International Journal of Scientific Research and Modern Technology (IJSRMT) ijsrmt.com
Volume 5, Issue 2, 2026
DOI: https://doi.org/10.38124/ijsrmt.v5i2.1264

Building Patient-Focused Change: Strategic Leadership and Service Continuity in Private Hospitals in Lebanon

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Publication Date: 2026/03/27

Abstract

This study examined the determinants of strategic and patient-focused change management in hospitals, emphasizing leadership, employee engagement, crisis preparedness, service continuity, and change monitoring mechanisms. Data from 211 hospital staff underwent factor analysis, identifying six organizational dimensions: Strategic and Patient-Focused Change Management, Employee-Centered Leadership, Crisis Preparedness and Benchmarking, Public Policy Perception, Continuity in Clinical Service Delivery, Change Monitoring and Evaluation Tools, and Strategic Leadership for Change. Reliability analyses indicated strong internal consistency (Cronbach's α = .843–.944). Multiple regression revealed that these factors collectively explained 76% of the variance in strategic and patient-focused change management (R^2 = .760, $F(5, 205) = 129.58$, $p < .001$), with strategic leadership as the most influential predictor (β = .421, $p < .001$).

The study's originality lies in developing and empirically validating an integrated model that unites leadership behavior, organizational preparedness, and service continuity—dimensions previously examined in isolation. Situated within the COVID-19 context, it provides novel insights into how hospitals sustain resilience and patient-centered care during crises. The findings underscore the importance of visionary leadership, participatory management, and structured operational mechanisms, offering a comprehensive framework and practical guidance for healthcare administrators navigating complex organizational change.

Keywords: *Strategic Leadership, Change Management, Employee-Centered Leadership, Hospital Administration, Crisis Preparedness, Patient-Centered Care.*

I. INTRODUCTION

In fragile healthcare systems—particularly those affected by political instability and economic turmoil—achieving meaningful and sustainable organizational change remains a persistent challenge. Lebanon's private hospital sector, long regarded as a cornerstone of the country's healthcare delivery system, has faced unprecedented pressures due to the COVID-19 pandemic and a protracted economic crisis (Aoun & Tajvar, 2024; El-Jardali, 2022). Despite ongoing debates on healthcare reform, improvements have remained limited, and many of the core systemic issues persist (Khalife et al., 2025).

While numerous change implementation models have been proposed, many rely on rigid theoretical frameworks that fail to reflect the complex, adaptive nature of frontline healthcare work. Harrison et al. (2021) highlight that such models often struggle to accommodate the dynamic and non-linear realities of healthcare environments. This critique aligns with Donaldson's (2001) contingency theory, which emphasizes the need for organizational strategies to adapt to contextual variables, rather than applying a one-size-fits-all model of change.

This investigation responds to these limitations by developing a novel, data-driven model of strategic and patient-focused change management, grounded in the lived experiences of nurses and frontline managers working in Lebanon's private hospitals. Rather than relying on pre-established theoretical assumptions, the study employs an empirical approach, drawing on survey data from 211 healthcare professionals to construct a multiple regression model. This model explores how key organizational drivers—including employee-centered leadership, crisis preparedness, benchmarking practices,

El-Kassem, R. C., & Yassine , A. A. (2026). Building Patient-Focused Change: Strategic Leadership and Service Continuity in Private Hospitals in Lebanon. *International Journal of Scientific Research and Modern Technology*, *5*(2), 156–161. https://doi.org/10.38124/ijsrmt.v5i2.1264

and change-monitoring mechanisms—interact to shape strategic leadership and, ultimately, deliver meaningful patient outcomes.

Employee-centered leadership, in particular, has emerged as a critical enabler of healthcare transformation, especially in resource-constrained and crisis-prone settings. By emphasizing staff empowerment, transparent communication, and shared decision-making, this leadership style fosters institutional readiness and enhances performance accountability. Patri, Suresh, and Prasad (2021) identify empowerment as one of the most influential leadership characteristics driving organizational preparedness for healthcare reform, particularly under lean implementation strategies. Their findings reinforce the view that readiness is not solely structural but deeply embedded in the relational dynamics between leaders and frontline professionals.

Through this lens, employee-centered leadership serves as a catalyst for internal performance monitoring and institutional adaptation, enabling strategic leadership to translate operational readiness into patient-centric transformation. This alignment ensures that leadership vision is informed by frontline insights, bridging the persistent gap between executive strategy and on-the-ground realities. Using standardized beta coefficients through multiple regression analysis, the current study isolates direct effects and clarifies causal effects often obscured in correlation-based models. Notably, the findings position employee-centered leadership as the primary catalyst for institutional readiness and performance tracking, thereby enabling strategic leadership to drive sustainable, patient-centered reforms.

This evidence-based framework contributes actionable insights for hospital administrators and healthcare policymakers aiming to build resilient, adaptive systems capable of responding to persistent crises. In doing so, the study offers a timely and context-sensitive alternative to theory-heavy models, contributing a grounded and scalable perspective to the global discourse on healthcare change management. It further emphasizes the roles of inclusive decision-making, adaptive leadership, and outcome-focused evaluation as foundational pillars for effective health system transformation.

- *Significance of Study*

This study holds both theoretical and practical significance, particularly within the context of fragile and crisis-affected healthcare systems such as Lebanon's. Theoretically, it contributes to a novel, empirically grounded model of patient-centered organizational change that diverges from traditional, top-down frameworks. By leveraging real-world data from frontline nurses and managers—the individuals most directly involved in service delivery and operational decision-making provides a unique, bottom-up perspective on what drives effective and sustainable changes in hospital settings.

It advances academic understanding by integrating leadership, crisis preparedness, benchmarking, and evaluation mechanisms. This model clarifies the causal relationships among these factors using rigorous statistical techniques, helping to fill critical gaps in the literature on change management and health systems resilience.

Practically, the findings offer concrete guidance for hospital administrators, healthcare policymakers, and international organizations seeking to strengthen institutional capacity in fragile environments. The study emphasizes the central role of employee-centered leadership in initiating and sustaining organizational change, highlighting the importance of leadership development, staff empowerment, and inclusive governance. It also underscores the enabling roles of crisis preparedness, performance benchmarking, and evaluation mechanisms in fostering adaptive, patient-focused strategic leadership.

Given Lebanon's ongoing socio-economic and healthcare challenges, the country's health system has been pushed to the brink of collapse by a combination of financial instability, political turmoil, the COVID-19 pandemic, and the aftermath of the 2020 Beirut port explosion. Bou Sanayeh and El Chamieh (2023) warn of a rapidly deteriorating hospital infrastructure, characterized by critical shortages in medical supplies, severe currency devaluation, and mass emigration of healthcare professionals. These systemic pressures have left hospitals unable to maintain basic services or meet operational costs. Complementing this view, a recent scoping review by BMC Health Services Research (2024) highlights the structural weaknesses and inequities in Lebanon's healthcare system, noting that decades of underinvestment, combined with ongoing crises, have compromised the sector's resilience and capacity for reform. These conditions create a uniquely fragile environment for implementing sustainable healthcare change, particularly at the frontline level. This research offers timely and context-specific insights that can inform efforts to enhance hospital system resilience. Its findings are also transferable to other countries facing similar fragility, offering a scalable model for leading and managing change effectively in uncertain and rapidly evolving environments. By translating frontline realities into a robust and actionable change model, this study bridges the gap between theory and practice and contributes to the broader goal of building responsive and equitable healthcare systems.

- *Research Problem*

In crisis-affected contexts such as Lebanon, private hospitals face the dual challenge of maintaining clinical service continuity while driving patient-centered organizational change. However, the mechanisms through which these hospitals can effectively implement and sustain such changes remain underexplored, particularly in environments characterized by economic instability and public health crises. The problem lies in understanding how strategic leadership, employee-centered practices,

crisis preparedness, and structured monitoring mechanisms interact to enable strategic and patient-focused change management that is both contextually relevant and operationally effective—without relying on imported or theoretical frameworks that may not fit the local healthcare realities.

➢ *Purpose*

The purpose of this study is to empirically identify and examine the key organizational factors that influence the successful implementation of strategic and patient-focused change management in private hospitals in Lebanon. Drawing on data from nurses and front-line managers, the study evaluates how strategic leadership, employee-centered leadership, crisis preparedness and benchmarking, continuity in clinical service delivery, and change monitoring and evaluation tools collectively shape effective change processes. By establishing strategic leadership as the most significant driver of patient-focused change, the research provides practical, evidence-based insights for hospital administrators and policymakers seeking to strengthen adaptive capacity, leadership responsiveness, and service resilience in fragile healthcare systems.

➢ *Main Research Question*

How do strategic leadership, employee-centered practices, crisis preparedness, and change monitoring mechanisms collectively influence the successful implementation of strategic and patient-focused change management in private hospitals in Lebanon during times of crisis?

➢ *Sub-Research Questions*

- *Strategic Leadership Dimension:*

How does strategic leadership contribute to driving and sustaining patient-focused organizational change in crisis-affected private hospitals?

- *Employee-Centered Practices Dimension:*

In what ways do employee-centered leadership and staff engagement practices affect the adaptability and effectiveness of change management processes?

- *Crisis Preparedness and Continuity Dimension:*

How does the level of crisis preparedness and continuity planning shape hospitals' ability to maintain clinical service delivery while implementing organizational change?

- *Monitoring and Evaluation Mechanisms Dimension:*

What role do structured monitoring and evaluation mechanisms play in ensuring that change initiatives remain aligned with strategic and patient-centered objectives?

- *Integrated Systems Perspective:*

How do the interactions among leadership, employee engagement, crisis preparedness, and monitoring practices create a synergistic framework for sustainable, contextually relevant change management in Lebanon's private healthcare sector?

II. PROCEDURES AND METHODS

➢ *Population and Sampling*

This study investigated patient-centered change implementation within private hospitals in Lebanon. Using a simple random sampling technique, responses were collected from hospitals across all Lebanese governorates to ensure diversity and representativeness. The final sample included 211 valid responses, consisting of 76 managerial staff and 135 nurses. The demographic characteristics profile reflected a reasonable composition, with 60% female respondents and a large segment (nearly 40%) between the ages of 30 and 39. Moreover, almost one-third of the sample had more than 20 years of experience in the private healthcare sector, enriching the study with seasoned perspectives on change implementation.

➢ *Instrumentation*

The instrument used in this research incorporated selected items from previously validated measures to guarantee reliability and contextual relevance. Constructs related to strategic change management and innovation were adapted from the work of Klammer et al. (2017) and Liao et al. (2017), while leadership elements were grounded in the approach outlined by Franco and Matos (2013). Measures reflecting patient-centered service dimensions were influenced by established service quality models such as SERVQUAL (Parasuraman et al., 1988) and further contextualized through recent studies focused on healthcare responses in Lebanon during the COVID-19 pandemic (Yaacoub et al., 2023). Although the main survey instrument was comprehensive, this study specifically utilized a targeted subset of items relevant to patient engagement and organizational change processes.

➢ *Factor Structure and Interpretation*

To examine the underlying structure of the leadership and change management constructs, a Principal Component Analysis (PCA) with oblique rotation was conducted, given the expected correlations among organizational factors.

The Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy was .909, exceeding the recommended threshold of .80 (Kaiser, 1974), which indicates that the data were highly suitable for factor analysis. Similarly, Bartlett's Test of Sphericity was significant (χ^2 = 9746.845, $p < .001$), confirming that the correlation matrix was not an identity matrix and that sufficient inter-item correlations existed to justify factor extraction.

The initial eigenvalues and scree plot supported the extraction of six components, each with eigenvalues greater than 1. These six components collectively explained 78.49% of the total variance, which is well above the commonly accepted benchmark of 60% in social sciences, suggesting a strong factor structure. The first factor accounted for 49.49% of the variance, followed by

Factors 2 to 6 contributing 12.15%, 6.42%, 4.11%, 3.42%, and 2.91%, respectively.

Given the oblique rotation, which allows for factor intercorrelation, the rotation sums of squared loadings indicated a well-differentiated yet conceptually related factor solution. This structure confirmed that the data could be meaningfully reduced to six correlated dimensions representing distinct but interrelated domains of hospital change management—namely, Strategic and Patient-Focused Change Management, Employee-Centered Leadership, Crisis Preparedness and Benchmarking, Continuity in Clinical Service Delivery, Change Monitoring and Evaluation Tools, and Strategic Leadership for Change**.**

Overall, these results validate the construct dimensionality and empirical robustness of the measurement model, providing a sound statistical foundation for subsequent reliability and regression analyses.

III. RESULTS

➢ *Factor Interpretations*

- *Factor 1: Strategic and Patient-Focused Change Management*

This 10 items factor (Q12, Q14, Q21, Q71 , Q28 , Q33 , Q29 , Q81 , Q34 , Q49) captures the hospital's capacity to manage organizational change strategically while maintaining patient-centered services. This composite variable (Y), derived from ten items, demonstrated excellent internal consistency (Cronbach's α = .944). Mean scores ranged from 3.81 to 4.43 on a five-point scale (N = 211), indicating generally positive perceptions. Items such as "Management of respiratory conditions" (M = 4.43, SD = 0.79) and "CEO responsibility for change efforts" (M = 4.38, SD = 0.71) highlight strong leadership engagement and clinical responsiveness. Lower ratings, such as for "Physiotherapy for persons with physical disabilities" (M = 3.81, SD = 1.01), suggest areas for further development. Overall, the hospital demonstrates a proactive, structured, and patient-oriented approach to change management.

- *Factor 2: Employee-Centered Leadership*

These 6 items factor (Q1, Q7, Q11, Q13, Q51, Q24) reflect leadership practices prioritizing employee involvement, diversity, and learning during change. Six items formed this composite variable (X1), showing excellent reliability (α = .916). Mean scores ranged from 3.37 to 3.65, with the highest item highlighting adoption of green initiatives (M = 3.65, SD = 0.87) and the lowest addressing diversification of activities during the financial crisis (M = 3.37, SD = 1.08). The results indicate moderate but positive perceptions of participatory leadership, staff engagement, and organizational learning.

- *Factor 3: Crisis Preparedness, Benchmarking, and Public Policy Perception*

This factor comprises four items (Q40, Q44, Q45, Q59) denoted (X2, α = .843). This factor reflects hospitals' capacity for crisis management and use of performance evaluation tools. Mean scores ranged from 3.71 to 4.12. High ratings for gap analysis (M = 4.12, SD = 0.73) and attainable vision (M = 4.04, SD = 0.69) highlight structured analytical approaches, while moderate perceptions of policy effectiveness (M = 3.71, SD = 0.83) indicate room for improving external policy engagement.

- *Factor 4: Continuity in Clinical Service Delivery*

This factor (Q9, Q64, Q68, Q53, Q25) captures the hospital's ability to maintain essential services while fostering staff development. These five items (X3, α = .848) showed mean scores from 3.97 to 4.13. High ratings for management of chronic diseases (M = 4.13, SD = 0.80) and infection control practices (M = 4.02, SD = 0.73) emphasize consistent clinical delivery. Moderate ratings for staff development (M = 3.98) and feedback integration (M = 3.97) suggest a balance between operational excellence and organizational learning.

- *Factor 5: Change Monitoring and Evaluation Tools*

This 4 items factor (Q35, Q22, Q46, Q48) represents systematic tracking, evaluation, and motivation during change (X4, α = .863). Mean scores ranged from 3.76 to 4.08. Leadership efforts to engage employees and generate excitement about change (M = 4.08, SD = 0.83) were highest, while formal monitoring tools such as balanced scorecards (M = 3.76, SD = 0.87) were slightly lower, indicating potential for stronger institutionalization.

- *Factor 6: Strategic Leadership for Change*

This factor comprising nine items (Q15, Q16, Q56, Q26, Q36, Q37, Q27, Q5, Q17) denoted (X5, α = .926), this factor reflects visionary, structured, and motivational leadership. Mean scores ranged from 3.81 to 4.51, with the highest rating for provision of new services during COVID-19 (M = 4.51, SD = 0.81). Strong ratings for CEO engagement (M = 4.34) and situational analysis (M = 4.28) highlight proactive leadership. Moderate scores for planning flexibility (M = 3.82) suggest areas for enhancement.

➢ *Regression Analysis*

Multiple regression analysis examined the predictive capacity of Factors 2–6 on Strategic and Patient-Focused Change Management (Factor 1). The model was significant, $F(5, 205) = 129.58$, $p < .001$, with $R^2 = .760$, indicating that 76% of the variance in Factor 1 is explained by the five predictors. Among them, Strategic Leadership for Change was the strongest predictor ($\beta = .421$, $t = 7.07$, $p < .001$). Significant contributions were also observed for Employee-Centered Leadership ($\beta = .183$, $p < .001$), Crisis Preparedness and Benchmarking ($\beta = .173$, $p = .003$), and Continuity in Clinical Service Delivery ($\beta = .173$, $p = .008$). Change Monitoring and Evaluation Tools showed a positive but non-significant effect ($\beta = .109$, $p = .073$). These findings suggest that leadership, employee engagement, preparedness, and service continuity are central to effective patient-focused change management.

Table 1 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.872[a]	0.76	0.754	0.33205

[a] Predictors: (Constant), Factor 6: Strategic Leadership for Change, Factor 2: Employee-Centered Leadership, Factor 3: Crisis Preparedness, Benchmarking, and Public Policy Perception, Factor 5: Change Monitoring and Evaluation Tools, Factor 4: Continuity in Clinical Service Delivery

Table 2 ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	71.434	5	14.287	129.577	.000[b]
	Residual	22.603	205	0.11		
	Total	94.037	210			

a. Dependent Variable: Factor 1: Strategic and Patient-Focused Change Management
b. Predictors: (Constant), Factor 6: Strategic Leadership for Change, Factor 2: Employee-Centered Leadership, Factor 3: Crisis Preparedness, Benchmarking, and Public Policy Perception, Factor 5: Change Monitoring and Evaluation Tools, Factor 4: Continuity in Clinical Service Delivery

Table 3 Coefficients[a]

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-0.195	0.173		-1.122	0.263
	Factor 2: Employee-Centered Leadership	0.137	0.034	0.183	3.982	p < .001
	Factor 3: Crisis Preparedness, Benchmarking, and Public Policy Perception	0.187	0.062	0.173	2.994	0.003
	Factor 4: Continuity in Clinical Service Delivery	0.183	0.068	0.173	2.669	0.008
	Factor 5: Change Monitoring and Evaluation Tools	0.109	0.060	0.109	1.805	0.073
	Factor 6: Strategic Leadership for Change	0.471	0.067	0.421	7.066	p < .001

a. Dependent Variable: Factor 1: Strategic and Patient-Focused Change Management

IV. DISCUSSION

The results underscore the centrality of strategic leadership in effective, patient-focused change management. The substantial variance explained by the model (76%) indicates that successful organizational transformation in hospitals depends not only on leadership but also on integrated organizational mechanisms, including employee engagement, operational continuity, and structured evaluation tools.

Strategic leadership emerged as the most influential determinant, confirming that visionary, motivational, and analytical leaders play a pivotal role in mobilizing staff and resources, particularly during crises such as COVID-19. Employee-centered practices further reinforce change management, highlighting the importance of participatory leadership, feedback integration, and staff empowerment, consistent with transformational leadership theory. Crisis preparedness and benchmarking mechanisms provide structured approaches for planning and performance improvement, while continuity in clinical services ensures that patient needs remain central during organizational change. Although formal change monitoring tools were less influential, their positive association suggests potential benefits if more systematically applied.

Collectively, these findings provide empirical support for a multidimensional approach to hospital change management, integrating leadership, operational, and evaluative dimensions. They extend the literature by offering an integrated framework that situates leadership, employee engagement, and clinical continuity as interdependent drivers of patient-centered change.

V. CONCLUSION AND CONTRIBUTION

This study demonstrates that strategic leadership, employee-centered practices, crisis preparedness**,** clinical continuity, and change evaluation mechanisms collectively explain a substantial proportion of variance in patient-focused change management. The original

contribution lies in developing a holistic, empirically validated model that links leadership behavior, organizational preparedness, and service continuity under one framework departure from previous studies that examined these dimensions in isolation. By situating the study in the context of the COVID-19 pandemic, it offers novel insights into how hospitals can maintain resilience, adaptability, and patient-centered service delivery during crises, providing both theoretical and practical contributions to healthcare management.

IMPLICATIONS AND RECOMMENDATIONS

- *Macro-Level Implications for Policymaking*

Policymakers should prioritize leadership development programs, integrating crisis preparedness, benchmarking, and performance evaluation mechanisms into hospital governance. Policies encouraging inter-institutional collaboration, transparency, and systematic accountability will enhance healthcare system resilience. Strengthening frameworks for employee engagement and strategic leadership at the national level can improve organizational responsiveness during public health crises.

- *Micro-Level Implications for Hospital Decision-Making*

Hospital administrators should focus on fostering participatory leadership, staff engagement, and feedback integration. Maintaining continuity in essential clinical services and systematically monitoring change initiatives with tools such as momentum maps and balanced scorecards are critical for sustaining transformation. Institutionalizing a learning-oriented culture ensures that lessons from past crises inform future strategic planning and policy adaptation.

- *Recommendations for Future Research*

Future research should test this integrated model across different healthcare systems, organizational types, and cultural contexts. Longitudinal studies could track the evolution of leadership practices and their impact on change sustainability. Incorporating qualitative methods may provide richer insights into staff experiences and leadership strategies during transformation. Finally, expanding the model to include digital transformation, sustainability, and health equity dimensions could deepen understanding of hospital adaptability in an increasingly complex healthcare environment.

- *Authorship, Ethics, and AI Disclosure Statement*

The dataset was originally collected by my co-author as part of his PhD research at the Lebanese University. The present manuscript reports a distinct study within the same general research theme and does not replicate the dissertation. The co-author contributed through data provision and scholarly input during manuscript development.

Survey data were collected in Lebanon with the approval of the relevant Dean at the Lebanese University (letter attached along submission). According to institutional regulations, IRB approval was not required for this type of research. All analysis, interpretations, and conclusions are the sole responsibility of the authors.

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