Summary

- Cardioversion to sinus rhythm should be considered for all suitable patients in atrial fibrillation
- In the short term both pharmacological and electrical cardioversion restore sinus rhythm
- Prophylactic treatment with antiarrhythmic drugs is advisable after cardioversion in high risk patients in view of the high relapse rate
- Anticoagulants should be started before non-emergency cardioversion—ideally two to three weeks before—and continued for at least four weeks after cardioversion in patients with atrial fibrillation of >48 hours' duration

Key references

- ACP/ACC/AHA Task Force Statement. Clinical competence in elective direct current (DC) cardioversion. *J Am Coll Cardiol* 1993;22:336-9
- Clark A, Cotter L. Practical procedures—DC cardioversion. *Br J Hosp Med* 1991;46:114-5
- Laupacis A, Albers GW, Dunn JE, Dunn MI, Feinberg W, Jacobson AK. Antithrombotic therapy in atrial fibrillation. *Chest* 1995;108(suppl):352-9S
- Lip GYH. Cardioversion of atrial fibrillation. *Postgrad Med J* 1995;71:457-65

The duration of the arrhythmia seems to be the most important factor influencing prognosis after cardioversion. Twice as many patients who have had atrial fibrillation for less than three months remain in sinus rhythm as patients who have had atrial fibrillation for more than 12 months.

A more comprehensive version of this article can be found in Lip GYH, *Postgrad Med J* 1995;71:457-65.

The source of the data in the box of recommendations for anticoagulation before and after cardioversion is Laupacis A *et al*, *Chest* 1995;108 (suppl):352-9S. The histogram was adapted from Dittrich *et al*, *Am J Cardiol* 1989;63:193-7.

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Job sharing at a children's hospital: evaluation by medical staff

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Abstract

Objective—To evaluate job sharing for registrars at Princess Margaret Hospital for Children, Perth, by seeking responses from members of the relevant medical teams.

Design—A questionnaire was sent to all 126 medical staff within the hospital (and three managers in medical administration) asking their views on job sharing for registrars.

Outcome measures—Whether job sharing should continue, who should do it, at what stage of training, and the effects on patient care.

Results—Among the 77 respondents (60%) there was broad support for the continuation of job sharing at the hospital: only 5 of 37 consultants and 2 of 19 non-job sharing registrars rejected the idea (with a further 4 consultants uncertain). 43% Of the consultants who had worked with job sharing registrars thought continuity of care was adversely affected.

Conclusion—The committee for physician training of the Royal Australasian College of Physicians emphasises that advanced training should be flexible, with a wide range of opportunities for individuals to plan an appropriate training programme in line with their personal goals. This study has shown that job sharing for registrars at Princess Margaret Hospital for Children allows this choice. Action on concerns over any adverse effects on patient care should resolve any persisting disquiet.

time they work, and each holds a permanent part time post.²² When the scheme started job sharing had not been implemented to any significant degree in other teaching hospitals in Australia,¹ and published reports are confined to sporadic single case reports.^{3,5} The aim of this study was to evaluate job sharing for registrars at Princess Margaret Hospital.

Methods

A questionnaire was sent to all medical staff at Princess Margaret Hospital and anonymous responses invited. The questionnaire was in a multiple choice format with some questions giving an option for comment. The questions covered five categories of data: (a) details of respondent, gender, and experience of working with a job share team; (b) views on who should be eligible to share jobs; (c) the future role of job sharing for registrars in the hospital; (d) the stage of training most suitable for job sharing; and (e) consultants' views on the impact of job sharing on patient care and supervision and training of registrars. In addition the medical administration department received selected questions on selecting partners for a shared job and the effect or otherwise on their workload.

Results

Information on the job share team rosters for 1989-93 showed that 53 of the 62 (86%) medical consultants had worked with a job share team at least once. Questionnaire response rates are shown in table 1. The ratio of the gender of the respondents was in keeping with the known ratio of men to women at each level. All registrars who had taken part in job shares were women and all but one had young children.

All medical groups supported the continuation of job sharing at the hospital (table 2). The responses to the remaining core questions were similar for each group and are presented as an overall response in table 2. Questions about patient care were directed to consultants, and these results are shown in table 3.

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Part time training has been a formal option for physician training in Australia for the past 10 years, provided that any position is equivalent to at least half of a full time post.¹ Since 1989 Princess Margaret Hospital for Children in Western Australia has combined part time working with job sharing and has employed at least two job share teams. Job sharing is an arrangement "whereby two people voluntarily share the responsibility of one full time position. The salary and benefits are shared between them according to the

Table 1—Questionnaire response rates

	Total	No (%) of respondents
Consultants	62	37(60)
Registrars (non-job sharing)	27	19(70)
Registrars (job sharing)	10	8(80)
Residents	26	10(38)
Administrators	3	3(100)

Table 2—Responses from medical staff

Should job sharing continue?	No	Yes	Uncertain	% Giving most common answer
Consultant	5	28	4	Yes 76%
Registrar (non-job sharing)	2	17	0	Yes 90%
Registrar (job sharing)	0	8	0	Yes 100%
Resident	0	10	0	Yes 100%
Administrator	0	3	0	Yes 100%
Should job sharing be limited to women?	59	4	4	No 88%
Should job sharing be limited to women with young children?	55	10	3	No 81%
Could a 12 month research grant be paid over two years at half the normal rate?	6	46	14	Yes 70%
Is job sharing more suited to:				
Advanced training		26		33.8%
Basic training		2		2.6%
Both		34		44.2%
No response or uncertain		15		19.4%
Should the number of job share positions be limited to:				
Unlimited number of positions		35		45.4%
> 3 pairs		2		2.6%
3 pairs		12		15.6%
1-2 pairs		14		18.2%
Uncertain		14		18.2%
Factors important in partnership selection:				
Personal compatibility		31		40.3%
Level of training		22		28.6%
Career aims		9		11.7%

Table 3—Views on patient management among 37 consultants who responded

Patient management	Adversely affected	Not affected	Uncertain	Beneficial
Continuity of patient care	16 (43%)	16 (43%)	5	
Ward rounds	15	15	6	1
Teaching rounds	7	20	7	3
Medical summary completion	2	24	10	1

Roster allocations from 1989 to 1993 showed that consultants who had or had not worked with a job share team were in similar medical specialties.

The availability of job sharing at Princess Margaret Hospital had influenced five out of eight registrars who took part in job shares and five out of 19 who did not in their decision to train in paediatrics. Of the 19 registrars who did not take part in a job share 10 considered applying for such a position in the future.

Influence on workload was not considered to be significant by the three medical administrators, though 17 out of 37 consultants believed there had been an increase in time taken to supervise, teach, and evaluate registrars.

Discussion

There is broad based support for the continuation of job sharing at Princess Margaret Hospital. The highest response rate was from those most affected—the

registrars—and nearly all of them wanted job sharing to continue. The poor response from residents was probably due to the fact that residents rotated to another teaching hospital within one week of distribution of the questionnaire.

Seventeen (46%) of the 37 consultants thought that their workload had increased (six consultants believed more than one aspect of their workload was increased). Sixteen thought that continuity of patient care was adversely affected, but 28 nevertheless considered that job sharing should continue. This suggests that while they are aware of some difficulties with job sharing they perceive the benefits.

To maintain continuity of patient care while job sharing good communication is paramount. Early and frequent liaison with consultant staff is necessary. Job share registrars need to recognise that they each need to contribute slightly more than half the time of a full time position to make job sharing a success. An accurate comparison of patient care by registrars who do and do not take part in job shares at Princess Margaret Hospital will require a further study.

In 1992 the medical administration department at the hospital, in collaboration with the registrars undertaking job shares, prepared guidelines for job sharing registrars,⁶ and these have facilitated the management of job sharing without any important problems over pay arrangements, holiday cover, sick leave, or other conditions of employment. Studies of job sharing in North America have shown that absenteeism is significantly reduced when people share jobs.⁷

Interestingly, there is no suggestion from this survey that job sharing should be limited to women or to registrars with children. With increasing demands for research experience as a component of advanced training the possibility of registrars combining a clinical load on a job share basis with a half time research component should be explored.

The Royal Australasian College of Physicians strongly recommends that basic training should be undertaken on a full time basis.¹ The respondents to this questionnaire seemed to find half time training equally suitable. In this study all but one registrar in a job share began working in that position around the time they had completed their basic training. The committee for physician training of the college also emphasises that advanced training should be flexible, with a wide range of training opportunities for individuals to plan their training programme in line with both the recommendations of the specialist advisory committees and their own personal goals. This study has shown that job sharing for registrars at Princess Margaret Hospital allows this choice. Action on concerns over perceived adverse effects on patient care should resolve any persisting issues.

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1 Sewell J. Part-time training. *Fellowship Affairs* 1994;13:31.

2 Equal Opportunities Commission. *Job sharing: improving the quality and availability of part-time work*. London: Equal Opportunities Commission, 1981.

3 Hildick-Smith M, Collier G, Potter V. The benefits and snags of job-sharing. *Practitioner* 1987;231:9-10.

4 Thornicroft G, Strathdee G. Job share a consultant post. *BMJ* 1992;305:1413-5.

5 Gibb S. A trainee's experience. *Fellowship Affairs* 1994;13:30.

6 Stace J. *Guidelines for job sharing for paediatric registrars*. Perth: Princess Margaret Hospital, 1992.

7 Olmsted B, Smith S. *Job share handbook*. 1st ed. Harmondsworth, Middlesex: Penguin, 1983.

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