LEADERSHIP IN PRACTICE | MODULE 02

Role, authority and the SAS leadership paradox

Separate expertise, responsibility and authority so that senior doctors are neither overlooked nor left carrying unsupported risk.

- ✓ 13 min reading
- ✓ Full teaching, practical next steps and reflection
- ✓ Six practice questions with answers and explanations
- ✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

Author: Dr N Aziz

Using this module

Independent education

This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

Capability, job title and organisational authority are different things. Safe leadership makes each explicit: what you are responsible for, what you may decide and who must support or escalate the decision.

Three next actions

- Map one responsibility against the authority and resources actually available.
- Clarify the escalation route for a decision you cannot safely make alone.
- Ask for material expectations and delegated authority to be recorded.

Learning objectives

- Separate capability, contractual identity, responsibility and formal authority.
- Recognise how labels influence access to opportunity and decision-making.
- Use a practical authority and responsibility check before accepting recurrent risk.

Why this matters

The SAS workforce does not tell one career story. It includes doctors at different stages of experience, responsibility and autonomous practice. Locally employed doctors are even more varied because employers use many local titles. When these categories are treated as a single level of capability, organisational decisions become inaccurate. Development may be offered to the wrong people, senior work may remain unrecognised, and responsibility may be allocated without matching authority.

The paradox is that an organisation may depend on an experienced doctor while its formal language continues to describe that doctor mainly by what they are not. A label such as 'non-consultant' or 'middle grade' can quietly influence who receives papers, chairs meetings, applies for roles or is believed when raising a concern. Correcting this is not a contest for status. It is necessary for safe workforce design and fair use of capability.

Keep four things separate

Contractual grade describes the employment framework. Professional capability describes what a doctor can safely and reliably do in a defined context. Responsibility describes the outcome or duty the person is expected to carry. Authority describes what the person is permitted and resourced to decide. These four things influence one another, but they are not interchangeable.

A specialist doctor may have extensive autonomous capability but limited authority over budget or workforce decisions. A newly appointed consultant may have broader formal authority while still learning the service. A locally employed clinical fellow may be highly experienced overseas but unfamiliar with a particular NHS process. Good leadership avoids assumptions in every direction and establishes the actual work, competence, limits and support.

How a label becomes a decision

Labels are not merely descriptive. They can act as organisational shortcuts. If a committee invitation, development programme or acting role is limited to a familiar title without examining the work, the label has become an eligibility decision. If senior clinical evidence is discounted because the speaker is described as 'only SAS', terminology has affected governance.

Sometimes a title-based distinction is legitimate. A statutory function, contractual responsibility or defined accountable role may require it. The task is not to remove every distinction. It is to ask whether the distinction is relevant to the purpose, supported by evidence and applied consistently. Where the real requirement is capability or experience, the criteria should say so.

Map responsibility against authority

For any leadership assignment, write down the expected outcome, decisions you may make, resources you can use, information you can access and matters that require approval. Then identify who will remove barriers and what should trigger escalation. This simple map exposes situations in which accountability has been transferred but authority has not.

A verbal invitation to 'lead on this' is not enough when the work involves rota change, job planning, finance, information governance or clinical risk. Clarification can be neutral and professional: 'To deliver this safely, I need to understand what I can decide, what requires approval and who will support escalation.' The aim is explainability, not territorial control.

Recognition versus symbolic inclusion

Representation is useful only when the person can influence the work. Inviting an SAS doctor to a group without timely papers, protected time, a clear remit or access to the decision-maker may improve the appearance of inclusion while leaving the decision unchanged. Similarly, celebrating SAS contribution during an awareness week does not correct routine exclusion from acting roles, leadership development or service planning.

A more credible test asks what changed because the perspective was present. Was a risk identified earlier? Were eligibility criteria revised? Did the service use capability more accurately? Did the representative have a route back to colleagues and receive feedback after raising an issue? Inclusion should produce a traceable opportunity to contribute, not simply a photograph or attendance list.

The paradox in job planning

Leadership work often accumulates in the spaces between programmed activities or sessions. A doctor may supervise, solve rota problems, represent colleagues and support governance without an agreed objective or time allocation. Because the work is being completed, the organisation may conclude that no additional arrangement is needed. The success of personal effort then hides the inadequacy of role design.

Job-planning discussions should describe the recurrent work, its purpose, expected outputs, time, authority and review. Not every telephone call should be counted mechanically, and not every voluntary contribution should become permanent. The question is whether the organisation is knowingly relying on a function that needs to be planned, governed and sustained.

From celebration to fair opportunity

Capability cannot be evidenced without opportunity. If acting roles, project leads and committee seats circulate through informal networks, some doctors will repeatedly appear more experienced because they were repeatedly given the work that creates experience. A fair system publishes opportunities, states relevant criteria, provides proportionate support and reviews who applies and who succeeds.

Doctors also carry responsibility. They should describe their capability accurately, seek feedback, prepare evidence and recognise gaps. Fair opportunity is not automatic appointment. It means access to compete and develop is not unnecessarily restricted by title, familiarity or assumptions about a career pathway.

A practical conversation about role design

Begin with the service need rather than personal recognition. Describe the recurrent work, the patients or staff affected, the present risk and the result the organisation expects. Then set out your contribution and the conditions needed for reliable delivery. Ask which decisions sit with you, which sit elsewhere and how disagreement or delay will be escalated.

Finish by agreeing evidence and review. This may include an objective, a named sponsor, access to a meeting, a job-planned allocation, data support or a time-limited pilot. Written clarity protects both the doctor and the organisation. It also allows the arrangement to be evaluated rather than remaining dependent on goodwill.

- Describe the work and risk before discussing title.
- Name the authority, information and time required.
- Agree who remains accountable for decisions outside your remit.
- Set a review date and evidence of success.

Common mistake

Avoid this	Accepting broad accountability on the strength of a verbal invitation while authority, time and support remain unclear.

Pause and reflect

What are you currently expected to deliver without matching authority or support?

Takeaways

- Expertise is not the same as formal authority.
- Accountability needs resources and escalation.
- Clear boundaries protect patients and leaders.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. Which statement best describes professional capability?

A. It is what a doctor can safely and reliably do in a defined context

B. It is identical to contractual grade

C. It is any task a doctor has previously observed

D. It is the authority to allocate organisational resources

2. An SAS doctor is asked to redesign a rota but cannot access workforce data or approve changes. What should happen first?

A. Ask for a consultant title

B. Clarify the outcome, decision rights, information, support and escalation

C. Decline all leadership work

D. Accept and solve the problem informally

3. When is a title-based restriction most defensible?

A. When it simplifies administration

B. When it is relevant to a defined contractual, statutory or accountable function

C. When it has always been used

D. When senior colleagues prefer it

4. Which is the best test of meaningful representation?

A. The perspective had a usable route to influence and its effect can be traced

B. The organisation publicised the meeting

C. The representative attended every meeting

D. The group included an SAS name

5. Why can invisible leadership work distort job planning?

A. It is always outside a doctor's contract

B. Successful personal effort can hide the time and governance the function requires

C. Only financial work can be measured

D. Leadership should never be job planned

6. What does fair opportunity require?

A. Removal of all eligibility criteria

B. Open access, relevant criteria, proportionate support and review of who benefits

C. The same outcome for every applicant

D. Automatic appointment of under-represented doctors

Answers and explanations

1. A — It is what a doctor can safely and reliably do in a defined context

Capability is task- and context-specific. It should not be assumed solely from title, and it is different from organisational authority.

Review the four distinctions: contractual grade, capability, responsibility and authority.

2. B — Clarify the outcome, decision rights, information, support and escalation

The task needs an explicit authority-responsibility map before accountability is accepted.

Return to 'Map responsibility against authority' and complete the Authority-Responsibility worksheet.

3. B — When it is relevant to a defined contractual, statutory or accountable function

A title distinction should be relevant to the purpose, evidence-based and consistently applied.

Review how labels become eligibility decisions and distinguish legitimate requirements from habit.

4. A — The perspective had a usable route to influence and its effect can be traced

Meaningful inclusion provides information, time, access and a route to influence rather than attendance alone.

Revisit 'Recognition versus symbolic inclusion' and ask what changed because the perspective was present.

5. B — Successful personal effort can hide the time and governance the function requires

When recurrent work is absorbed informally, delivery may conceal that the role needs time, authority and review.

Review 'The paradox in job planning' and list recurrent work currently dependent on goodwill.

6. B — Open access, relevant criteria, proportionate support and review of who benefits

Fair opportunity improves access to development and competition while preserving evidence-based selection.

Review 'From celebration to fair opportunity' and distinguish access from automatic selection.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

GMC: Leadership and management guidance
UK · https://www.gmc-uk.org/professional-standards/the-professional-standards/leadership-and-management/about-this-guidance

NHS Leadership and Management Framework
England and Wales · https://www.england.nhs.uk/leaders/nhs-leadership-and-management-framework/

FMLM: Leadership and management standards
UK · https://www.fmlm.ac.uk/professional-standards/leadership-and-management-standards-medical-professionals

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