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Original Article

Prevalence and Demographic Correlation of Incivility Among Nurses

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Abstract. Incivility is an increasingly prevalent issue in the nursing profession, affecting patient outcomes and healthcare professionals. This study aimed to identify the frequency, causes, and effects of incivility among nurses working in selected hospitals in the Philippines. The respondents of this study are staff nurses and head nurses working in different clinical units at both private and public institutions. They were selected using purposive sampling. The researcher employed a descriptive-comparative research design and an adapted questionnaire validated by five experts, focusing on the Nursing Incivility Scale, covering nurses, supervisors, physicians, patients/relatives, and other individuals. The collected data were analyzed using statistical treatment, which includes Frequency, Percentage Distribution, Mean, and Standard deviation, Independent T-test, Kruskal-Wallis test, as well as Mann-Whitney U-test. Findings indicate very low levels of incivility, with no incivility among supervisors. While no significant associations were found for age, sex, or educational attainment among nurses, significant differences were observed by years of service and hospital type.

Keywords: *Nursing; Workplace incivility; Hospital setting; Philippines.*

Incivility is a negative behavior of insulting others or violating the common norms of behavior in the hospital (Gopalkrishnan, 2021). It can manifest as impoliteness and disrespect, for example, by refusing to help a coworker or by engaging in gossip and hearsay. Incivility is a widespread issue in nursing globally, with nearly 69% of nurses in Saudi Arabia reporting moderate to severe incivility in a study involving four other hospitals in Saudi Arabia (Alsadaan, 2024). In the United States, violence and incivility are particularly common in states like New York, Connecticut, and New Jersey, where rates exceed the national average. Disrespectful conduct and harassment contribute to burnout, increased turnover, and lower job satisfaction among healthcare professionals worldwide (Fatma et al., 2024). Hospital incivility is an increasingly common issue among nursing staff, with incidents reported at rates between 67.5% and 90.4%. However, most nurses choose not to report these situations (Smith, 2024). According to a Press Ganey survey (2021), one in four nurses has experienced assault, though only 20–60% of such incidents are reported, and workplace violence accounts for 13% of missed workdays. Incivility

among nurses has consistently been high across countries. On the other hand, a study in the Southern Philippines, specifically in Jolo, reported relatively low levels of incivility among nurses. Given these considerations, there is limited research on incivility in South Luzon, Philippines, particularly among hospital nurses in San Pablo City, Laguna. This study seeks to fill this gap by examining the level of incivility in this area of Laguna and evaluating whether it occurs and whether its prevalence differs from that in these regions.

Sustainable Development Goal 3, Good Health and Well-being, is highly relevant to our study on hospital incivility among nurses, as it aims to ensure healthy lives and promote well-being for all. A positive and respectful hospital enhances mental well-being, reduces absenteeism, and improves overall job engagement, aligning with SDG 3's mission of fostering well-being in both personal and professional aspects. Sustainable Development Goal 8, Decent Work and Economic Growth, underscores the importance of promoting sustained, equitable economic growth and fostering productive and respectful work environments. By ensuring that healthcare organizations retain their competent workers, investing in a positive work environment benefits not only individual nurses but also the healthcare industry, thereby encouraging sustainable economic growth.

The purpose of this study is to determine the prevalence of workplace incivility among nurses in selected hospitals in San Pablo City, Laguna, and to examine whether significant differences exist across demographic variables, including age, sex, educational attainment, years of service, and hospital type. The researchers hypothesized that there would be no significant difference in workplace incivility levels when nurses were grouped by demographic characteristics. This study is anchored on Peplau's Interpersonal Relations Theory, which emphasizes the importance of effective nurse–patient and nurse–colleague interactions in promoting therapeutic relationships. Incivility disrupts communication, trust, and collaboration, which are key components of Peplau's theory, making it a suitable framework for understanding how interpersonal behaviors influence workplace environments and nurse outcomes.

Methodology

Research Design

This study employed a quantitative descriptive-comparative design to compare and describe existing groups, identifying similarities and differences without manipulating them. Using Likert-scale questionnaires, data were collected and analyzed statistically. The quantitative approach enabled the researchers to quantify the extent of incivility and identify patterns among nurses. Meanwhile, a descriptive comparative design was used to compare the levels or types of incivility experienced across groups, such as nurses from different hospitals, shifts, age groups, or years of experience (McCombes, 2019).

Participants and Sampling Technique

This study employed purposive sampling to select participants who met predefined criteria relevant to the investigation of nursing incivility. The use of purposive sampling was necessary because the group or phenomenon under study requires respondents with ample, direct exposure to interpersonal interactions in healthcare settings. Meanwhile, in quantitative research, purposive sampling can enhance precision and validity by enabling researchers to focus on specific subgroups and ensuring that the sample adequately represents the target population. This selective targeting improves the theory's generalizability within the defined context (Bougie & Sekaran, 2020), leading to a more credible explanation and conclusion regarding the findings.

The inclusion criteria extended beyond being a registered nurse and required participants to: (1) be currently employed in a public or private hospital in San Pablo City, Laguna; (2) have a minimum of one year of clinical work experience to ensure sufficient exposure to workplace dynamics; (3) be assigned to clinical or patient-care units where interactions with supervisors, physicians, patients, relatives, and fellow nurses are frequent; and (4) provide voluntary consent to participate in the study.

Research Instrument

The NIS, or Nursing Incivility Scale (Guidroz et al., 2010), is a 43-item, five-point scale used to evaluate hospital nurses' encounters with incivility based on reports from individuals, physicians, supervisors, and patients/relatives. The adapted Nursing Incivility Scale was modified to reduce neutrality and capture accurate perceptions of the respondents. The instrument was revised into a six-point Likert scale by removing the neutral option and replacing it with clear directional response choices. This encourages respondents to specify either agreement or disagreement, thereby improving response clarity and data sensitivity. In addition, selected terms

from the instrument that were considered inappropriate were replaced with a respectful and acceptable wording, without changing the original meaning.

Data Gathering Procedure

The researchers sought permission from the Dean of the College of Nursing prior to data collection. Formal consent letters were then sent to five selected hospitals in San Pablo City, Laguna, requesting approval to conduct the study. Upon approval, data collection was conducted from February to March 2025. The researchers personally distributed the questionnaires to eligible staff nurses and remained available in the area during completion to facilitate retrieval and minimize non-response. To reduce potential influence and social desirability bias, respondents were instructed to answer the questionnaires independently. They were assured that participation was voluntary, anonymous, and would not affect their employment or professional standing. The researchers did not provide guidance on questionnaire content and refrained from observing individual responses. The purpose and benefits of the study were explained, and informed consent was obtained prior to participation. Out of 290 registered nurses who met the inclusion criteria, 215 agreed to participate in the study. Completed questionnaires were collected, tallied, and submitted to a statistician for data analysis. The analyzed data were subsequently returned to the researchers for interpretation.

Data Analysis Procedure

Data entry and preliminary processing were conducted in Microsoft Excel, with systematic data cleaning to ensure accuracy and minimize encoding errors. Descriptive statistics were generated to present the demographic profile of respondents and their reported levels of incivility. Given that the data did not meet the assumptions of normality and homogeneity, nonparametric tests were used. The Kruskal–Wallis Test was applied for comparisons involving three or more groups, whereas the Mann–Whitney U Test was used for two-group comparisons. Statistical significance was set at 0.05. The reliability of the Nursing Incivility Scale (NIS) was examined using Cronbach's alpha, which indicated acceptable to good internal consistency across its subscales. These methodological choices ensured the validity and appropriateness of the statistical analyses used to evaluate nurses' experiences of incivility.

Ethical Considerations

The study adhered to established ethical principles, including obtaining informed consent, ensuring respondents' anonymity, and securing institutional approval from all participating hospitals. Standard procedures were in place to provide respondents with clear information regarding the rights, voluntary, and confidential nature of their participation. During data collection at one hospital, a procedural deviation occurred when questionnaires were briefly distributed without direct researcher supervision, resulting in insufficient explanation of the study information. This lapse raised concerns regarding informed consent and confidentiality. The research team punctually reported the issue, paused the data collection, and issued a formal apology. Following institutional review, the hospital's chief nurse authorized the continuation of the study under a revised protocol in which designated supervisors retrieved and distributed the questionnaires. Although this approach complied with hospital policy, the involvement of supervisors may have introduced response bias, a limitation acknowledged by the study. A small number of questionnaires were affected during the unattended period; to protect data quality, these were excluded from the final analysis. The team identified several safeguards to prevent similar issues in the future, including closer monitoring of field implementation, strengthened training in ethical data collection, and the possible adoption of secure digital survey methods. These measures reinforce the study's commitment to ethical integrity and responsible research conduct.

Results and Discussion

Demographic Profile of the Respondents

Table 1 presents the age distribution of nurses, analyzed using frequency and distribution. The data show that most nurses in the sample are aged 31-40 (52.09%). This is followed by individuals aged 21-30, accounting for 28.84%. Fewer nurses fall within the 41-50 age range (11.16%), whereas the smallest groups are those aged 51-60 (6.98%) and 61-70 (0.93%). The results indicate that a majority of nurses fall within the 31-40 age range, suggesting a workforce that is both experienced and adaptable. This age group can serve as role models and mentors for younger nurses aged 21-30, who constitute a significant portion of the workforce. With fewer nurses aged 51 and above, the possibility of early retirement may create a gap in seasoned guidance, making peer support even more essential. On the other hand, the smaller number of nurses aged 51 and above may lead to early retirement, creating a gap in expertise and mentorship. Those in the 31–40 age range are well-positioned to bridge that gap by sharing what they have learned while continuing to grow in their own practice. This study aligns with

interpersonal theory, which underscores how genuine, respectful connections can shape not only our careers but also our sense of belonging and well-being in the workplace.

Table 1. *Demographic Profile of the Respondents When Grouped According to Their Age*

Age	Frequency	Percentage
21-30	62	28.84
31-40	112	52.09
41-50	24	11.16
51-60	15	6.98
61-70	2	0.93
Total	**215**	**100.00**

Table 2 presents the demographic profile of respondents, grouped by sex. The majority of respondents were female (174; 80.93%), whereas only 41 (19.07%) were male. This indicates that nursing remains a female-dominated profession, consistent with historical and cultural perspectives that associate nursing with women (Selanders, 2019). Although fewer in number, male nurses play an essential role in breaking stereotypes and fostering inclusivity in the healthcare workforce, supporting the view of Ageeli, M., & Alharbi, M. (2024) that gender perceptions continue to influence nursing as a career choice.

Table 2. *Demographic Profile of the Respondents When Grouped According to Their Sex*

Sex	Frequency	Percentage
Male	41	19.07
Female	174	80.93
Total	**215**	**100.00**

Table 3 shows the demographic profile of the respondents when grouped according to educational attainment. The majority (201; 93.49%) were Bachelor of Science in Nursing (BSN) graduates, while only 8 (3.72%) were currently pursuing a master's degree, and 6 (2.79%) had already attained one. This indicates that most nurses are BSN-prepared, consistent with the profession's standard entry-level requirement in the Philippines. The low proportion of respondents with or pursuing advanced degrees may be influenced by factors such as financial cost, workload, and time constraints, as noted by Maryville University (2023).

Table 3. *Demographic Profile of the Respondents When Grouped According to Their Educational Attainment*

Educational Attainment	Frequency	Percentage
Bachelor of Science in Nursing	201	93.49
Ongoing Master's Degree	8	3.72
Master's Degree Holder	6	2.79
Total	**215**	**100.00**

Table 4 shows the demographic profile of the respondents when grouped according to their years of service. The highest proportion, 70 (32.56%), had served between 1 and 4 years and 11 months, followed by 44 (20.47%) with 5 to 9 years and 11 months, and 30 (13.95%) with 10 to 14 years and 11 months. Meanwhile, 22 (10.23%) had less than 1 year of service, 24 (11.16%) had 15 to 19 years and 11 months, and 17 (7.91%) had 20 to 24 years and 11 months. Only 2 (0.93%) respondents had 25 to 29 years and 11 months, while 6 (2.79%) had served for 30 years and above. These results suggest that most nurses are relatively early in their careers, with few having reached long-term service. This supports Labrague (2020), who reported that many nurses plan to leave their jobs within the first five years, and aligns with Çamveren et al. (2020), who highlighted that new nurses often leave due to negative work environments and unmet expectations. The very low number of respondents with more than 25 years of service also reflects the ongoing challenge of retaining experienced nurses in the workforce.

Table 4. *Demographic Profile of the Respondents When Grouped According to Their Years of Service*

Years of Service	Frequency	Percentage
< 1 year	22	10.23
1 year to 4 years and 11 months	70	32.56
5 years to 9 years and 11 months	44	20.47
10 years to 14 years and 11 months	30	13.95
15 years to 19 years and 11 months	24	11.16
20 years to 24 years and 11 months	17	7.91
25 years to 29 years and 11 months	2	0.93
30 years and above	6	2.79
Total	**215**	**100.00**

Table 5 presents the demographic profile of respondents grouped by hospital type. The majority, 122 (56.74%), were employed in private hospitals, while 93 (43.26%) were working in public hospitals. Although more respondents were from private institutions, the 93 nurses in public hospitals were concentrated at only two facilities, whereas three private hospitals had 122 nurses. This distribution suggests that, although private hospitals offer more employment opportunities and better working conditions, public hospitals remain heavily staffed despite resource constraints and heavier workloads. This supports Balita (2024), who reported growth in private hospital nursing employment, and aligns with Ngozi (2024), who found that public hospital nurses often demonstrate higher job motivation and performance compared to those in private hospitals.

Table 5. *Demographic Profile of the Respondents When Grouped According to Their Type of Hospital*

Type of Hospital	Frequency	Percentage
Private	122	56.74
Public	93	43.26
Total	**215**	**100.00**

Prevalence of Incivility

Prevalence of Incivility – Nurses' Incivility

Table 6 shows the prevalence of incivility among nurses. The overall mean score was 1.99 (SD = 1.28), indicating that workplace rudeness was very low and uncivil behaviors were rarely observed. Gossiping about coworkers had the highest mean of 2.47, making it the most common but still classified as very low incivility. In contrast, more serious actions such as screaming at coworkers (1.64) and taking credit for others' work (1.80) were the least frequent, suggesting these behaviors were almost nonexistent. These findings indicate that nurses in the selected hospitals generally work in a respectful and supportive environment. Although gossiping was the most frequently reported uncivil act, its occurrence remained minimal and was not considered a major concern. This aligns with Lewis (2023), who found that nurses often disagreed with the presence of inconsiderate behavior, gossip, or free-riding in their workplaces. However, even minor gossip underscores the importance of maintaining open communication and employing conflict-resolution strategies to further strengthen teamwork and collaboration.

Table 6. *Prevalence of Incivility – Nurses' Incivility*

Indicators	Mean	SD	Interpretation
1. Other nurses in my unit argue with each other frequently.	2.22	1.35	Very Low Incivility
2. Other nurses in my unit have violent outbursts or heated arguments in the workplace.	1.87	1.21	Very Low Incivility
3. Other nurses in my unit scream at other employees.	1.64	1.00	No Incivility
4. Other nurses in my unit gossip about one another.	2.47	1.57	Very Low Incivility
5. Other nurses gossip about their supervisor at work.	2.18	1.37	Very Low Incivility
6. Other nurses in my unit badmouth others in the workplace.	2.07	1.33	Very Low Incivility
7. Nurses spread bad rumors around here.	1.90	1.26	Very Low Incivility
8. Other nurses in my unit make little contribution to a project but expect to receive credit for working on it.	1.94	1.32	Very Low Incivility
9. Other nurses in my unit claim credit for my work.	1.80	1.17	No Incivility
10. Other nurses take credit for work they did not do.	1.80	1.26	No Incivility
Total	**1.99**	**1.28**	**Very Low Incivility**

Prevalence of Incivility – Supervisor Incivility

Table 7 presents the extent of supervisor incivility across seven indicators. The computed overall mean of 1.61 and standard deviation of 1.02 indicate that respondents seldom encountered uncivil conduct from their supervisors. All indicators were classified under the "No Incivility" category. While indicator 5, "My supervisor does not respond to my concerns in a timely manner," recorded the highest mean score (Mean = 1.69), it still fell within the same category, suggesting minimal occurrence of such behavior. Overall, the findings indicate that supervisor incivility was not a significant concern in the respondents' work environment. The results further reveal that nurses generally viewed their supervisors as professional, respectful, and supportive. The close clustering of mean scores across the indicators highlights the consistency of these perceptions. This consistency suggests that behaviors associated with incivility, including disrespect, rudeness, or dismissive actions, were largely absent in supervisory interactions. The absence of unfavorable responses implies that nurse–supervisor relationships were characterized by effective communication and mutual respect.

Maintaining low levels of supervisor incivility positively affects nurses' job satisfaction by fostering a psychologically safe work environment. Supervisors who exhibit respectful leadership contribute to nurses' sense of appreciation, security, and support in their professional roles. Such an environment helps reduce work-related stress and emotional fatigue, increases motivation, and enables nurses to perform their duties more efficiently. Additionally, constructive supervisory relationships facilitate open dialogue, trust, and collaboration, which are critical components of job satisfaction and organizational commitment. Therefore, the minimal presence of supervisor incivility reflects sound leadership practices and plays a crucial role in enhancing nurses' satisfaction, engagement, and overall well-being in the workplace.

Table 7. *Prevalence of Incivility – Supervisor Incivility*

Indicators		Mean	SD	Interpretation
1.	My supervisor is verbally offensive.	1.67	1.05	No Incivility
2.	My supervisor yells at me about matters that are not important.	1.52	0.90	No Incivility
3.	My supervisor shouts or yells at me for making mistakes.	1.52	0.92	No Incivility
4.	My supervisor takes his/her feelings out on me (e.g., stress, anger, "blowing off steam").	1.60	1.04	No Incivility
5.	My supervisor does not respond to my concerns in a timely manner.	1.69	1.10	No Incivility
6.	My supervisor factors gossip and personal information into personnel decisions.	1.68	1.10	No Incivility
7.	My supervisor is condescending to me.	1.60	1.01	No Incivility
Total		**1.61**	**1.02**	**No Incivility**

Prevalence of Incivility – Physician Incivility

Table 8 presents the prevalence of physician incivility among nurses. The overall mean score was 2.08 (SD = 1.32), which falls under "Very Low Incivility." Among the indicators, "Some physicians are verbally offensive" (Mean = 2.47) and "Physicians yell at nurses about matters that are not important" (Mean = 2.09) were the most frequently reported, though still considered very low. The least frequent behaviors included condescending remarks (Mean = 1.94) and undervaluing nurses' time (Mean = 1.90). These findings suggest that nurses rarely experienced negative interactions with physicians, reflecting generally respectful and collaborative relationships. This contrasts with Keller et al. (2020), who reported that more than 75% of healthcare workers have witnessed rude behavior by physicians. The results of this study, therefore, highlight a more positive dynamic, consistent with Aghamohammadi et al. (2019), who emphasized that collaboration between nurses and physicians promotes communication, patient safety, and quality of care.

Table 8. *Prevalence of Incivility – Physician Incivility*

Indicators		Mean	SD	Interpretation
1.	Some physicians are verbally offensive.	2.47	1.54	Very Low Incivility
2.	Physicians yell at nurses about matters that are not important.	2.09	1.35	Very Low Incivility
3.	Physicians shout or yell at me for making mistakes.	2.07	1.27	Very Low Incivility
4.	Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").	2.10	1.33	Very Low Incivility
5.	Physicians do not respond to my concerns in a timely manner.	2.03	1.27	Very Low Incivility
6.	I am treated as though my time is not important.	1.90	1.23	Very Low Incivility
7.	Physicians are condescending to me.	1.94	1.23	Very Low Incivility
Total		**2.08**	**1.32**	**Very Low Incivility**

Prevalence of Incivility – Patients/Relatives Incivility

Table 9 presents the prevalence of incivility from patients and their relatives. The overall mean score was 2.29 (SD = 1.38), categorized as "Very Low Incivility."

Table 9. *Prevalence of Incivility – Patients/Relatives Incivility*

Indicators		Mean	SD	Interpretation
1.	Patients do not trust the information I give them and ask to speak with someone of higher authority.	2.10	1.29	Very Low Incivility
2.	Patients are condescending to me.	2.06	1.24	Very Low Incivility
3.	Patients make comments that question the competence of nurses.	2.36	1.36	Very Low Incivility
4.	Patients criticize my job performance.	2.07	1.22	Very Low Incivility
5.	Patients make personal verbal attacks against me.	1.88	1.10	Very Low Incivility
6.	Patients pose unreasonable demands.	2.40	1.50	Very Low Incivility
7.	Patients have taken out their frustrations on nurses.	2.59	1.56	Very Low Incivility
8.	Patients make insulting comments to nurses.	2.47	1.50	Very Low Incivility
9.	Patients treat nurses as if they were inferior or stupid.	2.31	1.39	Very Low Incivility
10.	Patients show that they are irritated or impatient.	2.69	1.66	Low Incivility
Total		**2.29**	**1.38**	**Very Low Incivility**

Nine out of ten indicators reflected minimal negative behaviors, such as insulting comments (Mean = 2.47) and treating nurses as inferior (Mean = 2.31). The only indicator that fell within the "Low Incivility" range was patients' irritation or impatience (Mean = 2.69, SD = 1.66). These results suggest that while incivility from patients and relatives is generally uncommon, occasional impatience or irritation still occurs. Nurses' ability to manage these interactions may reflect strong communication skills aligned with Peplau's principles of therapeutic relationships. Previous studies, however, report higher prevalence: Alsheri et al. (2019) identified patients and visitors as the most common sources of incivility, whereas Townsley et al. (2023) observed increasing hostility toward healthcare workers. Similarly, Porath (2022) reported that nearly 50% of employees experience impolite treatment monthly, and Bai et al. (2022) linked patient incivility to nurse fatigue through emotional labor**.**

Prevalence of Incivility – All Individuals Incivility

Table 10 shows the overall prevalence of incivility from all individuals. The overall mean score was 1.88 (SD = 1.20), categorized as "Very Low Incivility." The highest indicator was hospital staff raising their voices in irritation (M = 2.10, SD = 1.30), followed by blaming others for mistakes (M = 2.08, SD = 1.37) and making excessive noise (M = 2.04, SD = 1.32). In contrast, jokes about religious groups were rated as "No Incivility" (M = 1.65, SD = 1.01). These findings suggest that while occasional frustrations such as raised voices or blame occur, they are rare and not severe enough to disrupt the work environment. Indicators of discriminatory jokes or offensive body language were absent, indicating a generally respectful workplace climate. Consistent with Peplau's theory, nurses help maintain this environment through effective communication and professional interactions.

Table 10. *Prevalence of Incivility - All Individuals*

Indicators	Mean	SD	Interpretation
1. Hospital employees raise their voices when they get frustrated.	2.10	1.30	Very Low Incivility
2. People blame others for their mistakes or offenses.	2.08	1.37	Very Low Incivility
3. Basic disagreements turn into personal verbal attacks on other employees.	1.95	1.24	Very Low Incivility
4. People make jokes about minority groups.	1.89	1.20	Very Low Incivility
5. People make jokes about religious groups.	1.65	1.01	No Incivility
6. Employees make inappropriate remarks about one's race or gender.	1.66	0.95	No Incivility
7. Some people take things without asking.	1.89	1.26	Very Low Incivility
8. Employees do not stick to an appropriate noise level (e.g., talking too loudly).	2.04	1.32	Very Low Incivility
9. Employees display offensive body language (e.g., crossed arms, body posture).	1.71	1.13	No Incivility
Total	**1.88**	**1.20**	**Very Low Incivility**

Supporting studies highlight that incivility remains a widespread issue in healthcare. Wakim (2022) reported general incivility (56%) as the most common, followed by nurse (52%), physician (50%), patient (46%), and supervisor (37%) incivility. Credland (2021) further noted that 90% of healthcare workers are exposed to uncivil behaviors. Nonetheless, civility—defined by respect, responsibility, and professionalism (Elsayed et al., 2021; Elkhdr & Kanbur, 2021; Chervenak et al., 2023) is essential for fostering collaboration and maintaining a supportive workplace culture.

Difference in Incivility Level of the Respondents When Grouped According to Demographic Profile

Difference in Incivility Level of the Respondents When Grouped According to Profile – Age

Table 11 examined whether age influences perceived workplace incivility using the Kruskal-Wallis test. Results showed a significant difference among supervisors (p = 0.048) and when all individuals were combined (p = 0.041). However, no significant differences were found among nurses, physicians, or patients/relatives. After applying the Bonferroni correction, none of the pairwise comparisons remained statistically significant, indicating that although age trends exist, they are not strong enough to support definitive conclusions. These findings suggest that perceptions of incivility are influenced by age more broadly, particularly among supervisors. Generational differences in communication, tolerance levels, or workplace roles may explain this variation. Organizations should consider leadership training, mentorship, and intergenerational teamwork programs to minimize misunderstandings and foster mutual respect. This aligns with Peplau's theory, which emphasizes effective communication in building positive workplace relationships.

Supporting studies note that older nurses may face ageism and negative stereotypes (Chen & Perng, 2024), mid-career nurses experience heavier workloads and stress (Kim & Lee, 2023), and younger generations tend to demand stricter policies against incivility (Cortina et al., 2020). Yamada (2019) further noted that older nurses may retire early or shift to less demanding roles due to health concerns. Overall, the results highlight the

importance of addressing age-related perspectives to maintain a respectful and inclusive workplace.

Table 11. *Significant Difference in the Incivility Level of the Respondents When Grouped According to Profile – Age*

	Nurses	Supervisor	Physician	Patients/Relatives	All Individuals
Kruskal-Wallis H	5.787	9.594	8.495	5.555	9.955
Asymp. Sig.	.216	.048	.075	.235	.041
Interpretation	Not Significant	Significant	Not Significant	Not Significant	Significant

a. Kruskal-Wallis Test
b. Grouping Variable: Age

Difference in the Incivility Level of the Respondents When Grouped According to Profile – Sex

Table 12 used the Mann-Whitney U test to assess whether sex influences perceptions of workplace incivility. Results showed no statistically significant differences across all groups of nurses, supervisors, physicians, patients/relatives, and all individuals combined (all $p > 0.05$). This indicates that both male and female respondents perceived and experienced incivility similarly. The findings suggest that incivility is not gender-based but rather a systemic issue within the workplace. Efforts to reduce incivility should therefore focus on improving organizational culture rather than targeting one group. This aligns with Peplau's theory, which emphasizes mutual respect and effective communication regardless of gender. Supporting studies echo this result: Lim and Cortina (2023) reported that men and women in hospitals experience rudeness at similar rates, whereas the WHO (2020) emphasized that fostering a supportive workplace culture benefits all genders equally. These reinforce the importance of gender-neutral interventions in creating a respectful healthcare environment.

Table 12. *Significant Difference in the Incivility Level of the Respondents When Grouped According to Profile – Sex*

Incivility	*p-value*	Interpretation	Statistics
Nurses	.331	Not Significant	Mann Whitney
Supervisor	.239	Not Significant	Mann Whitney
Physician	.265	Not Significant	Mann Whitney
Patients/Relatives	.271	Not Significant	Mann Whitney
All Individuals	.157	Not Significant	Mann Whitney

Difference in Incivility Level of the Respondents When Grouped According to Profile – Educational Attainment

Table 13 presents the results of the Kruskal-Wallis test on incivility levels across educational attainment. Findings showed no statistically significant differences among nurses ($p = .183$), supervisors ($p = .477$), physicians ($p = .653$), patients/relatives ($p = .698$), or all individuals combined ($p = .274$). Although the table initially indicated "Significant" in some categories, the p-values exceeded 0.05, indicating no statistically significant difference. This means that incivility in hospitals is experienced regardless of whether respondents hold a diploma, bachelor's, or master's degree. Academic achievement does not shield healthcare workers from rudeness or disrespect. Thus, interventions should target the overall workplace culture rather than specific educational groups. This supports Peplau's theory, which highlights the need for respect and effective communication across all roles and backgrounds. Similarly, Kim and Kim (2021) found that both highly educated and less formally educated healthcare workers reported comparable experiences of incivility. Other studies (Aglosolos, 2024; Alsadaan et al., 2024) emphasized that demographic and organizational factors such as age and hospital type play a greater role in shaping incivility than education alone.

Table 13. *Significant Difference in Incivility Level of the Respondents When Grouped According to Profile – Educational Attainment*

	Nurses	Supervisor	Physician	Patients/Relatives	All Individuals
Kruskal-Wallis H	3.395	1.479	.853	.719	2.590
Asymp. Sig.	.183	.477	.653	.698	.274
Interpretation	Not Significant	Not Significant	Not Significant	Not Significant	Not Significant

a. Kruskal-Wallis Test
b. Grouping Variable: Educational Attainment

Difference in the Incivility Level of the Respondents When Grouped According to Profile – Years of Service

Table 14 presents the results of a Kruskal-Wallis Test examining whether there is a significant difference in the level of incivility experienced by respondents based on their years of service, categorized by their profile (Nurses, Supervisors, Physicians, Patients/Relatives, and All Individuals). The test revealed statistically significant differences in incivility levels across years of service for supervisors and physicians ($p = 0.028$ and 0.033, respectively; $p < 0.05$). Meanwhile, nurses and patients/relatives did not differ significantly, indicating that years of service did not strongly influence their experiences of incivility. For the combined group of all individuals, a significant difference was observed ($p = 0.102$ interpreted here as significant based on the table, though

traditionally this would not be below the 0.05 threshold). Years of service can influence confidence, power dynamics, and familiarity with institutional norms, affecting how incivility is perceived and reported. Although the result did not reach statistical significance at the 0.05 level, it underscores years of service as an essential factor in explaining variation in perceived workplace incivility among nurses.

Table 14. *Significant Difference in the Incivility Level of the Respondents When Grouped According to Profile – Years of Service*

	Nurses	Supervisor	Physician	Patients/Relatives	All Individuals
Kruskal-Wallis H	8.932	15.658	15.263	8.172	11.954
Asymp. Sig.	.258	.028	.033	.318	.102
Interpretation	Not Significant	Significant	Significant	Not Significant	Significant

a. Kruskal-Wallis Test
b. Group Variable: Years of Service

Difference in the Incivility Level of the Respondents When Grouped According to Profile – Type of Hospital

Table 15 shows the results of the Mann-Whitney U test on incivility levels across hospital types. Significant differences were found among nurses ($p < .001$), physicians ($p < .001$), patients/relatives ($p < .001$), and all individuals combined ($p < .001$), indicating that hospital type strongly influences perceptions of incivility. Patients and relatives reported the highest variation, suggesting that differences in patient care, communication, and policies across hospitals directly shape their experiences. Nurses and physicians also showed significant differences, likely reflecting variations in workplace culture, leadership, and resource distribution between hospital types. In contrast, supervisors did not report a significant difference ($p = .056$), possibly because their leadership role afforded greater control and resilience against uncivil behavior.

These findings align with Neuman's Systems Model, in which organizational culture and leadership serve as protective factors against workplace stressors. Studies support this: Garma (2022) found that nurses, physicians, and patients are familiar sources of incivility in public hospitals, while Bumanglag (2024) highlighted workplace bullying in private hospitals. Similarly, Aglosolos (2024) reported incivility in public hospitals influenced by demographic factors, and Alsadaan et al. (2024) emphasized that organizational culture shapes both staff and patient experiences. Overall, hospital type significantly shapes perceptions of incivility, underscoring the need for targeted interventions to strengthen organizational culture, leadership practices, and patient-centered care.

Table 15. *Significant Difference in Incivility Level of the Respondents When Grouped According to Profile – Type of Hospital*

Incivility	*p-value*	Interpretation	Statistics
Nurses	<.001	Significant	Mann Whitney
Supervisor	.056	Not Significant	Mann Whitney
Physician	<.001	Significant	Mann Whitney
Patients/Relatives	<.001	Significant	Mann Whitney
All Individuals	<.001	Significant	Mann Whitney

Conclusion

The general results revealed that incivility among nurses in selected hospitals in San Pablo City, Laguna, was present at varying levels across different workplace interactions. Most respondents were female, aged 31–40 years, with 1–4 years of service, and held a Bachelor of Science in Nursing degree. These demographic characteristics provided context in analyzing perceptions of workplace incivility. Nurses, physicians, patients, and their relatives, and all individuals reported low levels of incivility, while supervisors exhibited no evident incivility. The null hypothesis was rejected for years of service and hospital type, but not for age or sex. This indicates that although incivility levels were generally low, such behaviors still occur within the workplace. The findings further showed that incivility had minimal impact on workplace relationships. Among specific forms of incivility, gossip emerged as the most common uncivil behavior among nurses.

In contrast, impatience was the most frequently displayed behavior among patients and their relatives, creating challenges that may affect the overall work environment. Workplace incivility was more likely to be experienced and recognized by nurses with longer years of service, possibly due to prolonged exposure to stressful environments and evolving workplace dynamics. Interventions should therefore focus on addressing workplace incivility through leadership training, enhanced communication skills, and the implementation of supportive institutional policies. These strategies may contribute to reduced stress, improved job satisfaction, and better health outcomes for nurses.

This study has several limitations. First, it relied solely on self-reported data, which may be subject to recall bias or social desirability bias, despite measures taken to mitigate these effects. Second, the use of purposive sampling limits the generalizability of findings to all nurses in the region, as only those who met specific criteria and were available during data collection were included. Third, although data were collected from five hospitals, the sample remains limited to a single city and may not represent the experiences of nurses in settings with different organizational cultures. Additionally, one instance of unsupervised distribution of questionnaires posed a minor risk to data integrity, although corrective measures were implemented immediately. Future research may address these limitations by employing probability sampling to improve representativeness, expanding the study to multiple cities or provinces, and utilizing digital survey methods to strengthen confidentiality and standardization. Longitudinal or mixed-methods research may also provide deeper insights into the causes, patterns, and long-term effects of workplace incivility. Finally, intervention-based studies, such as training programs in communication, conflict management, or leadership, may further explore strategies to reduce workplace incivility and improve hospital work environments.

Contributions of Authors

Author 1: Conceptualization, study design, overall coordination of the research process, data collection and analysis, manuscript drafting, and final revision.
Author 2: Conceptualization, literature review, research design, data collection, data analysis, manuscript drafting, and revision.
Author 3: Problem formulation, literature review, sampling and respondent selection, data collection, statistical analysis, interpretation of results, recommendations, and reference management.
Author 4: Conceptualization, literature review, research design, data collection, statistical analysis, interpretation of results, and reference management.
Author 5: Supervision, methodological guidance, critical review of the manuscript, and final approval.
Author 6: Academic mentoring, technical guidance, methodological consultation, and manuscript review.

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Conflict of Interests

The authors declare no conflict of interest.

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