed in the positive interaction between the two systems. For instance, some United Methodist gays and lesbians might become members of a congregation whose leader welcomes all who want to join, regardless of their condition of being, and makes sure that their human and civil rights are protected; (3) *contrast*, which assumes that both systems are different and valid but do not influence each other. For example, some people view sexual orientation as an outcome of a specific configuration of genetic, psychological, and social factors but encourage gays and lesbians to remain celibate. Thus they do not really challenge the accepted interpretation of religious beliefs about human sexuality but also do not reject those with alternative sexual orientations; and (4) *confirmation* of one system by the other and vice versa. Today, many Christian theologians reinterpret passages from the scriptures that have been used in the past to legitimize discrimination against homosexuals and affirm homosexual lifestyle as valid in spite of those biblical passages. At the same time, many gays and lesbians experience an urge for spirituality and wish to remain members of religious institutions or rejoin them. They search for religious institutions that allow them to affirm their religiosity without regard to their sexual orientation.

To stress even more strongly the multiplicity and complexity of possible models of interaction between ethical systems with reference to the HIV/AIDS pandemic, let me make a distinction between the social and the cultural aspects of such systems.

The Social Aspect of Ethical Systems

The social aspect of an ethical system is expressed by various categories of people engaged in a system that operates in a specific time and in a particular space. First, we can distinguish between producers and consumers of ethical systems, and then, on the continuum between these two polar positions, we can position the following categories of people involved.

On one end, we would place founders of ethical systems, either as authors of sacred texts or as authors of secular codes of ethics. In our discussion of the HIV/AIDS pandemic as a global health-care challenge, we need to take a closer look at the authors of scriptural passages commonly quoted in support of beliefs condemning homosexuality and the ideological context within which they operated. Also, we need to examine the ideological context surrounding actions of political authorities who in the past formulated and supported laws denying gays and lesbians their civil and human rights and of those who today are trying to enact new laws that would grant equal rights to gays and lesbians. Another category of "founders" is that of the authors of the codes of medical ethics who make sure that health-care professionals will not refuse medical treatment to people infected with HIV/AIDS, even if their religious beliefs are in conflict with these patients' lifestyle.

The ethical systems constructed by the founders are further processes by "interpreters"—theologians, scientists, and other scholars. For instance, some Christian theologians are today reinterpreting the sacred texts in such a way that all persons, regardless of any formerly stigmatized condition of being, could remain members of religious institutions that were not very friendly toward them in the not-very-distant past, could rejoin them, or could join for the first time. Scientists—those working in the natural sciences or social sciences and especially psychologists and political scientists—are ready to reinterpret the secular world in such a way that neither sexual orientation nor any illness is viewed as a specific aberration qualifying the victim for further victimization by existing social structures.

The various interpretations of ethical codes are further processes by "teachers," that is, all agents of socialization functioning in a given space at a given time: parents, teachers, peers, the media, religious leaders, and so on. They are the ones who shape the minds, systems of beliefs, and worldviews of subsequent generations and in a more or less successful way contribute to a higher or lower level of *moral literacy* within their communities. They are the ones who transmit the accumulated information and are responsible for the state of communal cosmoliteracy, ecoliteracy, sociolit-

eracy, cultural literacy, religioliteracy, and thus also of *moral competence*. The history of humanity provides numerous examples of the often-tragic consequences of the failure of the "producers" and "transmitters" to pass on to society in a timely fashion information necessary for survival. One example of such failure we observed on September 11, 2001. Even though the "founders," "interpreters," and many "teachers" knew about the development of world terrorism for years before the attack, most members of our society were taken by surprise. A similar failure can be observed in the case of the HIV/AIDS pandemic. The "experts" had the information and could have predicted the spread of the virus and of the accompanying diseases. However, many people, especially those who believed they could not contract it (heterosexual men and women), were taken by surprise.

The fourth category is composed of "activists" on behalf of ethical systems recruited from both faith-based communities and professional organizations. Many representatives of various religious communities and healthcare professions become actively involved in caring for people infected with HIV/AIDS not only in their own communities but also where they are needed the most today, in Africa.

Finally, we come to the other end of our continuum, to the "consumers." Here we meet ordinary persons who "live ethics" in their daily lives in a more or less informed way and with a higher or lower level of awareness of the ethical ramifications of their daily choices. Depending on the level of their moral literacy and moral competence, they may engage in protected or unprotected sex, use disposable or nondisposable needles, and take necessary precautions or not when engaging in activities considered dangerous with people infected with the virus. Above all, depending on their literacy and competence, they may get involved in the fight against this pandemic and help develop preventive measures to protect people from contamination, or they may do nothing and thus contribute to the further spread of HIV.

The foregoing categories of people obviously are not mutually exclusive. All of them can overlap and be intertwined. In addition, they can be further subdivided according to basic sociodemographic criteria, such as age, sex, sexual orientation, level and character of education, income, social class, race, ethnic origin, religious affiliation, degree of geographic, social, and intellectual mobility, and place of residence in both the macro/global and micro/local scales.

Obviously "producers" of specific ethical systems on average are ethically more literate, but not necessarily more moral, than "consumers." Numerous social and cultural factors condition the transmission of ethical information between various categories of people. Although ethics seems to be "democratic" in its accessibility to all, regardless of their sociodemographic characteristics, particular ethical systems are limited by being culture-specific and thus accessible in their unique manifestations only to members of a given community.

Besides focusing on categories of people involved, we need to mention social institutions founded to satisfy various needs, especially those related to the ethics of the global HIV/AIDS challenge—religious institutions, health-care structures, and political structures. All of them operate within the network of other social institutions. Piotr Sztompka's "model of social becoming" is extremely helpful in presenting the interaction between individuals, groups, and institutions dealing with the ethical questions discussed here. According to his model, reality unfolds where agents and structures meet at the level of agencies. Agencies, when placed in time and space, are conditioned by both constraints and resources coming from structures and from individual or collective agents, and thus they constitute "the unified 'socio-individual field in the process of becoming'" (Sztompka 1991, 83). Within that field agencies are actualized in praxis. For example, a health-care structure cannot exist without health-care personnel and patients. The daily interaction between health-care personnel and patients is praxis, and this praxis depends on the quality of the operation of the whole structure (hospital equipment, qualifications of doctors, and nursing staff, and so on) and the condition of patients (emergency situation, life-threatening condition vs. chronic illness, etc.)

All praxis, including moral praxis, is embedded in space, in the environment that connects a given praxis with other systems. This environment has two interconnected dimensions: the "material" that pertains to humans as biological organisms and the "ideological" that refers to humans as conscious subjects.

> Consciousness—individual, collective and social—is a pool of resources in the form of concepts, symbols, codes, frames etc. for the interpretation of the situation. It may keep people blind to some constraints or opportunities or open their eyes to them, supplying inadequate intellectual tools for grasping reality. . . . Thus the natural conditions, in their constraining or enabling influence on the agency, are to a large extent mediated by the "ideological milieu." (Sztompka 1991, 103)

The ideological milieu for ethical praxis in regard to the HIV/AIDS pandemic is composed of, among others, ideologies constructed by the medical establishment, religious institutions, and political authorities. Since HIV/AIDS has already reached the scope of a pandemic, we might state with a high degree of certainty that so far all three of the mentioned structures are failing. Within the medical establishment, in spite of a tremendous progress in medical research, HIV remains a serious, usually fatal disease that requires complex, costly, and difficult treatment regimens that do not work for everyone. Within religious institutions, interpreters and teachers of ethics also did not make much progress in the reinterpretation of sacred texts. Both activists and regular members of many churches still cite selected passages of those texts to legitimize stigmatization of individuals and social groups infected with HIV/AIDS. They reinforce the social and cultural marginalization of the ill. Moreover, once labeled, many

people tend to internalize their stigmatized identities, develop a negative self-image, and then accept their isolation from society. Some of them may even accept the interpretation of their condition as an actually deserved "penalty" imposed by God.

The ideological milieu also includes "political" consciousness developed and disseminated by a political authority that guards the opportunities and constraints of individual, collective, and social consciousness by means of varied forms of power, from totalitarian coercion to truly democratic freedom of choices. Those who have political power decide what kind of medical research will be financed and how much money is to be spent on health-care programs and education compared to, for instance, military programs. According to the World Health Organization (WHO) Report, in 1999 the world spent $16 billion for prevention of AIDS, TB, and malaria and $864 billion for military purposes (WHO 2000). The authors of the report estimated that since 1945, 150 million people have died from AIDS, TB, and malaria and 23 million, both military and civilians, have died as a result of war. They stressed that a "Strong national defence must include protecting the population from microbial invaders" and that "the key determinants of health—as well as the solutions—lie outside the direct control of the health sector. They are rooted in areas such as sanitation and water supply, environmental and climate change, education, agriculture, trade tourism, transport, industrial development and housing" (WHO 2000).

Praxis, including moral praxis, is also embedded in time. At any given time praxis influences structures (modifying or shaping new relational networks) and agents (modifying or shaping their capacities). As a result, new agencies emerge, societal potentialities for praxis change, and new praxis becomes the manifestation of the actualization of new agencies. This process goes on endlessly and produces historic tradition, which is both the result of and condition for praxis.

Praxis also influences the environments—nature and consciousness, as well as all of the links between structures, individuals and groups, and environments. In other words, all of these potentialities create the "socioindividual" field for praxis; and praxis, by means of feedback, modifies these potentialities. Social structures, agents, and their environments are interconnected, intertwined, and engaged in operations, actions, and praxis that form the "web of social life." Ethics in its social dimension functions as a system of many complex systems that are actualized by specific ethical agencies, which perform praxis according to the level of moral literacy and competence permitted by their respective communities and conditioned by political agencies and their own ethical praxis.

The current report of the WHO clearly indicates that we still have a long way to go to bring infectious diseases under control. If we, as representatives of a world superpower, do not expand our knowledge, literacy,

and competence and do not modify our emotional responses to the conditions in which 85 percent of humans live, we may win a couple of battles on behalf of gay men in Chicago or San Francisco but lose the global war against HIV and AIDS.

THE CULTURAL ASPECT OF ETHICAL SYSTEMS

The cultural aspect of ethics is very complex and is expressed by cognitive, emotional, and action-oriented dimensions. The cognitive dimension is composed of socially constructed and culturally legitimized complex systems of coded proscriptive and prescriptive information that directly shape our emotional responses to some relatively well defined situations and our behavior in those situations. Of course, contingency characterizing the social world makes people's emotional responses and behavior hard to predict. We respond not to the world as it is but to the world as it seems to us to be according to our own interpretations of interpretations provided by numerous sources of information. This information is composed of symbols, meanings, and myths related to what at a given time a society defines as most significant for its survival, and to models of and for the world. Such information shapes people's beliefs, attitudes, and actions toward the biophysical and social environments, and, if they are religious, also toward the Divine. It informs us about how to use the resources of the environment to satisfy in an ethical fashion—for the good of all—human needs, both fundamental and derivative. It links us to our particular societies and provides foundations for our relationship with people in our local communities and with all of humanity. It informs us about the origins of our society and causes of social events, and it instructs us how to cope with problems, how to make judgments, and how to satisfy our culturally activated needs.

The Cognitive Dimension. In relation to HIV/AIDS, the cognitive dimension of ethics comprises the constantly changing pool of information coming from scientists studying the virus and searching for a cure and a preventive vaccine. It also encompasses myths about the disease—narratives constructed and spread by those who either do not have access to scientific information or, if they do have such access, hide or distort information for ideological reasons or to help their own agendas. Some of the symbols and meanings reflect wide interconnectedness and interdependence of HIV/AIDS health-related issues and numerous other dimensions of cultures. In any society, when people deal with a serious disease, the key role is played by the "knowledge" of the origins of the disease, how it spreads, what categories of people are at high risk, and what patterns of behavior contribute to the development of this world health challenge. The interesting distinction between "innocent victims" and others who "deserve" to suffer from the disease could have developed only at a stage when people

became aware that the disease threatens all and not just selected, stigmatized populations.

The Emotional Dimension. The second dimension of the cultural aspect of ethics is the emotional dimension of human responses to societal beliefs in values, norms, and authorities that sanction them. Especially when those beliefs are challenged, the emotional resistance to change is strong even within a given system. For example, some Christian theologians are engaged in the reinterpretation of the biblical passages or reconceptualization of God. Their new approaches evoke feelings of anger, disappointment, frustration, threat, or even fear among some of their coreligionists, including other Christian theologians. Quite often they are accused of not being “true Christians.” Any conversations about issues related to religion, within the context of the American “religious culture,” are emotionally charged. Many conversations about human sexuality, within the context of the American “sexual culture,” are also emotionally charged. When these two topics are combined, the “emotional bombs” often explode, making communication extremely difficult and modification of beliefs almost totally impossible.

In a similar way, many scientists engaged in ethically controversial research evoke very negative emotions among some people, including other scientists working in the same discipline. Quite often they are accused of “playing God,” which might imply that they are not considered “true scientists.” Genetic research and especially stem-cell research are good examples of areas where resistance is often highly emotionally charged. Even if it means a cure or a vaccine to defeat a virus as potent as HIV, emotional responses might not permit a modification of existing ideological beliefs any time soon.

Readiness for Action. The third dimension of the cultural aspect of ethics is the readiness for action expressed in specific patterns of behavior and norms. I refer here to patterns of behavior that allow us to test, reenact, reinforce, and transmit the ethical information to subsequent generations. Each generation tries to ethically “clone” its descendants, and the descendants make all possible efforts to avoid it. Ethical knowledge is translated into guidelines for behavior that are believed to be defined and sanctioned by or on behalf of a given authority. The young are introduced to culture saturated with ethical content and are constantly reminded of the importance of obedience by being exposed to multiple examples of the execution of sanctions applied in case of deviance. The “moral equals” establish communities and within them actualize their “experience of being alive.”

In the context of the science-and-religion dialogue focusing on HIV/AIDS, it is helpful to remind ourselves of the socially constructed and

culturally sanctioned limitations to the ideal of democracy in the United States. Among our values and norms that guide our actions is the value of free choice. We can elect our political leaders and choose social groups to which we want to belong, places we want to live, careers we want to pursue, and friends we want to be around. In our cultural context, however, the ideal of democracy does *not* refer at all to forms of expression of our sexuality or ways of interpretation of "our" religion. Even today, many members of our society do not feel ready to accept diversity of sexual expression or diversity of religious expression. The least amount of choices is allowed when these two meet at the intersection of religious interpretation of human sexuality. For many followers of American pluralistic and diverse Christianity, there is only one right interpretation, and no alternative choices are acceptable. This attitude is not shared by all but still is held by too many.

Moreover, in American society the philosophy of individualism provided a foundation for specific patterns of behavior and norms. The September 11 attack and the events that followed this powerful manifestation of the disastrous effects of a merger between science (technology) and religion (ideology) provided an excellent example of the engagement and a major challenge for some other mainstream American values and norms. The media kept emphasizing a "sudden" connectedness and cooperation, maybe even total abolition of the "speciational" boundaries that for several centuries have separated individuals and subgroups within our society. People prayed together, provided emotional and financial support, and donated blood. Many members of our society seemed ready to suspend their predisposition towards ignorance and to acknowledge their lack of literacy in global history, politics, and world religions. Quite a number of them appeared prepared even to give up many of their freedoms in exchange for stricter surveillance of the private lives of citizens by the federal government. We can only hope that the door to a higher respect for all people, regardless of their condition of being, has been opened.

Moral Literacy, Competence, and Moral Impulse

In my interpretation, moral competence means a process of pragmatic adaptation of ethical beliefs to the requirements of a given period in the individual or group life. Moral competence might be limited not only by an insufficient level of literacy but also by human frailty, understood here as human susceptibility to seduction (Baudrillard 1983; Giddens 1990; Bauman 2000), in the broad postmodern understanding of this term and reinforced by the growing sense of *Unsicherheit,* which blends together uncertainty, insecurity, and unsafety (Bauman 1999, 5–6).

In this model the basic dimensions of moral competence are (1) self-identification (I am a moral person, which means that I make intentional

efforts not to hurt people, including myself); (2) character, intensity and frequency of emotional responses to the values and norms, especially the intensity of the predisposition to defend the ethical beliefs when they are challenged (I respect people regardless of their condition of being and, for instance, support the efforts of gays and lesbians to gain equal rights); (3) frequency of participation in ethical rituals (I am involved in volunteer work to care for people infected with HIV/AIDS); (4) level of commitment to following the norms (I respect people even if I don't understand their beliefs or their lifestyle); and (5) formal membership in organizations and institutions uniting people who share the same ethical beliefs (I belong to the Planetary Society and the American Academy of Religion).

These five dimensions help us interpret moral competence as a manifestation of individual or group connectedness to a specific ethical system by means of a complex web of interactions, influences, connections, conflicts, and contrasts. In social reality, for pragmatic purposes individuals and collectivities might combine elements of selected dimensions of one ethical system or of two or more systems. For example, some people might define themselves as "moral" individuals according to the teachings of the Decalogue but at the same time support accessibility of guns and capital punishment. Others might link some elements of systems they were "born into" with elements of ethical systems they encountered later in life. For instance, they might combine their "pro-life" ethics of the religious system they were "born into" with the stem-cell research medical ethics, guiding this research toward saving lives and enhancing the quality of life.

Now, if we return to our initial four models of interaction between different ethical systems—conflict, contact, contrast, and confirmation—we see that they can be applied only if ethical systems are analyzed at a high level of abstraction, in an essentialist way, detached from empirical life situations. In actual social and cultural contexts no ethical system functions as a monolithic entity; they are all hybrids (Werbner and Modood 2000). The concept of ethics covers an extremely diverse range of empirical manifestations of people's individual, collective, and institutionalized beliefs and patterns of behavior conditioned by those beliefs. We might gain a better understanding of the role of ethics in societies and cultures and of the interaction between different ethical systems, especially in the context of the current globalized exchange of information, only by means of an empirical social scientific study of actual manifestations of the implementation of specific elements of specific ethical systems in people's everyday life situations.

Embodied Ethics of Global Health Care

Once we put together what we have said so far about ethics, we end up with a model of embodied ethics. It reflects the potentialities existing within

social-individual-institutional agencies, which are actualized by these agencies in the process of praxis. The moral competence of any particular individual or group, whether a producer or a consumer, or anyone in between these two categories, embedded in definite time and space, in unique material and ideological environments, conditions the actual interplay between elements of any given ethical system. We wish that the processes of moral-competence formation helped eliminate beliefs untrue in their content but very true in their consequences. For example, beliefs constituting *social speciation* brought about the slaughter of human beings by other human beings on a scale with no parallel. "Even though all people are the same species, they divided themselves throughout history, territorially, culturally, and politically, into various groupings that consider themselves, more or less consciously and explicitly, the only truly human species, and *all* others (and especially *some* others) as less than human" (Erickson 1996, 51). Today such "slaughter of human beings by other humans beings" is performed by all of us bystanders who remain silent when the economic and political elites spend more money on industries that maintain human readiness to kill than on industries that would help create solid infrastructures in developing countries and effective global health-care systems. Beliefs constituting social speciation can be countered by social and cultural literacy, which contains the knowledge of human connections and relationships, commonalities and uniqueness, unity and diversity.

In the social world, feedback—the knowledge of actual outcomes of already-completed specific actions—consists in the fact that social practices are constantly reevaluated and revised in the light of the incoming information about those very practices. This "knowledge" can be named *sociological mindfulness*. Michael Schwalbe (2001, 3–4) defines sociological mindfulness as a practice of finding out how the social world works. It brings us a better understanding of the process of world making and appreciation of this world as a human accomplishment. Once we realize our power as agents, as "co-creators" (Hefner 1993), our lives become more interesting because we can then take the responsibility for remaking the social world in a more desirable way for all involved. The social world exists only because of shared beliefs, ideas, and patterns of action that are built into habits. It is durable because people do not doubt ideas that hold their social world together and affect their minds, and they recognize the power of tools (for instance, weapons) that might affect their bodies.

Sociological mindfulness forces us to see, recognize, and acknowledge—in spite of American individualism that strongly inhibits such mindfulness—how our lives are intertwined and how the existing connections sustain and obligate us. This mindfulness also challenges us to see things we would prefer not to see and, above all, to pay attention to the hardships and options (or lack of options) that other people face. It helps us see how our actions are the cause and consequence of what happens elsewhere and

how we are connected to the past. "Knowledge itself is the past living in our minds and habits. . . . Our language—each word, each grammatical rule—connects us not only to each other, but also to a common human past. . . . To be mindful of the past in the present involves listening to others here and now, in order to find out the meanings of the past and the feelings these meanings evoke" (Schwalbe 2001, 37–38). Once we understand how people's feelings about the past affect their behavior in the present, we can avoid repeating mistakes of the past and recognize old dangers when they arise in new forms. The social world as we know it could not continue to exist if we did not reenact it every day. Once we understand who "invents" stigmatizing labels, who benefits and who is hurt by given "inventions," how people create their own versions of truth, and why we insist that other people accept our picture of the world, we may collectively become involved in the construction of new images, new impulses, new needs and wants, and thus new social arrangements.

Maybe already today, by being involved in the project of the "Interfaith Dialogue on HIV/AIDS" we can start creating a powerful multifaith and multidisciplinary coalition that would work toward cultural change in our society—from the culture of victimization to the culture of prevention, from the culture of peace-loving individuals constantly prepared for war to the culture of war-rejecting individuals prepared for peace, from the culture that supports prayer for the success of those who kill (or die while involved in killing) to the culture that focuses on a good life for all. As members of a superpower, we have skills and means necessary to lead rather than to follow. What often seems to be missing is the "courage to care," to invest a bigger portion of our intellectual, financial, cultural, and political capital in the construction of the infrastructure for healing rather than killing. The distinction between "them" and "us" is more invalid today than ever before. Facing a global pandemic such as HIV/AIDS, especially in the context of the developing threat of world terrorism, we need to work together to increase the general level of moral literacy and competence of more and more people on the planet, and thus try to ensure more frequent occurrences of behavior guided by a "moral" impulse of mutual respect.

References

Altman, Lawrence K. 1981. Article in *The New York Times*, 3 July.
Baudrillard, Jean. 1983. *In the Shadow of the Silent Majorities*. New York: Semiotext(e).
Bauman, Zygmunt. 1993. *Intimations of Postmodernity*. London and New York: Routledge.
———. 1998. *Globalization. The Human Consequences*. New York: Columbia Univ. Press.
———. 1999. *In Search of Politics*. Stanford, Calif.: Stanford Univ. Press.
———. 2000. *Liquid Modernity*. Cambridge, U.K.: Polity Press.
Capra, Fritjof. 1996. *The Web of Life*. New York: Anchor Books.
Chrobot, Leonard. 1975. *The Integrated Pluralist*. Detroit, Mich.: Wayne State Univ. Press.

Erikson, Kai. 1996. "On Pseudospeciation and Social Speciation." In *Genocide, War and Human Survival,* ed. Charles B. Strozier and Michael Flynn, 51–57. Lanham, Md.: Rowman and Littlefield.
Funk, John. 2001. Combating complacency in HIV prevention. Unpublished paper submitted for SOC 110-01, Aurora University.
Giddens, Anthony. 1990. *The Consequences of Modernity*. Stanford, Calif.: Stanford Univ. Press.
Haught, John F. 1995. *Science and Religion. From Conflict to Conversation*. New York and Mahwah, N.J.: Paulist.
Hefner, Philip. 1993. *The Human Factor: Evolution, Culture, and Religion.* Minneapolis: Fortress.
McGrath, Alister E. 1999. *Science and Religion: An Introduction*. Malden, Mass.: Blackwell.
Schwalbe, Michael. 2001. *The Sociologically Examined Life*. Mountainview, Calif.: Mayfield.
Strassberg, Barbara. 2001. "Ethics of Contingency, Chaos, and Complexity." Paper presented at the conference "Human Frailty: Rights, Ethics, and the Search for Global Justice," University of the West of England, Bristol, September 2001.
Sztompka, Piotr. 1991. *Society in Action: The Theory of Social Becoming*. Chicago: Univ. of Chicago Press.
Werbner, Pnina, and Tariq Modood, eds. 2000. *Debating Cultural Hybridity*. London and New Jersey: Zed Books.
World Health Organization. 2000. Report at *www.who.int/infectious-disease-report*