2020

Perceptions of Public Sector Pharmacists Regarding Their Beliefs, Attitudes Towards Teamwork

Elijah Mohammed
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Elijah Mohammed

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Warren McDonald, Committee Chairperson, Health Services Faculty
Dr. Kenneth Feldman, Committee Member, Health Services Faculty
Dr. Donna Clews, University Reviewer, Health Services Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Perceptions of Public Sector Pharmacists Regarding Their Beliefs and Attitudes Towards Teamwork

by

Elijah Mohammed

MSc, University of Lagos, 2008

B. Pharm, University of Benin, 1984

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health Policy

Walden University

February 2020

Abstract

The workplace milieu in Nigerian public health facilities is marked with rivalry and lack of teamwork among health care professionals. Using a mixed methods research design with a phenomenological approach, the study evaluated the perceptions of public sector pharmacists regarding their beliefs and attitudes towards teamwork in their workplace. The study was based on the theoretical framework of theory of action, belief system theory (BST), cognitive-behavioral system, and self-perception theory. Using purposive sampling, experiential pharmacists working in a tertiary health facility in Nigeria were recruited as study participants. In the quantitative study, participants (n=12) were administered questionnaires with demographic questions and Likert scale closed-ended questions. The qualitative stage involved focus group discussions with participants (n=4) drawn from the same group used in the quantitative study. The quantitative and qualitative data were analyzed using SPSS version 20 and NVivo software respectively. Data from the focus group discussion were identified and categorized into themes using the BST construct. Results revealed that doctor's perceived superiority and ownership of patients, turf protection, lack of knowledge of the role of pharmacists, disparity in remunerations, poor communication, resistance to change, defective leadership style, and other factors were impediments to teamwork. While dynamism, innovation, ingenuity, and proficiency were believed to promote teamwork. The participants affirmed that they are team players, and that health care professionals working as a team would improve health care services in Nigeria. To improve health care services in Nigeria, there is need to address the impediments, while factors that promote teamwork should be strengthened.

Perceptions of Public Sector Pharmacists Regarding Their Beliefs, Attitudes Towards Teamwork

by

Elijah Mohammed

MSc, University of Lagos, 2008

B. Pharm, University of Benin, 1984

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health Policy

Walden University

February 2020

Dedication

I dedicate this work to Nigerians who are yet to fully enjoy the potentials of health care professionals in the country. I believe that in the nearest future the health care professionals will come together, put aside their various professional egos, to provide the optimal health care services Nigerians expect from them.

Acknowledgments

A number of people, through their patience, help and support played important roles to make this work possible. My greatest gratitude goes to Dr. Warren MacDonald my dissertation chair, whose patience, encouragement and support toward the realization of my dream cannot be quantified. He ensured I stayed on track and encouraged me in face of much distractions throughout my dissertation journey. Dr. Kenneth Feldman and Dr. Donna Clews for serving on my committee and supporting my efforts in providing positive guidance and feedback; and for their precious time. Similarly, my gratitude goes to Michael Miller, my form and style reviewer, whose “template transplant” and review contributed in no small measure to my success story.

I wish to express my gratitude to the management and staff of National Hospital, Abuja for the assistance with my data collection, and the entire members of my professional and academic cohort most especially Prof. (Mrs.) A. C. Ezike for their support and encouragement throughout the entire program. My wife, Rev. (Mrs.) A. O. Mohammed, and all the members of my family for believing in me and supporting me throughout the period of my academic pursuit in the Walden academic community.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Background

The World Health Organization (WHO) recognized Nigeria's health system to be weak and ranked it 187 of 191 in 1997 world rating of nations' health systems (WHO, 2000). The weak health system of the country has resulted to low service coverage and poor health status indicators (Nigeria Demographic and Health Survey [NDHS], 2013). Osaro and Charles (2014) identified that the quality of health care services in Nigeria has been suboptimal, and thus the provision of effective and safe care to patient and promotion of desired health outcomes is weak. They attributed these to unhealthy rivalries, lack of team spirit, and unharmonious working relationships, among health professionals (Osaro & Charles, 2014).

In Nigeria, health care delivery is carried out by various professionals who, because of the country's insistence on educational silos in their training, have inherent and diverse cultural dispositions in terms of beliefs, attitudes, and perceptions toward each other. This diversity causes conflict among them (Al-Sawal, 2013; Kalb & O'Conner-Von, 2012). Furthermore, the educational silos in health care training have created cocooned social individuals with negative biases and naïve perceptions of the roles of other members of the health care team (Grant, Finnocchio & The California Primary Care Consortium Subcommittee on Interdisciplinary Collaboration, 1995). In situations such as these, relationships among the health professionals are usually "fraught and combative rather than constructive and effective" (Iles, 2014, p. 44). Iles (2014) further explained that complex situations as this create "turf battles" and clan-

culturalization that end up molding the actors' work and relationship culture, which, if not kept in check in the course of time becomes ingrained in their daily activities.

Problem Statement

Nigeria's health system is weak and ranked 187 of 191 nations in 1997 (WHO, 2000). The effects of this include low service coverage and poor health status indicators (NDHS, 2013; WHO, 2000). Osaro and Charles (2014) identified that the quality of health care services in Nigeria has been suboptimal. They attributed this to unhealthy and unending rivalries, lack of team spirit, and unharmonious working relationships among health professionals (Osaro & Charles, 2014).

A preliminary literature review revealed that this problem of unhealthy and unending rivalries, lack of team spirit, and unharmonious working relationships among health care professionals is partly attributable to a foundational problem in their education. This foundational problem has to do with the country's insistence of educational silos in their training, which has produced health care professionals with inherent diverse cultural dispositions in terms of beliefs, attitudes, and perceptions toward each other (Kalb & O'Conner-Von, 2012). The effect is a creation of workplace relationships between these health professionals after graduation that is often "fraught and combative rather than productive and effective" in their collective primary purpose of promoting, restoring, and maintaining health of the citizenry (Iles, 2014, p. 44).

Purpose of the Study

In this study, I sought to explore and describe the lived experiences of pharmacists in public hospitals and factors that influence their perceptions about teamwork in their workplace (Creswell, 2013; Patton, 2015). The knowledge and experiences gathered from the study will help to enrich the body of knowledge concerning the promotion of teamwork and in the development of programs and policies for social change.

Theoretical/Conceptual Framework

I used the belief systems theory (BST) model to guide the development of research questions (RQs), data collection, and analysis process in the study. Grube, Mayton, and Ball-Rokeach (1994) explained that the belief system theory "provides a framework for understanding how attitudes, values, and behaviors are organized and the conditions under which they will remain stable or undergo change" (p. 153). They further explained that "beliefs and behaviors are interrelated, and the belief system serves as a framework that guides cognitive and motivational processes (e.g., information processing, selective forgetting and remembering, ego defense, decision making) that ultimately result in behavior" (p. 154). However, individuals' awareness about the connectivity of their various beliefs and the implications of such beliefs on their behaviors are made irrelevant in certain situations by psychological processes such as ego defense and in others by the complexity of BST (Grube et al., 1994).

Research Questions

The RQs used in the study were as follows:

RQ1: What are the perceptions of public pharmacists regarding teamwork in the workplace?

RQ2: How do public pharmacists' individual beliefs and attitudes help promote teamwork in health care practices in the workplace?

RQ3: What are the factors that influence the attitudes of public pharmacists toward teamwork in the workplace?

Source of Data

In this study, I used quantitative and qualitative methodologies in the collection of data using questionnaires and focus group discussion, respectively (Peredaryenko & Krauss, 2013). The study population that I used was 12 experiential Nigerian pharmacists with more than 5 years post National Youth Service Corps (NYSC) working experience and currently practicing in the public sector. I used a purposive sampling using selective experiential samples of participants with the necessary knowledge and experience in the study (Poulis, Poulis, & Plakoyiannaki, 2013; Rudestam & Newton, 2015).

An appropriate sampling process is a prerequisite to achieving the set objective of any research study (Robinson, 2014; Uprichard, 2013). The sample size so chosen is in consideration of data dependability and saturation standards requirement (Cleary, Horsfall, & Hayter, 2014). In a qualitative research, the sample size is important; the smaller the size, the easier it is to produce a rich and more concise documentation of

participants' live experiences of the phenomenon under consideration (Jenkins & Price, 2014; Ritchie, Lewis, Nicholls, & Ormston, 2013).

Nature of Study

I used the mixed methods research design for this study. The use of this type of research design enables a researcher to gain more insight into the situation under study from different perspectives and gather more comprehensive information and knowledge about the phenomenon for better understanding. It also helps to enhance the researcher's interpretation of the experiences associated to the phenomenon and increase reliability and credibility of the results (Creswell & Plano Clark, 2011; Ihuah & Eaton, 2013; Johnson, Onwuegbuzie, & Turner, 2007; Patton, 2015; Tashakkori & Teddlie, 2010). I used purposive sampling involving selected experiential participants to obtain information to facilitate the understanding of the phenomenon. (Patton, 2015; Rudestam & Newton, 2015).

Definitions of Terms

For this study, there are certain terms that need definition:

Attitude: A predisposition of an individual to respond positively or negatively toward an entity, situation, or certain idea.

Beliefs: The state of mind of a person in which trust is placed in something or an individual.

*Perception***:** The practice of translating sensory impressions into a logical and cohesive view of the world around an individual.

Phenomenon (as used in this study): Perceptions, beliefs, and attitudes concerning teamwork at the workplace.

Social phenomenon: Something that occurs or exists through the actions of an individual, group, or groups of people.

Teamwork: The combined efforts of a group to achieve a common purpose or goal.

Assumptions, Scope, and Limitations

Assumptions

To explore, understand, and describe the lived experiences of public sector pharmacists, I made the following assumptions:

1. Because I am part of the research instruments, I assumed that theoretical saturation could lead to the manipulation of data collection and analysis process.
2. I believed that all participants in the study would share their perceptions and experiences truthfully as they relate to their beliefs and attitudes concerning teamwork.
3. I also assumed that using purposive sampling reflects the inclusion criteria stated in the study flyer, and the information provided by the study participants would be pertinent enough to describe the phenomenon.
4. I also assumed that information gathered to generate themes would help provide answers to the RQs and explain the phenomenon.

Scope

My focus in the research problem was on the perceptions of public sector pharmacists regarding their beliefs and attitudes concerning teamwork. The location of the study was the Pharmacy Department, National Hospital, Abuja, Nigeria, a tertiary health care facility owned and managed by the federal government of Nigeria.

Limitations

Limitations of the study include the specific population and the single health facility that I for the study. The selection of participants was another limitation because only those who indicated interest in response to the flyers were for eligible to participate in the study. Information from the study was specific to public sector pharmacists, making it a challenge to generalize the findings to other health care professionals working within the same environment. Furthermore, in the data collection process, recall bias in terms of asking participants to provide information from reminiscence of past activities could threaten the internal validity of the research (Creswell, 2013).

Significance of the Study

I hoped that the study outcome would fill gaps in literature about the perceptions of pharmacists as they relate to their beliefs and attitudes concerning teamwork at their workplaces. The information arising from this study may enrich the body of knowledge of the phenomenon under study and contribute to positive social change. Furthermore, the study may enable me to gain an understanding and appreciate the prevailing cultural values, perspectives, beliefs, and attitudes of pharmacists about teamwork in the workplace. The outcomes of the study may help bring about a positive social change in

the Nigerian health sector by providing the necessary tools and facilitating development of policies needed to address the apparent uncooperativeness of health care professionals.

Summary

This chapter provided an overview of the study outlining the background, problem statement, purpose of study, theoretical framework, RQs, and the significance of the research. Also, in Chapter 1, I outlined aspects of teamwork and the need for harmony in the sector as a requirement for effective health care delivery. I also provided implications for social change and effects on health outcomes. In Chapter 2, I will highlight a general review of the literature that supports the opinions outlined in Chapter 1.

Chapter 2: Literature Review

Introduction

The essence of a literature review is to locate and summarize relevant studies about a topic (Creswell, 2013). Thus, I carefully reviewed the significant professional and academic works with respect to my study, and I synthesized information so garnered from experts in the field to produce foundational materials and perspectives that are relevant to my study.

Review of Professional and Academic Literature

The relevance of professional and academic literature is in the provision of research works pertaining to a given topic and to help limit the scope of work to the desired area of study (Creswell, 2013; Patton, 2015). Focusing on peer-reviewed scholarly literature, I searched for relevant materials from academic libraries with online databases and relevant journals. In addition, appropriate books related to the topic and reports from WHO and NDHS were searched for relevant materials (Creswell, 2013). Databases used for literature search included the Walden Library Database, SAGE Premier, ProQuest, Emerald Insight, ERIC, Google Scholar, among others.

The major key words used in the literature search include teamwork, beliefs and attitudes of health care workers, practice theories, building up teams, workplace effectiveness, and collaborative health care practice. The literature review was focused on three major areas: BST, beliefs and attitudes of health workers, and teamwork.

Theoretical Framework

Theories explain various human operations and are usually situational in nature. Their influence and framing of individuals' perceptions of the world around them are based on fundamental ethos in the form of values, beliefs, and assumptions, which then drive cognitive processes and behaviors of such individuals (Argyris, & Schön, 1974; Houchens & Keedy, 2009). According to Houchens and Keedy (2009), Argyris and Schön's (1974, 1978) framework for theories of practice provides an understanding of the meaningful work of health care workers in entrenching cooperative practice at their workplaces.

Theory of Action

The framework of theories of practice (Figure 1), which is premised on the theory of action based on the original set of underlying values, beliefs, and assumptions, posits that if application of a theory of practice to solve a problem results in a failed solution (outcome), then a revised theory of action based on the same underlying values, beliefs, and assumptions would give a positive and desired outcome (Houchens & Keedy, 2009).

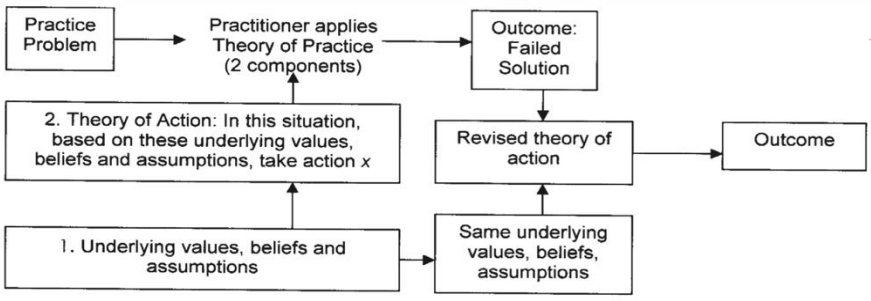


Figure 1. Theory of action based on the original set of underlying values, beliefs, and assumptions (Houchens & Keedy, 2009).

Belief System Theory

I used BST to guide the development of the RQs and analysis of the information gathered from the study. Grube et al. (1994) explained that BST "provides a framework for understanding how attitudes, values, and behaviors are organized and the conditions under which they will remain stable or undergo change" (p. 153). They further explained that "beliefs and behaviors are interrelated, and the belief system serves as a framework that guides cognitive and motivational processes (e.g., information processing, selective forgetting and remembering, ego defense and decision making) that ultimately result in behavior" (p. 154). However, individuals' awareness about the connectivity of their various beliefs and the implications of such beliefs on their behaviors are precluded by the complexity of BST and psychological processes such as isolation and ego defense (Grube et al., 1994).

Cognitive-Behavioral System

Dóci, Stouten, and Hofmans (2015) explained in their work that individuals' stable behavioral tendencies are influenced by their fundamental beliefs about themselves, others, and the world round them, and belief as a cognitive unit activates sequence of events that lead to behavioral response toward a given situation. However, based on their beliefs, same situational features could be encoded differently in the minds of different individuals, which then elicit different behavioral responses to the situation (Dóci et al., 2015). These individuals' core evaluations based on their fundamental beliefs according to Dóci et al. influence their "appraisals, expectancies, behavioral scripts, trait, and dispositional tendencies" (p. 2). However, this behavior associated with

their beliefs can change based on evaluation of skills and attitudes, perceptions, and trust in the workplace (Dóci et al., 2015).

The presence of trust creates an atmosphere of cordiality, care, and opportunity for self-development (Dóci et al., 2015). Furthermore, there is less authoritarianism and tight control land less intense monitoring, with the flow of information, responsibility, recognition, and autonomy given to subordinates where there is cordiality and subordinates are seen in a more positive light (Dóci et al., 2015). This cognitive mechanism of interactive exchange according to Dóci et al. (2015) "acts as a mediator between transformational behaviors and positive work outcomes" (p. 7).

Self-Perception Theory (SPT)

The first postulate of self-perception theory (SPT) as originated by Bem (1967, 1972) states that "individuals come to know their own attitudes, emotions and other internal states partially by inferring them from observations of their own overt behavior and/or the circumstances in which this behavior occurs" (Bem, 1972, p. 5). Circumstances may include apparent controlling variables of that behavior. Individuals are assumed to consider "the external stimulus conditions under which the behavior occurs" (Bem, 1967, p. 185). In other words, this postulation insinuates that obvious behavior and situational cues (circumstances/environment/stimuli) provides the individual an indication of his attitude towards the object in question. The second postulate of self-perception theory which suggests a partial identity between self- and interpersonal- perception, states that

> “to the extent that internal cues are weak, ambiguous, or uninterpretable, the individual is functionally in the same position as an outside observer, an observer who must necessarily rely upon those same external cues to infer the individual’s inner states" (Bem, 1972, p 5).

Research has shown that attitudes are both predictive of future behavior (Kraus, 1995) and influenced by past behavior (Eagly & Chaiken, 1993). Furthermore, research has established that the impact of past behavior on attitudes depends on attitude strength and behavior voluntariness (Bem, 1972; Chaiken & Baldwin, 1981; Olson & Stone, 2005). It has been demonstrated that attitudes differ in the extent to which they are durable and impactful (Eagly & Chaiken, 1998); strong attitudes are very durable and impactful, whereas weak attitudes are less durable and impactful. According to experiential evidence, strong attitudes are more predictive of future behavior than weak attitudes (Bassili, 2008; Cooke & Sheeran, 2004; Glasman & Albarracín, 2006; Krosnick & Petty, 1995; Schleicher, Smith, Casper, Watt, & Greguras, 2015). Also, research has provided evidence that attitude strength moderates both the extent to which an attitude predicts future behavior and the extent to which it is impacted by past behavior (Holland, Verplanken, & van Knippenberg, 2002; Krosnick, 1988). Based on earlier proven evidence of the relationships between behavior and self-perception on one hand, and attitude strength and behavior on the other hand, Ziegler and Schlett (2016), further proposed an attitude strength and self-perception framework to gain more insight into work behavior relationship and other work attitude related concepts. Drawing on self-perception theory (Bem, 1967, 1972), attitude strength and self-perception framework as

proposed by Ziegler and Schlett (2016), this study sought to gain an insight into the perceptions of public sector pharmacists regarding teamwork in their workplace. The self-perception theory was applied to understand the perceptions of the pharmacists towards teamwork. According to Bem's self-perception theory, it is possible for one to make interpersonal judgements in situations wherein the observer and the observed are the same individual; hence, the second postulation served to understand the perceptions of the pharmacists (acting as observers) regarding the attitudes of the other professionals towards teamwork.

Teamwork

According to the WHO, a team is a distinguishable set of two or more people who interact dynamically, interdependently, and adaptively toward a common and valued goal/objective/mission, who have been assigned specific roles or functions to perform and who have a limited lifespan of membership (WHO, 2012). Teamwork in provision of quality and effective health care involves the participation of diverse team members consisting of specialized health care professionals, patients, and family. An effective teamwork is now globally recognized as an essential tool for building and sustaining a more effective and patient-centered health care delivery system (Babiker et al., 2014). To achieve effective teamwork in health care delivery, an interdisciplinary team coherently bound by shared goals, trust, and open and collaborative interdependency has been proposed (Hall & Weaver, 2001; Morley & Cashell, 2017). Though tasks may be distributed among functional units of the team, strong communication, a common understanding of the interconnected work process, and shared ownership of the inputs

and outputs of the overall process are vital (Figure 2). In addition, such teams have more potential to pursue collective goals and achieve the best results using accepted and set standards. In the long term, such a team may also have a greater capacity for organizational learning, process improvement, and capability generation (Love & Roper, 2009; Oliver & Kandadi, 2006). The key concept hinges on synergy, that is, the whole is greater than the sum of its parts.

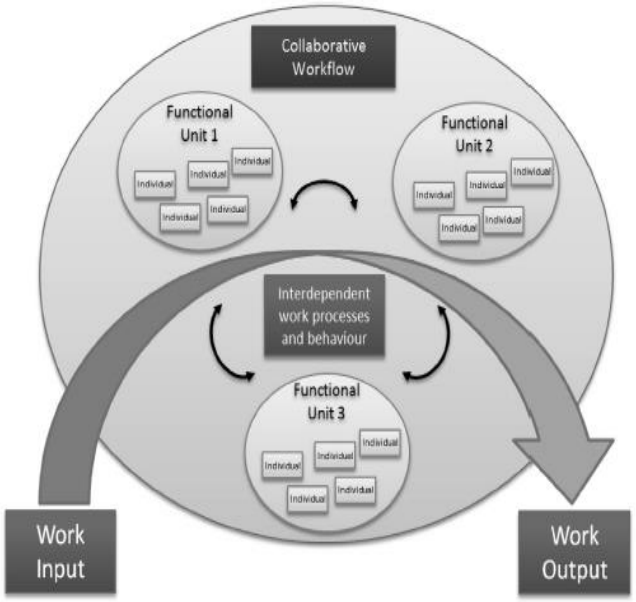


Figure 2. Proposed interdisciplinary team hinged on collaborative interdependency (Morley & Cashell, 2017).

Elements for effective teamwork are commitment and trust; open lines of communication; building and maintaining interpersonal relationships; mutual respect; diversity of capabilities; adapting to changing conditions; confidence and creative freedom; effective leadership; and clearly defined roles and goals (Oandasan et al., 2006; WHO, 2012). In the provision of health care, team members should be encouraged to ask

questions, share ideas or concerns, and discuss potential solutions. The strengths and skills of each team member must be used to achieve optimum patient care and workplace satisfaction. It is essential that all interdisciplinary team members are knowledgeable about each other's roles, responsibilities, and levels of accountability at the unit and organizational levels. This knowledge provides the essential framework needed to take advantage of each team member's professional skills and promote a cohesive teamwork approach to care (Davis, 2017).

Principles of Effective Teamwork in Health Care Delivery

Principles that characterize effective teamwork in health care delivery include shared goals, clear roles, mutual trust and respect, effective communication, measurable processes and outcomes, and effective leadership (Babiker et al., 2014; Mitchell et al., 2012).

Values Required of an Effective Team Member

Mitchell et al. (2012) identified five personal values that characterize the most effective members of high-functioning teams in health care. These values are congruent with the core competency domain of "values/ethics" of team members proposed in the Interprofessional Education Collaborative's (IPEC's) team-based competencies (IPEC, 2011; Mitchell et al., 2012). The values are as follows:

1. Honesty: Honesty is indispensable for continuous development and maintenance of mutual trust. Effective communication within the team is vital, including transparency and clarity about aims, decisions, uncertainty, and mistakes.

2. Discipline: Team members should carry out their roles and responsibilities with discipline and commitment, even when it seems inconvenient. Discipline allows teams to develop, maintain, and sustain their standards and protocols.

3. Creativity: Team members ought to have the ability and be enthusiastic and motivated to tackle emerging problems creatively. Effective teams should see errors and some unanticipated bad outcomes as potential opportunities to learn and improve.

4. Humility/Modesty: Team members should not believe that one type of training, profession, or perspective is superior to others, though they recognize differences in educational and other backgrounds. They also recognize that they are human and will make mistakes. Hence, a key value of working in a team is that fellow team members can rely on each other to help recognize and avert failures, regardless of their position in the hierarchy.

5. Curiosity: Team members should reflect on the lessons learnt in the course of their daily activities and apply the same in continuous professional development and contributions toward functioning of the team.

Benefits of Effective Teamwork

Effective teamwork is beneficial to the patient, team members, the team, the health facility, and society at large. A plethora of research have shown that teamwork can significantly reduce medical errors, improve health outcomes and quality of care, enhance patient safety, reduce patient morbidity, reduce workloads, increase job

satisfaction and retention, and improve patient satisfaction (Oandasan et al., 2006; WHO, 2012).

Barriers to Effective Teamwork

Barriers to establishing and sustaining effective teamwork in health care include changing roles, changing settings, health care hierarchies, unclear and poorly defined processes, individualistic nature of health care, instability of teams, unclear definition of roles, lack of explicit coordination, miscommunication, inability to resolve disagreement and conflict, certain policies and systems in the health care sector, poor interpersonal relationships, among others (Oandasan et al., 2006; Babiker et al., 2012).

Collaboration in Health Care Delivery

Collaboration is an essential component of teamwork. It has been demonstrated that a collaborative teamwork is more responsive; efficient; considerate of patient, family, and community roles; and that it provides improved health care (Oandasan et al., 2006; Schmitt, Blue, Aschenbrener, & Viggiano, 2011). Definitions of collaboration are varied (Morley & Cashell, 2017) and may be specific to a particular circumstance. Collaboration, a process in which people interact to achieve a common goal (Patel, Pettitt, & Wilson, 2012), is an efficient, effective, and satisfying way to offer health care services. It involves working together, negotiating agreement and managing conflict, and respecting (appreciating) and understanding one another.

Collaboration is an integration of activities and knowledge that requires a partnership of shared authority, responsibilities, and goals (Morley & Cashell, 2017).

Sullivan (1998) described four vital elements that provide a useful breakdown of behaviors and attitudes that, together, constitute collaborative practice in health care:

1. Coordination: Working to achieve shared goals.
2. Cooperation: Contributing to the team, understanding and valuing the contributions of other team members.
3. Shared decision making: Relying on constructive discussions, negotiation, communication, openness, trust, and a respectful power balance.
4. Partnerships: Open, respectful relationships cultivated in the course of time in which all members work equitably together.

Effective teamwork and collaboration in health care delivery are key strategies to improve performance in many aspects of health care, with the ultimate aim to achieve optimum health care delivery.

Teamwork, Beliefs, and Attitudes of Health Workers

There is lack of team spirit and harmonious working relationship among health care professionals in Nigeria (Osaro & Charles, 2014). This has created a workplace that is tense and "combative rather than productive and effective," leading to unending rivalries in the system. The consequence of these is suboptimal performance of health care services in the country (Al-Sawal, 2013; Osaro & Charles, 2014). The inherent and diverse cultural disposition of health professionals in terms of their beliefs, attitudes, and perceptions toward each other is partly responsible for the unending rivalries (Iles, 2014; Kalb & O'Conner-Von, 2012). Furthermore, their silos educational training has produced individualism and egoism in workplace relationship that are marked by mistrust and

unhealthy competition, making the health workers victims of circumstances with the primary focus of controlling turfs. It is, therefore, not surprising that under these circumstances, health care service remains suboptimal in quality (Houchens & Keedy, 2009, p. 52). In situations such as these, Houchens and Keedy (2009) advocated for theories of practice to fill the gap between theory and practice or between espoused theory and theory-in-use in workplaces. This will help create new norms of behavior and relationships among individuals that are mediated through change in their perceptions, attitudes, and beliefs (Houchens & Keedy, 2009).

Summary

Teamwork is *sine qua non* for any group to achieve a common purpose or goal. This concept should not be different in the health care system where professionals are expected to work as a team for optimal performance of health care services in a country. However, when the work environment is tense and combative rather than productive and effective, optimal performance cannot be achieved. From the literature review, it is evident that the quality of health care services in Nigeria has been suboptimal, which is partly attributed to unhealthy rivalries, lack of team spirit, and harmonious working relationships among health care professionals (Osaro & Charles, 2014); thus, the provision of effective and safe care to patient and promotion of desired health outcomes is weak. Based on the aforementioned notions that I have discussed; it was expedient to explore the perceptions of health care professionals regarding their beliefs and attitudes towards teamwork.

I used BST to explore and describe the perceptions of public sector pharmacists (study sample population) as it relates to their beliefs and attitudes concerning teamwork. The detail of the research is presented in Chapter 3.

Chapter 3: Research Design and Methodology

Introduction

The success of any research project depends on the research method and design used. Three research methods, namely quantitative, qualitative, and mixed (quantitative and qualitative) methods, are usually used by researchers (Patton, 2015). The research method deployed depends on the nature of research problem and strategies to be used in the scholarly study; the researcher's personal experiences and worldview assumptions; procedures of data collection, analysis, and interpretation; and the audiences for the study (Creswell, 2013).

Research Design and Rationale

I used mixed methods in this study because of the need for more comprehensive information and knowledge, richer datasets, and better understanding of the research problems by the process of phenomenon quantification. Qualitative method played a predominant role in my study because of its exploratory nature and the focus of the study was on a social phenomenon (human behavior), which I had no control over (Yin, 2014). The qualitative method that I used involved the gathering of various perspectives of study participants regarding the phenomenon. This method enabled me to explore the participants' experiences in their environment and document same. The method also served to understand the participants thought processes by which they construct meanings to their actions and behaviors. The explanation

of what these meanings represent helped me to elucidate the participants' actions or inactions at their workplace (Astalin, 2013; Birchall, 2014; Khan, 2014; Kothari & Garg, 2014; Patton, 2015). In addition, I used a minimal integration of quantitative method in the study, and subsequently analyzed the mutual implication of both methods as they affect the subject matter.

The use of mixed methods research design is a relatively new and distinct research methodology in the social and human sciences. It combines both qualitative and quantitative principles to broaden understanding of a given research work. Furthermore, this method strengthens the quality and validity of a study. It is useful when data triangulation is a necessity for validation (Kothari & Garg, 2014; Patton, 2015; Sparkes, 2014; Tseng & Yeh, 2013). In a mixed methods approach, the summation of the combined strength of both qualitative and quantitative methods makes up for weaknesses of each. Potential challenges with use of mixed methods approach include extensive data collection process, and time-consuming processes that involve analysis of both text and numerical data. Furthermore, significant time is needed for the researcher to become acquainted with qualitative and quantitative methodologies (Creswell, 2009; Patton, 2015; Venkatesh, Brown, & Bala, 2013). However, the mixed methods approach appeals to researchers when the data collection process complements the methodology deployed in a research work (Harrison, 2013; Sparkles, 2014). In addition to these, the triangulation of the results from both quantitative and qualitative studies will increase

reliability and credibility of the results (Creswell & Plano Clark, 2011; Ihuah & Eaton, 2013; Johnson, Onwuegbuzie & Turner, 2007; Tashakkori & Teddlie, 2010). The use of both methods reflects the same philosophical assumption of epistemology. In this situation, subjective evidence is from the research participants and the researcher relies on such information to become an insider of the whole process. Furthermore, qualitative approach under cultural diversities will help provide information about an unknown phenomenon; help in understanding the meaning that individuals hold about a problem, and provide information to address the gap between knowledge and reality (Creswell, 2013; Crosby, DiClemente, & Salazar, 2013). Patterns and themes generated from qualitative inquires in an exploratory research help discover information from study participants that may assist in addressing the gap between theory and practice.

A significant point to note in qualitative inquiry is that every researcher must be mindful of data saturation, which is characterized by absence of new themes or information in the process of data collection and exploration. It signifies the collection and exploration of enough data that represent the breadth and depth of a phenomenon without becoming overwhelmed and redundant (Fusch & Ness, 2015; Marshall, Cardon, Poddar, & Fontenot, 2013; Rudestam & Newton, 2015). Data saturation in a study is not usually guaranteed by the largeness of the sample size but by the quality of the samples. This explains the researcher's deliberate and purposeful selection of

participants (purposive sampling) whose contributions would give deeper understanding of the research topic or question and uncover a full array of perspectives from them (Ando, Cousins, & Young, 2014; O'Reilly & Parker, 2013; Rudestam & Newton, 2015). Purposive sampling served to get information that will help enrich the understanding of the phenomenon and provide a wide range of viewpoints from participants (Patton, 2015, Rudestam & Newton, 2015). The study design is therefore most ideal method of inquiry to explore the perceptions of public sector pharmacists regarding their beliefs and attitudes towards teamwork.

Methodology

The quantitative phase of the mixed methods study design involved administration of questionnaires with demographic questions and Likert scale closed-ended questions based on a five-choice scale; and in the qualitative, I used focus group discussion to gain insight into the participants' experiences of the phenomenon. The five-choice Likert scale ranged and scored from (1) strongly disagree, (2) disagree, (3) neutral, (4) agree, and (5) strongly agree, whereas the focus group discussion was facilitated by using semi-structured open-ended questions to guide the process. The quantitative data were provided by 12 experiential Nigerian pharmacists with more than 5 years post NYSC working experience and currently practicing in the public sector, subsequently four individuals from the same group were used for the

qualitative phase of the study (Cronin, 2014; Hyett, Kenny, & Dickson-Swift, 2014; McDonald, Brown, & Knihnitski, 2018; Yin, 2014).

I used SPSS (Version 20) to statistically analyze the quantitative data, which are presented in various tables for easy visualization. I recorded and transcribed the focus group discussions; information gathered were coded using NVivo software and categorized into themes using the BST construct.

The Role of the Researcher

In seeking to understand the study participants' perception as it relates to their beliefs and attitudes that concern teamwork, I acted as a researcher and served as the primary research instrument in data gathering and interpretation (Creswell, 2013; Davies & Dodd, 2012). During the study, I was involved in identification of RQs and the appropriate research approach for data collection, creation of research instrument, study participants' identification, and data analysis process to give answers to the RQs.

I am a trained pharmacist and currently work with the civil service of the country. I have a general and solid knowledge of the pharmaceutical landscape (both private and public sector) in the country and professionals working therein. I have a cordial relationship with the professionals, and I did not experience any difficulty in recruiting study participants and soliciting their cooperation and trust. Despite these factors, I took necessary steps to ensure a strong relationship with the participants to obtain their consent to participate and make them feel at home to enable them provide willingly relevant information for the study (Fink, 2014). Participants provided detailed answers through the use of closed-ended and open-ended questions respectively, which I

processed accordingly using the instrumentality of recording, coding, categorization and analysis as appropriate. My familiarity with the proposed participants and the terrain of their operation may have introduced information bias in the study, which could be in the form of transposition or misinterpretation of information. I tackled this bias by audio recording of the focus group discussion, efficient note taking, and seeking clarification from participants when necessary. I safeguarded the information generated from the focus group discussion, and the identities of participants by encoding the storage of information generated from the study and refraining from using names of participants (Collins & Cooper, 2014; Fink, 2014).

Target Population

The study population consisted of 12 experiential Nigerian pharmacists with over five years working experience, currently practicing in the public sector, knowledgeable about the topic and ready to share useful and rich information. Furthermore, participants selected were expected to demonstrate unalloyed willingness to partake in a focus group discussion involving unrestricted and honest conversation in a conducive environment that is at their convenience.

Sampling and Sampling Procedure

Sampling is an important feature of any study be it quantitative, qualitative or mixed methods. It is important because it is a major tool in achieving the objective of such study. The sample population for the study was twelve participants. As a phenomenological study, the sampling involved identifying and locating experiential participants that met both inclusion and exclusion criteria, rather than drawing randomly

from a convenient sample. The essence of this purposive sampling was to identify the population of interest that meets specific characteristics which best satisfy the recruitment criteria and provide answers to the RQs (Crosby et al., 2013). Study participants were recruited from the Pharmacy Department, National Hospital, Abuja, Nigeria.

Recruitment

The recruitment process was initiated by distribution of flyers after securing permission and ethical clearance from the management of the facility. The flyers (Appendix A) contained information such as the purpose of the study, eligibility criteria for participants and duration of the study. An appointed agent within the facility assisted in collecting completed flyers in sealed envelopes, from interested volunteers. The process of contacting them was by telephone calls that involved self-introduction and explanation of data collection process. Information received from the volunteers was used to recruit eligible participants. Thereafter, date, time, and location for the completion of the questionnaires were fixed with the selected participants. Afterwards, four of the participants were selected based on pre-defined criteria for the focus group discussion.

Inclusion and Exclusion Criteria

The following criteria were adhered to in the selection of study participants:

- Participant must be a Nigerian pharmacist.
- Hold over five years post-NYSC working experience.
- Currently practicing in the public sector.
- Be at least 28 years of age.
- Had worked or is working in a team of not less than 10 members.

- Very fluent in English language.

Volunteers that did not satisfy the criteria stated above were excluded from the study.

Selection Bias

Systemic errors are common selection process bias in research (Crosby et al., 2013). The adoption of purposive sampling served to identify experiential participants that enabled the researcher to properly categorize subjects to reflect the RQs criteria. As an active participant in the study, bias could creep into the study through my participation in the research and interpretation of information so gathered. To address this, I detached myself from any specific viewpoint that could introduce bias. Crosby et al., (2013) in their work explained that to address the risk of bias, researchers must refrain from whatever viewpoints that would introduce partiality into their work.

Data Collection Method

Questionnaire consisting of 19 closed-ended questions were developed and administered to the participants. In addition, open-ended questions were administered to a focus-group in the form of a discussion session. The construction of these questions was guided by BST and categorized into themes. The questions, which were geared toward answering the RQs, covered among others, knowledge and beliefs about teamwork, perceived beliefs and barriers that influence their workplace behaviors. This approach enabled the researcher extract information from participants about their lived experiences and perceptions as it relates to their beliefs and attitudes that concern teamwork at their workplace.

Data Collection Procedure

Place and time for the completion of questionnaire or focus group discussion with the participants respectively were pre-determined and agreed on by all concerned. Such a place was conducive enough to establish rapport to enable participants express themselves freely and without reservations (Turner, 2010). The researcher exhibited a high degree of warmness, caution, respect and equality before, during and after all the sessions. English was the official language of communication and the engagement with the participants for the completion of the questionnaires and focus group discussion sessions were 30 and 60 minutes respectively. Furthermore, the researcher cautiously and courteously probed and expanded participants' responses during the focus group discussion in order to extract more relevant information from answers to RQs.

The RQs in the questionnaire were grouped as follows (Appendix B):

- Demographic information: Q1 to Q4.
- Participants' knowledge about beliefs, attitudes and teamwork: Q5 to Q10.
- Participants' perceptions on tradition, sociocultural aspects.
- Beliefs about teamwork: Q11 to Q19.

The focus group discussion process took the following format:

- Self-introduction.
- Explanation of purpose of the discussion.
- Explanation of the rules for the discussion which included:
    - ✓ Duration of the discussion.
    - ✓ Voluntary nature of participants' involvement.

- ✓ Participants' ability to withdraw without penalty.
- ✓ Audio recording of the discussion.
- ✓ The anonymity of participants' identifications.
- ✓ Information sharing of the study result.

- Discussion proper using the focus group questions (Appendix C).
- Closing with thanks to the participants and informing them of when and how they will receive the outcome of the discussion.

Audio recording of discussion has its advantages, which include making information available for transcription and analysis without the researcher taking notes (Chenail, 2011; Turner, 2010). Data for the quantitative and qualitative components of the study were collected sequentially since both forms of data are related (explanatory and exploratory) (Creswell, 2009).

Data Coding and Analysis Procedures

The results from the focus group discussion was recorded and transcribed accordingly, to give a sense of direction and opportunity for probing and expanding on the participants' responses. Data collected was coded for further analysis. Using NVivo software, the BST construct was used to identify and categorize data into themes for further analysis. These categories took the forms of beliefs, attitudes, knowledge, socio-economic status, and perceptions. Patterns identification in the analyzed data enabled the researcher achieve saturation and provide answer to the RQs. Thereafter, conclusions were derived from them.

Ethical Considerations

The ethical foundation of my study was hinged on approval by the Walden University Institutional Review Board (Appendices D & E) and the National Hospital, Abuja, Nigeria Institute Review Board (IRB) Committee (Appendices F & G) upon the submission of the required documents. Trust and respect for participants and upholding of their views were maintained throughout the research process. Proper briefing of the participants concerning the study was done to ensure they are well informed. Consent forms were made available to the participants for their signature (Appendices D & E), and pseudo names were allotted to each participant to ensure confidentiality. Ethical principles applied in the research work included the respect of intellectual property, honesty and objectivity. Other ethical issues such as confidentiality, social responsibility and protection of human subjects were applied. Concerning the issue of intellectual property, all relevant referenced books, quotations and acknowledgement were properly cited, and all contributions from researchers were duly given credit. Misinterpretation of data and objectivity are issues that could raise ethical dusts in any research work. Information gathered in the study was coded into themes and where applicable, deliberate quotes from participants' responses were used to substantiate some issues.

Limitations

The study focused on the perceptions and lived experiences of the selected research participants only; this created a limitation to the study. The information gathered was limited to the participants and cannot be generalized to the entire country. However,

the outcome of the study would contribute to knowledge on the gap identified concerning the perceptions of public sector pharmacists regarding their beliefs and attitudes towards teamwork. Specificity of the sampling method restricts participants to unique criteria tailored to the provision of answers to the RQs.

Validity

Truthfulness about a given phenomenon and elimination of bias are key factors researchers should put into consideration to guarantee good quality studies (Davies & Dodd, 2012). This would ensure that what is to be measured in the research work is actually measured and its findings and undertakings are reliable (Creswell & Miller, 2000). Furthermore, the researcher closely monitored the use of research instrument in the generation of information by being fully engaged in the entire study. Also, the researcher's thoughts and insights were separated from the research work to minimize bias and distortions.

Informed Consent

Participation in the research was voluntary and participants were required to sign the consent forms (Appendix D & E) before partaking in the research process. This voluntary agreement gave credence to the information provided by participants about the research (Creswell, 2009). The informed consent written in English language, highlighted the nature of study, the purpose, the procedures of the research process, risks, and incentives where applicable and the use of the research results. Where necessary explanations were given to participants with emphasis on their right to discontinue the study, which was included in the consent form. The signing of the consent form was done

without compulsion and under a culturally acceptable way. Participants were given a copy of the signed consent forms and original copies were archived.

Summary

In Chapter 3 of this dissertation I described the study design, including data collection process, study population, data analysis, and ethical processes. The study was a phenomenological one which sought to explore and describe the lived experiences and perceptions of public sector pharmacists as they relate to their beliefs and attitudes that promote teamwork. Administration of questionnaires and focus group discussion were used as data collection tools. The RQs and the resultant data analysis were guided by BST to help describe the perceptions and beliefs of public sector pharmacists concerning teamwork. Adherence to ethical procedures was upheld in course of the study. Data collection was done after obtaining approvals from the Walden University Institutional Review Board and the National Hospital Institute Review Board Committee. Data gathered was coded to derive themes. Chapter 4 of the study outlined the result and challenges faced in course of data collection. The discussion of the result of the study, recommendations, and implications for social change formed the materials for Chapter 5.

Chapter 4: Presentation and Analysis of Data

Introduction

The richness and quality of data collected in a research is of great significance toward the success of the research and is, therefore, a major focus for any researcher (Anyan, 2013). In this study, data were collected from participants who had experience and understanding about teamwork in their workplaces and their practice environments. To fully understand the phenomenon under study, I used a mixed method research designed (Peredaryenko & Krauss, 2013).

Study Design

The mixed methods research design I used involved combined quantitative and qualitative approaches. In the quantitative study, I administered questionnaire with demographic questions and Likert scale closed-ended questions based on a five-choice scale (Appendix B). The questionnaire contained 19 statements classified into three domains – knowledge, perceived beliefs and barriers. The knowledge domain comprised two statements about education and training, and opportunities to learn new skills. The second domain, perceived beliefs, comprised seven statements about being a team player, participation in teamwork, teamwork is in the public interest, workplace supports teamwork, shared ideas about teamwork, appreciation of team members' contributions, and sharing of controlled areas. The third domain, barriers, comprised four statements about understanding of team members' roles and responsibilities, attitudes of team members, management/workplace policy, and existence of turf or no-go-areas.

For analysis of the demographic data, I calculated the frequency as the number of times a particular option was selected for an item, whereas the percent was the frequency divided by the size of the sample for that item and multiplied by 100. The cumulative percent provided the incremental percent from one time to the next, which is the percent value for a new item added to the percentage value of the next until the total is reached. Valid percent recognizes that there might be blank responses and gives the percentage after removing all the blank spaces.

I used the five-choice scale range: 5 for strongly agree, 4 for agree, 3 for neutral, 2 for disagree, and 1 for strongly disagree to determine the numerical responses for the Likert items. I determined the mean (*M*) and standard deviation (*SD*) using SPSS (Version 20). I used the average of the five-point scale, *M*=3.00 as a cut-off point; thus *M* above 3.00 indicated *agreed*, whereas below 3.00 *disagreed*.

The qualitative discussion involving focus group participants (consisting of four persons from the quantitative study population) provided more insight into the participants' experiences of the phenomenon. The focus group questions were structured open-ended comprising engagement, exploration, and exit questions respectively (Appendix C). I audio recorded the questions which were further transcribed accordingly. I used NVivo software to code the participants' responses to the focus group questions and thereafter thematically analyzed. I generated additional data from field notes and observations on some issues that cropped up during discussion (Cronin, 2014; Hyett et al., 2014; McDonald, Brown, & Knihnitski, 2018; Yin, 2014).

Research Questions

Three RQs were deployed in this study to draw inferences and deductions that would help to interpret respondents' daily realism through the identification of their lived experiences and perception as it relates to their beliefs and attitude that promote teamwork at their workplace.

RQ1: What are the perceptions of public pharmacists regarding teamwork in the workplace?

RQ2: How do public pharmacists' individual beliefs and attitudes help promote teamwork in health care practices in the workplace?

RQ3: What are the factors that influence the attitudes of public pharmacists toward teamwork in the workplace?

Findings

Demographic Findings

The quantitative data shows that most of the respondents are male (58.3%), 83.3% of them have their highest educational status of first degree, and 91.6% are over 30 years in age. The result further showed that 41.7% have 11-30 years of work experience while 50.0% and 8.3% have less than 10 years and over 30 years of experiences respectively (Tables 1a–1d).

Table 1a

Analysis of Gender of Participants

Gender	Frequency	Percentage	Valid percentage	Cumulative percentage
Female	5	41.7	41.7	41.7
Male	7	58.3	58.3	100.0
Total	12	100.0	100.0	-

Table 1b

Analysis of Age of Participants

Age (years)	Frequency	Percentage	Valid percentage	Cumulative percentage
<30	1	8.3	8.3	8.3
<40	7	58.3	58.3	66.7
<50	4	33.3	33.3	100.0
Total	12	100.0	100.0	-

Table 1c

Analysis of Educational Qualifications of Participants

Educational qualification	Frequency	Percentage	Valid percentage	Cumulative percentage
BPharm	10	83.3	83.3	83.3
FPCPharm	2	16.7	16.7	100.0
Total	12	100.0	100.0	-

Note. BPharm = Bachelor of Pharmacy; FPCPharm = Fellow of Postgraduate College of Pharmacy.

Table 1d

Analysis of Work Experience of Participants

Years of Post NYSC work experience	Frequency	Percentage	Valid percentage	Cumulative percentage
6-10	6	50.0	50.0	50.0
11-20	3	25.0	25.0	75.0
20-30	2	16.7	16.7	91.7
>30	1	8.3	8.3	100.0
Total	12	100.0	100.0	-

Findings with Respect to Research Questions /Inferential Findings

Three RQs were investigated in this study to deduce the perception of public sector pharmacists regarding their beliefs and attitudes that promote teamwork.

RQ1: What are the perceptions of Public Pharmacists regarding teamwork in the workplace?

This first RQ sought to identify the perceptions of pharmacists in public sector regarding teamwork. The result from the quantitative study (Table 2) showed that the pharmacists believed that they are team players (M = 4.33, SD = 0.89) and are comfortable participating in teamwork. They also agreed that working as a team has positively affected the patients at their workplace (M = 3.67, SD = 0.98). Furthermore, education and training were strongly perceived by the respondents as facilitating teamwork (M = 4.50, SD = 0.67) as well as professional regulatory bodies (M = 3.08, SD = 1.16). However, the respondents do not think the actions of the management promotes teamwork and their remunerations do not reflect their worth to teamwork and to the organization (M = 2.33, SD = 1.15).

The analysis of the focus group discussion further corroborates the quantitative findings on the perception of pharmacists on teamwork (Table 3). Several codes were identified to form the theme on the perception of pharmacists on teamwork: Theme 1. The codes are perceived superiority due to training, doctors' perceived ownership of patient, imbalance in remuneration, interdisciplinary rivalry, and leadership (Table 3).

Table 2

Quantitative Analysis of Perceptions of Pharmacists Regarding Teamwork

Statement/Question	Numerical Response		Remarks
	Mean	SD	
I am a team player	4.33	0.89	Agree
I am comfortable participating in teamwork	4.33	0.89	Agree
Do you feel that working as a team has positively affected the patients/clients at your workplace	3.67	0.98	Agree
Do you feel that education and training of team members play a role in promoting teamwork	4.50	0.67	Agree
Do you feel that professional regulatory bodies facilitate teamwork	3.08	1.16	Agree
Do you feel that management actions or inactions promote teamwork at your workplace	2.92	1.24	Disagree
Do you feel that your remunerations reflect your worth to the teamwork and by extension the organization	2.33	1.15	Disagree

SD = standard deviation

Table 3

Qualitative Analysis of Perceptions of Pharmacists Regarding Teamwork

Open coding	Summary of Participants' Responses
Doctor's perceived ownership of patient	The orientation of medical doctors from their training is that they own the patient, they do not share the patient with any other professional. That perception is still dominant, probably they are still being taught so in medical school. They act based on that perception, thereby technically excluding other professionals contributing to patient care. They fail to see patient care as the work of every member of the health care team.
Doctors' perceived superiority	Doctors don't see health care services delivery as teamwork in Nigeria, they see it as fully under their authority (a monopoly). They see other health care professionals as attendants, while they are the

	health care providers. This mindset does not encourage adequate contributions by other health professionals especially the pharmacists, in achieving the goal of patient care.
Doctors' lack of knowledge and understanding of the role of pharmacists	Occasionally, when the pharmacists try to engage the doctors, they do not want to carry pharmacists along. The doctors may not want to explain/discuss the case; sometimes they complain that they don't understand what the pharmacists are doing, for example, in the ward. Another issue is resistance from the doctors, who on seeing the pharmacist in the ward say openly, "What is the pharmacist looking for in the ward?"
Imbalance in remunerations	There is disparity in remuneration of health care professionals, with some earning significantly higher than others from a different profession. Consequently, there is demotivation of those earning less and you see people showing grievances here and there.
Interdisciplinary rivalry	There is this caustic relationship, manifesting as rivalry and challenge that doctors feel or tend to perceive when pharmacists raise a concern about prescription or drug dosage.
Defective leadership style	My personal opinion is that we do not have effective leadership, or those in positions of authority do not exercise leadership qualities necessary to accommodate and utilize highly trained pharmacists that are on ground. For teamwork to work in health sector we need to change leadership style.

RQ2: How do public pharmacists' individual beliefs and attitudes help promote teamwork in health care practices in the workplace?

This RQ sought to identify the individual beliefs and attitudes of public pharmacists that promote teamwork. From the results of the quantitative analysis (Table 4), the pharmacists agreed that having the health care professionals work together as a team is in the public interest (M = 4.25, SD = 1.22) and colleagues (pharmacists) share similar idea about teamwork (M = 4.00, SD = 0.60). However, they disagree with the statement that their workplace supports teamwork (M = 2.33, SD = 1.03) and that attitudes of other colleagues (doctors) are usually overwhelming (M = 2.92, SD = 0.67).

Table 4

Quantitative Analysis of Attitude and Beliefs of Pharmacists regarding Teamwork

Statement/Question	Numerical response		Remarks
	Mean	*SD*	
Health care professionals working as a team is in the public interest	4.25	1.22	Agree
My workplace support teamwork	2.33	1.03	Disagree
My colleagues (pharmacists) and I do share similar ideas about teamwork	4.00	0.60	Agree
My colleagues (pharmacists) attitudes are usually overwhelming at my workplace	2.92	0.67	Disagree
My immediate colleagues (pharmacists) understand the roles and responsibilities of all team members	3.58	1.24	Agree

SD = standard deviation

This position is further affirmed by the analysis of the focus group discussion (Table 5) where several codes were organized as a theme focusing on attitudes and beliefs of pharmacists and how it promotes teamwork: Theme 2.

Table 5

Qualitative Analysis Beliefs and Attitudes of Pharmacists regarding Teamwork

Open coding	Summary of participants' responses
Dynamism and nonconformity to stereotype	Factors that enable my experience as part of a team and contributions thereon is dynamism and not being stereotypical (i.e. as pharmacists, we are not just dispensing medications only).
Ingenuity and proficiency	Innovation and mastering of my discipline and roles in health care service are some of the factors that enable me to promote teamwork in this health institution. This is because when doctors come across a pharmacotherapeutic issue they don't have answer to, they come back to me (a pharmacist) for advice. If a pharmacist must report for example two case studies before the license is renewed annually, pharmacists will be forced to understand what a case study is, and then try to be involved. With this, nobody will ask what the pharmacists are doing with patients in the wards anymore.
Patient counseling and education on drug use	As a pharmacist, I believe in counseling patients about the use of their drugs. Sometimes patients don't understand their disease state, some may need life style modification and counseling from a pharmacist. What compels me to go to the ward is the fact that patients need someone to counsel and educate them on their medications, among other things.

Research Question 3: What are the factors that influence the attitudes of public pharmacists about teamwork in the workplace?

Research Question 3 sought to identify the factors that affect the attitudes of public pharmacists toward teamwork. From the results, public pharmacists agreed that the existence of turf areas so designated as no-go-areas by some members of the team (M = 3.08, SD = 1.16), and the appreciation and value attached to individual's expertise by

other team members (*M* = 3.42, *SD* = 1.08) are factors influencing public pharmacists' attitude toward teamwork. In addition, colleagues' willingness to cooperate on new practices, share similar ideas about teamwork and provision of opportunities for other team members to participate in controlled acts are other factors that influence the attitude of public pharmacists toward teamwork (*M*=3.67, *SD* = 0.65; *M* = 4.00, *SD* = 0.60; *M*=3.08, *SD* = 0.79 respectively). However, they disagree with the statement that opportunities to learn new skills through formal training are abundant in their workplace (*M* = 2.17, *SD* = 0.94) (Table 6).

Table 6

Quantitative Analysis of Factors That influence the Attitudes of Public Pharmacists Towards Teamwork in the Workplace

Statement/Question	Numerical response		Remarks
	Mean	*SD*	
Individual's expertise is appreciated and valued by team members	3.42	1.08	Agree
My colleagues (pharmacists) are willing to cooperate on new practices	3.67	0.65	Agree
My colleagues (pharmacists) and I do share similar ideas about teamwork	4.00	0.60	Agree
Opportunities to learn new skills through formal training are abundant in my workplace	2.17	0.94	Disagree
The sharing of controlled acts provides opportunities to promote teamwork at workplace	3.08	0.79	Agree
There are turf areas that are no-go-areas by some members of the team	3.08	1.16	Agree

SD = standard deviation

This position is further affirmed by the analysis of the focus group discussion where several codes were organized as a theme focusing on factors that influence the attitudes of public pharmacists about teamwork– Theme 3 (Table 7). Some of the factors identified in qualitative analysis are poor communication, imbalance in remunerations, interdisciplinary rivalry, defective leadership style, resistance to change, turf protection/uncharted territory for pharmacists, workplace policy, patients' empathy, among others (Table 7).

Table 7

Qualitative Analysis of Factors That Influence the Attitudes of Public Pharmacists Towards Teamwork in the Workplace

Open coding	Summary of participants' responses
Inappropriate recognition of pharmacists by other health care professionals	Doctors see health care service delivery as fully under their authority and other health professionals as attendants, while regarding themselves as health care providers. This mindset does not encourage adequate contributions by other health care professionals especially the pharmacists, in achieving the goal of patient care. Doctors by their actions technically exclude other professionals from contributing to patient care. They fail to see patient care as the work of every member of the health care team. Most times, doctors for example, don't even want to listen to the ideas of pharmacists. They will always want to impose their own ideas on the pharmacists.
Other health professionals not amenable to professional judgements/opinions of pharmacists	If I have a patient whose prescription needs a review and I contact a doctor, the reply you get sometimes is "Pharmacist dispense as such." On their part, nurses do not agree to effect changes on prescriptions until they get doctor's directives. The nurses give responses such as "you don't have the right to correct me." So, such matters are unattended to. Doctors or nurses will tell the pharmacist, "this is how it has been"; they don't want to alter the status quo.
Interdisciplinary rivalry	There is this caustic relationship in the form of rivalry and challenge that some health professionals feel or tend to perceive when the pharmacist raises a concern about prescription. If we can remove this idea and attitude of 'I know more than you,' I believe health professionals can work seamlessly as a team. Each person should try to see another's opinion as vital, and not to disregard it.
Imbalance in remuneration	It is perceived that only members of one group of health care professionals are remunerated 'appropriately.' This demotivates other professional groups, including pharmacists who show grievances here and there.

Defective leadership style	My personal opinion is that we do not have effective leadership, or those in positions of authority do not exercise leadership qualities necessary to accommodate and utilize highly trained pharmacists that are on ground. For teamwork to work in health sector we need to change leadership style. If we have people with open mindset, who are in policy making and implementation positions, and are aware of the essence of teamwork in health care delivery, I think the problem of rancor among health care professionals will become history in our health care system.
Poor communication	l don't think there is adequate communication among health care professionals.
Resistance to change and new ideas	There is usually resistance to change, especially when one is used to a particular system in a certain way. Change is usually difficult, even if it is to improve on the existing format or ways. People are usually resistant to trying a new approach. I think it is a mindset or attitude problem. We just need to be open minded, to know that someone may come with a better way of doing what we are already used to doing and be open to such changes.
Turf protection by doctors/uncharted territory for pharmacists	Occasionally when the pharmacists try to engage doctors, they do not want to carry the pharmacists along. They may not want to explain/discuss the case with the pharmacists. Sometimes the doctors openly complain about pharmacists "you are in the ward, we don't understand what you are doing in the ward." Another issue is resistance from the doctors. When they see pharmacists in the ward they say openly, "What is the pharmacist looking for in the ward, what is the pharmacist doing here?" If I can be given the opportunity to work in the ward and put in my own skill as pharmaceutical care provider that will augur well for improved health care delivery.

Workplace policy	Some policies that govern the health care operations in Nigeria are not equitable. These policies have technically excluded pharmacists as well as some other health care professionals from being adequately and optimally involved in patient care. This phenomenon is very difficult to alter or amend because the people or beneficiaries of the lopsidedness or imbalance in government policies on patient management seem to be resistant to any alteration, even though they know from experience in other countries that is not how it is done. Secondly because they have enjoyed the monopoly of such practice for a long time, they are resistant to any form of change even though it is positive and progressive.
Empathy for patients	What compels me to go to the ward is the fact that patients need someone to counsel and educate them on their medications, among other things.

Summary of Findings

Key Findings for Research Question 1: What are the perceptions of public pharmacists regarding teamwork in the workplace?

Most of the respondents agreed that they are team players and are comfortable working in teams. Majority of the respondents believed that all their colleagues (pharmacists) share similar views on teamwork. However, there was a general belief that their workplace does not support teamwork and that individual expertise is not appreciated and valued. Thus, they felt alienated and rejected by other health care professionals in the clinical team.

Key Findings for Research Question 2: How do public pharmacists' individual beliefs and attitudes help promote teamwork in health care practices in the workplace?

Majority of the respondents believed that health care professionals working as a team is in public interest and working as a team positively affects patient outcome in the workplace. Respondents also believed that effective communication, being innovative and proficient, and working professionally within their competences will promote teamwork.

Key Findings for Research Question 3: What are the factors that influence the attitudes of public pharmacists about teamwork in the workplace?

Most of the respondents believed that education and training facilitate teamwork. However, one-stop orientation and training of all health care professionals which should promote teamwork is not usually pursued by management at their workplace. This is because, according to the participants, the workplace does not have an all-inclusive structure and policy in place that promotes teamwork. Respondents also believed that impediments to teamwork include the display of no-go-areas attitude by some professionals mostly the doctors. They claimed that most doctors in their workplace do not see health care delivery as a teamwork, and that they lay claim to patients' ownership. Furthermore, the doctors see the presence of other health care professionals as irrelevant, an encroachment into their territory and consequently display resistance and clannish attitude toward them. These generate caustic relationship among the professionals.

Other identified factors that influence the attitudes of public pharmacists towards teamwork include resistance to change, qualitative, defective leadership style, and poor communication among team members. Intrinsic factors of the pharmacist such as being dynamic and non-stereotypical in his professional work, and openness to new ideas are

other enabling factors that influence the attitudes of public pharmacists to teamwork in the workplace. Alienation and poor recognition of pharmacists' professional roles in the team are additional factors influencing the attitudes of public pharmacists to teamwork. Empathy for patients is another factor that influences the attitudes of public pharmacists to teamwork as explained by a respondent as follows "What compels me to go to the ward is the fact that patients need someone to counsel and educate them on their medications, among other things."

Conclusion

Chapter 4 of this study included a review of the findings for the three RQs. These findings were based on the data collected from 12 public pharmacists using quantitative and qualitative methods. The result from the focus group discussion was used to further prove the findings from the quantitative analysis. Chapter 5 will contain a discussion of the findings, limitations of the study, and recommendations.

Chapter 5: Findings, Conclusions, and Discussion

Introduction

The current need for optimal performance by professionals in the health care space in Nigeria cannot be achieved without the necessary reforms needed to create a harmonious workplace environment devoid of rancor and unhealthy rivalries among health care professionals. Unhealthy rivalries, lack of team spirit, and harmonious working relationships among health professionals have been identified as some of the factors responsible for suboptimal performance of health care services in Nigeria (Osaro & Charles 2014). Furthermore, the silo educational training of Nigerian health professionals has produced individualism and egoism in workplace relationship that is marked by mistrust and unhealthy competition, making the health workers victims of circumstances with the primary focus of controlling turfs. Makowsky, Schindel, Rosenthal, Campbell, Tsuvuki, and Madill (2009) further posited that to attain successful implementation of team-based care, attention should be focused on practice structure and team processes. However, this is not achievable in a workplace environment that is tense, combative, rancorous and marked with mistrust among professionals with primary focus on controlling turfs. It is therefore not surprising that under these circumstances, the quality of health care services is suboptimal.

Overview of the Study

My purpose in this study was to explore the perception of public sector pharmacists as it relates to their beliefs and attitudes that promote teamwork. In this study, I provided knowledge about the fundamental living experiences and cultural values

of public sector pharmacists regarding teamwork in their workplace. The outcomes of the study would contribute to the body of knowledge that is related to promoting teamwork among health care professionals and would be important in developing practice structure and team processes.

I selected applicants for the program through an expression of interest in response to flyers. Experiential pharmacists that met the inclusion criteria were recruited using purposive sampling process devoid of biases.

I deployed Likert scale closed-ended questions based on a five-choice scale questionnaire and focus group discussion to collect the quantitative and qualitative data respectively. The questionnaire gathered demographic data of the participants, and elements of public pharmacists' perceptions regarding teamwork in the workplace. The qualitative component of the study involved focus group participants, consisting of four persons chosen from the quantitative study population and took the form of a group discussion that was facilitated by me. The discussion was guided with structured open-ended questions comprising an engagement, exploration, and an exit questions respectively. The essence of the focus group discussion was to provide more insight into the participants' experiences of the phenomenon under study.

Research Questions

I deployed three RQs in this study to draw inferences and deductions that would help to interpret respondents' daily realism through the identification of their lived experiences and perceptions regarding their beliefs and attitudes towards teamwork at their workplaces.

Within the framework of this study, the following quantitative and qualitative questions were investigated:

RQ1: What are the perceptions of public pharmacists regarding teamwork in the workplace?

RQ2: How do public pharmacists' individual beliefs and attitudes help promote teamwork in health care practices in the workplace?

RQ3: What are the factors that influence the attitudes of public pharmacists about teamwork in the workplace?

To address the RQs, I used Likert scale questionnaire consisting of statements categorized into three domains: knowledge, perceived beliefs, and barriers domains. Knowledge domain comprised of statements about education and training, and opportunities to learn new skills; perceived beliefs, comprised of statements about team player, participation in teamwork, teamwork is in public interest, workplace supports teamwork, shared ideas about teamwork, appreciation of team members contribution, and sharing of controlled areas; whereas barriers, comprised of statements about understanding of team members' roles and responsibilities, attitudes of team members, management/workplace policy and existence of turf or no-go-areas (Appendix B). I

conducted focus group discussion, using structured open-ended questions as a guide, which provided better insight into the participants' experiences of the phenomenon (Appendix C).

Summary of the Findings

Demographics

The collected demographic data included information on the participants' age, sex (gender), educational qualification(s), and years of experience expressed as years of post NYSC work experience. The study participants comprised 41.7% females and 58.3% males, most of which were below forty years (66.7%); 83.3% had Bachelor of Pharmacy (B. Pharm.) degree while 16.7% had additional post Bachelor's qualification of Fellowship of West African Postgraduate College of Pharmacists. About 75.0% of the participants had below 20 years of working experience while 25% had between 20 and 30 years of working experience.

Results of Quantitative Study

The data collected using the Likert scale closed-ended questionnaire based on a five-choice scale identified significant outcomes in the quest to ascertain the perceptions of pharmacists in public sector regarding teamwork. The result showed that pharmacists believed they are team players, are comfortable participating in teamwork, and that health care professionals working as a team has positive outcome on patients' health. They also perceived that education and training, and roles of professional regulatory bodies can facilitate teamwork; however, the respondents disagreed with the statement that their workplace supports teamwork. They agreed that their remunerations do not reflect their

worth to the team and the organization. Furthermore, the respondents agreed that having the health care professionals work together as a team is in the public interest and that attitudes of other colleagues (physicians) are usually overbearing. In identifying factors that affect the attitudes of public pharmacists toward teamwork, the respondents agreed that the existence of turf areas so designated as no-go-areas by some members of the team and lack of appreciation and value attached to individual's expertise by other team members are factors influencing public pharmacists' attitude toward teamwork. In addition, health care professionals' (non-pharmacists) unwillingness to cooperate on new practice areas, sharing ideas about teamwork and provision of opportunities for other team members to participate in their turf practice areas (e.g., ward rounds) are other factors that influence the attitude of public pharmacists toward teamwork. However, the respondents disagreed with the statement that opportunities to learn new skills through formal training were abundant in their workplace.

Results of Qualitative Study

Analysis of the focus group discussion identified that perceived superiority of doctors (physicians) arising from their training, doctors' perceived ownership of patient, imbalance in remuneration, interdisciplinary rivalry, doctors' lack of knowledge and understanding of the role of pharmacists, and defective leadership styles are some perceptions held by pharmacists regarding teamwork in their workplace. The respondents believed that dynamism and nonconformity to stereotype, ingenuity and proficiency, and the need to counsel and educate patients on drug use form part of their attitudes and beliefs that promote workplace teamwork. Some factors identified to influence attitudes

of public pharmacists toward teamwork in their workplace include inappropriate recognition of pharmacists by other health care professionals, other health professionals not amenable to professional judgements/opinions of pharmacists, poor communication among health care professionals, imbalance in remunerations, interdisciplinary rivalry, defective leadership style, resistance to change, turf protection/uncharted territory for pharmacists, workplace policy, and patients' empathy.

Overall Results

The perceptions of public sector pharmacists regarding their beliefs and attitudes towards teamwork is the main focus of this study. The identified perceptions of the respondents regarding their beliefs and attitudes towards teamwork are grouped into three domains - knowledge; perceived beliefs; and barriers that hinder the promotion of respondent's participation in teamwork at their workplace:

Knowledge. The knowledge component consists of education and training, and opportunities to learn new skills. To a reasonable extent the respondents perceived that most medical doctors lack knowledge and understanding of the role of pharmacists in clinical settings. They also perceived that education and training, and professional regulatory bodies can facilitate teamwork. In addition, colleagues'(non-pharmacists) unwillingness to cooperate on pharmacist's new practice areas (resistance to change), non-sharing of ideas about teamwork, and non-provision of opportunities for other team members to participate in controlled areas of practice (turf protection/uncharted territory for pharmacists) are part of the perception of respondents that influence their beliefs and attitudes that promote teamwork. However, the respondents disagree with the statement

that opportunities to learn new skills through formal training are abundant in their workplace.

Perceived Beliefs. From the results of the study, respondents believed that public sector pharmacists are team players, comfortable participating in teamwork at any given opportunity and that health care professionals working as a team has positive outcome on patients' health. However, they do not believe that their workplace supports teamwork.

Barriers. Lack of understanding of team members' roles and responsibilities, lack of appreciation and value of individual's expertise by other team members, uncooperative attitudes of team members, management/workplace policy, leadership styles, and existence of turf or no-go-areas, uncharted roles for pharmacists, all constitute factors militating against public pharmacists' attitude toward teamwork.

Discussion of Findings

The findings of this study revealed that public sector pharmacists are team players, who are comfortable participating in teamwork if provided with enabling environment. However, they believe that other health professionals do not appreciate their relevance and capacity to positively contribute and be fully integrated into the health care team; this they attributed to defective leadership styles and policies operating in the health care system, orientation given to other health professionals during their education and training, resistance to change, and caustic/unharmonious working relationship among health professionals. Nevertheless, public sector pharmacists believe that health professionals working as a team would lead to positive outcomes for the patient and improve health care services in Nigeria.

The study demonstrated that relationships exist among perceptions, beliefs, assumptions; and attitudes of public pharmacists toward teamwork. Human actions, which are usually situational in nature are customarily framed by the individual's perceptions of the world around him/her. Rudimentary ethos such as an individual's underlying beliefs, values and assumptions are central to these perceptions, which drive the individual's cognitive processes, and then manifest as the behaviors of such an individual (Argyris & Schön, 1974, 1978; Houchens & Keedy, 2009). The framework of theories of practice, which is premised on the theory of action based on the original set of underlying values, beliefs and assumptions, posits that if application of a theory of practice to solve a problem results in a failed solution (outcome), then a revised theory of action based on the same underlying values, beliefs and assumptions would give a positive and desired outcome (Houchens & Keedy, 2009). The principle of this theory of practice ought to be adopted by policy makers and health care workers in Nigeria to entrench cooperation, understanding of their practice structure and collaborative processes, in order to enhance teamwork and service delivery at their workplace.

RQ1 focused on the perceptions of public sector pharmacists regarding teamwork in the workplace. From the results of the study, respondents perceived that public sector pharmacists are team players, are comfortable participating in teamwork if given the opportunity, and that health care professionals working as a team has positive outcomes on patients' health. To the respondents, team in this context means clinical team. Hitherto, traditional professional activities of pharmacists were product oriented, and their interaction with other health care professionals were limited. Nowadays, pharmacy

practice has evolved and expanded with diverse clinical roles thereby affording pharmacists more opportunities to contribute to clinical and other aspects of patient care. Clinical pharmacy activities support a collaborative approach (with patients, care givers, prescribers and other health professionals) to medicines management and patient care (Adams & Blouin, 2017). Moreover, with the development of pharmaceutical care, today's pharmacist is well equipped with the requisite clinical and other expertise to carry out functions needed to achieve optimum patient care.

Participants also perceived that education and training, and roles of professional regulatory bodies can promote teamwork. Most of the respondents agreed that education and training facilitate teamwork, though training programs aimed at promoting teamwork among health care providers are not usually undertaken at the workplace. On-the-job education and training would help to unlearn the learnt culture in practice such as resistance to change, inappropriate disregard and uncouth behavior toward other professionals; and inculcate values such professionalism, effective communication skills, managing change and relationship building. Also, education and training packages such as continuing professional development/education and workshops would help to keep professionals up to date in current trends in their disciplines and other fields; this would help them keep abreast of the constantly changing health sector landscape.

However, they do not believe that their workplace supports teamwork as they strongly feel that management's actions or inactions do not promote teamwork. These situations are attributable, albeit partly, to the nonexistence of charted territory for pharmacists in public health facilities and perceived resistance from the physicians and some other

health care professionals who query the roles of pharmacists in the team. As stated by one respondent:

> The other health professionals say, "What is the pharmacist looking for in the ward"; and …. they complained that you are in the ward, they don't understand what you are doing.

The participants also perceived that the resistance to teamwork exhibited by other members of the clinical team (for example the physicians) is partly attributable to doctor's perceived superiority:

> Doctors don't see health care services delivery as teamwork in Nigeria, they see it as fully under their authority (a monopoly). They see other health care professionals as attendants, while they are the health care providers. This mindset does not encourage adequate contributions by other health professionals especially the pharmacists, in achieving the goal of patient care.

Another perception of pharmacists regarding teamwork is that doctors lack knowledge and understanding of the role of pharmacists: A participant stated:

> Occasionally, when the pharmacists try to engage the doctors, they do not want to carry pharmacists along. The doctors may not want to explain/discuss the case; sometimes they complain that they don't understand what the pharmacists are doing, for example, in the ward.

The lack of understanding of the roles of pharmacists, leads to resistance from other professionals, as opined by one participant: "Another issue is resistance from the doctors,

who on seeing the pharmacist in the ward say openly, “What is the pharmacist looking for in the ward?”

This lack of clarity of pharmacist’s roles and functions to the physicians is perceived by pharmacists as ‘resistance to their presence’; on the other hand, the presence of pharmacists is perceived by other members of the team (including the doctors) as a ‘threat.’ The consequences of these include unharmonious/caustic relationships, rancor, interprofessional rivalry and lack of team spirit.

Furthermore, participants perceived that physicians see the patient as their own and not to be shared with any other health care professional. This, the respondents believed may be a fallout of their training in school, and which they have carried over to their professional practice. In the words of one of the participants,

> “. . . medical doctors (physicians) in particular, their orientation from their training is that they own the patient, they do not share the patient with any other professional. This perception is still dominant probably they are still being taught today in medical school and they act based on that perception thereby technically excluding other professionals contributing to patient care. However, they fail to see it (patient management) as the work of every member of the health care team.”

Since the form of educational training received by Nigerian health professionals has been identified as a fundamental contributing factor, albeit partly, to the lack of harmonious working relationship among them, there is need to incorporate the tenets of teamwork in their curriculum.

The pharmacists also strongly perceived that their remuneration is not commensurate with the value added to the team and by extension the organization. Remuneration is the pay or reward given to an individual for work done (Maicibi, 2005). Remuneration may also be referred to as monetary or financial benefits that is accrued or given to an employee as a result of services rendered, commitment to the organization or reward for employment (Maicibi, 2005; Muchai, Makokha, & Namusonge, 2018; Ojeleye, 2017;). Employee remuneration serves to boost morale, increase motivation and promote team cohesion. Good remuneration improves productivity, while poor remuneration reduces motivation and morale of workers, ultimately reducing productivity (Maicibi, 2005; Muchai et al., 2018; Ojeleye, 2017). Furthermore, the long-established notion that individuals care about not only their own salary, but also their salary relative to that of their coworkers (Breza, Kaur, & Shamdasani, 2016, 2018) has implications for interprofessional teamwork. Remuneration and pay disparity have significant impact on the attitude and performance of workers in an organization. The perception of workers about salary inequality affects teamwork; this has strongly been manifested in the incessant industrial actions by different professional groups in the Nigerian health care sector. The existence and impact of disparity in the remunerations of health care professionals were expressed in the following words by one of the participants:

> It is perceived that only members of one group of health care professionals are remunerated ‘appropriately.’ This demotivates other professional groups, including pharmacists who show grievances here and there.

The existing disparity in the remuneration of health care professionals in the Nigerian health care system, results in poor team cohesion, with the attendant adverse effects on performance and patient outcomes.

Individuals' stable behavioral tendencies are influenced by their fundamental beliefs about themselves, others, and the world round them, and belief as a cognitive unit activates sequence of events that lead to behavioral response toward a given situation (Dóci et al., 2015). However, based on their beliefs, same situational features could be encoded differently in the minds of different individuals, which then elicit different behavioral responses to the situation (Dóci et al., 2015). The belief of the pharmacists of non-acceptance in the team by other health care professionals creates a perception that they are not wanted, and their opinions are not relevant. This creates a sense of alienation and irrelevance that breeds resentments, negativism and misunderstandings with negative behavioral outcomes (since beliefs and behaviors are interrelated). The consequences of these is a health care team without a team spirit, which will have a negative impact on practice structure and team processes at the workplace. This agrees with some of the factors earlier identified as being responsible for the suboptimal performance of health care services in Nigeria (Osaro & Charles, 2014). The essence of any health care team is to achieve a common purpose of positive patient outcomes with an optimal service delivery, and the integration of pharmacists into such team would help to achieve this purpose (Makowsky et al., 2009). Proper integration of all team members will increase each individual's awareness of potential roles and prospective benefits of respective members to the entire team, so that team members (such as pharmacists, nurses and

physicians) could play a part in and benefit from working together as a team (Makowsky et al., 2009). The pharmacist's contributions in such an integrated team include improving drug-therapy decision-making, access to and continuity of care, patient safety, and rational and cost-effective use of medicines (Makowsky et al., 2009).

RQ2 focused on public sector pharmacists' individual beliefs and attitudes that promote teamwork in health care practices in the workplace. The respondents believed that dynamism and nonconformity to stereotype, ingenuity and proficiency, and the need to counsel and educate patients on drug use form part of their attitude and beliefs that promote workplace teamwork as expressed in a response by one of the participants: "factors that enabled my experience as a team player is that we have dynamism and not being stereotype. In the sense that pharmacists should (not) just give medications; they should be open to ideas, that even the interns might have a suggestion that we think will work".

Another participant said: "Innovation and mastery of my discipline and roles in health care service are some of the factors that enable me to promote teamwork in this health institution."

Innovation and expertise in one's discipline are key competences necessary for relevance in collaboration and teamwork. Moreover, proficiency needed by a pharmacist in the health care team include the ability to counsel patients on drug use. One participant stated:

> As a pharmacist, I believe in counseling patients about the use of their drugs. Sometimes patients don't understand their disease state, some may need life style

> modification and counseling from a pharmacist. What compels me to go to the ward is the fact that patients need someone to counsel and educate them on their medications, among other things.

Along with the health care needs of the population, the pharmacist's role is expanding and evolving from the traditional product-oriented to patient-oriented functions. The traditional activities of the profession primarily focused on the dispensing, distributing and supply of medicines and other health products, while interaction with other health care professionals was somewhat limited. Services rendered by today's pharmacists include more patient-oriented, administrative and public functions; such as counseling, education, preventive care, health screening and advocacy, among others (Adams & Blouin, 2017; American Public Health Association, 2006). Nowadays, pharmacists also ensure the rational and cost-effective use of medicines, promote healthy living, and improve clinical outcomes by actively engaging in direct patient care and collaborating with many health care disciplines. With this expanding scope of practice, pharmacists are being recognized globally as part of interprofessional health care teams for providing improved and optimum patient care (Dalton & Byrne, 2017).

RQ3 focused on the factors that influence the attitudes of public sector pharmacists towards teamwork in the workplace. Factors identified by participants to exert a positive influence on the attitudes of public pharmacists toward teamwork include appreciation of an individual's expertise by team members, colleagues' willingness to cooperate on new practices/accept positive changes, allowing other team members to participate (sharing) in controlled acts, and empathy for patients. Demonstration of

relevant professional roles and expertise by an individual adds value to a team; appreciation of such contribution by other team members, boosts self-confidence, and strongly motivates such individual to perform better. Adding value to a team and cooperation on new practices are ways of enabling commitment to developing others and developing interpersonal relationships, which are important components of team cohesion.

On the other hand, factors that negatively influenced teamwork include lack of opportunities to learn new skills through formal training, existence of turf areas, turf protection by doctors, unchartered territories for pharmacists, inappropriate recognition of pharmacists by other health care professionals, other health care professionals not amenable to professional judgements/opinions of pharmacists, resistance to change and new ideas. Other factors identified to militate against teamwork are disparity in remuneration, poor communication, workplace policy and defective leadership.

Though majority of the respondents agree that education and training facilitate teamwork, they stated that appropriate orientation and training of all health care providers geared toward promoting teamwork are not usually pursued by management. According to the participants, the workplace does not have requisite policies, organizational structures and personnel development programs to promote teamwork. One respondent said: “Factors that impede my ability to promote teamwork in National Hospital is policy and the second one is perception.”

Moreover, they stated that to a large extent, existing policies are favorable to some subset(s) of health care professionals, and unfavorable to some. In the words of one

of the respondents: “some policies that govern the health care operations in Nigeria are not equitable. These policies have technically excluded pharmacists as well as some other health care professionals from being adequately and optimally involved in patient care”. Another respondent continued:

> The defective policy [policies] is very difficult to alter or amend because the people or beneficiaries of that lopsidedness or imbalance in government policy on patient management seem to be resistant to any alteration, even though they know from experience in other countries that is not how it is done. Secondly, because they have enjoyed the monopoly of such practice for a long time, they are resistant to any form of change even though it is positive and progressive.

The belief that their workplace was not supportive of teamwork as expressed by some respondents during the focus group discussion is due to lack of enabling organizational structures and policies at the workplace. In line with global trends and changing roles of pharmacists and other health care professionals, the Nigerian government should reappraise various policy thrusts as regards health care delivery in the country and effect requisite modifications necessary to achieve optimum health care delivery to the citizens. Another factor that was identified to adversely affect teamwork in Nigerian health care system is inappropriate recognition of pharmacists by other health care professionals. One participant stated:

> Doctors see health care service delivery as fully under their authority and other health professionals as attendants, while regarding themselves as health care providers. This mindset does not encourage adequate contributions by other

> health care professionals especially the pharmacists, in achieving the goal of patient care.

They stated that other health professionals are not amenable to professional judgements/opinions of pharmacists. This attitude exhibited by other health care professionals adversely affects patient care, as demonstrated by the following statement:

> If I have a patient whose prescription needs a review and I contact a doctor, the reply you get sometimes is, 'Pharmacist dispense as such.' On their part, nurses do not agree to effect changes on prescriptions until they get doctor's directives. The nurses give responses such as, 'You don't have the right to correct me.' So, such matters are unattended to.

Other health care professionals and the public are largely unaware of the changing and expanding professional expertise and roles of pharmacists and continue to underutilize them because they still see the pharmacists' role in health care as mainly a dispensing service. In order words, other health care professionals have a poor understanding of the emerging roles of pharmacists in health care, thereby diminishing their relevance in the clinical team. Besides dispensing medicines, the pharmacist's unique expertise includes pharmacotherapy, drug and health care information, access to care, prevention services, among others (Dalton & Byrne, 2017). Pharmacists are an integral part of the health care team and are among the most trusted and accessible health care professionals (Adams & Blouin, 2017). This accessibility allows them to perform more patient care activities, including counseling, medication management, and preventive care screenings. Due to their accessibility and regular interaction with patients, pharmacists are also in an

inimitable position to identify potential drug interactions and educate patients on the proper use of medications. These efforts have had significant positive impact on quality of care, patient satisfaction, and attainment of cost-effective health care (Dalton & Byrne, 2015. To ensure optimum patient care and patient safety, health care providers need to exchange, consider, examine and review a considerable amount of information (O'Daniel & Rosenstein, 2008; Stowasser, Allinson, & O'Leary, 2004). As medication specialists, pharmacists provide or evaluate much of the information used by doctors and nurses, in addition to providing information to patients. The historical purpose for the expansion of the pharmacist's role from dispensing to clinical pharmacy in the wards was to rectify prescriber errors through review of prescriptions/medication orders (Calvert, 1999). So, full integration and participation of pharmacists in health care teams is gold standard for optimum health care delivery. American Pharmacists Association (APhA) also suggests that the addition of a pharmacist in a collaborative, team-based setting can improve performance against quality indicators and national health goals (APhA, 2017). Respondents also believed that impediments to teamwork include the display of no-go-areas attitude and wrong perception by some health care professionals mostly the physicians, caustic relationship among health care workers, the physicians in their workplace do not see health care delivery as teamwork, and they lay claim to patients' ownership. Furthermore, they see the presence of other health care professionals as irrelevant, an encroachment into their territory and consequently display resistance and clannish attitude. Though participants agreed that sharing of controlled acts provides opportunities to promote teamwork at workplace; however, they acknowledged that there

are turf areas that are no-go-areas by some members of the health care team. This is typified by the fact that the physicians regard the presence of pharmacists for e.g. in the wards as an encroachment into their territory, consequently they show resistance toward pharmacists' participation in clinical ward rounds. This position is further affirmed in the words of a participant:

> Another issue is resistance from the doctors. When they see you in the ward, they say it openly, 'What is the pharmacist looking for in the ward, what is the pharmacist doing here?'

Since other health professionals regard some duties as their territory/turf areas/traditional roles, they exhibit resistance to change as explained by one of the participants in the following statement below: "They will tell you this is how it has been, they don't want to alter what has been."

Another respondent commented thus: "Doctors or nurses will tell the pharmacist, 'this is how it has been'; they don't want to alter the status quo."

This was further affirmed in the words of another participant:

> There is usually resistance to change, especially when one is used to a particular system in a certain way. Change is usually difficult, even if it is to improve on the existing format or ways. People are usually resistant to trying a new approach.

Tied to the aforementioned is unchartered territory for Nigerian pharmacists, in addition to the fact that their proficiency is far above the currently defined roles for pharmacists in Nigerian health sector. Worldwide, pharmacists are working in clinically advanced roles, and it is pertinent that Nigeria joins the trend. Through transdisciplinary approaches

involving teamwork, the Nigerian pharmacist's contribution to health care will aid in achieving optimal health outcomes. A plethora of studies have demonstrated that clinical interventions and other health care services provided by pharmacists reduce the risk of potential adverse drug events and health care costs, and also improve patient outcomes (Dalton & Byrne, 2017). Poor understanding of the roles of team members has been demonstrated to negatively impact on the functionality of the health care team and stunt the innovation of interprofessional practice and education (Hickey, Dumke, Ballentine, & Brown, 2018). As a respondent opined:

> "If I can be given the opportunity to work in the ward and put in my own skill as pharmaceutical care provider that will augur well for improved health care delivery."

Interdisciplinary rivalry among health care workers was also identified as a factor that militates against teamwork. One of the participants stated:

> "There is this caustic relationship in the form of rivalry and challenge that some health professionals feel or tend to perceive when the pharmacist raises a concern about prescription."

Globally, interdisciplinary teamwork and collaboration are increasingly favored as strategies to improve health care delivery (Bryant, Chaar, & Schneider, 2018). In an effort to proffer solution to the existing interdisciplinary rivalry among health care professionals, a participant opined:

> If we can remove this idea and attitude of 'I know more than you,' I believe health professionals can work seamlessly as a team. Each person should try to see another's opinion as vital, and not to disregard it.

Poor communication among health care professionals was also identified to exert a negative influence on the attitudes of public pharmacists toward teamwork as explained in the words of one of the participants:

> As for communication l don't think there is enough communication. Its [communication] a two-way thing. When there is inadequate communication then there is laxity in the teamworking (as one); that, I have experienced.

Communication improves the relationships among the team members, making them feel comfortable, satisfied, and motivated at work. Components of communication include listening with understanding, demonstrating effective relationships, verbal and visual communication, and use of factual information (data), among others (Dorji, Tejativaddhana, Siripornpibul, Cruickshank, & Briggs, 2019). Effective communication is an essential component of teamwork (Davis, 2017), as it reduces the chances of conflicts, promotes understanding and cohesion among team members. Understanding and also commitment to be understood among the team members in an organization are *sine qua non* in order to achieve effective communication. With an effective communication network, team members feel important and confident that their opinions count. Furthermore, when people communicate with intent and clarity, there are fewer misunderstandings, increased trust and improved teamwork. Consequently, they are satisfied, motivated and encouraged to perform better. Ultimately, the team is able to

utilize all its resources to complete tasks and projects. The importance of good communication in teamwork was reiterated by another respondent who said:

> But once the communication flows among the parties, when I see a challenge and I raise it and someone takes it up and acts on the issue that I have raised we will be able to achieve something. This has worked every time that I have done that.

Various studies have demonstrated that the promotion of teamwork in health care sector hinges on understanding, effective communication, information sharing and education of health care workers on their expected roles in current trend in health care services (Babiker et al., 2014; Davis, 2017; Oandasan et al., 2006). If communication in the workplace is poor and ineffective, workers are less likely inclined to collaborate with each other. Consequently, there is poor teamwork which may potentially lead to friction and rivalry among workers, as is obtained in Nigerian health care system. Since the professionals in the heath facility are the core of the organization, paucity of camaraderie and strong working relationships would significantly reduce outcomes.

Respondents also stated that defective leadership existing in the workplace negatively affected their attitude toward teamwork. A respondent stated, “So, for teamwork to ‘work’ we have to start from the leadership and (since) they make policy.”

Where understanding leadership is appropriately mixed with the right policy, there is general trust and unity of purpose among everyone; the resistance experienced by pharmacists may subside, and pharmacists may function fittingly in inter-professional teams as explained by one of the participants who had opportunity to work in a subsection of the hospital partly managed by a nongovernmental organization:

> Looking at the two units I have worked (in) and (compared with where I am now), I had cordial relationship with other health care providers, the leadership were actually forward-takers, they would unite together, promote avenue where they (everybody) come together and share suggestions and recommendations. They will actually listen, sit down and take decisions and put them into practice; that really helped us work together as a team.

The absence of empathetic organizational leadership in the general context of teamwork among health care professionals in the institution appears to be demonstrated in the nonexistence of policy that facilitates and structures that encourage teamwork among health care professionals. In the words of a participant: "… if we have people with (that) open mindset in policy making position I think this whole resistance will become a history in our health care system."

Leadership and management competencies are identified as key elements for improved health care systems (de Savigny & Adam, 2009; Vriesendorp et al., 2010;). The existence of competent managers at all levels is very important for the improvement of health care systems and to meet the dynamic challenges of the constantly changing the health sector. Competence is a tool used to improve performance excellence in an organization and it comprises of a set of knowledge, skills and ability required to perform a given task (Dorji et. al, 2019; Lekshmi & Radhika, 2016). According to The National Center for Health Care Leadership (NCHL), leaders in health organizations are expected to possess certain leadership and management competences spread across three competency domains namely people, execution, and transformation (NCHL, 2010).

People refers to the organizational atmosphere where employees are valued irrespective of backgrounds and provides a motivating environment for them to excel; execution is about transforming vision and strategy into optimal institutional performance; and transformation is visioning, energizing, and stimulating a change process that unites communities, patients, and professionals around new models of health care and wellness (McCleskey, 2014; NCHL, 2010). This NCHL model demonstrates that the use of these domains captures the complexity and dynamic leadership and management qualities and competencies of the health managers to effectively exercise and carry out their roles (NCHL, 2010). Seven key competency subdomains further identified to be essential for functional leadership and management roles in health care settings are communication, professionalism, managing change, relationship building, analytical thinking, leadership, and innovative thinking (Dorji et al., 2019). Remarkably, it is pertinent to note that the factors identified in this study to influence teamwork fall into and correlate with these identified domains and subdomains. This strongly drives home the fact that agencies responsible for health systems should also focus on recruiting competent leadership and managers in the health sector. Also, regular on-the-job training and refresher courses on these competencies will improve the capabilities of leaders and managers in the health care sector.

It is well recognized that collaboration by health care professionals at their workplace and teamwork is essential to achieve patient care and patient safety (Jeffs et al., 2013), however, the practical realization of collaboration in health system has been limited (Beveridge, Pannick, Sevdalis, & Wachter, 2014; Bryant et al., 2018).

Though individuals' core evaluations based on their fundamental beliefs influence their 'appraisals, expectancies, behavioral scripts, trait, and dispositional tendencies,' behavior associated with their beliefs can change based on evaluation of skills and attitudes, perceptions, and trust in the workplace (Dóci et al., 2015). The presence of trust creates an atmosphere of cordiality, care, and opportunity for self-development (Dóci et al., 2015). Where there is cordiality and subordinates are seen in a more positive light, there is flow of information; responsibility, recognition and autonomy are given to subordinates; and authoritarianism, tight control, and intense monitoring are reduced (Dóci et al., 2015). Thus, the perceptive mechanism of interactive exchange among the health care professionals needs to be improved since this mechanism acts as a mediator between transformational behaviors and positive work outcomes (Dóci et al., 2015).

As there is a gap/disconnect between principles inculcated during training of health professionals, policies, and reality in operations of health facilities; Nigerian health care system may need to develop theories of practice to fill the gap between theory and practice or between espoused theory and theory-in-use in workplace, as advocated by Houchens and Keedy (2009). This will help create new norms of behavior and relationship in individuals that are mediated through change in their perceptions, attitudes and beliefs (Houchens & Keedy, 2009).

Limitations of the Study

There are certain limitations to this study despite the guidance and supervision from an experienced researcher throughout the dissertation journey. Firstly, the study findings were limited by the size of the sample group. Although the study included pharmacists from a chosen public health care facility and met the set-out criteria, there is need to expand the sample size to include other facilities from the various six geopolitical zones of the country. Additionally, the sample population was limited to 12 participants in the given facility.

The impact of these limitations was minimized by taking some steps, which include experts' review of the statements used in the Likert Scale closed-ended questionnaire in order to minimize errors related to the questionnaire. The procedures and materials for the study were properly explained to participants, including a question and answer session for clarity and better understanding of the study by participants.

Implication for Practice

The quality of health care services in Nigeria is in a state of suboptimal performance and the need to up the game is not in doubt. Osaro and Charles (2014), wrote about the weakness in the provision of effective and safe care to patient, and promotion of desired health outcomes in Nigeria. They further explained that in Nigeria, the quality of health care services is suboptimal in performance and attributed this to "unhealthy rivalries, lack of team spirit and harmonious working relationship among health professionals." These factors need to be addressed in order to bring sanity in the

health care arena and improve performance in the quality of health care services in Nigeria.

This study identified education and training, policy direction, proper recognition and respect for each other, and clarity of roles of health care professionals in modern day patient management as major structures that are of highest predictive value for the promotion of teamwork in the health care arena. The management of health care facilities should increase the effectiveness and collaboration of health care professionals by clearly defining their roles and responsibility, give appropriate recognition and clearly communicate same to all concerned through a policy thrust. A clear definition and understanding of defined roles and responsibilities within the context of modern-day patient management would help check some health care professionals who in course of their practices tend to overstep their bounds and also for those who are involved in turf protection.

Education and training would help in unlearning the learnt practices that do not favor teamwork. As Kalb and O'Conner-Von (2012) pointed out, training of health professionals in educational silos as being practiced in the country usually produced health professionals with inherent diverse cultural dispositions in terms of beliefs, attitudes and perceptions toward each other. The consequences of such beliefs, attitudes and perception of what they were taught in their training schools upon their practice life usually create a workplace relationship that is restive (Iles, 2014). Public pharmacists and indeed health care professionals need educational and training support to help unlearn the learnt 'bad' practices both in school and out of school. This will help to minimize the

unnecessary entropy that currently bedevil the health care system in Nigeria and enable their collective primary purpose of promoting, restoring and maintaining health of the citizenry.

Recommendations

The roles and responsibilities of public pharmacists in teamwork needs to be clearly defined as practiced in most advanced countries like the United States of America, and such definitions need to be clearly articulated to everyone in the health care team to avoid ambiguity. The understanding of these roles and responsibilities by all concerned would enable a better charting of territory for pharmacists in their workplace and enable the health care system to fully maximize and benefit from their expertise. There is need to train the health care professionals to imbibe the culture of teamwork. These can be driven by appropriate policy framework to institute the needed changes that would improve health care service delivery in Nigeria.

Recommendation for Future Research

The study involved public sector pharmacists working in the same facility. However, there is need to widen the scope of study to cover the six geopolitical zones of the country in order to get a broader perspective of the phenomenon; the perspective of the physicians concerning the subject matter could also be an area for study.

Conclusion

In conclusion, the study demonstrated that perceptions of public sector pharmacists about health care professionals impact their beliefs and attitudes toward teamwork. They perceive and believe that some factors negatively affect teamwork at their work place, while some factors promote teamwork. In order to improve health care services in Nigeria, which hitherto has been suboptimal, there is need to address those factors that have a negative influence, while those that promote teamwork should be strengthened.

References

Adams, M. L., & Blouin, R. A. (2017). The role of the pharmacist in health care: Expanding and evolving. *NC Medical Journal, 78*(3), 165-167. doi:10.18043/ncm.78.3.165

Al-Sawal, A. (2013). Leadership of health care professionals: Where do we stand? *Oman Medical Journal, 28*(4): 285-287. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3725246/#

American Pharmacists Association (APhA). (2017). The role of pharmacists in a changing health care environment. Retrieved from https://www.pharmacist.com/article/role-pharmacists-changing-health-care-environment

American Public Health Association. (2006). The role of the pharmacist in public health. APHA Policy 200614. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/07/13/05/the-role-of-the-pharmacist-in-public-health

Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: development and refinement of a codebook. Comprehensive Psychology, *3*, Article 4. https://doi.org/10.2466/03.CP.3.4

Anyan, F. (2013). The influence of power shifts in data collection and analysis stages: A focus on qualitative research interview. *The Qualitative Report, 18*(18), 1-9. Retrieved from http://www.nova.edu/sss/QR/index.html

Argyris, C., & Schön, D. (1974). *Theory in practice: Increasing professional effectiveness*. San Francisco, CA: Jossey-Bass. Retrieved from http://coastalcluster.curtin.edu.au/local/docs/Organisational/Argyris%20and%20Schon%

Argyris, C., & Schön, D. (1978). *Organizational learning: A theory of action perspective.* Reading, MA: Addison Wesley. Retrieved from https://searchworks.stanford.edu/view/998904

Astalin, P. K. (2013). Qualitative research designs: A concept framework. *International Journal of Social Science & Interdisciplinary Research, 2,* 118-124. Retrieved from http://indianresearchjournals.com

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405. Retrieved from https://utsc.utoronto.ca/~kmacd/IDSC10/Readings/text%20analysis/themes.pdf

Babiker, A., El Husseini, M., Al Nemri, A., Al Frayh, A., Al Juryyan, N., Faki, M. O., . . . Al Zamil, F. (2014). Health care professional development: Working as a team to improve patient care. *Sudanese Journal of Paediatrics, 14* (2), 9-16. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27493399

Bassili, J.N. (2008). Attitude strength. In W.D. Crano, & R. Prislin (Eds.), *Frontiers of Social Psychology. Attitudes and attitude change*, (pp. 237 - 260). New York, NY: Psychology Press. Retrieved from http://www.communicationcache.com/uploads/1/0/8/8/10887248/attitudes_and_attitude_change_-_book_2008.pdf

Bem, D. J. (1967). Self-perception: An alternative interpretation of cognitive dissonance phenomena. *Psychological Review, 74*(3), 183-200. https://doi.org/10.1037/h0024835

Bem, D. J. (1972). Self-perception theory. In: L. Berkowitz (Ed.). *Advances in Experimental Social Psychology*, Vol. 6 pp 1-62. https://doi.org/10.1016/S0065-2601(08)60024-6

Beveridge, I., Pannick, S., Sevdalis, N., Wachter, R. M. (2014). Improving the quality and safety of care on the medical ward: a review and synthesis of the evidence base. *European Journal of Internal Medicine, 25*(10), 874-887. doi:10.1016/j.ejim.2014.10.013

Birchall, J. (2014). Qualitative inquiry as a method to extract personal narratives: Approach to research organizational climate change mitigation. *The Qualitative Report, 19*(38), 1-18. Retrieved from http://www.nova.edu/ssss/QR/19/19_38.html

Bryant, R., Chaar, B., & Schneider, C. (2018). Differing clinical pharmacy service models: Quantitative and qualitative analysis of nurse perceptions of support from pharmacists. *International Journal of Nursing Studies, 86*, 96-98. doi:10.1016/j.ijnurstu.2018.04.003

Breza, E., Kaur, S., & Shamdasani, Y. (2016). The morale effects of pay inequality. *National Bureau of Economic Research*, Working Paper No. 22491. Retrieved from https://www.nber.org/papers/w22491.pdf

Breza, E., Kaur, S., & Shamdasani, Y. (2018). The morale effects of pay inequality. *The Quarterly Journal of Economics*, *133*(2), 611-663. https://doi.org/10.1093/qje/qjx041

Calvert, R. T. (1999). Clinical pharmacy: A hospital perspective. *British Journal of Clinical Pharmacology*, *47*(3), 231-238. doi: 10.1046/j.1365-2125.1999.00845.x

Chaiken, S., & Baldwin, M. W. (1981). Affective–cognitive consistency and the effect of salient behavioral information on the self-perception of attitudes. *Journal of Personality and Social Psychology, 41*(1),1–12.doi:10.1037/0022-3514.41.1.1

Chenail, R. J. (2011). Interviewing the investigator: Strategies for addressing instrumentation and researcher bias concerns in qualitative research. *The Qualitative Report*, *16*(1), 255-262. Retrieved fromhttps://nsuworks.nova.edu/tqr/vol16/iss1/16

Chapman, A. L. N., Johnson, D., & Kilner, K. (2014). Leadership styles used by senior medical leaders: Patterns, influences and implications of leadership development. *Leadership Health Services*, 27, 283-298. doi:10.1108/LHS-03-2014-0022

Cleary, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: Does size matter? *Journal of Advanced Nursing*, *70*, 473-475. https://doi.org/10.1111/jan.12163

Collins, C. S., & Cooper, J.E. (2014) Emotional intelligence and the qualitative researcher. *International Journal of Qualitative Methods 13*(1):88-103 doi 10.1177/160940691401300134

Cooke, R., & Sheeran, P. (2004). Moderation of cognition-intention and cognition-

behavior relations: a meta-analysis of properties of variables from the theory of planned behavior. *British Journal of Social Psychology, 43,* 159–186. doi: 10.1348/0144666041501688

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: SAGE. Retrieved from http://www.ceil-conicet.gov.ar/wp-content/uploads/2015/10/Creswell-Cap-10.pdf

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: SAGE. Retrieved from http://www.ceil-conicet.gov.ar/wp-content/uploads/2018/04/CRESWELLQualitative-Inquary-and-Research-Design-Creswell.pdf

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice, 39*(3), 124-130. https://doi.org/10.1207/s15430421tip3903_2

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research*. Thousand Oaks, CA: SAGE.

Cronin, C. (2014). Using case study research as a rigorous form of inquiry. *Nurse Researcher, 21*(5), 19-27. doi:10.7748/nr.21.5.19.e1240

Crosby, R., DiClemente, R., & Salazar, L. (2013). *Research methods in health promotion (Laureate Education, Inc., Custom Ed.*). San Francisco, Jossey-Bass.

Dalton, K., & Byrne, S. (2017). Role of the pharmacist in reducing health care costs: current insights. *Integrated Pharmacy Research and Practice*, *6*, 37–46. doi https://doi.org/10.2147/IPRP.S108047

Davies, D., & Dodd, J. (2012). Qualitative research and the question of rigor. *Qualitative Health Research*, *12*(2), 279-289. doi: 10.1177/104973230201200211

Davis, C. (2017). Teamwork and the patient care experience. *Nursing Made Incredibly Easy*, *15* (5), 4. doi: 10.1097/01.NME.0000521812.07765.11

de Savigny, D., & Adam, T. (2009). Systems thinking for health systems strengthening. Alliance for Health Policy and Systems Research, World Health Organization, Geneva. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/44204/9789241563895_eng.pdf;jsessionid=459ECE01E01748CA30E56D74BFF66259?sequence=1

Dóci, E., Stouten, J., & Hofmans, J. (2015). The cognitive-behavioral system of leadership: cognitive antecedents of active and passive leadership behaviors. *Frontiers in Psychology*, *6*, 1344. http://doi.org/10.3389/fpsyg.2015.01344

Dorji, K., Tejativaddhana, P., Siripornpibul, T., Cruickshank, M., & Briggs, D. (2019). Leadership and management competencies required for Bhutanese primary health care managers in reforming the district health system. *Journal of Health Care Leadership*, *11*, 13–21. doi:10.2147/JHL.S195751

Doucette, W.R., Nevins, J., & McDonough, R.P. (2005). Factors affecting collaborative care between pharmacists and physicians. *Research in Social and Administrative Pharmacy*, *1*(4):565-578. doi: 10.1016/j.sapharm.2005.09.005

Eagly, A.H., & Chaiken, S. (1993). The psychology of attitudes. FortWorth, TX: Harcourt Brace Jovanovich.

Fink, A. S. (2014). The role of the researcher in the qualitative research process. A potential barrier to archiving qualitative data. *Forum: Qualitative Social Research, 1*(3) Retrieved from https://search-proquestcom.contentproxy.phoenix.edu/docview/867756578? accountid=458

Fusch, P.I., & Ness, L. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, *20* (9), 1408-1416. Retrieved from https://www.researchgate.net/publication/282955844_Are_We_There_Yet_Data_Saturation_in_Qualitative_Research

Gary, G. & Kothari, C. R. (2014). *Research methodology: Methods and techniques* (3rd ed.). New Delhi: New Age International Publishers.

Glasman, L. R., & Albarracín, D. (2006). Forming attitudes that predict future behavior: a meta-analysis of the attitude-behavior relation. *Psychological Bulletin, 132*, 778–822. doi:10.1037/0033-2909.132.5.778

Gordon, L. J., Rees, C. E., Ker, J. S., & Cleland J. (2015). Dimensions, discourses and differences: trainees conceptualising health care leadership and followership. *Medical Education*, 49: 1248–1262. doi: 10.1111/medu.12832. Retrieved from

https://eds-a-ebscohost-com.ezp.waldenulibrary.org/eds/pdfviewer/pdfviewer?vid=19&sid=b705b0a9-f283-48e9-8aa1-6aa1bb28a06d%40sessionmgr4010

Grant, R.W., Finnocchio, L. J., & the California Primary Care Consortium Subcommittee on Interdisciplinary Collaboration. (1995). *Interdisciplinary collaborative teams in primary care: A model curriculum and resource guide*. San Francisco, CA: Pew Health Professions Commission, 1995. Retrieved from https://www.med.mun.ca/getdoc/5662c96a-7a26-4fcf-b19c-ccb806a5df44/Common-barriers-to-interprofessional-health care-te.aspx.

Grube, J. W., Mayton, II D. M., & Ball-Rokeach S. J. (1994). Inducing change in values, attitudes, and behaviors: Belief system theory and the method of value self-confrontation. *Journal of Social Issues*, *50*(4), 153-173. Retrieved from http://eds.b.ebscohost.com.ezp.waldenulibrary.org/eds/pdfviewer/pdfviewer?vid=1&sid=ca8da810-56e1-41b9-b714-7e946239948b%40sessionmgr103

Hall, P., & Weaver, L. (2001). Interdisciplinary education and teamwork: a long and winding road. *Medical Education 35*(9), 867–875. https://doi.org/10.1046/j.1365-2923.2001.00919.x

Harrison, R. L. (2013). Using mixed methods designs in the Journal of Business Research, 1990–2010. *Journal of Business Research*, *66*, 2153-2162. doi: 10.1016/j.jbusres.2012.01.006

Hickey, E. L., Dumke, E. K., Rollin L. Ballentine, R. L. & Brown, B. L. (2018). Prospective health students' perceptions of the pharmacist role in the

interprofessional team. *Journal of Interprofessional Care*, *32*(2), 250-253, doi: 10.1080/13561820.2017.1381671

Holden, L.M., Watts, D.D., & Walker, P.H. (2010). Communication and collaboration: it's about the pharmacists, as well as the physicians and nurses. *BMJ Quality & Safety, 19,* 169-172. training that focuses on specific interactions among professional groups should target these concerns. http://dx.doi.org/10.1136/qshc.2008.026435

Holland, R. W., Verplanken, B., & van Knippenberg, A. (2002). On the nature of attitude-behavior relations: the strong guide, the weak follow. *European Journal of Social Psychology 32*,869–876.doi:10.1002/ejsp.135

Houchens, G. W. & Keedy J. L. (2009). Theories of Practice: Understanding the Practice of Educational Leadership. *Journal of Thought, 44,* 49-61. Retrieved from http://www.journalofthought.com/Issues/2009vol44issue34pdf/09houchens&keedy.pdf

http://www.iacis.org/jcis/jcis.php

Hyett, N., Kenny, A., & Dickson-Swift, V. (2014). Methodology or method?: A critical review of qualitative case study reports. *International Journal of Qualitative Studies on Health and Well-Being*, 9. doi:10.3402/qhw. v9.23606

Ihuah, P. W. & Eaton, D. (2013). The pragmatic research approach: A framework for sustainable management of public housing estates in Nigeria. *Journal of US-China Public Administration*, *10* (10), 933-944.

Iles V. (2014). The challenges of leading professionals. *The International Journal of Leadership in Public Services 10*(1), 44-51. Retrieved from http://search.proquest.com.ezp.waldenulibrary.org/docview/1493446561?accountid=14872

Jeffs, L., Abramovich, I., Hayes, C., Smith, O., Tregunno, D., Chan, W., & Reeves, S. (2013). Implementing an interprofessional patient safety learning initiative: insights from participants, project leads and steering committee members. *BMJ Quality & Safety*, *22*, 923 – 930. doi: 10.1136/bmjqs-2012-001720.

Jenkins, C., & Price, F. (2014). Voices: The value of 6-month clinical evaluation in stroke. The protocol for a planned qualitative study to ascertain the value of stroke follow-up to people affected by stroke. *BMJ Open*, *4*(10), 1-5. doi:10.1136/bmjopen-2014-006384

Johnson, R. B., Onwuegbuzie, A. J., & Turner L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Method Research*, *1*(2), 112-133. Retrieved from http://journals.sagepub.com/doi/pdf/10.1177/1558689806298224

Kalb, K. A., & O'Conner-Von, S. (2012). Strategies in education: breaking down silos, building up teams. *Health Progress (Saint Louis, Mo.), 93*(3). Retrieved from https://www.chausa.org/docs/default-source/health-progress/strategies-in-education---breaking-down-silos-building-up-teams-pdf.pdf?sfvrsn=0

Khan, S. (2014). Qualitative research method: Phenomenology. *Asian Social Science, 10*, 298-310. doi:10.5539/ass.v10n21p298

Kothari, C. R. & Garg G. (2014). *Research methodology: Methods and techniques* (3rd ed.). New Delhi, India: New Age International Publishers. Retrieved from https://www.academia.edu/11829088/Research_methodology_methods_and_techniques_by_C_R.Kothari

Krosnick, J.A. (1988). The role of attitude importance in social evaluation: a study of policy preferences, presidential candidate evaluations, and voting behavior. *Journal of Personality and Social Psychology*, 55,196–210.doi:10.1037/0022-3514.55.2.196

Krosnick, J.A., & Petty, R.E. (1995). Attitude strength: an overview. In R. E. Petty, & J. A. Krosnick (Eds.), *Attitude strength: antecedents and consequences* (pp. 1-24). Hillsdale, NJ: Erlbaum.

Lekshmi, P., & Radhika, R. (2016). Competency management as a strategy for performance appraisal. *Journal of Chemical and Pharmaceutical Sciences*, *9*(4),1909–1912. Retrieved from https://www.jchps.com/issues/Volume%209_Issue%204/jchps%209(4)%2019%20Lekshmi%201909-1912.pdf

Love, J. H., & Roper, S. (2009). Organizing innovation: complementarities between cross-functional teams. *Technovation*, *29*(3), 192–203. https://doi.org/10.1016/j.technovation.2008.07.008

Maicibi, N. A. (2005). *Pertinent issues in management: human resource and educational management* 1st Edition. Kampala: Net Media Publishers, Kampala.

Makowsky, M. J., Schindel, T. J., Rosenthal, M., Campbell, K., Tsuvuki, R. T. & Madill H. H. (2009). Collaboration between pharmacists, physicians and nurse practitioners: a qualitative investigation of working relationships in the inpatient medical setting. *Journal of Interprofessional Care, 23*(2):169-184. doi: 10.1080/13561820802602552.

Marshall, R., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does sample size matter in qualitative research? A review of qualitative interviews in IS research. *Journal of Computer Information Systems*, *54*(1), 11-22. https://doi.org/10.1080/08874417.2013.11645667

McDonald, M., Brown, J., & Knihnitski, C. (2018). Student perception of initial transition into a nursing program: A mixed methods research study. *Nurse Education Today*, *64*, 85–92. Retrieved from https://ac-els-cdn-com.ezp.waldenulibrary.org/S0260691718300558/1-s2.0-S0260691718300558-main.pdf?_tid=173b0f2f-d783-4d6b-b8df-55a7943f193c&acdnat=1529821007_823ba0d7a6016aaf5c2b451e0a42ec6b

Mitchell, P. H., Wynia, M. K., Golden, R., McNellis, B., Okun, S., Webb, C. E., . . . Von Kohorn, I. (2012). Core principles &values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. Retrieved from https://nam.edu/wp-content/uploads/2015/06/VSRT-Team-Based-Care-Principles-Values.pdf

Morley, L., Cashell, A. (2017). Collaboration in health care. *Journal of Medical Imaging and Radiation Sciences, 48* (2), 207-216. doi: https://doi.org/10.1016/j.jmir.2017.02.071

Muchai, H.W., Makokha, E.N., & Namusonge, G. (2018). Effects of remuneration system on organizational performance of teachers' service commission, Kenya. *European Journal of Business and Management, 10* (11), 132-141. Retrieved from https://pdfs.semanticscholar.org/ae87/0adabf92c1266b9ad9b94f499ec994bbb040.pdf

National Center for Health Care Leadership. (2010). National center for health-care leadership competency model: NCHL. pp. 2005–2010. Available from: http://www.nchl.org/Documents/NavLink/Competency_Model-summary_uid31020101024281.pdf.

NDHS (2013). Nigeria Demographic and Health Survey 2013. Abuja, Nigeria. National Population Commission (NPC) [Nigeria] and ICF International. 2014., and Rockville, Maryland, USA: NPC and ICF International. Retrieved from https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf

Oandasan, I., Baker, G. R., Barker, K., Bosco, C., D'Amour, D., Jones, L., . . . Way, D. (2006). *Teamwork in health care: promoting effective teamwork in health care in Canada, policy synthesis and recommendations*. Canadian Health Services Research Foundation. Retrieved from

https://www.researchgate.net/publication/249940003_Teamwork_in_Healthcare_Promoting_Effective_Teamwork_in_Healthcare_in_Canada

O'Daniel, M., & Rosenstein, A. (2008). Professional communication and team collaboration. In: R. Hughes (Ed.), *Patient safety and quality: an evidence-based handbook for nurses* (pp. 1–14). Rockville, MD: Agency for Health Care Research and Quality (US). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2637/

Ojeleye, Y. C. (2017). The impact of remuneration on employees' performance: A study of Abdul Gusau Polytechnic, Talata-Mafara and State College of Education Maru, Zamfara State. *Arabian Journal of Business and Management Review (Nigerian Chapter), 4*(2): 34–43. doi:10.12816/0037554

Oliver, S., & Kandadi, K. R. (2006). How to develop knowledge culture in organizations? A multiple case study of large distributed organizations. *Journal of Knowledge Management*. *10*(4), 6–24. doi: 10.1108/13673270610679336

Olson, J. M., & Stone, J. (2005). The influence of behavior on attitudes. In D. Albarracín, B. T. Johnson, & M. P. Zanna (Eds.), *The handbook of attitudes* (223–271). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

O'Reilly, M., & Parker, N. (2013). 'Unsatisfactory Saturation': A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research, 13*(2), 190–197. https://doi.org/10.1177/1468794112446106

Osaro, E., & Charles. A. T. (2014). Harmony in health sector: a requirement for effective health care delivery in Nigeria. *Asian Pacific Journal of Tropical Medicine, 7* (Supplement 1), S1 – S5. https://doi.org/10.1016/S1995-7645(14)60196-6

Patel, H., Pettitt, M., & Wilson, J. R. (2012). Factors of collaborative working: a framework for a collaboration model. *Applied Ergonomics, 43*(1), 1–26. https://doi.org/10.1016/j.apergo.2011.04.009

Patton, M. Q. (2015). *Qualitative research and evaluation methods: integrating theory and practice* (4th ed.). Thousand Oaks, CA: SAGE. Retrieved from https://trove.nla.gov.au/work/191834029

Poulis, K., Poulis, E., & Plakoyiannaki, E. (2013). The role of context in case study selection: an international business perspective. *International Business Review, 22*, 304-314. doi:10.10.1016/jibusrev.2012.04.003

Peredaryenko, M. S., & Krauss, S. E. (2013). Calibrating the human instrument: understanding the interviewing experience of novice qualitative researchers. *The Qualitative Report, 18*(43), 1-17. Retrieved from http://nsuworks.nova.edu/tqr.

Ritchie, J., Lewis, J., Nicholls, C. N., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. Thousand Oaks, CA: SAGE. doi:10.12759/hsr.29.2004.3.171-191

Robinson, O. (2014). Sampling in interview-based qualitative research: a theoretical and practical guide. *Research in Psychology*, 11(1), 25-41. doi:10.1080/14780887.2013.801543

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation* (4th ed.). A

comprehensive guide to content and process. SAGE Publication, Inc.

Schleicher, D. J., Smith, T. A., Casper, W. J., Watt, J. D., & Greguras, G. J. (2015). It's all in the attitude: the role of job attitude strength in job attitude– outcome relationships. *Journal of Applied Psychology, 100*, 1259–1274. doi: 10.1037/a0038664

Schmitt, M, Blue, A., Aschenbrener C. A., & Viggiano T. R. (2011). Core competencies for interprofessional collaborative practice: reforming health care by transforming health professional's education. *Academic Medicine 86*(11): 1351. doi: 10.1097/ACM.0b013e3182308e39

Sparkes, A. C. (2014). Developing mixed methods research in sport and exercise psychology: critical reflections on five points of controversy. *Psychology of Sport and Exercise, 16,* 49-58. doi:10.1016/j.psychsport.2014.08.014

Stowasser, D.A., Allinson, Y. M., & O'Leary, M. (2004). Understanding the medicines management pathway. *Journal of Pharmacy Practice and Research, 34*(4): 293-296. https://doi.org/10.1002/jppr2004344293

Sullivan, T. J. (1998). *Collaboration: a health care imperative* (pp. 646). New York: McGraw-Hill.

Tashakkori, A. & Teddlie, C. (2010). *Handbook of mixed methods in social & behavioral research* (2nd ed). Thousand Oaks: SAGE. doi: https://dx.doi.org/10.4135/9781506335193

The Interprofessional Education Collaborative (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington,

DC. Retrieved from https://www.aacom.org/docs/default-source/insideome/ccrpt05-10-11.pdf?sfvrsn=77937f97_2

Tseng, H. W., & Yeh, H. T. (2013). Team members' perceptions of online teamwork learning experiences and building teamwork trust: A qualitative study. *Computers & Education, 63,* 1-9. doi:10.1016/j.compedu.2012.11.013

Turner, D. W. (2010). Qualitative interview design*:* A practical guide for novice investigators. *The Qualitative Report, 15*(3) 754-760. Retrieved from: http://www.nova.edu/ssss/QR/QR15-3/qid.pdf

Uprichard, E. (2013). Sampling: Bridging probability and nonprobability designs. *International Journal of Social Research Methodology, 16* (1), 1-11. https://doi.org/10.1080/13645579.2011.633391

Venkatesh, V., Brown, S. A., & Bala, H. (2013). Bridging the qualitative-quantitative divide: Guidelines for conducting mixed methods research in information systems. *Management Information Systems Quarterly, 37*(1), 21-54. Retrieved from https://arizona.pure.elsevier.com/en/publications/bridging-the-qualitative-quantitative-divide-guidelines-for-condu

Vriesendorp S., Shukla, M., Lassner, K. J., de la Peza, L., Giorgis, B., Seltzer, J. B., . . . Buxbaum, A. (2010). Health systems in action: An eHandbook for leaders and managers. Cambridge, MA: Management Sciences for Health. https://www.msh.org/resources/health-systems-in-action-an-ehandbook-for-leaders-and-managers

World Health Organization (WHO). (2012). Being an effective team player. Retrieved from http://www.who.int/patientsafety/education/curriculum/who_mc_topic-4.pdf.

World Health Organization (2000). The World Health Report 2000. Retrieved from http://www.who.int/whr/2000/en/whr00_en.pdf

Yin, R. K. (2014). *Case study research design and methods* (5th ed.). Thousand Oaks, CA: SAGE.

Ziegler, R., & Schlett, C. (2016). An attitude strength and self-perception framework regarding the bi-directional relationship of job satisfaction with extra-role and in-role behavior: the doubly moderating role of work centrality. *Frontiers in Psychology*, *7*, 235. http://doi.org/10.3389/fpsyg.2016.0023.

Appendix A: Recruitment Flyer

The perception of Public Sector Pharmacists As it relates to their Beliefs and Attitudes that promote Teamwork

Volunteers Needed for Research Study

Research Study: Public Sector Pharmacists' Perception of Teamwork

Purpose: Public Sector Pharmacists Perception of Beliefs and Attitudes that Promote Teamwork.

Location: The study will take place in Abuja, Nigeria.

Eligibility: Participants must be currently practicing public sector pharmacists living in Abuja and over five years post NYSC working experience**,** be 28 years of age and above**,** and had worked or is working in a team of not less than 10 member-workforce.

Time of commitment from participants: 30 – 45 minutes.

Incentive provided: No incentive provision.

Contact Information
Name: Elijah Mohammed
Telephone: +2348038073595
Email: nae7mohammed@gmail.com; Elijah.mohammed@waldenu.edu

Interested persons please fill out your information below and place this form in one of the envelopes attached and give to the office clerk. The forms will be collected by (date to be specified). All interested persons will be contacted by (date to be specified)

Name: …….

Date: …….

Telephone No: …… **Suitable time to contact** ……

Appendix B: Questionnaire

Demographic Questions

Age: < 30 years ….. < 40 years….. < 50 years…..

Sex: Male….. Female……

Education:

BPharm…… MSc/Mpharm…….. FPCPharm…… PhD…….

Years of Graduation:

0 – 10 years….. 11 – 20 years..... 20 – 30 years….. > 30 years…….

Evaluations of public pharmacists' perceptions regarding teamwork in the workplace

How strongly do you agree or disagree with the following statements?	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
	1	**2**	**3**	**4**	**5**
1. I am a team player					
2. I am comfortable participating in teamwork					
3. Health care professionals working as a team is in the public interest					
4. My workplace support teamwork					
5. My colleagues and I do share similar ideas about teamwork					
6. Individual's expertise is appreciated and valued by team members					
7. My colleagues are willing to cooperate on new practices					
8. My contributions to the overall success of the organization is appreciated					
9. Opportunities to learn new skills through formal training are abound at my workplace?					

10. The sharing of controlled acts provides opportunities to promote teamwork at workplace.					
11. My colleagues' attitudes are usually overwhelming at my workplace					
12. Do you feel that working as a team has positively affected the patients/clients at your workplace?					
13. My immediate colleagues understand the roles and responsibilities of all team members					
14. My workplace helps to promote teamwork by bring all new health care professionals together at one-stop orientation					
15. There are 'turf' areas that are no-go-area by some members of the team					
16. Do you feel that education and training of team members play a role in promoting teamwork?					
17. Do you feel that professional regulatory bodies facilitate teamwork?					
18. Do you feel that management actions or inactions promote teamwork at your workplace?					
19. Do you feel that your remuneration reflects your worth to the teamwork and by extension the organization?					

Appendix C: Focus Group Questions

Engagement Question: Please tell me about your experience working with other health care professionals in your workplace

Exploration Questions: 1. What factors impede or enable your ability to promote teamwork in health care practices in your workplace?

2. What are your expectations from other health care professionals in your workplace that could promote teamwork?
3. What are the intrinsic values in you that could promote teamwork in your workplace?

Exit Question: Is there anything else you would like to say about teamwork?

Appendix D: Consent Form for Completion of Questionnaire

You are invited to complete a questionnaire on a research study on the public sector pharmacists' perception of their beliefs and attitudes that promote teamwork. The purpose of the study is to identify the lived experiences of pharmacists in public hospital and factors that influence their perceptions about teamwork in their practice environment. This study is being conducted for my dissertation toward the award of PhD in Public Health Policy of Walden University.

The title of the study is: *Perceptions of Public Sector Pharmacists Regarding their Beliefs and Attitudes Towards Teamwork*

The researcher is inviting pharmacists above the age of 30 years, working in the public sector, with an understanding about teamwork in their practice environment and have over five years post-National Youth Service Corps (NYSC) working experience. This form is part of a process called informed consent to allow you to understand this study before deciding whether to take part or otherwise.

Elijah Mohammed who is a doctoral student at Walden University is conducting this study.

There is no government or organization involvement in this private study.

Procedures:

If you agree to be in this study, you will be asked to:

- Meet with the researcher on an agreed date and time for about 30 minutes to complete a questionnaire.
- Answer questions about your perceptions and knowledge on teamwork, by completing

a questionnaire.

Voluntary Nature of the Study:

This is a voluntary study and you are free to accept or turn down the invitation. The study does not involve government and thus no government official at any level will treat you differently if you decide not to be in the study. You are free to decline answering any question raised in the questionnaire. You are also allowed to pull out of the study at any level if you decide to change your mind concerning the study. This implies you may stop at any time.

Those who are pregnant, elderly or individuals who are in crisis (victims of natural disaster or persons with acute illness) may decline to participate in the study.

Risks and Benefits of Being in the Study:

This study like any other study involve some risk of minor discomforts that are usually part of our daily life. These include stress, becoming upset and giving up some precious time.

However, being in this study would not put your wellbeing or safety at any risk.

Information generated from this study will be shared with public health professionals and policy makers. Such information will guide policy makers to understand the beliefs and attitudes of health care workers that promote teamwork and make decisions that will help improve health outcomes in the country.

Addressing factors that promote or impede the ability of health workers to adopt and practice teamwork in health care service delivery in their workplaces will reduce the

rancor and unnecessary entropy that concurrently bedevil the health care system in Nigeria.

Payment:

There is no financial reward attached to this study.

Privacy:

The identities of individual participants and the location of the study will not be shared as part of the reports coming out of this study. The personal information gathered in the study will not be used for any purpose outside of this research project. The security of the data will be maintained by using codes to identify participants instead of names. The transcripts will be kept in files coded by numbers and the data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

The researcher can be contacted now for any question. However, further questions can be asked via telephone number +2348038073595. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 1- 612-312-1210. Walden University's approval number for this study is 01-23-19-0358776 and it expires on January 22, 2020.

The researcher will give you a copy of this form to keep.

Obtaining Your Consent

If you feel you understand the study well enough to decide on it, please indicate your consent by signing below.

Name of Participant …….

Date of Consent …….

Participant's Signature …….

Researcher's Signature …….

Appendix E: Consent Form for Focus Group Discussion

You are invited to participate in a focus group discussion as part of a research study on the public sector pharmacists' perception of their beliefs and attitudes that promote teamwork. The purpose of the study is to identify the lived experiences of pharmacists in public hospital and factors that influence their perceptions about teamwork in their practice environment. This study is being conducted for my dissertation for the award of PhD in Public Health Policy of Walden University.

The title of the study is: *Perceptions of Public Sector Pharmacists Regarding Their Beliefs and Attitudes Towards Teamwork.*

The researcher is inviting pharmacists of 28 years of age and above, working in the public sector, with an understanding about teamwork in their practice environment and have over five years post-National Youth Service Corps (NYSC) working experience. This form is part of a process called informed consent to allow you to understand this study before deciding whether to take part or otherwise. **You are eligible to participate in the focus group discussion if you have completed the questionnaire, and are willing to participate in the discussion.**

Elijah Mohammed who is a doctoral student at Walden University is conducting this study and will also moderate the focus group discussion. There is no government or organization involvement in this private study.

Procedure:

As part of this study, you will be placed in a group of 4 individuals. Several questions would be put forward to the group by the researcher who will also facilitate the

discussion. This focus group discussion will be audio-recorded and it will be complemented with a notetaking process.

If you agree to be in this study, you will be asked to:

- Meet with the researcher on an agreed date and time for about 60 minutes for the focus group discussion, which will be recorded.
- Discuss and answer questions about your perceptions and knowledge of teamwork.
- Participate in a follow-up meeting later for about 15 minutes to review the study outcomes and evaluate researcher's interpretation to confirm validity.

Voluntary Nature of the Study:

This is a voluntary study and you are free to accept or turn down the invitation. The study does not involve government and thus no government official at any level will treat you differently if you decide not to participate. You are allowed to pull out of the study at any level if you decide to change your mind concerning the study. This implies you may stop at any time. Please note that there are no right or wrong answers to focus group questions. The researcher is interested to hear the many varying viewpoints and would like everyone to contribute their individual thoughts. Out of respect, please refrain from interrupting others. However, feel free to be honest even when your responses counter those of other group members. You are also free to decline answering any question raised during the discussion.

Those who are pregnant, elderly or individuals who are in crisis (victims of natural disaster or persons with acute illness) may decline to participate in the study.

Risks and Benefits of Being in the Study:

This study like any other study involves some risk of minor discomforts that are usually part of our daily life. These include stress, becoming upset and giving up some precious time.

However, being in this study would not put your wellbeing or safety at any risk. Information generated from this study will be shared with public health professionals and policy makers. Identifying factors that encourage or impede the ability of health workers to promote teamwork in health care practice in their workplaces will provide information that will guide policy makers to understand the beliefs and attitudes of health care workers that promote teamwork and subsequently make decisions that will help improve health outcomes in the country.

Payment:

There is no financial reward attached to this study.

Privacy:

The identities of individual participants and the location of the study will not be shared as part of the reports coming out of this study. The personal information gathered in the study will not be used for any purpose outside of this research project. The security of the data will be maintained by using codes to identify participants instead of names. Participants should keep all deliberations during the focus group discussion confidential. The transcripts will be kept in files coded by numbers and the data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

The researcher can be contacted now for any question. However, further questions can be asked via telephone number +2348038073595. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 1- 612-312-1210. Walden University's approval number for this study is 01-23-19-0358776 and it expires on January 22, 2020.

The researcher will give you a copy of this consent form to keep.

Obtaining Your Consent

If you feel you understand the study well enough to decide on it, please indicate your consent by signing below.

Name of Group Participant …….

Date of Consent …….

Group Participant's Signature …….

Researcher's Signature …….

Appendix F: Request for Approval to Conduct Research at National Hospital Abuja

November 30, 2018
The Chairman,
Institute Review Board,
National Hospital,
Abuja.

APPLICATION FOR ETHICAL CLEARANCE TO CONDUCT RESEARCH STUDY

I am writing to request permission to conduct a research study at your institution, specifically the pharmacy department. I am currently enrolled in the Doctor of Philosophy online program at Walden University, Baltimore, United States of America, and am in the process of writing my Doctorate Thesis. The study is entitled ***The Perception of Public Sector Pharmacists As it relates to their Beliefs and Attitudes that Promote Teamwork***.

I hope that you will allow me to recruit 12 number of Pharmacists from the hospital to anonymously complete a 1-page questionnaire (copy enclosed, Appendix A) and take part in a focus group discussion. Interested pharmacists, who volunteer to participate, will be given a consent form to be signed (copy enclosed, Appendix B) and returned to the primary researcher at the beginning of the survey process.

If approval is granted, pharmacist participants will complete the survey in a seminar room or other quiet setting on the hospital site. This will be conducted after office hours and I wish to also seek your permission for use of this time. The survey process should take no longer than one hour. The survey results will be pooled for the thesis project and individual results of this study will remain absolutely confidential and anonymous. Should this study be published, only pooled results will be documented. No costs will be incurred by either your institution or the individual participants.

Your approval to conduct this study will be greatly appreciated. I will follow up with a telephone call next week and would be happy to answer any questions or concerns that you may have at that time. You may contact me at my email address: elijah.mohammed@waldenu.edu or nae7mohammed@gmail.com.

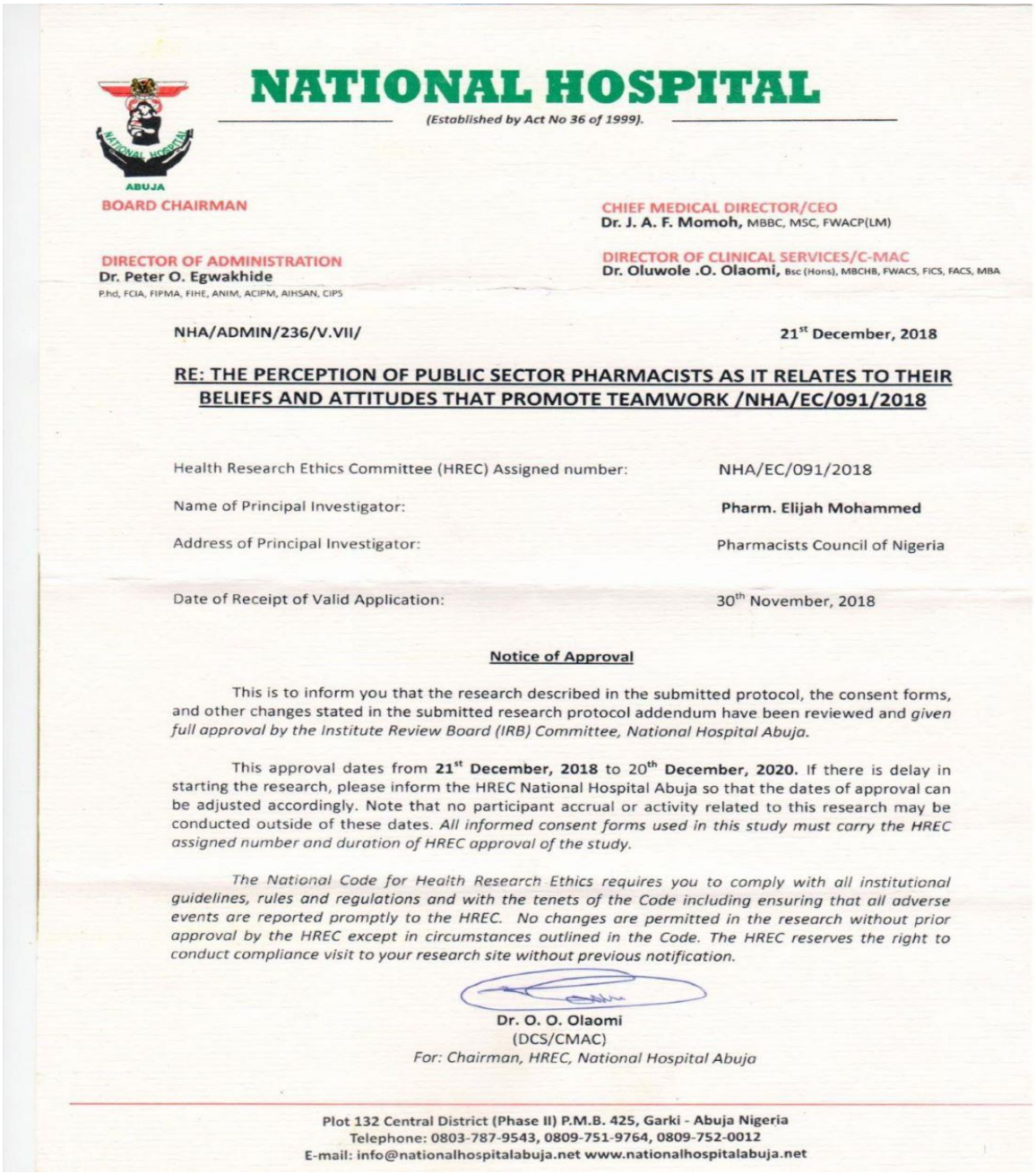
If you agree, kindly issue a letter of cooperation acknowledging your consent and permission for me to conduct this study at your institution.

Yours Sincerely,

Elijah Mohammed

Campus: Walden University
Student ID: A00358776
College: Health Science
Department: Health Sciences
Concentration: Public Health Policy

Appendix G: Approval by Institute Review Board Committee National Hospital Abuja



NATIONAL HOSPITAL

(Established by Act No 36 of 1999).

ABUJA

BOARD CHAIRMAN

CHIEF MEDICAL DIRECTOR/CEO
Dr. J. A. F. Momoh, MBBC, MSC, FWACP(LM)

DIRECTOR OF ADMINISTRATION
Dr. Peter O. Egwakhide
P.hd, FCIA, FIPMA, FIHE, ANIM, ACIPM, AIHSAN, CIPS

DIRECTOR OF CLINICAL SERVICES/C-MAC
Dr. Oluwole .O. Olaomi, Bsc (Hons), MBCHB, FWACS, FICS, FACS, MBA

NHA/ADMIN/236/V.VII/ **21st December, 2018**

RE: THE PERCEPTION OF PUBLIC SECTOR PHARMACISTS AS IT RELATES TO THEIR BELIEFS AND ATTITUDES THAT PROMOTE TEAMWORK /NHA/EC/091/2018

Health Research Ethics Committee (HREC) Assigned number:	NHA/EC/091/2018
Name of Principal Investigator:	**Pharm. Elijah Mohammed**
Address of Principal Investigator:	Pharmacists Council of Nigeria
Date of Receipt of Valid Application:	30th November, 2018

Notice of Approval

This is to inform you that the research described in the submitted protocol, the consent forms, and other changes stated in the submitted research protocol addendum have been reviewed and *given full approval by the Institute Review Board (IRB) Committee, National Hospital Abuja.*

This approval dates from **21st December, 2018** to 20th **December, 2020.** If there is delay in starting the research, please inform the HREC National Hospital Abuja so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study.*

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit to your research site without previous notification.

Dr. O. O. Olaomi
(DCS/CMAC)
For: Chairman, HREC, National Hospital Abuja

Plot 132 Central District (Phase II) P.M.B. 425, Garki - Abuja Nigeria
Telephone: 0803-787-9543, 0809-751-9764, 0809-752-0012
E-mail: info@nationalhospitalabuja.net www.nationalhospitalabuja.net