Nurses

LBrown, Leo C.

REPORT OF THE FACT - FINDING PANEL

In the Matter of

CALIFORNIA NURSES' ASSOCIATION AND THE BAY AREA HOSPITALS NEGOTIATING COMMITTEE

San Francisco, California

November 14, 1966

FAK

REPORT OF THE FACT-FINDING PANEL

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Monday, November 14, 1966, Leo C. Brown, chairman

Establishment of the Panel

During the summer of 1966, disputes of serious proportions arose between the staff nurses and the administration of two local Bay Area district hospitals. The primary issue was the appropriate level of nurses' salaries. Failure to agree led the nurses at one hospital to refuse to report for duty during a four-day period. Shortly thereafter, nurses at the second government hospital threatened mass resignations and the nurses at private hospitals in the Bay Area initiated similar action. Representatives of the private hospitals met with officials of the California Nurses' Association in an effort to resolve the dispute. When these conferences reached an impasse, the parties agreed to submit most of the questions at issue to an impartial Fact-Finding Panel. On August 2, 1966, the California Nurses' Association and the Bay Area Negotiating Committee signed a Memorandum of Understanding which provided that they would request the Honorable Edmund G. Brown, Governor of California, the Honorable W. Willard Wirtz, Secretary of the Department of Labor, and the Honorable John W. Gardner, Secretary of the Department of

Health, Education and Welfare, jointly to select a three-man Fact-Finding Panel to study and make recommendations on the matters in dispute between them. On September 14, 1966, the parties were notified that the three above-named officials had designated the following as members of the Panel: The Reverend Leo C. Brown, S.J., Chairman, Professor Howard E. Durham, and Adolph M. Koven, Esq.

The Panel conducted public hearings on the issues in dispute for eight days between October 3, 1966, and October 19, 1966, at San Francisco, California. During these hearings the parties presented oral and written evidence and arguments to the Panel to support their respective positions and thereafter were given an opportunity to file post-hearing briefs.

In the proceedings, the California Nurses' Association was represented by Mr. John Paul Jennings, of Jennings, Gartland and Tilly, and the Bay Area Hospitals Negotiating Committee was represented by Mr. Laurence Corbett, of Corbett and Welden. A list of the hospitals represented by the Negotiating Committee is attached as an Appendix A to this report. The record of the proceedings included 1029 pages of testimony and 23 exhibits.

The Memorandum of Agreement stipulated that the Panel would make advisory recommendations to the parties on or before December 1, 1966, and that the parties would advise the Panel and each other, no later than December 15, 1966, regarding their respective positions on the Panel's recommendation.

Background of the Dispute

The California Nurses' Association has maintained collective bargaining relationships with Associated Hospitals and Affiliated Hospitals and with certain of the other hospitals involved in this dispute since the late 1940's. The current contracts with Associated Hospitals, Voluntary Hospitals, and Kaiser Hospitals are two-year agreements which became effective on January 1, 1965; all of them contain provision for interim reopening at the end of the first year on salaries and per diem rates and, in the Kaiser Hospitals only, on shift differentials. The CNA in late 1965 indicated its intention to open all of these agreements, proposing changes that exceeded the limited scope of the reopening defined by the contract. Negotiations resulted in agreements with Associated Hospitals and Voluntary Hospitals covering a number of salary and fringe items, both of which were ratified by the CNA membership affected early in 1966. Kaiser traditionally has awaited the outcome of Associated Hospitals' negotiations and has then bargained on the basis of the pattern so established. Kaiser's offer of a generally similar proposal, following acceptance by the nurses of Associated Hospitals' settlement in February 1966, was rejected by the CNA. No further progress was made in subsequent meetings.

The CNA agreement with Affiliated Hospitals, covering the same two-year period, provides for an automatic salary increase to be effective January 1, 1966, rather than a reopening clause. The most recent contracts for the two remaining

hospitals, Albany and Vallejo became effective on January 1, 1963 and March 1, 1963, respectively. The Vallejo contract was for a three-year term which expired February 28, 1966. Negotiations for renewal had reached a standstill by July when the parties agreed to participate in the fact-finding procedure before the Panel. Albany Hospital, where the contract had expired on December 31, 1963, adopted changes negotiated by Associated Hospitals in 1964 but did not enter into a written contract. Thus, when the situation arose which led to this proceeding, some two-thirds of the hospitals before this Panel had existing contracts with the CNA.

The convention of the American Nurses' Association, held in San Francisco in June 1966, adopted a goal of $6,500 as an annual minimum salary. Shortly thereafter, the dispute referred to earlier developed between the nurses at the two district hospitals, Washington Township and Eden Hospital, and the nurses threatened mass resignations unless the hospitals met their proposals for substantial salary increases. On July 7, 1966, Washington Township Hospital adopted the CNA proposal then before it and agreed further to place in effect any adjustment in excess of that amount that might be adopted by Associated Hospitals, based on 36 proposals which the CNA had placed before them. On the same date the private hospitals in the San Francisco Bay Area met to consider the situation. The following night, representatives of the hospitals met with the CNA to propose a uniform General Duty Salary Structure and

asked CNA to withdraw any threats of resignation while negotiations on the proposal took place. The CNA rejected the proposal and insisted upon an immediate settlement of the salary issue and a week's extension to settle all other matters. Hospital representatives at the meeting lacked authority to agree to these conditions. On Sunday, July 10, 1966, no nurses reported for duty at Eden Hospital. Four days later Eden's Board agreed to the terms that Washington Township Hospital had accepted and the nurses returned to duty.

During the remainder of July, there were several meetings of the CNA with the Bay Area Hospitals Negotiating Committee, newly formed to represent jointly the various private hospital Associations. The hospitals first offered uniform salary ranges with increases effective July 17, 1966, January 1, 1967, and January 1, 1968. This was rejected by the CNA because it failed to deal with all issues. A second Negotiating Committee proposal, offering an immediate salary range of $500 to $570 per month for general duty nurses and submission to advisory fact-finding of the issues involving January 1, 1967 salary scales, holidays, vacations, and sick leave, was rejected by the CNA for the same reason. On August 2, 1966, the parties reached agreement. They entered into the Memorandum of Understanding which provided that 26 issues would be submitted to a three-man Panel for fact-finding and recommendations and that all remaining issues would be referred to local negotiations. Pursuant to that agreement, the Panel was appointed.

The issues presented to the Panel fall into three broad categories: (1) proposals for salary increases in various forms, including the establishment of a classification system; (2) fringe proposals which would result in more time off; and (3) fringe proposals which would increase compensation. In addition, there were ten issues retained by the parties for settlement through local negotiations. The 26 issues submitted to the Panel are shown in the Memorandum of Understanding between the parties dated August 2, 1966. It appears as Appendix B of this report.

Positions of the Parties

The arguments presented by the parties in support of their respective positions are stated in detail in the record of the hearings and in their briefs. Therefore, it is not necessary to repeat them in detail in this report.

In general, the CNA urged substantial salary increases for nurses based on increased responsibilities due to advances in medical science, to the development of new medical technology, and to the changing role of the nurse in the hospital structure. The CNA contended that the greater demands upon nurses and the higher levels of responsibility they have accepted have not been recognized or adequately compensated; as a result, broad inequities have developed in their salary structure. The objective of the CNA proposal now before the Panel is, they state, to bridge the gap that has developed and

to remove the inequity.

The Hospitals contended that nurses' salaries were appropriately adjusted by the interim increase made effective on July 17, 1966. They pointed out that Bay Area salaries for nurses, after the adjustment, compared favorably with the highest non-governmental salaries for nurses in other major cities, that the new rate was 13.5% above the negotiated salary rate that had resulted from many years of collective bargaining, that it was the largest increase the nurses had ever received, and that, therefore, recognition had been given to the nurses' changed job content and such inequity as may have existed had been cured. Moreover, the Hospitals stated, the interim adjustment had resulted in placing the nurses in the traditional pattern of relationships with other hospital classifications.

The Hospitals argued, further, that the base salary for nurses should remain at the level of the interim adjustment to permit reasonable recognition of job differences when a classification system is negotiated. The Hospitals supported development of a classification plan and urged that the study should be in depth, that it should be carried out in accordance with accepted principles, and that matters properly included in a classification system should not be acted upon by the Panel but should be considered by the parties in relation to the classification plan. With regard to the fringe items, the Hospitals cited the shortage of nurses and asked the Panel to recommend against proposals that would remove nurses from their

jobs for an increased amount of time. They claimed that present fringe policies are in line with prevailing practice in industry generally and pointed to the substantial cost of many of the CNA proposals. Finally, the Hospitals noted that cost increases resulting from settlement of this dispute will necessarily be borne by the patients, since hospitals have no margin to absorb them. They urged that the Panel consider equity for the patients and the public, as well as for the nurses, in determining their recommendations.

Discussion

Salary Levels

The major issue in dispute is the amount by which present salary ranges for general-duty nurses should be increased. Prior to July 17, 1966, salary ranges for general-duty nurses approximated $435 - $500 but were not identical among the hospitals involved in this proceeding. The interim adjustment made effective on that date established a range of $500 - $570 per month in all of the hospitals covered by the Memorandum of Understanding. The CNA has proposed a further increase to a range of $600 - $730 per month, retroactive to July 17, 1966, and subsequent adjustments to $644 - $862, effective January 1, 1967 to December 31, 1967, and $745 - $998, effective January 1, 1968 to December 31, 1968. In each case a rate below the minimum of the range was proposed for nurses with less than one year of experience. Thus, the Panel is asked to determine the

appropriateness and fairness of the interim salary scale, to recommend whether or not a further increase retroactive to July 17, 1966 should be recommended, and, in addition, to recommend salary scales covering the period from January 1, 1967 to December 31, 1968.

A. Changes in Job Content

Historically, the role of the nurse has always been that of providing direct patient care under the medical direction of a physician. She has administered medication and has observed patient condition and has reported to the physician, alerting him when in her judgment the patient's condition warranted such a course. This basic role remains unchanged. The modifications in the content of the job the nurse performs have arisen from changes in the environment in which her role is now carried out, changes which have materially affected the nursing function. Broadly, this result derives from (1) changes in medical science and equipment, (2) the leadership function that has accrued to the registered nurse, and (3) changes in medical practice resulting in more responsible duties.

Advances in medical science and equipment have created a potential for preservation of life and restoration to health in many situations formerly beyond hope of accomplishment. Closed and open heart surgery, brain surgery, chest surgery, surgical procedures and therapy in the treatment of cancer, for example, have saved many lives. At the same time, these complex procedures have resulted in increasing the number of hospital

patients in extremely critical condition. While observation of patients has always been a function of the nurse, her responsibility becomes sharply increased when that observation includes large numbers of such critically-ill patients. Thus, because of such new medical techniques, evidence presented to the Panel indicates that an individual nurse will normally be required to be responsible for the care of a higher proportion of critically-ill patients than in past years. Moreover, in part because of this change, she now must perform certain functions formerly performed only by physicians because life-saving procedures must be instituted promptly, sometimes before the physician can arrive. Finally, nurses must now know how to utilize and monitor recordings on complex new medical apparatus, such as cardiac monitoring equipment, thermal equipment, intermittent positive pressure breathing machines, suction equipment, or other types of apparatus. Although it was clear from the evidence that all nurses do not perform all of these functions, unquestionably there is sufficient use of new complex equipment to have increased the job-content requirements for staff nurses generally.

A second area of increased responsibility results from the modifications in nursing-staff structure that have occurred in recent years. Almost universally, on present-day hospital staffs, registered nurses are responsible for supervising other licensed and unlicensed hospital personnel. Evidence presented to the Panel indicated the typical structure of a

nursing-care unit to be composed of one registered nurse with varying numbers of licensed vocational nurses and nurses' aides assigned to provide patient care under direction of the registered nurse. Unlike the former structure in which the registered nurse provided direct bedside care to a more limited number of patients and shared responsibility for the unit with other registered nurses similarly assigned, the full nursing responsibility now usually rests upon a single registered nurse. Thus, she now is responsible for a larger total number of patients and for directing their care through subordinates. The attributes of a supervisory role include both responsibility for training subordinates to perform more effectively and responsibility for the work carried out by subordinates. The new leadership role of the registered nurse covers such responsibilities though she is not technically considered a supervisor. She has assumed this broader function without any reduction in the level of responsibility she continues to have in her more traditional role of providing direct patient care.

A third factor which has significance in evaluating changes in the job content of general-duty nurses is the reduction in the average length of stay of hospital patients. Formerly, patients remained in hospitals during substantial periods of convalescence. The current trend is to release patients as soon a s possible to complete the convalescent period at home. One effect of this change is to increase the proportion of

more seriously ill patients under nursing care at any given time, and consequently to increase the degree of nursing responsibility inherent in maintaining observation of patients. Important among the advances made in medicine is the advent of a wide range of new drugs. Remarkable as they are in their curative powers, these drugs or many of them may produce dangerous side effects, and if normal does are exceeded these drugs may have harmful, even lethal, results. Although the responsibility for prescribing such drugs is the doctor's, the nurse must be alert to dangerous side effects and must know the customary doses. Thus, advances in pharmacology have given a new dimension to the nurses' responsibility for administering medication.

The Panel finds the evidence convincing that there has been a substantial change in the functions of the nurses, that the change has added additional duties and has significantly increased the responsibilities assigned to general-duty nurses.

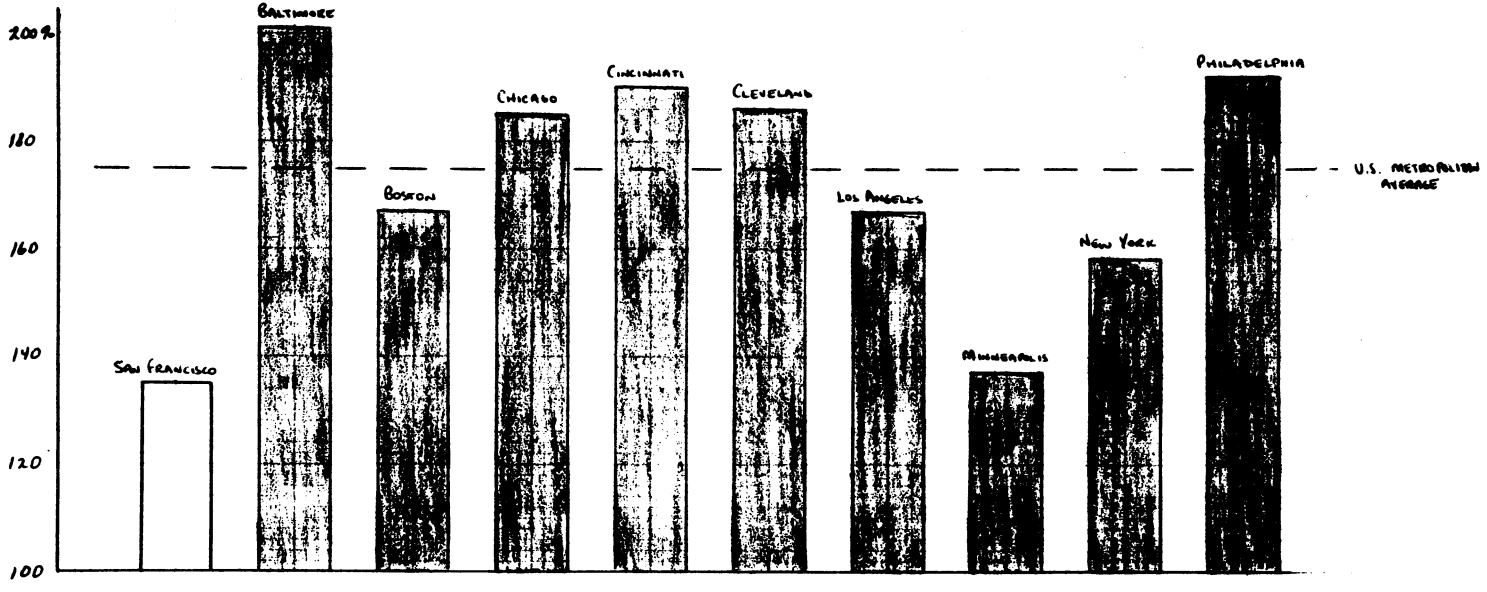
B. Salary Comparisons

A major consideration urged in support of an increase in the basic compensation for nurses is that the wages of nurses have not been increasing as rapidly as the compensation of other hospital personnel.

The latest data available on compensation in hospitals are found in Industry Wage Survey, Hospitals, Mid 1963, a Bureau of Labor Statistics publication that was made part of the record of this hearing by the parties. It may be interesting

CHART 1

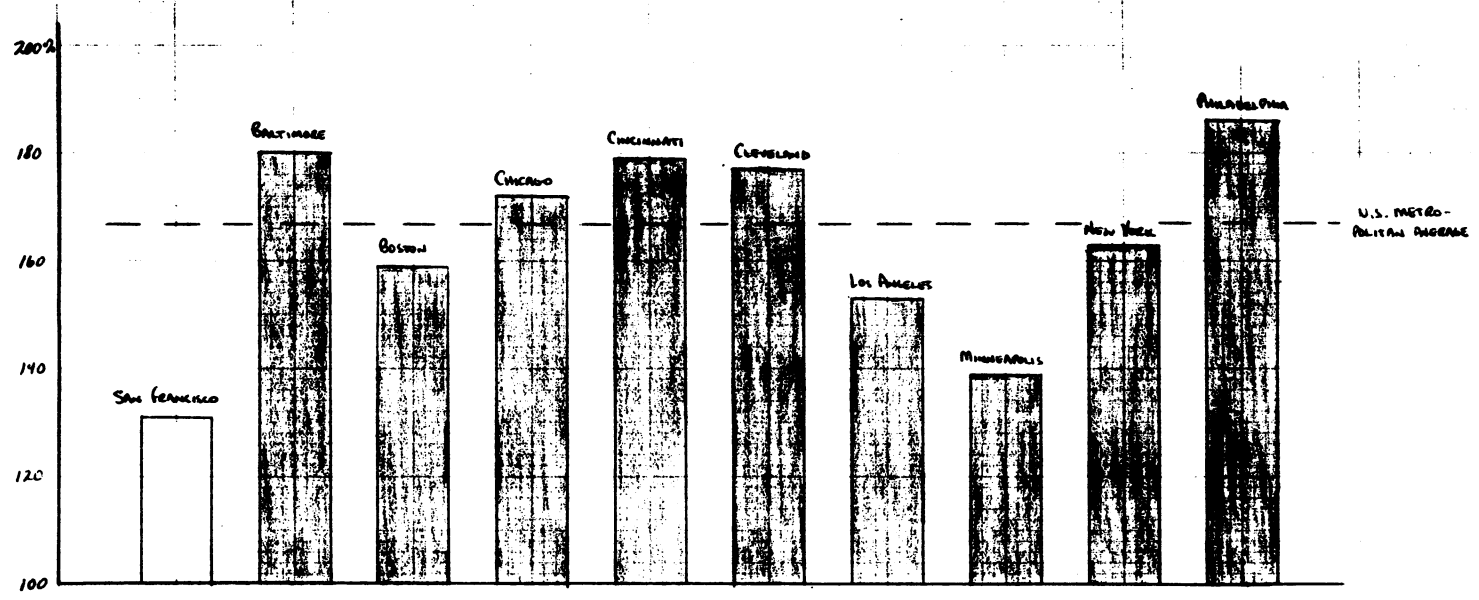
GENERAL DUTY NURSES' AVERAGE EARNINGS AS A PERCENTAGE OF MAIDS' AVERAGE EARNINGS*



* SOURCE: INDUSTRY WAGE SURVEY: HOSPITALS, MID-1963, U.S. DEPT. OF LABOR, BUREAU OF LABOR STATISTICS, BULL. NO. 1409.

CHART 2

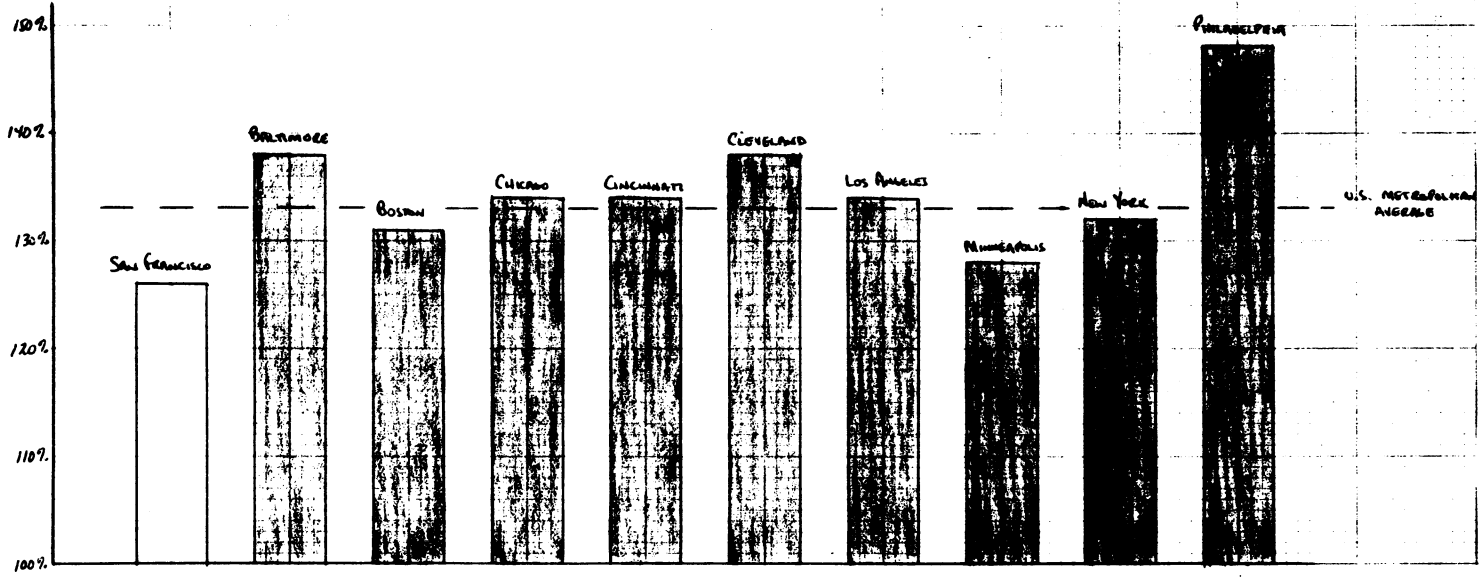
General Duty Nurses' Average Earnings as a Percentage of Nursing Aids' Average Earnings *



* Source: Industry Wage Survey; Hospitals, May-1963, U.S. Dept. of Labor, Bureau of Labor Statistics, Bull. No. 1409.

CHART 3

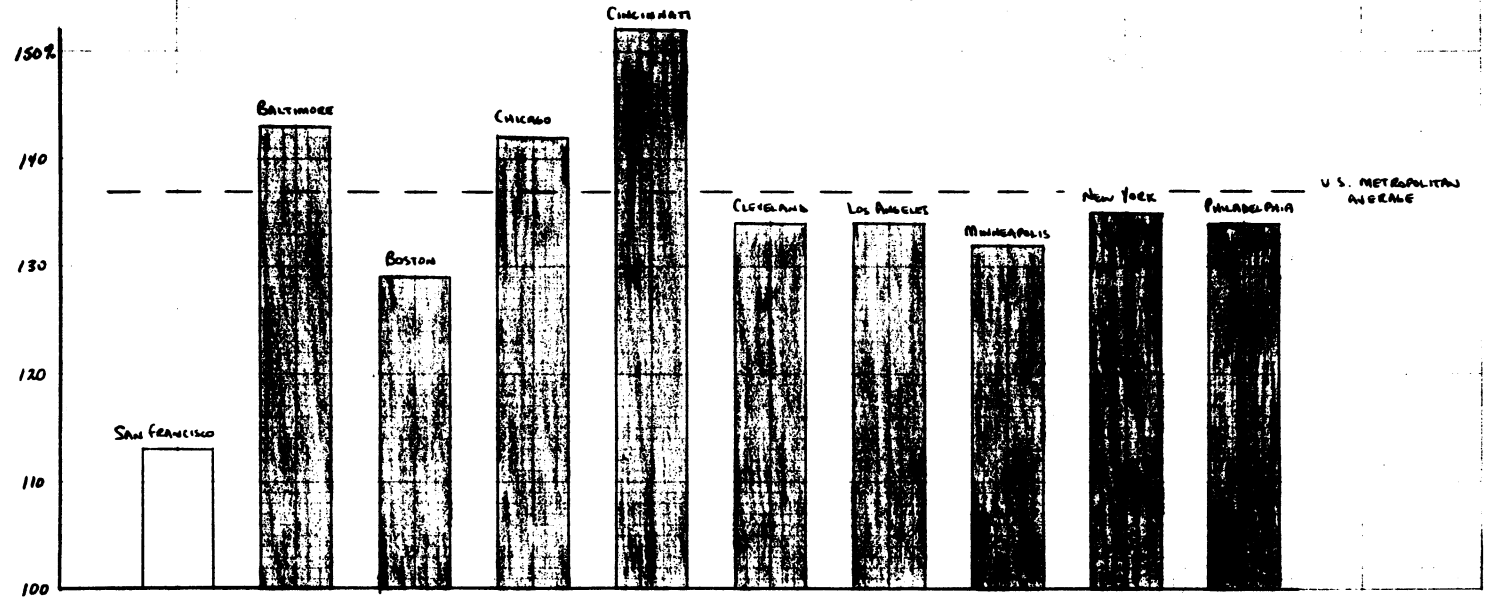
General Duty Nurses' Average Earnings as a Percentage of Licensed Practical Nurses' Average Earnings*



* Source: Industry Wage Survey: Hospitals, May-1963, U.S. Dept. of Labor, Bureau of Labor Statistics, Bull. No. 1409.

CHART 4

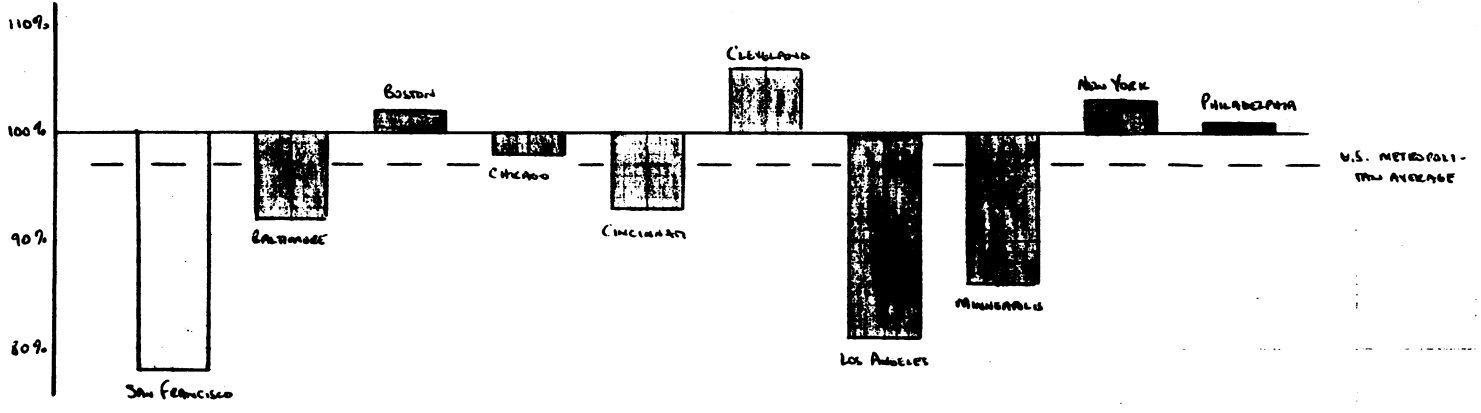
GENERAL DUTY NURSES' AVERAGE EARNINGS AS A PERCENTAGE OF SWITCHBOARD OPERATORS' AVERAGE EARNINGS *



* SOURCE: INDUSTRY WAGE SURVEY: HOSPITALS, MID-1963, U.S. DEPT. OF LABOR, BUREAU OF LABOR STATISTICS, BULL. NO. 1409.

CHART 5

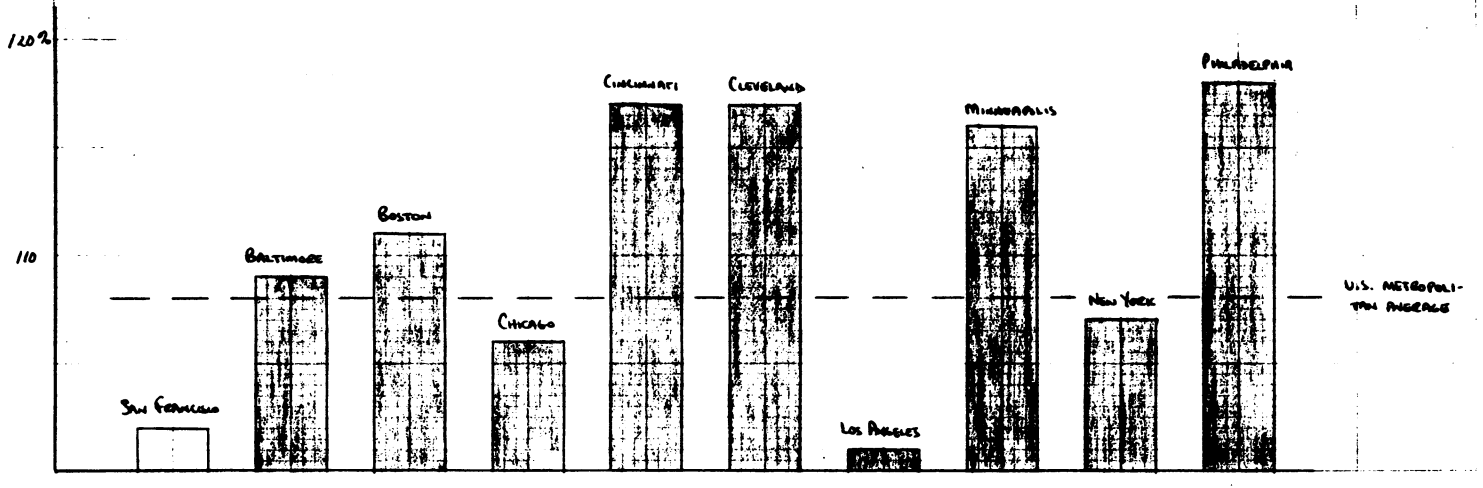
GENERAL DUTY NURSES' AVERAGE EARNINGS AS A PERCENTAGE OF MEDICAL TECHNOLOGISTS' AVERAGE EARNINGS.*



* SOURCE: INDUSTRY WAGE SURVEY: HOSPITALS, MID-1968. U.S. DEPT. OF LABOR, BUREAU OF LABOR STATISTICS, BULL. NO. 1659.

CHART 6

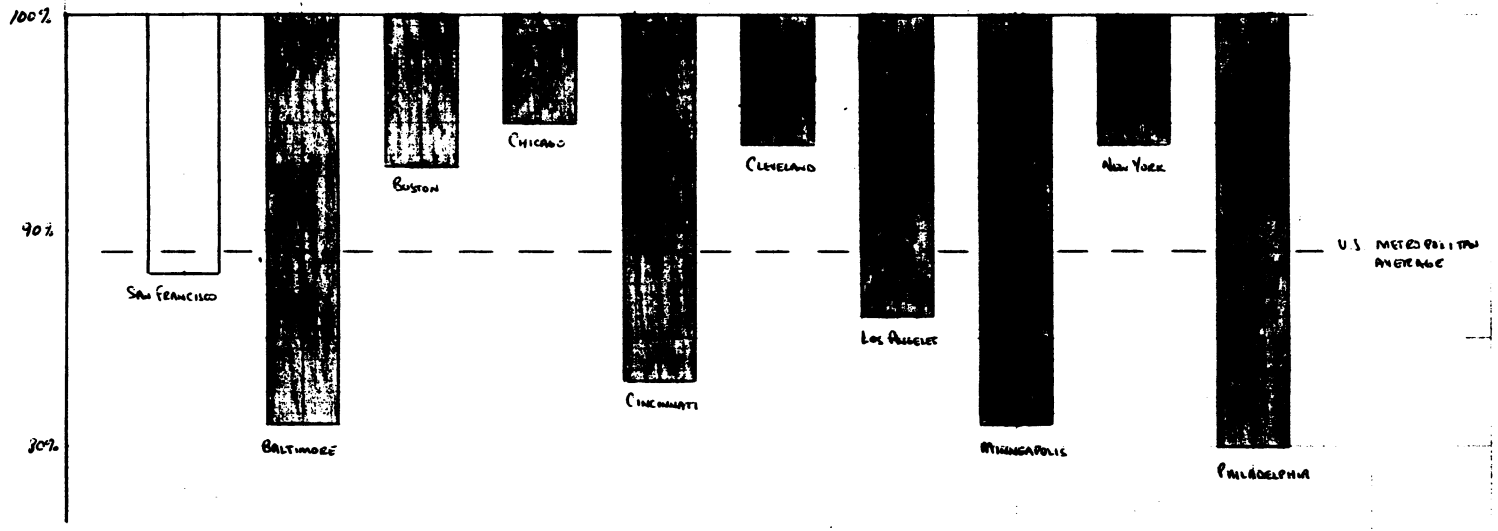
General Duty Nurses' Average Earnings as a Percentage of X-Ray Technicians' Average Earnings *



* Source: Industry Wage Survey: Hospitals, May 1963, U.S. Dept. of Labor, Bureau of Labor Statistics, Bull. No. 1409

CHART 7

GENERAL DUTY NURSES' AVERAGE EARNINGS AS A PERCENTAGE OF PHYSICAL THERAPISTS' AVERAGE EARNINGS *



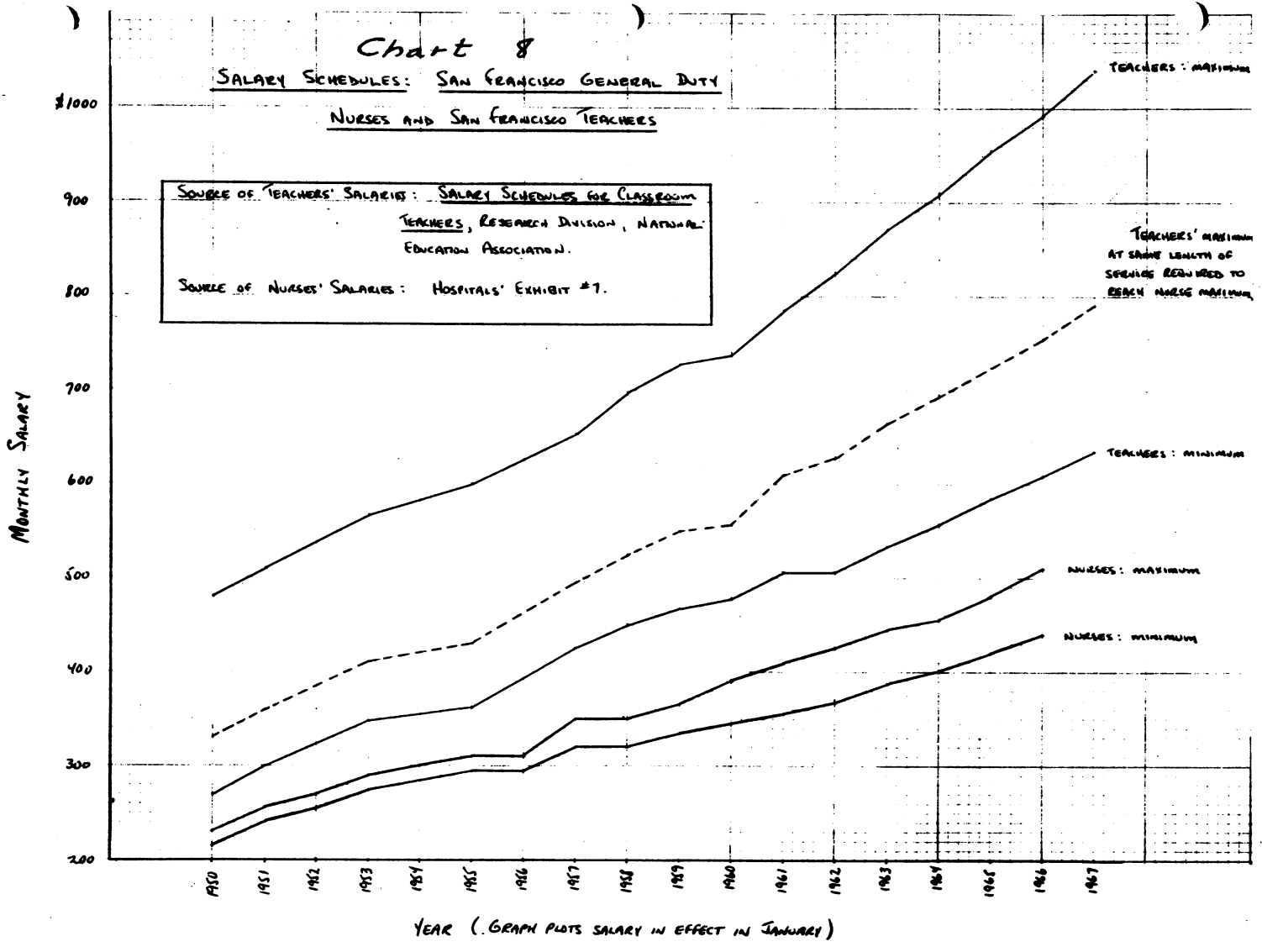
* SOURCE: INDUSTRY WAGE SURVEY: HOSPITALS, MID-1963, U.S. DEPT. OF LABOR, BUREAU OF LABOR STATISTICS, BULL. NO. 1409.

Chart 8

Salary Schedules: San Francisco General Duty Nurses and San Francisco Teachers

Source of Teachers' Salaries: Salary Schedules for Classroom Teachers, Research Division, National Education Association.

Source of Nurses' Salaries: Hospitals' Exhibit #1.



to compare the compensation of nurses in terms of the compensation of other hospital groups, both for major metropolitan areas and for the United States as a whole. This is done in Table I and in the charts that follow.

Table 1 shows for all metropolitan areas in the United States and for a number of selected cities compensation of general duty nurses as a percentage of the compensation of a number of selected occupations in hospitals. In each case the salary is the arithmetic mean for the occupation in question. For example, Table 1 shows that the average compensation for nurses in all metropolitan areas was 175 percent of average compensation for maids. It shows that in San Francisco average compensation for nurses was 135 percent of the compensation for maids. Similar comparisons are made between the compensation for nurses and for selected classes of hospital employees for all metropolitan areas and for selected cities. These comparisons are also shown graphically in Charts 1 to 7 that follow.

Chart 1, for example, shows that in mid-1963 compensation for nurses in San Francisco, when stated as a percentage of the compensation of maids in hospitals, was lower in San Francisco than throughout all metropolitan areas in the United States and in the other cities shown on the chart. The other charts make similar comparisons, stating compensation for nurses as percentages of compensation paid to other classifications of hospital workers.

TABLE 1 - GENERAL-DUTY NURSES' AVERAGE EARNINGS AS A PERCENTAGE OF AVERAGE EARNINGS OF OTHER HOSPITAL EMPLOYEES*

	All U.S. Metropolitan Areas	San Francisco	Baltimore	Boston	Chicago
Maids	175%	135%	201%	167%	185%
Nursing Aids, Female	167	131	180	159	172
Licensed Practical Nurses	133	126	138	131	134
Switchboard Operators	137	113	143	129	142
Medical Technologists	97	78	92	102	98
X-Ray Technicians	108	102	109	111	106
Physical Therapists	89	88	81	93	95

	Cincinnati	Cleveland	Los Angeles	Minneapolis	New York	Phila.
Maids	190%	186%	167%	137%	158%	192%
Nursing Aids, Female	179	177	153	139	163	186
Licensed Practical Nurses	134	138	130	128	132	148
Switchboard Operators	142	134	134	132	135	134
Medical Technologists	98	106	81	86	103	101
X-Ray Technicians	106	117	101	116	107	118
Physical Therapists	95	94	86	81	94	80

*Source: Industry Wage Survey: Hospitals, Mid-1963
U. S. Dept. of Labor, Bureau of Labor Statistics, Bull. No. 1409

In general, it may be said that the data in Table 1 and in the charts show that in mid-1963 nurses' compensation was a very much lower percentage of the compensation of unskilled hospital workers in San Francisco than in major metropolitan areas. Nurses in San Francisco also compared unfavorably with nurses elsewhere when their salary was stated in terms of the salary paid to the switchboard operator. When nurses' compensation was stated in terms of the earnings of medical technologists the San Francisco nurse fell quite far below the national average, 78 percent as compared to 97 percent.

These comparisons might be made even more relevant. For example, in mid-1963 throughout metropolitan areas in the United States, the average compensation of the general-duty nurse was 175 percent of the maid's salary; if this same relationship prevailed today in San Francisco the nurse's average compensation would be in excess of $600. (Hospitals' Exhibit 101 shows the maids in the Associated Hospitals as receiving a range from $337.13 to $350.13, whereas in the Affiliated Hospitals the comparable range is from $355.77 to $368.77.) Hospitals' Exhibit 96 shows the average for medical technologists as $592.95. The effective date for this average is not shown. If nurses in San Francisco were paid the percentage of San Francisco technologists' earnings that is characteristic of the relationship that prevails between earnings in these two occupations throughout metropolitan areas, 97 percent, San Francisco nurses would have been earning $575.16 per month

when the data were gathered for Hospitals' Exhibit 96.

A second consideration urged by CNA is that compensation for nurses is below compensation for other comparable professions and notably below that of teachers. Minimum and maximum monthly salaries for San Francisco nurses and teachers are plotted in Chart 8 for the period from January 1959 to January 1967*. Teachers' salaries for San Francisco and Oakland were obtained from Salary Schedules for Classroom Teachers, a yearly publication prepared by the Research Division of the National Education Association. The minimum and maximum rates shown are for a teacher with a Bachelors' Degree or its equivalent. Monthly figures were obtained by dividing the annual salary by ten. Also shown is the maximum to which the teacher's salary may rise after the length of service required by nurses to reach their maximum, that is, after five years.

The salary scales in the various hospitals party to this fact-finding were not precisely uniform for the period covered by this exhibit. The salary data plotted, taken from CNA Exhibit 50, are representative. See also Hospitals' Exhibit 7.

Some question may be raised about the propriety of showing the teacher's monthly salary as one-tenth of her annual salary. But as the essential comparison made in Chart 8 is in terms of relative movement of the salaries, this procedure does not affect the result.

A glance at the curve identified as "teachers' minimum" shows that it rises in almost a straight line, that is, the

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*Basic data for this construction are found in Appendix C.

salary increases at a fairly constant rate. Minimum teachers' salaries rose from $300 per month in 1951 to $636 in July 1966; that is an increase of $336 in 16 years. If minimum salaries for nurses had moved in similar fashion, they would have advanced from $240 in 1951 to $576 by mid-1966. Other features of this chart deserve comment. While in the beginning of 1966 there was a spread of $169 between minimum salaries for nurses and teachers, there was a spread of $482 between maximum salaries. The teachers' minimum was 38 percent greater than the nurses' minimum, but the teachers' maximum was 95 percent greater than the nurses' maximum.

Measured by the typical differential that exists between the compensation of nurses and the compensation of nurses' aides and service personnel or by the characteristic relationship between the salaries of nurses and medical technicians, the disparity in the compensation of nurses in the San Francisco Bay Area is large. The comparison of the compensation of nurses and teachers leads to a similar conclusion. The minimum monthly salary of teachers rose $309 between January 1951 and January 1966, an increase of 103 percent; during the same period the monthly minimum salary of nurses rose $200, or 89 percent. In comparing increases in minimum salaries of employee groups absolute increases (as contrasted to relative or percentage increases) deserve to be given considerable weight. If minimum salaries of nurses had increased by the same absolute amounts as the starting salaries of teachers since 1951, nurses would have

been receiving minimums of $549 per month in January and $576 in July 1966. Moreover, the Panel doubts that the difference in the starting rates of classroom teachers and nurses, well in excess of $100, reflects a comparable difference in training and responsibility.

In the Panel's judgment the evidence just discussed suggests that an inequity exists in the compensation of nurses in the San Francisco Bay Area.

C. The San Francisco Bay Area

Both the CNA and the Hospitals placed in evidence certain wage statistics for other occupations and other industries in the San Francisco area, showing their relationship to wage levels in other cities. Data provided by the CNA tended to show San Francisco wage levels at or near the top in all comparisons. The Hospitals cited other statistics indicating that in many instances San Francisco wages were not in top position and pointed out, further, that wage levels in the surrounding Bay Area were sometimes below those in San Francisco. However, the amount of such data in the record, supplied by both parties, provides an inadequate basis for any clear determination by this Panel that San Francisco ranks first, second, or lower among major cities with respect to average wage levels. Nor is a determination necessary. Wage comparisons with unrelated jobs in other industries can provide only general background for determination of pay issues,

Nevertheless, the Panel cannot completely ignore the

situation reflected in the record and in other published data. The Bureau of Labor Statistics family budget survey shows San Francisco to be a high-cost-of-living area. The exhibits reflect the fact that the city is a high-wage area. In the past the salaries for nurses in Bay Area hospitals have tended to be in the upper levels of salaries in hospitals in other major cities, thus conforming to the pattern in industry generally. For this reason the Panel believes that it should give weight to recent changes in salaries for nurses in other high-wage-area cities.

Inter-urban comparisons of nurses' compensation at this time must be considered unreliable because nurses' salaries are extremely fluid. Substantial changes are occurring rapidly in many cities. With full recognition of that fact, the Panel has examined salary adjustments recently made effective in New York and Los Angeles. Pursuant to the recommendations of an arbitrator, staff nurses in New York City hospitals received an increase of $900 in annual salaries, resulting in a range of $6050 - $7490, effective January 1, 1966, and provision for a further increase of $350 to be effective January 1, 1967, resulting in ranges of $6400 - $8200. Similarly, the following recommendations made by a consulting firm, an increase of more than $1300 annually has been agreed upon for nurses in Los Angeles, resulting in ranges of $6600 - $7800 effective September 1, 1966. The nurses in Los Angeles, however, refused to agree to the amount of a second increase proposed by the consultant to become effective April 1, 1967, which would have resulted in a

range for staff nurse of $6840 - $8100. The amount of that second increase has not yet been determined.

The Panel finds that San Francisco is among the group of cities considered as high-cost-of-living and high-wage areas. It finds, further, that salary increases for nurses in the general magnitude of $1200 to $1300 annually have recently been recommended by third parties and the recommendations have been adopted in two other cities which also generally are classed in the high-cost-of-living and high-wage-area group, one of them the major metropolitan area closest to San Francisco. All of these facts the Panel considers factors of some significance for its recommendations for the Bay Area.

The Panel concludes, therefore, that despite the interim adjustment of July 1966, an inequity continues to exist in the salary level for nurses in the San Francisco Bay Area; that changes have occurred in the duties and responsibilities of registered nurses employed in hospitals; that these changes warrant a reevaluation of the relative position of nurses compared with other hospital personnel in the current hospital salary structure; that, despite increased responsibility, nurses in the Bay Area have failed even to maintain their salary position of a decade and more ago compared with other hospital personnel and other comparable professions in the area; and that salaries for nurses in other comparable cities have moved significantly ahead of those now in effect in the San Francisco Bay Area. On the basis of these facts, the Panel concludes further that a

substantial salary increase for nurses should be recommended in this case. Regard for probable increased costs to the public, to which the Panel has given consideration, should not be a basis for continuation of an inequitable condition which requires one group of employees to contribute more than its fair share to the public welfare. The Panel recommends the following salary ranges:

Effective	1st Year	2nd Year	3rd Year	4th Year	5th Yr. & Thereafter
7/17/66	$525	$540	$555	$575	$595
10/24/66	550	565	580	600	620
1/1/67 *Staff Nurse I, $550					
1/1/67 Staff Nurse II	575	600	625	650	675
4/1/67 *Staff Nurse I, $575					
4/1/67 Staff Nurse II	600	625	650	675	700

Classification

The CNA has proposed that a classification plan be established in the Bay Area hospitals that will give recognition to qualities such as greater education, including continuing education, in-service training, superior performance, or greater skills which an individual registered nurse may bring to the job. The CNA notes that all nurses are not equal in these respects and urges that superior achievement and performance be encouraged and

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*Staff Nurse I is an R.N. with less than three months of hospital, clinic or similar nursing experience. She will move automatically to Staff Nurse II on completing a total of three (3) months of such nursing experience.

Basic wages in effect until December 31, 1967.

recognized. The CNA position is set forth more fully in Guide on Recommended Personnel Policies (CNA Exhibit 52). Representatives of the hospitals have indicated acquiescence to developing a classification system and have participated in some preliminary discussions of it.

In supporting the idea of a classification plan, however, the Hospitals urge most strongly that the parties use accepted methods of job evaluation and examine carefully each step of the process in relation to their own situation. To function well, a classification plan must be designed for the conditions to which it will be applied. Normally, such plans are not readily transferrable from one operation to another, and even when used within the same industry may require modifications to fit the peculiar organization of an individual institution.

A classification plan, the Hospitals observe, must have objective features. It should incorporate clear job definitions which are based on adequate job descriptions. The logic of job evaluation is that it differentiates between the qualifications required by different jobs on the basis of differences in elements that comprise each job. Thus the development of a classification plan calls for an analysis of job elements or factors. At each stage the process requires study and care; it also may require considerable time. Many job evaluation plans have been developed through this procedure, some of them in hospitals. The Hospitals believe that the parties should explore carefully past experience in this area. They observe further

that classification is related only remotely to salaries. A classification and evaluation system effects a relative ranking of jobs according to the relative demands they make on job-holders in terms of training, experience, responsibilities, etc.; the setting of salary scales is a procedure of pricing the jobs in accordance with the ranking that has already been made through the process of job evaluation.

The Hospitals have directed the attention of the Panel to one further point. The present undifferentiated salary structure provides automatic increments based on tenure. Where salary ranges exist in job-classification systems, the range normally is used to recognize superior job performance in the form of merit increases within the range, Classification plans thus distinguish between the individual incumbent and the job content. The job is ranked according to such factors as qualifications required, duties, and responsibilities; evaluation of individual performance permits salary advances within the range applicable to that job. The Hospitals suggest that in order to recognize superior performance, the parties may wish at some future date to reconsider their present structure of automatic within-grade salary increases based upon tenure alone.

From what has been said it is clear that the Panel, with its extremely limited knowledge of hospital organization in general and of the differing systems of organization among the hospitals party to this proceeding, is wholly unable to devise a job classification system for the parties. For this reason they have

referred this issue back to the parties for negotiation, referring at the same time a number of issues that are properly part of or related to the classification issue.

In addition to recommending negotiation of these classification issues and to afford the parties the greatest possible flexibility, the Panel has also recommended a simultaneous wage reopening. To be of the greatest possible assistance to the parties the Panel has decided to retain some measure of jurisdiction in this case pending agreement on these matters that are now subject or will become subject to negotiations. The Panel therefore instructs the parties to inform it of their progress in periodic reports on negotiations.

Specifically the Panel recommends all of the following items be made subject to negotiation which shall commence no later than January 1, 1967, and conclude no later than October 1, 1967. The parties will report to the Fact-Finding Panel every sixty days the status of negotiations on these matters. If the parties cannot agree on these items they shall be subject to the continuing jurisdiction of this fact-finding board. Effective date of negotiated settlement or fact-finding recommendations will be January 1, 1968:

1. Classifications to be negotiated: Job content of Clinical Staff Nurse I, II and III, Head Nurse, Supervisor and the applicable differentials, if any.

2. Tenure credit for experience (Item No. 5 CNA Exhibit 39).

3. Promotion (Item No. 6, CNA Exhibit 39).

4. Education premium (Item No. 7, CNA Exhibit 39).

5. Relief in higher classification (Item No. 9, CNA Exhibit 39).

6. Double time when assigned additional duties such as dual assignments (Item No. 12, CNA Exhibit 39).

7. Full-time float-nurses premium (Item No. 16, CNA Exhibit 39).

8. Base salary shall be open for negotiation in addition to the above-described classification negotiations.

Other Issues

1. Per Diem Rate (Item No. 8, CNA Exhibit 39).

In its Exhibit 39 CNA said:

> The number of part-time nurses employed in the Bay Area is significant. Many hospitals could not operate without them. Nurses employed intermittently, or on a regular schedule of less than 20 hours per week, do not receive the usual fringe benefits. Thus, the proposal for 20 percent in lieu of fringe benefits added to the prorated salary.

The Panel judges that the cost of fringe benefits for the full-time nurse should be prorated and paid to the part-time nurse in proportion to the amount of time she actually works. For this reason, the Panel recommends that the parties work out a proration of the contractual benefits taking care to avoid any duplication of benefit credits.

2. Holidays (Item No. 21, CNA Exhibit 39).

CNA requested two additional paid holidays and three days of personal leave. Some of the hospitals who are party to this proceeding now grant eight paid holidays annually, others grant

seven. The Panel believes that the record supports a recommendation of eight holidays. Certain considerations suggest that the added holiday should be the individual's birthday.

3. Holidays Worked (Item No. 10, CNA Exhibit 39).

CNA in its Exhibit 39 said with respect to this issue:

> Currently most nurses (75% according to CNA Questionnaire) work on holidays. When they work they are given another day off with straight-time pay within 30 days. This is not premium payment, but rather a postponement of the holiday.
>
> The practice in other industries, for many years, has been to pay a premium in cash. The next CNA exhibit shows that 94% of workers covered by contracts in this metropolitan area receive premium pay; the greatest percentage receiving double-time.
>
> The CNA proposal amounts to 1/2 pay additional, since the nurse does get another day off with pay. The proposal is modest, we believe, in view of the constant inconvenience, and the comparative data above.

The Panel believes that the nurse who is obliged to work on one of the scheduled holidays should be paid a premium (time and one-half rate) for the inconvenience of working the holiday. In addition, she should receive holiday pay for the holiday if she qualifies for it under the agreement.

4. Shift Differential (Item No. 14, CNA Exhibit 39).

In discussing this proposal CNA said in its Exhibit 39

> Most of the San Francisco non-governmental hospitals now pay 9% of the first-year rate for the 3-to-11 shift, and 6% of the first-year rate for the 11-to-7 shift.
>
> S.F. City and County and U.C. Hospitals pay 10% above the nurses' regular rate. In S.F. City and County facilities the 10% differential amounts to a prevailing payment of $62 to $75 depending upon the tenure step of the nurse.

* * *

> In view of the difficulty in hiring nurses, particularly for the 3-to-11 shift, because these are the social hours; and in view of the reports that evening and night nurses have heavier patient loads, the CNA proposal does not seem unreasonable as a recruiting device.

The Panel believes that the record justifies a recommendation of a shift differential of 9 percent of the first-year rate of Staff Nurse II (See Item No. 1 of the Panel's recommendation below) for the shift that begins in the afternoon (at about 3 or 4 p.m.) and 6 percent of that rate for the shift that begins at night (about 11 p.m. or midnight).

5. Automatic Approval of Leaves for Professional Activities (Item No. 18, CNA Exhibit 39).

> CNA Exhibit 39 summarized the CNA position on this proposal as follows:
>
> The nursing profession, and nursing organizations, like other professions and professional organizations, are involved, from time to time, in activities such as educational conferences, conventions, seminars, committee meetings, study groups, legislative hearings, etc.;
>
> Many nurses wish to participate, but generally have difficulty obtaining such leaves. (There are exceptions, however.)
>
> Participation is important, not only to the individual R.N. but also to nurse colleagues, patients and employers of nurses.
>
> CNA proposes automatic approval of such leaves for legitimate professional activities, without pay, but without change of anniversary date.

The Panel agrees with CNA that the desires of nurses to improve their competence and to keep abreast of developments within their profession should be encouraged. At the same time

it recognizes that in considering requests for leaves, hospital administrators must always be guided by the staffing needs of the hospital. The Panel's recommendation in this matter says in effect that legitimate requests of nurses for leaves to participate in professional activities should be granted if staffing needs of the hospital permit. It does not recommend automatic leaves in the sense that a request must be approved once it has been made. It leaves the hospital administration the judge of its staffing needs, but assumes that it will act in good faith.

6. Dental Insurance (Item No. 25, CNA Exhibit 39).

> In its summary of the CNA position on this matter, CNA Exhibit 39 said:
>
> Paid Dental Insurance is becoming a part of many union Agreements in the Bay Area and in California generally.
>
> According to the California Dental Service in San Francisco, an organization which sells such insurance, approximately 546,000 men, women and children in the Bay Area are now covered by Dental Insurance fully paid by employers, usually at 5¢ per hour.

This proposal contemplates a relatively costly new fringe benefit. The Panel's recommendation would oblige the hospitals to discuss this matter with CNA prior to January 1, 1968, only if such benefits shall have been granted to the Hospital and Institutional Workers Union through a collective bargaining agreement with the Associated, Affiliated, Voluntary, or Kaiser Hospitals.

7. Term of the Agreement.

The Panel's recommendation contemplates an agreement that becomes effective as of July 17, 1966, and runs through December

31, 1968. It provides, however, for a reopening on basic salary as of January 1, 1968, and for the negotiation of classifications and certain related matters and that the effective date of any negotiated settlement or fact-finding recommendation on basic salary or on classifications and related matters shall be January 1, 1968 (See Recommendations II, 1 to 8, below).

The observation in the Recommendations that the parties may undertake economic action with respect to the open items identified above (and in Section II of the Recommendations) implies that such action should be undertaken only after earnest efforts to reach agreement, after reporting the impasse to the Panel, and after giving full consideration to whatever recommendations the Panel might make in the matter. It also implies that the Panel before making recommendations might hold a hearing and request the parties to present evidence and argument on the matters in controversy.

8. CNA requests about which the Panel is silent.

The failure of the Panel in its Recommendations to mention or to make a specific recommendation with respect to particular CNA requests is to be regarded as a recommendation that such requests be dropped.

The reasons for recommending dropping of such requests should be obvious. The Panel has recommended adjustments that are unprecedented in magnitude. The Panel has also left basic salary and a number of other cost items open for negotiations in 1968. These negotiations may result in further additions to

hospital costs. The parties themselves left to local negotiation a number of other issues which likewise are potentially quite costly. We are dealing, therefore, with an increase in payroll costs that is already very large and that may become even larger during the current contract period. Hospitals may adjust to some of this increase in costs by improved utilization of their staffs. Such improvements, however, can be realized only slowly. And the resulting economies, the Hospitals contend, will not be of such magnitude as to compensate for any major increase in nurses' compensation but that the greater part of such costs must be passed on to the public in the form of higher hospital rates. On the basis of all the evidence the Panel recommends that those requests be dropped about which it is silent in its Recommendations.

RECOMMENDATIONS

I. Salary:

Effective	1st Year	2nd Year	3rd Year	4th Year	5th Yr. & Thereafter
7-17-66	$525 ($25)	$540 ($25)	$555 ($25)	$575 ($25)	$595 ($25)
10-24-66	550 ($25)	565 ($25)	580 ($25)	600 ($25)	620 ($25)
1-1-67 *Staff Nurse I,	$550				
1-1-67 Staff Nurse II	575 ($25)	600 ($35)	625 ($45)	650 ($50)	675 ($55)
4-1-67 *Staff Nurse I,	$575				
4-1-67 Staff Nurse II	600 ($25)	625 ($25)	650 ($25)	675 ($25)	700 ($25)
	($100)	($110)	($120)	($125)	($130)

*Staff Nurse I is an R.N. with less than three months of hospital,

clinic or similar nursing experience. She will move automatically to Staff Nurse II on completing a total of three months of such nursing experience.

These basic wages will remain in effect until December 31, 1967.

II. The following items are subject to negotiation which shall commence no later than January 1, 1967 and conclude no later than October 1, 1967. The parties will report to the Fact-Finding Panel every 60 days the status of negotiations on these matters. If the parties cannot agree on these items they shall be subject to the continuing jurisdiction of this fact-finding board. Effective date of negotiated settlement or fact-finding recommendations will be January 1, 1968:

1. Classifications to be negotiated:
   Job content of Clinical Staff Nurse I, II and III, Head Nurse, Supervisor and the applicable differentials, if any.

2. Tenure credit for experience
   (Item No. 5, CNA Exhibit 39).

3. Promotion (Item No. 6, CNA Exhibit 39).

4. Education premium (Item No. 7, CNA Exhibit 39).

5. Relief in higher classification (Item No. 9, CNA Exhibit 39).

6. Double time when assigned additional duties such as dual assignments (Item No. 13, CNA Exhibit 39).

7. Full-time float-nurses premium (Item 16, CNA Exhibit 39).

8. Base salary shall be open for negotiation in addition to the above described classification negotiation.

III. Per Diem Rate (Item No. 8, CNA Exhibit 39):

In connection with each of the above-described adjustments, the parties will work out a proration of contractual fringe benefits provided to the full-time nurse. This proration will be computed so that fringe-benefit credit will not be duplicated (e.g., social security shall not be an additional cost factor). The parties shall have worked out the arithmetic of this computation no later than November 15, 1966.

IV. Holidays (Item 21, CNA Exhibit 39):

Eight holidays (one of which shall be the nurse's birthday) shall be the minimum number of paid holidays in the hospitals subject to this proceeding. Any birthday subsequent to July 17, 1966 shall be a paid holiday, provided that the nurse has had a year of continuous employment. Any such birthday occurring between July 17 and October 24, 1966 shall be satisfied by granting an alternate day off with pay.

V. Holidays Worked (Item No. 10, CNA Exhibit 39):

Effective October 24, 1966, a nurse working on one of the scheduled holidays shall receive time and one-half for all hours worked on the holiday and the holiday pay, if any, to which she is entitled.

VI. Shift Differential (Item No. 14, CNA Exhibit 39):

Effective January 1, 1967, the shift differential shall be 9 percent on the evening shift and 6 percent on the night shift of the first-year rate of the Staff Nurse II salary range.

VII. Automatic Approval of Leaves for Professional Activities (Item 18, CNA Exhibit 39):

The Panel believes it is desirable for the nurses to participate in professional activities so long as it is not inconsistent with staffing requirements of the hospitals and that the hospitals should grant such leaves.

VIII. Dental Insurance (Item No. 25, CNA Exhibit 39):

In the event that dental benefits are added to Associated, Affiliated, Voluntary or Kaiser agreements with the Hospital & Institutional Workers, the hospitals will discuss this matter with the CNA prior to January 1, 1968.

IX. Term of Agreement:

Standard duration clause running from July 17, 1966 to and including December 31, 1968 except that an opening shall be provided on January 1, 1968, at which time either party may undertake economic action with respect to the items for which the Agreement is open as above described.

X. There shall be no reduction of present salaries or fringe benefits by reason of the Fact-Finding Panel recommendations.

--- ---

Respectfully submitted:

/s/ LEO C. BROWN
Leo C. Brown, Chairman

/s/ ADOLPH M. KOVEN
Adolph M. Koven

/s/ HOWARD E. DURHAM
Howard E. Durham

Recommendations issued:
San Francisco, California
October 21, 1966
Opinion issued:
San Francisco, California
November 14, 1966

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APPENDIX A

Participating Hospitals and Clinics

Group Identification & Name

Associated Hospitals for the East Bay

1.	Alameda Hospital	2070 Clinton Avenue	Alameda
2.	Alta Bates Community Hospital	Webster at Regent	Berkeley
3.	Children's Hospital of the East Bay	51st & Grove	Oakland
4.	Herrick Memorial Hospital	2001 Dwight Way	Berkeley
5.	Merritt Hospital	Hawthorne & Webster	Oakland
6.	Peralta Hospital	450 30th Street	Oakland
7.	Providence Hospital	30th & Summit	Oakland
8.	St. Rose Hospital*	27200 Calaroga Ave.	Hayward

Independent Hospitals of the East Bay

1.	Albany Hospital	Main Avenue & Masonic	Albany
2.	Vallejo General Hospital	601 Tennessee Street	Vallejo

Affiliated Hospitals of San Francisco

1.	Callison Hospital	1055 Pine	San Francisco
2.	Children's Hospital	3700 California	" "
3.	Golden Gate Hospital	1065 Sutter	" "
4.	Hahnemann Hospital	3698 California	" "
5.	Mary's Help Hospital	145 Guerrero	" "
6.	Mount Zion Hospital & Medical Center		
7.	Notre Dame Hospital	1600 Divisadero	" "
8.	St. Joseph's Hospital	Park Hill & Buena Vista Ave. E.	" "
9.	St. Luke's Hospital	1580 Valencia	" "
10.	St. Mary's Hospital	Hayes & Stanyan	" "
11.	Sutter Towers**		" "

Voluntary Hospitals of San Francisco

1.	Franklin Hospital*	14th & Noe	San Francisco
2.	French Hospital	5th Ave. & Geary	" "
3.	Presbyterian Medical Center*	Clay & Webster	" "
4.	St. Francis Memorial Hospital	900 Hyde	" "

Kaiser Medical Care Entities

Hospitals:

1.	KFH - Oakland*	280 W. MacArthur Blvd.	Oakland
2.	KFH - Richmond	14th & Cutting Blvd.	Richmond
3.	KFH - Sacramento*	2025 Morse Ave.	Sacramento
4.	KFH - San Francisco*	2425 Geary Blvd.	San Francisco

Kaiser Medical Care Entities
Hospitals (Continued):

5.	KFH - Santa Clara*	900 Kiely Blvd.	Santa Clara
6.	KFH - South San Francisco*	500 Grand Ave.	S. San Francisco
7.	KFH & KFRC - Vallejo	2600 Alameda St.	Vallejo
8.	KFH - Walnut Creek*	1425 So. Main St.	Walnut Creek
9.	KFH - Hayward*	27400 Hesperian Blvd.	Hayward

Kaiser Medical Care Entities
Clinics:

1.	PMG - Antioch*	3400 Delta Fair Blvd.	Antioch
2.	PMG - Hayward*	27400 Hesperian Blvd.	Hayward
3.	PMG - Martinez*	525 Green Street	Martinez
4.	PMG - Napa	3284 Jefferson	Napa
5.	PMG - Oakland*	280 W. MacArthur Blvd.	Oakland
6.	PMG - Redwood City*	910 Maple Street	Redwood City
7.	PMG - Richmond*	14th & Cutting Blvd.	Richmond
8.	PMG - Sacramento*	2025 Morse Avenue	Sacramento
9.	PMG - San Francisco*	2200 O'Farrell	San Francisco
10.	PMG - San Rafael (Marin)*	1930 4th Street	San Rafael
11.	PMG - Santa Clara*	900 Kiely Blvd.	Santa Clara
12.	PMG - South San Francisco*	500 Grand Avenue	S. San Francisco
13.	PMG - Sunnyvale*	690 Grape Avenue	Sunnyvale
14.	PMG - Vallejo*	2600 Alameda St.	Vallejo
15.	PMG - Walnut Creek*	1425 So. Main St.	Walnut Creek

*The hospital adopts the conditions negotiated by the group of which it is a member but does not have a contract with the California Nurses' Association.

**The hospital is a member of Affiliated Hospitals; it has a contract with California Nurses' Association but did not participate in providing information for presentation to the Panel.

APPENDIX B

CALIFORNIA NURSES'ASSOCIATION
Administrative Office
185 Post Street
San Francisco 94108 - YUkon 6-2220

MARIAN ALFORD, R.N.
Executive Director

C O P Y

520 West Seventh Street, Los Angeles 90014 - MAdison 7-4261

MEMORANDUM OF UNDERSTANDING

Whereas The Bay Area Hospitals Negotiating Committee on behalf of its named participants and The California Nurses' Association have agreed to submit 25 issues to the fact finding and to refer 12 other issues to local negotiations with individual hospitals or Associations, as the case may be; and

Whereas the hospitals on July 17, 1966 have placed in effect a range of $500 to $570 a month for general duty nurses; and

Whereas the nurses have rejected the above mentioned range and have proposed instead a range of $600 to $720 a month; and

Whereas the said interim adjustment for the period July 17, 1966 through December 31, 1966 is the only remaining issue to be resolved;

Now, therefore, it is hereby agreed:

1. The Hospitals and CNA will jointly petition the Governor of the State of California, the Secretary of Health, Education and Welfare, and the Secretary of Labor to appoint a three member fact finding panel. This fact finding Panel shall make advisory recommendations as hereafter outlined with respect to the following:

   A. The 25 cost items, including salary commencing January 1, 1967, which the parties agreed to submit to the panel on July 29, 1966. In connection with these matters it is stipulated that the recommendations shall cover a period of time two years, January 1, 1967 through December 31, 1968.

   B. The appropriateness and fairness of the interim salary scale for general duty nurses of $500 to $570 a month placed in effect by the hospitals on July 17, 1966 for the period July 17, through December 31, 1966. In the event that the parties accept a recommendation that such interim adjustment should be higher, then at the option of each

hospital such retroactivity may be paid in a lump sum or in equal monthly installments up to twelve commencing February 1, 1967, provided that such retroactivity recommendation shall not be applicable to any hours worked prior to July 17, 1966.

2. The Panel shall hold hearings jointly with both parties who shall present oral and written evidence and arguments to support their respective positions.

3. On or before December 1, 1966, the panel shall submit its recommendations to the parties, who shall advise the panel and each other no later than December 15, 1966, regarding their respective positions on the panel's recommendations.

4. Negotiating matters referred to local hospitals or hospital groups may commence at such time as the respective individual hospitals or hospital Associations agree with CNA, provided, however, that any and all threats of economic action, including resignations or other forms of stoppage shall be withdrawn pending the results of fact finding with respect to all recommendations of the panel.

5. It is agreed that for the purpose of equitably dividing the cost of the Panel, including expenses connected therewith, the following organizations shall bear an equal share

   A. Affiliated Hospitals
   B. Associated Hospitals and Voluntary Hospitals
   C. Kaiser Foundation Hospitals
   D. California Nurses' Association

6. Finally, it is agreed that the following is in full settlement of all current discussions between CNA and the hospitals. Neither the CNA, its agents, members or supporters nor the hospitals, their agents or employees shall in any way discriminate against any person, organization or each other by reason of CNA activity, submission of resignations, failure to submit resignations, or any legitimate activity occurring during the July 1 to August 3, 1966 controversy.

IN WITNESS WHEREOF the undersigned have executed this Memorandum of Understanding on this 2nd day of August 1966.

CALIFORNIA NURSES' ASSOCIATION

BY: (s) A. Lionne Conta

BAY AREA HOSPITAL NEGOTIATING COMMITTEE

By: (s) Lawrence P. Corbett
(s) Arthur Mendelson
(s) Edwin Bell

CALIFORNIA NURSES' ASSOCIATION

August 2 1966

RESULTS OF BAY AREA NEGOTIATIONS TO DATE

A. COST ITEMS TO BE PRESENTED TO A FACT FINDING PANEL: (To be comprised of three members: one appointed by the Governor of the State of California, one by the Secretary of Health, Education and Welfare, and one by the Secretary of Labor.

The Panel will make advisory recommendations to both parties.

The Panel shall hold hearings jointly with both parties who shall present oral and written evidence and arguments to support their respective positions.

On or before December 1, 1966, the Panel shall submit its recommendations to the parties, who shall advise the Panel and each other, no later than December 15, 1966, regarding their respective positions on the Panel's recommendations.

Negotiations on other matters requested by CNA, of the Hospitals, will be on an individual basis between CNA and the individual hospitals or groups of hospitals involved.

The parties agree to share equally the cost of compensating the Panel, together with reimbursement for administrative expenses of the Panel.

1. Amount of Interim Salary for the agreed upon period July 17, 1966 to December 31, 1966. (Sum to be paid on or after February 1, 1967 in one lump sum or equal monthly payments up to 12 months.)

2. Salaries to be effective January 1, 1967 - December 31, 1968.

3. Head Nurse -- 15% above General Staff Nurse II

4. Supervisor -- 15% above Head Nurse

5. For each (5) years' previous experience, one year tenure credit, applicable to currently employed and newly employed.

6. Promotion -- Promote from current tenure step to same step in salary range to which promoted.

7. Education premium -- 5% additional for Baccalaureate Degree
10% additional for Masters Degree

8. Per Diem Rate -- For nurses employed intermittently, or working less than twenty hours per week: prorate of full time salary plus 20% in lieu of fringe benefits.

9. Relief in higher classification -- Payment for major portion of each shift worked. Payment to reflect exact percentage differential in salary range of nurse relieving and nurse relieved.

10. Holidays worked -- Premium pay at the rate of 1-1/2 time in cash, plus one (1) paid compensatory day off.

11. Saturday or Sunday work -- 15% additional over regular rate, plus every other weekend off.

12. Call-back guarantee -- Four (4) hours at double time after completion of eight (8) hours per day and forty (40) hours per week.

13. Double time when assigned additional duties such as dual assignments.

14. Shift differential -- 15% above nurses' regular rate for 3 to 11 shift.
10% above nurses' regular rate for 11 to 7 shift.

15. Nurses to work double shifts only in compliance with IWC orders. (Double time for second shift of double shift.)

16. Full time float nurses to be paid 10% above nurses' regular rate of pay.

17. Half tuition paid by hospital for nurses studying toward Degrees.

18. Upon request, automatic approval of professional leaves for professional business up to 30 days without pay and without change of anniversary date.

19. Five (5) days paid education leave per year.

20. Sick leave -- 90 day accumulation. Elimination of all waiting periods.

21. Holidays - Add choice of two (2) religious holidays, plus three (3) days per year personal leave paid by employer.

22. Vacations - one week after six (6) months; four (4) weeks after one (1) year.

23. Life insurance -- increase to $5,000 ($2,500 of each type)

24. No discrimination against any registered nurse who files complaint with Industrial Welfare Commission directly or through CNA Field Representative.

25. Dental insurance paid by employer.

26. Vacation relief.

NON-COST ITEMS TO BE PROCESSED THROUGH LOCAL NEGOTIATIONS UNDER EACH HOSPITAL CONTRACT OR GROUPS OF HOSPITAL CONTRACT

A. Membership in CNA -- Mandatory within 90 days after initial employment,

B. Monthly meetings of Professional Performance Committee in each hospital with Director of Nursing Service, Hospital Administrator and CNA RN Field Representative. Purpose: to discuss constructively matters relating to constantly improving patient care and professional performance. (All contractual matters excluded.) CNA representatives to attend as time permits.

C. Effective in-service training program.

D. Effective performance evaluation program.

E. Joint preparation of up-to-date job descriptions during term of Agreement.

F. Clause providing that there shall be no dismissals except for just cause. Nurse and/or representatives may protest dismissal within five (5) calendar days after nurse and CNA are notified of dismissal and reason for same. Protest to be made through grievance procedure if the nurse and/or CNA consider the dismissal to be for reasons other than just cause.

G. Retirement Plan Improvements -- a) increase benefits by 100%
b) improve vesting provision to provide 50% vesting after fifteen (15) years continuous service and 5% per year thereafter.
c) add voluntary contributory program
d) where applicable, drop qualifying age to 25
e) where applicable, drop 2 years qualifying period.

H. Health Plan -- Add major medical and surgical, plus coverage for dependents under 21.

I. No discrimination in employment, or employment conditions, due to sex, race, creed, national origin, political affiliation or age.

J. Extension of current Kaiser-CNA Agreement to cover all facilities north of the Tehachapi. CNA requests representation election under the auspices of California State Conciliation Service as soon as possible if voluntary extension of master agreement is not granted.

K. Head nurses to be included under CNA agreements with Affiliated and voluntary hospitals of San Francisco. If voluntary inclusion not granted, CNA requests representation election under the auspices of California State Conciliation Service.

L. Retirement plans at least equivalent to Associated and Kaiser retirement plans to be instituted by January 1, 1967 in the following hospitals: Vallejo General; Concord Community; Pittsburg Community and Antioch.

PROPOSALS THAT HAVE BEEN DELETED BY MUTUAL AGREEMENT

1. Request that Directors of Nursing study the institution of Clinical Staff Nurse class.

2. Elimination of time clocks, but retention of timecards.

3. Meetings of Professional Performance Committee in each hospital with Medical Staff Representatives when requested by Committee to discuss matters relating to patient care. Dates of meetings to be arranged by mutual agreement.

PROPOSALS ACCEPTED FOR IMMEDIATE ACTION

1. Concerted effort by hospitals to protect evening and night nurses during change of shifts when leaving and entering the premises - after nurses covered under each contract indicate which hospitals need to take action.

A FINAL POINT OF AGREEMENT

Neither the CNA, its agents, members or supporters nor the hospitals, their agents or employees shall in any way discriminate against any person, organization or each other by reason of CNA activity, submission of resignations, failure to submit resignations, or any legitimate activity occurring during the July 1 to August 3, 1966 controversy.

APPENDIX C

SALARY SCHEDULES, SAN FRANCISCO TEACHERS AND NURSES 1946 - 1966

Date effective	Teachers[1] Minimum[3]	Teachers[1] Maximum[3]	Staff & General Duty Nurses[2] Minimum	Staff & General Duty Nurses[2] Maximum
Jan. 1946			$200	$215
Jan. 1947			200	215
Jan. 1948			215	230
Jan. 1949	$270	$480		
Jan. 1950				
Jan. 1951	300	510	240	255
Jan. 1952			255	270
July 1, 1952			260	275
Jan. 1953	347	567	275	290
Jan. 1954			285	300
Jan. 1955	362	600	295	310
Jan. 1956			295	310
Jan. 1957	425	652	320	350
Jan. 1958	450	697	320	350
Jan. 1959	467	727	335	365
Jan. 1960	477	737	345	390
Jan. 1961	506	785	355	410
Jan. 1962	506	824	367	425
Jan. 1963	533	871	387	445
Jan. 1964	557	908	400	455
Jan. 1965	584	954	420	480
Jan. 1966	609	992	440	510
July 17, 1966	636	1040	500	570

1/ San Francisco teachers salary schedules are found in Salary Schedules for Classroom Teachers, a publication of the Research Division of the National Education Association.

2/ Source of salary figures for Staff and General Duty Nurses: Bay Area Hospitals' Negotiating Committee, Exhibit #7.

3/ Salaries quoted in source cited in footnote #1 are for teachers with a Bachelor's Degree or equivalent. Minimum and maximum monthly salaries arrived at by dividing annual salaries by ten (10).

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