The Convergence of Customer Orientation and Collaborative Health Care Leadership in Lithuania

Birutė Mockevičienė, Vaida Servetkienė and Danguolė Jankauskienė
Mykolas Romeris University, Vilnius, Lithuania
birutemockevicienee@gmail.com
vaida.servetkiene@gmail.com
danguole.jankauskiene@sam.lt

Abstract. Improving health care quality is a continuous goal that requires constant attention and innovative solutions. One of the sources from which we can learn about what quality changes are needed is patient experience. "Collaboration" is one way to develop instruments and use them to gather knowledge about patient needs related to the patient journey and measures to improve the quality of services, such as service collaboration. The direction, in terms of the identification of patient needs and relatively urgent changes to the system, depends on the organizational culture determined by leadership. Different approaches towards leadership initiate different outcomes and consequences. Collaborative health care leadership comes with the decision to strengthen collaboration between health professionals and patients, thus addressing service quality gaps. Therefore, it becomes important to understand patients' expectations in terms of such cooperation. **The study aim is** to investigate whether patient satisfaction barriers can be linked to shortages in collective leadership. All three dimensions of collaborative leadership (horizontal collaboration, interorganizational (vertical) collaboration, and collaboration with patients) demonstrate the link between leadership and accepted health care quality.

Keywords: patient journey, collaborative leadership, health care service quality

1. Introduction

Improving health care quality is a continuous goal that requires constant attention and innovative solutions. One of the sources from which we can learn about what quality changes are needed is patient experience, which is not so easy to translate into quality management information (Agoritsas, Schiesari and Perneger, 2011). However, it has been proposed that interactivity helps to better access the patient experience (Philpot *et al.*, 2019). It is currently recognized that directions for improving health care quality can be identified through new interactive methods, such as patient journey. Patient journey (McCarthy *et al.*, 2016) provides new and instant information on the current status of quality of service. Recent research increasingly shows that the development of health services is focused on patient needs, which are most keenly focused on patient involvement and collaboration (Tretiakov, Whiddett and Hunter, 2017). As such, collaboration is a guiding trend for the collection of patient needs regarding patient journey and quality improvement measures such as collaboration in service provision. Once the patient's needs are identified, transformational changes in health care services are required, which may be difficult to initiate in the current fixed management structure with the current leadership style. The direction in the identification of patient needs, and then the relatively urgent changes to the system, depends on the organizational culture determined by leadership. Different approaches towards leadership initiate different outcomes and consequences (Endres and Weibler, 2017). Collaborative health care leadership comes with the decision to strengthen collaboration between health professionals and the patient (Buyan, Aylott and Carratt, 2020), thus addressing service quality gaps. A comprehensive stream of literature regarding collaborative leadership demonstrates desirable new values in health care quality management. Therefore, it becomes important to understand patients' expectations in terms of such cooperation. Although there is evidence to support the relationship between collaborative leadership and improved quality of patient care, there is a gap in managerial knowledge about how patient-reported quality disparities/imperfections may be related to a specific type of collaborative leadership. The research question then becomes: can collaborative leadership be identified as desirable or lacking in existing quality management systems in terms of patient satisfaction with services?

The study aim is to investigate whether barriers to patient satisfaction identified by patients may be linked to the absence of collaborative leadership. For this purpose, it is first of all necessary to assess how the health care delivery system works from a patient perspective and which elements of collaborative leadership could have the potential to eliminate quality gaps. As qualitative research, patient journey mapping was used to identify health care quality gaps. Patient journey can also be used to capture the moment of the complaint in the organizational chain and identify which health care professionals interacted at a particular point in the service. This approach provides valuable insights. Organizational, procedural, and staff interaction moments can lead to the leadership

elements necessary to deal with quality improvement. The qualitative study was later refined by a patient survey (quantitative research) to determine patient expectations and satisfaction.

2. Literature review

Health care service quality. Presently, quality has become the main construct that shapes health care services in terms of medical professionals (physicians), health care institutions (hospitals), and executives who lead health care infrastructure (Buttell, Hendler and Daley, 2008). To measure the quality of health care services is a complex task, mainly due to the asymmetry of knowledge between the patient (service user) and the service provider (Upadhyai, Upadhyai, Jain, Roy and Pant, 2020). The patient cooperates with the health care practitioner and becomes a co-producer of the service, providing the information needed for the selection of the best health care decisions. Meanwhile, the health care service provider uses the patient's information and their own professional knowledge and skills to select the best care outcome. Seeking to reduce the asymmetry between patients and service providers, the different dimensions of health care quality have been analyzed in great depth (Upadhyai *et al.*, 2020). Those dimensions are efficiency, cost effectiveness, performance, the interpersonal relationships of management, the amenities of care, responsiveness to the patient's preferences, and patient safety (Ransom, Joshi and Nash, 2005). This also leads to the dimension of physical access to health care, which is one of the most important quality indicators (Gulliford, Figueroa-Munoz and Morgan, 2002) that significantly determines quality output and patient satisfaction (Manzoor *et al.*, 2019). Knowing that accessibility is higher if patients and medical staff are involved in both maintaining and improving the quality of services (Mosadeghrad, 2014), leadership has a relatively clear course of action to strengthen cooperation between all health care actors, including the patients. The basic concept of patient-centered healthcare is realized by involving the patient in decision-making and implemented by measuring patient satisfaction and studying the subjective quality of healthcare. Meanwhile, there is still a lack of management linkages with quality dimensions that can realize greater patient engagement, satisfaction, and service quality. The ever-increasing complexity of the service (Plsek and Greenhalgh, 2001) (new health technologies, holistic patient needs, psychological security and motivational health solutions) makes it necessary to use collaborative leadership skills to mobilize the collective efforts of relevant actors to improve this access in a timely manner.

Collaborative leadership. Leadership in the health sector could be described as a social construct that affects the success of the organization and the quality of its activities (Endres and Weibler, 2017). Whether natural or accidentally created managerial and organizational barriers to the provision of health care services are often the cause of imperfections in the quality of health services. Eliminating such barriers requires a coordinated effort that brings together heath care practitioners and patients. The coordinating element in management is ensured through adequate forms of leadership. A leadership style capable of overcoming boundaries within a health care system should be focused on unification and commitment to one common goal. Due to the complexity of quality perception, the leadership construct is increasingly modelled to include not so much individual-centered, but more dynamic, process-oriented, and group-driven functioning within an organization valuable for the health care sector (Tretiakov, Whiddett and Hunter, 2017). The leadership context is no longer tied to formal responsibilities or hierarchy in the organization, but instead emphasizes the emerging potential for supervision through formal divisions, organizational functions, and performance.

Collaborative leadership represents the shift from traditional leadership, with the attributes of authority, to collaboration, and is defined as leadership with the "distribution of leadership influence across multiple team members" (Carson, Tesluk and Marrone, 2007). As such, collaborative leadership is a concept that encourages teamwork. Collaborative leadership is already recognized as a competency domain for practitioners, and we can take Canada as an example where it is promoted through the Canadian Interprofessional Health Collaborative framework (Iachini *et al.*, 2019). The importance of collaboration leadership is confirmed by its prevalence in other sectors, such as marketing and sales, where more emphasis is placed on customer focus and multi-relationship collaboration between teams (Accardi-Petersen, 2011). Collaborative leadership constructs are developed to such a level that their potential benefits are already agreed upon. There are numerous advantages gained from collaborative leadership in health care:

- By structuring key collaborative leadership achievements, research shows that the "adoption of collaborative patient care enhances physical access to healthcare services" (Okpala, 2017). Studies show that access to health care is increasing due to: collaborative leadership skills that are more often formed in a network, collaborating between different providers of health care, and engaging the patient in a

network. Increasing collaboration in the provision of services at the primary health care level is also reflected in greater accessibility.

- A collaborative leadership approach can increase a patient's access to health care by ensuring a link between the patient and the funding institution.
- A collaborative leadership approach can also help to increase the availability of health care resources and involve more staff who work in a team and share responsibilities and knowledge to address a patient issue. By involving different stakeholders for structural and organizational adjustments, a greater degree of patient satisfaction can be achieved.
- **Collaborative leadership implementation**. In considering how to select the content of the implementation of collaborative leadership, the Social change model of leadership is effective (Komives and Wagner, 2009)(Iachini *et al.*, 2019). The Social change model embraces seven values: a) commitment, b) consciousness of self, c) congruence, d) collaboration, e) common purpose, f) controversy with civility, and g) citizenship. All together, these values represent the necessary interconnection between three different levels of interaction: individual, group, and community approaches.

By balancing individual intentions to be committed through the values of commitment, consciousness, and congruence, harmony is achieved through collective efforts (through the values of cooperation, common purpose, and consensus with citizenship) directing coherent strengths for the sake of citizenship.

Although the need for its expediency and efficiency has been proven, collaborative leadership is one of the most difficult forms to achieve and overcome, and its implementation becomes an important challenge of organizational management (Accardi-Petersen, 2011). Implementation difficulties are related to the complexity of dimensions of quality, mainly due to the fact that "complex patient needs, different roles of actors, different responsibilities among a variety of care providers, along with historical tensions stemming from timing of professional socialization," along with the "professional hierarchy within healthcare," all impact leadership within interprofessional teams (Reeves *et al.*, 2010).

The main managerial elements of collaborative leadership. The essence of cooperative leadership is collaboration, that can involve "simple coordination, synergistic behavior, mutual work processes, partnerships, and so on" (VanVactor, 2012). Adapting Jerry D. VanVactor's model (VanVactor, 2012), we can distinguish several multi-directional collaboration vectors: a.) cooperation between health care professionals; b.) cooperation with patients; and c.) the impact of cooperation on performance, when performance indicators are formed based on the available knowledge about service quality measurement, including patient feedback and satisfaction. In the following, we organize this research based on these dimensions and draw up a framework of collaborative leadership as multidirectional and reciprocal cooperation with those actors:

1. with different teams of health care providers;
2. within health care providers teams;
3. with other health care organizations and across health care structural levels; and
4. with patients.

After grouping the elements of collaboration according to the organization's dependencies, three types of collaboration are distinguished for the study: 1) vertical cooperation (when specialists from different levels of health care in a network provide an integral service to the patient); 2) horizontal cooperation (supposing each specialist works in a supported interdisciplinary team); and 3) collaboration with the patient.

3. Methodology

3.1 Qualitative analyses

The study is based on qualitative focus group interviews.

Method. Patient journey mapping technology was chosen for the study. Patient journey mapping is intended to study the patient's experience using health care services (or a set of them) and to reflect the emotional reaction caused – from the first contact in order to receive the desired service to the result obtained at the end of the process. It is a useful tool when trying to describe a patient's experiences, thoughts and reactions (McCarthy *et al.*, 2016).

The patient's journey is understood as the patient's encounters with health care providers in the health care system, starting from registration with a primary health care specialist complaining about their health condition to treatment, rehabilitation, and care at a specialized tertiary health care level. The construct of the patient's journey, when the patient's opinion, experience and expectations are recorded throughout their treatment, helps not only to detect health care service irregularities, but also to make timely management decisions, especially in order to shorten the time intervals between different stages of the journey (Philpot *et al.*, 2019).

The following ontology is used to structure the patient journey process: emotional journey, physical journey, and equipment-related touchpoints. This is a way to recognize "the patient's behavior, their feelings, motivations and attitudes" at each stage of the journey (McCarthy *et al.*, 2016). In this way, the patient pathway ontology can relate the patient experience to the organizational structure, relationships between elements, and leadership (Perzynski *et al.*, 2019). This study was carried out over two weeks in November 2020.

Participants. Three focus groups with 10–12 participants in each group were gathered for a discussion of issues regarding patient experience. Participants represented three different patient audiences: parents of children with nephrological and oncological diseases, young patients (around 18 years of age) with nephrological diseases, and adults with oncological diseases.

Instrument. Some unstructured interview questions were presented to the focus group for discussion, following Myers and Newman's unstructured interview recommendations (Myers and Newman, 2007).

Focus group participants were asked to briefly describe their positive and negative experiences of interacting with the health care system since the onset of illness (i.e., first visit to the doctor, outpatients, tests, hospital stay, rehabilitation, nursing, social and educational experiences, and other areas). Discussions regarding the major problems and the smoothest encounters at each stage took place separately. We focused on the following ideas: where were the most common problems encountered and what needs were not addressed; where were the most unpleasant memories of encountering organized care experienced; and what would patients suggest fixing.

Data. The data was available as transcribed text. The responses were grouped into categories and subcategories by means of the NVivo quality data analysis software. Coding and categories are detailed in previous research articles (Mockevičienė and Jankauskienė, 2021). Frequency of used concepts was identified, with the distinction of major problems. The specific categories used to code observations were problems/challenges (any issues that could be recognized as complaints, dissatisfaction, unmet needs, or discomfort).

3.2 Quantitative analyses

The primary objective of the quantitative survey was to identify the most important gaps in health care service quality, while the secondary objective of this survey was to determine patient satisfaction with services, seeking justification for collaborative leadership interventions. The questionnaire consisted of 29 questions split into 6 groups according to the topic of the questionnaire: 1) general (demographic, educational, employment) questions; 2) experience of using health care services; 3) meeting patients' expectations; 4) availability and quality of services, issues identified by patients; 5) patients' behavior, collaboration between doctors and patients; and 6) overall evaluation of health care services.

For most questions, 5 response options were given based on a Likert scale ranging from 1 (*did not meet at all*, *very poor*, or *never*) to 5 (*fully met*, *very good*, *regularly*). The survey was carried out via telephone (CATI) between 17 March and 9 April 2021, and 1,033 respondents took part.

Data analysis. The data obtained from the survey were processed using Microsoft Office Excel 2016 and Statistical Package for the Social Sciences (SPSS) 26, applying methods of descriptive statistics.

4. Findings

In order to highlight which elements of collaborative leadership can be useful in solving the current problems of inconsistent quality limiting patient satisfaction, it is necessary to have a good understanding of systemized patient opinion. Therefore, we will first present information about patient experience collected from focus group interviews.

4.1 Analysis of focus group interviews

In order to understand how often one or another problem was mentioned during the interviews, the frequency of categories was recorded. An analysis of the most common problems during the patient journey identified 16 categories, and individual codes were grouped. All identified inconsistency and quality gaps, as often encountered in conversation, are presented in Table 1. It is not surprising that not all categories that correspond to barriers to patient satisfaction appear to the same extent at different patient stages. At some stages, one or another complaint dominates.

During discussions with patients, several stages of the patient journey clearly emerged: symptoms, diagnosis, treatment, rehabilitation, examination, and follow up. Such discretization is sufficient so that research participants can easily assign their experiences and remember the problems encountered. The discretization of steps along the patient journey has also contributed to the possibility of revealing quality disparities associated with the secondary specialist level.

Horizontal cooperation. Patients are best acquainted with the primary care level, so the longest and most detailed discussions took place specifically about the activities of the general practitioner and their related experience. Problems related to diagnostics such as late diagnosis, lower expertise in rare diseases, and lack of information were mentioned. During the interviews, the majority of complaints and criticisms were made about secondary-level specialists. At all patient journey steps, the secondary level of practitioners was usually mentioned. Such an emphasis perhaps indicates not so much the content of the clinical competence of secondary level specialists, but rather their isolation and fragmentary participation in the patient's journey. This is most likely due to the fact that in the post-diagnostic period of a disease, the main contact person with the patient is usually a general practitioner or a specialist of a high tertiary level. Short-term and fragmented contacts with other specialists lead to a more fragile emotional connection with the patient and more frequent complaints. This should not be surprising, because such fragmentary relations with the patient – when the patient is referred to the secondary level for examination and returns to their treating physician for intermediate diagnosis, treatment and care – are presumed in legal acts (rules and procedures regulating the course of treatment).

Vertical (interorganizational) cooperation (physician, pharmacist, policy maker). A lack of initiative of the general practitioner and interference with the reimbursement of medicines were more often encountered at the treatment stage. The issue of medication was the most sensitive issue at this stage for all discussants. Although patients mentioned the family doctor regarding the issue of prescribing and obtaining medicines, this is a problem of greater content, which combines the reimbursement rules approved at the political level, the doctor's competence in selecting the medication, the ability to quickly access information about the reimbursement options, and the pharmacist who serves e-prescriptions in the pharmacy.

Collaboration with patients. Deficiencies in cooperation with the patient were highlighted at all stages, especially when secondary specialist services were accessed. This was mostly mentioned in the context of complaints about a lack of information or a lack of clarity regarding health condition. For instance, the "monitoring" patient journey stage is characterized by the theme of cooperation, when both the patients themselves and the doctors or their institutions are visible in the dichotomy of cooperation. Some complaints were related to the services of a psychologist. Patients were also doubtful as to whether their specialist addressed their problem with sufficient depth. Such complaints seemed to be more emotional in nature and were perhaps caused by low cooperation and a lack of mutual understanding.

Communicational links between stages of the patient journey. The stories of patients were consistent here: greater complexity occurred when categorizing patients' experiences as they encountered the system repeatedly for a new ailment. Although it would seem that a trip should repeat itself and proceed consistently, these stories show that there was no such consistency. Instead, patients went to the general practitioner, then to the emergency medical service. They were then directed to take a step back, and when they got there, they felt as if their needs were not being met, their condition was being ignored, and their treatment or diagnosis was considered inappropriate until they reached the station where they received treatment for the first time. This is usually the tertiary level. Such dynamics of the patient journey signal a lack of cooperation between different stages and miscommunication at the primary levels.

4.2 Analysis of the survey

Frequency of patient visits to health care institutions. According to the survey, all 1,033 respondents visited primary-level health care institutions in the last 3 years, and 92% of respondents used the services of these institutions 1 to 3 times a year. Furthermore, 990 respondents visited secondary-level institutions (specialist doctors), with 64% visiting such institutions 1 to 3 times a year, while 507 respondents visited specialists at tertiary-level institutions, with 190 (or 37%) attending 1 to 3 times a year.

Most common issues encountered by patients. The survey showed that the vast majority (70%) of respondents stated that they did not encounter any issues in their contact with the health care system. In the following discussion of the issues most frequently encountered by patients, we will only consider the responses of those respondents who did experience difficulties in using health care services.

Horizontal cooperation. Of those who had experienced difficulties, as many as 99% mentioned the issue of "difficulty in getting access to specialists," with more than half (65.1%) saying that they experienced this "regularly" or "frequently." The situation is different regarding the issue of empathy ("Is there a lack of understanding, attention, or compassion from medical staff?"). While 70% of respondents said that they had experienced this "often," only around 3% said they had experienced it "regularly."

The most common issues encountered by the respondents were difficulties in gaining access to primary-level doctors (65% of respondents experienced this either regularly or frequently) and waiting time (most respondents had to wait for a week up to a month in order to visit a GP).

Vertical (interorganizational) cooperation. The only issue identified as very acute (experienced on a regular basis) was limited access to specialist doctors.

Other issues were mentioned as frequently occurring. Among them were issues such as "difficulties in getting reimbursement for medicines and medical aids," and "failure on the part of the doctor to prescribe sufficient tests and comprehensive diagnostics."

The situation changes considerably when it comes to the lack of information obtained about an illness from medical staff. In this respect, the majority of the respondents (67%) rarely experienced this absence. An even greater difference is observed when it comes to rehabilitation services and cooperation between health care professionals. In this area, complaints accounted for less than 5% of respondents.

Cooperation with the patient. The level of cooperation with the patient is well revealed by the patient's behavior in case of illness, recorded in terms of when they apply to the health care institution. Behavior in the event of an ailment reflects a certain degree of trust in the system. Thus, the study showed that if the ailment is not serious, the first thing to do is to discuss it with family members and acquaintances (37% of the respondents claim so), to view available sources on the internet (22.5%), or to consult a doctor that the patient is acquainted with (22.4%). Referring to a general practitioner (GP) was only the fourth most frequent choice (12.9%). Consulting a pharmacist was completely unpopular (only 5.3%), despite the fact that a framework for pharmaceutical care and pharmacists is already being set up to provide advice to patients. For more serious ailments, it was more common to wait for them to subside than to go to the GP straightaway (54.4%). However, a fairly significant percentage of the respondents would seek help from their GP or call an ambulance. Moreover, a fairly adequate perception of the functioning of the system is manifested in the fact that only 0.2% of the respondents would call an ambulance.

The success of treatment depends to a large extent on a patient's attitude to it, i.e., the extent to which the patient is willing to follow the recommendations of a health care professional. It is encouraging that 54.2% of the respondents firmly chose the answer "yes, I follow all" with regards to this topic. The rest indicated that they do not follow all prescriptions. When it comes to the reasons that make it most difficult to follow prescriptions, two seem to dominate: improvement in health condition or fear of side-effects ("I stop taking a medicine because I start feeling better or my health condition does not improve" – 45.3%; "I stop taking a medicine when I learn about its side-effects" – 34.5%). Only 0.9% of the respondents admitted that they do not follow doctors' recommendations because of their current habits. The rest, however, doubt the effectiveness of their doctor's prescription (3.4%) or do not feel they have received enough information (4.9%).

The alternative opinion of doctors (to be tested again for the same symptoms) is sought by as many as 34.2% of respondents. Others do so with a "maybe" proviso, and no respondent answered negatively to a repeat test.

When assessing the doctor's matter-of-fact approach during a visit, the majority of assessments were very positive. However, there is still a gap between how doctors usually communicate and what patients expect. Patients expect more attentive and empathic communication, rather than matter of fact. As many as 70% of the respondents would prefer empathic communication.

When patients' expectations are considered in the context of the concept of patient-centered care, shared decision-making with a patient becomes one of the indicators of health care service quality. However, it is puzzling that as many as 53.8% of the respondents felt as if their doctor "usually does not take into account" or "does not take into account" the patient's opinion when making decisions on tests and selecting the method of treatment. The rest acknowledged that their opinion is considered, with 13.8% saying it is always taken into account.

5. Discussions and conclusions

In order to investigate whether patient satisfaction can indicate the desirability of collaborative leadership for quality management improvement, data on the evaluation of health care services by patients were collected in two ways: qualitative and quantitative study. All three dimensions of collaborative leadership (horizontal collaboration, vertical (interorganizational) collaboration, and collaboration with patients) demonstrate the link between leadership and accepted health care quality. The links between quality disparities/imperfections and elements of collaborative leadership is summarized in the Table 1.

The areas where patients are most sensitive to service quality (service infrastructure, service availability, staff behavior) are filled with a greater need for information and greater personal attention to the patient's problem. Patients' subjective well-being (including psychological well-being becoming more and more recognizable as a part of treatment) and engagement in choosing a treatment strategy are an indication that the existing health care service system has reached the saturation of its quality improvement and does not satisfy patients' current emotional needs.

Elements of this research clearly indicate the considerable potential of collaborative leadership in solving quality gaps. The complaints of patients – such as missing information from other specialists, not knowing whether specialists review all performed tests, consultations being too short, and the long times before specialists accept consultations – show that health care providers' teamwork is weak and internal horizontal communication is without results. With horizontal collaboration, specialist teams could manage patients' emotions more effectively, hear patients' problems in time during the patient journey, and reach treatment solutions after responding.

The insufficiency of inter-organizational cooperation is seen even more clearly. Patients complain about the involvement of secondary specialists in their treatment plan; they are always looking for additional specialist consultations and alternative diagnosis. In addition, there are minimal social services and limited educational services. All of this shows not only that there is no connection between different levels of health care, but also that there is no integration between the nature of health, social and education services.

The elements of collaboration with patients are the easiest to capture. The very fact that patients do not feel included in the decision-making process of choosing a treatment strategy and that they would prefer empathic communication, but instead receive business-like communication, shows that the average patient does not feel as if they are part of a collaborative process. Nevertheless, it should be clarified that, at the tertiary level, patients with very serious health issues (oncological patients) are engaged widely and they respond with greater satisfaction.

Table 1: Link between elements of collaborative leadership and representation of findings

	Elements of Collaborative Leadership	**Quality disparities/imperfections according patients Study I (focus group interview)**	**Quality disparities/imperfections according patients Study II (Survey)**	**Actors involved**

1	**Horizontal cooperation**	• Week team work: (Short consultation, lack of information)	• Week team work (short consultation, lack of information)	Primary level (general practitioner**)**
2	**Vertical (interorganizational) cooperation**	• Limited links between patient journey stages (lack of communication between stages during the patient journey, uncertainties within the medication and prescription procedures	• Independent operation between primary, secondary, and tertiary levels and limited communication (long wait for secondary level specialists for consultation, more than 4 weeks, certain dissatisfaction with the services of secondary level of specialists	Specialists of primary-, secondary-, tertiary - levels, Pharmacy, Regulatory bodies
3	**Collaboration with patient**	• Limited (Follow up stage – patients are not involved in decision making; Lack of engagement; There is a lack of empathy, compassion)	• Limited (Referral to a general practitioner is only the fourth most common choice for a patient's with health issues; Lack of engagement; There is a lack of empathy, compassion; Desire for empathic communication)	Medical staff from every health care level, pharmacists.

In summary, it can be determined that despite the compliance of essential elements of health service quality with patients' expectations and a positive assessment of services (efficiency of service procedures), there are still certain elements of service quality that require the organizational contribution of the service provider. This research demonstrates limited patient involvement, decision making and information interpretation. A study of patient experience alone (patient satisfaction or subjective quality assessment) may indicate the need for changes in leadership principles that could lead to more collaborative health care. Therefore, in response to the question raised by the study "whether collaborative leadership is desirable or lacking in the existing quality management systems from patient satisfaction?", patient satisfaction studies can be an indication of the leadership style if the components of the considered leadership style are defined in advance, as was done in this study. The missing elements of collaborative leadership are more easily captured in the direct objects of the study (on cooperation with patients), but they can also be traced in the indirect elements of the study (collaboration in the team).

Practical implications of the study include linking patient satisfaction surveys with elements of collaborative leadership so that patient feedback can be used to inform management decisions and thereby improve the quality of healthcare.

However, some limitations of the study are related to the research framework, which was conducted from the patient's perspective, asking how they evaluate health services (health care system output), but not asking direct questions about the dominant leadership style as an input variable. The limitation arises from the recommendation to formulate direct questions in sociological surveys.

Further research could be organized through a direct study of collaborative leadership, organizing research on internal leadership practices from an organizational perspective to measure how specifically management is organized and what collaborative practices are fostered that could be related to specific patient dissatisfaction.

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