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Ciel Benedetto:
A History of the Santa Cruz
Women's Health Center 1985-2000

Interviewed
by Irene Reti

Edited by Irene Reti & Randall Jarrell

Santa Cruz,
California
2000

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Introduction

The Santa Cruz Women's Health Center (SCWHC) was founded in 1974 by the Santa Cruz Women's Health Collective. The collective joined a self-help women's health group that had been active in Santa Cruz for about two years, and an abortion referral and counseling group. Many of the original fourteen founders were UCSC students or graduates, or community activists in the home birth, and women's liberation movements. The early SCWHC worked locally to secure abortions for women by driving them to Oakland but eventually arranged for abortions to be done in Santa Cruz. For one year abortion services were provided in the office, but due to opposition from anti-abortionists, the collective was forced to discontinue those services and closed the clinic. In 1975, the center re-opened, obtained a clinic license from the state of California, and began to provide gynecological health care and

health education to women in Santa Cruz County, including birth control, VD testing and treatment, and pregnancy screening.

The Santa Cruz Women's Health Center was part of the women's health movement, which emerged out of the confluence of the feminist movement with the consumer and holistic health movements of the late 1960s and early 1970s. The Boston Women's Health Conference in 1969, and the meeting of an illegal abortion group, "Jane," in Chicago, in the same year, are the first documented meetings of the women's health movement.¹ Self-help gynecology, home birth, and the critical need for legal, and then safe abortions were key parts of its agenda.² The Boston Women's Health Collective produced mimeographed informational sheets on women's health which eventually were published as *Our Bodies, Ourselves: a Book by and for Women*, in 1973.³ By 1976, over 1200 women's health centers had been founded in the United States. They provided health education, referral services, advocacy, and clinical services

¹ Ciel Benedetto, written communication.

² Wang Zheng, "The Emergence of the Women's Health Movement," Master's Thesis, University of California, Davis, 1988.

³ Boston Women's Health Collective (New York: Simon and Schuster) 1973.

in a supportive, women-run environment in which women were active participants in their care.⁴

The SCWHC operated as a collective, using a consensus decision-making process.⁵ The early SCWHC saw itself as an activist, rather than a service organization. Central to its philosophy was the feminist imperative that women control their own bodies. Medicine and health care were vehicles for achieving women's liberation. The collective began as an all-volunteer organization, with the exception of medical providers, who were paid. The collective's first members were paid under a CETA [United States Comprehensive Employment and Training Act] grant in the late 1970s.

⁴ Carol S. Weisman, Barbara Curbow, and Amal J. Khoury, "The National Survey of Women's Health Centers: Current Models of Women-Centered Care," *Women's Health Issues* vol. 5, no. 3 (Fall 1995): 103-17.

⁵ In their unpublished 1981 case study written for a UCSC class on alternative work structures, "The Santa Cruz Women's Health Collective: Collective Organization of Work," Dana Frank and Tinka Gordon discuss the SCWHC consensus decision-making process: "Consensus is a process of group decision-making in which all those who participate in a discussion must agree before a final decision is reached. Any one person can 'block consensus' by expressing disagreement; a final decision by consensus can at times take three meetings. Members of the Health Collective are firmly committed to consensus because it ensures that the opinions of all members are incorporated before any decision is implemented. They feel that hierarchical or majority decision-making structures deny a voice to some women affected by a decision, and thereby deny them power."

In 1984 the Women's Health Collective faced two crises. Attempts to diversify the organization and make it more race and class inclusive had led to internal tensions and strife. The organization also faced a financial crisis due to budget cuts in the Reagan era and its lack of experience with fundraising and business management. As UCSC alumna Lisa Stein wrote in her senior thesis on the SCWHC, "The contemporary dilemma that has touched all such organizations is the conflict that arises between running a successful business and maintaining an ideological commitment to one's cause."⁶

Although the collective was never formally dissolved, the Center decided in 1984 to recruit an administrative coordinator and hired Ciel Benedetto, has held the position since that time. The organization today is hierarchical but still adheres to democratic management policies.

The SCWHC has changed from an advocacy/activist organization to a primarily service-providing organization, a transformation that has also taken place in many other feminist organizations, particularly those working with survivors of domestic violence. Nevertheless, feminist

⁶ "Santa Cruz Women's Health Collective in Transition: Collectivist Organizations and the Politics of Women's Health," Senior Thesis, University of California, Santa Cruz, 1984, p. 95.

activism is still a core value of the SCWHC's mission; many board members, staff, volunteers are actively involved in policy issues affecting women, people of color, and health care consumers

I conducted this oral history with Ciel Benedetto in two 90-minute interviews on September 9 and 15, 1999. These interviews document the Santa Cruz Women's Health Center's remarkable transition from a groundbreaking, struggling socialist-feminist collective to a thriving feminist organization with a million-dollar-plus budget responding to the challenges of operating in today's complex, managed health care environment. Benedetto has skillfully guided the SCWHC through this transition, maintaining the organization's committed feminism, while also developing a diverse staff which serves its clientele with the highest medical standards. The Santa Cruz Women's Health Center is celebrating its 25th anniversary this year, and is one of the few remaining women's health centers in the country.

Benedetto, the working-class daughter of Italian and English immigrants, grew up in New York City and came to UC Santa Cruz to study religious studies in 1974. While at UCSC, she became interested in women's studies and ended up receiving her B.A. in women's studies in

December 1978. She focused her studies on women and health: concentrating on women's health issues in prison, mental health, and the issue of forced sterilization. Benedetto gained administrative experience when she was an active member of UCSC's Women's Studies Collective. After graduating, she spent a year traveling internationally and then worked for five years for a mental health organization in Salinas, California, which presented alternatives to psychiatric hospitalization.

Benedetto discusses the early history of the SCWHC, focusing on the challenges to the organization in terms of race and class diversity and inclusivity in the early 1980s, prior to her appointment as administrative coordinator in 1984. Her goals of diversifying the staff, the board, and the clientele of the clinic have largely been realized during her tenure.

The early SCWHC focused primarily on reproductive health care. Benedetto has enlarged the organization's mission to include not only gynecological care for healthy women, but to become a primary care clinic serving women during their entire life cycle. Today the SCWHC provides over 8000 patient visits a year in the areas of general medicine, gynecology, prenatal care, family planning, and pediatrics. Agency staff and volunteers also provide information and referral services, low cost

acupuncture, free mental health and nutritional counseling, health and HIV education and counseling.

Benedetto discusses the SCWHC's relationship with local health organizations, as well as her communication with women health workers in India, South Africa, and Nicaragua. As one of the oldest and most resilient women's health centers still operating in the United States, the SCWHC is a visible and inspiring member of the international women's health movement, as well as a vital member of the Santa Cruz community.

Benedetto attributes the organization's longevity to its adaptability in the face of the many political, social, and economic changes which have taken place in the health care field since the 1970s. As a major provider of managed medical care to a large number of MediCal patients, the organization has been able to depend on a stable income. Benedetto also credits the Santa Cruz community for its financial support and its many talented and committed volunteer staff and board members. Benedetto characterizes the Volunteer Health Workers Internship Program as a "feminist incubator" which has trained over 500 women in

health care skills over the years, of whom sixty women have become physicians, and others, political activists and labor union organizers.

Benedetto emphasizes the critical importance of paying competitive salaries to medical clinicians and staff. She outlines the agency's fundraising efforts as well as the successful 1997 purchase of the building the clinic had leased for over twenty years. She assesses the directorship position and explains how she has avoided burnout in her 16 years as director, an unusually long term for a director of a nonprofit organization, “. . . burnout comes from different places, but boredom is part of burnout. I can say I have never been bored, ever, in this job . . . the sense of satisfaction that I have has far overshadowed any burnout. Overwhelmingly, people love this place and so appreciate what we do. There's just not much in life like that.” She also expresses her appreciation for the many hard-working staff of the SCWHC, saying, “my job is totally reliant upon the work of others.”

The oral history also documents the SCWHC's efforts to serve a diverse group of women—young and old; lesbians; and those living with disabilities. Benedetto describes the challenges of serving each of these

populations and discusses the growth of the SCWHC staff which now numbers 26, including 7 medical practitioners.

Benedetto notes that, “Many of the successes of the women’s health movement have now been incorporated into mainstream medical practice. These changes have been as small as the presence of heated speculums in gynecological offices, and as large as a national initiative for breast cancer research. Hospital-based women’s health centers became popular in the mid-1980’s; notions of informed consent and access to one’s own medical records are now standards of practice; women have entered medical school in record numbers; and access to pap smears has reduced mortality from cervical cancer.”⁷

The survival of the SCWHC is a remarkable example of the success and resiliency of a grassroots feminist organization. During the last 25 years the Santa Cruz Women’s Health Center has published an internationally distributed newsletter and health education materials; provided new contraceptive methods such as the cervical cap; made a strong commitment to diversity and bilingualism; trained effective

⁷ Ciel Benedetto, written communication.

consumer, health, and women's rights advocates; developed model community participation programs; and expanded medical services including prenatal care, pediatrics, and general medicine.

This manuscript was transcribed verbatim and returned to Benedetto for additions and corrections. Benedetto checked the manuscript carefully and made a number of small changes and corrections. She added written comments, as well as the timeline and articles included in the appendix. She kindly lent us the two photographs reproduced here. I wish to thank Jacquelyn Marie, Women's Studies Librarian at McHenry Library, who suggested this oral history, and who was curator of the Library exhibit, "The Politics of Women's Health: Santa Cruz and Beyond," in the spring of 1999, in which the history of the SCWHC was a centerpiece. I also thank Randall Jarrell, Director of the Regional History Project, for her assistance with many phases of this project.

Copies of the manuscript are on deposit in the Bancroft Library, University of California, Berkeley; in Special Collections at McHenry Library at the University of California, Santa Cruz; and the Santa Cruz

Women's Health Center library. The Project is supported administratively by Christine Bunting, acting head of Collection Planning, and University Librarian, Allan J. Dyson.

—Irene Reti

April 27, 2000
Regional History Project
McHenry Library
University of California, Santa Cruz

Coming to Santa Cruz

Reti: Please tell me about your personal background, where you were born, and how you ended up in Santa Cruz.

Benedetto: I was born in New York Hospital, New York City, one of four children. I am the child of Italian and English immigrant families. In my senior year in high school UCSC was on the cover of *Life Magazine*. I remember seeing this photograph of redwoods and telling my mom, “I don’t know where that place is, but I want to go to school there.” But the idea of going out-of-state and paying out-of-state tuition was just absolutely not in the picture for me.

But I moved to California in the late 1960s and had always wanted to live in Santa Cruz. And so, to be honest, at a certain point in my life in the mid-1970s, I both wanted to come back and finish college, and move to Santa Cruz, and they were equally compelling. I had many reasons in my life why I thought going to college would be a good idea, mostly because I was moving with a really fast crowd that followed me when I went to Arizona and I still didn't get rid of them then. I thought, what is the one thing I could do that would so put these artists off that they wouldn't want to follow me? I decided to be a college student, which at that time was thought to be . . . totally selling out, totally square and bourgeois, the idea that I actually wanted to complete my college education. I thought about a bunch of different places and decided that from what I knew of UCSC it was suited to me, because I wanted to be able to direct my own learning and I thought it was that kind of campus. It was all predicated on getting financial aid and at that point I was a California resident . . .

Reti: When was this, 1975?

Benedetto: I applied and was accepted in 1974. I did get financial aid and in those days both because of the cost of living and the nature of

financial aid, I pretty much, other than small national direct loans, got all grants and work study.

So that's how I literally ended up at UC Santa Cruz. I actually came to study religious studies. I was very interested in Indic religions and came primarily to study the Sanskrit and Tibetan languages. I took some women's studies classes as electives. Religious studies was its own department at that time. I really needed a refuge and women's studies helped me with having a perspective, a filter through which to look at religious studies. I became less and less interested in the spiritual, sociological, and psychological content of the material and more and more interested in the historical content of what I was learning about religious studies. The historical impact of religion really grabbed me.

I ended up becoming a women's studies major and would have graduated with both degrees if I hadn't had several things happen in the religious studies department that prevented me from doing so, one of which today, I would have had a place to go and complain about, and it would never have happened. But back then there was really no one to go to and no one to complain to. I ended up deciding for my mental health [based on] the

advice of people I trusted in the department, that it would be best if I completed my thesis, but just didn't graduate from that department, lest I take on a certain professor. So that's how I got here.

Reti: You graduated in women's studies. Were you active in feminist work and organizations as a student?

Benedetto: I was active as a student. I had been active really ever since my adolescence. I probably in some ways was less active as a student, except for the women's studies department was a very politically active group of people. Within the context of women's studies I did a lot. But I had been a political activist since I was a teenager in a variety of different movements and brought all of that with me. I did some work regarding forced sterilization which was a statewide initiative at the time, through my work as a student, but that's something I would have done anyway. I also did some work with women's health issues in prison, which I probably would have done anyway. I wasn't necessarily a joiner. I'm still today not a very good joiner of organizations. If I had to name a student organization I was a member of I'd probably falter because I don't think I was really ever a member of any, other than the Women's Studies

Collective, which ran the program at the time. I didn't really join, that I can remember, student organizations. But that is sort of a trend for me. I never really joined Students for a Democratic Society either, but was very involved in direct political action. It's hard for me to find a political group that I agree with so wholeheartedly that I want to be a member of that group. That probably says more about me than anything else. I do aspire to be in WILPF [Women's International League for Peace and Freedom]. There's nothing stopping me other than time and doing it. That's a group that I really admire. Other than that I haven't been very organization-oriented as a person, but issue-oriented.

Reti: Now what about the period after you graduated, but before you came to work at the Women's Health Center?

Benedetto: When I graduated from UCSC in 1978, I was a member of a delegation that went to China. I graduated in December and two days later was on a plane to Hong Kong. I stayed three weeks with the delegation, but I also had a really good friend who was Chinese-American whose family was still in China. I stayed with her family an additional six weeks in China. I spent about nine weeks in China and about a year in

different parts of the world. I had really wanted to travel my whole life. I spent most of my time in Asia and Europe. Then I came back to this area.

Reti: How did you end up becoming the director of the Women's Health Center?

Benedetto: Well, one of the really great things that I experienced in the Women's Studies Collective was learning how to do administration, through course work, electives, and independent studies, and also because the students ran the program. A lot of what I learned there I had in the back of my mind and wanted to apply. I had learned about administration and found that I actually had some ability in that area.

But I also had developed a really great interest in women and psychiatry and the mental health system, particularly from the political standpoint. It started, actually, when I lived in San Francisco, and then I studied it somewhat in school, so when I came back to this area I got a job working for an organization called Interim, Inc., in Monterey County, which at that time anyway was fairly radical and presented alternatives to psychiatric hospitalization. I worked there for five years. It was a very

fulfilling but very sad job, extremely sad, because as a society we are a whopping failure at dealing with issues of mental health, and psychological and psychiatric problems. You can only have so many clients commit suicide without falling apart yourself. The system fails so many people.

For me the breaking point was when a client who I really loved had her children taken away from her. She killed herself in the bathroom outside of the adoption bureau office in Monterey County. The father of her child was involved in organized crime in Salinas, a very powerful family, and basically they were no more fit to raise that child than she was. They talked the authorities into having her lose custody. The whole thing was really sick, horrible. That was it for me. I thought, I have to do something that is positive, that I can leave work everyday thinking, okay, even if I haven't helped anyone today, I have not harmed anyone. When you work in the mental health field if you want to keep your ethics in check you really have to ask yourself that question, because you are a part, even if you are in an alternative program, of something that is trying to control people, somewhat for their own good, possibly, for their safety. But I

really questioned many days whether I had been able to help someone or hurt them in some way. So I decided I was going to look for something more life-affirming than trying to patch up the holes in our non-existent mental health system.

Becoming Director of the Santa Cruz Women's Health Center

I saw an ad in the newspaper for a job as administrative coordinator of the Santa Cruz Women's Health Center. Of course, having lived in Santa Cruz since 1975 . . . this was 1984 already, I knew a lot about the Women's Health Collective.¹ I knew many people from UCSC Women's Studies, like Laura Giges, who had been involved here. I knew a lot about it. I almost knew too much about it. I was very aware of it and had actually steered clear of it up until that point.

I grew up around a lot of political people and I developed my political ideas fairly early in life. I considered myself a very serious person politically. I had certain ideas about what was legitimate political

¹Benedetto provided the following written clarification, "The Santa Cruz Women's Health Collective operated the Santa Cruz Women's Health Center. The Collective, it seems, never formally dissolved, but did so *de facto* after the transitional years of 1982-1984. When I arrived there was no collective."—Editors.

organizing and what wasn't. Somehow this organization never quite appealed to me in that kind of political way. I steered clear. I saw this job and thought it was an opportunity to be health-oriented, to be doing something positive, and to make an impact that I could measure. When I went home at night I'd know I'd done some good.

I decided really as a fluke to apply for this job, and was offered it, much to my absolute and total surprise. I had a background in school in administration and a lot of community organizing experience. The organization I worked for before this one was similar in the sense that I pretty much could make that job whatever I wanted. I, with two other people, had rewritten the personnel policies for the entire organization. I had done a lot of administration and grantwriting. So it was not that I came totally unprepared; I just hadn't quite done this.

I was very aware this had been a collective and I was the first formal [director]. . . even though as it turned out as I delved into the history, it had always really had an administrator or administrators. Several people had played that role and either made it public or didn't; they had either in an obvious way played that role, or in a not so obvious way. I don't

consider myself the first administrator, but I'm the first person who has [explicitly had] that role. That concerned me, in terms of what that [role] meant and what the expectations of me were.

Reti: I'm familiar with the history of the Women's Health Center, but the reader of this oral history probably won't be. Could you give a brief recap of what had happened before you came, the history of the organization [when it was a collective], and at what point you walked in?

Early History of the Santa Cruz Women's Health Collective

Benedetto: Okay. A lot of this has been documented, so I don't feel

in

terms of historical accuracy I should be the last word, since I was an outsider for some of it, and a lot of it I have learned from reading documents. In one of the agency newsletters, there is an article by Laura Giges called "The Challenge of Change," [see Appendix A] which I believe is probably a pretty fair and objective account. One of the things I've been doing recently, because we are trying to purge this building of 25 years of records, is I've read almost every piece of paper, deciding what to keep and what not to keep, of collective notes and everything else. It

was very useful to me, actually, to re-read some of those notes that resulted in important decisions.

My understanding of the history of the Women's Health Center starts in 1982, because that's what I know the most about. [It reflects much of what] was going on in the United States in the women's movement at that time. If you read the histories of and news media accounts about women's, feminist organizations in the late 1970s and early 1980s, people started questioning from within and without the organization about how inclusive these organizations were. Beyond being inclusive: can certain groups of women speak for all women? Was there a singular movement or were there many movements? Who is it that's visible to the country and to the world as leaders of the so-called women's movement? Are those people who are leaders really the people who are doing the work? Those were the very good and hard questions that people started to ask.

I'd like to believe that a lot of these organizations started asking these questions on their own out of heightened awareness. Some of them did. But most of them did because in almost all of these organizations there were one or two women of color who basically did the work for a long

time saying nothing, and then spoke up, or some of them came in speaking up. There were two such women in this organization who spoke up. One woman in particular, who was the only woman of color in sight for a very long time, was helped by her own consciousness and awareness, and women from the outside saying, hey, wait a minute. What's going on here? Is this an organization for all women or is this the Santa Cruz white Women's Health Center? What is this about? What is the composition of our community?

So in one regard the struggles of this organization very much reflect the society and the growing awareness that was out there. It's a complex situation because you have to really look at the prior history to understand who formed this organization, and how that changed over time. The combination of college students and non-college students. There was the home birth movement. There was a whole bunch of different people involved, who came from very different perspectives. For the most part, they were white, middle-class women. And in this organization that began to be questioned.

Add to that questioning, the layer that this organization was a collective, and a collective in a really pure sense, meaning operating from what I considered to be the purest sense of consensus for many years, which means you don't cop out and vote when you can't decide. I am reporting from what other people told me about the ultimate demise of the collective, and the evolution toward an organization with a more formalized hierarchical structure. During the era of the collective, there was not necessarily a prioritizing of what decisions could take five hours to arrive at and what could take one hour. So decisions about very important policy, crucial mission issues, and how many paper clips to buy, could be processed (that's an exaggeration, but . . .) by a group of people who clearly didn't need to be home by a certain time or had many hours to spend doing that.

There's that whole rubric, which I think is crucial to understand in order to grasp why this particular history of this organization happened the way it did. There's a certain amount of sameness that is needed in order for that particular kind of consensus process to work. It's not that you can't have difference and have consensus, you really can, but a very different

kind of process needs to happen and a structure needs to be put in place that allows people who are coming from entirely opposing views, but have a task to accomplish to do that. I think the Quakers have good models for that. There're different groups, historically, that have good models for that.

This socialist-feminist collectivism model was quasi-stolen from the Chinese Cultural Revolution, and very much taken from the Left in the United States. Even much of the lingo came directly out of the Cultural Revolution. At least the propaganda, and I don't mean that with a big P, like horrible propaganda, but the propaganda that published materials that the Cultural Revolution's leaders purposely sent translated into English into the West, specifically criticism/self-criticism, was adopted by the feminist movement. This came directly from what was happening in villages in China, which was part of the Cultural Revolution, and abhorred by most people as incredibly fascistic, and may or may not have been.

These particular circumstances could probably not have happened at any other point even in American history. Women were not only coming

together to improve health care for women, but at the time abortion was not legal. There were virtually no women doctors in this town. It was and still is an extremely conservative medical community. I mean that in a bad way. In the medical community there are two kinds of conservative. One is the good way, which means people only cut on you if you they absolutely have to, or use the least invasive procedures. But medically conservative in the sense of backward, means not considering women to be full human beings, not embracing the civil rights movement—that kind of conservative.

If you look it at in that whole rubric, things become more complex. You had the civil rights movement in this country. You had the Chinese Cultural Revolution, which captured the attention of the Left, and filtered its way into feminist organizations, including this one, which declared itself at the time a socialist-feminist organization, and a collective. Then you also had the beginnings of the gay rights movement. You had the stereotype that this place was entirely started and run by lesbians, which has never been true and is still not true, if you are looking

at total numbers of people, and total numbers and percentages of lesbians.

At the same time, even though you had people who grew up in the civil rights movement, and whose families supported the civil rights movement, they did not easily identify racism or discrimination in their own midst. That was a national phenomenon and it occurred here. Part of it, I still see today. I see it in my everyday life—if people don't have different kinds of people in their lives, going out and trying to get them is not only tokenism, it's incredibly confusing. So that's part of what was going on.

A political analysis then got applied that showed that the Women's Health Collective in fact did have conscious and unconscious barriers to women different from the women who were operating it at the time.

Reti: You are talking primarily in terms of race and class diversity?

Benedetto: I've expanded it more, because I think, as I said, it's far more complex than that. Those are the more glaring and obvious omissions.

But it could also be even political persuasion if you want to look at it that way. Is this a place only for feminists? Is this a place only for certain kinds of feminists? Is this a place only for healthy women? It sounds like a funny notion, but when I got here I thought by and large this was a place for healthy women.

The reason I am saying this is that in terms of my own role, too, I had very specific goals when I took this job which I thought were important. I was very aware of the history and of a bold move which had been made, which would never have been made today. At a certain point the collective struggled with trying to “integrate” and failed. I’m using the words that I’ve seen written down. Again, and this is just my point of view, it failed because none of the people they were seeking to include were in their life in any other way. And so when you are trying to bring them into a collective. . . you’re not trying to bring them into a store. You’re not trying to bring them into the motor vehicle bureau, where you have something that people need. People want to drive! You want to go to one of the most diverse places? It’s where people really need something. The DMV I’ve always thought, is one of the greatest places, if they’ll let

you, they don't like you to, to do outreach. Of course very few people go physically to the office anymore. But in the old days when you did, that was the greatest place anywhere to do any kind of outreach. Any kind of person you ever want to deal with, except maybe for people who have servants who send people to take care of their driving needs, is going to be in the DMV.

But this is not like that. You don't have this universal appeal, at least you didn't then, where people really need something so they come to you. The Women's Health Collective was like a family. How does someone get into this family? The other kind of quality that I remember from that time, when I was an outsider, which I both envied but sort of questioned, was this sense that this was the in-group in town.

Reti: I remember that.

Benedetto: In fact, people who applied to be volunteers and collective members got turned down all the time. Being let in was this honor. I think it was an honor, but on the other hand, that way of being is

antithetical to true diversity and any understanding we might have of diversity today, any sense of democracy, really.

It's not a straight issue of integrating by ethnicity. There are so many complexities that have to do with that time, the politics, and in some ways, maybe the foolishness and impetuosity of youth, things that people do at a certain age and then look back on when they get older and think, how could I ever have thought that? I've had many notions myself like this. How could I have ever thought that? How could I have ever done that? It's really like watching a child grow and develop.

So from what I've read and talked to people about, after several years of struggling and after succeeding in bringing women of color onto the board, if not directly as much into the staff, a decision was made by the collective to basically fire half the women and hire fifty percent women of color. This probably violated some labor laws. It definitely would not be done today, post-Proposition 209.² But it was done then. I was not involved in that decision. I think it was a bold move and the only thing

²Proposition 209, the California Civil Rights Initiative, made it illegal for the state of California to "grant preferential treatment" to anyone on the basis of race, sex, color, ethnicity or national origin," and was passed by the voters in November, 1996.—Editors.

that would have ever changed this organization. When you look at any political movement you need everybody. You need the most radical people. In any true revolution you need the people threatening violence even if they don't do it. You need the people who are saying, oh violence is evil. You need people writing pamphlets. You need people who only believe in one part of something. You need every single part of the continuum for change to take place, especially in institutions. I still think without taking that bold move this organization would have never moved any farther.

Reti: Now what year was that?

Benedetto: I believe that was 1981-82 by the time that happened. Also, at the time there was very little funding in this organization. It came and went. That was the other thing, the methods by which some people got paid and others didn't, and how it was decided who got paid. Some people devoted their entire life to this place and didn't get paid. Others did get paid. They were different times. It's way too expensive for people to live today for people to spend so much time volunteering. I mean we can't even conceive that people could do that. Right?

Reti: I
know.

Benedetto: Only really wealthy people can volunteer in this day and age and not really worry about earning money. And these were not, by and large, wealthy people. These were people, for the most part, from either working-class or middle-class backgrounds, mostly middle-class backgrounds, from what I understand, who were probably not leading a middle-class lifestyle themselves. But that's the background from which they came. So that's what happened. Women of color were hired.

Then there was this supposed collective. Prior to that from what I know the board was needed minimally to satisfy state law requirements. It was probably there enough to satisfy the law, but was not necessarily a visionary board. The collective was visionary. This issue galvanized the board and made the board a lot more important. Clearly only a board could make these sorts of decisions and implement them. The board was very much involved with some of these changes.

I don't believe there was ever a conscious decision for the collective to dissolve. When I arrived there was no written document that said we

operated as a collective but we're not anymore. There was no collective. There was nothing. If there was something in writing it was not passed on to me. Maybe I'll find it in a box still.

From what I understand, the tyranny of that kind of collective process was incompatible with diversity. You had women with kids, women who had to have second jobs, women with obligations to other family members who could not sit and would not sit for hours in collective meetings. You had women who really disagreed and would break consensus. But you had no way of voting, or having some agreement about what would happen when you couldn't reach full consensus. None of these things were in place. There was diversity without consensus and the collective just ceased from happening.

Furthermore, there were, understandably, still a lot of hard feelings. People did not 100% support what had happened, how this was accomplished. In any kind of affirmative action recruiting situation, people on both sides of it live with the stigma.

There was a *de facto* destabilization of the collective prior to my coming, and an absolute economic meltdown. The board moved in and laid off all but one person and then restructured, hiring very few people back. Financial challenges, and also the whole fallout of what had gone on before then, affected staff morale, and the ability to function, to maintain medical services.

Goals as Administrative Coordinator of the SCWHC

Before I accepted the job I talked to a lot of people, because I had known about a lot of what had gone on in this organization. After having consulted with the people whom I trusted, and asking a lot of questions, I decided well, I'm going to try this. When I came, there were two things that were important to me that I told people who hired me I would do. It was very important to me to have practices in place that were legal, that were functional . . . For one thing, if you have a rule that says 50% of people have to be women of color, today that would probably be considered to be discrimination and we could be sued, but also, all you have to have is an odd number of people to be out of compliance with something that's as important as that. You can't have half a person. How

do you count someone who is biracial? Well I knew enough about administration to be very nervous about these so-called rules that were probably illegal and weren't implementable.

But what was more important to me, I said, was that I had absolutely no interest in working for an organization that only serves white women. I said, "You might have succeeded to a degree in diversifying your staff, but when I look out in the waiting room this is all I see. If that's what you want to do I have no interest in doing that. If you hire me, I will guarantee you that the women who come here will represent our community in at least the same numbers proportionally to the population or even in greater numbers, because these are the people who may be underserved."

The other thing was I wanted to serve sick women. I didn't want to just be here when women were well. That's easy. I wanted to be able to be here for women when they were sick and still try to provide them with the highest quality care. Those goals have not changed.

Those are the two things that I thought I could accomplish being here, that I could make an impact on and make me feel like when I left work every day, that yes, I'd done something good, and I didn't have to wonder whether I'd harmed anyone.

That's how we got to where we are today in terms of understanding our hiring procedures, how we look at our programs, how we select our board members. Many of these things are institutionalized in a way where diversity is just a big part of every aspect of who we are. It doesn't mean it doesn't need to be maintained. It always needs to be maintained. People always need to be vigilant.

It's a kind of a mentality, in a way, of how you approach everything that you do, and also who you have in your life. When you have diversity in your life, it's very easy to perpetuate it. When you don't, it's extremely difficult and confusing. Many organizations that I know and respect are often in this situation because of funding, or because they have maybe other motivations going into it and they are out there looking for Spanish-speaking clients, Spanish-speaking board members, without any connection to or understanding of that community. It's very

uncomfortable for them, but it's twice as uncomfortable for the people they are trying to track for services who they are not prepared to serve. Part of it is figuring out what people want and need, and providing that. It's like the DMV example. When you really provide something that people need, outreach is almost a term that's just outdated and unnecessary. People will find what they need.

Reti: Well it certainly seems like women need low-cost, high-quality health care in this community, in every community. So that shouldn't be a problem.

Benedetto: That's right. Unless your practice is so limited that you only do family planning, or you are seen as an organization that only promotes abortion; you are not there to help women when they are pregnant and need help. It's perception. Perception will hinder you. The benefits, I think, of this organization being a primary care provider now, is that you are right, a cold might bring somebody in off the street. Someone has a cold and needs health care, and guess what, we're here and we can help you with that. Sometimes. Western medicine sometimes doesn't do such a good job with colds. But whatever it is we offer that.

When you know you want to serve a certain population there are things you can do. Let's say they perceive a barrier that's not there. A big part of our decision to do pediatrics was feeling like there's a population of women who weren't necessarily taking care of themselves but would take care of their children if push came to shove. We decided if we saw those kids we'd see those women in here. We'd see the grandmothers. We'd be able to do breast exams. We'd be able to talk to teenagers about family planning, once we have people in our practice. You can do that when you have representatives of those communities working for you. They can say my people need . . . there're no pediatricians that speak Spanish, or there're no pediatricians who will take MediCal anymore. We need prenatal care, or diabetes is the hugest problem we face and we need . . . So that's what makes it easier, when you know what the needs truly are and you can offer them.

Developing a Family Practice Model

Reti: Can you tell me more about this idea of serving sick women instead of only healthy women, because that's not entirely clear to me.

Benedetto: Well the Women's Health Center here has always been a little bit broader than reproductive health centers, per se. But still when I first came here, most appointments would be for annual exams. There was a practice of women's health, maybe in a more expansive way than many of the other women's health centers in the United States, but certainly people were being referred out at the drop of a hat for things that are considered a basic part of medical practice, let's say in a private doctor's office. It was part of our evolution to hire certain types of doctors interested in doing a family practice model, not necessarily family practice meaning seeing everyone in the family, but family practice meaning seeing a person from birth until death. It's a life cycle model of looking at things. There are some external forces, I think, that encouraged us to do full primary care, like managed care coming into being. But it was also a slow sort of evolution that did that.

Also, one of the things I observed, is that when women weren't feeling well and left here and we referred them to somebody, we had absolutely no control and very little accountability for what was going to happen to that person. I thought, and it wasn't just me, a lot of this came from our

medical staff, that we could and should be providing a lot of that for women. It's a big job. Life was a lot easier when we just did women's health. Education was a lot easier when we just did women's health.

You need to have written materials about women's health, hopefully all of them in English and Spanish, which is a constant struggle. When you do full primary care for women and children what are you going to have, medical textbooks available? Every imaginable subject comes up. Just some simple functioning thing that is such a core of our mission, like providing health education and prevention information, verbally, and in writing, repetitively, which is how we all learn, by repetition, is a huge challenge. The level and the quality of materials available on most subjects are not really great. We used to be very picky about what we would hand to a patient. Well you can't be that picky when you are just searching for something, anything in Spanish about a certain subject. You can publish articles yourself about women's health, because it's a defined set of things. But when you need to really have a lot of information about diabetes and you need to have a series of things, some of which are much

more sophisticated than others, you really need to rely upon the expertise of others. You cannot produce all those things yourself.

So anyway, I'm not saying that expanding to primary care was entirely my idea. It's something that I gratefully got nudged into by our medical practitioners and other forces. It's something I wanted, but never really saw how to do. It just happened because it had to. It had to happen to keep our good clinicians happy here so that they could use their clinical practice skills. It happened because of managed care. And it happened because many of our patients had nowhere else to go, and were not quite ready for specialist care but needed help with specific kinds of ailments.

Today, I'd have to say first and foremost, we are a medical service organization. I don't think it has to be that way, or be that way forever. But particularly since about 1995, which began the era of tremendous expansion of our medical practice, including newborns to seniors, our focus had to be serving people well medically.

The third thing is that you cannot be advocates for people if you don't have information and you don't provide them with quality services. You

owe it to your clients. Maintaining quality medical care for me is the bottom line. I can't sleep at night unless I believe that we are doing that. When I don't feel like we're doing it as well as we can, in that regard, I try to be a perfectionist. You can never be perfect. I do lose sleep over that kind of thing. Medical quality is a huge job, a job unto itself. Until we get over these growing pains of how do you expand your practice to include kids and older women, and to manage chronic and serious illness, to see people through dying . . . all of that, some of the more obvious sorts of advocacy and education things that we used to do have taken a back seat to our efforts to not only expand our services tremendously but to do them well, and to do them according to what our standards are for how people should be served.

Relationship with Other Community Health

Organizations Reti: What is your relationship with other health organizations in this community, such as Planned Parenthood and Salud Para La Gente?

Benedetto: Well, there are now only three of us, where there used to be four, because Planned Parenthood took over the Westside Health Center.

We all formed a coalition. . . I think it was my second day at work that we formed a coalition. The relationships vary in intensity like any relationship, but we are all very mutually supportive of each other. Several of us have considered merging. Two of us did. The Santa Cruz Westside Community Health Center and Planned Parenthood did merge.

For many years I was very, very involved in Salud in Watsonville, and their change in leadership has changed that for me, not on my end, but in terms of their interests in that kind of affiliation and the kinds of problems and challenges they've had to deal with down there. In general, I would say, very collaborative, very supportive. We've done a lot of very successful projects together.

Reti: Now what about with women's health centers across the country, and internationally?

Benedetto: Well they are dwindling. . . one of the things I did when I first took this job, was that I tried to visit all the feminist health centers in the state, at least. And realized, there was really no connector even at that point, in 1984. People were happy and interested to talk to me to various

degrees, of their own stress and what was going on in their jobs. At that time, I thought it was really important that we stand together. The reality of geography and economics and difference, I think, make it really difficult.

I have quite a bit of correspondence, internationally, and as of tomorrow or Monday, now that I finally have e-mail, it could get greater. But that's what I'm afraid of. I'm really afraid of that. And that's because our name is so out there. So, for instance, because we are listed in *Our Bodies, Ourselves*, because of the whole history of this place that is known to anyone who studies the feminist health movement, a lot of people contact us. We probably get letters monthly from India, from all parts of Africa, and from, really any imaginable country . . . usually it's people who don't have access to resources who ask for help of some kind and we always try to give that help.

Reti: When you say help, do you mean medical information?

Benedetto: They often want books of any age, and have a list of books which are antiquated, which we have multiple copies of. I don't care if I

need to go to Bookshop Santa Cruz and write out my own check; we always try to accommodate them and send them what they ask for. That attitude has resulted in us getting a lot of other letters, however. So we have some connections there. There are some South African women who actually visited here, who do HIV work, whom I corresponded with, whom I had made friends with. And a former volunteer of ours runs a clinic in Nicaragua. We are very intimately involved in supporting and helping that project, providing medical supplies. It's not just a clinic, it's a women's cooperative in a small village in Nicaragua. We're like a sister organization to that group of women, who are incredible.

Reti: What's the name of their project?

Benedetto: It's the Maria Luisa Ortiz Cooperative in Mulukuku, Nicaragua.

I stay in contact with the Lyon-Martin Clinic in San Francisco, and we are going to try help them with this breast cancer risk study that they're trying to do regarding lesbian breast cancer risk. I try to stay in touch

with other feminist health centers in California and elsewhere, but there is no formal national organization.

Reti: Not even an e-mail list?

Benedetto: Not that I know of. There are probably political and historical reasons for that also. There's actually a group called the Feminist Women's Health Centers. Carol Downer is one of the founders and she's one of the founders of the women's health movement. They went off on their own way. They had a center in Atlanta, I believe, one in Nevada, and three in California. They kind of became an entity to themselves and they do confer with each other.

There are very few [women's health centers] left. There's one in Boulder. There's one in New Hampshire. And there's, of course, Fenway in Boston, but that's a bigger thing. St. Marks in New York has changed dramatically. In California there're three or maybe four that still exist. So when you are talking about freestanding feminist women's health centers, including the Feminist Women's Health Centers by name—I could probably count them on all of my fingers.

The Success of the Santa Cruz Women's Health Center

Reti: What do you think accounts for the longevity of the Santa Cruz Women's Health Center?

Benedetto: Adaptability. That could be either good or bad, depending on your point of view. Once the decision was made to do medical services, rather than just education and advocacy, a path got formed. Unless you are going to do the most narrow kind of health services and make it still predominantly self-help, there are regulatory bodies. You can't just be out there practicing medicine the way you feel like it.

So certain things were in place long before I got here, like a clinic license. We are heavily regulated, and I think the regulations are good regulations. They are all for patient quality. In a way, a weird way, it's like patient's rights coming back at us, all of the things people fought for in the state of California. There are a lot of protections under clinic license regulations, and under managed care regulations, which are things we fought to make real in California. They come back at you when you are the one providing the service, which is right.

Once those decisions are made, you are on a certain path. You can't kind of dabble in medicine, and be doing these other things. So for better or worse I think that path is what's carved the way. Like you were saying, if you offer something that somebody needs. . . so there's a combination of that path being forged and deepened and widened, and maybe getting so wide that all other services and programs are just little side roads, if we are using the road analogy.

I ask myself this question all the time: what's more important? Why can't we go back to doing this? Why can't we still do it that way? Honestly, I can tell you, that providing medical quality to a large group . . . and at this point we have 4000 patients in our practice every year, gobbles up most of our energy and time. Just doing that is a huge job. It's needed in this community, unlike many others that I can think of. There's really no competition, *per se*. It's a little bit different in Watsonville, but much different in Salinas, and much different in Alameda County, where there are a certain number of professionals in the medical community who have a commitment to serving poor people, but also have made a living doing so, have huge practices, and are either threatened or are in competition

with community clinics. I do have a lot of communication with community clinics in the whole state of California, not necessarily women's clinics, but all kinds of clinics. I'm part of organizations, and pick up the phone on a weekly basis and talk to somebody about a problem that we are having. When I talk to somebody in Alameda and tell them the proportion of the MediCal clients we had related to the managed care plan, they cannot believe it, it's so high. They are fighting for managed care patients . . . they have to put the same resources we did into becoming managed care providers, and they have maybe 200 people in their practice, in a county the size of Alameda, where we have nearly 1000 MediCal clients in our practice, in a county the size of Santa Cruz. So part of it is the need issue.

Part of it is the community. This organization would not be here if the community didn't support it and didn't see it as important. There're some unique factors, I think, that come into play. And we also have attracted an incredibly talented and committed volunteer staff and board. I'm not the only one who's been here a long time. There's someone who predates me here, who just went out on her second maternity leave and came back . . .

she has a different job but she started as a volunteer here in 1983. That's part of it too. I do not want to minimize the talent of the people who work here, their dedication.

But also, not being afraid to be good business people. By that I mean, unless you don't care about your finances, or unless it's a hobby, if you offer something that people don't need or want, you are going to go out of business. We don't perceive it that way. It's not the way we approach it, but when I look at it analytically, it's kind of the same thing. We look at it from the point of view, like we might do a survey of all of our clients, or of the community, or . . . we might say what is needed, or there's an obvious need. When you see all these women showing up in the emergency room without having had prenatal care, and delivering, a need is obvious. When everyone else was afraid to do HIV testing and there was no county HIV testing program . . . some things are just so glaring you step in and you do them. We're not necessarily thinking, oh marketplace . . . what's our share of the market? We never think that way. But when you look back on it, it's kind of similar in a way. You have to meet a need.

We always struggle within our mission. We check our mission every few years and ask, are we living up to our mission, and also [questions like]—can our mission support pediatrics? Many people think we should see men here. Some of those people work here. That's the one issue that we as an agency would really need consensus on. I don't mean unanimous consent, but a real strong sense. That's an issue that comes up every three years or so and people make a compelling argument, but not compelling enough. That's the one thing that most of us are just not willing to budge on.

Reti: What is the argument that they make on behalf of serving men?

Benedetto: That men are an important part of women's lives; that there isn't such a good service for men and we should be providing that, and that it's important, in order to safeguard the health of the family, if you are really trying to do prevention, to know every member of that family, medically as well as. . . so there's all kinds of arguments for why. It's never that's where the money is or that's where the market is. It's never been looked at in that way. It's more . . . I can't do my job as well as I could if I saw everyone in this family.

Reti: I
see.

Benedetto: These are legitimate good arguments that have not quite made it. We do have a process here. There is not enough agreement that this would not shake the core of our mission. We regularly review our mission. We talk about whether or not we should do pediatrics. We thought that when we looked at what our mission is, children really should fit into that mission. We felt very strongly that was in line with our mission. We could easily offer pediatrics, and that would actually be a good thing to do, for a variety of reasons. That's how we make decisions.

Fundraising

Reti: You are now a million-dollar organization. You said when you came to work here it was just after an economic meltdown. What happened in between?

Benedetto: Well the annual budget when I came was \$167,000, including Familia Center.³ Part of what's happened is inflation. Even our sense as a society of how much \$100,000 is has changed . . . it was a lot of money at one time! (laughter) It is alarming. I mean a million dollars,

don't get me wrong, a million dollars still seems like a heck of a lot of money to me. Especially since we have a second administrator now, and she's going to be responsible for a lot of that.

Part of it is everything we've talked about. It's the evolution over time of developing services. One thing I did not talk about, which is an important element in the Women's Health Center, when I first came clinicians were not even employees. They were contracted. There was this collective, or non-collective; there was this group of people who were still very much committed. Technically the collective still wasn't dissolved, nor did it exist. There was a board, a very active board, and then there were these people who provided the medical care directly, who were not even employees. They were contracted consultants who did not have seats on the board, did not come to staff meetings, did not have any say really, other than providing health care at the time. They seemed to have a lot fewer responsibilities than the rest of the staff. So a big part of our evolution has been integrating our medical staff into our staff, and

³La Familia Center was established in 1983 by a group of Latina, Native American and white women, operating out of the Women's Health Center and is now independent. It offers the predominantly low income and Latina residents of the Beach Flats community a bilingual health clinic.

figuring out how to do that. We have been figuring out how to have people who make very different amounts of money, according to their education and that kind of thing, still have a say, sit in the same meetings and still have access to decision-making processes. That has also been a huge part of our evolution.

Part of the thinking has arisen from the issue of quality of medical care. At a certain point it became obvious to us that we could not really sustain a substantial medical practice out of the goodness of heart of medical clinicians who were making less than they could make anywhere else, without benefits, without a say. I will take both credit and responsibility for this. I did make it a priority to find the money to pay our clinicians at least the bottom of what clinicians were making elsewhere. It took a really long time; it took ten years. At the same time, also, being aware of what everyone else in the organization is earning. So it's never just them. But that was a big part of what we did. Particularly when we decided to do primary care and to be involved in managed care, we needed to have a doctor who was on staff at the hospital. You have to pay people for that kind of inconvenience, for being called at 3 o'clock in the morning. One

of the reasons why our budget is so big is that we have doctors earning, you know, probably not the greatest doctor's salaries, but they are in the realm of doctor salaries. That can really run your budget up.

Reti: Where is the funding coming from? Who are your primary supporters?

Benedetto: It comes from a variety of sources, from client fees, which can be anything from zero to the top of our scale; from third-party payers, which would include MediCal and Medicare, which again, for the most part don't pay 100% but pay something. We have a small state grant every year for providing subsidized care. Well, it's getting bigger actually. It's about \$40,000 this year. We get foundation grants and we do fundraising, receive donations and have special campaigns. During almost three years of managed care operations we were heavily supported by foundations for some operating costs for hiring the doctors. We needed to hire RNs and have a RN presence, which we'd never had. All of those things were expensive and came from foundation grants to assist us, maybe not for what we considered to be the right reasons. Maybe the foundations thought managed care was the greatest thing and they were so happy we

were going to be involved. It's a combination of all of those things: fundraising and grantwriting, foundation grants, state and federal government grants, patient fees, insurance and MediCal—all of that together is what makes up our financial picture.

Buying the Building

Reti: Okay. And now you are expanding in this building and possibly building a second story?

Benedetto: We're probably not building a second story. We bought this building in October of 1997. We've been renting this building since before I got here.

Reti: You've been here as long as I can remember.

Benedetto: Yes, it was on Chestnut Street for a short time without a clinic, and at people's houses before then. But in terms of being an office that people came to, this is probably the only office that's ever been. Our landlord inherited the building from his mother. One day he just walked in my office and said, "I'm selling the building." In 1992 when we did the

renovation and expansion, we had written into our lease that we would have to have the first option to buy because we had put a lot of money into this building already. So that's what happened. We had a very short period of time in which to decide. We basically had the greatest realtor on earth and she helped us look elsewhere. After looking at other places to lease and to buy this really was the best and only choice that we could come up with.

Using all of the space in the building will minimally meet our needs. We may someday build a second story, but it's a much more complex issue than one might imagine. It's an engineering challenge. We'd have to spend probably \$10,000 to even determine if we could build a second story. Before we bought the building I had an engineer look at the building and give me some advice. He thought it probably could support a half story up there. We need to have an elevator. That's \$40,000. So you know, it may be at some point that we move some things out of here, as much as I would hate, philosophically, to move administration out or the business office out. We may need the space clinically for education, and for some of the other programs that we're trying to invigorate right now.

Our plan right now is: we inherited a lease that we had to and wanted to honor, contrary to what the *Santa Cruz Sentinel* reported. We basically worked with Herland Book Café to do what they want to do. They wanted to close the café and get out of their lease early. We let them do that. We're sitting there with an office that we really can't use for a variety of reasons, and we're not going to renovate twice. So we're going to partially use it, until they're out of the rest of the building, which at this point will probably be next spring, at the end of their lease. There're certain parts of this building we never really finished, never really renovated. So we'll probably do a major renovation at that point, tie in the other side, update our medical equipment, and our reception and office furniture. We need to do something a little different about kids in the waiting room. We'll do a bunch of those things at that time.

Reti: And you had some help from the city of Santa Cruz?

Benedetto: They gave us a short-term loan for the down payment until we could raise the money to pay it back. That was a huge loan, \$228,000, a lot of money. Our mortgage is now what we were paying in rent.

Reti: That's great. How is your relationship with the city?

Benedetto: Excellent. Many years of putting time in on both sides. Excellent relationship. I was grilled by the city manager, Dick Wilson, which makes sense. He had me in his office and said, "I hold you personally responsible for this loan. If you . . ." And I just said, "I've never done anything but do exactly what I said I was going to do. So you have no reason to worry about this because we would never default on a loan." Which is something not that unusual in people borrowing government money, but . . . so they were tremendously helpful.

Alternative Healing

Reti: I thought we could continue by talking about how wholistic health is integrated into the Women's Health Center.

Benedetto: Okay. Wholistic is sort of an old-fashioned word that's rarely used anymore, actually. It's more of a philosophy than a healing modality. It used to mean both. And in my experience, wholistic now means an approach, not a practice. Why don't you tell me what you mean by wholistic so I know how to answer the question.

Reti: Treatments like acupuncture and massage.

Benedetto: Those are either called complementary therapies or allied health professions, or just what they are, whereas wholistic health is more of an approach which says that a person is everything that they are, and everything is connected. You can't just treat a person's symptom, but also the person's emotional and spiritual health, as well as physical health. In my mind, that's what wholistic means. You could be not wholistic and do acupuncture. You could be wholistic and do any modality.

Basically, our clinical services are derived from the Western medical model. There's no doubt about that. That's why most people come to us. It's what we primarily do. We do offer acupuncture services here and we do have a mental health counselor who works with us. We do work a lot with chiropractors and refer to and work with herbalists, and home birth midwives.

But in terms of what we do here, things are changing rapidly in medicine. For instance, three years ago there was no major manufacturer utilizing herbs directly, producing herbs for consumption, other than in a

pharmaceutical way that's part of a medication that was recognized. As that changes I think you will see more and more herbal medicine integrated into all practices, because that's what the public wants, that's what they are asking for, that's what's selling. You also have the major pharmaceutical companies and over-the-counter companies producing these things. Whether that's good or bad, I don't know. There used to be constant warnings that we got from the FDA and from these companies about not allowing patients to take matters into their own hands and take herbs. Now some of those same corporations are themselves producing herbs without any more study, really. It's really questionable whether that's good or bad. They decided there was money to be made in herbs, and luckily they do sort of coincide, I think, with the herbs that are being used nationally. They tend to be the herbs that are tried and true, like echinacea, Dong Quai, St. John's Wort—these things that have been used in Europe for hundreds of years.

The European model is that you can go into a pharmacy and get herbal medicines and what we consider to be pharmaceuticals. The pharmacist is equally knowledgeable about both of those and there are all kinds of

compounds that have been used for centuries that work. We've never really had that model here. That model is also in Mexico and some Latin American countries.

What most clinicians have told me is that there is time in your life to be a physician, a nurse practitioner, or an herbalist. It's a very rare person who takes the time to study more than one modality and do it well enough to be able to offer that service. A physician can basically become an acupuncturist by taking a six-week course in acupuncture. They do not follow the same regulations that someone who is not a physician does. In many other parts of the country you have a lot of physicians who for pain management learn acupuncture and hang out their shingle as acupuncturists. It's been hard to find a Western-trained clinician who also knows about wholistic health. Then there's a licensure issue. We are a community clinic that's licensed and so we have to be really careful not to offer what's not licensed. In this country herbalists are not licensed.

If you define our practice as everyone we refer to and work with, we include modalities other than Western medicine. But in the physical walls of this building, we give a lot of emotional support. We prescribe

some herbs if the clinician is knowledgeable. We refer a lot to massage practitioners and chiropractors and . . . stress reduction and hypnotism and all kinds of things. But most of our clinicians here are trained in a Western medical model. For instance, in this state naturopaths are not licensed. That's a model in which a person operates as a medical doctor and also prescribes herbs. We had a member of our board who is a naturopathic physician who lived in this community for awhile. She went and got her acupuncture license. Once you've got a license . . . As an acupuncturist she could do a lot. But if she wanted to prescribe something Western she couldn't, because her degree was not recognized in this state. Chiropractors use herbs a lot. They use their chiropractic license. So part of it has to do with where we happen to exist. I think there's room for real growth here, in terms of using more complementary medicines. Integrating our acupuncture services more into what we do, I think, would be a direction for us to look at.

Serving Older Women

Reti: How has the Women's Health Center dealt with issues of ageism, or aging women? Those are two separate questions, in some ways.

Benedetto: Well, there are a couple of ways I can think of to answer that question. One of the things about being around for 25 years is that the agency ages and the people who've been here for a long time age. So there's a natural growth and understanding of issues, at least to mid-life women and beyond, simply by the age of the people who we have represented.

Two aspects of this are our hiring practices and who is on the board. It's easier for me to think about it on separate levels. On the board level, recruiting women over 60 has been important. We've successfully done that over the last ten years or so. We've always had at least one woman over the age of 60 on our board. We also have a goal to have someone under 25 on our board. When I think of ageism, I think of it going all ways. More prejudice happens for younger people, but more discrimination happens for older women, so we often think of or prioritize discrimination over prejudice concerns. I think people have a lot of prejudices about young people, but in terms of open discrimination, it's a young person's world in a lot of ways.

We've been here 25 years, so clients who were 50 twenty-five years ago, are now 75. We have families that have three generations coming here at this point: daughter, mother and grandmother, and in some cases great-grandmother.

Then there are also issues that arise, or opportunities that arise that might bring somebody into your practice. You might look at the age range that you are serving and you might say, where are the 50 to 65 year-olds? There are three things that have happened that I can think of.

One is we made a conscious decision about eight years ago that we wanted to serve more women at that point over 50. We set out to do that by trying to contact women and let them know that they could come here, even though they weren't necessarily thinking about reproducing. Women still thought of the Women's Health Center as a reproductive health center. And so we did that in a very conscious way. That was very successful. We started doing a lot of work on menopause because that service brings people in.

Another thing was being members of the Breast Cancer Early Detection Project, which offers free clinical breast exams and mammograms and biopsies if needed, to women fifty and over, or forty and over, if they have symptoms or a family history. We're listed as part of a state network so we get referrals for people for that program. And there's a lot of outreach that also happens in a tri-county area.

The last thing was totally unexpected, but something that we were really pleased with in the end. When the MediCal managed care entity started—I won't go too much into the boring technical details of managed care—but one of the ways that MediCal works is that if patients don't choose a provider they are auto-assigned to a practice. The providers are allowed to have some limitations for geography or gender, if it fits into what your practice is. Because at that time we weren't yet doing pediatrics, and we didn't see men, that left two categories of patient aid types, codes that were auto-assigned to us: women with disabilities and older women in significant numbers to our total county population. Significant. We have one of the largest practices of women who have MediCal who are older or have disabilities in the whole country. You have to be very low

income. You qualify for MediCal even if you have Medicare, if you have an income that's 100% below the federal poverty level. So it's the same guidelines for anyone else. We didn't realize how many people didn't have doctors. We thought, they have Medicare, they are taken care of.

We've discovered two things in the process. One is that there were quite a few low income women who had MediCal and Medicare who might have gone to a specialist if they needed them, and used their Medicare, but did not have a primary care doctor, one person coordinating all their care. So we became that for them and we're actually very successful. So that's the client side.

The staffing side . . . we're very well represented in the younger ages and the mid-life. Probably our age range of people who work here is about 19 to 60.

Reti: That's a pretty good age range.

Benedetto: Yeah, I'm always thinking we can do better. I'm thinking, well we don't have anyone seventy! In terms of the bigger issue, the way you

actually posed the question, how do we deal with ageism—any of our own biases as individuals or any sort of internalized discrimination we have as an institution, we always try to be aware of and work on. Sometimes you just stumble upon it. You turn around and look at who you have, who you have working there, who you have on your board and you realize that there must be a conscious obstacle to serving certain people or involving certain people.

The process of how people are treated is a major issue and I think we do a really extraordinary . . . I can't even say *we* because it's not me, I'm not interacting as much with our clients at this point, but I think the people who work here do an extraordinary job of treating older women with respect, helping them to access the care that they need and at times to deal with very difficult times in their life. I'm very proud of that. Ironically it's something . . . everyone gets older. Everyone doesn't become black. Everyone doesn't become a lesbian. Everyone doesn't become disabled, although many of us do. But getting older is something we all do. You learn by experiencing either your own parents or grandparents getting older. The attitudes that you have when you are really young

change when you're not really young anymore. And when there are enough of you as the core of an agency it shifts your points of view.

If anything, I think we need to be conscious of making sure young people are represented here on every level. I think at this point we have the other end covered. But we need to make sure that we consider the concerns of young women, that we're treating them with respect and respecting their choices. I think that consciousness is not so much on our mind lately as older women's issues, because of the change in our practice in the last four years.

Serving Lesbians

Reti: Okay. I have a series of questions along these lines. What about lesbians? How do you respond to the lesbian community?

Benedetto: The Women's Health Center has this reputation and always had long before I got here, of being a lesbian-run organization, which has never been true and still is not true. It's always been a combination of heterosexual and bisexual and lesbian women who have run this place. The reputation certainly is there but whether or not it's true . . . And it's

one of those things; you don't want to deny that that's true either. (laughter) You know what I mean? When people say that . . . we pretty much have people trained regardless of their sexual orientation not to say no, we're not! (laughter) There are times when you have to elaborate a little bit more. But we hear all the time that it's a bunch of lesbians over there. We don't say oh no we're not. We might engage in more of a conversation about what makes them think that. Is that problematic for them and what does that mean for them? But certain things have changed. The agency did publish *Lesbian Health Matters!*,⁴ which was the first book of its kind. It put the agency on the international map in that regard. Ironically, many of the women who wrote that book no longer consider themselves to be lesbians or they are . . . maybe they do consider themselves to be lesbians but happen to be involved with men at the moment. I'm always saying that just to show that sexual orientation also can be a continuum for people, and the important part is the awareness and embracing and welcoming . . . putting yourself in a position to welcome everyone.

⁴Mary O' Donnell [et al.], (Santa Cruz, Ca.: Santa Cruz Women's Health Collective).

Sometimes in life you make decisions that have repercussions, and you may not want those repercussions, but you have to live with the consequences. For instance, when we made certain decisions to really diversify our client base ethnically, to fill a certain need in terms of prenatal care, to provide pediatric services as part of a feminist vision, there's no question it alienated some of our lesbian clients who really wanted and legitimately so, to come into what they considered to be an all-woman environment. Some of them told us so directly, and some of them told us with their walking shoes to somewhere else. There are now three, that I know of, relatively "out" lesbian physicians in this town, so there are alternatives that people didn't have before.

We have discussed this really long and hard, about taking responsibility for your decisions, what that means, and how things appear versus how they are. What we've decided at this point in time, is that if serving a more diverse ethnic community, and knowing that in order to do this we had to welcome their families, not necessarily medically, but into our waiting room, was going to alienate people, we had to decide that that was more fully carrying out our mission, and we could not preserve a

pretty much women-only space. There are times when there's one person who is a patient. There's a woman who has six people with her—kids, men, women—and that's a part of cultural diversity. Or when you see older women and they are accompanied by their sons . . . we had to make some decisions that made us way less identified as a lesbian clinic.

We decided if the lesbians didn't feel comfortable here, I don't mean this as defensive as it sounds, we decided that maybe this wasn't the place for them at this point in our evolution and theirs, and that's okay with us. We would help in whatever way to direct them to where they needed to be.

But we have a similar feeling about heterosexuals or . . . who knows if they are heterosexuals, but people who are very disturbed by having any mention of gays and lesbians in our waiting room, or by our staff, who are very "out," that this is not the place for them. We're not going to make any excuses. We're not going to pretend that we are not a very lesbian-supportive and identified agency to a degree. If someone doesn't feel comfortable here they have other choices, and we will help them find them. We will stand behind being a place for everyone, which includes lesbians. This is also a place for people who want to have their male

partners, sons, and fathers be able to come with them into a medical practice.

Women Living with Disabilities

Reti: Other than through managed care, are there ways that you've tried to respond to women living with disabilities?

Benedetto: Well, it's always in our mind that we can do better. The whole world is not set up for lots of things in life. Certainly there always has to be an awareness that this is a societal problem that's a little beyond us. There are things we can do. We can look at the design of our building, and anytime we do a renovation we've put a lot of thought into that. We've put a lot of thought into having an exam table that goes down to wheelchair height, which was three inches. Most hydraulic tables only go down to 21 or maybe 23 inches. Ours goes down to 18. We had to search nationwide, look in catalogs for disabled people, and even then we could not find a gynecological table like that. We had to have stirrups manufactured, put on, and machined. It cost us \$5000 to get a table, so that if a woman did have upward mobility she could get herself on the

table and also we wouldn't be lifting people so high. From a wheelchair to an exam table, if you think about how high that is, it's a lot. So we've put a lot of thought into some things.

There's some training that we do. There was a really great organization a few years back that put out this guide to pelvic exams for disabled women. It gives tips about different kinds of mobility issues from the clinician standpoint, and it was really great in terms of helping our people learn from the gynecological end of things how to deal with it. There's training that we get and give to our clinicians, our volunteers, and our staff. And I think there's always more that we can do.

For instance, if someone was sight-impaired and came into our waiting room there's really not much for them. We've gone back and forth. We used to have some things in Braille. Well a lot of people are not learning Braille any more. You get immobilized thinking, well what do you have—tapes—what is it that people use? You are sort of reliant upon disability advocates to tell you. That's an area I'd like us to still think about, just in terms of our waiting room, having some really big print things there, or maybe tape recorders that we could lend while someone is sitting there so

that they have something to listen to while they are waiting, like other people have things to read. Those are the areas that I think we could improve upon.

For a long time, well actually ever since I've been here, we've always had someone on staff who can sign. And right now that person moved back to Mexico. She signed and she spoke Spanish, which is very rare. We have some very limited signing now. But it's never even been a thought. We've always had two or three people here who could sign. And so that's always something, to make sure that someone can come in, or we can arrange for a translator or something like that. Fax machines have greatly improved our ability. Some of our patients we correspond with through faxes back and forth and really don't have to use the operator anymore. There are some technological things like that that have been great.

We've on and off had people with disabilities on our board, or we have people on our board who become disabled during their board term. Society is in flux over who [is considered] disabled and uses that label. It used to be a very clear thing, and it's no longer clear. Sometimes someone will be on the board for a year, and say well I'm really disabled, I have

glaucoma, or I have diabetes, or I have arthritis, or I have lupus. When something is a larger societal question it's hard to say well, what do we mean by disabled?

Reti: What do you mean, that's changed?

Benedetto: Well a few years ago someone with diabetes would not call themselves disabled. It was if you were blind, if you were deaf, or if you were in a wheelchair, "retarded," or if you were developmentally disabled. It was very limited. It did not connote chronic illness, necessarily, unless it impaired your being able to walk, talk, hear, or see.

Reti: It was defined in terms of the senses.

Benedetto: Right. But the Americans with Disabilities Act actually expanded a lot and so people's consciousness has changed about . . . yes, I'm disabled, I have arthritis pain. So it's a little bit more of a tricky question in terms of representation on our board. If someone asks me do we have someone in a wheelchair on our board, I'd say no we don't at the moment. But do you have people with other kinds of disabilities? Yes we

do. And would the “disability community” look at our board and say you have a disabled person on your board? I don’t know the answer to that question at this point. But we are always recruiting for the board from that community, since it is a part of our population that we serve.

Reti: It’s amazing what you have to think about.

Benedetto: There’s a lot to think about. And then when you talk about staff recruitment, that’s a whole other thing. If we look at numbers I would say that’s the area that we have done the poorest in terms of either recruitment or hiring people. It’s not like we have a lot of people applying that we’re not hiring. It’s a major issue. You really need to think about your workplace. We’ve done a series of renovations, which is really different from building something from the ground up. There’re certain things that you inherit and there are others that you can change on a limited budget. I think that’s an area of the agency to look at. What are the obstacles to someone with a disability working here? What positions have we created that someone with different disabilities could do? So much involves the physical building, equipment, and expenditures of capital. We need to think about these questions for the future.

Staffing Issues

Reti: Let's talk about staff. What would you say are the challenges and rewards of being a staff person at the Women's Health Center?

Benedetto: We've gone through tremendous change in the last four years. Tremendous growth, which affects what's being expected of people. You know I have this fantasy of working for Cellular Phones because every time I walk down the street there's someone there reading a book. (laughter) Nobody here has a job like that. It's a very demanding workplace. The community really demands a lot of us. We demand a lot of ourselves, but we've taught the community to demand excellence and competence. There are very high expectations of us in everything that we do. There are a lot of places you can work other than this where you are allowed to make mistakes. Most people are not very understanding in a medical setting if you make a mistake. Just think about it as a patient.

If you add on to that our goals for ourselves of excellence, there's a lot of pressure. Over time, even when you have a very good staff retention rate, which we have, people leave. The minimum here for most people is five

years. When people are leaving they are taking five, eight, ten, twelve plus years experience with them. People say, oh people aren't irreplaceable. Well I don't agree with that. I think people are irreplaceable, because people are complex and give a whole variety of things you can't replicate. Someone might come in, who in their own way is just as valuable, but in terms of spirit and morale, which is what we're talking about, it really affects morale when you have long-term staff people leave. But that is less of an issue than the fact that in the last ten years our staff has grown from eight to about twenty-something people. We're adding four to five positions this summer alone. That makes it a different kind of workplace. The morale changes a lot with what's going in the outside world, what's going on in the medical field. There are times, honestly, anyone in any kind of service endeavor . . .

It's not just that . . . we live in a stressful place. I think modern life itself has a certain degree of stress to it. We're in a transition period because of the expansion and also our decision to do primary care, pediatrics, and managed care, which means we're not competing, at least not yet, for clients but we are competing, in a business sense, for survival. We need to

operate as a business as well as a community organization. That in and of itself puts a lot of pressure on people.

I look at staff retention as the bottom-line measure of morale. There are certain positions here that we have a hard time filling and retaining. Then there are some where the minimum time someone would ever seem to be here is about five years. In modern life at this point four years is the average that people stay in one profession, or even in one corporation . . . you know I've missed the boat because supposedly you're not supposed to stay anywhere more than four years anymore because there's no benefit to it. And in fact there are a lot of disadvantages most places. Government jobs are a little different, but retirement plans don't reward longevity anymore unless you are in a government-type situation. In the corporate world and even in the more creative world, moving every four years is the way things are going in the U.S. right now. So I look at staff retention as the ultimate measure of morale.

When I first came here everyone did almost everything, with the exception of medical treatment. It worked for a few people really well, who loved to have a variety of tasks and complexity, but for most people it

didn't work. They told me it didn't work. So we've played back and forth with streamlining jobs, cross-training, a whole variety of things. We've tried it all. What seems to be the practical thing to do is to create a true hierarchy. We definitely have a hierarchy at this point, of which there is a bottom. The bottom includes entry-level positions in which people don't need to have that many skills, don't need to use that many skills. And those, surprise surprise, are the positions that we have difficulty filling and retaining. Whereas the jobs that have more parts to them, that are more complex . . . There doesn't seem to be a practical solution right now for that. We've tried it both ways, and haven't quite figured out how to do all the tasks we need to do, utilize people at different levels of skills, take their families into account, and everything that we need to take into account, and build jobs that make sense and reward people.

If you really want to understand staff morale you have to do pretty in-depth interviewing of all staff. But in general I'd say it fluctuates a lot. It kind of depends who you ask at what point in time. I think we've been through a rough patch, just in terms of transitions. Hopefully at the end of this period there will be a sense of stability and safeness, which I think

for most people is what creates a sense that things are okay. People don't do well when you have too many changes, like every week there's a new face. You asked me at a time when there's this patch of that and I think when we're over this patch it will be fine. We are constantly rediscovering how you build some kind of democratic management into a place with around twenty people. You have people who are just looking for a job and you have people who are looking for a cause. You have medical professionals who are weighing you against all their other career options, and some who are here for political reasons, or some combination of the two or three. When you want to be fair and when you have ethics, things are much more difficult. (laughter) In some ways, not in the payoff. I think it actually makes good business sense too. There're just certain things we would never do here because of a sense of ethics, that are considered basic business practices. It takes a lot of forethought and respecting of people, and a continual reminder that we are creating this, that we do have power and control within the law and within our clinic license of what we do.

Beyond that the “them” is us. And a dynamic sometimes does get created of us and them. I suppose if there’s ever a “them” it’s me, you know, and I’m sort of the aikido kind of “them.” If I step out of the way of something then there is no “them.” I don’t know what your experience is working at the University, but there’s a certain “us-and-them-ism” that’s kind of healthy in a work environment. When you don’t have that it can turn in in ways that can be very unhealthy. An identified enemy, or a potential enemy is much healthier than feeling anyone around you could become the enemy. A long time ago I had to reconcile with being the boss.

We talked a little bit last time about the job I came into versus the job I have now. It’s not what I signed up for. I really believed that I was coming into much more of a collective, cooperative thing than what happened the first couple of years. I struggled probably for about four years of trying to not be the boss. I really didn’t want to be the boss. I certainly wasn’t paid to be the boss. I kept trying to find ways where I had certain tasks but I really wasn’t the boss. I had to accept that and let other people lead, in terms of what kind of boss they needed me to be. For better or worse, I

became the kind of boss that people around me wanted or needed. Some of it could be overt, like someone has to take control and you're it. Or it could be covert, like there are certain standards that must be met. If other people are not taking responsibility for certain basic things, I'm the one who says no, this is not acceptable, this is not what the community demands and expects and deserves. I don't have a conflict with that anymore. It's not what I signed up for. It's not really what I wanted to do. But once I stopped fighting it, it was a lot easier for me to have that role. When you have twenty-something people it's just a really different kind of situation than eight or nine.

Volunteers

We've made some major changes. Volunteers used to do very different kinds of things here. We clung to volunteers doing certain kinds of jobs, and it was creating certain kinds of problems. When we surveyed our clients, what was so important to us as staff, was not important to them at all. What was important to them was competence, being able to have appointments around their work schedule and their children. To them

these volunteers whom we loved and still love so much were slowing them down, slowing their appointment down.

So that's what I mean. When you really involve people, structure a way of asking some questions, and are willing to really seriously take what they think . . . that's how we ended up doing pediatrics. It was important to X amount of our clients that we do peds. That's a very important part of strategic planning, to involve the community in some way and get out of your own little box of thinking.

Doing that process, continuing our pursuit to pay liveable wages has become a major issue for this agency and for many because a liveable wage in this community has a totally different meaning than the rest of the United States. (laughter) You know?

Reti: Yes. It's terrible.

Benedetto: The idea that gets thrown around a lot is nine dollars an hour is now considered the liveable wage.

Reti: You can't live on nine dollars an hour in Santa Cruz.

Benedetto: Right. So most of our entry level positions here are now about nine. But you wonder about that.

Then the education and advocacy point of our work . . . that's where we need volunteers. Personally, I think, except for some very few select people who are on their way to medical school or whatever, I think where volunteers in the community belong are in education, advocacy, and outreach—helping us with strategic planning and things like that. That's where I think we most need community members at this point, to help us refocus a little bit on the education and advocacy part of what we do, to try to define what that should be and do it well.

Reti: How does the Volunteer Health Workers Internship Program work?

Benedetto: Well historically it's the oldest program we have, since this was a volunteer-based organization for years. At this point we've trained probably a minimum of five hundred women, from our inception. It's a very important part of what the Women's Health Center does. Regardless of what they do here, the thing about that training is that it involves classroom training, homework, and on-the-job training. In the classroom

training women learn a lot about their bodies. Some women have never worked with all women in their entire lives, and so there's an incredible bonding that goes on, and it's eye-opening. We deal with issues of sexual orientation, with abortion, but in a way that people can really talk about all of their feelings. We talk a lot about class.

Reti: So you're talking about a structured training program?

Benedetto: Yes. Everyone goes through a very structured training that involves a weekly class of three hours. Reading, homework assignments, and training to work four hours a week in the agency in some capacity. We usually ask people to make an eighteen-month commitment. Most don't, lately. And that's part of the re-examining.

What we've decided is that the training itself is valuable. We may in the end decide to do mostly the training and take on very few volunteers to actually work in the agency. The information is valuable in and of itself. We have probably about sixty doctors now among our former graduates, which is incredible, and many other people who are in the health professions, and who are political activists and labor union organizers. It's

a feminist incubator. People come who really are not formed in their ideas about life, or about politics, or about their own bodies.

It's a great forum for people to explore what they really think about things, to be in an environment where some of their ideas might be challenged. I think it's one of the most important things the Women's Health Center has ever done and will ever do.

It's the actual figuring out how to get people to work in this physical building at this point which is a huge challenge for us, and also just making sure that the jobs are enjoyable and fulfilling. I feel a big obligation to volunteers. I'd rather have nobody, than have somebody who is not doing what they want to do and it's not fulfilling. Some people just want to be of service. And those people I kiss their feet. They will do anything anytime because they have their own reason for wanting to help, and realize that everything needs to get done in an organization. But those people are rare and are jewels. Most people, and rightfully so, have something they want to give and something they want to get. From my point of view, if you can't give the give part, if you can't give them what they need, you have no right to take what they have to offer. You really

have to cultivate and prepare an environment that's ready to accept volunteers and utilize them well. We do that to varying degrees, depending on what else is going on here. When you have a lot of paid staff coming and going it's a really hard time to take on volunteers. This year, for instance, we'll probably just take on about ten people. All paid staff people have to go through our training too. It's part of our orientation. There will be about seven staff members and ten community volunteers who are all going through the classroom training.

Reti: Who teaches it?

Benedetto: We've done it all different ways. You can imagine in 25 years every way of doing it. We've probably had two people teach it at one point. We've probably had sometimes where every class was taught by someone outside of the agency. Now there's probably an equal mix of bringing in people from the outside and staff people here teaching. And former volunteers and current volunteers. All kinds of people teach. It's a really fun, enjoyable thing that we do that I love doing. I'm always seeing volunteers, no matter where I go and that's a really great connection.

I've made a lot of personal friends that way. A lot of extraordinary people find their way here. A person who is a very close friend of mine is English. She was taking a break from medical school and she called me up one day and said, I'll do anything. She was one of those "I'll do anything people." She went through our program, stayed here for almost two years, and did any number of things—studies, worked in the front office, helped out as a medical assistant. She did everything. She's a really wild woman. She also reads Tarot and is a psychiatrist, now in England. So I've personally made incredible connections with people who found their way here into our program. A lot of our staff people are former volunteers. Less so than in the past. But that's how a lot of the people who ended up working here began here. And still is to a certain degree.

The Future of the Santa Cruz Women's Health Center

Reti: Could you talk about what you see happening in the next five years, the vision of the Women's Health Center, and how you fit into that?

Benedetto: We've pretty much always operated on a strategic plan since I've been here. I don't know if you've ever been through a strategic

planning process. It's a little harder in a big bureaucracy to make your dreams come true. But here it's been really miraculous. We've done three in the time that I've been here. One was when I first came. We probably should do another one. We used to do three-year plans and then we moved to five. So we've done three and tried to do one three years ago. And because of managed care, and so many clinics throughout the whole country closing just because of the business part of medical care, what the consultant that we used told us is, you cannot do a strategic plan; you have no idea what's going to happen. Your strategic plan has to be to respond to this challenge of managed care.

So we did. We had a strategic plan that had some small parts to it. The first part was: we want to survive. We believe we can. Therefore we rededicate ourselves to our feminist mission. We're going to do two things. We're going to move forward in a business sense but we're also going to cling to our mission like nobody's business. There're certain things we will not give up and will not do. Then we had a whole list of the things we were going to do: hiring RNs; hiring different kinds of doctors; changes in some personnel policies that would benefit the staff; upgrading

salaries. We've basically done all of that. Right after that the building came up for sale. We didn't choose that. But in hindsight it's probably one of the best things that ever happened to this agency in the long run in terms of the future and assets . . . things that I would have never thought about, not coming from landowners. But it happened. And it took us about two years to do that.

So five years down the road we're without a strategic plan. We really need to do one and I think we're in a position to do one. We're in the best financial shape we have ever been, and that's lasted for about three years. That enables us to do a lot. It enables us to envision beyond this point. I can't really say what we should be doing in the next five years, other than to really be doing a full strategic plan process that involves not only the volunteers, staff, board, clients, but also the community at large. We've done it in a variety of ways. We've made a video where we interviewed people. We've done surveys and questionnaires.

Reti: Interviewed people in the community?

Benedetto: Oh yes, we had one of the board members walking down the Pacific Garden Mall. She had an idea of what she wanted to capture— what do people think of the Women's Health Center and what do they think it should be? That's how I know people think we're all lesbians, because if you randomly ask people on the mall what they think . . . they'll say, oh yeah, it's a bunch of lesbians. It's not for me. So that's what I mean when I say strategic planning, is to try to come up with a methodology that includes the community at large to some degree.

I believe that women and children deserve a beautiful place to come to, particularly low income people. I would like to see this place create a beautiful, workable environment where people feel valued when they walk in the door, [feel that] the way this place looks is that I'm an important person and I deserve to be in a beautiful place. I think you can do that within a reasonable budget, it's just a matter of how you're looking at what your goals need to be and how to make the facility work for people. We don't have a great waiting room right now for kids. The noise level can get pretty wild.

Then specifically on the advocacy/education issues, there're some areas that I'd like to see us take more leadership in, like the breast cancer issue. We are involved in the local consortium.⁵ We've been so focused on making the medical services work for our clientele which we so painstakingly developed. I think we're at a point now where we can really look at a little bit more broadly what health is, how to be more of a presence in the community in terms of a health message and an education message, as well as a medical message. I think that's a big part of what we do, but I don't think it should be the only thing that we do.

Assessing the Directorship

Reti: How have you managed not to burn out? Or maybe you are burned out.

Benedetto: Well I can't say I haven't burned out several times. I've been here for fifteen years, so there's plenty of opportunity to burn out. I feel like I've had at least three, five-year jobs. It is so totally different from the

⁵The Central Coast Women's Cancer Consortium oversees the Regional Breast Cancer Early Detection Program which encompasses Santa Cruz, San Benito, and Monterey Counties.—
Editors.

job I came to that it's hard for me to connect to that person, but what's even harder is to connect to what I did then versus what I do now. Part of it has been challenge; burnout comes from different places, but boredom is part of burnout. I can say I have never been bored, ever, in this job. But if it's about fatigue and stress and problems, there have been times when problems can seem absolutely overwhelming, and those are times I think we all have in our jobs, any of us with stressful jobs.

How I've dealt with it in the past, is keeping my eye on my goals and keeping focused on what I think is important in trying to deal with problems, but not have them take over my life and obscure the greater purpose. The sense of satisfaction that I have has far overshadowed any burnout. We do constant service evaluations here, and we also collect and encourage complaints, and deal with all complaints. There are not that many businesses where you really know what people think. For better or worse, I really feel like I know. Overwhelmingly, people love this place and so appreciate what we do. There's just not much in life like that. I really consider complaints a blessing and a gift, because for every one person speaking up, you know you have ten who didn't, and it's a chance

to improve and make things better. When we do our service evaluations our approval rate is 99-100%. It's outrageous! And the complaints are for the most part very valid and very focused on either human mistakes, which everyone makes, or things really out of our control and everyone's control, but nonetheless unacceptable, that have to do with our society and rules that we have to adhere to. So that is very reinvigorating for me.

The other thing [that helps prevent burnout] is the closeness of the personal relationships I have with people I work with. My job is totally connected to the work of others; in fact my job is totally reliant upon the work of others. That's a very commanding sort of relationship to have with people—in which you really respect people whom you work with, and you know that they are working very hard, and have the best of intentions. You know that when problems arise you try to work on them, but in general people are not here to create problems or to slack off. People work very, very hard here. That to me is rewarding.

Then there's just a lot of variety, for better or worse. You never know what could happen at the Women's Health Center on any given day. Really. Anyone could walk in the door, and I mean anyone. I mean *anyone*! From

a news personality, to a cultural icon, to a homeless person off the street who maybe used to be a cultural icon. Anyone could walk off the street wanting to get something or give something. Or the street could get flooded and I'd have to close down the street single-handedly in four-feet of water, which happened last year during that rain. You never know exactly what's going to happen here.

Sometimes I wish some of those things wouldn't happen. Not everything that happens is good. There're earthquakes and potential floods, and there's also some heartbreak too. Some of our clients have really hard lives. We encounter a lot of domestic violence. We encounter a lot of child abuse and sexual abuse. People sometimes come here who don't need medical care. They need tender loving care. There's all of that. But that's not boring. It's many things, but what it's not is boring.

This is a wonderful place where wonderful things happen and lives are transformed. The people who work here transform their own lives by what they do and being the best they can be, but also there are clients of ours . . . no one has ever listened to them. Those of us who have good friends, or who have ever had therapy may take this for granted, and

forget there are still people who have no one to listen to them. No one! Sometimes I am really annoyed and I know I have a lot of work to do, but there's someone in front of me who simply needs to be listened to and guess what, I'm the one. I'm the only available one, or I'm the one standing there, or I'm the best one or whatever. You have to stop and think, okay, what's our greater purpose? Part of what I need to do here today is listen to this person who doesn't really want anything but to be listened to. That's a huge challenge and I think really important. I give a lot of credit, particularly to our clinicians. We have a lot of clients in our practice right now who are diagnosed with psychiatric disabilities. To do that job well and with integrity, is a big job. Again in a system that totally fails people. People will use, understandably, the service, the access that they have. Then you become all things to all people. It's really challenging for everybody involved.

I probably feel the most insulated that I've ever been right now. Some of it has been very intentional. One of the things I've tried to do is to delegate more and not feel like I have to have my nose in everywhere. To be

honest, I still have those tendencies. It's just my nature, but I try to fight my nature.

I keep in contact because I'm around a lot and I am a very proactive kind of person. I don't just stay in my office. I talk to people. A lot of our clients know me because I often will help somebody at the front desk. I sometimes do the work at the front desk. There're a lot things I still help out with. I do it on purpose. There's a very functional way that I do it. Also, it's one of the few areas where I can help out, at the front desk. I know the most about those functions of the agency, versus being a medical assistant at this point. At one point I could almost do every job in this agency. I taught myself to do it, so I would know what people needed to do. Well you can't do that forever. And if you really, truly delegate you don't know.

People are sometimes shocked; I remember one of our patients was shocked that I didn't know that she had breast cancer. I told her, well you know confidentiality, we have a rule here. Nobody opens a medical chart unless they have a reason to. Just working here and knowing somebody is not the reason to open that chart. Even if you open that chart you only

look at what you need to look at. Part of it for me is confidentiality and wanting to respect people's privacy. The other night I went to hear Reuben Blades at the Catalyst. I was looking around and I kept thinking, how do I know all these people? And it finally dawned on me that many women in that audience were our clients. Young Latinas. It was a big relief because I'm the kind of person who has to remember where I know somebody from. (laughter) It made me feel really good, but, I thought, okay, I need to not go up to these people and say, where do I know you from. When I don't know where I know somebody from I let them say hi to me first, which many of them do. They want to talk about their medical problem with me when I'm dancing, even though I don't really want to. The longer we are here as an entity, and the longer I'm in this community, I really respect people's privacy. In the past, when I was a lot more involved, trust me, I just knew too much. I knew which lesbian was, using her exact words, slinking in here to get birth control because she was having an affair with a man but didn't want anyone to know! Well, I'm not the best person to know that at this point. Not that I would tell anyone. I would never tell anyone. I hold a lot of secrets. But I don't want to know those secrets. I want people to have a sense that they don't need

to see me every time they are in here and tell me why they are here, especially people who I know, and I know a lot of people. That doesn't mean that I'm not out in the front room a lot, that I don't talk to people, that I don't know people. But it means I don't know any longer, and rightfully so, the intimate details of their life unless they tell me, or unless I have to help them with a problem.

Because of my background in mental health a lot of calls still do get referred to me. We all here develop our areas of expertise. Sometimes I really stumble on it, like when the agency needed somebody to rewrite their booklet on herpes. Well, I've never had herpes. I've never been particularly interested in herpes, but I love to write and I love to do research so I'm now sort of this expert on herpes.

There're several topics that I have learned a lot about over the years. I do know a lot about breast cancer. I know a lot about endometriosis. So I do talk to quite a few people on the phone and sometimes in person who need counseling, advice, or education on those topics, and I stay in touch also that way.

It only occurred to me, really, in the last ten to fifteen years when people come and interview me from the University, how unique it is that I am working in the field that I studied at the University, which was women and health. It is really just amazing to me. It is a very enriching experience personally, not monetarily. At that point in California history, in my history, I could have become a technical writer in Silicon Valley, retired, and now had a meaningful job like this! But in terms of my own personal values, to be able to do something that matters is such an honor and a privilege; the fact that I was given an opportunity to do work I had such interest in is a really a unique opportunity.

Reti: Thank you so much!

Benedetto: Oh, you're welcome.

SANTA CRUZ WOMEN'S HEALTH CENTER HISTORY/TIMELINE

Early 1970's: Study group travels to national and regional Women's Health Movement meetings, patient's rights group forms.

Early 1970's: Files on quality of care provided to women by local doctors made accessible to community.

1974: Self-help groups start.

1974: Beginning of medical services operating under private physician's license.

1974-2000: SCWHC Volunteer Health Worker Internship Training Program teaches future doctors, policy makers, activists and health care field workers about their bodies and the politics of health care.

1974: Under pressure from medical community, local law enforcement shuts down facility due to performance of abortions.

Mid-1970's: Hiring of first paid staff.

1975: Application for clinic license under Womankind Clinic name. Resumption of medical services two days per week.

1976-1987: Newsletter group produces internationally distributed publication.

Mid-to-late 1970's: Publication of health education pamphlets/handouts on variety of topics: herpes, self-exam, PID, patient's rights, home remedies for vaginitis among others.

Mid-to-late 1970's: Reproductive rights coalition begins.

1977-1994: Teaching of fertility awareness.

1978-79: Publication of *Lesbian Health Matters!*, the first publication of its kind in the country.

1978: "Taboos and Tranquilizers" slideshow developed. The story of women as patients and healers.

1981-1984: “The Challenge of Change”—diversification of agency; bilingual capability built; formation of Familia Center and transformation of collective.

1982: SCWHC one of the first cervical cap study sites in the nation.

1983: Low cost acupuncture services begin.

1984: Hiring of first formal administrator.

1985-86: Familia Center spins off from the SCWHC.

1986: Update of herpes booklet published.

1984-2000: Expansion of days, hours, staff and scope of services. (addition of : coloscopy, women’s primary care, pediatrics, Breast Cancer Early Detection Project and prenatal care programs).

Mid to late 1980’s: Development of menopause program and services.

SCWHC staff and volunteers respond to AIDS crisis as it emerges.

Develop local protocols for HIV testing. Educate self and community about women and HIV.

1988-89: Co-sponsorship of “Celebrating Women Conference” at UCSC.

1989: 15 year anniversary celebration.

1989: Loma Prieta Earthquake shakes things up.

1991-1992: Facility expansion and renovation. SCWHC enters the computer age.

1992: UCSC Women’s Center and SCWHC bring Gloria Steinem and Dolores Huerta for SCWHC fundraiser. Sell-out event at the Civic.

1993: Updating of Home Remedies for Vaginitis publication.

1994: Breast Health Video produced; joint project of SCWHC and Wolfe Video.

1994-1996: Strategic planning re: managed care.

1995: Hiring of new medical director, Catherine S. Forest, board certified in family practice, with admitting privileges at Dominican

Hospital.

1996: Beginning of MediCal managed care.

1996: Free mental health counseling offered.

1996: Tony Bennett performs sell out benefit concert for SCWHC at the Santa Cruz Civic.

1997: Nutritional counseling project

begins. **1997:** Hiring of second physician

on staff. **October 8, 1997:** purchase of

building! **1999:** Hiring of two nurse/case

managers.

1999-2000: Hiring of second administrator—Associate Director/Fund Development .

May 2000: Executive transition. New Executive Director, Dorian Seamster hired.

santa cruz women's health center Newsletter



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The Challenge of Change

by Laura Giges

Over the past year, the Santa Cruz Women's Health Collective (SCWHC) has begun to confront its racism. This process has involved understanding and accepting that each of us internalizes racism of our society on many levels and that this racism is ingrained in all of our assumptions, values, and judgements. Confronting racism also means acknowledging the privilege that white women have--such as the ability to choose when and if to challenge the status quo of racial inequality.

The process is shaking some of our basic structures; creating conflict, frustration, pain, excitement, and new visions. What follows is an account of changes taking place, of which there are as many versions as there are women in the collective.

Throughout the ten years of the SCWHC's existence, the membership has been almost entirely white, middle-class women. While the experience of each woman of color who has worked in the collective has been different, all have expressed feelings of isolation, resentment, and anger in being the only (or one of the few) woman of color at any given time. They have criticized collective members for failing to raise issues of racism and to acknowledge racial/cultural differences among members. They have emphasized the collective's failure to serve the total Santa Cruz community and to be an organization in which women of color would choose to participate.

Although most of us in the collective have not been oblivious to our homogeneity and its consequences, our past efforts towards change never significantly altered the racial composition of the group or our clientele. Our

periodic discussions about racism and affirmative action were provocative, yet seemed to exist in a vacuum with little translation into change. Sometimes they would spawn new projects such as outreach task groups; however, as we never thoroughly examined or understood the hows and whys of our basic homogeneity our solutions were either inappropriate, premature, or too limited.

Like many other feminist groups, we had an intellectual commitment to fighting racism yet we lacked the knowledge and to some extent the willingness to affect change within our own organization.

Last winter (1981) we set up two in-house workshops on racism, facilitated by, two women from the community who have worked extensively with this issue. Many of us were frustrated with our abstract discussions about class and race. The workshops represented a possible catalyst for the changes necessary to continue moving forward as a political women's group.

In the two workshop sessions, we explored the ways in which we have perpetuated our predominately white

membership. One way, for example, has been making seniority an important hiring criteria when one of the few paid positions has opened up in the past. Consequently, jobs generally have gone to long-time volunteers, invariably white. Since neither our work nor the racial composition of our staff exhibited a commitment to women of color, few have volunteered at the SCWHC. While many Third World women lack the economic means to volunteer, those who might have been interested had little incentive to be a part of a primarily white women's organization.

One of the most powerful aspects of the workshops was discussing the implications of our structure (who has jobs, how volunteers become involved, ways of working together). Our failure--for whatever reasons--to include and serve women of color could be translated into an unspoken priority given to white women's health care rather than health care for all women. Although none of us could accept this assumption once verbalized, acknowledging that we had created our organization meant accepting responsibility for the work we did and who we reached.

We looked at other issues involved in making major change: giving up control. and losing our support system. Having invested large amounts of ourselves and our time in creating the collective, it became difficult to identify in what ways the resistance to change resulted from our fears of any major change or from racist attitudes. As a result of these workshops, we made challenging racism A strong priority, although we did not quite know at this point what that would ultimately mean.



In remembering this part of our process it seems that the extent to which we explored our individual racism set the stage for problems that were to arise later. We tried to allow for feelings--including fears--about changing to be

expressed, yet we rarely challenged where these came from. our reluctance to confront one another, to take risks, kept us from probing the root,; and extent of our personal racism. it felt "OK" to express feelings, yet "not OK" to dig too deeply, especially if the feelings were of pain. The lack of honest dialogue kept us from growing together politically and instilling group trust and solidarity.

In the summer of 1981 we received a one year state grant to hire two bilingual/ bicultural health counselors. Hiring these two Latinas was the first major step towards changing the full-time paid staff of the SCWHC to represent the community. It also marked the beginning of our outreach efforts into Santa Cruz's Latina Communities (see "Have Van, Will Travel" in this issue).

A process of change had begun, yet no plans had been made to alter the all-white permanent paid staff of six. We devoted an all-day retreat in August to the development of an affirmative action plan to include women of color on full-time paid staff.

We focused on the paid staff for several reasons. Although the ideal of a collective is that all members have equal access to power, in reality, those who work the most hours (usually the paid staff) have more impact on the direction and work of the SCWHC. For women of color to be in positions of [lower, we realized that a racially diverse paid staff was crucial. In addition, we realized that we would continue to attract few women of color as volunteers with an all-white paid staff. Further, we knew the area of paid work was the hardest to confront given the scarcity of -jobs in the SCWHC and the difficult economic times.

Major decisions were made at the retreat: we set a goal to have paid staff be at least 50% women of color, with current staff willing to give up jobs, if need be, to reach this goal. We allowed ourselves One year to make the changes. Although there was disagreement, we reached consensus after a long and difficult day.

Over the next month or two, several women in the collective expressed discontent with the decision to give up jobs as a way to reach our goal. They wanted to

reevaluate the decision for a variety of reasons. Some felt the decision had happened too fast to fully consider its impact. Other issues included; a SCWHC principle of providing stable jobs for its workers was being violated; it would not be "good" for the SCWHC to lose skilled women with an indepth knowledge of its functioning; and new women would not be as committed as long-time workers.

Others felt angry and frustrated that members had allowed consensus to be reached and now wanted to retract it. They felt it was demoralizing, a step backwards, and that the collective would protract the decision-making over so long a time that it would get lost or diluted. In addition, some women felt that there were racist undertones to different arguments for reconsidering the retreat decisions.

In spite of this, few personal confrontations took place. While it was inevitable that this part of the process would be difficult, our failure to challenge each other completely prevented us from hearing or understanding each others' feelings. During this time the same "positions" were reiterated over and over again. The one

Point on which we could agree was that our process--the basis for much pride in the past--was breaking down. Although the retreat decisions were eventually reaffirmed, the frustration continued and morale was low.

At the same time, the Latina women were responding to the racism they experienced in the SCWHC. As a result of personal interactions with the individual members and group interactions (where racism was expressed more often in what was not said or done than in what was) these women became angry and let the rest of us know their feelings.

One focal issue at this point was our weekly general meetings, which had always been the place for major discussion and decision-making. Though collective process is by nature slow (as decisions are made on the basis of an entire group's input) the implementation of our affirmative action plan was particularly tedious. After attending a few meetings, the women of color felt disgusted and alienated, and decided they could not participate anymore. They pointed out the racial/cultural style of our process: the tones and terms in which we

speaking; the lack of expression of "not nice" but heartfelt anger and resentment; and the slowness--despite lengthy discussions--in making changes, which they viewed as avoiding the issues.

These women felt that they did not have the time in their lives to talk for hours and make no decisions, especially when the necessary action to be taken seemed obvious to them. Increasing their frustration was the feeling that their input was ignored.

The criticisms made by the women of color magnified those of our own, and added to the general despair. We began to realize that our ways of working together were no longer working for anyone.

What we didn't realize at this point was the inevitability of what we were going through in deciding to be a racially mixed group. Somewhat naively, we had thought that we could change who we are and who we serve without affecting how we work and how decisions get made.

As different ones of us began to talk to friends, to read, to attend racism workshops outside the SCWHC, we realized that having thrown all of the pieces of the collective up in the air, we were mistaken in expecting them to fall into place in a similar pattern, rather than to take radically new forms. Recognizing that we needed new ways of working together, we began to let go of the feelings that we knew what was right for the SCWHC. As the "we" of the SCWHC was changing, new ways of working together would emerge.

Reaching this point was a breakthrough. Accepting the disorder brought by transition allowed us to stop berating ourselves for our state of confusion. It also encouraged us to turn to the community for greater participation in our programs. One concrete example was the development of a multi-cultural community advisory board which meets monthly with us to discuss new directions.

There is much work to do in broadening the scope of our staff and our services. Having set a timeline for hiring

more women of color on staff, we are struggling to work together as a whole collective.

Hard decisions, are still to be-made and we are far from feeling cohesive as a group. Communication among ourselves is inadequate; many of our former methods of sharing information and making decisions are in question. Our process has become fragmented, so not everyone is getting information or participating in important discussions (especially lower-time Unpaid workers). This contributes to women feeling misunderstood, disrespected, and angry.

We are examining and evaluating our old ways of working together in order to decide what we want to keep and what we need to change. This process is changing all of our lives personally, and is reconnecting us with our political goals.

We who have been in the collective for many years set the changes in motion. We continue to work hard and to challenge ourselves. Yet we could not be where we are without the women of color in the collective who have

taken on the risks and struggle of joining a white women's group, bringing their anger, visions and love to us. Together we are giving birth to a new collective.

Our Center, Ourselves: 25 years and Counting: a Celebratory Reflection on the History of the Santa Cruz Women's Health Center (SCWHC)

By Ciel Benedetto

published in *La Gazette*, April 2000

I wonder if the handful of women who began meeting in their Santa Cruz living rooms in the early 1970's to discuss their bodies and their rights as patients had any notion that their pioneering efforts would result in the creation of a "feminist institution" that would endure beyond a quarter of a century. The creation, evolution, and survival of the SCWHC are nothing short of miracles and a demonstration of what can be born of our dreams. These founding sisters and those who followed dared to envision an entirely new paradigm for the patient and health care provider relationship. Although the "Collective," (as many in the community still refer to when speaking of the SCWHC), ended sometime between 1981

and 1984, the spirit and vision of our founding sisters are very much alive to this day.

Today, it is difficult to conceive of the obstacles these women faced and the bravery required to "stare down" the male medical establishment and create a model of health care run by and for women. Their success depended upon support from trailblazing male and female medical professionals and community political activists. Imagine the late 1960's/early 1970's in Santa Cruz and in much of the U.S.A. There are few if any women doctors of any kind; women gynecologists are rare; abortion is not yet legal; informed consent is not the law of the land or state; there are few bilingual medical providers and no "out" lesbian providers. Also, patient education is a foreign/unfamiliar concept to many; *Our Bodies, Ourselves* is not yet published; speculums are not warmed before pelvic exams.

The founding SCWHC visionaries and warriors were not, however, alone. Across the United States and in other countries all over the world, small community-based feminist women's health centers were sprouting up. U.S. activists involved in the Women's Liberation Movement, many

of whom honed their community organizing skills in the Civil Rights Movement and in the "New Left," started revolutionary self-help, education, advocacy, and ultimately women's medical organizations. Abortion rights were central to the movement but not the only organizing principle. The publication of the newsprint edition of *Our Bodies, Ourselves* circa 1970, by the Boston Women's Health Book Collective, provided the Women's Health Movement with a bible. If *OBOS* was the bible of this revolution, then mirrors, speculums, and flashlights were the icons.

Each of these organizations founded by activists had a unique approach, philosophy, and "politic." The Santa Cruz Women's Health Collective selected a "socialist feminist" identity implying a global mission beyond health care and concerning children and men, as well as, women. Over time, the history of the SCWHC mirrored the women's and feminist movements in this country. During the twenty-five-year history, the SCWHC staff, board and volunteers have had to grapple with the challenges of meeting formidable internal and external expectations and forces every step of the way. SCWHC survived and thrived because of the

ability and willingness of organization policy makers to: listen to the changing voices of the clients and community; make at times difficult pragmatic compromises when faced with seemingly unmovable and at times destructive external forces governing the U.S. health care system; promote medical excellence as a core value; challenge the status quo; take business and political risks, and cultivate and call upon community support in the unique region in which the SCWHC resides. Regardless of the challenges and struggles, the core mission has never been compromised.

In my view, there were two decisions that in a sense sealed the future fate of the SCWHC. One was a defining move that would chart the agency's future course and identity. This was when the women of the SCWHC summoned the courage to not only condemn racism in the larger society; and in the women's movement, but confronted the organization's internal racism and culture of exclusion. This internal revolution attracted the national attention of the Women's Movement and changed the face of the SCWHC. As with all social and revolutionary change, there were mistakes made and pain caused by the actions of that time. The struggles

born of those bold actions strengthened and matured the organization and, in part, made the SCWHC what it is today. Most probably, the events that took place during this period in the early 1980's ultimately resulted in the dissolution of the collective. As far as I can tell, and as far as written documentation shows, the collective never formally was dissolved or ended; it seemed to just cease to function and over time evolved into something else. This is a part of the history not well documented that should be recaptured and written down. Today, the SCWHC is a diverse organization and therein lies its strength. The challenge of achieving true inclusivity is a lifelong pursuit particularly within a society that stills fears rather than respects and values difference.

Another defining decision, that actually predated the first, was when the collective decided to add medical services to the existing education, self-help and advocacy programs. So much of the SCWHC history from 1984 to the present involves the development of full medical services for women and children. The SCWHC was one of the first feminist clinics to move beyond well-woman care and float the radical notion that women's health centers should treat the sick, as well as, the healthy. Given the high

standards set by SCWHC collective members it was not possible to have education and advocacy as the main program or services and just dabble in medicine. Once the organization moved from solely offering self-help type services and hired its first licensed medical professional a certain course was charted. Medical services have evolved steadily since the mid-1970's. In the mid-1980's the scope of the medical practice began to expand to include other than what was considered classic women's health services. In 1996, pediatrics was added and the medical practice expanded to provide a full range of primary medical services for women and children. Today, the youngest SCWHC patient is not yet born (we have a prenatal program) and our oldest patient is over 100. SCWHC staff assist clients in living healthier lives, in surviving and managing chronic and life threatening illness, and also have in recent years assisted some patients with the process of dying.

Education and advocacy are needed every bit as much today as they were when the SCWHC was founded. Perhaps the SCWHC could and should have taken a different course; one that did not include becoming medical providers and strictly adhering to the mission of education and advocacy.

Such an organization is sorely needed today. SCWHC staff and board have decided over and over again that as long as access to quality, affordable medical care is not a right that all in our country enjoy that the SCWHC would stay in the medical practice business. There is also the issue of how medical services are delivered to women, a quality issue.

There are losses and sacrifices in creating a well-run, stable medical and health education center that was born of a political movement. By nature, political movement and activism thrive on a certain level of chaos, unpredictability, and risk-taking. Mistakes and blunders are part of the artistic and creative political processes. These values are not however tolerated well in our roles as patients. In a medical setting we demand competence and a certain level of predictability, stability, and safety. There is no safety in revolutionary movements. Patient advocacy in its purest sense is not possible when an organization is also the patient's medical provider; there is a level of objectivity demanded that is just not there. The volunteerism that created and maintained this organization for many years is just not possible in this day and age when many have to work two jobs to barely scrape by. The creation of a hierarchy, albeit a women-

designed and-run hierarchy, meant the loss of very valuable, radical and innovative collective processes and principles that the SCWHC could not figure out how to maintain and survive and grow as a medical organization. The SCWHC was not alone in that struggle. A model for feminist collective purism in Geneva, Switzerland *Dispensaire de Femmes*, (which paid everyone, including doctors, the same and had no formal hierarchy long after most U.S. health collectives morphed into some form of democratic hierarchical management), succumbed to "structure" some years after the SCWHC collective dissolved. Participation in the Collective radically changed women's lives and fostered a sense of belonging and group ownership that were unparalleled. The Collective years were vital to the history and evolution of the SCWHC.

The Santa Cruz Women's Health Center remains a nationally known feminist institution that is a source of pride for our community. The organization serves and evolves at the will and by the support of our local community. There are so many milestones from the last twenty-five years worth noting that it is impossible to name them all.

Some of the "greatest hits" include: driving women to abortion providers out of the area when there was no local provider; ten years publication of a first-rate newsletter distributed all over the world; the publication of *Lesbian Health Matters!* in 1979 (the first and still only one of a few of its kind); the launching and spin-off of Familia Center and development and cultivation of bilingual and bicultural staff; developing a prenatal program to provide access to care to low-income and undocumented women; offering low-cost acupuncture services; assisting SCWHC volunteer Dorothy Granada in the set-up of a women's health center in Mulukuku, Nicaragua; participation in the Breast Cancer Early Detection Program; making the successful transition as MediCal managed care providers; addition of pediatric services in 1996; and the purchase of the facility in 1997.

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Appendix E:

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