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ORIGINAL ARTICLE

Exploring medical teachers' perceptions and experiences of workplace incivility in medical colleges of Khyber Pakhtunkhwa: a qualitative study

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ABSTRACT

Objective: To explore medical teachers' perceptions and experiences regarding workplace incivility in medical colleges of Khyber Pakhtunkhwa, Pakistan.

Methods: This qualitative phenomenological study was conducted among faculty members from public and private medical colleges in Khyber Pakhtunkhwa province of Pakistan. Fifteen full-time faculty members were recruited through purposive sampling to ensure representation across gender, academic rank, years of experience and clinical and basic science disciplines. Semi-structured interviews were conducted between July and October 2025, transcribed verbatim, and analyzed thematically using Braun and Clarke's six-phase framework.

Results: Analysis generated six major themes: (1) nature and manifestations of incivility, (2) sources and power hierarchies, (3) triggers and escalation pathways, (4) multidimensional impact, (5) coping and response strategies and (6) institutional culture and policy gaps. Participants described incivility as a continuum of overt and covert behaviors, including humiliation, sarcasm, exclusion, and institutional practices perceived as unfair. Reported impacts included psychological distress, reduced work engagement, impaired professionalism, and disruption of teaching and teamwork. Incivility adversely affected psychological wellbeing, motivation, teaching performance, professional relationships and faculty retention. Most participants adopted passive coping strategies because of fear of retaliation and limited confidence in reporting systems. Institutional silence, weak policy implementation and gender-related inequities were perceived as perpetuating uncivil behaviors.

Conclusion: Workplace incivility was perceived by faculty as a persistent challenge in medical colleges, negatively affecting faculty wellbeing and professional performance. Strengthening institutional accountability, grievance mechanisms, and leadership development may help foster a more respectful and supportive academic environment.

Keywords: Incivility (MeSH); Workplace Incivility (MeSH); Professionalism (MeSH); Education, Medical (MeSH); Faculty (MeSH); Qualitative Research (MeSH); Organizational Culture (MeSH); Communication (MeSH).

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INTRODUCTION

Civility is a fundamental social construct that reflects respect, ethical conduct, and consideration for others, enabling individuals and institutions to function harmoniously within society.[1,2] In professional environments, civility supports trust, collaboration and psychological safety, all of which are essential for sustaining productive workplaces and professional identity formation.[3,4] Conversely, the erosion of civility threatens organizational culture by normalizing disrespect, silence, and power misuse, ultimately undermining institutional effectiveness.[5] In academic and healthcare settings, where professiona-lism, mentorship and teamwork are core values, civility plays a critical role in safeguarding ethical practice and educational quality.[6]

Workplace incivility is defined as low-intensity deviant behavior that violates norms of mutual respect, including dismissive communication, exclusion, subtle hostility, and non-responsiveness.[2] Although often ambiguous in intent, such behaviors accumulate over time and can escalate into hostile work environments through reciprocal cycles of retaliation.[2,7] International studies in medical and academic contexts have consistently linked faculty incivility to burnout, emotional exhaustion, reduced job satisfaction, impaired collaboration, and compromised teaching and learning outcomes[4,8,9]. Persistent exposure to incivility also erodes psychological safety, discourages reporting, and reinforces a culture of tolerance toward disrespectful behaviors.[1,10] Despite increasing global attention, most empirical evidence on faculty incivility originates from Western contexts, limiting transferability to low- and middle-income countries.[11,12]

Despite growing recognition of faculty incivility globally, there is a lack of empirical, context-specific research examining how faculty incivility is experienced, interpreted, and managed within Pakistani medical colleges, particularly in Khyber Pakhtunkhwa (KP), Pakistan.[13] Existing national studies have largely focused on student incivility, leaving faculty perspectives underexplored and theoretically underdeveloped.[11,13]

Medical colleges in KP operate within organizational structures characterized by hierarchical authority, power distance, bureaucratic processes and gender-related inequities, all of which may influence the occurrence, interpretation, and reporting of uncivil behaviors.[5,14] Without understanding how incivility manifests and is sustained within this cultural and organizational context, institutional policies and professionalism frameworks remain insufficient and poorly targeted.[11]

Guided by the Spiral Theory of Incivility,[2] this study aimed to explore medical teachers' perceptions and experiences of workplace incivility in medical colleges of Khyber Pakhtunkhwa, Pakistan. Specifically, the study sought to examine how faculty members perceive and experience workplace incivility, identify its perceived causes and consequences and explore potential strategies for its prevention and management. By generating contextually grounded evidence, the study aimed to inform leadership practices, strengthen policy implementation and promote professionalism and respectful workplace cultures within medical education institutions.

METHODS

A qualitative phenomenological design was adopted to capture the lived experiences of faculty members.[15] The study was conducted in both public and private medical colleges across Khyber Pakhtunkhwa, Pakistan. Ethical approval was granted by the Institutional Ethics Board of Institute of Health Professions Education and Research (IHPER), Khyber Medical University (KMU), Peshawar, Pakistan (Ref No: 1-13/IHPER/MHPE/KMU/25-08, dated: September 26, 2025) and by the Advanced Studies and Research Board, KMU, Peshawar, Pakistan (Reference #: DIR/KMU-AS&RB/EP/ 003372, dated: September 25, 2025).

Purposive sampling was used to ensure diversity across gender, academic rank, and clinical specialty, consistent with phenomenological inquiry.[16] Eligible participants were full-time medical faculty with at least one year of teaching experience who provided informed consent. Visiting faculty and individuals undergoing active disciplinary proceedings were excluded to minimize role-related bias. Fifteen faculty members from disciplines including anatomy, community medicine, pediatrics, obstetrics and gynecology, anesthesia, ophthalmology, dermatology, nephrology, and dentistry participated in the study. Written informed consent was obtained from all participants. Confidentiality and anonymity were assured by replacing names and institutional identifiers with coded labels (Interviews 1-15). Data were collected between July and October 2025 using semi-structured, in-depth interviews guided by the Spiral Theory of Incivility.[2] The interview guide was pretested and refined prior to data collection. Interviews explored participants' understanding of incivility, personal experiences, perceived causes, impacts on professional and personal well-being, and suggested institutional responses. Interviews lasted approximately 35-45 minutes and were conducted either face-to-face in a private setting or online via Zoom, depending on participant availability and preference. The use of mixed interview modes was adopted to enhance accessibility and participation while maintaining methodological rigor, an approach supported in qualitative research when topic sensitivity and participant convenience are considerations.[17] All interviews were audio-recorded with permission and transcribed verbatim. Member checking was undertaken by returning transcripts to participants for verification and clarification. Data saturation was assessed concurrently with data collection and analysis. After the thirteenth interview, no new themes or substantive variations in participants' experiences were emerging. Two additional interviews were conducted to confirm thematic redundancy, at which point saturation was deemed achieved.[18] The final sample size of fifteen participants was therefore considered sufficient to capture the depth and breadth of faculty experiences within the study context.

Data were analyzed thematically following Braun and Clarke's six-phase framework: familiarization, coding, theme generation, theme review, theme definition and naming, and reporting.[19] Initial coding was conducted independently by two researchers (SN, BJ), using an inductive, data-driven approach. Codes and preliminary themes were then compared during iterative analytic meetings, and discrepancies were resolved through discussion and consensus. Where differences persisted, a third qualitative researcher (NA) was consulted to achieve analytic agreement. Reflexive journaling was maintained throughout the analytic process to bracket researchers' assumptions and enhance interpretive transparency. Credibility and dependability were further strengthened through peer debriefing and the maintenance of a comprehensive audit trail documenting coding decisions, theme development and analytic refinements.[20]

The research team included faculty members with backgrounds in medical education and qualitative research. Recognizing that prior professional experiences and assumptions could influence data interpretation, reflexivity was actively maintained throughout the study. Reflexive journaling was used to document assumptions, emotional responses, and analytic decisions during data collection and analysis.[21] Regular peer debriefing within the research team was conducted to challenge interpretations and minimize individual bias. Bracketing was consciously practiced to prioritize participants' voices over researchers' preconceived understandings of incivility in academic medicine.[20]

RESULTS

Fifteen faculty members (both male and female) participated, with teaching experience ranging from two to thirty years. Participants represented various disciplines and both public and private

institutions (Table I).

Themes and subthemes: Thematic analysis revealed six major themes: (1) nature and manifestations of incivility; (2) sources and power hierarchies; (3) triggers and escalation pathways; (4) multidimensional impact; (5) coping and response strategies; (6) institutional culture and policy gaps. The findings are presented narratively below with embedded participant quotations and summarized in Table II.

Theme 1: The multifaceted nature of incivility: Incivility was perceived as a continuum of disrespectful behaviors that disrupted professional decorum. Faculty described experiences ranging from overt aggression, such as public humiliation, shouting, or threats, to subtle acts of exclusion and sarcasm. One participant stated,

"It is not always shouting; sometimes just being ignored in meetings feels more humiliating" (Interview 2).

Structuralized forms of incivility, including biased Annual Confidential Reports (ACRs) and punitive transfers, were also reported. According to one senior teacher,

"The system itself sometimes behaves rudely; fairness feels multiplied by zero" (Interview 4).

Such institutionalized practices reinforced perceptions of enduring injustice.

Theme 2: Sources and power hierarchies: Incivility was described as pervasive across organizational layers. Senior faculty often used authority to dominate or silence juniors, while peers engaged in rivalry and competition.

A participant noted, "Seniors control opportunities and use them as tools for punishment" (Interview 10).

Table I: Demographic characteristics of study participants

Variable	Category	Frequency (n=15)
Gender	Male	7 (46.7%)
	Female	8 (53.3%)
Type of Institution	Public	9 (60%)
	Private	6 (40%)
Academic Rank	Lecturer	3 (20%)
	Assistant Professor	5 (33.3%)
	Associate Professor	4 (26.7%)
	Professor	3 (20%)
Teaching Experience (years)	1-5	3 (20%)
	6-10	4 (26.7%)
	11-20	4 (26.7%)
	>20	4 (26.7%)

Table II: Themes, subthemes and illustrative participant quotations

Theme	Subthemes	Illustrative Quotations
Nature and Manifestations of Incivility	Overt aggression; Covert disrespect; Structuralized incivility	"Public humiliation and shouting are common ways of putting people down." (**Interview 3**) "It is not always shouting; sometimes just being ignored in meetings feels more humiliating." (**Interview 2**) "Sarcasm is used cleverly so no one can formally complain." (**Interview 6**) "The system itself sometimes behaves rudely; fairness feels multiplied by zero." (**Interview 4**)
Sources and Power Hierarchies	Senior dominance; Peer rivalry; Administrative interference; Student misconduct	"Seniors control opportunities and use them as tools for punishment." (**Interview 10**) "Questioning authority is seen as disrespect, even when it is academic." (**Interview 5**) "Jealousy and competition create invisible walls among colleagues." (**Interview 7**) "Applications get conveniently lost, and clerks use their power to threaten." (**Interview 9**)
Triggers and Escalation Pathways	Workload pressure; Favoritism; Policy gaps; Poor communication	"Everyone is overburdened, and frustration spills over as rude behavior." (**Interview 6**) "A small remark becomes a major issue when politics prevails." (**Interview 8**) "Favoritism fuels resentment and turns colleagues against each other." (**Interview 3**) "Policies exist only on paper, leaving space for bias and manipulation." (**Interview 9**)
Multidimen-sional Impact	Psychological distress; Family strain; Professional stagnation; Attrition	"That incident still haunts me; it was deliberate and meant to humiliate." (**Interview 1**) "I feel anxious before meetings because I never know who will attack." (**Interview 4**) "The stress from work transmits to home; it affects relationships too." (**Interview 7**) "It kills creativity and passion for teaching; people eventually leave." (**Interview 5**)
Coping and Response Strategies	Silence; Avoidance; Informal support; Limited confrontation	"I used to react, but now I simply ignore; it is safer that way." (**Interview 1**) "Complaints disappear; no one dares to speak." (**Interview 7**) "Talking to trusted colleagues helps, but formally nothing changes." (**Interview 6**) "Prayer and talking with friends keep me sane." (**Interview 7**)
Institutional Culture and Policy Gaps	Culture of silence; Gender bias; Weak enforcement	"Incivility is so common that people think it is normal." (**Interview 8**) "Female faculty are often asked to manage extra work quietly." (**Interview 12**) "If women complain, they are labeled difficult or emotional." (**Interview 11**) "Policies exist on paper but not in practice." (**Interview 9**)

Another highlighted peer hostility:

"Jealousy and competition create invisible walls among colleagues" (Interview 7).

Administrative staff were also cited as sources of incivility, as procedural delays and clerical manipulation became mechanisms of control:

"Applications get conveniently lost, and clerks use their power to threaten" (Interview 9).

Some participants also mentioned instances of student misconduct, including false complaints, which exacerbated the uncivil environment.

Theme 3: Triggers and escalation pathways: Workload pressure, resource scarcity, favoritism, and lack of clear job descriptions were identified as triggers. Participants reported that even minor disagreements could spiral into prolonged conflicts.

As one faculty member observed, "A small remark becomes a major issue when politics prevails" (Interview 8).

The absence of fair and consistent policies was described as a major driver of escalation:

"Policies exist only on paper, leaving space for bias and manipulation" (Interview 9).

This environment fostered cycles of retaliation, reflecting the "spiral of incivility" described in the theoretical framework.

Theme 4: Multi-dimensional Impact: The personal and professional toll of incivility was significant. Participants described mental and emotional strain manifesting as stress, anxiety, and reduced motivation.

One respondent shared, "That incident still haunts me; it was deliberate and meant to humiliate" (Interview 1).

Faculty reported carrying negative emotions into family life: "The stress from work transmits to home; it affects relationships too" (Interview 7).

Professionally, incivility eroded enthusiasm for teaching and research. Another participant remarked, "It kills creativity and passion for teaching" (Interview 5).

At the institutional level, incivility disrupted teamwork and caused attrition, described by one participant as "a slow brain drain" (Interview 10).

Theme 5: Coping and response strategies: Most faculty relied on passive coping strategies, such as avoidance, silence, and emotional withdrawal.

One participant stated, "I used to react, but now I simply ignore; it is safer that way" (Interview 1).

Fear of retaliation and lack of faith in reporting mechanisms perpetuated this silence: "Complaints disappear; no one dares to speak" (Interview 7).

Few participants adopted active strategies, such as calm confrontation or reporting to superiors, but these were rare and often ineffective. Informal peer and spiritual support networks provided emotional relief, as expressed by one teacher:

"Prayer and talking with friends keep me sane" (Interview 7).

Theme 6: Institutional culture and policy gaps: The broader institutional culture was characterized by tolerance and normalization of disrespect.

Faculty described a "culture of silence" where incivility was accepted as routine.

Female faculty members noted gender-based inequities, such as being assigned to inconvenient schedules or being excluded from decision-making.

One participant explained, "Female faculty are often asked to manage extra work quietly; complaining is seen as unprofessional" (Interview 12).

Policies addressing harassment existed but did not encompass incivility, leaving a significant procedural gap.

The sentiment "Policies exist on paper but not in practice" (Interview 9) encapsulated the widespread distrust of institutional fairness.

DISCUSSION

This study demonstrates that workplace incivility in medical colleges of Khyber Pakhtunkhwa (KP), Pakistan, is systemic, persistent and embedded within organizational and cultural structures rather than arising from isolated interpersonal misconduct. The findings suggest that incivility persists because it is normalized within hierarchical academic systems where authority is rarely questioned, accountability mechanisms are weak, and silence is often rewarded. Such environments allow disrespectful behaviors to be rationalized as administrative control, seniority, or institutional necessity, thereby sustaining cycles of incivility. These interpretations align with international evidence showing that uncivil climates erode trust, hinder collaboration, and compromise teaching quality and patient safety.[1,4,6,7,10,12,22,23]

Incivility in this study was manifested not only through interpersonal disrespect but also through institutionalized practices such as biased evaluations, punitive transfers, and administrative manipulation. These findings extend the Spiral Theory of Incivility by Andersson and Pearson by demonstrating that organizational systems themselves can act as agents of escalation, reinforcing harm through structural mechanisms rather than individual intent alone.[2] This pattern parallels Smith and Freyd's concept of institutional betrayal, where institutions fail to protect their members and instead contribute to their distress.[24] Hierarchical authority and power imbalance emerged as central drivers, consistent with studies showing that rigid hierarchies in healthcare suppress speaking up and perpetuate fear-based cultures.[4,5]

Environmental stressors such as excessive workload, favoritism, unclear role expectations, and policy ambiguity further explain why incivility persists. In the absence of transparent and consistently applied procedures, minor disagreements escalate into prolonged conflicts, reflecting the spiral effect described in the

theoretical framework. Similar escalation patterns have been reported in South Asian academic and healthcare institutions, where weak governance and discretionary decision-making amplify workplace conflict.[14,25] These regional parallels enhance the contextual relevance of the findings and suggest that incivility in KP medical colleges reflects broader structural challenges within comparable low- and middle-income settings.

The multidimensional impact of incivility identified in this study including psychological distress, burnout, disengagement, and attrition helps explain its long-term persistence. Faculty experiencing repeated incivility often adopt "toxic resilience," tolerating disrespect to survive professionally, which unintentionally reinforces uncivil norms.[25] This emotional exhaustion and disengagement mirror findings from regional and international studies linking incivility to reduced productivity, impaired mentorship, and deteriorating institutional reputation.[12]

Passive coping strategies such as silence and avoidance were dominant, reflecting deep mistrust in grievance and reporting systems. This pattern indicates institutional governance failure rather than individual weakness, as faculty perceived formal mechanisms as biased, inaccessible, or retaliatory. Similar patterns have been reported in Pakistani and regional organizational studies, where fear of repercussions discourages reporting and sustains incivility.[14] Gendered experiences further compounded these dynamics, with female faculty facing dispro-portionate workloads, exclusion from decision-making, and heightened vulnerability to marginalization, echoing regional evidence on gendered power asymmetries in academic medicine.[9]

Implications for reform and practice: Taken together, these findings underscore the urgent need to translate existing policies into consistent action. Accountability systems must be strengthened through transparent, HR-led inquiry processes, clear standard operating procedures, and protection against retaliation. Robust faculty development programs should be instituted, focusing not only on teaching skills but also on leadership, communication, emotional intelligence, and fostering psychologically safe and civilized workplaces. Establishing strong, confidential incident reporting systems and providing mentoring and psychosocial support for faculty exposed to repeated incivility are critical for breaking cycles of silence. Participants' emphasis on accountability aligns with culturally grounded principles such as Jaza and Saza (reward and sanction), suggesting that contextually responsive governance, combined with transformational leadership and gender equity in leadership roles, may offer sustainable pathways to restoring trust and professionalism.[26]

Strengths and Limitations of the study: Provides rich, contextual insights into the dynamics of workplace incivility in a previously underexplored region. The inclusion of faculty from multiple disciplines and institutional types strengthens its transferability. However, the small sample size limits generalizability, and participants' self-reports may reflect selective experiences. Further large-scale, mixed-method research is required to quantify prevalence and assess intervention outcomes.

CONCLUSION

Workplace incivility in medical colleges of Khyber Pakhtunkhwa is a pervasive and institutionalized phenomenon. It undermines faculty well-being, erodes professionalism and weakens academic and organizational performance. Addressing it requires coordinated reforms, including clear policies, HR-led grievance mechanisms, leadership and communication training and gender-inclusive governance. Fostering civility and mutual respect is crucial for creating a favorable academic climate and enhancing the quality of medical education.

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AUTHORS' CONTRIBUTION

The following authors have made substantial contributions to the manuscript as under:

SN: Conception and study design, acquisition of data, drafting the manuscript, approval of the final version to be published

BJ: Acquisition of data, drafting the manuscript, approval of the final version to be published

NA: Analysis and interpretation of data, critical review, approval of the final version to be published

Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST

Authors declared no conflict of interest, whether financial or otherwise, that could influence the integrity, objectivity, or validity of their research work.

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DATA SHARING STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

DISCLAIMER

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AI-assisted tools (ChatGPT, OpenAI, GPT-5, 2025) were used for organizing qualitative codes, refining text, and improving clarity. The tools were not used for data generation or analysis. All outputs were critically reviewed and revised by the authors to ensure accuracy and integrity.

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