assessment of today's child (particularly around the pubertal age range), and we would advocate the use of the revised TW3 version. In fact, to continue using TW2 bone ages is akin to using the 1966 height and weight charts instead of the more recent 1995 versions.

M Lynn Ahmed

Department of Paediatrics, University of Oxford, John Radcliffe Hospital, Oxford, UK

Justin T Warner

Department of Child Health, University Hospital of Wales, Heath Park, Cardiff, UK
J T Warner, Department of Child Health, University Hospital of Wales, Heath Park, Cardiff CF14 4XW, UK;
Justin.warner@cardiffandvale.wales.nhs.uk

doi: 10.1136/adc.2005.090134

Competing interests: None.

References

- 1 **Tanner JM**, Whitehouse RH, Cameron N, *et al*. *Assessment of skeletal maturity and prediction of adult height (TW2 Method)*, 2nd edn. London, UK: Academic Press, 1983.
- 2 **Vignolo M**, Naselli A, Magliano P, *et al*. Use of the new US90 standards for TW-RUS skeletal maturity scores in youths from the Italian population. *Horm Res* 1999;**51**:168-72.
- 3 **Tanner JM**, Healy M, Goldstein H, *et al*. *Assessment of skeletal maturity and prediction of adult height (TW3 Method)*, 3rd edn., London: WB Saunders, Harcourt Publishers Ltd 2001.
- 4 **Cox LA**. The biology of bone maturation and ageing. *Acta Paediatr Suppl* 1997;**423**:107-8.
- 5 **Tanner J**, Oshman D, Bahhage F, *et al*. Tanner-Whitehouse bone age reference values for North American children. *J Pediatr* 1997;**131**(Pt 1):34-40.

Compliance with inhaled corticosteroids is important when considering adrenal suppression

We read with interest the article by Paton *et al*¹ reporting the results of low-dose Synacthen tests in children prescribed fluticasone propionate. The finding of flat adrenal responses in 2.8% of the children tested (all prescribed ≥ 1000 μ g of fluticasone propionate per day) provides further evidence of the potential dangers of high doses.

We recently published the results of standard-dose Synacthen tests in children recommended ≥ 1000 μ g of fluticasone propionate per day. Of the 29 children tested, 3 were found to have complete adrenal suppression.² In his editorial, Russell³ highlights compliance with the treatment as likely to be important, given the fact that not all patients taking high-dose fluticasone propionate have adrenal failure. In our study, the first of its kind to our knowledge in this context, we examined compliance in terms of the actual amount of fluticasone propionate prescribed over the past year in primary care relative to that recommended by the hospital specialist. The three children with adrenal suppression had actually been prescribed only a median of 493 μ g fluticasone propionate per day over the past year, compared with a median of 433 μ g in the normal group. Overall, there was an inverse correlation between the actual prescribed daily dose of fluticasone propionate and the peak cortisol response to Synacthen ($r = -0.44$, $p = 0.03$).²

Our study was relatively small in size and used a pragmatic measure of compliance; however, the results suggest that compliance with treatment should be considered and that in reality children with adrenal suppression may be receiving smaller doses of fluticasone propionate than we think.

Malcolm Brodlie

Northumberland Child Health Centre, Northumberland, UK

Steven Cunningham

Department of Respiratory and Sleep Medicine, Royal Hospital for Sick Children, Edinburgh, UK

Correspondence to: Dr M Brodlie, Northumberland Child Health Centre, Ashington, Northumberland NE63 9JJ, UK; malcolm_brodli@hotmail.com

doi: 10.1136/adc.2006.111732

Competing interests: None declared.

References

- 1 **Paton J**, Jardine E, McNeil E, *et al*. Adrenal responses to low dose synthetic ACTH (Synacthen) in children receiving high dose inhaled fluticasone. *Arch Dis Child* 2006;**91**:808-13.
- 2 **Brodli M**, McMurray A, Crofton PM, *et al*. Strategies to screen for adrenal suppression in children with asthma should take account of compliance with inhaled corticosteroids. *Eur J Pediatr* [Epub ahead of print]. Doi: 10.1007/s00431-006-0260-7.
- 3 **Russell G**. Very high dose inhaled corticosteroids: panacea or poison? *Arch Dis Child* 2006;**91**:802-3.

A view from the other side of the table

The transition from specialist trainee to consultant is an important one. Many newly appointed consultants feel inadequately prepared to deal with new management roles such as sitting on an interview panel.^{1,2} Conducting an interview can be as challenging as attending one. One has to exercise keen judgement to separate the cream out of the multitude of applicants. Courses to hone individuals' techniques for conducting interviews are run by most trusts. However, experience from courses is nowhere as close to the real-life experience of conducting interviews. I recently had the opportunity of being part of an esteemed panel of interviewers. The post in question was that of specialist registrar in paediatrics in the northern deanery.

Seven members were present on the panel, of whom I was the only registrar, but my role was as important as that of anyone else. My first task was to produce a short list of applicants. After getting a grasp of the person specification, which helps to identify the essential and desirable criteria of each candidate, I went through each application carefully. In effect, candidates were not shortlisted if they did not meet all essential criteria. Desirable criteria included experience of research, publications, certificate in medical education, prizes and other achievements, or specialist clinical experience—for instance, echocardiography. The more of these a candidate possessed, the better their chances of making it to the short list. I scored each application independently and so did all the other panel members. The scores were then

totalled and a merit list created. We aimed at producing a candidate short list, the number of candidates included on it being double the number of posts being contested. If a wide variation in scores between panelists was noticed for any individual candidate, the applicants' credentials were re-evaluated and discussed, and decision made by consensus.

I prepared for the interview, to ask questions, rather than answer them. Scoring was carried out based on structured guidelines. This, for me, was an excellent learning experience. I had the opportunity to learn different methods of questioning and to gain insight into how responses are assessed. I am now wiser about what impresses panelists and what does not. This will no doubt enrich my own interviewing skills and prove invaluable when I compete for posts in the future. After the last candidate was interviewed, scores from the panelists were compared. I was pleased (and relieved) to discover that my scoring of candidates was in agreement with that of most other panel members.

I strongly feel that deaneries and trusts should try this system more often to provide their future consultants with a taste of the process of candidate selection. The success of this exercise, if indeed adopted, will depend on whether or not the trainees participate alongside other panel members in the entire process of job selection, right from short listing to ultimately deciding on the successful candidates.

Acknowledgements

I thank Dr David Milligan, consultant neonatologist, Royal Victoria Infirmary, Newcastle upon Tyne, UK, for support and guidance during the interview.

Atul Gupta

Freeman Hospital, Newcastle upon tyne, UK

Correspondence to: Dr A Gupta, Freeman Hospital, Newcastle upon tyne NE7 7DN, UK; atulgupta@doctors.org.uk

doi: 10.1136/adc.2006.113670

Competing interests: None.

References

- 1 **Beckett M**, Hulbert D, Brown R. The new consultant survey 2005. *Emerg Med J* 2006;**23**:461-3.
- 2 **Paice E**, Ginsburg R. Specialist registrar training: what still needs to be improved? *Hosp Med* 2003;**64**:173-6.

High-dose inhaled fluticasone, adrenal crisis and a fatal accident inquiry

Russell, in his editorial "Very high-dose corticosteroids: panacea or poison?",¹ speculates about the reasons why "the practice of using increasingly high doses of inhaled corticosteroid therapy, particularly of fluticasone, became commonplace in the UK." He blames doctors: "it appears that better disciplined clinicians elsewhere in the world were less willing to stray beyond licensed dosages" and also the raising of the licensed dose of fluticasone propionate in children, from 200 to 400 μ g/day, although this happened in 2001, at least 5 years after this prescribing practice became commonplace.²