11 Dean B, Barber N. Validity and reliability of observational methods for studying medication administration errors. *Am J Health Syst Pharm* 2001;58:54-9.
12 Dean BS, Barber ND. A validated, reliable method of scoring the severity of medication errors. *Am J Health Syst Pharm* 1999;56:57-62.
13 Department of Health and Social Security. *Report of the working party on the addition of drugs to intravenous infusion fluids (Breckenridge report).* London: DHSS, 1976.
14 Brzozowski DF, Hale KM, Segal R, Mirtallo JM. Pharmacists' opinion about and compliance with recommendations for intravenous admixture practices. *Am J Health Syst Pharm* 1987;44:2077-84.
15 Delaney T. EAHP survey of hospital-based pharmaceutical services in Europe, 1995. *Eur Hosp Pharm* 1996;2:92-105.
16 Armour DJ, Cairns CJ, Costello I, Riley SJ, Davies EG. The economics of a pharmacy-based central intravenous additive service for pediatric patients. *PharmacoEconomics* 1997;10:386-94.
17 Chan R, Ryan M, Moriarty S, Feely J, Sabra K. The impact of a centralized reconstitution of intravenous additives service on administration times of intravenous antibiotics. *Eur J Hosp Pharm* 1993;3:93-5.
18 Cousins DH, Lee M, Stanaway M, Neary C. Implementation and evaluation of a centralised IV additive service for antibiotic injections. *Pharm J* 1989;242:HS14-6.
19 Wilson M. An evaluation of the cost effectiveness of a centralised intravenous admixture service. *Proc Guild* 1990;27:3-11.
20 Allan Flynn E, Pearson RE, Barker KN. Observational study of accuracy in compounding iv admixtures at five hospitals. *Am J Health Syst Pharm* 1997;54:904-12.
21 Mays N, Pope C. Observational methods in health care settings. *BMJ* 1995;311:182-4.

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Discrimination in the discretionary points award scheme: comparison of white with non-white consultants and men with women

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Editorial by Raftery

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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. Together, the discretionary points and distinction awards cost 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

Distribution of discretionary point awards by ethnic group and sex for consultants in England and Wales and Scotland

	Race*				Sex†			
	White	Non-white	Total	Ratio‡ (95% CI)	Male	Female	Total	Ratio§ (95% CI)
England and Wales								
No eligible for award	16 411	2395	18 806	—	17 105	5284	22 389	—
No with award	9 261	983	10 244	—	9 540	2351	11 891	—
% with award	56.43	41.04	—	1.37 (1.31 to 1.44)	55.77	44.49	—	1.25 (1.21 to 1.30)
No with award beyond								
D1	7 414	706	8 120	1.53 (1.44 to 1.63)	7 622	1732	9 354	1.36 (1.30 to 1.42)
D2	5 361	459	5 820	1.70 (1.57 to 1.86)	5 540	1124	6 664	1.52 (1.44 to 1.61)
D3	4 222	326	4 548	1.89 (1.70 to 2.10)	4 408	805	5 213	1.69 (1.58 to 1.81)
D4	3 488	245	3 733	2.08 (1.84 to 2.35)	3 643	627	4 270	1.79 (1.66 to 1.94)
D5	1 319	70	1 389	2.75 (2.17 to 3.48)	1 304	223	1 527	1.81 (1.57 to 2.08)
D6	594	23	617	3.77 (2.49 to 5.70)	577	96	673	1.86 (1.50 to 2.03)
D7	235	10	245	3.43 (1.82 to 6.45)	229	45	274	1.57 (1.14 to 2.16)
Mean age (years)	36.3	39.0	—	—	36.7	37.1	—	—
Scotland								
No eligible for award	2 533	140	2 673	—	2 087	677	2 764	—
No with award	1 310	54	1 364	—	1 136	270	1 406	—
% with award	51.7	38.5	—	1.34 (1.08 to 1.66)	54.4	39.9	—	1.36 (1.23 to 1.51)
No with award beyond								
D1	984	29	1 013	1.88 (1.35 to 2.60)	869	174	1 043	1.62 (1.41 to 1.86)
D2	707	19	726	2.06 (1.35 to 3.14)	635	103	738	2 (1.65 to 2.42)
D3	503	6	509	4.63 (2.11 to 10.18)	457	66	523	2.25 (1.76 to 2.86)
D4	394	4	398	5.44 (2.06 to 14.36)	359	50	409	2.33 (1.76 to 3.09)
Mean age (years)	35.4	40.4	—	—	35.7	35.5	—	—

*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, 14 consultants did not provide information.
‡In England and Wales, χ^2 for the linear trend was 316 (P<0.0001); in Scotland χ^2 was 35 (P<0.0001).
§ In England and Wales, χ^2 for the linear trend was 347 (P<0.0001); in Scotland χ^2 was 79 (P<0.0001).

Scottish Advisory Committee on Distinction Awards. These disaggregated data included date of birth, sex, ethnic origin, specialty, level of award or number of discretionary points held, and the year the awards or points were granted.

We categorised the ethnic groups Bangladeshi, black African, black other, Chinese, Indian, and Pakistani as non-white and compared these groups with consultants who described themselves as white. Consultants classified as from any other ethnic group and those who did not give their ethnic origin were excluded. We divided the number of consultants with discretionary points by the total number of consultants who did not receive distinction awards, as consultants without awards are eligible for discretionary points. We compared the proportion of consultants with discretionary points between white and non-white consultants and between men and women (table).

In England and Wales, white consultants had 1.37 (95% confidence interval 1.31 to 1.44) times as many awards as non-white consultants, and men had 1.25 (1.21 to 1.30) times as many as women; in Scotland the ratios were 1.34 (1.08 to 1.66) and 1.36 (1.23 to 1.51). The ratios increased with increasing level of award (table).

Comment

Non-white and female consultants may be disadvantaged under the discretionary point award scheme. The non-response rate of 16% (3597/22389) in England and Wales may have affected the results. To negate the differences, all the consultants who did not give their ethnic group and received awards would, however, have to be non-white. Non-white consultants are older when appointed, and, therefore, their period of eligibility for discretionary awards is less than for white consultants. Non-white consultants may also be concentrated in specialties which are less likely to receive awards.[2 3] The reason for differences in the number of points awarded to men and women is unclear, but differences could be due to discrimination.[4]

Points are awarded by local decision making groups which usually consist of three non-eligible consultants and three managers. The deliberations of these groups are not usually open to scrutiny. The lack of published data on the scheme locally and nationally is a continued source of concern. Employment tribunals have already found in favour of consultants who have alleged racial discrimination.[5] Without effective monitoring, it is impossible to judge whether the scheme is operated fairly and without discrimination.

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1 Department of Health. *Consultants discretionary points*. London: Department of Health, Dec 1995. (Advance letter (MD)6/95; Annex B modified December 1999.)
2 Esmail A, Everington S, Doyle H. Racial discrimination in the allocation of distinction awards? Analysis of list of award holders by type of award, specialty, and region. *BMJ* 1998;316:193-5.
3 Bruggen P, Bourne S. The distinction awards system in England and Wales 1980. *BMJ* 1982;284:1577-80.
4 Beecham L. Women consultants lag behind in merit awards. *BMJ* 1994;308:1106.
5 Wise J. Trust accused of racism in awarding payments. *BMJ* 2000;320:269.

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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 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 and had been able to die comfortably.

Hilary Fox *general practitioner, Oakham*

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.