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Inter-professional shared decision making and organizational citizenship behaviour of tertiary health institutions in South-South Nigeria

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Abstract
This study examined the relationship between inter-professionalshared decision making and organizational citizenship behaviour of tertiary health institutions in south-south Nigeria. The study applied survey research design.A total of four hundred and sixty-four (454) doctors and nurses in five teaching hospitals in South-South Nigeria, constituted the population of the study. The hypotheses formulated for the study were tested using Structural Equation Modelling (SEM). The outcome of the analyses revealed a significant positive association between the shared-decision making and the measures of organizational citizenship behaviour (altruism, conscientiousness and courtesy). It was concluded that inter-professionalshared decision making drives organizational citizenship behaviour of tertiary health institutions in South-south Nigeria. Therefore, it was recommended that health institutions shouldprovide education and training to healthcare professionals on the principles of shared decision-making, including patient-centered care, empathy, and respect; create a supportive environment that encourages and reinforces altruistic behaviour; involve patients and families in the shared decision-making process to ensure that their values and preferences are incorporated into the decision-making process.

Keywords: Shared Decision Making, Altruism, Conscientiousness, Courtesy, OCB

Introduction

The healthcare industry in Nigeria is currently challenged by outbound medical tourism, deteriorating medical infrastructure, low government budget allocation and poor compensation for public healthcare workers, all of which have prompted a large number of skilled medical practitioners to relocate overseas in search of better employment opportunities. Those who have remain offer the bare minimum in service due to poor treatment and funding inadequacies that have led to ageneral dissatisfaction with the system (Ibeh, 2022) [23]. It therefore becomes almost impossible to see healthcare works exhibit citizenship behaviours at their places of work.

Tertiary health care institutions are an important component of the healthcare system of any country. Their role in enhancing specific and overall health parameters of community is immense ranging from complex specialized clinical care to supervision, training, development of guidelines and quality assurance. They are built with a vision to foster advanced medical education and research (Bali *et al*., 2021) [5]. In general, organizational citizenship behaviours are not included in the employee's mission definitions. In this respect, there are no criminal sanctions if these behaviours are not carried out. There is also no reward in the event of these behaviours (Podsakoff *et al*., 2009) [45]. It is stated that many factors have been effective in demonstrating the organizational citizenship behaviour of employees. In the context of tertiary health institutions, the more people who demonstrate organizational citizenship behaviour, the more benefit the institution will have. A number of employees exhibiting this behaviour will start to feel as if they are in the scope of other employees (Bommer *et al*., 2003) [10]. Apart from the ability of employees to act as organizational citizenship due to their own characteristics, they can also demonstrate organizational citizenship in the context of their organization's behaviours and organizational support (Karaalioğlu, 2019) [25]. Inthis regard, the employee may be inclined to demonstrate organizational citizenship behaviour to institutions that give confidence and support to them. The social support behaviours of the institution can be effective for employees in addressing organizational citizenship behaviour (Nguyen & Nguyen, 2017) [31]. Organ (1988) [38] identifiedfive dimensions of organizational citizenship behaviour: conscientiousness, sportsmanship, civic virtue, courtesy, and altruism. These five dimensions cover such organizational behaviours as helping co-workers, following company rules, not complaining, and actively participating inorganizational affairs. In this study however, altruism, conscientiousness and courtesy served as the measures of organizational citizenship behaviour.

Several factors have been identified as predictors of organizational citizenship behaviour -job satisfaction and commitment, employee engagement and human resource development climate (HRDC) (Ahmed *et al*., 2012) [3], but the interest in this study is the role of inter-professional shared decision making on organizational citizenship behaviour.In the management of a serious mental patient, for example, services from different professionals like a psychiatrist, case managers, pharmacists, nurses, physicians, and sometimes occupational therapists work together as a team to achieve the desired result (Anna & Woolley, 2016) [4]. As the delivery of healthcare becomes more interconnected, the collaboration of physicians, nurses, pharmacists, social workers, and other disciplines becomes increasingly important. The World Health Organization (WHO) has linked inter-professionalshared decision making with better outcomes in infectious disease, non-communicable diseases, family health, humanitarian efforts, and responses to epidemics (Green & Johnson, 2015) [19].

Extant studies on the predictors of organizational citizenship behaviour abound, e.g. perceived organizational support (Obiora & Jaja, 2015) [33]; organizational justice (Evawere, Eketu & Needorn, 2018) [17]; human resource diversity

management practices (Omoankhanlen, 2021) [35, 36, 37]; impression management (Omoankhanlen & Issa, 2021) [35, 36, 37]; psychological contract fulfillment (Omoankhanlen & Yakubu, 2021) [35, 36, 37]; and social intelligence (Oshi, Akaibe & Chikwe, 2021) [40]. However, there appears to be no empirical study that have examined the relationship between inter-professional collaboration and organizational citizenship behaviour, especially of tertiary health institutions in South-South region of Nigeria. Furthermore, there appears to be no study that have deployed structural equation modelling in testing the association between interprofesional shared decision making and organizational citizenship behaviour, leaving a methodological gap. Consequently, this study represents a unique departure from similar studies as it fills the identified contextual and methodological gap by determining the relationship between inter-professional shared decision making and organizational citizenship behaviour of tertiary health institutions in South-South Nigeria, using structural equation modelling.

Statement of the Problem

Despite abundant evidence for the positive effects of inter-professional collaboration, studies have shown that the uptake of inter-professional collaboration in organizations remains weak and it is also inadequately practiced in healthcare teams, especially in Africa (Bardet *et al*., 2015; Kebe *et al*., 2020) [6]. A study in South Africa showed that healthcare professionals have diverse opinions of perceptions on inter-professional collaboration indicating a lack of knowledge on inter-professional collaboration in the healthcare field (Ellapen *et al*., 2018) [16]. Another study done in two Kenyan sub-county hospitals to examine the role of clinical leadership revealed that most clinical heads, nurses in charge, and other mid-level managers have an intimidating leadership style that affects the practice of inter-professional collaboration (Nzinga *et al*., 2018) [32]. Inadequate inter-professional shared decision making has been associated with medication errors, patient safety problems, team conflict and patient mortality (Bender *et al*., 2013) [8]. Thus, there is a great need for research onshared decision making, in association with inter-professional shared decision making, particularly in tertiary health institutions in Nigeria.

In the context of healthcare settings, an essential aspect of inter-professional shared decision making involves the cooperative engagement between doctors and nurses. Trust is fundamental for effective teamwork, as it influences communication, information sharing, and joint decision-making processes (Körner, 2010) [27]. Shared decision-making empowers healthcare professionals to jointly participate in clinical discussions, consider various perspectives, and collaboratively determine the most appropriate treatment plans for patients. Despite its significance, achieving effective shared decision-making between doctors and nurses proves challenging due to differences in professional roles, hierarchies, and communication patterns. These challenges can lead to barriers in the realization of cohesive teamwork and hinder the delivery of patient-centered care (House & Havens, 2017) [21]. In practice, the hierarchical structure inherent in healthcare organizations often affects the willingness of nurses to actively engage in shared decision-making with doctors. The asymmetry in power dynamics create an environment where nurses sometimes hesitate to express their opinions or engage in open discussions, leading to potential missed opportunities for holistic patient care. Furthermore, factors such as time constraints, workload pressures, and inadequate communication channels further exacerbates these challenges, impeding the seamless exchange of insights and collaborative decision-making processes (McInnes *et al*., 2017) [29].

On this premise, it could be argued that medical workers poor show of citizenship behavour in tertiary health institutions in a fall out of the afore-stated anomalies bedeviling the sector. It is against this backdrop that this study seeks to determine if inter-professional shared decision making of medical workers can help improve organizational citizenship behaviour.

Objectives of the Study

1. To assess the relationship between shared-decision making and altruism in tertiary health institutions in South-south Nigeria.
2. To ascertain the relationship between shared-decision making and conscientiousness in tertiary health institutions in South-south Nigeria.
3. To investigate the relationship between shared-decision making and courtesyin tertiary health institutions in South-south Nigeria.

Research Hypotheses

As a guide to the rest of the study, the following null hypotheses are framed:

H_{01}: There is no significant relationship between shared-decision making and altruism.

H_{02}: There is no significant relationship between shared-decision makingand conscientiousness.

H_{03}: There is no significant relationship between shared-decision making and courtesy.

Literature Review

Theoretical Framework: Collaboration Theory

Collaboration Theory (CT) explains specifically how people can coordinate to determine positive references (Colbry *et al*., 2014) [13]. CT encompasses how collaboration works regardless of whether there exists a formal structure between a manager-with-subordinate or subordinate with-subordinate (Huxham, 2010) [22]. According to Huxham (2010) [22], collaboration theory takes into consideration the ways of building group cohesion, influencing others as well as organizing work. This theory enhances collaborative relationships through socialization, which involves learning from others' expertise. At the interpersonal level, collaboration has been described as an influence tactic for gathering cooperation (Yukl *et al*., 2005) [49]. As an influence tactic, collaboration was most likely to engender commitment while the exchange was most likely to result in compliance. The other areas in which interpersonal collaboration influences are teamwork, leadership, followership, shared leadership, and social exchange. The theory also explains how speaking and understanding work in conversation, and asserts that conversation partners must act collaboratively to reach a mutual understanding. Healthcare professionals are very interdependent due to the complexity of health problems and this makes it important to work in collaboration with their colleagues and the patient to provide better care (D'Amour *et al*., 2005) [15]. The collaborative theory is therefore important in this study as an inter-professional collaboration among healthcare

workers because it not only requires coordination among their colleagues and superiors but also tactical influence by building group cohesion, teamwork, establishing working relations, and also learning from each other (Huxham, 2010) [22]. Collaboration theory encourages the practice of sharing ideas and building the spirit of trust and harmony to realize a collective action for achieving a common goal, particularly among such interdependent health professionals (Colbry *et al*., 2014) [13]. The collaborative model of care supports and promotes the healthcare professional's role in attaining better patient outcomes. To be successful in providing safe and quality care in any healthcare institution, a collaborative approach must be instilled.

Concept of Shared-Decision Making

Shared decision making is a two-way communication process between patients and healthcare professionals, where both collaborate in making healthcare decisions. (Charavel *et al*., 2001) [11]. Charles *et al*. (1999) [12] conceptualised decision making as a dynamic process and identified a typology of actions that come under this heading including information exchange, deliberation and decision making. In theory, both patients and healthcare professionals follow a series of actions, including sharing information, identifying the task of making a decision, understanding the best evidence about risks, and identifying the benefits of different types of therapy (Légaré and Witteman, 2013) [28]. Based on this information, both parties deliberate, culminating in patients and healthcare professionals reaching a consensus (Charles *et al*., 1997). This model assumes that both health professionals and patients can contribute relevant information during the decision-making process. Adams and Drake (2006) [2] note that healthcare professionals have the newest evidence-based information on diagnosis, the course of illnesses, and treatment options. Although patients may have limited knowledge of medical issues, they are the experts on their treatment preference, their own values, and their treatment goals (Charles *et al*., 1997). Taking into account the voices of both of these parties together, can, therefore, make for better decisions for patients (Slade, 2017) [48].

A systematic review which explored patients' experience of clinical assessment involved twelve studies (ten quantitative studies, one qualitative, and one mixed methods) of patients with bipolar disorder (Fisher *et al*., 2016) [18]. In this review, the one qualitative study included took place in the UK and involved 28 patients with mental illness (Bilderbeck *et al*., 2014) [9]. The review found that patients desired more active roles in decision making, and that the advanantages of implementing shared decision making included improved treatment adherence, increased patient satisfaction, and reduced suicidal ideation. Whilst the reviews findings are informative, the scarcity of qualitative studies raises concerns of the absence of the patient voice. The most recent systematic review aimed to examine a rationale for shared decision making in mental healthcare (James & Quirk, 2017) [24]. The results suggested that shared decision making was widely acceptable and was considered to bring benefits to mental healthcare.

Organizational Citizenship Behaviour

Organizational citizenship behavior has been defined by Organ (1988) [38] as individual behaviour that is discretionary, not directly or unequivocally recognized by the formal reward system, plus that in the collective promotes theeffectual functioning of the organization. With OCB, the emphasis is on the discretionary attitudes and behaviours of workers that are beyond the call of obligation (Podsakoff et al., 2014) [44]. OCBs are the behaviours that are voluntary to employees which are not part of employees' prescribed functions (Oladipupo, 2016). Thus, the behaviour is rather a matter of personal choice, such that its omission is not generally understood as punishable nor rewarding (Ojebola et al., 2020) [34]. They are discretionary, beyond-role behaviours and gestures that are not explicitly recognized by the formal reward system but are considered important in promoting organizational effectiveness (Organ, 2018) [38]. It is informal; that is, it is not recognized by the formal structures of a firm, and hence, not rewarding, it is desirable for the firm to progress and make headway in the ever competitive business environment.

Citizenship behaviours are often referred to as extra-role behaviours, pro-social organizational behaviours, and contextual performance, among other terms (Podsakoff *et al*. 2000). The practical importance of organizational citizenship behaviours (OCB) for public organizations is that the behaviours of employees can enhance the effectiveness of the organization through resource transformation, innovation, and adaptation (Organ 1988) [38].

Measures of Organizational Citizenship Behaviour

Altruism

The word altruism (from the Latin alter, "other") was coined by Auguste Comte in the 1830s as a general term to designate care for others (Morrison & Severino, 2007) [30]. Khalil (2004) [26] defined this phenomenon as a person's predisposition to think about the welfare and rights of others. It is considered a behaviour that is performed voluntarily and intentionally without expecting anything in return (Morrison & Severino, 2007) [30].

Therefore, altruism is explained as an ethical behaviour that focuses on the welfare and help of others without expecting an external reward (Simmons, 1991). These are behaviours that can be observed in many circumstances, both in everyday situations and in situations of distress (Becker, 1976). More specifically, within organizations, altruism refers to those voluntary behaviours of helping another person with an organizationally relevant task or problem (Organ, 1988) [38]. Altruism in organizations therefore involves helping coworkers with work-related problems and includes actions such as "helping to solve a problem", "covering another person's position" and "guiding and helping new people who join the company" (Smith *et al*., 1983). As more concrete examples of altruistic behaviours in organizations we can mention the following: helping colleagues with different linguistic backgrounds to develop their activities or helping with the tasks of an employee who is in a state of stress. Likewise, recent research (Guinot *et al*., 2016) [20] has shown some benefits of altruism in organizations. For example, evidence shows that behaviours based on generosity and helpfulness lead to the creation of interpersonal relationships based on mutual trust. Also, these behaviours tend to improve health and longevity, as well as social integration within companies (Morrison & Severino, 2007) [30].

Conscientiousness

Conscientiousness is related to self-control and process of planning, organizing and execute tasks successfully (Rothmann & Coetzer, 2003) [46]. Conscientiousness is "manifested in achievement orientation (i.e., hardworking and persistent), dependability (i.e., responsible and careful) and orderliness (i.e., planful and organised)" (Rothmann & Coetzer, 2003) [46]. Persons scoring high on conscientiousness tend to be systematic in their approach and are characterized by efficiency, tenacity, and a strong sense of duty; they have a strong will to perform and are intrinsically motivated to work hard to achieve their goals; and they are ambitious and have high expectations of themselves and others. Conscientiousness persons tend to finish work-related tasks independent of inspiration or a sense of joy. Instead, they can motivate themselves to finish the task at hand even if the task is monotonous or boring (Sjöberg, Sjöberg, & Henrysson Eidvall, 2021) [47].

Persons that score high on conscientiousness tend to put allot of effort into planning and organizing which generates predictability and enables a high and even level of efficiency; they are punctual, fulfil deadlines, and finish what they started; and they tend to take obligations seriously and are therefore often perceived as reliable, dutiful, conscientious, and loyal (Sjöberg, Sjöberg, & Henrysson Eidyvall, 2021) [47]. Highly conscientious persons care about rules and regulations, respects norms and authority, and make an effort to fulfil others' expectations (Sjöberg, Sjöberg, & Henrysson Eidyvall, 2021) [47]. Persons scoring low on conscientiousness tend to be "careless, irresponsible, lazy, impulsive, and low in achievement striving" (Barrick, Mount, & Judge, 2001, p 11) [7]. They tend to feel less obliged to follow rules, norms, and authority (Sjöberg, Sjöberg, & Henrysson Eidvall, 2021) [47].

Courtesy

Courtesy includes behaviours, which focus on the prevention of problems and taking the necessary step so as to lessen the effects of the problem in the future. In other words, courtesy means a member encourages other workers when they are demoralized and feel discouraged about their professional development. Early research efforts have found that employees who exhibit courtesy would reduce intergroup conflict and thereby diminishes the time spent on conflict management activities (Podsakoff *et al*., 2000). Courtesy includes actions demonstrating special attention to establishing relationships characterized by kindness and co-operation, for example trying to avoid arguments and being willing to keep other people's best interests at heart (Ozturk, 2010) [41]. Courtesy refers to continuous interaction among organization members, who work for shared purposes of the organization, and collective, positive behaviours such as communicating with the other members the work accomplished, and decisions made. Creating an environment in which all parties affected by decisions could contribute to the decision-making process will open channels for required communication which is vital (Bingöl, 2003).

Courtesy has to do with positive relationship during co-operational processes in an organization which helps in reducing and preventing work-related issues that involve individual problems through positive attitude. This is as Podsakoff *et al*. (2000) stated that assessing and doing what is best for an employee can help in strengthening courtesy behaviour among the organizational staff. Courtesy could be said to be the gesture that help others in preventing interpersonal problems from occurring, such as giving prior notice of the work schedule to someone who is in need, consulting others before taking any actions that could disrupt others (Organ, 1990).

Empirical Review

A survey study conducted by Collette *et al*. (2017) [14] to assess the state of collaboration between 355 nurses and 80 physicians at a non-academic acute care hospital indicated that effective communication is an important determinant for success in collaborative practice amongst healthcare practitioners. The study found a lack of proper communication among physicians and nurses which resulted in an inadequate and improper transfer of patient-related information. Efficiency in the transfer of important patient information is highly dependent on inter-professional collaboration and significantly reduces the risks of clinical errors. According to Collette *et al* (2017) [14], there was a greater collaboration and communication amongst physicians themselves than between physicians and nurses. The authors recommended that healthcare professionals need to enhance communication amongst themselves to improve inter-professional collaboration and cope with the complex healthcare needs of a higher number of chronically ill patients.

A systematic review done by Abd Hamid *et al*. (2016) [1] to examine the relationship between inter-professional communication and inter-professional collaboration (IPC), highlighted the importance of inter-professional communication among professionals to achieve positive IPC. The study reviewed 200 pieces of literature on inter-professional care, health care management, and health sciences related to inter-professional communication and identified inter-professional communication as a core competency of IPC. Abd Hamid *et al*. (2016) [1] reported that poor communication is the main contributor to poor quality of patient outcomes while good communication amongst health care professionals can improve the inter-professional collaboration and in the end, will enhance the patient health outcomes. The authors recommended that every healthcare professional should have the competency of effective communication to develop good collaboration and obtain considerable patient outcomes.

Peyrat-Guillard and Glińska-Neweś (2014) [42] presented links identified among manifestations of employee positive relationships and organizational citizenship behaviour. The presentation is based on the results collected through a questionnaire survey conducted in Polish companies. The data analysis shows particular associations between positive relationships and organisational citizenship behav-iour (OCB). Their results suggest that OCB-I (the behaviours targeted toward other individuals in an organisation) may be triggered by respect and acceptance and that OCB-O (i.e. the behaviours targeted toward an organisation itself) may be considered as effects of the relationships manifesting honesty and reliability. They suggestted research avenues to capture the processes behind the described associations.

Piedra (2013) [43] explored the relationship between employee trust and organizational citizenship behaviour. The demographics data requested gender, age, ethnic background and years in the workforce. The organizational citizenship behaviour scale measured the participant's assistance within the organization, and communication with

co-workers and supervisors and dedication to the organization (Organ, 1988) [38]. The Pearson Product Moment Correlation calculated the extent to which there is a positive relationship between employee trust and organizational citizenship behaviour. The R-squared was used to calculate the relationship between the demographics and the variables. The results showed that there tends to be a relationship between employee trust and organizational citizenship behaviour. The Pearson Correlation = 0.158, SE of r = 0.138, Calc t = 1.146, Crit t = 2.16, df = 48 and Rsquare = 0.024. Further research recommended on the variables employee trust and OCB.

Methodology

This study applied a cross-sessional survey research design. The target population for this study is the entire public tertiary health institutions in South-South Nigeria. But the accessible population comprised of nurses and doctors of five teaching hospitals in five states in South-South Nigeria. Thus, medical personnel from teaching hospitals are in better position to offer objective responses on issues of inter-professional collaboration as it affects organizational citizenship behaviour. Information obtained from the various hospitals revealed that there are a total of four hundred and sixty-four (454) doctors and nurses in the teaching hospitals studied. The sample size for this study was determined using the Krejcie and Morgan Sample Size Determination Table, which is estimated to be 208 as the sample size from the population size of 454.The data used for this study was basically obtained from respondents with the use of a structured questionnaire. The data were analyzed using different statistical methods and regression analysis as undertaking using Structural Equation Modelling.

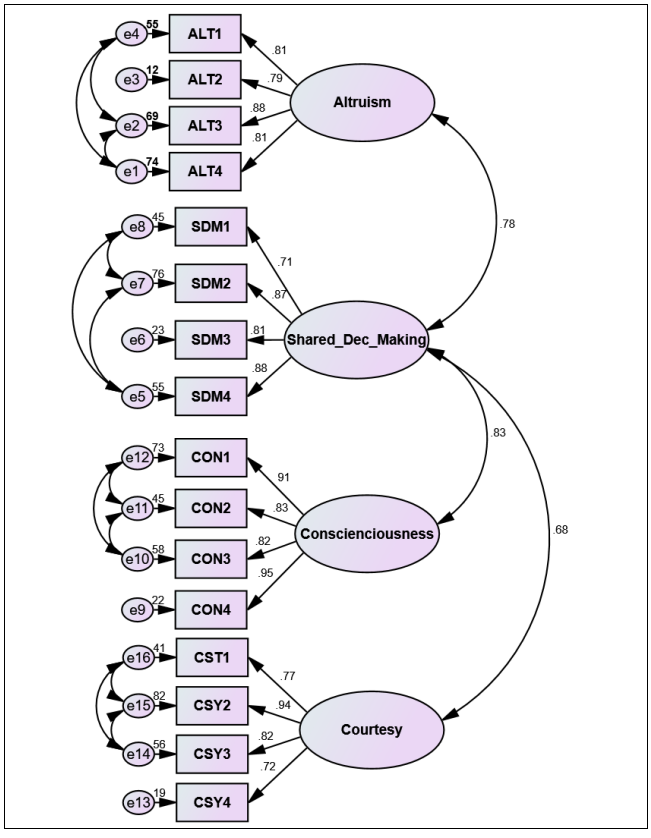

Fig 1: Structural Model of Hypotheses 1, 2 and 3.

Results

Shared-Decision Making and Organizational Citizenship Behaviour

Presented in table below is the result for the tests for the hypotheses of the study. The third set of hypotheses (hypotheses 1-3) assessed the extent to which shared-decision making impacts on the measures of organizational citizenship behaviour. They are listed as follows:

H_{O1}: There is no significant relationship between shared-decision making and altruism of tertiary health institutions in South-south Nigeria.

H_{O2}: There is no significant relationship between shared-decision making and conscientiousness of tertiary health institutions in South-south Nigeria.

H_{O3}: There is no significant relationship between shared-decision making and courtesy of tertiary health institutions in South-south Nigeria.

The first hypothesis (H_{01}), states that there is no significant relationship between shared-decision makingand altruism. However, table 4.33 indicates that shared-decision making has a positive and significant relationship with altruism of Tertiary health institutions in South-south Nigeria. (β= 0.744, r=1.371, p<0.005). Thus, $Ho_7$was not supported. The evidence presents shared-decision making as a strong predictor of altruism of hospitals inSouth-south of Nigeria. Statistically, it shows that when shared-decision making goes up by 1 standard deviation, altruism goes down by 0.744 standard deviation. In other words, when shared-decision making goes up by 1, altruism goes up by 74.4%. The regression weight for shared-decision making in the prediction of altruism is significantly different from zero at the 0.005 level (two-tailed).

The second hypothesis (H_{02}), states that there is no significant relationship between shared-decision making and conscientiousness. However, table 4.33 also suggests that shared-decision making has a moderate and significant relationship with conscientiousness of hospitals in South-south of Nigeria (β=-0.713, r=0.933, p<0.005). Thus, $Ho_8$was not supported. This means that the shared-decision making of tertiary health institutions in South-south, Nigeria, will lead to conscientiousness. Statistically, it shows that when shared-decision making goes up by 1 standard deviation, conscientiousness goes up by 0.713 standard deviation. In other words, when shared-decision making goes up by 1, conscientiousness goes up by 71.3%. The regression weight for shared-decision making in the prediction of conscientiousness is significantly different from zero at the 0.005 level (two-tailed).

The third hypothesis (H_{03}), states that there is no significant relationship between shared-decision making and courtesy. However, table 4.33 also suggests that shared-decision making has a moderate and significant relationship with courtesy of hospitals in South-south of Nigeria (β=-0.814, r=1.643, p<0.005). Thus, $Ho_9$was not supported. This means that the shared-decision making of hospitals in South-south, Nigeria, will lead to courtesy. Statistically, it shows that when shared-decision making goes up by 1 standard deviation, courtesy goes up by 0.814 standard deviation. In other words, when shared-decision making goes up by 1, courtesy goes up by 81.4%. The regression weight for shared-decision making in the prediction of courtesy is significantly different from zero at the 0.005 level (two-tailed).

The results from these relationships indicate that shared-decision making as a significant predictor of organizational citizenship behaviour of tertiary health institutions in South-south Nigeria. Thus all three null hypothetical statements of no significant relationships between shared-decision making and the measures of organizational citizenship behaviour are not supported, based on the lack of statistical evidence to show otherwise.

Discussion of Findings

The outcomes of the study reveals that there is a significant positive correlation between inter-professional shared decision making and organizational citizenship behaviour, and that organizational climate moderates the relationship between the both variables.

Shared-Decision Making and Organizational Citizenship Behaviour (H_{01}– H_{03})

The findings on hypotheses 1-3 are that there is significant positive relationships between shared-decision making and organizational citizenship behaviour. This is in line with Khasawneh (2011) investigated the relationship between shared leadership and organizational citizenship behaviour among faculty members in Jordanian public universities. Shared leadership is defined as a process in which multiple individuals lead together, share responsibility for decision-making, and work collaboratively to achieve common goals (Khasawneh, 2011). To establish the relationship between shared leadership and organizational citizenship behaviour, the study formulated research questions that aimed to validate the constructs of shared leadership and organizational citizenship behaviour in Jordan.The study found a positive relationship between shared leadership and organizational citizenship behaviour, indicating that shared leadership can positively influence faculty members' organizational citizenship behaviour. Overall, the study provides valuable insights into how shared leadership can positively impact workers'behaviour. It also highlights the importance of developing a global workforce for the 21st century by promoting shared leadership practices that foster collaboration, responsibility-sharing, and effective decision-making among team members.

Participation in decision making is linked to organizational citizenship behaviour in many ways. First, employees' participation in decision making can enhance a sense of fairness and trust in the organization, as they can defend their own interests (Bogler &Somech, 2005). Employees who view their institutions as behaving in their interest experience greater job satisfaction, and also act to return the favour by exhibiting more organizational citizenship behaviour (McNeely & Meglino, 1994). Second, as employees understand work processes and challenges better than administrators or policymakers, their participation ensures that better information is available for making decisions to facilitate successful teaching (Conley & Bacharach, 1990), and also they will get information on shaping their decisions which can enhance willingness to engage in organizational citizenship behaviour.

Previous research has shown that employees tend to exhibit more OCB the more they perceive procedural fairness in decision-making (Greenberg, 1990; Konovsky & Pugh, 1994; Moorman *et al*., 1998). Shared decision-making is associated with perceived support from the supervisor, probably because the opportunity to participate in decision-making implies respect for the rights of individual employees and a full-status relationship with the immediate supervisor (Konovsky & Pugh, 1994; Tyler & Lind, 1992). Behaving as a 'good' organizational citizen can be considered a way of maintaining balance in the employee–supervisor relationship (Deluga, 1994; Mowday, 1991; Organ, 1990).

Conclusion

From the findings of the results and discussions, with reference to the aim and objectives of the study, the study found that inter-professional shared decision making drives organizational citizenship behaviour of tertiary health institutions in South-south Nigeria. Therefore, the study conclude that shared-decision making could remarkably improve altruism, conscientiousness and courtesy of tertiary health institutions in South-south Nigeria. Based on the findings and conclusions, the following made the following recommendations:

1. Health instutitions should provide education and training to healthcare professionals on the principles of shared decision-making, including patient-centered care, empathy, and respect. This training can help healthcare professionals to understand the importance of these principles and how they can be applied in practice.
2. Health institutions can create a supportive environment that encourages and reinforces altruistic behaviour. This can include recognition programs, peer support, and leadership that promotes and models altruistic behaviour. They can provide feedback and evaluation to healthcare professionals on their performance in shared decision-making. This feedback can be used to identify areas for improvement and to recognize and reinforce positive behaviours.
3. Healthcare organizations should involve patients and families in the shared decision-making process to ensure that their values and preferences are incorporated into the decision-making process.

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