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Customer Incivility, Person-Organization Fit and Psychological Well-Being in Healthcare: Does Ethical Leadership Matter?

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Abstract

Purpose - Drawing on expectancy violations theory (EVT), this study aims to identify a linking mechanism and a boundary condition of the association between customer incivility (CI) and employees' psychological well-being in healthcare organizations. Specifically, the study examines the mediating role of person-organization fit (PO fit) on the CI-psychological well-being link, and the moderating role of ethical leadership on this mediated relationship.

Design/Methodology/Approach - Time-lagged data was collected from 345 nurses working under 33 supervisors in a district-level public hospital in Malaysia, and generalized multilevel structural equation modelling (GMSEM) in STATA was used to test the proposed moderated mediation model.

Findings – The results showed that CI impaired nurses' psychological well-being by reducing their sense of fit with the organization. Moreover, when ethical leadership was high, this negative relationship between CI and well-being via PO fit disappeared.

Practical Implications – Given the negative effect of customer incivility on nurses' PO fit and psychological well-being, healthcare organizations need to take proactive steps to reduce the occurrence of incivility and protect employees. Nurturing ethical leadership could also be beneficial and will help satisfy employees' expectations about organizational care and dignity at work. This, in turn, will restore employees' sense of congruence with their organizations and promote well-being.

Originality/value - The study introduces EVT as a new lens to analyse the association between CI and well-being. It also extends the CI literature by establishing PO fit as a linking mechanism

of the CI-well-being association. Additionally, by identifying the role ethical leaders can play in reducing the negative effect of CI, the study addresses calls for research on the moderators that attenuate the harmful effect of CI on employee well-being.

Keywords Customer incivility; Ethical leadership; Person-organization (PO) fit; Psychological well-being; Expectancy violations theory.

Paper type Research paper

Introduction

In the last few years, customer incivility has resulted in increased costs and detrimental effects to service organisations (Vasconcelos, 2020; Mostafa, 2022). Customer incivility is conceptualized as low-quality interpersonal treatment employees receive from their customers with an ambiguous intent to harm (Guidroz *et al.*, 2010), and can include behaviors, such as customer s' condescending comments, verbal attacks or undue demands (Sliter *et al.*, 2010; van Jaarsveld *et al.*, 2010). Mistreatment from customers is endemic in service organizations including healthcare settings, which constitute the context for this research. Within the healthcare context, customers are the patients and their visitors. Therefore, customer incivility (henceforth CI) in the current study refers to mistreatment perpetrated by patients and their visitors upon healthcare staff during service interactions.

Customer incivility in the healthcare sector has been an increasingly concerning issue internationally (Guppy *et al.*, 2024; Freedman *et al.*, 2024). Extant research in this regard has highlighted many negative implications of incivility for the well-being of the healthcare staff, such as poor mental health, disengagement from work, emotional exhaustion and burnout (Guppy *et al.*, 2024). Despite this, there have been relatively few attempts to assess the processes

that underpin the association between incivility and its consequences on healthcare professionals (Mostafa, 2022). This study adds to the incivility research in healthcare by analyzing nurses' experience of CI and its association with their well-being. CI is a daily hassle that nurses experience as being "part of the job" (Yragui *et al.*, 2017). According to an estimate on incivility, approximately 9 out of 10 nurses are seen to experience abuse at work (Winstanley and Whittington, 2002) and have identified their patients as the main perpetrators of this abuse (Farrell *et al.*, 2006). Since healthcare organizations cannot impose sanctions on customers through workplace mistreatment policies to limit uncivil behaviors (Wilson and Holmvall, 2013), typically such unpleasant customer interactions increase emotional work demands (van Jaarsveld *et al.*, 2010), which compromise nurses' well-being (Farrell *et al.*, 2006; Sommovigo *et al.*, 2022). This study focuses on psychological well-being, which can be defined as the general state of an employee's experience and functioning at work (Warr, 1987). We operationalize psychological well-being as employees' work-related general well-being.

Customers' uncivil behavior negatively violates employees' expectations regarding the established norms of social interactions and mutual respect in service encounters. Therefore, this study draws on expectancy violations theory (EVT; Burgoon and Hale, 1988) to identify a linking mechanism and a boundary condition of the association between CI and psychological well-being. EVT postulates that individuals have shared expectations (i.e., expectancies) in interpersonal interactions based on prevailing cognitions about the anticipated behavior from different stakeholders involved in a given situation (Burgoon and Hale, 1988). Individuals interpret social interactions through violations of "expectancies", which can be both positive or negative (i.e., violation valence), and the extent to which they deem it rewarding to interact with the instigator of the violation (i.e., communicator reward valence). Unmet or negatively valenced

expectancies instil negative outcomes, while expectancy confirmations promote positive outcomes, such as well-being.

Firstly, we examine the mediating role of person-organization fit (PO fit) in the CI-well-being link. Kristof (1996) defines PO fit as the compatibility between employees and organizations when they share similar characteristics. PO fit is largely influenced by employees' relationship with an organization's different affiliates, including customers (Anaza, 2015). Drawing on EVT, we propose that CI is associated with reduced PO fit because abuse by customers not only negatively violates employees' expectancies about dignified service interactions, but also contravenes organizational support towards employee welfare and sufficient professional care against mistreatment at work (Wen *et al.*, 2016). The more recurrent the mistreatment, the more likely it is that service employees question their organization's capacity and value system to create a decent and healthy work environment governed by clear social rules. This expectancy violation undermines employees' belief that they share the same social values with the organization, thereby rendering them as "outsiders" in the organization (Ouyang *et al.*, 2015). The reduced level of PO fit, in turn, would compromise employees' perceived well-being, as the loss of shared value congruence resulting from the negatively violated expectations would impair their sense of worth, esteem and psychological safety at work (Biswas and Bhatnagar, 2013).

Secondly, we examine ethical leadership as a moderator of the relationship between CI and PO fit and consequently employee well-being. Leaders are crucial for implementing organizational values and their behavior determines employees' expectations from the organization (McDermott *et al.*, 2013). Ethical leaders, in particular, embody the moral standards and values of organizations (De Hoogh and Den Hartog, 2008). The focus of ethical leaders on

upholding social rules and dignity in working relationships fulfils service employees' expectations about organizational care, the appropriate and moral leader behaviour in interpersonal interactions, and establishes them as "rewarding and valenced" representatives of the organization. This, consistent with EVT, should satisfy shared expectations between leaders and their subordinates regarding the appropriate conduct in personal interactions and managements' moral duty at work, which, in turn, should attenuate individual-organizational value incongruence resulting from customers' immoral conduct to improve service employees' sense of well-being.

The proposed relationships are tested using data from Malaysia. Malaysia's nurse-to-population ratio is 3.4:1000 population (World Bank, n.d.), which is much lower than the OECD average of 9.2:1000 (OECD 2024). The situation is worrying as the public healthcare sector struggles with high resignation rates and the inability to retain experienced nurses, and a 60% shortage is projected by 2030 (Rozali, 2025). Incivility has been identified as one of the key challenges faced by public healthcare workers in Malaysia (Khalid, 2024); and has contributed to poor well-being among nurses (The Star, 2023). Therefore, the urge to support nurses' well-being in the public healthcare sector, thereby sustaining them in the workforce, has become a critical issue in Malaysia.

Our study makes several contributions to existing research. Firstly, we provide a new theoretical lens to delineate the association between CI and employee well-being. Prior research has overlooked the role of negative and positive "expectancy violations" in interpersonal workplace interactions, which are vital factors affecting employee well-being in organizations (Mostafa *et al.*, 2023). Accordingly, this study draws on EVT as an overarching framework, which serves as a new angle to understand the CI-well-being association. EVT has been

previously used in healthcare research to explain patient-provider interactions and patient-treatment expectations (Dean *et al.*, 2019; Buchholz *et al.*, 2022; Cockle and Ogden, 2022; Bute *et al.*, 2024). However, it has seldom been used to understand how healthcare professionals' interactions with key stakeholders, such as customers and leaders, are related to well-being at work (Mostafa *et al.*, 2023). Second, by examining the mediating role of PO fit, the study provides a better understanding of "why" CI relates to employees' sense of impaired well-being. Most of the extant literature has shown that positive work environment factors, such as HRM practices and positive leadership styles, can shape individuals' sense of compatibility with their organization and its values (Mostafa, 2016; Raja *et al.*, 2018). Nevertheless, the link between negative factors in the work environment, such as recurrent mistreatment by customers, and PO fit remains elusive. Additionally, previous research seems to have overlooked PO fit as a potential mechanism of the relationship between CI and employee well-being. By understanding the CI-well-being link from the angle of "perception of congruent values with the organization", this study provides a novel account of the consequences of CI and its link to well-being. In so doing, it establishes CI as one of the antecedents of PO fit in healthcare organizations. Thirdly, by examining the moderating role of ethical leadership, the study identifies "how" service organizations may ameliorate the consequences of CI, and answers calls for research on the moderators that attenuate the harmful effects of CI on employee well-being (e.g., Baker and Kim, 2020). Although scholars have started to examine how leadership styles, such as transformational or servant leadership, could attenuate the negative effects of workplace incivility (Arnold and Walsh, 2015; Mostafa, 2022), research has not yet considered ethical leadership as a possible moderator of customer incivility. Ethical leadership is different from other leadership styles because, rather than being concerned with inspiring followers as in

transformational leadership or serving stakeholders as in servant leadership, it explicitly focuses on ethics and compliance with normative standards and expectations (Lemoine *et al.*, 2019). By examining its role in the CI-PO fit-well-being nexus, this study adds to the limited number of studies that have identified a positive factor, such as leadership behaviors, that could diminish the negative effects of CI on employee well-being (e.g., Arnold and Walsh, 2015; Jang *et al.*, 2020). The choice of ethical leadership as a moderator of CI is meaningful as adherence to ethics and moral duty at work are central to healthcare organizations (Mostafa and Abed El-Motalib, 2020), and this style of leadership epitomizes ethics and moral values at work (Brown *et al.*, 2005), which CI violates. Therefore, it is expected that by enacting honesty, fairness, integrity, and respectfulness in working relationships, ethical leaders would buttress PO fit perceptions in healthcare organizations and help mitigate the adverse influence of CI on the well-being of service staff.

Theoretical framework

Customer incivility, PO fit and psychological well-being

The adverse influence of negative customer-employee interactions for employee well-being is well documented (see Wilson and Holmvall, 2013). Yet, little is known about the psychological mechanisms responsible for this relationship (Baranik *et al.*, 2017). We propose that perceived PO fit may be one such mechanism in service organizations. Conceptually, ‘fit’ between the person and the organization can be categorized as ‘complementary’ as well as ‘supplementary’. Complementary fit occurs when an individual’s characteristics add something that is missing to the organization, while supplementary fit is achieved when an employee’s characteristics align to those of the organization and its employees (Kristof, 1996). We conceptualize PO fit as

supplementary fit because this study considers the extent of "expected" congruence between organizational and employee values in achieving employee well-being.

In line with EVT, we argue that CI leads to reduced levels of PO fit and consequently reduced well-being. Customers are amongst an organization's important affiliates particularly in service settings, such as hospitals (Anaza, 2015). Due to the conceived nature of the customer-provider relationship in such settings, customers enjoy a superior social position in service encounters (Wilson and Holmvall, 2013). Particularly, in hospitals, fulfilling customer needs is the over-arching goal of the healthcare service delivery. Yet, despite this, the inward-focused tendencies of customers induce expectations that sometimes contradict the established norms of conduct in patient-nurse interactions. Violations of the established rules in interpersonal interactions in service settings are known to undermine the appropriateness of social conduct and instil discontent (Mostafa *et al.*, 2021).

From an EVT perspective, employees expect civility in verbal and non-verbal communication from their customers and mutual respect in service encounters. When the customer-employee interaction slips off its anticipated balance of civility, it can be construed as a type of social "rule breaking behaviour" (Mostafa *et al.*, 2021, p. 359), which negatively violates employees' normative expectations in interpersonal conduct. Therefore, according to EVT, employees experiencing CI in hospitals will perceive negative expectancy violations in the service exchange relationship with their customers.

In addition, equally importantly, CI signals low organizational support towards employee welfare (Wen *et al.*, 2016). Service employees hold expectations about their organizations' obligations towards them, such as upholding social rules of dignity in the workplace, opportunity for fair interpersonal interactions, and safeguarding their well-being (Mostafa *et al.*, 2023).

Enactment of incivility by customers negates social and professional dignity at work, respectful social interactions, and signifies a negatively violated expectation of an organization's care for its employees. Employees who experience incivility continually may blame their organization for its incomplete social rules and standards, lax implementation, and reduce their trust in and commitment to the organization (Guo and Qiu, 2019; Hodgins *et al.*, 2014). Consequently, such employees are more likely to view themselves as "outsiders" rather than "insiders" of the organization (Ouyang *et al.*, 2015), which, in turn, lowers their sense of cohesion and compatibility with the organization. Overall, CI devalues and challenges service employees professionally by violating their social expectations recurrently, which impends their sense of self-esteem, and consequently compatibility with their organization (Park and Kim, 2020). This is evidenced by research that has shown that positive relations between employees and organizations' affiliates, including customers, make employees' personally and psychologically more connected to the organization (Anaza, 2015). Therefore, poor customer-employee relations resulting from CI are more likely to reduce employees' attraction, affiliation, and perception of congruence with their organization.

Theoretical insights from the PO fit literature suggest that PO fit is related to increased well-being because it inculcates a sense of belongingness amongst employees, which heightens their sense of psychological safety (Biswas and Bhatnagar, 2013). High PO fit levels indicate an agreement between organizational and employee characteristics and values (Kristof-Brown *et al.*, 2005; Kristof, 1996). From an EVT perspective, this is a positively valenced conformity (i.e., expectancy confirmation) because individuals expect congruence between them and their organizations' values. This positively valenced agreement makes it easier for employees to affiliate at work and communicate with other organizational employees, and receive appropriate

support, which fosters a sense of well-being (Edwards and Cooper, 1990; Mostafa, 2016). Likewise, employees with high PO fit understand expectations and desired behaviors at work and make required work adjustments. This enhances the likelihood of attainment of work and personal goals for individuals, which improves well-being (Mostafa, 2016). Therefore, following the tenets of EVT, we argue that service employees who experience incivility from customers are likely to develop a lack of congruence with organizational values (lower PO fit), which in turn compromises their sense of well-being.

Hypothesis 1: *PO fit mediates the relationship between CI and psychological well-being.*

The moderating role of ethical leadership

We draw on EVT to argue that ethical leadership will weaken the negative association between CI and PO fit. EVT states that interpersonal interactions, which confirm individuals' expectations and are initiated by individuals holding high communicator reward valence, produce positive effects. Leaders in service organizations are considered "valenced" organizational representatives who embody and institutionalize organizations' values and develop employees' cognition about expectations of their role, specifically in situations involving dysfunctional behaviors (e.g., mistreatment by customers) (Mostafa *et al.*, 2023; Mostafa, 2022). Ethical leaders, in particular, are likely to complement the needs and expectations of service employees and remind them that their core values about service to others are meaningful and consistent with their organization's values, and that their personal interests are less important than upholding these values, even when it requires personal sacrifice, such as enduring incivility from their service recipients (Potipiroon and Ford, 2017). We argue that, due to the distinctive focus of ethical leaders on upholding moral standards and integrity, they are "valenced leaders" who could be a crucial source of social influence at work to frame an ethical

work context that, despite CI, can help develop individual-organizational value congruence for three reasons.

First, ethical leaders display and encourage the implementation of service values in decision making, moral standards and integrity, identify organizational requirements, and provide care, compassion, and individual consideration for followers, even when faced with significant external pressure, such as CI (De Hoogh and Den Hartog, 2008). This satisfies the underlying needs and expectations of service employees about appropriate leader behavior, upholding norms of social interactions and morality at work, which, in turn, strengthens PO fit. Since, a leading factor for attaining PO fit is to reduce ambiguity, the guidance that ethical leaders provide is likely to deliver the role clarity that followers need and aspire to maintain PO fit. Likewise, explicit communication about ethical norms, overt setting of standards, and constant feedback make followers aware of what is expected of them and what they can rationally and morally expect from other organizational stakeholders (Vullinghs *et al.*, 2020). This further reassures employees' expectations about dignity in social interactions and helps them maintain a sense of PO fit, even when they endure mistreatment by customers.

Second, leaders who enact individual consideration reflect a unique form of compassion for their followers, which generates an emotional connection between followers and leaders. When this occurs, one may also expect the follower to communicate the impact of incivility to the leader, which will allow employees to use emotion-focused coping by drawing on the support of the leader to buffer the negative outcomes of CI (Arnold and Walsh, 2015). This again is an expectation conformity about the appropriate leader-subordinate behaviour, which would allow an opportunity to strengthen the level of congruence of employees with the organization and its values.

Finally, the expected trust between ethical leaders and employees also serves as a means to promote PO fit, even when employees encounter CI. Ethical leaders create ethical work environments where socially and ethically responsible organizational behavior can flourish. Such environments engender trust as they signal that the organization upholds social norms of conduct, commits to its employees, and treats them with respect (Mostafa and Abed El-Motalib, 2020). Additionally, when employees are respectfully treated and appreciated in the organization, they are more likely to define themselves as "insiders" of the organization (Ouyang *et al.*, 2015) which helps mitigate the incivility-induced incongruence between personal and organizational values and re-aligns employees to organizations. Therefore, when employees' trust their leaders and perceive their organization as supportive as anticipated, they will be more likely to "engage psychologically" with the organization (Edwards, 2009, p. 93) and thus perceive PO fit even when mistreated by other stakeholders, such as customers.

Hypothesis 2: *Ethical leadership moderates the relationship between CI and PO fit, such that the negative relationship between CI and PO fit will be weaker when ethical leadership is high compared to low*.

Following the convention of moderated mediation and based on hypotheses 1 and 2, we further posit that when ethical leadership is high, the negative relationship between CI and psychological well-being via PO fit will be weaker.

Hypothesis 3: *Ethical leadership moderates the indirect relationship between CI and psychological well-being via PO fit, such that the mediated relationship will be weaker under high than low levels of ethical leadership.*

See Figure 1 for the conceptual model.

----------INSERT FIGURE 1 ABOUT HERE----------

Method

Participants and procedure

This study adopted a correlational and time-lagged design. The data for the study was collected from a district-level public hospital in Malaysia. Access to the hospital was negotiated through personal contacts. Once approval was received from the hospital's management, all nurses in the hospital were invited to take part in the study and complete the paper and pencil survey. Prior to starting the survey, participants were informed of the study's aims/objectives and the right to refuse participation or withdraw from the study at any time. The authors confirm that this study adheres to the relevant ethical guidelines for human subjects, and that the anonymity and confidentiality of the participants were maintained throughout the study. The university's Ethics Review Board reviewed and approved this study's procedures [MASKED FOR REVIEW].

Data was collected from nurses in three waves, at an interval of two weeks each. The two-week time interval is commonly used in organizational behavior research to mitigate issues related to common method bias and respondent attrition (e.g., Ho and Astakhova, 2020; Melody *et al.*, 2016; Mostafa *et al.*, 2025). This short time lag is viewed as methodologically robust and helps ensure a good level of respondent continuity at successive time points (Mostafa *et al.*, 2021).

A non-participating contact person in the hospital administered the questionnaires. To ensure anonymity, a unique ID number was assigned to each participating nurse to link his or her responses at successive phases of the survey. At Time 1, nurses appraised their supervisors' ethical leadership behaviors and the extent to which they perceived incivility from patients or their visitors, along with evaluating their supervisors' transformational leadership attributes (as a

control variable) and their demographics. At Time 2, nurses' perceptions of PO fit were recorded. Finally, after another two weeks, at Time 3, nurses evaluated their perceived psychological well-being.

The choice of sample size in the current research was mainly driven by the study's data analysis method (generalized structural equation modelling (GMSEM)). Scholars have provided differing guidelines for the appropriate sample size when using SEM (Hoe, 2008). For example, some suggest a minimum ratio of at least 5 respondents per parameter is paramount in SEM, while others suggest that a ratio of 10 respondents for each estimated parameter is ideal (Hair *et al.*, 2010). Garver and Mentzer (1999) argue that 200 is the critical sample size for SEM, and as a rule of thumb, sample size above 200 should offer enough statistical power for trustworthy data analysis (Hoe, 2008). Contrarily, Iacobucci (2009) argues that SEM models can perform well even with small samples of 50 to 100 participants. The choice of the appropriate sample size in SEM is also influenced by model complexity, the amount of missing data, estimation technique, and multivariate normality (Hair *et al.*, 2010). Simple models with complete and normally distributed data can usually perform well with smaller sample size than models that are complex and have missing or non-normally distributed data (Hair *et al.*, 2010). In line with the differing rules of thumb and considering the complexity of the study's statistical model, a sample size of 300-400 was deemed appropriate for the present study.

Out of the 396 questionnaires distributed at Time 1, we received responses from 350 nurses for an initial response rate of 88%. Of these 350 nurses, 347 completed the questionnaires at Time 2 (99% response rate), and at Time 3, survey responses were collected from 345 nurses (99% response rate).

The final sample consists of 345 nurses working under 33 supervisors. To assess the adequacy of this final sample size, a post-hoc power analysis was conducted using the structural equation models tool, semPower (Moshagen and Bader, 2024). For the study's CFA, the achieved power was almost 1 with an alpha level of 0.05, RMSEA of 0.057, 828 degrees of freedom, and 39 indicators. This confirms that the sample size is large enough to detect existing effects.

The percentage of females in the final sample was 93%. Most of nurses were 40 years old or less (82%), had less than 15 years of tenure at the hospital (78%) and had completed a college degree (80%).

Measures

Following Brislin (1980), the questionnaire was translated from English into Malay and then translated back into English by a bilingual researcher. We used a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree) for all the items included in the questionnaire.

Customer incivility. CI was measured using the 10-item scale developed by Guidroz *et al.*, (2010). Sample items include "Patients/visitors treat me as if I am inferior or stupid" and "Patients/visitors criticize my job performance". Cronbach's α was 0.948.

Ethical leadership. Brown et al's (2005) 10-item scale was used to measure ethical leadership. Sample items include "My supervisor makes fair and balanced decisions" and "When making decisions, my supervisor asks, "what is the right thing to do?". Cronbach's α was 0.952.

Person-organization fit. Nurses' perceptions of PO fit was measured with the 3-item scale developed by Cable and DeRue (2002). Sample items include "My personal values match my hospital's values and culture" and "My hospital's values and culture provide a good fit with the things that I value in life". Cronbach's α was 0.863.

Psychological well-being. Banks *et al.*'s (1980) 12-item scale of the general health questionnaire was used to measure nurses' psychological well-being. Sample items are "Recently, I have been able to concentrate" and "Recently, I have been thinking of myself as a valuable person" with a Cronbach's α of 0.956.

Controls. We controlled for transformational leadership to ensure that our results highlight the unique contribution of ethical leadership over and above transformational leadership. Four items from the scale developed by Podsakoff *et al.*, (1990) were used to measure transformational leadership and its four different facets, namely, idealized influence, inspirational motivation, individualized consideration, and intellectual stimulation (Bass, 1985). Sample items include "My supervisor inspires others with his/her plans for the future" and "My supervisor leads by 'doing' rather than simply by 'telling'". Alpha for this scale was 0.879. Prior research has also shown that employees' gender, age, education, and organizational tenure are related to both PO fit (e.g., Mostafa, 2016; Raja *et al.*, 2018) and psychological well-being (e.g., Sliter *et al.*, 2010; Sood and Kour, 2023). Therefore, this study controlled for these variables as well.

Analytic strategy

Nurses were nested within supervisors. Further, the ICC1 value for psychological well-being was 0.10, which suggests that 10% variation in psychological well-being of nurses would be attributable to their supervisors, implying significant between-group variance. Although the ICC1 co-efficient is modest, the nested nature of the data necessitates a multilevel analysis. Consequently, we used Generalized Multilevel Structural Equation Modelling (GMSEM) technique in STATA to test our hypotheses. We grand mean centred all variables, and all relationships were examined simultaneously.

Results

Measurement model

We tested a measurement model to determine if items adequately reflected their respective underlying constructs. This measurement model provided a good fit to the data (χ^2 = 1742.534, df = 828, $p < 0.001$; CFI = 0.982, TLI = 0.980, RMSEA = 0.057). Almost all indicators had statistically significant ($p < 0.001$) factor loadings on their intended constructs.

To assess discriminant validity, the fit of the hypothesized five-factor measurement model was compared with other plausible alternative models (see Table 1). The five-factor model fitted the data significantly better than other plausible models with fewer factors. Thus, discriminant validity was attained.

----------INSERT TABLE 1 ABOUT HERE----------

Descriptive statistics

Table 2 presents the means, standard deviations, and intercorrelations among the study's variables. As shown in Table 2, all constructs had high internal consistency as their composite reliabilities exceeded 0.80 and average variance extracted (AVE) scores were more than 0.50. Additionally, the square root of the AVE for each construct exceeded its respective inter-construct correlations. Together, this exhibits evidence of measurement validity according to Fornell and Larcker's (1981) criteria. Consistent with previous research (e.g., Mostafa *et al.*, 2021; Hoch *et al.*, 2018), the correlation between ethical leadership and transformational leadership was high (r = 0.76, $p < 0.001$). Nevertheless, as the square root of the AVE for both constructs was higher than the corresponding inter-construct correlation estimate (0.853 for transformational leadership and 0.855 for ethical leadership), both constructs are conceptually distinct from each other.

----------INSERT TABLE 2 ABOUT HERE----------

Hypothesis testing

Table 3 presents the results of the moderated mediation model. Results exhibited a negative association between CI and PO fit (β = -0.140, p < 0.001, effect size = -0.205). PO fit was positively related to well-being (β = 0.443, p < 0.001, effect size = 0.392). Additionally, the indirect effect of CI on well-being via PO fit was significant (β = -0.061, p = 0.001, 95% CI -0.10 to -0.024). This provides support for Hypothesis 1. Since the direct relationship between CI and employee well-being was non-significant (β = -0.045, p = 0.262, effect size = -0.059), this mediation is full rather than partial.

The interaction term of CI and ethical leadership was significant and positive (β = 0.121, p < 0.001). Figure 2 presents the simple slope plot for this interaction following Aiken and West's (1991) approach. The negative relationship between CI and PO fit was significant when ethical leadership was low (β = −0.270, SE = 0.050, z = -5.36, p < 0.001) and was non-significant when ethical leadership was high (β = −0.009, SE = 0.053, z = −0.17, p = 0.868). This provides support for Hypothesis 2.

The indirect relationship between CI and well-being via PO fit was significant and negative when ethical leadership was low (β = -0.120, p < 0.001, 95% CI -0.173 to -0.065) but non-significant when the level of ethical leadership was high (β = -0.004, p = 0.868, 95% CI -0.050 to 0.042). These results provide support for Hypothesis 3.

----------INSERT FIGURE 2 ABOUT HERE----------

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Discussion

Drawing on EVT, we proposed a moderated mediation model in which ethical leadership moderated the relationship between CI and psychological well-being via PO fit. Our results supported all our hypotheses. We found that PO fit fully mediated the relationship between CI and well-being. Moreover, supervisors' display of ethical leadership attenuated the negative relationship between CI and PO fit as well as the indirect relationship of CI on well-being through PO fit.

Past studies have established that CI is detrimental to employee well-being (see systematic reviews by Schilpzand et al., 2016; Vasconcelos, 2020), especially in the service-sector (e.g. Arnold and Walsh, 2015; Chaudhuri et al., 2023). Our findings extend the literature by highlighting the mediating role of PO fit in this relationship. The results confirm that employees tend to develop negative perceptions of the organisation when the customer-employee interaction slips off the anticipated balance of civility (e.g. Bamfo et al., 2018; Chaudhuri et al., 2023). This is reflected in a reduced sense of compatibility with the organisation, and consequently lower well-being.

The moderating role of ethical leadership in the CI-PO fit- well-being relationship is in line with past studies that have shown that line managers play a key role in mitigating the adverse effects of stressful work environments in general, and CI in particular, on employees (e.g. Chaudhuri et al., 2023; Tan et al., 2020). Our study specifically supports existing research, which suggests that leadership plays a significant role in ameliorating the deleterious effects of CI on employee outcomes including their well-being (Arnold and Walsh, 2015; Mostafa, 2022; Jang *et al.*, 2020). Given the unique characteristics of ethical leaders, such as consideration behaviour, honesty, trust, and interactional fairness (Brown et al., 2005), such leaders are a major source of influence, and help shape the ethical work context. Therefore, despite CI, employees

working under ethical leaders are likely to develop increased levels of value congruence with the organisation, and consequently experience improved well-being.

Theoretical implications

First, by introducing EVT as a theoretical framework, the study provides an additional account to understand the relationship between CI and well-being. The extant literature has ignored the role of expectancy violations in social interactions for managing the well-being of individuals who endure CI. Accordingly, EVT directs us to understand the CI-well-being association from a new angle. It suggests that employees regard CI as a negatively valenced violation of social norms and acceptable behavior in service encounters by customers and the organization (Mostafa, 2022; van Jaarsveld *et al.*, 2010). It supports that this expectation violation influences the interpretive process, which develops perceived employee-organizational value incongruence that determines well-being at work. This is a meaningful extension, specifically for the nursing context. Nurses are active participants in delivering the aims of healthcare organizations. They are more likely to engage with work if they feel their values are strongly compatibility with their respective hospitals' values. Therefore, identifying factors in the work environment that may compromise (i.e., CI) the compatibility of nurses with their organizations is not only significant for nurses' welfare but also for the quality of care at the desired professional standard.

Second, the study provides a greater understanding of the "why" of the relationship between CI and well-being. PO fit was tested as the underlying mechanism linking the negative association between CI and well-being. This is a meaningful addition to the existing literature which posits a link between positive work environment factors, such as HRM practices and positive leadership styles, and PO fit (e.g., Raja *et al.*, 2018; Mostafa, 2016), but overlooks associations between negative work environment factors, such as CI and PO fit. Drawing on

EVT, we argued that CI signals to employees' unmet expectations about shared standards of acceptable behaviour and values in service tasks. Furthermore, CI signifies an organization's disregard towards upholding the rules of civility in service encounters and employee welfare. This makes nurses perceive themselves as "outsiders" in the workplace who do not share similar characteristics with the organization (Ouyang *et al.*, 2015). Although this theoretical assertion is empirically supported in the study, it is noteworthy that the strength of the association between CI and PO fit is modest (β = -0.14). Future research could examine if other types of workplace incivility, such as supervisor or co-worker incivility, could relate to PO fit.

Notable here is that our study found that PO fit fully mediated the relationship between CI and well-being, and the indirect effect of PO fit accounted for 56% of the variance in well-being. In other words, the experience of CI does not compromise well-being per se, but rather the interpretive mechanism that CI triggers - perceived value incongruence between employees and their organizations due to negative expectancy valence - impairs well-being associated with incivility. Our results suggest that, if nurses were able to maintain their value congruence with the organization, impairment of well-being would be less likely to occur. These findings are consistent with EVT, as the theory postulates that unmet or negatively violated expectancies bear ramifications for employee outcomes (Burgoon and Hale, 1988). It is worth highlighting that the finding of full mediation suggests that PO fit is of great importance in explaining the CI-employee well-being relationship but does not imply that there are no other possible mediators of this link (Kenny and Judd, 2013; Preacher and Kelley, 2011; Rucker *et al.*, 2011). Therefore, to extend the scope of our study, future research could also examine other mediators, such as organizational identification or perceptions of organizational support or even other types of fit, such as person-vocation and person-job fit, in the CI-well-being link.

Lastly, our findings on the moderating role of ethical leadership help advance knowledge on "how" to limit the harmful effects of CI for improved well-being, and strengthen the use of EVT to guide this process. The results indicate that the negative effect of CI on PO fit and consequently well-being disappears when supervisors display higher levels of ethical leadership. Ethical leaders have a unique and important role in tackling CI in service organizations because this style of leadership symbolizes moral values and acceptable behaviors in workplaces, even when CI undermines such values. The distinct focus on social rules and dignity in this leadership style confirms employees' expectations about the normative rules about how leaders should treat their subordinates and protect their dignity at work more generally. Hence, leaders' display of ethical values will make nurses less likely to perceive that their organization disregards their maltreatment by customers due to lax ground rules. This way, our study extends the scope of boundary conditions of incivility beyond personal and organizational attributes, and the limited leadership styles, such as transformational and servant leadership (Arnold and Walsh, 2015; Jang *et al.*, 2020; Mostafa, 2022). Since we present ethical leadership as a buffering resource for nurses experiencing incivility from customers, our study is particularly useful for healthcare settings where workplace incivility is common (Mostafa, 2022).

Practical implications

Given the negative effects of CI on employees, healthcare organizations need to take proactive steps to reduce the occurrence of incivility and protect employees. For example, continuous customer feedback processes could be implemented to address service failures diligently. This will signify organizational commitment towards effective service delivery and minimize further customer mistreatment (Mostafa, 2022). Likewise, healthcare organizations could adopt a zero-tolerance policy towards patients and their relatives who mistreat staff and widely display

notices, which prompt customers to be respectful towards employees (Shao and Skarlicki, 2014). This will satisfy employees' expectations about organizational care and dignity at work, which will restore their sense of congruence with their organizations and promote well-being.

Healthcare organizations also need to establish clear guidelines and policies to support healthcare workers when dealing with CI. For example, they need to train employees on how to respond to uncivil customer behaviors and ensure that mental health services and resources, such as counselling and peer support groups, are available when needed. They should also provide clear reporting mechanisms and ensure that employees have a clear point of contact when they are mistreated and are seeking help. This will help ensure that a comprehensive support system within the hospital is available to safeguard employees' psychological well-being.

At the national policy level, government bodies or organizations responsible for the supervision and management of public health (such as the ministry of health) need to establish clear and strict anti-incivility protocols that should be implemented in all healthcare organizations. They should also consider running public campaigns in the media (e.g. TV, radio, press and social media platforms) to enhance public awareness of the harmful effects of uncivil behaviors towards healthcare workers and the intolerance of such behaviors.

Healthcare organizations could also benefit from nurturing ethical leadership through different strategies such as hiring ethical leaders and providing ethics training to existing leaders (Mostafa and Abed El-Motalib, 2020). When hiring new leaders, management may use interview questions that focus on ethical dilemmas or rely on integrity tests as a selection tool. Also, training can be provided to existing leaders on communicating the importance of ethics and handling ethical issues, such as CI. Leaders need to be reminded of their duty of care towards subordinates, not just patients, and should be trained on how to support workers when

encountering rude customers. This will help assure healthcare employees of workplace support and strengthen their favorable perceptions of the organization and their line managers or supervisors. Nonetheless, healthcare organizations should be mindful that incivility is often difficult to detect and address due to its ambiguous nature, low reporting rates, and the prevalence of blame culture (Guppy *et al.*, 2024). Accordingly, a long-term commitment and a steady flow of resources may be required to tackle and prevent its occurrence.

Limitations and future directions

Despite the temporal separation of variables at three time points, the study precludes causality in the hypothesized relationships. Even though a two-week time lag between waves of data collection is a common practice in prior research to mitigate issues related to common method bias (e.g., Ho and Astakhova, 2020; Melody *et al.*, 2016; Mostafa *et al.*, 2025), a longer time lag would be ideal for capturing changes in incivility and well-being. An experimental design can also help better establish causality. Single-source bias is also a concern due to the use of self-report measures (Podsakoff *et al.*, 2003). However, existing research has considered self-report measures most appropriate to evaluate CI, ethical leadership, PO fit and psychological well-being considering these are all subjective perceptions (Arnold and Walsh, 2015; Baker and Kim, 2020; Mostafa *et al.*, 2021). Finally, the generalizability of the results is limited because data came from nurses working in only one public hospital in Malaysia. Future studies could replicate our results in more hospitals, in both the public and private sector, and in other countries to establish generalizability.

Conclusion

This study has shown that CI impairs employees' psychological well-being by reducing their sense of fit with the organization. However, the negative relationship between CI and well-being

via PO fit disappears when employees work under ethical leaders. The study contributes to illuminating the link between CI and employee well-being, and provides a better understanding of *why* and *how* they are related.

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Table 1

Measurement Models Comparisons

Model	**χ^2 (df)**	**$\Delta\chi^2$**	**CFI**	**TLI**	**RMSEA**	**SRMR**
Five-factor model (baseline model)	1742.534 (828)	-	0.982	0.980	0.057	0.044
Four-factor model (combined EL and TL)	2066.997 (836)	324.463**	0.976	0.974	0.065	0.050
Three-factor model (combined CI and PO fit and EL and TL)	3177.922 (843)	1435.388**	0.954	0.950	0.090	0.092
Two-factor model (combined EL, TL, CI, and PO fit)	8242.715 (849)	6500.181**	0.853	0.844	0.159	0.190
One-factor model	11871.783 (854)	10129.249**	0.781	0.769	0.193	0.275

Note. The $\Delta\chi^2$ is in relation to the baseline model; $^{**}p < 0.01$

Customer Incivility = CI; Ethical Leadership = EL; Transformational Leadership = TL

Source: Authors own work

Table 2

Descriptive Statistics

Construct	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1. Transformational Leadership	.85 (.91)								
2. Gender	0.02								
3. Age	0.05	0.39**							
4. Education	- 0.06	0.16	0.20***						
5. Tenure	- 0.01	0.45***	0.78***	0.17**					
6. Customer Incivility	- 0.08!	- 0.381***	- 0.19***	-.06	- 0.23***	.87 (.97)			
7. Ethical Leadership	0.76***	0.10	0.04	- 0.08	- 0.01	- 0.21***	.85 (.96)		
8. PO Fit	0.08	- 0.12	0.10	- 0.09	0.04	- 0.26***	0.10*	.89 (.91)	
9. Well-being	0.12*	- 0.01	0.26***	- 0.01	0.22***	- 0.22***	0.20***	0.48***	.87 (.95)
Mean	4.51	1.93	1.90	3.16	2.42	2.41	4.88	5.70	5.28
Standard Deviations	1.18	0.25	0.76	0.60	1.04	1.13	1.08	0.77	0.87

Note. *Leading diagonal shows the AVE square root and composite reliability (in parentheses). Sub-diagonal entries are intercorrelations.*

! $p < 0.10$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Source: Authors own work

Table 3

Results of Moderated Mediation Analyses

	PO Fit				**Well-being**			
	***β* (SE)**	**z**	**LL**	**UL**	***β* (SE)**	**z**	**LL**	**UL**
Transformational Leadership	0.023 (0.048)	0.48	- 0.070	0.116	- 0.006 (0.050)	- 0.13	- 0.105	0.092
Gender	- 0.328 (0.164)	-1.99**	-0.651	-0.005	- 0.235 (0.176)	- 1.33	- 0.582	0.110
Age	0.107 (0.078)	1.38	-0.045	0.260	0.167 (0.083)	2.01**	0.004	0.331
Education	- 0.134 (0.067)	- 1.98**	- 0.266	- 0.001	- 0.021 (0.071)	- 0.31	- 0.161	0.118
Tenure	-0.018 (0.057)	-0.32	-0.130	0.094	0.087 (0.060)	1.44	-0.031	0.205
Customer Incivility	- 0.140 (0.039)	- 3.58***	- 0.215	- 0.063	- 0.045 (0.042)	- 1.08	- 0.129	0.037
Ethical Leadership	0.010 (0.052)	0.17	- 0.094	0.112	0.10 (0.056)	1.75*	- 0.011	0.209
Customer Incivility × Ethical Leadership	0.121 (0.032)	3.79***	0.059	0.184	- 0.040 (0.034)	- 1.16	- 0.108	0.027
PO Fit	-	-	-	-	0.443 (0.060)	7.43***	0.326	0.560
Indirect effect								
Customer Incivility ⟶ PO Fit⟶ Well-being	-	-	-	-	- 0.061 (0.091)	- 3.25**	- 0.010	- 0.024
Conditional Indirect Effect								
Low Ethical Leadership (-1SD)	-	-	-	-	- 0.120 (0.027)	- 4.35***	- 0.173	- 0.065
Moderate Ethical Leadership	-	-	-	-	- 0.061 (0.091)	- 3.25**	- 0.010	- 0.024
High Ethical Leadership (+1SD)	-	-	-	-	- 0.004 (0.024)	- 0.17	- 0.050	0.042

Note. *$p < 0.10$; **$p < 0.01$; ***$p < 0.001$

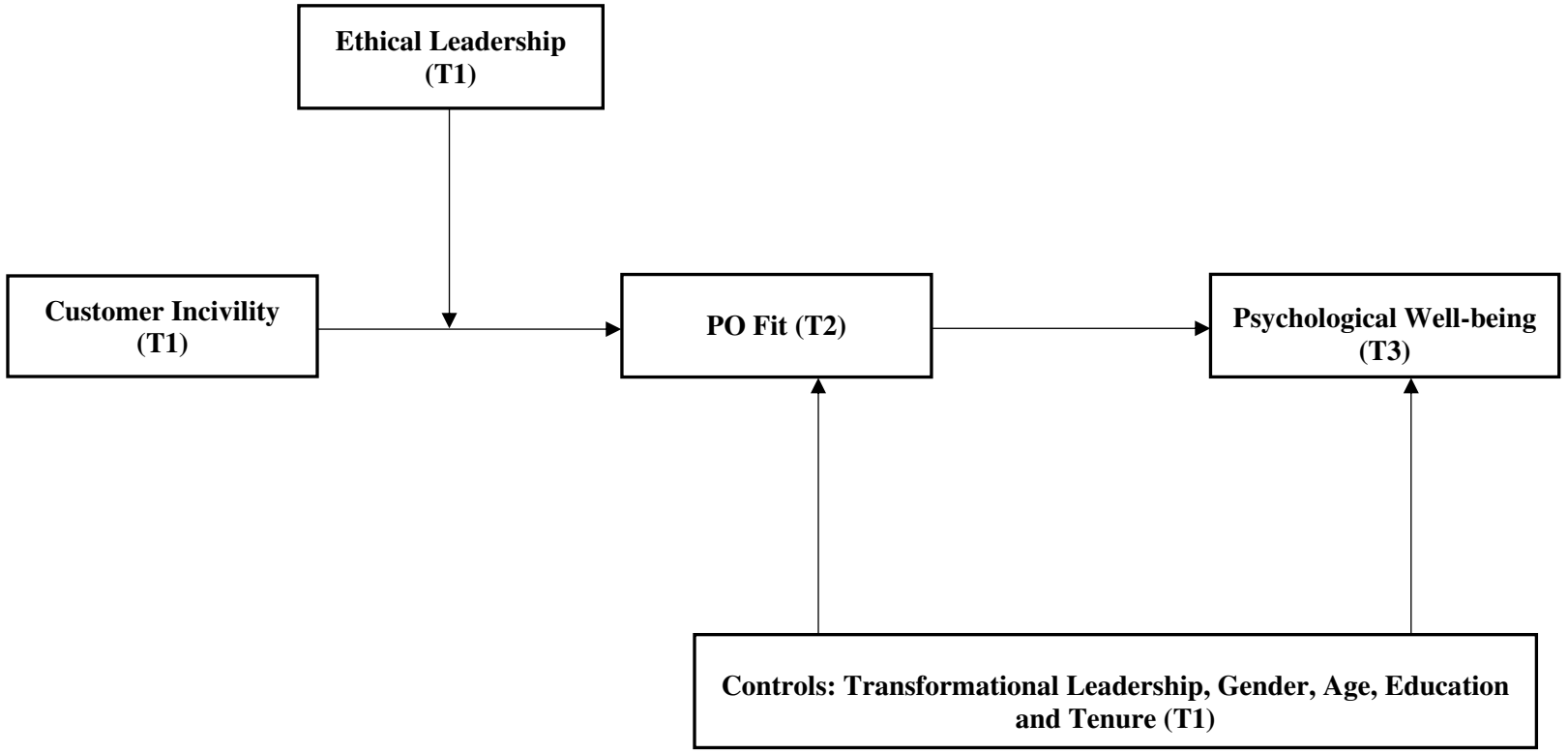
SE = Standard error

95% Confidence interval lower limit = LL; 95% Confidence interval upper limit = UL

Source: Authors own work

Figure 1

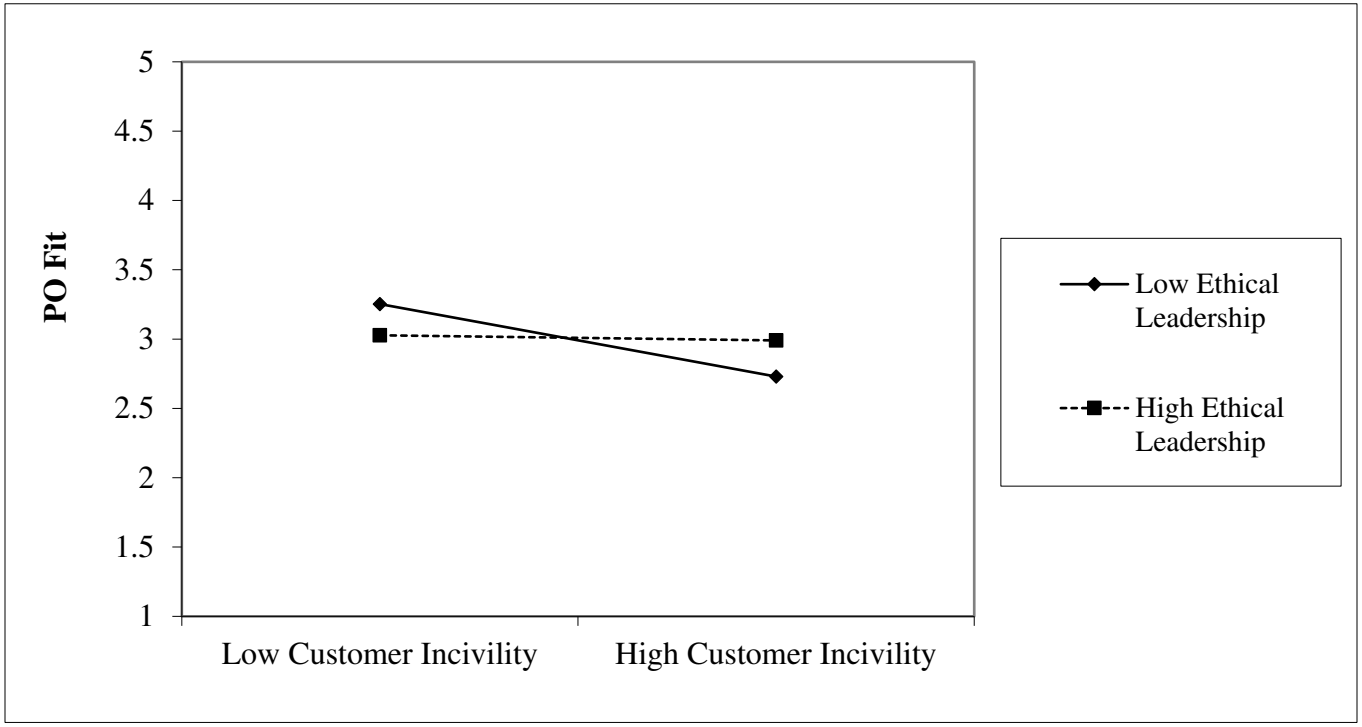
The proposed research model



Source: Authors own work

Figure 2

Plot of moderation of ethical leadership on the relationship between customer incivility and PO fit



Source: Authors own work