

Impact of a Hospital-Wide Nursing Strike on an Emergency Medicine Residency: Lessons Learned

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Introduction

After negotiations failed, and with 10 days prior notice, a nursing strike began at our large urban academic hospital at 6 AM on January 9, 2023. The goals of the strike were to improve pay, working conditions, and patient safety. As preparation for a potential strike began in the emergency department (ED), questions arose regarding residents' roles: Which tasks were appropriate? Can residents handle medications? How might work hours be affected? How should the emotional aspects of the strike be addressed?¹

While prior studies have briefly discussed anticipatory strike planning from a hospital operations standpoint,²⁻⁴ there is less information on proper preparation of residency programs for a nursing strike. Residency programs present unique challenges due to the need to comply with Accreditation Council for Graduate Medical Education (ACGME) and local graduate medical education (GME) rules,⁵ and maintain their educational mission. As labor union actions increase nationwide, we present lessons learned, with an ED focus, during a 3-day nursing strike in New York City.

Early Effects of the Strike

Our hospital experienced gaps in nurse staffing despite some union nurses remaining and nursing contributions from other hospitals in our system, emergency travelers, and non-unionized nurse managers. Further stress on the hospital and ED was somewhat mitigated by a few factors. First, our hospital was able to shift patients to other hospitals within the health system that were unaffected by the strike, while media coverage and local awareness of the strike likely contributed to a decrease in walk-in ED patients. In smaller health systems or in areas with lower health care density, shifting resources and diverting patients may be more challenging.

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Editor's Note: The online supplementary data contains the staffing hours and costs.

Lesson 1: Identify Which Tasks Residents Can and Cannot Perform

Creative solutions to maintain patient care during the strike were explored. Among those were opportunities for residents to moonlight in-house to help alleviate patient care burden. This raised the pressing question of what could be asked of residents within ACGME guidelines. The ACGME mandates that any clinical work, including moonlighting, and educational activities must not exceed 80 hours per week.⁶

Our GME office provided the following guidelines:

- Work hour restrictions would remain in place.
- Weekly conferences would continue without interruption.
- Patient care responsibilities for surgery and anesthesiology residents could shift if elective procedures were canceled.
- Residents would not be asked to move their vacations.
- Residents and fellows could be offered extra shifts for extra pay.

While residents cannot be relied upon for non-physician tasks during their normal work duties, the ACGME does not specifically comment on non-physician tasks in a moonlighting capacity. Therefore, we relied on institutional guidance to determine acceptable tasks. Our institution's GME office gave instructions regarding residents who signed up to work outside of their normal duties. These aimed to avoid relying on residents for "non-physician obligations"⁶ and included: "Residents and fellows will not be required to perform functions typically performed by nurses. This includes but is not limited to medication administration, transfusion, daily nursing care, and RN documentation."

We worked closely with operations leadership, physician assistant (PA) leadership, and the GME office to coordinate the planned operational changes. Our chief residents were integral partners in coordinating

moonlighting residents and monitoring for effects on education.

Lesson 2: Patient Volumes May Be Affected

Three hundred ninety adult patients registered over the 3 days, a 34% decrease from the same 3 weekdays in 2022 that had 593 adult patient registrations. The hospital was on full emergency medical services (EMS) diversion for the first day of the strike, followed by critical care diversion for the remainder. Residents already scheduled to work were expected to maintain their usual patient care roles during the strike. Therefore, residents on shift saw fewer patients.

Lesson 3: Creating a Novel Role Helped Balance Operational Needs and Education

We did not modify the existing resident work schedule to preserve normal educational opportunities. The operations leadership requested that we help create novel ad hoc positions to be offered for moonlighting in response to the anticipated lack of nursing staff. We created “zone captains,” a role suited to moonlighting senior residents, aimed at concentrating available nursing staff in the truly nursing-only roles, and providing senior residents novel practice in triaging tasks and prioritizing ED flow. Zone captains sought to optimize available resources to match the needs of both the patients and the department.

Chief residents also offered “nursing-support” shifts to faculty, residents, and PAs (including from other departments). The department reimbursed these hours at normal moonlighting rates. Residents scheduled for sick call were not allowed to moonlight.

The zone captains triaged needs of their zone while also performing and delegating tasks, including but not limited to placing IVs, performing EKGs, placing patients on monitors, obtaining vital signs, transporting patients to/from radiology, collecting urine samples, and providing food and blankets to patients.

Zone captains worked closely with ED technicians to help them prioritize tasks. Zone captains also managed staff who were reassigned to the ED, such as urology and renal fellows who helped place foleys, cardiac anesthesiologists who placed IVs, and orthopedics PAs. Other than a few common, non-controlled medications which were accessible without a nurse, medication administration was performed by nursing staff. These roles were designed for the ED. A similar structure with experienced clinicians managing a team of moonlighters, redeployed staff, and other additional resources may be applicable in other patient care settings.

Lesson 4: Budgeting for Personnel Costs

In total, offered moonlighting shifts included 10 day shifts (7 AM-7 PM), 5 midday shifts (11 AM-11 PM), and 7 night shifts (7 PM-7 AM). This represented 264 available moonlighting hours per day. Residents were given the option to take partial shifts in order to maximize flexibility and remain within ACGME duty hours.

The online supplementary data contains a table with the cost of moonlighting time. The total cost to the hospital was \$35,310 over 321 hours (\$110/hour). One hundred fifty-five hours were filled by residents, with the remaining 166 filled by PAs. Fourteen (out of 99 total) residents worked 19 shifts, with an average shift length of 8 hours (range: 1.5-12 hours). Nearly 75% of the hours covered occurred on the first 2 days of the strike, totaling 239 hours. For reference, this represented approximately 18% of the 1780 hours of nursing staffing in the ED the preceding Monday through Wednesday.

Lesson 5: Expect and Acknowledge a Spectrum of Emotions

As the strike approached, our residents experienced a variety of reactions, from sympathy and support for our nurses, to a sense that nurses were abandoning patients. Picket lines were just outside the main ED entrance. Many residents have strong personal and professional relationships with our nursing colleagues and wanted to both serve patients and support the striking nurses. Many residents would visit the picket lines and join the nurses before or after shifts. Residency leadership facilitated conversations during that week’s didactic conference to allow residents to share and process their feelings.

Residency leadership was careful to avoid either disparaging or supporting the nursing union’s actions. Our emphasis was on keeping patients safe. This goal was in line with both those supporting and opposing the strike: poor patient outcomes, whether rightly or wrongly attributed to the strike, would negatively affect all parties. Communications outside of the residency’s purview included at times inflammatory social media posts and other messaging, from both sides. Thus, it was of the utmost importance for residency leadership to focus on supporting residents, rather than attempting to shape a narrative.

Conclusion

Labor action from unions may substantially affect residents. In preparing and responding to a nursing strike, our residency leadership team learned several applicable lessons that may be valuable for any GME program preparing for nursing labor action.

Consistent communication between the residency leadership team, GME office, operations team, and residents is critical. While careful planning with as much notice as given is key, flexibility and adaptability with roles and staffing are even more important. Ultimately, residency leaders must anticipate, acknowledge, and empathize with the diverse emotions that residents and staff will feel during labor action. It is imperative that every decision is anchored in this understanding and fosters a supportive environment for trainees.

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