The discretionary points award scheme is one of the main mechanisms for rewarding consultants beyond their basic salaries in England, Wales, and Scotland. Half of all consultants have received awards. To assess whether any disparity between the discretionary points awarded to consultants in England and Wales and in Scotland is associated with ethnic origin and sex, we used data for 2000-1 from the Advisory Committee on Distinction Awards for England and Wales and the NHS about £251m ($410m; €380m) each year. Each discretionary point is worth £2645, so a consultant with the maximum of eight discretionary points earns £87 280.

Department of Health guidance for awarding points instructs employers to ensure that consultants are treated equally regardless of colour, race, sex, religion, politics, marital status, sexual orientation, membership or non-membership of trade unions or associations, ethnic origin, age, or disability.1 We assessed whether any disparity between the discretionary points awarded to consultants in England and Wales and in Scotland is associated with ethnic origin and sex.

Methods and results

We used data for 2000-1 from the Advisory Committee on Distinction Awards for England and Wales and the

<table>
<thead>
<tr>
<th>Race*</th>
<th>Sex†</th>
<th>England and Wales</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No eligible for award</td>
<td>16 411</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No with award</td>
<td>9 261</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% with award</td>
<td>56.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No eligible for award beyond</td>
<td>14 254</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No with award</td>
<td>9 100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% with award</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

*In England and Wales, 2425 consultants, and in Scotland, 91 consultants did not give their ethnic group and we classified 1172 as “other ethnic group.”†In England and Wales, 71 consultants did not provide information.
A memorable patient
Leaving mercy to heaven

I was her general practitioner for several years, first as a trainee and then a partner in the practice. Over that time she gradually became more disabled with osteoarthritis and progressed from being a surgery attender to one whom I visited at home when necessary. She used to send me flowers at Christmas. She was one who used to say “Don’t get old.” Many say that, but with her I once joked, “It’s better than the alternative,” and we shared a laugh.

Later she developed atrial fibrillation and took warfarin. She was intolerant of non-steroidal anti-inflammatory drugs, and we struggled to manage her painful arthritis with analgesia, while she became increasingly immobile. She was always cheerful and uncomplaining and bore her increasing disability with fortitude. Sometimes she referred to “the alternative” as an option she might prefer to her current condition.

Then she got worse, and I admitted her to our cottage hospital for pain control and rehabilitation. While there, she had a myocardial infarction and developed heart failure. She didn’t want to be transferred, and she made it clear she didn’t want to live any longer. She held my arm and looked into my eyes and said, “You will help me won’t you?” I treated her pain with regular opiates and told her she would not be in pain and that the analgesia might shorten her life. I expected her to die, but after a couple of days she began to get better, the opiates were no longer justified, and she was weaned off them.

Suddenly one day she asked to go home. We all felt she was too frail to manage, but she was adamant and a care package was arranged. The day after she went home, I visited, and she said she was coping. The next morning I was called urgently as she had been found dead by the morning carer. She had taken an overdose of co-proxamol and had blocked her nose and mouth with pieces of tissue. She must have struggled to open the container for the pills, and she died in discomfort.

I had always felt glad that legislation protects me from the requirement to administer euthanasia and that I do not have to require that administration and that I do not have to take that difficult ethical step. This patient made me think again. I would still find it difficult to cross the line between relieving pain and deliberately ending life, but I wish she had not been alone.

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Contributors: AE planned the study, supervised the analysis, and wrote the paper. PA obtained the data, carried out the analysis, obtained the background information, and commented on drafts of the paper. SE suggested the idea for the paper and commented on drafts. AE is guarantor.
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Competing interests: AE and SE are members of the Medical Practitioners Union, which is opposed to distinction awards and discretionary point awards.

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