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NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

The American Jewish Committee, founded in 1906, is the pioneer human-relations agency in the United States. It protects the civil and religious rights of Jews here and abroad, and advances the cause of improved human relations for all people.

MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
May 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, NY 10019
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CONTACT: Press - Natalie Flatow
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PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR RELEASE AFTER 2 P.M.
THURSDAY, MAY 12, 1983

NEW YORK, May 12....Howard I. Friedman of Encino, California, a partner in the Los Angeles law firm of Loeb and Loeb, was elected 19th National President of The American Jewish Committee today at the organization's 77th Annual Meeting at the New York Hilton Hotel.

He succeeds Maynard I. Wishner of Chicago, President of Walter E. Heller & Company, the principal commercial financing and factoring operating subsidiary of Walter E. Heller International Corp., who served three years in the presidential post, and who today was elected an Honorary President.

In his acceptance speech before an audience of more than 500 AJC leaders from across the country, Mr. Friedman described his hopes and plans for the directions the AJC will take in the coming years. He said:

"Throughout its 77 years, The American Jewish Committee has made a dramatic and enduring contribution to the vitality of American and Jewish life. In the years to come, the need for an organization uniquely blending both the American ethos and the Jewish ethos, committed to the primacy of process, profoundly dedicated to the flowering and strengthening of pluralism in American society, and to the maintenance and enhancement of Jewish life in the world, will be such as to make that 77-year record only a prelude to the even greater contributions which the Committee will continue to make. Never before have the needs of the surrounding society and the needs of the Jewish community been more compelling in requiring the special attributes of the American Jewish Committee."

Mr. Friedman, who is a business trial attorney and a Fellow of the American College of Trial Lawyers, served as Deputy Attorney General for the State of California from 1955 to 1957. In that post, he was involved in a case before the

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U. S. Supreme Court that involved precedent-making litigation between the states of California and Arizona over the use of Colorado River water.

An active community leader, he is a member of the Board of Directors of the Jewish Federation Council of Los Angeles, and of the Business Development Center of Southern California, formerly known as the Interracial Council for Business Opportunity.

He is Honorary Chairman of the Board of Overseers of Hebrew Union College's California School, Vice Chairman of HUC's Board of Governors, and a member of the Board of Directors of the University of Judaism.

A native of Chicago, Mr. Friedman attended the University of Oklahoma, where he was a member of Phi Beta Kappa and received the Silver Letseizer Award as outstanding male graduate. He earned a Master of Arts degree in political science at the University of Chicago and a law degree at Yale University, where he was Note Editor of the Yale Law Journal.

Mr. Friedman was a captain in the Air Force, serving in the Judge Advocate's Division. He was also a teaching fellow at Stanford University Law School.

He is married to the former Wilma Mann of Tulsa. They have three children - Lesley, Harry, and Beth.

At the same session of AJC's Annual Meeting, a number of other leaders were elected to positions of top responsibility. Theodore Ellenoff of New York was elected Chairman of the Board of Governors. Alfred H. Moses of Washington was elected Chairman of the National Executive Council. Robert S. Jacobs of Chicago was elected Chairman of the Board of Trustees.

Shirley M. Szabad of Scarsdale, N. Y., will be the new National Secretary, and Emily W. Sunstein of Philadelphia will be Associate Treasurer.

Six AJC leaders were designated National Vice Presidents for the first time. They are Norman E. Alexander of Westchester, Howard A. Gilbert of Chicago, Alan C. Greenberg of New York, Robert H. Haines of New York, Robert L. Pelz of Westchester, and David F. Squire of Boston. Raymond F. Kravis of Tulsa was elected an Honorary Vice President.

Founded in 1906, The American Jewish Committee is this country's pioneer human relations organization. It combats bigotry, protects the civil and religious rights of Jews at home and abroad, and seeks improved human relations for all people everywhere.

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May 2, 1983
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HOWARD I. FRIEDMAN -- ACCEPTANCE SPEECH

FOR OVER 25 YEARS THIS ORGANIZATION HAS PROVIDED TO ME THE INTELLECTUAL AND EVEN THE EMOTIONAL MOORINGS FOR COMMUNAL LIFE AND FOR FINDING A SENSE OF PURPOSE IN MY OWN LIFE. SO MANY OF YOU IN THIS ROOM ARE NOT ONLY COLLEAGUES, BUT ARE AMONG WILMA'S AND MY CLOSEST AND MOST CHERISHED FRIENDS. IT IS A HUMBLING AND SOBERING EXPERIENCE TO BE GIVEN THE KIND OF RESPONSIBILITY BY SUCH AS YOURSELVES AND BY THIS GREAT ORGANIZATION AS YOU HAVE SEEN FIT TO CONFER UPON ME. I MUST SAY IT IS ALSO SOMEWHAT EGO-MASSAGING, AND I HAVE TRULY ENJOYED THE PROSPECT OF ASSUMING THIS POSITION.

WHATEVER EGO UPLIFT THE PROCESS ENTAILS, IT IS IMMEDIATELY HUMBLING FOR ONE IN MY POSITION TO TAKE A WALK DOWN THE CORRIDOR ON THE 8TH FLOOR OF THE BUILDING ON 56TH STREET AND RECALL THE GREAT LEADERS OF AMERICAN JEWISH LIFE WHOSE PICTURES ARE ON THE WALL OF THAT CORRIDOR AND WHO ARE MY PREDECESSORS AS PRESIDENT OF THE AMERICAN JEWISH COMMITTEE. THE STANDARDS WHICH THOSE DISTINGUISHED AMERICAN JEWS HAVE SET FOR THIS POSITION ARE TRULY AWESOME, AND ONE'S OWN SENSE OF SELF-CONFIDENCE MUST NECESSARILY WILT IN THE FACE OF THE RECORD OF ACHIEVEMENT WHICH THAT GROUP HAS ESTABLISHED.

WHEN LOUIS MARSHALL BECAME PRESIDENT OF THE AMERICAN JEWISH COMMITTEE IN 1912, HE DELIVERED A VERY BRIEF ACCEPTANCE SPEECH. I QUOTE IT IN ITS ENTIRETY:

"I AM VERY APPRECIATIVE OF THE HONOR. I WAS

PERSUADED TO ACCEPT THE OFFICE BECAUSE OF THE ASSURANCE THAT WE WOULD STILL BE ABLE TO CALL UPON JUDGE SULZBERGER FOR HIS ADVICE AND COUNSEL. INASMUCH AS THE AMERICAN JEWISH COMMITTEE HAS BEEN CONDUCTED ON THE THEORY THAT WE ARE ALL PRIVATES, THIS MEANS NO CHANGE IN ADMINISTRATION. WE WILL ALL CONTINUE TO ACT AS ONE IN THE CAUSE IN WHICH WE ARE SO GREATLY CONCERNED."

IN TRUTH, I COULD STOP THERE BY MERELY SUBSTITUTING THE NAMES OF MAYNARD WISHNER, RICHIE MAAS, ELMER WINTER, PHIL HOFFMAN AND MORRIS ABRAM FOR THE REFERENCE TO JUDGE SULZBERGER, EACH OF WHOM HAS IN WORD AND DEED MATCHED THE ASSURANCE GIVEN MARSHALL BY JUDGE SULZBERGER. INDEED, WILMA SAYS I SHOULD STOP THERE. HOWEVER, I AM UNDER A MANDATE FROM SELMA TO GIVE YOU A 15 OR 20 MINUTE SURVEY OF MY OWN VIEW OF THE AMERICAN JEWISH COMMITTEE, PAST, PRESENT AND FUTURE, AND AS A PRIVATE, I WILL SURELY FOLLOW THAT INSTRUCTION.

SURELY, THE QUINTESSENTIAL ACHIEVEMENT OF THE COMMITTEE OVER THE PAST 77 YEARS HAS BEEN ITS UNIQUE BLENDING OF THE AMERICAN AND JEWISH EXPERIENCE, PARTICULARLY AS THAT BLEND HAS TAKEN ROOT IN AMERICAN LIFE. WE ARE AN ORGANIZATION WHICH HAS UNIQUELY SEEN ITSELF AS A CELEBRANT OF THE AMERICAN JEWISH EXPERIENCE. JEWISH LIFE OVER THE CENTURIES HAS ALWAYS REFLECTED THE CREATIVE INTERFACE BETWEEN THE JEWISH VALUE SYSTEM AND THE SURROUNDING CULTURE IN WHICH JEWS HAVE FOUND THEMSELVES. THOSE SURROUNDING CULTURES AND THE JEWISH VALUE SYSTEM HAVE EACH BEEN

THE BENEFICIARIES OF CONTRIBUTIONS FROM THE OTHER. WHETHER IT WAS IN THE INTERFACE BETWEEN THE JEWISH PEOPLE AND HELLENISM OR THE ENCOUNTER WITH ISLAM, OR THE ENCOUNTER WITH EUROPEAN CHRISTIANITY, OR THE EXPERIENCE OF 19TH CENTURY EMANCIPATION, JEWISH LIFE AND THOUGHT BEAR THE INDELIBLE STAMPS OF THOSE HISTORIC AND CULTURAL EXPERIENCES. ONE CANNOT UNDERSTAND MAIMONIDES WITHOUT IMMERSING ONESELF IN ARISTOTLE. MENDELSSOHN AND KROCHMAL ARE UNINTELLIGIBLE EXCEPT IN THE RESPECTIVE FRAMES OF REFERENCE PROVIDED BY LEIBOWITZ AND HEGEL AND KANT.

BUT THE AMERICAN EXPERIENCE IS SINGULAR AND UNIQUE IN THE RICHNESS AND DIVERSITY OF THE JEWISH ENCOUNTER WITH THE SURROUNDING CULTURE. THIS COUNTRY WAS PREMISED ON OPENNESS AND DIVERSITY UNDER CONDITIONS OF FREEDOM, AND THAT HAS PROVIDED AN EPOCHAL SETTING FOR THE FLOWERING OF JEWISH LIFE IN A SURROUNDING CULTURE WHICH IS CONSCIOUSLY COMMITTED TO DIVERSITY, PLURALISM AND FREEDOM. THE SYMBIOTIC INTERCHANGE OF JEWISH AND AMERICAN VALUES AS REFLECTED IN THE AMERICAN EXPERIENCE HAS ALWAYS BEEN THE PRIMARY CHARACTERISTIC OF OUR ORGANIZATIONAL COMMITMENT, AND SURELY IT SHOULD AND WILL CONTINUE TO BE OUR HALLMARK.

WE HAVE ALSO STOOD FOR AND ESTABLISHED AS A GUIDING PRINCIPLE OF JEWISH LIFE THROUGHOUT THE DIASPORA A PROFOUND COMMITMENT TO THE MAINTENANCE OF JEWISH COMMUNITIES AND JEWISH LIFE WHEREVER THEY MAY BE FOUND, PROVIDED THAT THE SURROUNDING CULTURE IS COMPATIBLE WITH THE PRESERVATION OF JEWISH LIFE.

WHERE IT IS NOT, WE HAVE STEADFASTLY SUPPORTED EMIGRATION OF JEWS TO OTHER PLACES WHERE JEWISH LIFE CAN TAKE ROOT. IN ALL OF THIS WE HAVE STOOD FIRMLY FOR THE AUTHENTICITY OF ISRAEL AS A PLACE FOR THE FLOURISHING OF JEWISH LIFE AS WELL AS FOR THE AUTHENTICITY OF THE DIASPORA FOR THE SAME PURPOSE.

ONE CANNOT THINK OF THE HISTORY OF THIS ORGANIZATION WITHOUT BEING POIGNANTLY REMINDED OF ITS PIONEERING CHAMPIONSHIP OF THE CAUSE OF HUMAN RIGHTS THROUGHOUT THE WORLD. WHETHER IN THE CONTEXT OF THE UNITED NATIONS OR IN THE CONTEXT OF SEEKING THE APPROVAL OF INTERNATIONAL CONVENTIONS PROVIDING FOR THE RECOGNITION OF HUMAN RIGHTS OR THE MOVEMENT ON BEHALF OF SOVIET JEWRY, OR THE EFFORTS TO ASSIST THOSE IN TOTALITARIAN OR AUTHORITARIAN COUNTRIES WHOSE HUMAN RIGHTS HAVE BEEN JEOPARDIZED OR DESTROYED, THIS ORGANIZATION HAS BEEN IN THE FOREFRONT. AGAIN, THAT PRIMARY COMMITMENT TO HUMAN RIGHTS WILL LIKEWISE ALWAYS BE ONE OF OUR HALLMARKS.

OUR NAME AND OUR HISTORY HAVE BECOME ALMOST SYNONYMOUS WITH THE CONCEPT OF CONSTRUCTIVE INTER-GROUP RELATIONS IN AMERICA AND ELSEWHERE. THE SOCIOLOGICAL TERM FOR WHAT WE HAVE ALWAYS BEEN ABOUT IN THIS AREA IS "PLURALISM", AND A REGARD FOR THE LEGITIMACY OF ETHNIC AND RELIGIOUS DIFFERENCE. HERE, TOO, OUR PAST IS ONLY PROLOGUE AND OUR CONTINUED COMMITMENT TO THE DEVELOPMENT OF BETTER HUMAN RELATIONS, THE CONSTRUCTION OF COALITIONS AMONG DIVERSE GROUPS, AND THE CREATION OF A CULTURAL CLIMATE WHICH ACCEPTS DIVERSITY IN THE CONTEXT OF A

UNIFYING NATIONAL ETHOS CONTINUES TO BE AT THE VERY CORE OF OUR BEING.

FINALLY, WE HAVE ALWAYS STOOD FOR A SENSE OF THE PRIMACY OF PROCESS. TO US, THE MANNER IN WHICH POLICY IS DETERMINED AND THE RULES OF DIALOGUE AMONG PEOPLE AND GOVERNMENTS ARE AS VITAL AS ANY SUBSTANTIVE POSITION WHICH CAN BE IMAGINED. CIVILITY IN DIALOGUE, DEFERENCE TO OPPOSING VIEWS, A RECOGNITION OF THE LIMITATIONS AS WELL AS THE OPPORTUNITIES FOR PROBLEM-SOLVING ALL REFLECT A SENSE OF PROCESS AND PROCEDURE WHICH ULTIMATELY SEPARATES THE CIVILIZED FROM THE UNCIVILIZED. HERE, TOO, OUR PAST UNDERGIRDS OUR FUTURE, AND THE ONGOING COMMITMENT TO PROCESS AS A CIVILIZING ELEMENT IN NATIONAL DISCOURSE WILL CONTINUE TO MARK THE WORK OF THE COMMITTEE.

AS LOUIS MARSHALL REFERRED IN HIS ACCEPTANCE SPEECH TO "THE CAUSE IN WHICH WE ARE GREATLY CONCERNED", ONE MUST RECOGNIZE THAT THE CAUSE CONTINUES TO BE THE SAME NOW AS IT WAS THEN, VIEWED IN ITS BROADEST SENSE, BUT THE SPECIFICS HAVE OF COURSE CHANGED AND ARE CHANGING RAPIDLY. IT IS TO THOSE CHANGES IN THE NATIONAL AGENDA AS THEY RELATE TO THE COMMITTEE THAT I SHOULD LIKE TO DEVOTE SOME ATTENTION. IN SUBSTANCE, WHILE OUR "CAUSE" CONTINUES TO BE THE SAME AS IT HAS ALWAYS BEEN, THE SPECIFIC APPROACHES APPROPRIATE TO THE TIMES ARE IN A STATE OF MAJOR FLUX, REQUIRING THE BEST OF OUR THINKING AND DEDICATION.

IN VIEWING THE DOMESTIC SCENE, ONE MUST FIRST IDENTIFY OUR BASIC STANCE TOWARD THE PRESENT CONDITION OF THIS COUNTRY.

TO MUCH OF THE ELITE IN OUR TIME, THIS COUNTRY IS SEEN AS A REPOSITORY OF SEVERE SOCIAL ILLS AND EVEN AS THE SOURCE OF EVIL. IT IS MORE THAN JUST A MALAISE THAT IS REFLECTED IN SUCH VIEWS -- IT IS A SENSE OF HOSTILITY AND ONGOING TENSION BETWEEN THE OPERATING CURRENTS OF OUR CULTURE AND WHATEVER IS CONSIDERED TO BE HEALTHY AND CONSTRUCTIVE. A LEADING WEST COAST RABBI (SPEAKING ONLY FOR HIMSELF AND NOT NECESSARILY REFLECTIVE OF RABBINICAL OPINION) -- A MAN FOR WHOM I HAVE THE HIGHEST RESPECT AND AFFECTION, RECENTLY PUT THE MATTER IN THESE EXTREME TERMS: "THIS COUNTRY HAS BECOME A VULGAR, VOLATILE, UNHAPPY PLACE, AN INSULT TO THE POSSIBILITIES OF HUMAN FULFILLMENT." LET ME STATE AS CATEGORICALLY AS I AM CAPABLE THAT WE UNEQUIVOCALLY REJECT THAT DIAGNOSIS. TO US, THIS IS NOT ONLY THE COUNTRY IN WHICH HUMAN FULFILLMENT IS POSSIBLE, IT IS THE COUNTRY IN WHICH THE MAXIMUM OF HUMAN FULFILLMENT OCCURS DAY IN AND DAY OUT. IT IS STILL THE PLACE IN WHICH OUR OWN SCHEME OF VALUES AS JEWS FIND THE RICHEST SOIL FOR PLANTING AND NOURISHMENT. AND ABOVE ALL, IT CONTINUES TO BE THE CONTINUING HOPE OF THE WORLD. HERE AS ELSEWHERE, WE RECOGNIZE THAT THE PERFECT IS THE ENEMY OF THE GOOD, AND WE EMBRACE THIS LAND AS BEING GOOD TO A MEASURE BEYOND THE EXPECTATIONS AND EXPERIENCE OF ANY OTHER COUNTRY IN HUMAN HISTORY.

AT THE SAME TIME, WE MUST ACKNOWLEDGE THAT MANY OF THE CONVENTIONAL TRUTHS WHICH HAVE PREDOMINATED IN THE LAST 25 YEARS, PARTICULARLY IN THE DOMESTIC ARENA -- TRUTHS WHICH WE HAVE UNABASHEDLY EMBRACED TO OUR ENDURING CREDIT, MAY NO LONGER SUFFICE

IN RESPONDING TO CURRENT CHALLENGES. AS TEDDY WHITE HAS PUT IT: "WHAT WERE ONCE CREATIVE TRUTHS HAVE BECOME BARS ON A PRISON OF DOGMAS."

THUS, THE ROLE OF GOVERNMENT, ITS CONTINUING POTENTIAL, AS WELL AS ITS EVER MORE CLEAR LIMITATIONS AS A DEVICE FOR EFFECTING CONSTRUCTIVE SOCIAL CHANGE, MUST BE CONTINUALLY RE-EVALUATED. WHILE WE MUST NOT THROW THE BABY OUT WITH THE BATH, IT IS BECOMING ALMOST AXIOMATIC THAT GOVERNMENT ALONE IS NOT CAPABLE OF EFFECTING FULL SOLUTIONS TO SOCIAL PROBLEMS IN THIS COUNTRY. WHAT IS BECOMING EQUALLY CLEAR IS THE NEED FOR REHABILITATING AND REINFORCING THOSE MEDIATING INSTITUTIONS AND STRUCTURES WHICH STAND BETWEEN THE INDIVIDUAL CITIZEN AND GOVERNMENT -- THE INSTITUTIONS OF FAMILY, CHURCH, NEIGHBORHOOD, VOLUNTARY ASSOCIATIONS OF ALL KINDS. THOSE INSTITUTIONS HAVE SURELY DECLINED IN IMPORTANCE IN RECENT YEARS, AND THEY NEED TO BE RECOGNIZED AS PRIMARY STRUCTURAL SOURCES FOR THE DEVELOPMENT OF A SENSE OF COMMUNITY. PROGRAMS NEED TO BE EVALUATED IN TERMS OF THEIR EFFECT UPON THOSE INSTITUTIONS AND IN TERMS OF THE USE OF THOSE INSTITUTIONS AS DELIVERY SYSTEMS TO PEOPLE IN NEED.

ALLIED WITH THIS IS THE GROWING REALITY THAT THE PRIVATE SECTOR IS A VITAL AND NECESSARY COMPONENT OF THE MOSAIC OF MEDIATING INSTITUTIONS IN AMERICAN LIFE. INDEED, THE GROWTH OF THE PRIVATE SECTOR REPRESENTS THE GREATEST POTENTIAL FOR EFFECTING REAL SOCIAL CHANGE OF ANY INSTITUTION THAT I CAN THINK OF. MORE PEOPLE ARE MOVED FROM THE UNDERCLASS TO THE MIDDLE CLASS BY VIRTUE OF GROWTH IN THE ECONOMY AND IN THE PRIVATE

SECTOR THAN AS A RESULT OF GOVERNMENT PROGRAMS. FOR US, AN ORGANIZATION WHOLLY DEDICATED TO MOVING THE UNDERCLASS INTO THE MAINSTREAM, THE PRIVATE SECTOR REPRESENTS A PRINCIPAL OPPORTUNITY TARGET FOR SUPPORT, AND OUR AGENDAS SHOULD BE ADJUSTED SO AS TO RECOGNIZE THE IMPORTANCE OF THE PRIVATE SECTOR.

THOUGH IN FACT WE HAVE ALWAYS BEEN A CENTRIST ORGANIZATION, I BELIEVE WE NEED TO ARTICULATE MORE EMPHATICALLY AND AFFIRMATIVELY THE COMPONENTS AND INGREDIENTS OF OUR COMMITMENT TO THE CENTER. THAT INVOLVES A RECOGNITION THAT THE CENTER IS NOT SIMPLY EQUIDISTANT BETWEEN THE EXTREMES, BUT STANDS FOR SOMETHING ITSELF. AND WHAT IT ESSENTIALLY STANDS FOR IS THE IMPORTANCE OF PROCESS AND THE EMBRACE OF THE SURROUNDING CULTURE. THOSE ARE THE ELEMENTS WHICH GIVE CONTENT AND MEANING TO THE IDEA OF THE CENTER, AND THEY, TOO, REFLECT THE CORE OF OUR OWN SOCIAL COMMITMENTS.

FINALLY, FROM THE POINT OF VIEW OF THE DOMESTIC AGENDA, WE NEED TO ARTICULATE MORE PRECISELY WHAT WE STAND FOR. WHAT WE TRULY STAND FOR, IT SEEMS TO ME, IS NOT THE "DEFENSE" OF JEWISH INTERESTS AS SUCH, THOUGH THAT IS OF COURSE PART OF OUR COMMITMENT, NOR THE DEFENSE OF INDIVIDUAL RIGHTS GENERALLY, THOUGH THAT, TOO, IS PART OF OUR AGENDA. PRIMARILY WHAT WE STAND FOR IS THE NOTION OF PURSUING JEWISH VALUES IN THE AMERICAN SETTING AND CONTRIBUTING JEWISHLY TO AMERICA'S CAPACITY TO MEET ITS CHALLENGES. CENTRAL TO THAT NOTION IS THE CONVICTION THAT JEWS ARE NOT MERELY A SOCIOLOGICAL OR DEMOGRAPHIC STATISTIC OR GROUPING IN AMERICA.

TO BE JEWISH DENOTES A WORLD VIEW, A SCHEME OF VALUES, A PHILOSOPHY OF LIFE IN THIS WORLD, A SOPHISTICATED MEMORY OF THE PAST, A PROFOUND AND ABIDING COMMITMENT TO THE FUTURE, AN INSIGHT INTO THE CHARACTER OF SOCIETIES AND SOCIAL ORGANIZATION, A STAYING POWER WITH ADVERSITY, AND ABOVE ALL, A COMMITMENT TO COMMUNITY AS THE SOURCE OF VALUES. THESE QUALITIES TRANSCEND SUPERFICIAL DISTINCTIONS BETWEEN LIBERALS AND CONSERVATIVES, BETWEEN REFORM, CONSERVATIVE OR ORTHODOX, AND ANY NOTION OF CULTURAL DISTINCTIONS BETWEEN SEPHARDI AND ASHKENAZI.

WHAT ARE SOME OF THESE JEWISH VALUES WHICH SHOULD ANIMATE AND GUIDE THE DEVELOPMENT OF OUR DOMESTIC AGENDA? WHILE THE CATALOG WILL NOT BE EXHAUSTED BY WHAT FOLLOWS, SURELY THE FOLLOWING MUST BE INCLUDED:

THE IDEA THAT PEOPLE ACQUIRE THEIR VALUES AND THEIR IDENTITY THROUGH COMMUNITY RATHER THAN THROUGH INDIVIDUAL SELECTION.

THE IDEA THAT HUMAN BEINGS ARE CHARGED WITH RESPONSIBILITIES RATHER THAN BEING GIVEN THE OPPORTUNITY FOR SELF-FULFILLMENT AS THE GUIDING PURPOSE OF LIFE. PRIVATISM IS NOT THE TOUCHSTONE.

THE IDEA THAT HUMAN BEINGS ARE IN PARTNERSHIP WITH GOD IN THE ONGOING BUT NEVER ENDING TASK OF PERFECTING THE WORLD, AND THAT THE PRIMARY RESPONSIBILITY OF LIFE IS TO CONTRIBUTE TO THAT PROCESS, KNOWING FULL WELL THAT IT WILL NEVER BE CONCLUDED.

THE IDEA THAT THE WORLD IS REDEEMABLE AND IS NOT CONDEMNED TO A BLEAK FATE.

THE IDEA THAT WORK IS COMMUNALLY PURPOSEFUL AND THAT THROUGH WORK, INDIVIDUALS CONTRIBUTE TO THE PROCESS OF PERFECTING THE WORLD.

THE IDEA OF FULL FREEDOM OF INQUIRY, INCLUDING THE RIGHT AND OBLIGATION OF DISSENT, EVEN AS TO THE MOST SACRED PROPOSITIONS. THE JEWISH ETHOS IS PREMISED UPON LAW, BUT IT IS EQUALLY PREMISED UPON QUARRELING WITH THE LAW.

THE IDEA THAT HUMAN BEINGS, BOTH INDIVIDUALLY AND COLLECTIVELY, ARE RESPONSIBLE FOR HISTORY.

THE IDEA OF SOCIAL HARMONY AS AN OBJECTIVE OF THE SOCIAL PROCESS, THAT PEACE IS AN UNALLOYED GOOD AND THAT CIVILITY IS THE PRIMARY INSTRUMENT FOR ITS ATTAINMENT.

THE IDEA OF SOCIAL JUSTICE, NOT JUST IN ITS SUPERFICIAL ASPECT IN TERMS OF HELPING THE POOR AND NEEDY, BUT IN ITS BROADER ASPECT DEALING WITH THE HEALTH OF SOCIETY AND THE NEED OF CREATING CONDITIONS IN WHICH ALL ACQUIRE A CONSTRUCTIVE STAKE IN SOCIETY.

THE IDEA THAT PROCREATION IS AN OBLIGATION OF LIFE, NOT FOR THE MERE SURVIVAL OF THE JEWISH PEOPLE, BUT FOR ASSURING THAT THERE WILL BE PEOPLE FOLLOWING US WHO WILL CONTINUE TO ENGAGE IN THE OBLIGATION TO ASSIST IN THE PERFECTING OF THE WORLD.

THE IDEA THAT HUMAN LIFE IS THE PRIMARY VALUE, AND ITS CONDITION IS TO BE IMPROVED IN THIS WORLD AND NOT SERVE AS PREPARATION FOR ANOTHER WORLD.

I BELIEVE IT IS FAIR TO SAY THAT EACH OF THESE IDEAS REPRESENT KEY ASPECTS OF THE JEWISH ETHOS, HONED AND CULTIVATED

OVER A 4,000 YEAR HISTORY. THOSE IDEAS SHOULD INFUSE OUR OWN ACTIVITIES AND THE SETTING OF OUR AGENDA, AND ABOVE ALL, SHOULD PROVIDE TOUCHSTONES FOR THE MEASUREMENT OF PROGRESS IN SOCIAL PLANNING AND PROGRAMMING.

MOVING FOR A MOMENT TO THE FOREIGN AGENDA, THERE, TOO, IT SEEMS TO ME THAT NEW EMPHASES ARE REQUIRED WHILE WE CONTINUE TO BE PROFOUNDLY DEDICATED TO THE PROTECTION OF JEWISH COMMUNITIES THROUGHOUT THE WORLD, AND ABOVE ALL, TO THE PROTECTION OF ISRAEL, IT IS INCREASINGLY CLEAR THAT THOSE OBJECTIVES CAN ONLY BE REALIZED IN THE BROADER CONTEXT OF A RECOGNITION THAT AMERICA AND THE IDEA OF FREEDOM ARE THE INDISPENSABLE KEYSTONES IN WORLD AFFAIRS FOR THE ACHIEVEMENT OF OUR OBJECTIVES. THE ABILITY OF OUR OWN COUNTRY TO ENGAGE EFFECTIVELY AS THE PRIMARY SOURCE OF STRENGTH AND POWER IN DEFENSE OF THE WEST AND ITS IDEAS IS INDISPENSABLE TO THE PROTECTION OF JEWISH LIFE THROUGHOUT THE WORLD. NEVER HAS THERE BEEN SUCH A CLOSE CONNECTION BETWEEN THOSE JEWISH INTERESTS AND THE INTERESTS OF THE UNITED STATES. IF AMERICA IS FALTERING, BOTH IN ITS SENSE OF RECTITUDE AS A PLAYER IN THE INTERNATIONAL SCENE AND IN ITS POWER TO OPERATE EFFECTIVELY, THOSE JEWISH INTERESTS MUST ULTIMATELY BE IMPAIRED. HENCE, I BELIEVE THAT IN THE COMING YEARS WE MUST INCREASINGLY RECOGNIZE AND EMBRACE THE GENERAL FOREIGN POLICY CAPACITY, POWER AND LEGITIMACY OF THE UNITED STATES IN ORDER TO PURSUE THE PROTECTION OF ISRAEL AND JEWISH COMMUNITIES THROUGHOUT THE WORLD. IT WILL NOT BE EASY TO FORGE THOSE LINKS WHICH TIE US TO THE PRIMARY INGREDIENTS OF AMERICAN FOREIGN POLICY. BUT THE NECESSITIES OF THE TIME AND THE ESSENTIAL CHARACTER OF THE

THREAT TO JEWISH AND AMERICAN INTERESTS POSED BY THE SOVIET UNION AND BY THE MENTALITY OF MUCH OF THE THIRD WORLD LEAVE US NO ALTERNATIVE. WHAT IS TRULY AT STAKE FOR US AND FOR AMERICA -- THE VALUES AND ETHOS OF THE WEST AND THE AMERICAN WILL TO SAFEGUARD THOSE VALUES. AND ONLY THE AMERICAN IDEA, AS SO UNDERSTOOD, IN THE REALITY OF THE PRESENT WORLD MAKES IT POSSIBLE FOR JEWISH SURVIVAL.

THROUGHOUT ITS 77 YEARS OF ACTIVITY, THE AMERICAN JEWISH COMMITTEE HAS MADE A DRAMATIC AND ENDURING CONTRIBUTION TO THE VITALITY OF AMERICAN AND JEWISH LIFE. IN THE YEARS TO COME, THE NEED FOR AN ORGANIZATION, UNIQUELY BLENDING BOTH THE AMERICAN ETHOS AND THE JEWISH ETHOS, COMMITTED TO THE PRIMACY OF PROCESS, PROFOUNDLY DEDICATED TO THE FLOWERING AND STRENGTHENING OF PLURALISM IN AMERICAN SOCIETY, AND DEDICATED TO THE MAINTENANCE AND ENHANCEMENT OF JEWISH LIFE IN THE WORLD, WILL BE SUCH AS TO MAKE THAT 77-YEAR RECORD OF ACHIEVEMENT ONLY A PRELUDE TO THE EVEN GREATER CONTRIBUTIONS WHICH THE COMMITTEE WILL CONTINUE TO MAKE. NEVER BEFORE HAVE THE NEEDS OF THE SURROUNDING SOCIETY AND THE NEEDS OF THE JEWISH COMMUNITY BEEN MORE COMPELLING IN REQUIRING THE SPECIAL ATTRIBUTES OF THE AMERICAN JEWISH COMMITTEE.

THOUGH 77 YEARS MAY SOUND LIKE ADVANCED AGE, THEY REPRESENT FOR US MERELY THE INCUBATION PERIOD FOR OUR CAPACITY TO WORK EFFECTIVELY IN THE JEWISH AND AMERICAN INTEREST. CICERO REMINDS US THAT " . . . GREAT DEEDS ARE NOT DONE BY STRENGTH OR SPEED OR PHYSIQUE, THEY ARE THE PRODUCTS OF THOUGHT AND CHARACTER AND JUDGMENT. AND, FAR FROM DIMINISHING, SUCH QUALITIES ACTUALLY

INCREASE WITH OLD AGE." THOSE QUALITIES OF THOUGHT, CHARACTER AND JUDGMENT REPRESENT THE ESSENTIAL RESOURCES OF THE AMERICAN JEWISH COMMITTEE, AND THEY HAVE NOW MATURED THROUGH TIME TO THE POINT WHERE THEIR CAPACITY FOR SERVICE HAS NEVER BEEN GREATER.

NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

The American Jewish Committee, founded in 1906, is the pioneer human-relations agency in the United States. It protects the civil and religious rights of Jews here and abroad, and advances the cause of improved human relations for all people.

MORTON YARMON, Director of Public Relations

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FOR RELEASE AFTER 10 A.M.,
THURSDAY, MAY 12, 1983

NEW YORK, MAY 12 . . . A noted American Jewish leader today warned the American Jewish community that it would not survive if it did not make Jewish education its top priority.

Rabbi Arthur Hertzberg of Temple Emanu-El in Englewood, N.J., made his remarks at a meeting of the American Jewish Committee's Jewish Communal Affairs Commission, chaired by Robert S. Rifkind of New York. The meeting was part of AJC's 77th Annual Meeting, which continues through Sunday at the New York Hilton Hotel here.

At the same session at which Rabbi Hertzberg spoke, AJC's newly-launched National Committee on Jewish Education, a branch of the Jewish Communal Affairs Commission, held its first meeting. Co-chairmen of the new committee are Solomon Fisher, former President of AJC's Philadelphia Chapter, and Marshall Zissman, Chairman of AJC's Chicago Chapter.

"Jews are united," began Rabbi Hertzberg, "for three tasks: to fight anti-Semitism, to defend Israel, and to aid the unfortunate, such as the elderly poor; these tasks are by common consent the responsibility of 'the total Jewish community.'"

However, he continued, "Jewish education -- the transmission of Jewish religion, tradition, and culture -- is regarded as a partisan task, which belongs to those who care about such matters.

"Thus, while the community as a whole makes an effort to involve every Jew as a Jew in the battles against anti-Semitism, on behalf of Israel, and in Jewish charities, the community as a whole does nothing to involve and persuade Jews -- especially the marginal ones -- that they should be associated with their Jewishness as a positive value."

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Because of this failure, argued Rabbi Hertzberg, the number of Jews directly concerned with Jewish life -- "even the defensive aspects of Jewish life" -- is getting smaller: "Why fight against anti-Semitism if you are ceasing to be a Jew? Why care about Israel if it is becoming, in your consciousness, just another state? Why give to specifically Jewish charities when the problem of poverty is universal?"

"The truth," asserted Rabbi Hertzberg, "is that the organized Jewish community has been living off the momentum of religion, its spiritual ideals and commitment, and as that momentum has slowed in a large segment of the community, we now have the problem of an aging leadership and membership in much of organized Jewish life."

Warning that the structure of Jewish life could not "long survive in America if, as is now true, more than half the Jewish children are getting no Jewish education," Rabbi Hertzberg urged that the "effort to reverse this trend take precedence over all other endeavors of American Jewry."

Calling assimilation the "central danger to Jewish life in the Diaspora," Rabbi Hertzberg declared: "Every organized Jewish community must be finding Jews to be educated and it must be funding the Jewish education of those who cannot afford it. Such efforts must today be at the very top of their order of priorities."

Opening the meeting of the new National Committee on Jewish Education, which followed Rabbi Hertzberg's address, Yehuda Rosenman, Director of AJC's Jewish Communal Affairs Department, asserted that Jewish communities had "historically recognized the centrality of Jewish education to Jewish survival."

AJC believes, Mr. Rosenman continued, "that the cause of Jewish education requires the intense involvement and serious commitment of all Jews, lay as well as professional educators."

Therefore, Mr. Rosenman went on, "we call upon the leadership of AJC chapters throughout the country to become familiar with the educational goals, programs, and curricula in the Jewish schools of their communities and to make their voices heard on the local, regional and national levels in support of educational accountability."

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Rabbi Hertzberg, an Adjunct Professor of History at Columbia University, has published many books on Jewish issues. He is President of the American Jewish Policy Foundation, a Vice President of the World Jewish Congress, a past President of the American Jewish Congress, a past member of the Board of Governors of the Jewish Agency for Israel, and a past member of the Executive of the World Zionist Organization.

Founded in 1906, the American Jewish Committee is this country's pioneer human relations organization. It combats bigotry, protects the civil and religious rights of Jews at home and abroad and seeks improved human relations for all people everywhere.

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5/5/83
83-960-175
EJP, REL, Z

NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

The American Jewish Committee, founded in 1906, is the pioneer human-relations agency in the United States. It protects the civil and religious rights of Jews here and abroad, and advances the cause of improved human relations for all people.

MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
MAY 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, NY 10019
1-212-586-7000

PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR RELEASE AFTER 8 P.M.,

WEDNESDAY, MAY 11, 1983

CONTACT: PRESS -

Natalie Flatow
Joyce Kaplan
Ralph Bass

TV-RADIO -

Amy Goldberg
Laurie Chock

NEW YORK, May 11 ... Nobel Laureate Isaac Bashevis Singer initiated tonight a wide-ranging discussion of "Jewish Life: Yesterday, Today and Tomorrow" at the opening plenary session of the American Jewish Committee's 77th Annual Meeting, which continues through Sunday at the New York Hilton Hotel.

The occasion was the 10th anniversary celebration of Present Tense magazine, published quarterly by the American Jewish Committee.

Writer and theologian Arthur Cohen and novelist Hugh Nissenson joined Mr. Singer, contributing their own insights into the spirit and reality of Jewish existence over the decades.

Adele Bergreen who, with her husband Morris, established the Bergreen Institute of Foreign Policy Studies and Publications, a grant from which established Present Tense, spoke briefly to the audience of literary and civic figures in praise of the magazine.

"It has been a most rewarding experience," Mrs. Bergreen said, "to watch the magazine develop, as we hoped it would, into a prestigious journal of world Jewish affairs -- a publication that is both thoughtful and readable, with an openness to varying shades of opinion, and a humane, compassionate view of the Jewish condition, its problems and hopes."

-more-

Murray Polner, editor of Present Tense,who also spoke, was described by Mrs. Bergreen as "a wise and skillful editor who set both the style and the standard of excellence which have become the magazine's hallmarks."

The current (Spring, 1983) issue of Present Tense includes articles by Wolf Blitzer, Stephen S. Rosenfeld, Barbara Probst Solomon, William Korey, Chaim Bermant, Walter Goodman, Israel Shenker, and Lucy Komisar.

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83-860-165
5/3/83
A, EJP, Z

NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

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MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
May 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, NY 10019
1-212-586-7000

CONTACT: Press - Natalie Flatow
Joyce Kaplan
Ralph Bass

TV-Radio - Amy Goldberg
Laurie Chock

PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR RELEASE AFTER 2 P.M.
WEDNESDAY, MAY 11, 1983

NEW YORK, May 11....Three experts in the field of education today urged city and state governments to increase their efforts and their financial support to effect a "return to excellence" in urban elementary schools.

The three represented three national organizations that have long recognized the need for improvements in this country's system of public education, and have worked together toward achieving those changes. The speakers were Dr. Beverly P. Cole, National Director of the National Association for the Advancement of Colored People; Dr. Carol Saunders Gibson, Director of the Education Division, National Urban League; and Frank Goldsmith, Chairman of the American Jewish Committee's National Education Committee.

Their discussion was the feature of a special meeting of AJC's National Education Committee this afternoon, prior to the opening session tonight of the organization's 77th Annual Meeting, which continues through Sunday at the New York Hilton Hotel.

Sounding the keynote of the meeting, Mr. Goldsmith called for what he termed "drastic reforms" in the public education system. He listed "stricter standards for students and teachers, concentration on basic academic subjects, and a recognition of the vital role that dedicated teaching plays in giving young people the opportunity to develop their skills fully." He declared that "our educational system is our first line of defense, because without it we will fail economically, scientifically and culturally in a tough and competitive world."

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All three speakers noted the report of the National Commission on Educational Excellence, which was released last week. Mr. Goldsmith noted especially that the report "differs from previous calls for educational reform because of its emphasis on quality and standards."

"At the same time that we applaud this emphasis," he added, "it is important to note that many of the changes called for have already been instituted throughout the country. In a number of states and communities, standards for student achievement have been established; college and university entrance requirements are being stiffened; a number of communities have raised requirements for teaching licenses; and many states are developing comprehensive schools improvement strategies."

Both Dr. Cole and Dr. Gibson expressed the special concern of inner-city schools today concerning the high cost of computers -- the subject which provided the title for the session, "Computers: The New C in the ABC's."

"The only way our children can compete is to hit the ground running," Dr. Gibson declared, and added:

"We need vigorous and rigorous curriculum in urban elementary schools. But we fear that these schools, which are frequently underfunded, stand the danger of falling further behind because of loss of federal funds, and will not be able to provide the computer literacy that is already taking place in affluent suburban districts."

Dr. Cole, while agreeing that urban schools needed both computers and the software to go with them, cautioned against placing exorbitant stress on mechanical processes.

"The story on the computer is not in yet," she said. "Kids must not rely on them to do their thinking. If they do, Lord help us if the battery goes dead!"

Dr. Cole commented particularly on the fact that colleges were requiring higher test scores for admission today than in recent previous years.

"Our children must be prepared to meet that demand," she said, "and we must devise ways to help them."

One such aid to inner-city and minority students, she said, was a testing project offered by NAACP.

"Our project helps kids develop the test sophistication that prep schools have been giving their students for years," she said.

She also noted the controversy that has arisen about the effectiveness of commercial coaching enterprises, and said:

"Those who can afford that kind of coaching don't worry about the controversy. They just go."

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* * *

May 6, 1983
83-960-176
A, EJP, NEG-A, NPL-A, Z

NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

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MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
MAY 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, N.Y. 10019
1-212-586-7000

PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR RELEASE AFTER 3 P.M.,

WEDNESDAY, MAY 11, 1983

CONTACT: PRESS -
Natalie Flatow
Joyce Kaplan
Ralph Bass

TV-RADIO -
Amy Goldberg
Laurie Chock

NEW YORK, May 11 . . . . An authority on contemporary Jewish life asserted today that America and American Jewry were "complementary moral communities," and that Jews should use their "deepened and enriched Judaism" to help "make the United States a model pluralistic society."

Dr. Jonathan Woocher, Assistant Professor in the Hornstein Program in Jewish Communal Service at Brandeis University, made his remarks at a meeting of the American Jewish Committee's Community Services Committee, chaired by Ben Kohl. The session was part of AJC's 77th Annual Meeting, which continues through Sunday at the New York Hilton Hotel here.

The history of American Jewry, said Professor Woocher, "has been dominated by a single theme -- the quest for a synthesis of 'Americanness' and Jewishness." This quest, he continued, "has shaped the evolution of American Jewish identity and community, redefining the meaning of Jewishness for the American Jew and prescribing the ever-changing terms of his enthusiastic participation in American life."

Asserting that American Jews had sought varying types of "synthesis" over the years, Professor Woocher said that the first type sought was "adjustment -- a reshaping of Jewish self-definition and behavioral norms to fit the American environment."

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The second, he said, was "adaptation -- a blending together of the patterns of Jewish and American life to fashion a unique American Jewish culture, sheltering Jewish ethnic identity within the fold of an Americanized institutional fabric."

More recently, he continued, the primary American Jewish form of synthesis had been "self-assertion: feeling comfortable in their Americanness, Jews have turned inward to try to recapture their sense of cultural distinctiveness and to secure their position in the American arena of group competition."

Running through every phase of this "ongoing synthesizing process," Professor Woocher went on, has been American Jewry's conviction that "Americanness and Jewishness are essentially compatible."

"By defining themselves as a moral community within a moral community," he said, "Jews justified both their quest for group survival and their identification with the values and culture of the American society around them."

However, Professor Woocher asserted, "the latest edifice that Jews have constructed is showing cracks, thanks to a growing doubt about the character of America as a moral community and a narrowness of vision that rationalizes a Jewish retreat into collective or individual inwardness."

"Jewishness and Americanness," he stressed, "loom as potential psychic and social antagonists, with the result that the capacity of Jews to maintain the synthesis is being threatened."

To heal these "cracks," Professor Woocher said, American Jewry must build a new form of synthesis -- "affirmation."

"What must be reaffirmed," he said, "is the vision of both American and American Jewry as complementary moral communities, and the vision of a Jewish community that assumes an exemplary role within the society as a whole. The fruits of Jewish self-assertion -- a more authentic Jewish rootedness in Judaic values, a firm sense of Jewish peoplehood -- can and must be incorporated within this renewed affirmation of moral community.

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"But included in this affirmation must be a commitment to self-transcendence, a commitment to defining the Jewish place in American society as one of participation in America's communal development and America's quest to fulfill its moral purposes.

"In light of its history and program, the American Jewish Committee is perhaps uniquely suited to champion this model of American-Jewish synthesis. AJC can help American Jews focus once again on the critical task of applying their deepened and enriched Jewishness to the work of creating a model pluralistic society in which they can pursue their unique destiny as both Jews and Americans.

"AJC is in a position where it can afford to assume a semi-independent stance vis-a-vis the current communal consensus. In doing so, it may also help to strengthen its appeal to those American Jews who are seeking an opportunity to apply their Jewishness in a morally significant way."

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83-860-148
4/28/83
A, EJP, REL, Z

NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

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MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
MAY 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, N.Y. 10019
1-212-586-7000

PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR RELEASE AFTER 9:30 A.M.,

SUNDAY, MAY 15, 1983

CONTACT: PRESS -

Natalie Flatow
Joyce Kaplan
Ralph Bass

TV-RADIO -

Amy Goldberg
Laurie Chock

NEW YORK, May 15 . . . . The head of Italy's Jewish community said today that new anti-Jewish attitudes stemming from the Middle East conflict now posed greater dangers for European Jewry than older and more familiar forms of anti-Semitism.

Tullia C. Zevi, President of the Union of Italian Jewish Communities, said also that "classic" anti-Semitism was diminishing in Western Europe but, she stressed, "continued vigilance against known neo-Nazi and anti-Semitic forces" was still necessary.

Mrs. Zevi, the first woman to serve as Italian Jewry's President, made her remarks at a session of the American Jewish Committee's 77th Annual Meeting, which today concludes its five-day agenda at the New York Hilton Hotel here. Rita E. Hauser, outgoing chairman of AJC's Foreign Affairs Commission, presided at the session at which Mrs. Zevi spoke.

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Declaring that "dealing with anti-Semitism is now more complex than it was just a few years ago," Mrs. Zevi said that anti-Israel feelings that arose in many Western European countries after the Lebanon war had "spilled over" onto local Jewish communities, causing a "tense and at times dangerous atmosphere."

Reports on these trends, she said, were given at a recent forum on anti-Semitism attended by Jewish communal leaders from nine Western European countries. The forum, held in Paris, was sponsored by AJC's European office.

Contributing to the tense climate, continued Mrs. Zevi, were the efforts of "Libyan and other Arab sources" to "purchase favorable opinion, for example, by giving job training to unemployed youths, who are then marshalled for rallies demonstrating support for the Arab cause."

Mrs. Zevi reported also that European Jewish communities viewed recent terrorist attacks "not as a sign of growing European anti-Semitism, but as an attempt by Arab forces to bring the Middle East conflict to Europe, and thus frighten Europeans away from pro-Israel activities."

Participants at the forum on anti-Semitism, Mrs. Zevi said, strongly urged Western Europe's Jewish communities to intensify their joint efforts against anti-Jewish activities and attitudes.

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# # #

83-960-162
5/2/83
A, EJP, FOR, REL, Z

THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, PLaza 1-4000

United States-Saudi Relations: Time for a Reevaluation

A Foreign Affairs Department Background Memorandum

by Lois Gottesman, Research Analyst, Mid-East Affairs Division

The saying "Nations don't have friends, they only have interests" sums up neatly what the Reagan Administration is now discovering about Saudi Arabia: The web of relations between Washington and Riyadh is based not on common traditions or shared world views, but purely on self-interest. When these interests coincide in reaching toward a common objective, Saudi Arabia is touted in Washington as our indispensable and trustworthy ally. When they differ and clash—as, most recently, over the situation in Lebanon and President Reagan's September 1, 1982 Middle East peace initiative—Administration officials have in the past tended to play down differences by stressing how "moderate" the Saudis are in comparison with radical anti-American Arab states such as Libya and South Yemen.

The truth is that when it suits their purposes and interests, the Saudis will go along with American policy—and reap the benefits, political as well as military and economic, therefrom. But this does not mean that their goals are the same as, or even necessarily compatible with, those of the United States. Policymakers in Washington are finally beginning to realize this.

Differing Views on Lebanon

Nowhere has the divergence of views between Riyadh and Washington been sharper than in the efforts currently underway to reach agreement on a withdrawal of Syrian, PLO and Israeli forces from Lebanon and the establishment of a strong, central government in an independent, united and prosperous Lebanon. Here the U. S. and Saudi Arabia appear to be working at cross-purposes.

Since the end of the war between Israeli and Palestinian forces in Lebanon and the evacuation of the PLO from Beirut, the United States has worked toward the realization of three related goals—the withdrawal of all foreign forces, the rehabilitation of Lebanon, and security on Israel's northern border. For all this the U. S. has been counting on Saudi Arabia, as an alleged "moderate" whose goals are the same as ours, to persuade the PLO, the Syrians and the Lebanese to go along with these goals. But Saudi help, it is now clear, has not been forthcoming for the furtherance of these American aims. Rather than encourage the Lebanese to reach agreement with the Israelis and the Syrians to leave Lebanese soil, the evidence suggests that the Saudis have done the opposite.

For example, the Israeli demand, in the tripartite negotiations with the U. S. and Lebanon, for normalization of relations and an end to the state of war between Israel and Lebanon (though not a full-scale peace treaty), backed by the U. S., is rejected by the Saudis, and they have made their rejection felt. There is some evidence to suggest that the Lebanese, if left alone, would accept normalization—after all, it already exists to some extent, de facto. But Saudi Arabia has made it clear that any political agreement between Lebanon and Israel, as opposed to security arrangements, would be met with a Saudi penalty—reneging on their offer to provide financial assistance for the reconstruction of the Lebanese economy, estimated to cost at least $10 billion. Secretary of State George Shultz, in testimony before the Senate Foreign Relations Committee on February 15, 1983, indirectly confirmed reports that Saudi aid to Lebanon has been made contingent on progress towards the withdrawal of foreign forces from Lebanon, but progress on Saudi terms. As one Lebanese negotiator put it earlier (The New York Times, January 23, 1983), "The Saudis have told us explicitly that we can give Israel whatever is necessary on the security issue and they will support us. But when it comes to normalization,'Wait for the train,' they say. 'We must all deal with Israel together. Don't be another Sadat.' " The Saudis have even threatened to cut off any aid to Lebanon if the Lebanese agree to normal commercial relations with Israel.

As for Syria, it is an open question as to "who is pressuring whom." The U. S. has apparently left it to the Saudis to convince or persuade the Syrians to pull out their troops and the Saudis seem to be still supporting a Syrian military presence in Lebanon. The last Arab League summit in Fez in September 1982 did not even deal directly with Lebanon's official plea for the withdrawal of the Arab League mandate from the Syrian "Arab Deterrent Force," which has provided the fig leaf of legitimacy to the 30,000 Syrian troops in Lebanon. Syria also still holds the option of playing the spoiler in any negotiations for troop withdrawal by refusing to go, and it is uncertain whether the Saudis, who have provided much financial support to Syria, will bring any real pressure to bear on Syria, or whether they will continue to go along with Syria's rejectionist demands as they have in the past.

The Middle East Peace Process

On the subject of an overall solution to the Arab-Israel conflict, Saudi Arabia and the U. S. have made no progress in bridging the significant differences between their two positions. The U. S. view, laid out in President Reagan's September 1 peace initiative, is that the Arabs must finally come to terms with Israel on the basis of direct negotiation and compromise. Thus neither Israel nor the Arabs would get their maximum demand—neither Israeli sovereignty over the West Bank, nor an independent Palestinian state with Jerusalem as its capital. Israel would have to withdraw from most of the territories occupied in the 1967 war and freeze the construction of new settlements. In return, the Arabs would finally have to "accept the reality of Israel" and her right to secure, recognized borders.

The Reagan plan was presented with the understanding of the State Department that Arab moderates such as Jordan and Saudi Arabia, both of which were consulted in advance, would back the plan. Not only have the Arabs not backed the plan; but a few days later they put forth their own "peace plan," formally adopted in Fez, on September 9, 1982, which contains demands that far exceed and are inconsistent with the President's proposals. The Fez declaration called for Israeli withdrawal from "all Arab territories occupied in 1967 including Arab al-Quds (Jerusalem)," the dismantlement of Israeli settlements and the "establishment of an independent Palestinian state" with Jerusalem as its capital. The Arab League also reaffirmed the PLO as the sole and legitimate representative of the Palestinians, thus effectively barring Jordan or any other party from negotiating on their behalf. There was no explicit recognition of Israel, as called for by President Reagan. Instead, there was only a vague reference to the U. N. Security Council guaranteeing peace "among all states of the region, including the independent Palestinian state." This was seen by some observers as opening the door to Moscow's participation, since the Soviet Union is a permanent member of the Security Council. In view of the Soviet invasion of Afghanistan, one would have expected the Saudis to oppose Moscow's involvement in the region. Yet their animosity against Israel still outweighs the Saudis' concern about Soviet penetration of the region.

The Fez declaration, it must be emphasized, is based closely on a Saudi plan presented a year earlier by then Crown Prince and now King Fahd and incorporates most of the earlier provisions, with a few minor changes. The Saudi plan had also laid down conditions, such as the cutting of American support for Israel, an end to Israeli "arrogance" and abandonment of the American-sponsored Camp David peace process—conditions which run counter to the spirit and the letter of the President's initiative.

Nor has Saudi opposition been limited to rejection of the plan by their own government; the Saudis have also worked to prevent others from endorsing it. King Hussein of Jordan, who is called upon to play a crucial role in the President's proposals, has made it clear he cannot act without a "green light" from the Arab states. The adoption of the Fez declaration effectively ruled this out.

Saudi refusal to recognize Israel has not abated; the call for "jihad with funds, self-sacrifice, information, economy and weapons if necessary" for the "liberation of Jerusalem and the occupied territories" made in January 1981 by then Crown Prince Fahd has never been retracted.

Oil Price and Production

There are other areas in which Saudi Arabia has acted in a fashion contrary to U. S. interests, and chief among them is in oil pricing and production. Saudi Arabia has played a leading role in keeping the price of oil artificially high and in attempting to minimize the effects of the oil glut by limiting the production of OPEC members. It should be recalled that the huge hikes in oil prices (from $3 a barrel in 1973 to over $30 a barrel in 1982) engineered by Saudi Arabia and Iran has led to economic recession, inflation, and a whole host of other problems for the United States, other industrialized countries, as well as the oil-poor developing nations. A drop in oil prices now would be extremely beneficial to oil consumers the world over; the Saudis are fighting it, however, in order to continue to maximize their profits as well as to bolster the OPEC cartel, which is weakened by the current glut in global oil supply.

It was the Saudis, as well, who in 1980 opposed the filling of the American Strategic Petroleum Reserve (SPR), designed to provide the United States with a cushion against a future cut-off of foreign oil. Saudi officials, it was reported at the time, threatened to cut back oil production if the U. S. continued to purchase oil for the stockpile. In fact, the U. S. for a time acceded to Saudi pressure and deferred purchases for the SPR, although energy independence is clearly in the American national interest.

Strategic and Military Issues

The sale in 1981 of AWACS planes and F-15 enhancements to the tune of $8.5 billion provided another clear example of Saudi and American divergences of view. The American administration's expectation was that in exchange for the sale, the Saudis would share all information gathered by the AWACS, allow their use in an emergency by the U. S. and provide for an American military presence in Saudi Arabia well into the 1990's. These hopes have not been fulfilled; Saudi Arabia to this day has not signed the agreement confirming these arrangements. The Saudis have also acted to prevent other Arab states from providing similar services to the U. S. Late in 1981 it was learned that the Saudis had offered to give $1.2 billion in aid to the Sultan of Oman if he would renege on his agreement to make Omani facilities available to the U. S. Rapid Deployment Force. The Saudis have also attempted to dissuade him from holding joint military exercises with the U. S., though without success.

The Key to Saudi Behavior

In all of the situations discussed above, the unspoken assumption of the United States has been that the Saudis are "our friends," that therefore they would naturally adopt policies that would complement and enhance our own, rather than work against them. Thus, Saudi backing of the Arab "peace plan" has been interpreted by some in the Administration as a positive step and the maximum the Saudis could be expected to do, and not as rejection of President Reagan's September 1 peace initiative.

Proponents of this view also point to the close economic ties between Saudi Arabia and the United States as proof of Saudi friendship and moderation. Saudi Arabia is the largest customer for U. S. goods and services in the Middle East, with imports from the U. S. totalling $9 billion in 1982 (compared to $7.3 billion in 1981). Over the years, from the establishment of diplomatic relations in 1947 through 1979, Saudi Arabia purchased $56 billion worth of U. S. products, of which more than half was spent on military arms and services. And most of Saudi Arabia's huge budget for defense expenditures ($20.7 billion in 1980) goes for American weapons and military technology.

Still, lucrative commercial and military sales are quite distinct from shared policy objectives, and, as the history of the relationship shows, the Saudis have naturally acted in all instances, and can be expected to act in the future, in their own interest, as they perceive it. In this connection it is instructive to remember that before 1970, Saudi Arabia was regarded as a weak, vulnerable desert kingdom with a host of external enemies and an abundance of oil. The oil shock of 1973-74 and the subsequent transfer of billions of dollars from the oil-consuming industrial nations to Saudi Arabia have made it seem that Saudi Arabia is far stronger than it really is. It is still a weak, vulnerable desert kingdom with a host of external enemies as well as internal problems brought on by rapid modernization. Thus, Saudi policy is aimed at protecting Saudi interests, whether from a perceived threat from the West or the Soviets, or, more immediately, from other Arabs with their eyes on Saudi Arabia's riches. Added to Saudi fears of threats from Arab leftist radical elements is the fear of militant fundamentalism of the type promoted by Khomeini's Iran in the vulnerable sheikhdoms of the Persian Gulf.

Because of their basic weakness, the Saudis consciously refrain from taking initiatives on controversial issues. This policy has been described as 'waiting for an Arab consensus,' in order to minimize the risks to Saudi Arabia. In that sense Saudi policy pronouncements have conformed with the lowest common denominator of Arab politics, including the refusal to explicitly recognize Israel.

A striking example is the question of Arab support for King Hussein to join the Reagan peace process. Hussein has made his acceptance contingent on a "green light" from the PLO and the Arab states. The latter—foremost among them Saudi Arabia—will not give any go-ahead to Hussein without the consent of the PLO, which in effect has rejected the Reagan plan. At the recent meeting of the Palestine National Council, the quasi-parliament of the PLO, in Algiers, the PLO declared the Reagan plan to be "not acceptable...as a sound basis for a just solution of the Palestine problem." (The New York Times, Feb. 22, 1983) Saudi Arabia and other Arab "moderates" are unlikely to challenge this rejectionist PLO stance. It will be further proof of how far the Arab consensus still is from readiness to negotiate a genuine and lasting peace with Israel, in accordance with the Camp David peace process sponsored by the United States.

Policymakers in Washington should beware of the kind of wishful thinking that assumes Saudi acceptance of U. S. Middle East policy goals. The Saudis, it is clear, will not endorse any policy that is not perceived by them to further their own interests, or that will expose them to risks they are unwilling to take.

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March, 1983
83-580-6

NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

The American Jewish Committee, founded in 1906, is the pioneer human-relations agency in the United States. It protects the civil and religious rights of Jews here and abroad, and advances the cause of improved human relations for all people.

MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
MAY 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, N. Y. 10019
1-212-586-7000

CONTACT: Press - Natalie Flatow
Joyce Kaplan
Ralph Bass

TV-Radio - Amy Goldberg
Laurie Chock

PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR IMMEDIATE RELEASE

NEW YORK, May 13. . .The recent drop in oil prices will in the main be beneficial to the United States and the rest of the world, reports the new issue of Petro-Impact, quarterly publication of the American Jewish Committee's Institute of Human Relations that reports on "petro-dollar influence in American Affairs."

The newsletter was distributed today at AJC's 77th Annual Meeting, which continues through Sunday at the New York Hilton Hotel.

According to the publication, some sectors that stand to gain are the auto industry, the airlines, the trucking and railroad industries, tourist, hotel and restaurant businesses, and public utilities.

"The most controversial aspect of the decline in oil prices involves the impact on U.S. banks with large outstanding loans to oil-producing countries," Petro-Impact asserts. However, it quotes a senior bank executive: "What's good for the world's economy is good for the world's banking system."

-more-

NOTE: For a copy of the latest issue of Petro-Impact write: Morton Yarmon, American Jewish Committee, 165 East 56th Street, New York, NY 10022.

The newsletter also reports on the Birmingham, Alabama, conference of last March, organized by the American Arab Affairs Council, a pro-Arab lobby based in Washington. The conference was underwritten by several corporations who deal extensively with the Arab world, Petro-Impact states, and similar meetings are slated for St. Louis and Wisconsin in the fall.

The Birmingham conference, according to Petro-Impact, "served as a platform for harsh criticism of Israel and its American supporters, as a number of speakers urged participants to lobby Congress and the White House for a more pro-Arab American Middle East policy."

The report states also that a majority of analysts are convinced that lower energy costs are the right medicine for an ailing world economy. For instance, U.S. Secretary of the Treasury Donald Regan recently estimated that a 10-percent cut in oil prices would reduce America's oil bill by $10 billion. In West Germany and France the savings would be equally impressive, totalling some $2.9 billion and $1.75-2.19 billion, respectively.

There are ways by which the U.S. can keep prices down and encourage domestic production, according to the report:

1. The U.S. could impose an oil-import tariff if the price drops further. A $10 a barrel tariff would reduce imports by one million barrels a day. Chairman of the Federal Reserve Board Paul Volcker has advocated the oil-import tax if the price falls below $25 per barrel.
2. The U.S. could continue filling the Strategic Petroleum Reserve at a rapid rate. By the end of the 1983 fiscal year, the U.S. will hold $357 million barrels (the goal is 750 million).
3. The U.S. could support the creation of a World Bank affiliate organization to help finance oil exploration and drilling in developing countries.
4. The U.S. could negotiate long-term purchasing agreements with countries outside of OPEC, such as Mexico, Norway and China.

Recent trade figures indicate that U.S. business in the Middle East has not suffered as a result of recent political events, the newsletter states. According to the U.S. Department of Commerce, the U.S. enjoyed a $5 billion trade surplus with the Middle East in 1982, with exports up $1.3 million for the year.

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"OPEC is counting on a world-wide economic recovery to spur demand for oil again," declares Petro-Impact, yet U.S. utilities used 40 percent less oil in 1982 than they did in 1977, and demand for oil has decreased among all OPCD countries as a result of conservation, substitution and improved efficiency.

Founded in 1906, the American Jewish Committee is this country's pioneer human relations organization. It combats bigotry, protects the civil and religious rights of Jews at home and abroad, and seeks improved human relations for all people everywhere.

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NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

The American Jewish Committee, founded in 1906, is the pioneer human-relations agency in the United States. It protects the civil and religious rights of Jews here and abroad, and advances the cause of improved human relations for all people.

MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
MAY 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, N.Y. 10019
1-212-586-7000

CONTACT: PRESS - Natalie Flatow
Joyce Kaplan
Ralph Bass

TV-Radio - Amy Goldberg
Laurie Chock

PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR RELEASE AFTER 2 P.M.
FRIDAY, MAY 13, 1983

NEW YORK, May 13 ... Peter G. Peterson, Chairman of the Board of the investment banking firm of Lehman Bros., Kuhn, Loeb, Inc., today charged that current policies of the Reagan Administration "threaten short-term and long-term economic growth," and discard principles of "fairness to the poor and fairness to our children."

Addressing the 77th Annual Meeting of the American Jewish Committee, which continues through Sunday at the New York Hilton Hotel, Mr. Peterson stated that federal spending "is tilting toward vast middle- and upper-income entitlement programs such as social security, federal and military pensions, and the like."

The former U.S. Secretary of Commerce told the audience of 350 Jewish leaders that the Administration's budget priorities "are having an uneven impact on the poor compared to middle- and upper-income groups."

Also addressing the session was Richard Weiss of Los Angeles, chairperson of AJC's Domestic Affairs Commission, who announced that the agency was launching a major research initiative called "Jews on the Edge."

According to Mr. Weiss, "the project will analyze the impact of recession and technological change on poor and economically vulnerable Jews." He added that Federations and Jewish social service agencies in selected cities around the country would cooperate in gathering and analyzing the data, and in recommending appropriate action.

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Alfred E. Moses of Washington, D.C., newly elected chairperson of AJC's National Executive Council, moderated a panel discussion on national economic and social policy. He called attention to AJC's long-standing support for government programs to aid the disadvantaged, and stated that "the government has a moral obligation to assist people in genuine need."

Mr. Moses also asked whether the AJC should support some form of national service for the nation's youth. He called upon the agency's leadership "to evaluate national social programs to make certain that public resources are being allocated in a fair and equitable manner."

The panelists were: Howard Miller of Los Angeles, Robert S. Rifkind of New York, David Squire of Boston, and Emily Sunstein of Philadelphia.

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5/10/83
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NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

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MORTON YARMON, Director of Public Relations

77TH ANNUAL MEETING
MAY 11-15, 1983
NEW YORK HILTON HOTEL
SIXTH AVENUE AT 53RD STREET
NEW YORK, NY 10019
1-212-586-7000

PRESS ROOM: MADISON SUITE, 2ND FLOOR

FOR IMMEDIATE RELEASE

CONTACT: Press - Natalie Flatow
Joyce Kaplan
Ralph Bass

TV-Radio - Amy Goldberg
Laurie Chock

NEW YORK, May 12. . . Although ethnic background has a powerful influence on health care, it is still being largely ignored as a significant factor by medical professionals.

This is one of the major conclusions of a study sponsored by the American Jewish Committee's Institute on Pluralism and Group Identity, made public today at AJC's 77th Annual Meeting, which continues through Sunday at the New York Hilton Hotel.

The study, entitled Ethnicity and Health Care, was prepared by Ellen L. Rautenberg, Director of Long-Range Planning in the New York City Department of Health. It is the first in a series of Institute-sponsored studies entitled Pluralist Papers now in preparation.

For health-care workers to be able to offer "culturally sensitive care," Ms. Rautenberg asserts, "ethnic and religious beliefs and customs must be respected, and must be flexible enough to meet the needs of diverse individuals."

"Even though many health professionals at some point in their years of training and health practice are likely to come in contact with significant numbers of patients who are influenced by their ethnic backgrounds," Ms. Rautenberg writes, "they rarely feel a need to gain an understanding of these individuals' cultural beliefs. Similarly, their years of professional development do not adequately prepare them for serving the needs of these groups."

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NOTE: For a review copy of "Ethnicity and Health Care," please write to Morton Yarmon, American Jewish Committee, 165 East 56th St., New York, NY 10022.

Among Ms. Rautenberg's recommendations:

* Provide adequate translation services in health delivery settings and provide signs, consent forms, etc., in the patient's language.

* Offer some ethnic foods on a hospital menu and attempt to accommodate a person's food preferences when prescribing special diets to be followed at home.

* Expect nursing personnel to know how to care for a black person's hair and skin and to spot evidence of jaundice or cyanosis in people with dark skin.

* Support folk medicine practices used in conjunction with scientific medicine and allow consultations by acupuncturists, chiropractors or spiritualists.

"The challenge that the health care delivery system faces," Ms. Rautenberg writes, "is whether ethnicity will function as a possible force or as a factor which limits equality of access. Effective delivery of service can best take place within a setting which understands, respects and encourages the expression of ethnic, religious and racial diversity."

She recommends training for health providers, policy-makers and community leaders aimed at increasing knowledge about and sensitivity toward the health cultures of various ethnic groups.

Unfortunately, Ms. Rautenberg adds, "when confronted with habits, beliefs and practices different from those taught to them by their ethnic groups or in professional school, physicians and other practitioners often disregard these 'traditional' ways as irrelevant. Thus they can fail the patient by alienating him or by misreading symptoms..."

What seems obvious and desirable to the provider may seem quite otherwise to the patient, Ms. Rautenberg points out, calling attention to Jewish Sabbath observances forbidding writing or the payment of money, various ethnic food patterns, Latin-American customs, etc.

Joseph Giordano, director of the American Jewish Committee's Caplan Center on Ethnicity and Mental Health, commenting on the study, says, "We have found, after ten years of study of mental health care, that a greater sensitivity of ethnicity has resulted in greater accessibility and acceptability by people who previously did not use such services because the services were incompatible with their own values.

"Our own studies on health and mental health behavior also reveal ethnic differences, ranging from expressions and reactions to pain to willingness to agree to hospitalization."

In a foreward to Ms. Rautenberg's study, Irving M. Levine, Director of the AJC's Institute on Pluralism and Group Identity, states the Institute's aim:
"to bring the social sciences and the humanities into closer contact with the values and life styles of America's diverse groupings."

At the same time, he adds, "Every precaution must be taken to assure that competing group demands do not deteriorate into polarization, negativism or destructive group chauvinism."

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4/26/83
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NEWS FROM THE COMMITTEE

ajc THE AMERICAN JEWISH COMMITTEE Institute of Human Relations, 165 E. 56 St., New York, N.Y. 10022, (212) 751-4000

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FOR RELEASE AFTER 2 P.M.
THURSDAY, MAY 12, 1983

NEW YORK, May 12 ...."The Authoritarian Personality," the monumental study of the origins of prejudice sponsored by the American Jewish Committee shortly after World War II, is now available in an abridged, paper-back edition, it was announced today at the AJC's 77th Annual Meeting, continuing through Sunday at the New York Hilton Hotel.

The new version of the book, which has been listed in the New York Times as "one of the 62 social research contributions that have made the greatest advances in the 20th century," was published by W.W. Norton & Company in the United States and England, and by George J. McLeod Ltd., in Canada. It was published originally in hard cover by Harper & Row in 1950, and reprinted as a paper-back by W.W. Norton & Co. in 1969.

"The Authoritarian Personality" was the fifth in a series of five volumes titled "Studies in Prejudice," a pioneering attempt to investigate scientifically the nature of racial, religious, and ethnic intolerance, and to analyze the effect of these prejudices on those who hold them, as well as on the life of the country as a whole.

The project was initiated in May 1944 by Dr. John Slawson, then Executive Vice President of AJC, who is now Executive Vice President Emeritus. It was carried on by AJC's Department of Scientific Research in cooperation with leading universities and colleges throughout the country, and incorporated the research and writing of anthropologists, historians, sociologists, psychologists, and other social scientists. Four scholars are listed as the authors of "The Authoritarian Personality": T.W. Adorno, Else Frenkel-Brunswik, Daniel J. Levinson, and R. Nevitt Sanford.

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THE PLURALIST PAPERS

ETHNICITY and HEALTH CARE

by

Ellen L. Rautenberg

ajc

INSTITUTE ON PLURALISM AND GROUP IDENTITY

THE AMERICAN JEWISH COMMITTEE, 165 East 56 Street, New York, N.Y. 10022

THE INSTITUTE ON PLURALISM AND GROUP IDENTITY

The American Jewish Committee's Institute on Pluralism and Group Identity engages in a broad program of action-research, policy analysis and bridge-building on ethnic concerns in the U.S.A. It also promotes ethnic dialogues among many groups who have previously been unfamiliar with each other's agendas.

IPGI's work has contributed new knowledge and new insights into such phenomena as the psychology of group identity, the acculturation of new immigrants, teenage bigotry, ethnicity and aging, cross-cultural parenting factors, ethnicity and the economy, ethnic images in the media, and the art and science of coalition-building.

The Institute develops specially tailored training packages for civic and ethnic communal leaders, intergroup relations specialists, educators, mental and physical health care providers and business, labor and governmental leaders.

The Institute's publication catalog contains over 100 listings. **The Pluralist Papers** are a new series of occasional monographs that originated in the Spring of 1983.

In his book **The One and the Many** historian Arthur Mann credits Irving M. Levine, the Institute on Pluralism and Group Identity's founder and director with launching "the new pluralism" movement when he organized and chaired the historic June 1968 Fordham University **National Consultation on Ethnic America** and then went on to create the National Project on Ethnic America.

It is to continue to probe the meaning of the "new pluralism" or the "new ethnicity" as others have called this movement, that **The Pluralist Papers** are dedicated.

ABOUT THE AUTHOR

Ellen L. Rautenberg previously served as a health consultant to the Institute on Pluralism and Group Identity, and is now Director of Long Range Planning for the New York City Department of Health.

ETHNICITY AND HEALTH CARE

Acceptability Through Cultural Sensitivity

Health care is clearly one of today's crisis issues and one that is sure to predominate public policy debate throughout the 1980's. While health status indicators still show vast differences between segments of our population, pressures to contain the inflation in health care costs continue to mount. Although improving health status and decreasing cost seem to some to be mutually exclusive objectives, planners stress the idea that accessible and appropriate services need not be those of the highest technology and, hence, the highest cost. One low cost approach to improving accessibility and increasing appropriate utilization is enhancing acceptability. It is an approach that is given *much lip service* but little evidence in ideas for change in health service delivery. It is the thesis of this paper that not until the health service delivery system becomes more acceptable to the population, particularly to various underserved ethnic groups, will equality of access and appropriate utilization occur.

Acceptability implies degree of satisfaction with service resulting in its appropriate use. Evidence of consumer dissatisfaction with medical care as it is currently being delivered is abundantly reflected in survey results.[1] Increasing numbers of malpractice suits, shopping for physicians, degrees of patient noncompliance, use of non-medical healers, and delay in seeking care are signs of dissatisfied consumers. Demands for a variety of changes in service delivery from use of nurse-midwives to consumer control of facilities are other indications of this alienation. Consumers are demanding that the policies of health facilities and the attitudes of health personnel reflect their needs as patients rather than the desires of the health professionals. Patients are asking for personalized treatment and a comprehensive type of care that includes not only a biomedical approach but one that incorporates the social, psychological and cultural dimensions of causation, treatment and cure. The need for this multifaceted approach is great and will only be heightened as both emphasis on prevention increases and the amount of acute illness seen by practitioners declines relative to the number of patients presenting with chronic conditions requiring adjustments in life style and compliance with lifelong treatment regimens.

Since the 1960's, a time when many social programs came into existence and when interest in group identity was heightened, the concept of connecting services to the special needs of ethnic, racial, religious and regional groups has grown. This can be traced both to consumer demands and to a recognition of research findings highlighting the ethnocultural factor in health, both mental and physical. Progress can be seen in the development of more culturally sensitive programs and treatment methods and in the increased numbers of bilingual and bicultural health workers.

The mental health field has been more advanced than the medical field in addressing the acceptability of its services to ethnic and racial minority groups. Recognizing that cultural variation in emotional language, family structure, and belief systems often creates problems of alienation, self-esteem and identity, community mental health programs have been advocates for culturally compatible services for both non-white and white ethnic groups. Yet, even though this need has been isolated, special mental health services for ethnic minorities are still a rarity.[2]

As is true in both the mental health and physical health fields, the ethnic factor is clearest and most often understood by practitioners as it relates to the rates of mortality/natality and incidence/prevalence of diseases. It is widely known that mental and physical disorders are not distributed randomly in the population but vary by subgroup. Those providing and planning health services use this epidemiological information in differential diagnosis and resource allocation but frequently are unfamiliar with or ignore information related to ethnic cultures that can be useful in communicating, developing treatment regimens and planning programs for specific groups. In reference to planning services for European ethnic groups, the report of the President's Commission on Mental Health states:

> Although today there is an increasing acceptance of ethnic diversity as a positive and constructive factor in American life, attitudes toward ethnicity and ethnic pluralism are ambivalent at best. Diversity is still often associated with divisiveness. One area this ambivalence is reflected in is the planning and delivery of mental health services. In the field of mental health, where feelings, attitudes and behavior are prime areas of intervention, diagnostic evaluations, treatment plans and delivery of services have largely ignored the importance of ethnocultural factors. As a result of this neglect, services have not adequately responded to the mental health needs of diverse European American groups. For many, services have not been accessible.[3]

Among the recommendations made in the report of the President's Commission is one specifically concerned with training mental health workers to be more knowledgeable and conscious of ethnocultural patterns of behavior in order to deliver transcultural care.

This ethnocultural consciousness includes much more than interpreting ethnicity to mean distinctiveness of race, religion or national origin. It means accepting ethnicity as involving "conscious and unconscious processes that fulfill a deep psychological need for security, identity and a sense of historical continuity" and, as such, are critical in the development of values, attitudes, and behavior patterns.[4] These patterns have been found to significantly influence utilization of services, perception and expression of symptoms, health practices and compliance with treatment. This paper suggests that, in light of societal concern with variation in health status and accessibility of services, the health profession has ignored ethnocultural factors far too long.

Comprehensive Care: More than the Medical Model

In times past, the compassion and bedside manner of the physician compensated for lack of biotechnical methods. As medical knowledge increased, so has the physician's reliance on it, often at the expense of the humanistic aspects of medicine. The medical model most often views the origin of illness as inside the individual at the micro-biological level. "The whole individual and the society in which he/she operates are lost in a welter of organs, tissues, cells, bacteria and procedures."[5] Defining disease in somatic terms and assuming that control of illness is possible only by the application of scientific methods has not proven sufficient. Slowly, attention is being given to the host of cultural, social and psychological factors that are features of disease and important components in the curing process. Increased professional interest in the fields of community

medicine, family practice and primary care, the philosophical background of which includes an emphasis on the cultural, social and psychological antecedents and consequences of illness, reflects this realization.

A comprehensive approach to patient care necessitates an understanding of the beliefs and attitudes of the patient toward health and illness. The patient and the individual care provider are often from different sociocultural backgrounds, have different verbal and nonverbal communication patterns and speak many different languages. They may have lifestyles, values and attitudes that lead to entirely different health behaviors in the face of the same symptoms. All too often the health profession, itself a cultural distinct entity, and its practitioners disregard the patient's perspective and background assuming it to be similar to their own. It is the unique practitioner who acknowledges, understands and respects these differences and adjusts his or her approach to care in light of the customary health beliefs and practices of the patient. Nowhere is this more necessary and more difficult than in today's urban hospital, where a practitioner serves a multiethnic population, both indigenous and migrant.[6] In describing this problem, one practitioner says:[7]

> In providing mental health services to migrant populations, the complications become evident if we focus on a neighborhood such as Manhattan's Upper West Side. In this one community, there are immigrants from Great Britain, Ireland, Greece, Israel, Sweden, Germany, Poland, Czechoslovakia, Austria, Hungary, the U.S.S.R., Italy and Canada. There are also Puerto Ricans, Portuguese, Mexicans, Cubans and Cuban-Chinese. Other West Side residents come from Haiti, the Dominican Republic, Columbia, Equador, Costa Rica, Jamaica, St. Thomas, St. Croix, Barbados, Trinidad, various islands in the East and West Indies, Japan, China, Korea, India, Pakistan, and the Philippines —as well as blacks and whites from rural America.

Cultural Differences in Health Behavior

Ethnic and social class differences in health behavior have been explored in the literature of public health, medicine, nursing, sociology and anthropology. Emphasis on a cross-cultural approach to the study and practice of medicine has increased as recognition of the cultural aspects of health behavior grows. Consequently, health related subspecialties within established fields - transcultural nursing, medical anthropology, medical sociology and ethnomedicine - are receiving increased attention. As one medical sociologist has so aptly put the relationship of health and culture:

> ...in all societies, health, illness, and medicine constitute a nexus of great symbolic as well as structural importance, involving and interconnecting biological, social, psychological and cultural systems of action. In every society, health, illness, and medicine are related to the physical and psychic integrity of individuals, their ability to establish and maintain solid relations with others, their capacities to perform social roles, their birth, survival, death, and to the ultimate kinds of "human condition" questions that are associated with these concerns. As such, health, illness and medicine also involve and affect every major institution of a society, and its basic cultural grounding.[8]

Basic to a discussion of cultural variation in health behavior are differences in use of services themselves. Many studies attempting to explain utilization differences between social groups have found "divergent value preferences in the decision to seek care." These preferences are not solely the result of unequal access to services or variation in information about service but are tied to the "differential experience of life" resulting from differences in "location in the social structure, the principle components of which are ethnicity and socioeconomic status."[9] Although much has been written about the relationship of both ethnicity and socioeconomic status to health behavior, somewhat surprisingly "where both have been treated simultaneously, ethnicity seems to be the more important predictor..."[10]

Comparative studies designed to elucidate variation in health behavior do reveal characteristic ethnic group differences. In a classic study, Zborowski analyzed attitudes and reactions to pain among Jewish, Italian, Irish and "Old Americans." He found that hospitalized Jewish and Italian patients were very emotional in their expression of pain, "Old Americans" tended to be stoic, Irish were likely to ignore pain. He discovered that the Jewish and "Old Americans" were more future-oriented and concerned with the diagnostic meaning of pain while the Italians were more interested in relief of pain. Zborowski saw a considerable difference in attitude toward the physician; the Italian and "Old Americans" were confident in the physician's ability to relieve pain and cure while the Jewish patients were skeptical and tended to seek additional consultations.

Zborowski postulated that the uninhibited display of emotional behavior of Jewish and Italian patients "often conflicted with the patterns of behavior expected from a patient by American or Americanized medical people ... provoking distrust in American culture instead of provoking sympathy." On the other hand, "Old American" patients were found to withdraw from society as a reaction to pain and seek to avoid being a "nuisance" when hospitalized. Emotionality was viewed by them as purposeless, hindering the effectiveness and efficiency of the medical team. As expected, the attitudes and behaviors of medical personnel toward particular patients were reflected in their cultural expectations. Unemotional behavior was "expected by American or Americanized members of the medical or nursing staff, and the patients who did not fall into this pattern were viewed as deviants, hypochondriacs and neurotics."[11]

Croog showed that the ethnic background of the individual plays an important role in the perception and expression of illness symptoms. On a standardized questionnaire, healthy Italian and Jewish army inductees reported the highest number of symptoms while those of Irish, British and German origin reported the lowest. Croog speculated that if the physician understood the ethnic differences in the expression of symptoms he or she may be aided in evaluating and delivering treatment.[12]

Zola studied ambulatory Italian, Irish and Anglo-Saxon Americans and their decision to seek medical care. He found that holding differences in objective symptoms constant: Italians sought care when symptoms interfered with social and personal relationships; the Irish sought care only after receiving the approval of others; and Anglo-Saxons sought care when vocational or physical activity was hindered by a symptom. Similar to the Zborowski and Croog findings, Zola found Italians to be most disturbed by diffuse pain while the Irish tended to place the

focus of pain in specific body locations. Italians averaged the largest number of symptoms while Irish averaged the smallest. Italians admitted that their symptoms made them irritable while the Irish denied that their symptoms affected their behavior.[13] Zola explains these observations as follows:[14]

> While there has long been recognition of the subjectivity and variability of a patient's reporting of his symptoms, there has been little attention to the fact that this reporting may be influenced by systematic social factors like ethnicity. Awareness of the influence of this and similar factors can be of considerable aid in the practical problems of diagnosis and treatment of many diseases, particularly where diagnosis is dependent to a large extent on what the patient is able and willing, or thinks important enough to tell the doctor.

He goes on to say that:

> The strongest evidence in support of this argument is the different ethnic perceptions for essentially the same disease...it is striking that pattern of response can vary with the ethnic background of the patient. There is little known physiological difference between ethnic groups which would account for the differing reactions.

Ethnic groups have also been found to differ in their preferred source of care. This is exemplified in attitudes toward hospitalization versus care in the home. Zborowski noted that Jewish and Italian patients were disturbed by the impersonal nature of the hospital and by the necessity of being treated there instead of at home, while "Old Americans" preferred hospital treatment to home care in order to minimize disturbance and inconvenience to the family.[15] Spanish-speaking individuals in the Southwest were found to be very similar to Jews and Italians in their attitudes toward hospitalization specifically and to the whole of Anglo-scientific medicine generally. The impersonality, separation from family, formality, and patient passivity required during hospitalization was viewed as detrimental to the healing process.[16] Chinese Americans have also been observed to be reluctant to be admitted to hospitals. They often believe hospitals are unclean and individuals go there only to die. Translation services will probably be unavailable and chinese food will not be served. Mutilating surgery may take place, and it is feared that the patient's spirit may get lost and be unable to find its way home.[17] Finally, in traditional Greek culture, hospitalization has symbolized desertion of the patient by his family; the Greeks continue to feel that human companionship is as important to critically ill people as it is to the healthy and may be more resistant to hospitalization than other groups.

The above studies and examples were cited in an attempt to demonstrate that the reason why a particular patient seeks care, focuses on some symptoms rather than others or behaves differently from another patient is not solely related to the objective features of the disease itself. Ethnic group membership has been shown to be an important variable in these differences. An understanding of these cultural differences can aid health personnel and planners in their interactions with patients, in the provision of care and in the creation of a culturally appropriate delivery system. These findings argue for the need to develop "pluralism in the organization of health services," tailoring services to the "value preferences of the target group" and not assuming that the system that effectively serves the white middle class will equally serve ethnic or racial minorities.[18]

Basic to a pluralistic approach to the delivery of services is an understanding of the culture of the particular target group. To be most effective, the planner and provider must recognize the ethnic diversity in the patient population and the variety of "health cultures." Health cultures are defined as:

> ...shared assumptions about the maintenance of well-being and the appropriate means of achieving that state, however diversely it may be defined. Such assumptions relate not only to the nature of the material and social world but also to the nature of the biological world, i.e. to ways in which the human body is viewed and seen as functioning. Body image and anatomical knowledge are fundamental in this regard as are ideas about disease causation, symptoms, diagnosis, treatment and other facets of health.[19]

More often than not, lack of information about the health cultures of various groups limits the perspectives of providers and makes a difference, often a negative one, in the provision of services.

Health Culture and Compliance

The field of medical anthropology has provided valuable insights into the health cultures of less complex, non-western societies and is beginning to discern similar cultural patterns in various white and non-white American ethnic groups. The application of these ideas to American clinical practice is still in its infancy. Little attention is paid to how patients perceive their symptoms, what they believe about the etiology of their illness and how their beliefs about cure differ from those of western "orthodox" medicine. When confronted with habits, beliefs and practices different from those taught to them by their ethnic groups or in professional schools, physicians and other practitioners often disregard these "traditional" ways as irrelevant rather than adaptive. Thus, they can fail the patient by alienating him or by misreading symptoms and treating in such a way as to deny or contradict the patient's and his culture's world view. Examples of value conflict between the culture of medicine and the culture of the patient are easily found. The following should serve to give the reader a flavor:

* The Anglo health worker so regulated by clocks and time-consciousness, can have difficulty with Indian time. Time is on a continuum with no beginning and no end. In many Indian homes, there are no clocks...The Indian may eat two meals today and three meals tomorrow, or perhaps four. If medications are timed with meals, this becomes a crucial factor for the Anglo nurse to understand and adapt to.[20]

* The West Enders (Italian-Americans in a Boston neighborhood) view illness as resulting either from a break-down in self-control, or from conditions beyond the individual's control. The first type is thought to require self- or group-inflicted punishment as a part of the treatment. In the second type of illness, the doctor's services may be used, but the possibility of a cure rests to a considerable extent on the workings of fate...As the lack of self-control is considered a

personal failing, treatment thus must be punishing as well as therapeutic. For example, an ulcer patient with whom I talked refused to follow the diet prescribed by his doctor. He felt it would do no good, and that a more painful treatment - he did not specify what - would be needed.[21]

* A 26 year old Guatemalan woman who had resided in the U.S. for 10 years and who was being treated for severe regional enteritis with intravenous hyperalimentation and restriction of all oral intake had become angry, withdrawn and uncooperative. She believed her problem to be caused by the witchcraft of her fiance's sister. She also believed that since she could no longer regulate her hot/cold balance of nutrients, the basis of the traditional health beliefs of the folk medical system she grew up in, she had been written off by her doctors as unlikely to live...When the psychiatric consultant encouraged the patient to express her ideas about the illness, she was visibly relieved to find her ideas treated with respect, although her doctor indicated he did not share them.[22]

* Chinese patients frequently switch doctors and herbalists and may see two or three during the same period. This shopping around for doctors is an attempt to find the most promising cure. It is important for the health professional to know what medication that patient is receiving from each doctor, and the patient must give this information to his doctors. But a Chinese patient is often reluctant to tell his doctor directly that he is seeing another one for fear that the doctor will "lose face."[23]

These examples range from the subtle differences in time orientation between the provider and the Native American patient to great disparities in actual ideological systems of belief - the popular or folk vs. the scientific health systems. To communicate and treat most effectively, the provider must know something about the beliefs, values and practices of the patient and the cultural setting from which he comes and to which he will be returning after obtaining health services. Although the patient has utilized the scientific health system, it cannot be assumed that he is using that system to the exclusion of alternative systems and that when he returns to his cultural, economic and familial environment that the recommendations of the scientific medical provider will be supported. Often these environmental factors will explicitly contradict the advice given in the medical setting, leading to dissatisfaction with the medical encounter and ultimately preventing the patient from carrying out a prescribed treatment regimen.

One group of factors that has been strongly associated with patient adherence to treatment is quality of interaction between physician and patient, both the effectiveness of the actual communication of information and the emotional tone of the interaction itself. In New York City alone, the Hispanic Research Center at Fordham University, the Center for Puerto Rican Studies at John Jay College and the Puerto Rican Research Consortium have sponsored numerous public policy studies that dramatize the weakness of social service delivery systems that fail to acknowledge the language diversity of their clientele.[24]

Much has been written about the extensive problems of communication of information in the medical setting between those whose culture and native language is the same. Cultural distance between patients and providers is exemplified by the extent to which patients fail to understand words commonly used by physicians. Even when educational differences are controlled for, this misunderstanding has been positively correlated with ethnicity.[25] It is safe to say that language, social distance and discomfort between provider and patient contribute to noncompliance. When patients are satisfied with the medical encounter, when information is effectively communicated, when their expectations have been met, when they have been received with respect, friendliness and without hostility, tension and punitiveness, higher rates of compliance result.

Lower degrees of compliance have also been found in groups whose cultures have strong popular (family, social network or community) or folk (nonprofessional healers) traditions.[26] The individual, to the degree that he desires membership in a cultural group, would tend to gravitate to the collectively held health beliefs and practices of the group and away from those of scientific medicine. The more ethnocentric and cohesive the ethnic group, the less likely the objectives of the formal medical care system will be accepted. Those individuals holding less scientific, more popular beliefs have been found to have more negative attitudes toward medical care and to interact almost exclusively with people from their own ethnic background.[27] To the extent that the medical profession is aware and makes use of information relating to the patient's ethnocultural identification and the health beliefs of that group, better communication, patient satisfaction and increased compliance can be expected to result.

Access Barriers: From Chicken Soup to Formal Titles

Although evidence suggests that during the last decade medical care has become more accessible to ethnic and racial minorities, barriers to service are still present, health status varies widely, and many are resolutely adhering to traditional health beliefs and practices. These can range from common home remedies to unusual spiritual/religious beliefs. The degree to which the popular and the scientific systems are combined varies within and among ethnic groups. In cultures where traditional views are strong, scientific medicine is often used as a last resort after home remedies or, in some cases, healers have failed to cure. In some traditional systems, whole categories of ethnically specific health problems are viewed as out of the realm of the scientific medical practitioner. This can be the cause of patient delay in seeking "appropriate" medical care.

It is estimated that 70-90% of all episodes of illness are managed outside the scientific health care system. Of these episodes, the vast majority are handled at home with traditional remedies including the use of patent medicines. When examining the health cultures of various ethnic groups a vast array of home remedies, often passed down through families for generations, can be found. Some groups treat sore throats with tea mixed with lemon and honey, others with chicken soup and still others by wrapping a salted herring in a towel and putting it around the neck. For ear infections, warm cod liver oil in the ear, melted chicken fat and sugar in the ear, salt pork in the ear and warm salt put in a stocking and put behind the ear are all reported to be the home remedies of various groups.[28]

> Faith in the correctness of one's own medical and health beliefs probably characterizes all people; it is one of the most important symbols around which the group organizes its perception of its ethos, its uniqueness, its vital essence. Therefore to abandon traditional health beliefs is a far greater step than to accept a new mode of therapy: it means relinquishing a major suport to a group's sense of identity and view of itself. Hence, all kinds of accommodations are made and all manner of rationalizations appear, to justify continuing faith in the old system while simultaneously accepting the new.[29]

Popular medical practices often make use of common sense remedies and spiritual/religious beliefs. This coupled with the self-limiting and psychosomatic nature of many conditions leads to a "cure" that is then attributed to the method. Barriers between the patient and the scientific system also encourage use of the popular/folk systems. In addition to cost, these barriers include language, transportation, waiting time, eligibility requirements, and the social distance between providers and consumers created by professionalism, religion, race and national origin. To increase the relevance of the scientific medical system to ethnic groups, these access barriers and the indigenous popular health system should be recognized and accommodations made by both individual providers and health care institutions.

Through the interview process the practitioner can seek information concerning adherence to scientific and nonscientific belief systems. Information can be obtained about the beliefs the patient holds about his illness, the meaning it has for him, his expectations about the course of his disease and what he hopes treatment will accomplish. By comparing the patient's model with that of the doctor, discrepancies that will cause problems in clinical management can be determined. For example, if the practitioner suspects that the symptoms and/or behaviors of a Puerto Rican patient indicate acceptance of hot-cold theories, it is in the interest of good therapy to acknowledge awareness of this system, determine its degree of relevance to the patient and attempt to incorporate its rules into the treatment plan. The following illustrates how a common dietary regimen can be modified for a patient believing in hot/cold theories:

> When prescribing a diuretic, routine medical practice is to encourage the patient to eat bananas, oranges, raisins or other dried fruit in order to maintain the potassium balance in the system. With patients who adhere to the hot-cold theory, however, this advice may have untoward consequences, since all these foods are considered cold or cool. As a result, when the patient contracts a common cold or other cold-classified illness, he will stop eating these potassium sources because they are contraindicated for his immediate condition...a way out of this dilemma might be for the physician to prescribe potassium in solution as a "vitamin" (and therefore hot) when the patient has a cold or to suggest hot foods rich in potassium (like coffee, cocoa, peas etc.), in addition to the usual cold foods, so that patients have enough options to make choices within the hot-cold system themselves.[30]

The preceding example illustrates how the individual clinician can revise strictly defined scientific therapies to accomplish treatment goals in ways that will be more culturally appropriate for the patient. So too can the practitioner adjust his or her manner of approach based on a sensitivity to communication patterns,

both verbal and nonverbal, that are comfortable for the patient. Social work literature discussing practice with Mexican-American clients emphasizes: establishing "feelings of friendliness" before beginning a discussion of serious affairs; conversing on a first name basis rather than with formal titles such as Mr., Mrs., Doctor or Nurse; and creating an atmosphere of informality in office decor by use of home furniture, plants and pictures. In a similar fashion, comfort with physical contact and degree of modesty have also been found to vary by ethnic group. Both Hispanic and Russian immigrants have been found to be more physical than other groups in this society; with these groups, empathy can often be communicated in a more physical way than with patients from groups with stronger taboos concerning touching.[31]

Reducing Conflict in the Delivery Setting

It is not surprising that evidence indicates that staff and patients having similar cultural beliefs and practices tend to readily identify with one another as language, mannerisms, interests and experiences stimulate desire to help one another.[32] Increased use of bilingual and bicultural professionals and paraprofessionals are two approaches that have helped bridge the culture gap between institutions and the consumers of their services. As equal employment opportunity laws, affirmative action in education and continued community pressure increase the ethnic mix of workers within health care institutions, clinical and administrative policies and procedures must also be analyzed to assure their flexibility in support of culturally sensitive care. Unfortunately, in the name of the efficient operation of a large bureaucracy, care is largely standardized and impersonal.

Even seemingly benign policies and procedures such as delivering ice water to patient rooms and requiring patient signatures on admitting forms reflect institutional values and can violate traditional ethnic and religious beliefs. What seems obvious and desirable to the provider may seem quite otherwise to the patient. Examples in every area of the hospital can be found. The following illustrates this point:

* When a Jewish patient is admitted on the Sabbath or one of the holy days, his religious scruples should be given every consideration...The patient should not be compelled to produce documents, sign application forms or admission documents or be pressured for advanced payment...If emergency surgery on the Sabbath is required, oral consent in the presence of witnesses suffices to give the hospital the legal protection it needs.[33]

* A health professional needs to be alerted to food patterns so that a therapeutic diet compatible with the patient's beliefs and preferences can be selected. Some older Chinese believe that drinking ice water shocks the system and is harmful to health. Also, because of a history of inadequate sanitation in China, Chinese have habitually boiled their drinking water. As a result, many Chinese prefer to drink hot water, which is often brought to the hospital in a thermos by their families. If there is no family, the professional might inquire if the patient would like hot drinking water.[34]

* How many nurses would think of providing a space for several American Indian family members to have a prayer or "sing" for the hospitalized family member? If the family should indicate a need for such a ceremony, they should be accommodated.[35]

* The lighting of candles on the eve of the Sabbath and Holy Days is a religious duty most sacred to the Jewish woman. Inability to perform this rite because of confinement to an institution can lead to deep anguish on the part of the patient...If it is impossible to allow the woman to light wax candles in her room because the presence of oxygen tents or other flammables preclude any open flames, substitute arrangements can be made. Under these conditions an electric candlestick...will serve both the religious and psychological needs of the Jewish patient.[36]

The above were cited as examples of the needs of individuals within ethnic groups: not every Chinese patient prefers hot drinking water, not every Jewish patient observes strict Sabbath rules. The health delivery system must not only have an understanding of the variety of health cultures in its patient population but must avoid stereotyping patients based on ethnic classification. Individuals assumed to be in the same ethnic group may manifest health behaviors and may have very different needs; in fact, what some may consider and classify for statistical purposes as one ethnic group like Hispanic, may, in actuality, be a number of culturally distinct groups:

> Compared to Puerto Ricans, Cubans have an almost fanatic interest in their bodies and its functioning; they have high expectations of health care and are aggressive in seeking this help; they are cooperative with medical personnel and anxious to give full historical and current information about their health. The expectation by white Anglo health workers that other Spanish-speaking clients will show similar behavior works a disservice on the Puerto Ricans who need far more encouragement, explanation, and gentle questioning.[37]

So it seems that to achieve a delivery system that is truly acceptable to underserved ethnic group members, cultural sensitivities at the level of the individual health worker and at the institutional level must increase. Although the preceding narrative has been primarily concerned with patient care, a word should be said about the relationship of these concepts to human relations in other areas of the delivery system. Conflicts, misunderstandings and insensitivities are not unique to the provider-patient relationship. Today's health delivery system is staffed by a variety of providers from every racial, religious and ethnic group. Relationships between staff members are often strained due to intergroup differences in behavior, style, communication patterns and language that exacerbate common superior-subordinate stresses. That ethnic and racial groups are not randomly distributed within organizational hierarchies and that dissatisfaction results, no one will be surprised to learn. The effect on patient care of intraorganizational struggle is a matter of speculation but is surely not a positive one.

Tensions in the health care system are most often confined within the boundaries of the individual institution, occasionally they will extend outside, even

into the public policy arena. Internally, both the efforts of affirmative action and cost containment programs (often at odds with one another) have stressed organizations. Decisions made directly or indirectly appear to be to the advantage of one group over another. Externally, recent legislation restricting practice by foreign medical graduates (FMG's) and the closing of Sydenham Hospital are examples of situations where intergroup conflict plays a role. Several issues including competition with U.S. medical school graduates and complaints regarding substandard medical and language skills led to federal legislation greatly restricting opportunities for FMG's to enter, train and practice in this country. Predictably, the law has stirred controversy and led to charges that "the overall tone" of P.L. 94-484 is "xenophobic."[38] In the case of Sydenham Hospital, the New York City Health and Hospitals Corporation, in response to pressures to reduce the cost of the municipal system, chose to close a hospital which groups in the community defined as a cultural asset as well as a much needed facility.

Any health administrator, health worker or health planner could cite other examples where cultural insensitivities, either perceived or real, have caused conflict between staff members, between staff and patients and between institutions and the communities they serve. The time is ripe for a multilevel approach to improve intragroup and intergroup relations in health care. Reducing polarization can aid professionals, patients and communities in recognizing the commonality of their problems and coalescing around solutions. The following conclusions and recommendations may be a place to begin.

Conclusions

Basic to any discussion concerning improving the acceptability of services to underserved ethnic groups is a focus on increasing recognition throughout the delivery system that health care not only involves the diagnosis and treatment of the microbiological aspects of illness but must include an assessment of cultural, social and psychological factors that contribute to causation and cure. Cure of the microbiological is insufficient if the root cause lies elsewhere. A comprehensive approach to care demands addressing multiple aspects of causation.

> Clearly many psychological, social, and cultural factors are implicated in the transition from health to illness to patienthood. Indeed, they may be the critical determinants of how and whether patients enter a health care system and comply with the requirements of medical care. Despite its obvious importance, consideration of what underlies an individual's ability or willingness to acknowledge illness and enter a health care system is largely ignored in modern teaching.[39]

In order for physicians and other health care personnel to be able to give a comprehensive type of care training in the behavior and social sciences, cultural awareness must be more fully incorporated into professional, inservice and continuing education curriculums. As one physician has suggested:

> Medicine's unrest derives from a growing awareness among many physicians of the contradiction between the excellence of their biomedical background on the one hand and the weakness of their qualifications in certain attributes essential for good patient care on the other.[40]

An interdisciplinary approach to teaching and curriculum revisions in professional and inservice programming should help improve the provider's "qualifications in certain attributes." But, with a few isolated exceptions, "admonitions that one must under understand a client in terms of social and cultural context have not been accompanied by constructive suggestions on experiential, didactic or training techniques."[41] One federally funded study designed to investigate the extent of cultural awareness activities in professional schools concluded that:

> Even though many health professionals at some point in their years of training and health practice are likely to come in contact with significant numbers of patients who are deeply influenced by their ethnic backgrounds including bilingual/bicultural individuals, they rarely feel a need to gain an understanding of these individuals' cultural beliefs. Similarly, their years of professional development do not adequately prepare them for serving the needs of these groups.[42]

Complementing improvements in training and education is accelerating the hiring of bilingual/bicultural health workers in areas with responsibility for policy and patient care. Increasing the admission of ethnically identified individuals to professional schools is important for achievement of this objective. Bilingual staff members solve only the problem of providing translators for patients. Bicultural staff members in addition to their translation skills can serve as "cultural specialists" or "culture brokers" transforming a typically unicultural encounter to a transcultural one.

For health care workers to be able to offer culturally sensitive care, institutional policies and decisions must support their efforts. Policies should be analyzed to determine whether ethnic and religious beliefs and customs are being respected and, more importantly, examine the degree to which policies are flexible enough to meet the needs of diverse individuals. Admittedly it is difficult to please everyone all the time particularly in an environment where a variety of ethnic groups are being served, but, it is important to be able to change procedures as needs are identified. Culturally-sensitive health services would:

* provide adequate translation services in health delivery settings and provide signs, consent forms, etc., in the patient's language.

* offer some ethnic foods on a hospital menu and attempt to accommodate a person's food preferences when prescribing special diets to be followed at home.

* expect nursing personnel to know how to care for a black person's hair and skin and to spot evidence of jaundice or cyanosis in people with dark skin.

* support folk medicine practices used in conjunction with scientific medicine and allow consultations by acupuncturists, chiropractors or spiritualists.

* be aware that the quiet Irish person may be experiencing a lot of pain but not expressing it.

* understand that the fear of the Chinese person about having blood drawn relates to blood being seen as the source of life and not regenerated once removed.

Work must also be done to examine and reduce prejudices that lead to intergroup conflicts between health workers and between institutions and the communities they serve. The tense and unproductive atmosphere resulting from antagonisms between these groups cannot lead to anything but less than optimal patient care.

In summary, ethnic revitalization and immigration movements have intensified ethnic identification among members of many groups in American society. These movements have resulted in what has been termed a "new pluralism." The challenge that the health care delivery system faces is whether ethnicity will function as a positive force or as a factor which limits equality of access. It is the thesis of this report that effective delivery of service can best take place within a setting which understands, respects and encourages the expression of ethnic, religious and racial diversity. Changes in approaches to planning and patient care are necessary and must accommodate needs, beliefs and practices of individual groups.

FOOTNOTES

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77th Annual Dinner
The American Jewish Committee
Thursday, May 12, 1983

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Thursday, May 12, 1983

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New York City

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