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Professional Practice (Leadership in Emergency Services)
Authenticity and the role of the leader

Assignment Part I

“Critical Evaluation of five leadership theories and their relevance to my workplace”

Assignment Part II

“A Critical Analysis of my personal leadership style, qualities and skills”

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At the time of writing this I have been in managerial roles for almost 20 years mostly outside of the NHS. Then ten years ago started the process of retraining as a Paramedic in Swansea University, qualifying as a Paramedic almost eight years ago. Since qualifying as a paramedic, I've worked mainly in Cardiff and progressed into a managerial post of a Clinical Team Leader (CTL) then Operations Manager after one year. During this time, I have witnessed the evolution of the management structure withing the Welsh Ambulance Service Trust. Today I hold a more clinically dedicated managerial role of Senior Paramedic (SP) for the last eighteen months. As a clinical leader I aspire to provide robust, inspirational leadership focusing on the clinical competence of staff under my supervision, which I will explore further throughout this exercise. My career pathway has so far provided me with invaluable experience and insight into diverse leadership and management styles, enabling me to appreciate their relevance in the workplace, particularly within the healthcare sector.

Using this experience and undertaking research on leadership theory, this essay aims to critically evaluate, analyse, and appraise five key leadership theories. I will explore their relevance to the workplace—particularly within the ambulance service. It will also examine personal leadership styles and behaviours to assess whether these, alongside established theories, provide sufficient evidence to inform future clinical leadership practice.

The main body will involve a thorough critique of leadership theories that underpin leadership and management in healthcare settings. Each theory will be considered in terms of its effectiveness and applicability to leadership within the environment in which I work. The section will end by providing recommendations for applying an appropriate leadership model within this context.

In addition, personal leadership behaviours and styles will be characterized and assessed to determine whether they support or challenge current leadership approaches. This analysis will help establish whether changes in clinical leadership practice are warranted based on theoretical and personal insights. The first part of the assignment will end with proposals for the practical application of leadership models within the ambulance service.

When considering leadership styles, it is first worth considering what we mean by leadership and what this looks like in practice. The research available has a broad spectrum of opinion for some leadership is about influencing to achieve a goal, Ward (2020), for others it's about inspiring and guiding, (Antonakis & Day (2018). For some it is too multifaceted and therefore too difficult to accurately define, Grint (2010). In the role that I work in leadership has played an important role, and there are situations where different leadership styles are required.

Effective leadership is widely recognised as critical to the ongoing success and development of health and social care organisations, Ham (2011). In the prehospital setting in which I currently work, leadership is not just considered desirable but something that the paramedics must understand, embrace and importantly be able to demonstrate to prove they are meeting the requirements of their professional registration, (Health & Care Professions Council 2024). So, the expectation for paramedics is that they can demonstrate these leadership skills even when they are not specifically employed in a leadership role, moreover it's about the ability of paramedics to show leadership in order to function well in their role.

The discussion will begin with an examination of Trait Theory, one of the earliest frameworks for understanding leadership (Hunt & Fedynich, 2019). This theory proposes that effective leaders are born with inherent qualities that make them predisposed to lead successfully. Commonly identified traits include intelligence, self-assurance, determination, integrity, and sociability (Northouse, 2016).

Recognising these traits within individuals allows organisations to identify potential leaders for targeted development or specific leadership responsibilities (Zaccaro, 2007). Additionally, individuals aspiring to leadership roles can engage in self-reflection to assess and enhance their personal traits, fostering continuous improvement (Northouse, 2018). I have applied this reflective approach in their own practice to develop leadership skills and address particular challenges encountered in their role.

The theory suggests that these traits can be identified and measured to predict leadership effectiveness. Despite its strengths, trait theory faces several criticisms. One major limitation is its lack of explanatory power. While it describes *what* traits individuals possess, it does not account for *why* those traits develop or how they

interact with environmental factors, Fleeson & Jayawickreme (2015). Another criticism concerns the theory's neglect of situational influences. Research shows that personality expression varies depending on context, implying that traits may not consistently predict behaviour across situations, Fleeson (2004).

Some studies have examined this further by looking at how personality traits link with success or failure in leadership, Hoffman et al, (2011). In this study Hoffman looked at dispositional traits such as motivation, energy, integrity and what it described as more malleable traits such as interpersonal skills and decision making. The study concluded that dispositional traits were more difficult to change whereas proximal traits can be honed through training and education but both personality groupings are strongly linked to effective leadership.

While Trait Theory provides a foundational understanding of leadership qualities, its relevance in contemporary practice is limited, Morgeson & Ilies (2007). Modern organizational environments are complex and require more than inherent traits to navigate effectively, Derue et.al (2011). Furthermore, the emphasis on innate characteristics can overlook the importance of skill development and situational factors, Ng et al., (2008). However, the theory's focus on integrity and self-confidence remains pertinent, as these traits are consistently valued in today's leaders Leroy et. al (2012). In my experience, possessing self-confidence has been crucial when making decisive choices, particularly in high-pressure situations.

Behavioural Theory developed as an evolution from Trait Theory, addressing its shortcomings by emphasizing leaders' actions rather than their innate characteristics (Johns & Moser, 1989). Early influential research from institutions like Ohio State University and the University of Michigan played a pivotal role in defining leadership behaviours. These studies distinguished between two primary types of leadership behaviours: those that are task-focused and those that prioritize relationships (Yukl, 2013). Leaders who adopt a task-oriented style concentrate on clarifying objectives, structuring tasks, and ensuring that performance criteria are met. In contrast, relationship-oriented leaders prioritize nurturing interpersonal connections, fostering team unity, and supporting the well-being of their employees.

The appeal of Behavioural Theory lies in its focus on practical leadership development, offering a structured approach for leaders to cultivate behaviours that

improve their effectiveness (Northouse, 2016). Nonetheless, the theory has limitations, as it does not fully consider the influence of varying contexts or the ever-changing nature of leadership scenarios. Modern leadership demands adaptability, and a strict classification of behaviours may overlook the subtle complexities present in contemporary organisations (Yukl & Mahsud, 2010). In my own experience, achieving a balance between task-focused and people-focused behaviours has been essential. For example, during high-pressure incidents, it was vital to uphold team morale while ensuring tasks were completed efficiently, highlighting the importance of applying behavioural flexibility in practice.

Transformational Leadership, first conceptualized by Burns (1978) and further developed by Bass (1985), emphasizes motivating and inspiring followers to achieve outstanding performance levels (White, 2018). Leaders who adopt this approach engage with their teams through role modeling, providing visionary guidance, stimulating creative thinking, and offering tailored support to individuals (Avolio et al., 1999). This leadership style is noted for cultivating an environment of trust, encouraging innovation, and supporting personal growth, which collectively contributes to enhanced well-being among team members (Jacobs et al., 2013).

Transformational Leadership is highly relevant in contemporary practice, particularly in environments that require adaptability and innovation, Korejan (2016). It aligns well with the modern emphasis on employee engagement and organizational culture, Deschamps et. al. (2016). However, this approach relies heavily on strong emotional intelligence can be difficult to consistently maintain, Barr and Dowding (2022).

Transformational leadership, despite its widespread acclaim, has also faced significant criticism. Northouse (2016) highlights concerns that transformational leadership may be perceived as vague and overly idealistic, lacking a clearly defined process and measurable parameters. Critics argue that the broad and often ambiguous nature of the model makes it challenging to isolate its core components, thereby limiting its practical applicability (Northouse, 2016). Furthermore, Cherry (2020) notes that the theoretical constructs of transformational leadership often overlap, raising concerns about the reliability and distinctiveness of its defining factors. Another point of contention is the tendency of this leadership approach to emphasize innate personality traits rather than learned behaviours, potentially

excluding individuals who do not exhibit these traits naturally. This focus may inadvertently reduce diversity in leadership by marginalizing voices that do not conform to the idealized transformational profile, ultimately limiting the range of perspectives and creative solutions within organizations.

In my professional experience, adopting a transformational approach has been beneficial in driving change initiatives and fostering a culture of continuous improvement. For example, during a major organizational restructure, employing inspirational motivation helped to alleviate anxieties and encourage a forward-thinking mindset among team members.

The Servant Leadership model, introduced by Greenleaf (1970), focuses on leaders adopting a servant-first mindset, where the primary concern is addressing the needs and growth of others. Leaders who practice this style demonstrate qualities such as empathy, attentive listening, responsible stewardship, and a strong dedication to supporting their followers' development. This leadership model highlights the importance of ethical behavior and fostering a sense of community. Ragnarsson et al. (2018) emphasize that both the aspects of “serving” and “leading” are essential for an organization’s success. From my personal perspective, these attributes are commonly found among healthcare professionals, as their roles inherently involve prioritizing the needs of individuals within the community they serve.

Canavesi and Minelli (2022) highlighted in a systematic review that Servant Leadership remains highly relevant in contemporary practice, particularly in fields that prioritise ethical conduct, workforce satisfaction, and overall employee wellbeing. This leadership style fosters a nurturing organizational environment and can enhance staff engagement, commitment, and loyalty. Nevertheless, the approach may be less suitable in fast-paced, results-focused settings where quick decision-making and immediate action are essential.

Servant leadership is most effective in environments that prioritize collaboration, ethical behaviour, and the long-term development of people and communities. It thrives particularly well in service-oriented organizations such as healthcare, education, and non-profits, where leaders are expected to place the needs of others above their own, Spears (2010). In such contexts, servant leaders foster trust, empathy, and empowerment, resulting in higher job satisfaction, employee

engagement, and organizational commitment (Eva et al., 2019). For example, in healthcare settings, servant leadership has been shown to improve both team dynamics and patient outcomes by cultivating a culture of compassion, listening, and support (Neill & Saunders, 2008). Moreover, because this leadership style emphasizes ethical conduct and social responsibility, it is particularly well-suited for guiding organizations through complex social challenges and change initiatives (Liden et al., 2008). By focusing on serving others, servant leaders help build resilient, people-centred organizations capable of sustaining long-term success and trust.

Throughout my leadership journey, integrating the principles of servant leadership has been instrumental in cultivating trust and promoting a collaborative team culture. By giving careful attention to colleagues' concerns and supporting their professional development, I have noticed improvements in motivation, engagement, and overall team performance.

The environment in which I lead is highly dynamic, with patient needs, operational pressures, and situational variables constantly changing. This requires a flexible approach to leadership that can respond to the demands of each scenario. Situational leadership, as described by Hersey and Blanchard (1969), provides a useful framework for adapting leadership style according to the competence and commitment of team members. This model identifies four primary approaches—directing, coaching, supporting, and delegating—each designed to suit different levels of follower readiness. Yevgen (2018) highlights that effective leadership is influenced by three factors: the leader's personal traits, the team's characteristics, and the context of the situation. In prehospital care, leaders often work with unfamiliar personnel in urgent or high-pressure incidents, requiring rapid assessments of team abilities and the ability to adjust one's leadership style accordingly (Blanchard, 2019).

The strength of situational leadership lies in its adaptability, particularly in environments like UK ambulance services, where teams are diverse and conditions change rapidly (Newton & Harris, 2015). Its flexibility enables leaders to tailor their approach to the needs of both the situation and their team, enhancing short-term effectiveness (Robertson, 2010). However, critics have noted several limitations. The

model's prescriptive nature can oversimplify complex leadership dynamics, focusing on immediate tasks rather than longer-term strategic goals (Gaille, 2018).

Additionally, the framework has been criticized for limited empirical validation and conceptual clarity, with concerns that rigidly categorizing followers may not accurately reflect their actual skills or motivations (Graeff, 1997). Yukl (2013) further argues that situational leadership provides little guidance on how leaders should assess follower readiness or diagnose situations accurately, which can result in inconsistent application. Thompson and Vecchio (2009) also highlight that the model assumes leaders can adjust their style seamlessly, which may not be practical in high-pressure scenarios where habitual responses dominate. Finally, situational leadership focuses primarily on leader-follower interactions and often overlooks broader organizational influences, such as team culture and systemic factors, which are critical to effective leadership in complex settings.

In my experience, applying situational leadership has been invaluable, particularly when managing a diverse team with varying skill levels. Adjusting my leadership style to provide more guidance to novice employees while granting autonomy to experienced team members has optimized performance and engagement.

Reflecting on these theories and models in the context of my leadership experience reveals the multifaceted nature of effective leadership. Each theory offers valuable insights but also has limitations that necessitate a more integrated and flexible approach. Trait Theory highlights the importance of inherent qualities, but its applicability is limited without considering situational factors. Behavioural Theory provides actionable strategies for developing leadership skills, yet it may not fully capture the complexity of different contexts.

Transformational Leadership aligns well with contemporary organizational needs for inspiration and innovation but requires sustained emotional investment. Servant Leadership emphasizes ethical considerations and employee well-being, essential for building a supportive culture, but may not always align with high-pressure environments. Situational Leadership offers the necessary adaptability for varied contexts but can oversimplify the intricacies of leadership dynamics.

In the dynamic and unpredictable environment of prehospital care, no single leadership theory can fully address the range of challenges encountered.

Paramedics and senior leaders often face situations requiring rapid decision-making, complex clinical judgments, and sensitive team management under pressure. In this context, adopting a hybrid leadership approach that combines elements from Transformational, Servant, and Situational Leadership can be particularly effective.

Transformational Leadership contributes the motivational and visionary aspect of leadership, encouraging team members to exceed expectations and engage fully with their responsibilities. By inspiring staff through clear values, personal example, and intellectual stimulation, leaders can foster a culture of innovation and continuous improvement even in high-pressure scenarios. For example, a senior paramedic leading a multi-agency response to a major incident can use transformational principles to maintain morale, encourage problem-solving, and ensure clear communication of objectives.

Servant Leadership complements this by placing an emphasis on ethical practice, empathy, and the well-being of team members. In the prehospital setting, staff may face emotionally charged or traumatic events, making it essential that leaders demonstrate compassion and actively support their teams' professional and emotional development. By prioritising the needs of team members, listening attentively, and providing mentorship, leaders can enhance trust, engagement, and long-term staff retention. This approach aligns closely with healthcare values of patient-centered care, as staff who feel supported are better equipped to deliver high-quality clinical outcomes.

Situational Leadership adds the critical dimension of adaptability. Prehospital teams frequently comprise personnel with varying levels of experience and competence, sometimes working together for the first time during urgent incidents. Situational Leadership encourages leaders to adjust their style—whether directing, coaching, supporting, or delegating—based on the capabilities, confidence, and motivation of team members. By accurately assessing both individual and group needs, leaders can ensure operational effectiveness without compromising team cohesion.

Combining these approaches allows leaders to be both aspirational and pragmatic. A hybrid model enables the leader to motivate and inspire (transformational), care for and develop team members (servant), and adapt strategies to the specific circumstances at hand (situational). In practice, this integrated approach can lead to

improved team performance, enhanced staff well-being, and better patient outcomes, particularly in the fast-paced, unpredictable environment of emergency medical services. It also provides a framework for reflective practice, allowing leaders to evaluate the effectiveness of their decisions and adjust their approach in future scenarios.

When examining established leadership theories, it is crucial to incorporate contemporary perspectives to ensure their relevance in modern times. The rise of digital technology, globalization, and changing workforce demographics have transformed organizational landscapes. Current leadership research emphasizes the importance of agility, emotional intelligence, and inclusivity. Concepts such as Adaptive Leadership, Heifetz (1994), which focuses on navigating complex change, and Inclusive Leadership, which prioritizes diversity and equity, are increasingly significant in today's professional practice.

Moreover, the COVID-19 pandemic has underscored the need for resilience and empathy in leadership. This is particularly poignant to me as the first leadership role obtained in WAST was just at the outbreak of the pandemic, and although I had leadership experience to fall back on, nothing compared to the challenges it presented. Leaders must now navigate remote work environments, address mental health concerns, and foster a sense of community despite physical distance. Integrating these contemporary insights with traditional leadership theories can enhance their applicability and effectiveness, Hailey (2021).

The critical evaluation of leadership theories and models reveals that while each offers valuable insights, their relevance to modern professional practice depends on their integration with contemporary perspectives and practical application. Trait Theory, Behavioural Theory, Transformational Leadership, Servant Leadership, and Situational Leadership each contribute to a comprehensive understanding of leadership. However, in my experience the complexities of today's organizational environments necessitate a flexible and adaptive approach.

Reflecting on my leadership experiences, it is evident that a hybrid approach, drawing from multiple theories, is most effective in addressing diverse challenges and fostering a positive organizational culture. By staying informed about current research and continuously reflecting on practice, leaders can navigate the evolving

landscape of professional practice and drive meaningful change. That said some of the leadership theories considered highlight that changing personal beliefs, values and experiences may influence my future leadership style or approach and my views on the best approach to leadership may evolve organically over time.

The second part of this assignment centres on a reflective evaluation of my leadership journey and development, drawing on a specific leadership scenario to critically examine my personal leadership style. This section will explore the leadership skills and qualities demonstrated, assessing their impact on individuals in the workplace. It will also outline a personal development plan, included in the appendix, identifying targeted areas for growth and improvement.

Leadership and teamwork are intrinsically linked, with both being essential to achieving shared goals and fostering a positive work environment characterised by role clarity, trust, open communication, and consultation (West et al., 2014). Effective team leadership directly influences team performance, and West (2014) identifies three core elements in team leadership: leading for the long term, managing over the medium term, and coaching in the short term.

My professional background began with two years as a paramedic before progressing into leadership positions, including Clinical Team Leader (band 6), Duty Operations Manager (band 7), and later Senior Paramedic. These roles have afforded me numerous opportunities to evaluate and refine my leadership approach within the operational healthcare context.

The Health and Care Professions Council (HCPC, 2021) emphasises both reflection-in-action and reflection-on-action as tools to critically assess and improve professional practice. Reflection enables healthcare professionals to analyse their experiences, draw lessons, and apply these to future practice (Jasper, 2003; Vague, 2019). Reid (1993) highlights that reflective practice supports the delivery of holistic, high-quality patient care, while Jasper (2003) proposes that experiential reflection can be more valuable for professional growth than formal teaching.

Within healthcare, professional values such as autonomy, beneficence, non-maleficence, and justice are critical for ethical, safe, and effective care (Gabel, 2011; Lynch, 2015). Leaders who model these values foster trust, respect, and a positive team culture, improving both morale and patient outcomes (Dawson et al., 2011). Additionally, incorporating human factors principles can strengthen communication, collaboration, and systemic efficiency (Flin et al., 2008). For my own development, the PGCert programme provides an opportunity to enhance emotional intelligence,

self-awareness, and interpersonal skills, complementing my existing clinical and operational expertise (Goleman, 1998).

For this reflection, I have applied Borton's (2007) model—'What?', 'So What?', and 'Now What?'—as it provides a clear and practical structure for analysing events and identifying learning outcomes (Dabell, 2018). All individuals mentioned are anonymised in line with the Data Protection Act (1998) and HCPC Standards of Ethics, Performance and Conduct (2016)

What?

This reflection aims to assess my leadership actions and decision-making during a particular event, highlighting key lessons to improve future practice. The goal is to enhance my capacity to adjust leadership styles, create effective strategies for team management, and improve both patient outcomes and staff experiences in my position as a Senior Paramedic (SP) within a UK ambulance service. My role involves a wide range of responsibilities, including overseeing staff performance, providing clinical leadership, managing complex incidents, and addressing difficult conversations. As a relatively new manager in my organisation, I have rapidly adapted my leadership skills to meet the demands of various situations, recognizing that this role differs significantly from my previous position. Reflecting on my prior experience as an Operations Manager in a banking environment, the pace was slower, the consequences of poor performance were less critical, and conversations tended to be less emotionally charged.

Having recently transitioned from previous leadership positions, I have had to adjust my approach to the faster pace and higher stakes of frontline ambulance service leadership. While my earlier managerial role in the banking sector involved less emotionally charged situations and fewer immediate consequences, the clinical environment demands rapid decision-making and effective conflict management under pressure. Through reflection, I have identified that I find initiating challenging conversations with long-serving staff particularly difficult, preferring to de-escalate rather than confront hostility. This aligns closely with my Insights Discovery profile results, which describe me as a composed, reflective "peacekeeper" who seeks harmony, prioritises responsibility, and often puts the needs of others ahead of my own.

The scenario in question occurred early in my tenure as a Clinical Team Leader (CTL) and reflects Benner's (1982) novice-to-expert framework, as I was in the early stages of competence. On a night shift as the sole CTL in the region, I was balancing hospital delays, rising demand, and staff without breaks when I received a call from the A&E nurse in charge regarding an alleged incident. She reported that a paramedic had been verbally intimidating towards a triage nurse during handover.

Aware of the potential impact on interprofessional relationships, I prioritised addressing the matter immediately. I reassured the nurse in charge that the matter would be addressed promptly. Although still relatively new to the role and finding the prioritisation of multiple competing demands challenging, Locating the individual via our system, I contacted them and arranged to discuss the matter over the phone once they completed their handover. The paramedic named in the complaint was known for being direct and occasionally confrontational, with a reputation for responding poorly to feedback.

While waiting, I spoke to the triage nurse to hear her perspective, practising active listening and demonstrating empathy—attributes associated with compassionate leadership (West et al., 2014). She agreed to engage in mediation after I had first spoken with the paramedic.

When the paramedic had completed their handover, I called again to outline the nature of the discussion I wished to have. Their initial response was defensive, dismissive, and at times verbally aggressive. Despite being early in my CTL tenure, I remained composed and assertive, making it clear that the complaint needed to be addressed. I asked them calmly to lower their voice and maintain professionalism, focusing on resolving the issue constructively. This approach demonstrated both self-awareness and self-management, aligning with Goleman's (1998) emotional intelligence framework, and ensured that the conversation remained solution-focused despite the tension.

Emotional intelligence (EI) plays a pivotal role in navigating and resolving workplace conflicts effectively (Goleman, 1998). Recognising and understanding one's emotional triggers is a critical element of managing disputes constructively (Mayer, Salovey, & Caruso, 2008). The use of self-management strategies enables individuals to regulate their emotions, preventing escalation during moments of

tension (Brackett & Katulak, 2006). Furthermore, empathy and active listening are integral aspects of EI, fostering mutual understanding and facilitating resolution in conflict situations (Salovey & Mayer, 1990). While the development of EI is a gradual process, it contributes significantly to building stronger, more resilient workplace relationships (Boyatzis, 2018).

I adopted a combination of situational and directive leadership by clearly stating that the paramedics behaviour was inappropriate and outlining the need for a constructive resolution. I informed them that I would be liaising with the nurse in charge and proposed mediation as a suitable approach to address the matter promptly. Encouraging the paramedic to participate in this process reflected a coaching-oriented leadership style, in line with CIPD (2007) principles.

To minimise disruption to the nurse's shift, I arranged for the mediation to take place at the hospital. I facilitated the discussion, ensuring all parties—the nurse in charge, the nurse involved, and the paramedic—were given equal opportunity to present their accounts. Each individual provided context regarding the challenges of a high-pressure shift, including the strain of working in an overcrowded emergency department and the frustration caused by delays in handing over a critically unwell patient. Throughout the conversation, I demonstrated both firmness and empathy, focusing on achieving a resolution that was acceptable to everyone involved (Hougaard et al., 2020).

By the end of the mediation, both parties had apologised and committed to maintaining professionalism in future interactions. I documented the incident with a formal note on the paramedics personnel file and reiterated the expectation of respectful and professional communication, aligning with the WAST behavioural standards and the NHS Wales values framework (NHS Wales, 2024). I also requested that the paramedic complete a written reflection on the event, with the aim of fostering self-awareness and learning for future practice. This process illustrated how decisive, authoritative leadership, when balanced with coaching and compassion, can effectively resolve workplace conflict (Wang et al., 2019).

Using coaching leadership, I made it clear that in future to act professionally in his interaction with other healthcare professional. In the context of healthcare leadership, coaching can be an effective approach to helping paramedic team

members avoid conflict with colleagues by improving self-awareness, emotional regulation, and interpersonal skills. High-pressure environments such as pre-hospital care can amplify stress responses, making constructive communication essential (NHS Leadership Academy, 2013). Coaching provides a structured space for reflection, allowing staff to recognise their behavioural triggers and develop strategies to manage them before tensions escalate (Whitmore, 2017). This process encourages empathy and active listening—key skills for fostering mutual respect and collaboration within multidisciplinary teams (Cox et al., 2018). By focusing on relationship-building, perspective-taking, and constructive dialogue, coaching supports paramedics in navigating disagreements professionally and maintaining team cohesion during complex and time-critical incidents (Clutterbuck, 2014). Over time, these skills contribute to a positive workplace culture, reducing conflict and enhancing patient care outcomes (Health Education England, 2020).

Reflecting on my approach to managing conflict, I utilised the Blake and Mouton Managerial Grid leadership questionnaire, which identified my dominant style as a “Team Leader” (high concern for both people and production) (Blake and Mouton, 1985). This leadership style emphasises collaboration, mutual respect, and shared problem-solving, aligning well with effective conflict resolution strategies in healthcare teams (Northouse, 2021). Recognising that I naturally strive to balance achieving operational goals with maintaining positive interpersonal relationships has helped me to approach conflicts as opportunities for collective improvement rather than confrontation. In practice, this means fostering open communication, encouraging all perspectives to be heard, and working towards solutions that satisfy both staff needs and organisational priorities (Goleman, 1998). Through this reflection, I have become more aware of how my leadership style supports a constructive and inclusive approach to resolving disputes within high-pressure paramedic team environments.

So what?

Reflecting on the incident that took place approximately three years ago, despite feeling inexperienced and new to leadership at the time, I believe I made the correct decision by addressing the issue immediately. My main goal was to prevent the situation from escalating and causing ongoing tension between the two staff

members. I maintained a calm and composed demeanour, managing to stay confident despite the paramedic's attempts to intimidate me, which may have been influenced by my relative newness in the role (Allen & Allen, 1989). I demonstrated compassionate leadership towards the nurse involved, who was visibly distressed by the situation, applying a leadership approach I regularly use when supporting staff through difficult or emotional circumstances (Hougaard et al., 2020).

This compassionate leadership was reflected in my active listening to the nurse's concerns and my reassurance that the matter would be handled promptly, helping her feel secure and less anxious about future encounters with the paramedic. According to NHS England (2020/21), it is essential for all staff to feel safe and confident when sharing their experiences or emotions. In this case, I aimed to build the nurse's trust by showing that I was committed to resolving the conflict and ensuring her well-being going forward. My Insights Discovery profile highlights consistency and reliability as key strengths, and I believe this was evident to the nurse as I worked towards a fair resolution.

In healthcare, effective leadership requires more than just operational oversight; it demands a commitment to understanding and responding to the needs of team members in a considerate and supportive manner. Compassionate leaders actively engage with staff concerns, demonstrating understanding, offering appropriate support, and taking action that aligns with both staff welfare and organisational priorities (West et al., 2017). Within the NHS, leaders in formal positions are expected to model kindness, nurture collaboration, and create an environment that supports innovation and mutual respect (NHS England, 2022). Research has shown that compassionate leadership is strongly associated with improved staff engagement, reduced workplace conflict, and better patient care outcomes (Boorman, 2009; West and Chowla, 2017). Building trust and mutual respect within teams strengthens collaboration and encourages open communication, which in turn fosters a culture of continuous improvement (Cummings et al., 2021).

Reflecting on a specific incident early in my leadership career, I recognise that I acted in a manner consistent with these principles. Confronted with a situation involving an experienced paramedic known for challenging behaviours, I approached the matter directly, maintaining professionalism and emotional control. Although the

interaction was difficult, I believe my actions conveyed both authority and fairness, which not only resolved the immediate conflict but also improved my working relationship with the colleague involved. Following the incident, the paramedic—who had previously shown limited respect for my authority—began to seek my advice on clinical and operational matters. This suggested a shift in his perception of me as a credible and trustworthy leader, despite my relatively short tenure in the role.

This experience reinforced the importance of adaptability, empathy, and active listening—traits identified as key to effective conflict resolution in high-pressure environments such as pre-hospital care (Hofmeyer et al., 2020). It also aligned closely with findings from my Insights Discovery profile, which highlighted my inclination to seek understanding of others' perspectives and maintain strong team relationships. However, I also became aware of the need to balance my moral convictions with an openness to alternative viewpoints, ensuring that team members feel empowered to act from shared values rather than simply conforming to my own perceptions of the “right” approach (MindTools, 2023).

Another aspect of how I managed this I did reflect on is my initial decision to discuss the issues with the member of staff over the phone rather than face to face. The academic evidence shows that conflict resolution in healthcare settings can be approached through various communication channels, with telephone and face-to-face interactions being common methods. Each has distinct advantages and limitations, and their effectiveness depends on context, urgency, and the nature of the dispute.

Telephone conflict management offers immediacy, allowing leaders to address issues promptly without the delays associated with arranging in-person meetings (Salas et al., 2017). This can be particularly beneficial in urgent operational environments, such as ambulance services, where rapid intervention may prevent escalation and protect patient safety (NHS Leadership Academy, 2021). However, telephone conversations lack non-verbal cues such as body language, facial expressions, and posture, which are integral to understanding emotional states and building rapport (Mehrabian, 2017). Without these cues, there is a greater risk of misinterpretation or an escalation of negative tone (Caron, 2020).

In contrast, face-to-face resolution allows for richer communication through both verbal and non-verbal channels, enabling leaders to convey empathy more effectively and pick up on subtle emotional indicators (Hargie, 2011). It also facilitates a more collaborative environment where participants can feel heard and respected, which can strengthen trust and working relationships (West et al., 2017). However, arranging in-person meetings can delay resolution and may be logistically challenging, especially when staff operate in dispersed locations or under time-critical pressures.

In determining which method is best, research suggests that high-stakes or emotionally charged conflicts are generally more effectively managed face-to-face due to the depth of communication possible (Hargie, 2011). Conversely, lower-intensity disputes or situations requiring rapid intervention may be appropriately managed via telephone, provided the leader actively listens, uses clear language, and follows up with in-person discussion where needed (NHS England, 2022). Ultimately, the optimal approach is situational, balancing timeliness, emotional sensitivity, and the goal of maintaining long-term staff cohesion. For me I feel that a face-to-face discussion would have been better in this example and that is how I have managed these situation since this experience.

To further appraise my approach in handling the conflict, I have applied Kolb's Experiential Learning Cycle (1984), a model that frames learning as a continuous process involving four interconnected stages: Concrete Experience, Reflective Observation, Abstract Conceptualisation, and Active Experimentation. This framework is particularly relevant for leadership development in healthcare, where leaders are constantly required to learn from fast-moving and emotionally charged situations.

The Concrete Experience stage refers to engaging directly in an event. In this scenario, my concrete experience was managing the conflict between the nurse and the paramedic in real time. The immediacy of the issue, combined with the high-pressure environment of A&E and my relative newness in the leadership role, made this a particularly challenging but valuable learning opportunity. Acting decisively to address the complaint, facilitate mediation, and maintain operational flow formed the foundation of the experience.

Reflective Observation involves reviewing the situation and considering different perspectives. After the incident, I reflected on how I balanced compassion for the nurse with assertiveness towards the paramedic, recognising that these contrasting approaches were necessary to meet the needs of each party. I also noted areas where my approach could have been improved, such as implementing a more formalised structure to the mediation process or involving a neutral third party to further ensure fairness and objectivity.

The Abstract Conceptualisation stage focuses on drawing lessons from the experience by linking it to relevant theory and leadership principles. In reflecting on this incident, I connected my actions to conflict resolution theory, particularly the importance of addressing interpersonal disputes promptly to prevent escalation (Rahim, 2011). I also recognised that my ability to switch between supportive and authoritative styles mirrored the flexibility emphasised in Situational Leadership theory, even though I was not consciously applying it at the time.

Finally, Active Experimentation involves applying what has been learned to future practice. From this incident, I have committed to developing a structured conflict resolution protocol for my role, which will include early intervention, formal mediation frameworks, and scheduled follow-up. I have also decided to build stronger pre-emptive relationships with staff members, which I anticipate will increase trust and openness, making it easier to resolve disputes before they escalate.

By using Kolb's Experiential Learning Cycle, I have been able to break down the incident into a process of learning that moves beyond simply reacting in the moment. The model highlights how leadership competence is not only built through direct action but also through reflection, theoretical understanding, and the deliberate application of new strategies. This structured approach to reflection will support my continued growth as a Senior Paramedic and help me develop more consistent, evidence-based responses to future challenges in the workplace.

One area of my practice as a manager that I am determined to maintain is my strong focus on relationship management as highlighted in my insights report. I have found that the ability to maintain strong relationships with stakeholders can be put under pressure in conflict situations. Effective leadership extends beyond internal team management to include the ability to navigate conflict with external stakeholders and

partners, which is essential for sustaining long-term professional relationships (Cameron & Green, 2019).

Conflict can arise due to differing priorities, resource constraints, or misaligned expectations, and leaders must approach these situations with a combination of negotiation, communication, and emotional intelligence (Goleman, 1998). Applying collaborative and interest-based strategies allows leaders to address the root causes of disagreement while preserving trust and credibility (Fisher, Ury & Patton, 2011). For example, actively listening to stakeholders' concerns, validating their perspectives, and seeking mutually beneficial solutions promotes transparency and shared ownership of outcomes (Deutsch, Coleman & Marcus, 2014).

Leaders who demonstrate consistency, fairness, and adaptability are more likely to maintain constructive relationships, even during challenging interactions (Northouse, 2016). In healthcare and emergency services, where inter-organizational collaboration is critical, managing conflict effectively ensures seamless patient care, resource coordination, and the long-term viability of partnerships (West et al., 2015). Ultimately, leadership that prioritizes relationship-building and conflict resolution fosters resilient networks that can adapt to evolving challenges while supporting organizational objectives.

Now what?

Peer Feedback and Leadership Validation

Following the incident, I sought feedback from both the oncoming duty Clinical Team Leader (CTL) and my Locality Manager (LM) to evaluate my approach. The CTL noted that, in his own practice, he might have delayed addressing the matter until the paramedic returned to station, whereas my decision to deal with it immediately ensured that the issue did not escalate during the shift. The LM, in contrast, commended my decisiveness and conflict resolution skills, noting that prioritising the resolution prevented potential harm to patients and maintained team cohesion. Such feedback reinforced my confidence and provided external validation that my approach was aligned with effective leadership practice in urgent care environments (Goleman et al., 2013; NHS Leadership Academy, 2021).

The LM also highlighted that my composure in managing a difficult and assertive colleague demonstrated interpersonal skill and professional resilience. This

affirmation was particularly meaningful as I was still relatively new to my leadership role and had questioned whether I had managed the incident with sufficient compassion and authority. Having senior leaders confirm that they would have acted similarly reassured me that I was developing the right instincts for effective leadership.

Self-Awareness and Leadership Style Development

Reflecting on this episode underscored that leadership styles can vary significantly between individuals yet still produce positive outcomes. As Yukl (2013) suggests, adaptability in leadership is crucial for addressing dynamic and context-dependent challenges. Discussing the incident with peers deepened my awareness of how my approach influences staff behaviour, team morale, and service performance. It also highlighted areas for further development—particularly the need to maintain empathy even when dealing with unacceptable behaviour.

My Insights Discovery profile, completed some years after the incident, described me as a relationship-focused leader who values trust, loyalty, and understanding multiple perspectives. Looking back, I realise I applied these principles in the incident by listening to all parties, asking about wellbeing, and seeking to understand the paramedic's behaviour. At the same time, I maintained clear boundaries to ensure professional standards were upheld. However, the profile also cautioned me against applying my own moral framework too rigidly—a reminder to ensure that my “right thing” aligns with a shared team ethic rather than a solely personal view (Scoular and Linley, 2010).

Sustaining Compassion While Protecting Self-Care

As my career has progressed, I have developed a more approachable leadership style, with staff often coming to me with both operational and welfare concerns. While this demonstrates trust, I recognise the risk of overextending myself—particularly when I take calls during rest days. West et al. (2020) emphasise the importance of leaders safeguarding their own wellbeing in order to maintain their capacity to lead effectively. Modelling a healthy work–life balance not only sustains personal resilience but also sets an example for the team.

Personal Learning and Growth

This incident became a turning point in building my confidence in managing

challenging conversations. Previously, I found such situations anxiety-provoking, but repeated exposure and reflection have improved my ability to remain calm, authoritative, and compassionate under pressure (Salas et al., 2017). In hindsight, I might have explored more deeply whether there were personal factors influencing the paramedic's behaviour, but I remain confident that my actions prioritised both team integrity and patient safety.

The mediation process ultimately enabled both parties to voice concerns and agree on a constructive resolution. This outcome reinforced my belief that clear, timely intervention and open dialogue can prevent conflict escalation, protect staff wellbeing, and uphold professional standards (Morrow et al., 2022).

In considering this event further, I recognise that it provided an important learning opportunity in developing my leadership style and ability to navigate emotionally charged situations. At the time, my decision to intervene immediately was influenced by an understanding that unresolved interpersonal issues can quickly erode team cohesion, lower morale, and ultimately compromise patient care (Morrison, 2008). By acting promptly, I was able to contain the conflict and prevent it from creating a ripple effect within the wider team.

The incident also reinforced the importance of emotional intelligence in leadership, particularly the elements of self-awareness, self-regulation, empathy, and social skills outlined in Goleman's (1998) model. Remaining composed under pressure allowed me to manage my own emotional response and avoid being drawn into a defensive or confrontational stance. This, in turn, modelled the type of professional conduct expected in high-pressure healthcare environments. By demonstrating empathy, I was able to acknowledge the nurse's feelings while maintaining fairness towards the paramedic, ensuring both parties felt heard.

Another significant takeaway was the role of communication in conflict resolution. Using open, non-judgemental language and framing the discussion around behaviours rather than personal attributes helped reduce defensiveness and encourage constructive dialogue (Fisher & Ury, 2012). This approach not only resolved the immediate issue but also provided both individuals with an opportunity to reflect on their professional interactions, which can reduce the likelihood of similar incidents reoccurring.

From a leadership development perspective, this event strengthened my confidence in applying a flexible leadership style, adapting my approach depending on the needs of the individuals and the context. While I was still relatively new to my role, the experience affirmed my ability to lead with both authority and compassion, balancing the need for accountability with the responsibility to support and develop staff.

Ongoing Leadership Development

The experience emphasised the need for continual self-belief and alignment of my leadership actions with the core values of compassion, fairness, and accountability. Knowing when to escalate issues and seek senior input remains a critical skill in my role, and this incident demonstrated the value of validating decisions with trusted colleagues. Their recognition of my ability to handle a complex situation early in my leadership career was a key motivator in my decision to undertake the PGCert in healthcare leadership. This academic journey has deepened my understanding of leadership theory and equipped me to adapt my style to diverse scenarios within the ambulance service.

Conclusion

Reflecting on this incident has strengthened my appreciation of the nuanced balance between compassion, authority, and adaptability in leadership. By integrating reflective practice into my role, I continue to develop a more flexible and confident approach to managing interpersonal challenges. The literature reinforces that effective leaders adapt their behaviours to suit the context while maintaining a core set of values (Alimo-Metcalfe and Alban-Metcalfe, 2008). Going forward, I intend to incorporate these lessons into my personal development plan, ensuring that my leadership continues to support both team wellbeing and high-quality patient care.

This experience has also highlighted the importance of emotional intelligence in diffusing conflict before it escalates, as well as the value of establishing trust with staff so that they feel comfortable raising concerns (Goleman, 1998). In future, I will aim to strengthen my conflict prevention strategies through proactive relationship building, clearer communication of expectations, and early intervention when tensions arise. Additionally, embedding structured mediation techniques into my leadership toolkit will provide a consistent, fair, and transparent approach to

resolving disputes. By combining these strategies with ongoing self-assessment and professional development, I can ensure that my leadership style continues to evolve in line with the needs of both my team and the wider healthcare system.

Appendix – Personal Development Plan (PDP)

Development Area	Objective	Actions Required	Resources/Support Needed	Timescale	Success Criteria / Measures of
Conflict resolution skills	Enhance ability to manage and resolve interpersonal conflicts promptly and effectively	Attend formal NHS/HEE conflict resolution and mediation training	Access to CPD funding; Support from line manager to attend course	Within 6 months	Successful completion of training; Positive feedback from staff following mediation situations
Structured mediation process	Develop and implement a clear framework for handling disputes	Research NHS Wales/WAST mediation guidelines; Draft and pilot mediation checklist	NHS mediation resources; Peer feedback	Within 3 months	Framework approved by line manager; Implemented in at least 2 incidents
Assertive communication	Improve ability to communicate expectations clearly while	Complete assertiveness training or online CPD module	Online CPD access; Coaching from mentor	Within 4 months	Self-reported confidence increase; Reduced escalation

	maintaining professional ism				in future disputes
Leadership self- awareness	Strengthen understandi ng of personal leadership style and its impact	Complete at least one additional leadership self- assessme nt tool (e.g., MBTI, DISC) and reflect on results	Access to assessment tools; Mentor guidance	Within 2 months	Reflection included in CPD log; Action points integrated into practice
Emotional resilience	Increase capacity to remain calm and focused under pressure	Participate in resilience and wellbeing workshops ; Practice stress managem ent techniques (mindfulne ss, breathing)	Workshop access; Wellbeing resources	Ongoing , with review at 6 months	Reduction in stress levels (self- assessme nt); Ability to manage high- pressure incidents without escalation

Notes:

- This PDP will be reviewed in 6 months with my line manager to assess progress and adjust objectives as needed.
- Outcomes and reflections from each action will be recorded in my CPD portfolio in line with HCPC requirements.

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