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The hidden cost of abusive supervision: rudeness, sabotage, and ethics

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Abstract

Abusive supervision in healthcare settings can have detrimental effects on employee behavior and patient care, making it crucial to understand the underlying mechanisms and mitigating factors. This study examines the impact of abusive supervision on patient-directed service sabotage, focusing on the mediating role of workplace rudeness and the moderating effect of work ethics. Data were collected from 305 hospital nurses, and structural equation modeling (SEM) was used to test the proposed model. The findings reveal that abusive supervision significantly increases workplace rudeness, which in turn escalates to service sabotage. However, strong work ethics were found to weaken the link between rudeness and sabotage, demonstrating their protective role in this negative cycle. The moderated mediation analysis further confirms that work ethics reduce the indirect impact of abusive supervision on service sabotage through rudeness. These results contribute to our understanding by illustrating how ethical standards can buffer against the negative consequences of abusive supervision, providing practical implications for enhancing leadership practices and promoting ethical behavior in healthcare environments.

Keywords Abusive supervision, Workplace rudeness, Work ethics, Patient-directed service sabotage, Social exchange theory, Health service organizations

Introduction

Behaviors can be "caught," just like diseases. Researchers have been examining behavioral contagion in organizations for about 40 years, and their findings have supported this phenomenon. Preliminary studies in this field mainly concentrated on the impact of positive behaviors [1–4], however, more recently researchers have started to emphasize that negative behaviors can spread as well [5–8]. For instance, studies on teams and groups have demonstrated that antisocial behaviors are contagious [9, 10]. Similarly, when employees feel that there has been unjust treatment by their supervisors, they frequently transfer this harshness to customers [11]. These kinds of treatments are very damaging to the service sector, especially in the healthcare sector. This sector has been regarded as a high-pressure work sector where the high pressure of supervisors and jobs usually leads to the mistreatment of patients [12].

In today's dynamic and highly competitive healthcare environment, quality in patient care is of great importance not only for the sake of patients but also for the sustainability and reputation of a given healthcare organization. Despite this, a negative work-related factor such as abusive supervision massively affects the quality of patient care. Though abusive supervision has been a topic of considerable research interest for the past two decades as a form of supervisory behavior characterized by sustained display of hostile verbal and non-verbal behaviors by supervisors toward subordinates [13, 14], this behavior has been researched in relation to negative consequences within organizations [15, 16]. However, the means by

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which abusive supervision influences employee behaviors that can directly affect patient care have received relatively less attention in this research [17].

Service sabotage, especially in the context of patients, is a very big threat to health institutions because it compromises patient safety and satisfaction and might land the institution in possible legal complications [18]. For these reasons, it is important to study the precursors of this destructive behavior. A recent study proposes that abusive supervision has a significant effect on service sabotage [19], similarly, another study suggested that there is a relationship between abusive supervision and rudeness [20]. Rudeness, often a reaction to mistreatment at the moment, not only lowers the quality of the immediate work environment but has the potential to escalate into more severe forms of workplace deviance such as service sabotage. Precisely what conditions encourage this escalation, however, has been somewhat under-examined, leaving a critical gap in current literature.

The present study has thus used social exchange theory (SET), which argues that the nature of exchanges between supervisors and subordinates molds employees' attitudes and behaviors [21, 22]. Negative exchanges represented by abusive supervision can trigger negative reciprocation [23], which gets reflected in the form of employee rudeness toward a patient who then receives this through service sabotage. On the other hand, SET also provides room for individual differences, such as work ethics, which moderates the effect of such negative exchanges. For example, workers with a strong work ethic may resist the urge to engage in deviant work behavior even when they are being maltreated [24], so that possibly, the vicious cycle of such relationships can be broken.

The current study examines the mediating role of employee rudeness in the relationship between abusive supervision and service sabotage directed toward patients, considering the moderating effect of work ethics. Integrating such variables to be presented in a single, coherent model, the current study will not only add to our global understanding of how toxic leadership behaviors trickle down to affect the quality of patient care but, rather importantly, explain how individual characteristics, such as work ethic, may potentially serve as protective factors against such detrimental outcomes.

The theoretical implication of the findings of the current study will further extend the SET, adding the moderating role of work ethics in healthcare settings where ethical standards are clearly defined. Practically, this research will contribute insights to various healthcare organizations, including recommendations regarding the importance of supervisory behavior and employee ethics for preventing service sabotage and ways to diminish associated risks and enhance patient care outcomes. The research model of the current study is shown in Fig. 1.

Theory and hypotheses

Social exchange theory

The social exchange perspective argues that social exchange theory offers a good theoretical explanation for understanding the relational dynamics between supervisors and employees [25], particularly in environments where abusive supervision exists. This negative supervisory behavior describes, in effect, employee outcomes in terms of workplace interactions, including rude behavior and patient-directed service sabotage. According to the tenets of SET which argue that workplace interactions reflect social transactions or the competitive attempts of individuals to maximize rewards and minimize costs. Abusive behaviors by supervisors disrupt the perceived fairness and balance in these exchanges [26], which leads to employees reciprocating their own negative behaviors so as to rebalance the relationship.

In the healthcare context, the exchange comes in the form of employee rudeness, response to what they perceive as inequity and abusive treatment from their supervisors. SET explains that these negative

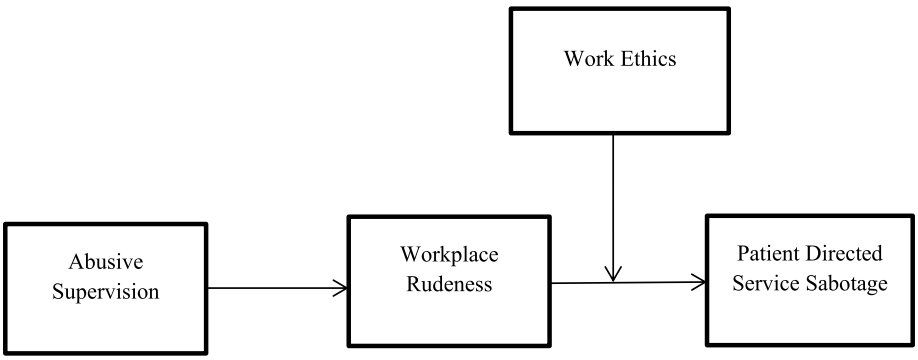

Fig. 1 Research model

interactions have the potential to spiral where incivility leads to more serious behaviors, including even service sabotage, especially when the target is a vulnerable party, in this case, patients. However, SET does acknowledge the role of individual differences [27] such as work ethics in moderating these negative responses. Strong work ethics will enable the employee to desist from reciprocating abusive supervision with harmful behaviors in turn stopping the negativity loop. This study, through the application of SET, brings to light the subtlety of interaction among supervisory behavior, employee ethics, and service results within healthcare environments.

Abusive supervision and workplace rudeness

Defined as the persistent exhibition of aggressive behaviors of the supervisors toward their subordinates [28, 29], abusive supervision strongly influences the behavior of employees and the workplace. Abusive supervision is a destructive form of supervision and would hence lead to several possible negative outcomes [23], one of which would be workplace rudeness. Workplace rudeness entails subtle, low-intensity deviant behaviors that violate the norms of respect and civility [30].

SET provides a theoretical lens through which the abusive supervision/workplace incivility relationship can be viewed. SET argues that employees will act in ways that indicate exchange under conditions of perceived equity or inequity in the workplace [21]. Employees view abusive supervision as a violation of the psychological contract, whereby justice will prevail and the organizational contract will be restored. This sense of injustice often results in workplace incivility where members start manifesting their unhappiness and striking back at the offending party in ways that are less overt but still disturbing [20].

Empirical findings support this relationship, in that employees experiencing abusive supervision indulge in more counterproductive work behaviors than other employees [31], including rudeness [32]. These are means to handle the stress and frustration caused by such treatment towards an employee's life. Also, rudeness can be another way through which one can take charge of their surroundings, subtly challenging the authority of an abusive boss without direct confrontation. Based on this theoretical and empirical foundation, we hypothesize the following:

> H1: *Abusive supervision is positively related with workplace rudeness*

Workplace rudeness and service sabotage

Workplace rudeness, subtle low-intensity deviant behavior that deviates from respect norms, can have significant downstream effects on employees' behaviors [30], including service sabotage. In healthcare, for example, service sabotage could mean intentional practices by employees leading to the degradation in the quality of care for patients, thereby posing important risks to the safety of patients and the reputation of the organization. Social Exchange Theory further helps to give a strong explanation of the relationship between workplace rudeness and service sabotage. The SET postulates that relations in the workplace are based on reciprocity [26], where individuals respond to others' behaviors based on their perceptions of the equality or inequality of social exchange [33, 34]. In another vein, when employees encounter rudeness or are victims of rudeness, this circumstance could signify an imbalance in social exchange that can be perceived as a sense of inequity and lead to the development of anger [32]. The latter negative emotions could prompt employees to regain balance by acting out retaliatory behaviors, specifically service sabotage [35].

In this regard, the literature suggests that when employees perceive any breach in the social contract [36], because of workplace rudeness, they respond by withdrawing their positive contributions to the organization and resorting to behaviors that harm the organization. This corresponds with SET in the sense that the employees may view service sabotage as a way to even the score by further responding to mistreatment through low levels of commitment to providing high-quality service [20]. More empirical evidence has also supported the idea that rudeness at the workplace seems to degenerate further into some of the most extreme forms of deviant work behaviors [30, 37]. In this regard, some studies have identified employees experiencing or witnessing a rude event at work as more predisposed to engaging in counterproductive work behaviors directed at the deliberate undermining of service quality [32, 38]. This information corresponds to SET's assumption that employees if they feel mistreated, react through sabotage because it is one way of regaining control and trying to get a fair environment back again in the organization. Based on this theory and empirical evidence, we postulate the following hypothesis:

> H1: *workplace rudeness is positively related with patient directed service sabotage*

Mediating role of workplace rudeness

In the workplace, abusive supervision has been shown to lead to a variety of negative outcomes, particularly through the lens of SET [21, 26]. According to SET, employees respond to the quality of their interactions with supervisors and the organization based on the perceived fairness of these exchanges [17, 39]. When

employees experience abusive supervision, they perceive a violation of the social contract, leading to feelings of injustice and a desire to restore balance [26, 40]. This often results in retaliatory behaviors, one of which is workplace rudeness. Workplace rudeness, in turn, can further exacerbate negative behaviors in the workplace [30], particularly in the form of service sabotage. Rudeness creates a toxic work environment, lowering employees' emotional and cognitive resources and making them more likely to engage in behaviors that harm the organization [37], such as deliberately compromising the quality of service provided to patients.

SET provides a coherent explanation for this process, suggesting that when employees experience abusive supervision, they may initially respond with rudeness as a form of low-level retaliation. As these negative exchanges accumulate, employees may escalate their retaliatory behaviors to more severe actions [17, 21], such as service sabotage, particularly when they perceive that rudeness alone is insufficient to restore perceived fairness in the exchange relationship [35]. Empirical research supports the mediating role of workplace rudeness in the relationship between abusive supervision and more severe workplace deviance [32]. Studies have shown that employees who experience abusive supervision are more likely to engage in rudeness [11], which then predicts further negative behaviors like service sabotage. This suggests that workplace rudeness serves as a critical link between the initial experience of abuse and the subsequent escalation to more harmful behaviors. Based on this theoretical and empirical foundation, we hypothesize:

> H3: *Workplace rudeness mediates the relationship between abusive supervision and patient directed service sabotage*

Moderating role of work ethics

Work ethics, described as a set of moral principles guiding employee behavior within the work arena [41], assumes critical influence in shaping how employees react to such adverse conditions as abusive supervision. SET posits that employees respond to the quality of exchanges with their supervisors and organizations based on perceived fairness and reciprocity [21]. As the above example illustrates, employees with abusive supervision may feel a strong urge to get back at their supervisors in the form of negative behaviors of workplace rudeness and service sabotage [11, 32]. Individual differences, such as strength in an employee's work ethic, can moderate these responses. Employees with strong work ethics are more likely to stick to ethical standards and moral obligations even under mistreatment [17, 42]. These workers might view retaliatory acts, such as rudeness and sabotage, as inappropriate and not aligned with their values and morals. Therefore, they might not engage in such actions even if they are subjected to abusive supervision, thereby breaking the vicious cycle that would typically arise in accordance with SET.

On the other hand, an employee with a poor work ethic is likely to have the tendency to reciprocate perceived injustice with negative behaviors, as predicted by SET principles [39]. Empirical evidence shows that work ethics moderate the relationship between negative behaviors and employee outcomes [43]. For instance, employees who have strong ethical beliefs are less likely to engage in counterproductive work behaviors as a response to injustice [44]. This means that work ethics may serve to protect employees from the negative influence of abusive supervision on workplace rudeness and service sabotage. Based on this theoretical and empirical ground, we proposed the following hypothesis:

> H4: *Work ethics moderates the relationship between workplace rudeness and patient directed service sabotage, such that the positive association between rudeness and sabotage is weaker for employees with strong work ethics*

Moderated mediation can explain the interaction effects between abusive supervision, workplace rudeness, service sabotage, and work ethics. A moderated mediation effect is one in which the strength of an indirect effect (mediation) varies depending on boundary conditions. SET provides a useful lens through which to consider how abusive supervision contributes to service sabotage via workplace rudeness and in turn, moderating effects of an employee's work ethic and its influence on that link. Abusive supervision will instill a sense of injustice likely to make employees act rudely in the first instance of retaliation [23]. This form of rudeness is what could then transform into counterproductive work behavior of an extreme kind, such as service sabotage, as employees try to realign equity in their work situation [35]. However, the degree to which this escalation occurs may depend on the employee's work ethic. Employees who have a strong work ethic are unlikely to allow their feelings of mistreatment to materialize as destructive behaviors toward the organization [45], like service sabotage, even if they behave rudely in the workplace [11]. This might suggest that work ethics moderate the indirect effect of abusive supervision on service sabotage through rudeness. In more specific terms, a strong work ethic would moderate the power of rudeness to predict service sabotage between abusive supervision and organizational behaviors, in that employees would be less likely to proceed with the escalation of negative behavior.

Empirical work also indicates that ethical values can slow down the process of translating negative experiences into destruction. Studies have shown that strong ethical values reduce negative emotional reactions in general, which then trigger unfair treatment as a result of perceived unfairness [46]. On this theoretical and empirical basis, we postulate that:

> H5: *Work ethics moderates the mediated relationship between abusive supervision and patient directed service sabotage through workplace rudeness, such that the indirect effect of abusive supervision on sabotage via rudeness is weaker for employees with strong work ethics.*

Methods

Participants and procedure

The majority of research on rudeness and sabotage has used samples from the service sector, including hotels, restaurants, hospitals, customer service centers, airline services, and transportation firms [30, 37, 47]. As the sample of this present study, nurses were targeted in hospitals, as their work entails high emotional labor, interaction with supervisors, and patients regularly. In addition, because many hierarchical structures occur in hospital settings where there is an imbalance of power between supervisors and subordinates, nurses are highly susceptible to the outcomes of abusive supervision. Such power dynamics can exacerbate the already negative effects that toxic leadership, manifesting as abusive supervision, has on the behavioral aspects of both employees and their patients. The context of the health sector in Pakistan provides a very unique setting in which these issues may be considered. For example, the cultural norms of Pakistan tend to respect authority and hierarchical-oriented structures that may influence the way nurses contemplate and respond to abusive supervision. Abusive supervision may be magnified in those cultures where subordinates feel less empowered to challenge authority, leading to destructive behaviors like workplace rudeness and patient-directed service sabotage.

Thus, researching this demographic will provide an opportunity to study abusive supervision dynamics in a high-stakes environment that is also culturally peculiar and will yield valuable lessons that perhaps can be generalized to other healthcare settings with similar hierarchical and cultural norms [48, 49]. Because the focus of this current study is on Pakistani nurses, we believe the findings will carry wider implications for health settings around the world, particularly where similar organizational structures and cultural factors exist. In addressing abusive supervision and workplace rudeness in relation to patient service sabotage in this context, we aim to extend the understanding of how leader behaviors are influential in healthcare delivery across divergent cultures and organizational environments. According to earlier research, hospital nurses engage in a lot of adverse behaviors while on the job [50]. As a result, we chose to include nurses in the sample for this investigation.

In light of probable emotional and psychological impacts, considering the various discussions on sensitive issues like abusive supervision, several steps were taken to ensure that all participants were protected in terms of well-being and confidentiality: ethics approval of data collection from the Ethics Committee. All data was collected anonymously to maintain participant confidentiality, and no response had identifying information linked to such data. Participants were told that their participation was voluntary, and they could withdraw at any moment in time without any repercussions. In addition, we have ensured data confidentiality, which was used only for research purposes. Data was well stored and nobody but the team had access to information. Consent was obtained from all participants before beginning the process. All participants were thoroughly informed about the aims of the research study, the type of questions, and sensitive topics that may arise. The design of this study is cross-sectional, consistent with some past studies [51–54]. Over two rounds, we collected information from nine big hospitals in Pakistan. The administrators of the hospitals and their ethics committees permitted us to commence the study. Following our meeting with the head nurses of each department, we requested that they urge nurses to take part in the survey by outlining the objectives and conditions of the current study. Following that, we distributed 600 questionnaires to department heads, who assisted in forwarding the questionnaires to their followers. It was explained to each participant that in exchange for their time, they would receive a 300 PKR ($1.10) mobile gift card. Two days later, we went to the hospitals to collect the surveys, and we collected 456 questionnaires, representing a 76.00% response rate. Abusive supervision, workplace rudeness, work ethics, and demographic characteristics were measured in the first survey.

A follow-up questionnaire measuring patient-directed service sabotage was given to all workers who finished the Time 1 survey three months later. A total of 305 Time 2 surveys, of which 63.6% were female, were potentially matched with a corresponding survey at Time 1. The mean age of the nurses was 32.39 years (SD = 7.08), and their mean tenure in the hospital was 6.30 years (5.15).

Measures

Unless specified all items were evaluated on a five-point Likert scale ranging from 1 (strongly disagree) to

5 (strongly agree) which is consistent with past studies [55–58].

Abusive supervision was measured using Mitchell and Ambrose's [35] 5-item scale. One sample item includes "*My supervisor ridicules me.*" *Workplace rudeness* was measured using a 3-item scale adopted from Foulk et al's [30] study. Sample item included: "*I feel angry to others as a result of my supervisor's treatment of me.*" To gauge *patient directed service sabotage*, we employed the five-item Skarlicki et al's ([59]) scale. We changed the scale's term "customers" to "patients" for the current study in order to better suit the nurses' context. With a five-point Likert scale ranging from 1 = never to 5 = frequently, respondents rated the items. One such item was "*Purposefully transferred the patient to the wrong department.*" Ten items created by Sharma and Rai [60] were used to gauge *work ethics*. A sample item was: *"Even in this fast-changing world, sincerity, hard work, and integrity continue to be the golden keys to success in one's work life."*

Analysis and results

Using accepted practices, the validity and construct reliability were evaluated. All composite reliability (CR) ratings were substantially greater than 0.80 and Cronbach's alpha for all measures was higher than the predetermined cutoff point of 0.70 (see Table 1). These results demonstrate that the research items were internally consistent and represented the intended superordinate structures. Additionally, all factor loadings were significant and above 0.60 (see Table 1), indicating that these measures had appropriate levels of convergent validity [61–63]. We also provide two additional examples of adequate discriminant validity. First, according to Fornell and Larcker [61], every average variance extracted (AVE) value was higher than the squared correlation between any two constructs (see Table 2). Second, all measures' heterotrait-monotrait (HTMT) ratio values were significantly below the 0.85 limit [64].

Since we obtained data from a single source (nurses), we used a partialing-out marker variable technique to mitigate the possibility of common method bias (CMB). This method is used by calculating the correlation between latent variables or any measure without a theoretical relationship with significant variables included in the hypotheses, and the marker variable. After running two distinct models, one with and one without the marker variable, we assessed the R^2 of our model's endogenous constructs. We have enough evidence to conclude that CMB is not a cause for concern in our analysis because there was no discernible difference in R^2 between models for either of the variables being studied. Finally, our main hypothesis tests revealed substantial interaction effects, further supporting the absence of CMB. Further, we run the confirmatory analysis for the model testing and results show significant fit where fit indices (i.e., $\chi2 = 415.09$, df = 224, $\chi2/df = 1.85$, CFI = 0.96, TLI = 0.95, IFI = 0.96, NFI = 0.91, and RMSEA = 0.05) backing the fit of this model [65, 66].

Table 1 The output of the measurement model includes factor loading, Cronbach's alpha, composite reliability (CR), and average variance extracted (AVE)

Constructs	Items	Loadings	CR	Alpha	AVE
Workplace Rudeness (WR)	WR1	0.846	0.868	0.866	0.687
	WR2	0.816			
	WR3	0.824			
Abusive Supervision (AS)	AS1	0.760	0.883	0.881	0.601
	AS2	0.772			
	AS3	0.754			
	AS4	0.781			
	AS5	0.808			
Work Ethics (WE)	WE1	0.798	0.947	0.946	0.641
	WE2	0.789			
	WE3	0.810			
	WE4	0.779			
	WE5	0.802			
	WE6	0.808			
	WE7	0.818			
	WE8	0.781			
	WE9	0.820			
	WE10	0.802			
Patient Directed Service Sabotage (PDSS)	PDSS1	0.829	0.896	0.895	0.632
	PDSS2	0.836			
	PDSS3	0.724			
	PDSS4	0.791			
	PDSS5	0.791			

All loadings are significant at the $p < 0.001$ level

Hypothesis testing

This study used maximum likelihood estimation to analyze the relationships between studied variables using structural equation modeling (SEM). The structural model's standardized path coefficients are shown in Table 3, and the model's fit is supported by a number of model fit indices, including $\chi2 = 453.94$, df = 246, $\chi2/df = 1.84$, CFI = 0.95, TLI = 0.95, IFI = 0.95, NFI = 0.91, SRMR = 0.05, and RMSEA = 0.05. There is a significant positive relationship between abusive supervision and workplace rudeness ($\beta = 0.44$, $p < 0.01$), as well as workplace rudeness and patient directed service sabotage ($\beta = 0.26$, $p < 0.01$). H1 and H2 are therefore supported. The next step was to test the mediation of consumer inspiration using bootstrapping. According to Hayes'

Table 2 Mean, standard deviation, and correlation matrix of the study variables

Constructs	Mean	SD	1	2	3	4	5	6	7
1. Age[1] (T1)	32.39	7.08	-						
2. Gender (T1)	0.36	0.48	−0.14*	-					
3. Experience[1] (T1)	6.30	5.15	0.27**	−0.07	-				
4. Abusive Supervision (T1)	3.75	0.80	−0.14*	0.01	0.02	**(0.78)**			
5. Workplace Rudeness (T1)	4.04	0.94	0.12*	−0.08	−0.05	0.38***	**(0.83)**		
6. AI Ethics (T1)	3.02	1.34	0.02	0.02	0.11*	−0.26**	−0.10*	**(0.80)**	
7. PDSS (T2)	3.62	0.79	−0.01	−0.05	0.09	0.23**	0.19**	−0.42***	**(0.79)**

Age and experience are in years. $N = 305$. PDSS = Patient Directed Service Sabotage. Values in diagonal are square roots of AVE. T = Time. *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

[67] guideline, 5000 bootstrapping replications were employed to confirm that the upper and lower bounds of the confidence intervals (CIs) comprised zero, indicating an insignificant mediating effect. Table 3 illustrates that the indirect impact has a value of 0.05 and the CIs for the mediation of workplace rudeness on the relationship between abusive supervision and patient directed service sabotage do not include 0 (95% CI = 0.01, 0.11). These results suggest that a mediating influence is present. H3 is therefore supported.

Table 3 indicates a significant interaction between workplace rudeness and work ethics (β = -0.32, $p < 0.01$), which suggests that work ethics moderates the association between workplace rudeness and patient directed service sabotage. Additionally, Fig. 2 indicates that nurses with a high degree of work ethics have a weaker (β = -0.06, $p > 0.05$) relationship between workplace rudeness and patient directed service sabotage than those with a low degree of work ethics (β = 0.58, $p < 0.01$), supporting H4.

This study examined moderated mediation using model 14 in the PROCESS macro. Table 4 demonstrates that the impact of abusive supervision on patient directed service sabotage through workplace rudeness at the different levels of work ethics has a moderated mediation index of -0.08, with a 95% confidence interval (-0.13, -0.04) that excludes 0. These results demonstrate how, through workplace rudeness, work ethics mitigates the impact of abusive supervision on patient directed service sabotage. H5 is therefore supported.

Discussion

The findings of this study offer significant insights into the dynamics of abusive supervision, workplace rudeness, service sabotage, and the moderating role of work ethics in healthcare settings. Confirmatory results and deeper explanations of the hypothesized relationships on how negative supervisory behaviors can cascade to detrimental consequences with potential patient care impairments are discussed. There is a significant positive relationship between abusive supervision and workplace rudeness, consistent with prior studies that found that employees under supervisory hostility usually react defiantly to those behaviors [11, 31]. This result is in line with the SET dynamics, which posits that employees who feel unfairness in their exchanges with supervisors, largely characterized by abuse, will respond with social norm violations in the form of rudeness [32]. The positive relationship between workplace rudeness and patient-directed service sabotage may provide support for the claim that rudeness can further escalate to other serious counterproductive work behaviors [38]. This finding would support

Table 3 Results of hypotheses testing

	β			Supported
H1: Abusive Supervision–> Workplace Rudeness (WR)	0.44***			Yes
H2: WR –> Patient Directed Service Sabotage (PDSS)	0.26***			Yes
Moderation				
Work Ethics–> PDSS	-0.42***			
H4: WR* Work Ethics–> PDSS	-0.32***			Yes
Mediation				
	β	**LL**	**UL**	
H3: Abusive Supervision –> WR –> PDSS	0.05*	0.01	0.11	Yes

LL = lower level; UL = upper level; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

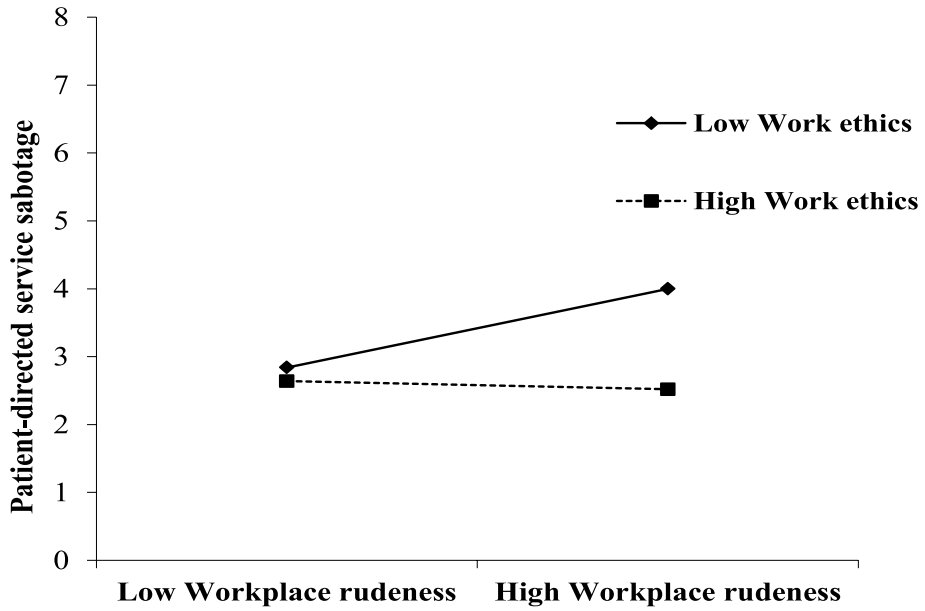

Fig. 2 Moderating impacts of Work ethics on the relationship between Workplace rudeness and Patient directed service sabotage

Table 4 Results of moderated mediation

Work Ethics	Indirect effects	SE	Boot LL 95% CI	Boot UL 95% CI
Workplace Rudeness				
-1 SD	0.19	0.05	0.08	0.29
Mean	0.07	0.03	0.02	0.14
+1 SD	-0.04	0.03	-0.11	0.02
Index of Moderated Mediation				
(H5)	-0.08	0.02	-0.13	-0.04

CI = Confidence Interval; Bootstrap sample size = 5000

theories of emotional contagion and resource depletion, in which rudeness represents one avenue through which a toxic work climate would erode employee emotional resources and give rise to these detrimental service behaviors [12, 68]. In a healthcare context, this is even more alarming because it affects the quality of care given to patients which could put their safety and well-being at risk.

It further established that workplace rudeness mediates the relationship between abusive supervision and service sabotage. The present result builds on past research by offering empirical support that rudeness serves as a fundamental way that abusive supervision underlies the worse forms of workplace deviance and, apparently, was a key mechanism. The result also reinforces the cascade effect of unfavorable supervisory behavior in the sense that initial reactions towards such acts of rudeness can progressively turn into more harmful deeds like service sabotage when employees seek to restore perceived fairness [32]. As for the healthcare administrator, this finding would be important to recognize how supervisory practices might indirectly affect patient care through the influence on employee behavior.

The interaction between workplace rudeness and work ethics was significant in moderating the relationship between workplace rudeness and service sabotage. More clearly, it was found that employees who possess strong work ethics would less likely escalate rudeness to patient directed service sabotage. Thus, this finding supports the notion of work ethics serving as a sort of buffer that would minimize the effects of workplace incivility outcomes [43]. These also relate to SET in the sense that high-ethic employees would not retaliate to further disrupt the social exchange and sabotage the organization. The study's moderated mediation analysis found the effect of abusive supervision on service sabotage through workplace rudeness to be weak for those employees who have stronger work ethics. This particular result has great implications as it argues that the dual role of work ethics—one is directly moderating the relationship of rudeness and sabotage, while another effect in the whole pathway from abusive supervision to sabotage—is in the entire way. We expand on and extend previous research to a considerable extent because this result, which demonstrates that ethical values may disrupt the negative cycle [69], does offer a more nuanced understanding of the conditions in which the conduct of adverse supervisors has deteriorated outcomes [28].

Finally, the sample of this study were nurses working in Pakistani hospitals. The sample of hospital nurses in Pakistan was selected because health is a high-pressure environment, but, probably even more importantly, the cultural norms of working that persist in this region. Pakistani organizational culture tends to be very hierarchical; respect for authority and obedience to supervisors are deeply inculcated. A contextual setting such as that can escalate the abusive supervision itself, further disempowering employees from voicing concerns or challenging authority. Thus, abusive supervision and these other negative supervisory behaviors may affect subordinate behaviors such as workplace rudeness and patient-directed service sabotage-even more.

Theoretical implications

The findings of this scholarship have important implications for both theory and literature, particularly in the areas of organizational behavior, healthcare management, and Social Exchange Theory. This study extends SET by indicating how negative exchanges at the workplace, such as abusive supervision, can lead to retaliatory behaviors that escalate from rudeness into even more severe acts like service sabotage. The results underline that workplace rudeness forms a critical mediating mechanism in such processes and, through the recent empirical support for the proposition that initial deviant low-level behaviors can escalate into more damaging actions when employees perceive an ongoing imbalance in their social exchanges, broadens the application of SET by detailing the processes through which negative leadership behaviors affect broader organizational outcomes [23].

The existence of work ethics as a moderating variable in the relationship between workplace rudeness and service sabotage introduces a new dimension to SET. Conventionally, SET has long worked by giving an explanation according to reciprocal exchanges made under perceived fairness [21, 25]. Individual differences, such as work ethics, were found to significantly change the expected outcomes of these changes. Employees high in work ethics may break the negative feedback loop that SET suggests and resist escalation into deviant behaviors. It means that SET can be further refined by using personal values and moral principles as moderators that will influence the negative workplace experience [20]. The study further supports the damaging consequences of abusive supervision, which are consistent with other studies linking hostile supervisory behaviors with diverse forms of workplace deviance [32, 70], but it is more advanced than previous research in that it provided empirical support to the progression from behaviors to rudeness and finally to service sabotage. This will make the outcomes of abusive supervision much better understood, particularly in high-risk environments like healthcare, where such behaviors could even bring direct negative consequences to the decline of patient care [71]. This is an important addition to health management literature since it points out the processes in detail by which negative supervisory behaviors result in deteriorating patient care.

Identification of workplace rudeness as a mediator and work ethics as a moderator in the same relationship gives meaningful insights to the healthcare manager into the actual dynamics that are at work in their context. The findings contribute to new insights on boundary conditions of work ethics that may buffer the escalation of negative behaviors in healthcare settings. In doing so, the study aligns with much literature on organizational ethical behavior (Li et al. [72]; Khan, Khan, and Soomro [73]), but the unique contribution is therefore centered around how these dynamics can play out in environments in which the stakes are particularly high, such as patient care.

Practical implications

The results of this scholarship have several significant practical implications, particularly for their leadership practices, and their strategies for managing employees. First, the current study demonstrates the serious need for most healthcare organizations to take strategic measures in order to manage abusive supervision. Given that a definite link has been established between abusive supervision and negativity in employees manifested in workplace rudeness and service sabotage, organizations should institute training programs targeted at the development of positive leadership skills and the limitation of hostile supervisory behaviors. This could be in the form of leadership development programs with a high focus on emotional intelligence, conflict resolution, and ethical decision-making [21, 74]. Second, employees with high work ethics do not escalate workplace rudeness into service sabotage. Organizations in the healthcare sector should, therefore, make conscious efforts to build a work environment that is high on ethicality. This may come in the form of ethics training, and clear codes of conduct supplemented by reinforcement in terms of rewards for ethical behavior [42, 73]. By reinforcing these values, organizations can set in place a culture in which the workers feel obligated to maintain high levels of ethical standards even under stressful situations.

Third, as workplace rudeness is identified as a mediator that can eventually cause much stronger negative behaviors, therefore, organizations should start implementing measures to reduce such incidents such as training programs on interpersonal communication, conflict management, and respect at the workplace. Organizationally, it may also help to build an open and supportive organizational climate that can allow employees to report rudeness

without fear of reprisal. Fourth, the direct relation of the phenomenon of workplace rudeness to patient-directed service sabotage mandates proactive policy efforts on the part of healthcare organizations. The existence of causes, like abusive supervision and poor work-related ethics, at their core will minimize cases of service sabotage and, thus, maintain high patient safety and quality of care. Regular monitoring and evaluation of employee behavior, with quick interventions at incidence, can assist in maintaining high standards of patient care [10, 71].

Fifth, since work ethics play a big role in diminishing negative behaviors, healthcare organizations should consider having general support programs developed and implemented to strengthen ethical behaviors. These can be mentoring programs, employee assistance programs, and regular workshops on how to deal with ethical dilemmas in health care. Organizations will, therefore, be able to assist employees in handling such rather difficult challenges and situations while keeping high standards of ethics through the provision of continued support and resources. Finally, the results of moderated mediation suggest that targeted interventions—such as ethics training that is custom-designed to fit supervisory and employee needs—will have more effect in preventing the escalation of negative behaviors. Organizations could be tailor-made so that the interventions designed will address some of the specific dynamics revealed in this study, cutting across both direct and indirect factors contributing to service sabotage.

Limitations and future research

Similar to any other research, this article has certain limitations. Firstly, this research was conducted in a very specific context of health care, considering only a small group of employees and organizational settings. Hence, although the results might still be very relevant for discussing the interconnections between abusive supervision, workplace rudeness, and service sabotage in other contexts, they might not hold in totally different branches or cultures. Further research in different sectors and cultures could examine these interactions, which affect the unique pressures and dynamics of healthcare environments in ways that differ in non-healthcare settings. Future research could explore these relationships in different industries and cultural settings to assess the generalizability of the findings. Comparative studies in different sectors like hospitality, education, or corporate environments could be important to give a more general understanding of abusive supervision and the work ethics influence on employee behavior and organizational outcomes.

Secondly, the study employed a cross-sectional design, thus it may be difficult to establish causal inferences about the relationships among variables. While the findings show that there is an important linkage between studied variables, due to the cross-sectional nature of the data, it precludes the examination of these relationships in the long run. To investigate the temporal dynamics of these relationships, the necessity of longitudinal research is called for. Longitudinal designs would also allow one to investigate the potential causal pathways and the long-term effects of interventions that aim at preventing these undesired behaviors. Third, this study relies heavily on self-reported data, exposing itself to social desirability and recall biases. Employees may underreport their involvement in negative behaviors, such as rudeness or service sabotage, or over-report their adherence to ethical standards, potentially leading to bias in the data. Future research could consider the use of a multi-method approach to data collection and may incorporate objective measures, such as peer reports, supervisor ratings, or observational data along with self-reports. Finally, one can go ahead and carry out experimental designs aimed at manipulating variables such as perceived abusive supervision or ethical climates so as to observe their impacts on the behavior of members of staff. This would increase the validity of the results and give a more comprehensive understanding of the relationship being investigated.

Authors' contributions
J.C. and D.G. wrote the main manuscript text and G.H.K.Z. wrote the method section and prepared figures 1-2. All authors reviewed the manuscript. J.C. and D.G. are co-first authors.

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Data availability
The data that support the findings of this study are available from Comsats University Islamabad, Islamabad, Pakistan, but restrictions apply to the availability of these data, which were used under license for the current study and so are not publicly available. The data are, however, available from the authors upon reasonable request and with the permission of Comsats University Islamabad, Islamabad, Pakistan.

Declarations

Ethics approval and consent to participate
Ethical approval for this study was taken from the Ethics Committee of the Department of Management Science Comsats University Islamabad Islamabad Pakistan .

Consent for publication
N/A.

Competing interests
The authors declare no competing interests.

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