

**Between Institutional Deficiency and Patient
Gratitude: The Quest for Recognition at work among
Medical Residents in Algeria□**

**بين القصور المؤسسي والامتنان المرضى:
سعي الأطباء المقيمين في الجزائر نحو الاعتراف في العمل**

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Received: 2025/09/09

Accepted: 2026/03/01

Abstract:

This article examines the issue of recognition at work among medical residents in Algeria. It identifies the different forms and sources of recognition or non-recognition within the Bejaïa University Hospital and explores the experiences, perceptions, and expectations of medical residents. These young doctors face numerous responsibilities, including patient care, medical research, and the supervision of interns. They perform these duties within a deteriorating professional environment and under a demanding yet incomplete training system. As a result, they often suffer from a significant lack of institutional recognition. While recognition from peers is partial and situational, and acknowledgment from supervisors remains limited and discreet, patient recognition is notably increasing. This rise in patient gratitude stands in stark contrast to a professional context that emphasizes performance and technical skills. Faced with these challenges, resident physicians develop coping strategies, where self-recognition, based on the results of work—particularly the technical aspects of medical procedures—becomes the main source of the quest for recognition at work.

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Keywords: recognition at work; Medical Resident; need of recognition; professional identity; residency.

ملخص:

تهدف هذه المقالة إلى عرض إشكالية الاعتراف في العمل لدى الأطباء المقيمين في الجزائر. تحديدا نسعى إلى تحديد الأشكال والمصادر المختلفة للاعتراف، أو عدم الاعتراف، داخل المستشفى الجامعي ببجاية وفهم تجارب الأطباء المقيمين وتصوراتهم وتوقعاتهم اتجاه هذه المسألة.

يواجه الأطباء المقيمون في المشافي الجزائرية مجموعة من المسؤوليات المتعددة، تشمل رعاية المرضى، البحث، والإشراف والتعلم والتكوين في سياق مهني متدرج وتدريب متطلب ولكنه ناقص. يعانون من ضعف الاعتراف المؤسسي، في حين ينالون اعترافا جزئيا وسياقيا من قبل زملائهم (أقرانهم)، واعترافا غير معنن وغير رسمي من قبل المكونين. في هذه الظروف يصبح الاعتراف المتزايد من قبل المرضى ضروريا لتعويض بيئة مهنية تركز على الأداء والتقنية. في مواجهة جميع هذه التحديات، يطور الأطباء المقيمون استراتيجيات تقوقع، حيث يصبح الاعتراف للذاتي، القائم على نتائج العمل وخاصة الفعل الطبي في جانبه التقني، محور هويتهم المهنية والمصدر الرئيسي لإشباع حاجاتهم للاعتراف في العمل.

الكلمات المفتاحية:

الاعتراف في العمل، الطبيب المقيم، الحاجة إلى الاعتراف، الهوية المهنية، الإقامة الطبية.

1. Introduction

Medical residents occupy a central role in Algeria's public health system. As practitioners in training, they are required to work full-time under the guidance of teaching staff and department heads. Their responsibilities include various activities such as patient care, diagnosis, prevention, emergency services, research, teaching practical or supervised work to medical students, and training paramedical staff (Article 9 of Executive Decree No. 11-236 on the status of residents in medical sciences). Thus, they assume direct responsibility for patient care while still being apprentices. Their multiple tasks demand the mobilization of specific decision-making, relational, and emotional skills to ensure optimal patient care. This accumulation of responsibilities, compounded by inadequate recognition and support,

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can lead to stress, anxiety, burnout, and even depression. It is not uncommon for a resident doctor to resign or be excluded from training.

The context in which resident doctors practice and train in Algeria is often described as "failing." Medical practice in university hospitals (UHCs) is frequently subpar, with working conditions marked by a lack of resources, insufficient infrastructure, and weak supervision. This professional context dismantles the idealized image of medicine, reducing it to "a medical practice cobbled together and practiced by health professionals, totally disenchanted and frustrated...who limit themselves to demanding more technical and therapeutic means" (Mehtoul et al., 1998, p. 11).

Despite their significant contribution to hospitals, resident physicians face numerous relational challenges, including interpersonal tensions with peers, clinicians, learners, nurses, patients, their families, and administrators. Their daily practice, characterized by long working hours, heavy workloads, and immense pressure from societal expectations of quality care, is subjected to centralized decision-making. This can render them invisible and poorly recognized by the public. Such invisibility is compounded by a socialization, from their early years in medical training, that emphasizes rigor and technical improvement, often overshadowing the human and relational aspects of the medical profession.

Observing the practices of resident doctors reveals a crucial reality: the need for recognition at work is deeply felt by these professionals in Algeria. As DUBET (2017, p. 17) states, "the more work requires subjective commitment in relationships with others, the more it is confronted with human tragedies, the more recognition is essential." Indeed, faced with the complexity of the professional world and the reality of medico-social issues, resident doctors often express discontent through daily discourse, reflecting a sense of malaise, abandonment, and disinterest on the part of authorities concerning the quality of their training and working conditions. The strike and multiple demonstrations by residents in 2018, which paralyzed university hospitals (UHCs) for more than eight months, illustrate this situation. Furthermore, a strong tendency toward emigration is evident, with 1,200 Algerian general practitioners who passed the "PACES» in France in 2022.

This article examines the issue of recognition at work among medical residents at Bejaïa University Hospital. It aims to understand

how residents experience and perceive recognition or non-recognition in their professional environment and to identify their needs and expectations regarding recognition. The study is guided by the following overarching research question: How do medical residents at Bejaïa University Hospital experience recognition at work, and what are their perceptions, needs, and expectations concerning its forms and sources?

2. Understanding recognition in the medical field

2.1. On the concept of recognition at work

Axel HONNETH defines recognition as "a fundamental expectation, an intrinsic need inherent in human nature." Indeed, the personality of the individual is only formed when they learn to see themselves through the supportive and encouraging gaze of others, which highlights their positive traits and abilities. Thus, each individual is fundamentally linked to a context of social exchange organized according to normative principles of mutual recognition, so that the absence of recognition leads to experiences of contempt (Fall, 2015, p. 191).

SAINSAULIEU and DUBAR both consider that recognition is at the heart of the construction of identities at work, viewed as a process of self-investment in lasting relationships, which call into question the reciprocal recognition of partners. At SAINSAULIEU, the notion of identity is used to identify "the ways of being of an actor, recognized or not, in the organization, as a result it refers just as much if not more to affective logics rooted in forms of relationships between the individual and the collective than to actor strategies - alliance, opposition, neutrality - defined from power games in the organization" (Dubar, 1998, p. 389).

Recognition, according to BRUN and DUGAS (Brun & Dugas, 2005), is this unambiguous demonstration of the fact that our achievements, our work practices, and our person are appreciated at their fair value. It represents an act of appreciation and judgment, a symbolic, affective, concrete, or financial retribution. Thus, if the worker invests in his work, it is because he holds expectations (not illusory) of recognition in return for this investment. This recognition is reflected in the attribution of value and affective meaning, which are transmitted verbally but also by participation in decision-making, participation in action, and the legitimization of norms and rules that

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contribute to establishing the foundations of this recognition. Indeed, signs of recognition complement forms of material compensation and are sometimes more valuable than them (Fall, 2015, p. 190).

Concerning the nature of recognition sought in work and at work, researchers DUGAS AND BRUN (Brun & Dugas, 2005) distinguish four integrated dimensions of recognition: existential recognition, recognition of results, recognition of investment, and recognition of work practice. They explain that the four forms of recognition are essential and inseparable, each of them meeting specific needs. Recognition at work comes in various forms depending on the nature of the social relationships and the actors involved (Brun & Dugas, 2005, pp. 83-85) :

- Institutional or organizational recognition, emanating from the organization itself and encompassing employee policies, development opportunities, work recognition and material resources.
- Vertical recognition, coming from hierarchical superiors, including forms of appreciation and encouragement in the face of difficulties.
- Horizontal recognition, coming from colleagues and peers, expressing appreciation of work and recognition of contributions to the team.
- External recognition, emanating from customers, financiers and external partners.
- Social recognition, emerging from relationships between the community and organizations, assessing their social utility and recognizing their contribution to society.

The lack of recognition at work leads to an increasing focus on this lack. This feeling can manifest itself in different ways: a feeling of exploitation or injustice or a feeling of uselessness. They come to believe that they perform their work less well than their colleagues do and less well than they should. This delicate situation leads to a feeling of indignity and shame, particularly dissonant among those who were initially motivated and passionate about their work. (Daloze et al., 2007, p. 86). The emergence of a complaint of recognition can be understood as the symptom of a crisis in the modes of recognition at work and more broadly in the modes of social integration. The manifestations of non-recognition are expressed in various forms. A first form concerns a feeling of frustration, which arises from the perception of a gap between

the individual's commitment to work and the modes of remuneration. Another aspect is the need for legitimization of professional practices, as well as the ethical doubts that affect the very foundations of action (Osty, 2005).

Finally, it is important to question the binary nature of recognition (Daloz et al., 2007, p. 86) which is never totally present or absent, but rather relative. Recognition always exists to a certain extent, but it is often insufficient in terms of quantity, quality or duration. This quest for recognition can be expressed through social demands. However, even if certain objectives are achieved, this is not enough to compensate for the experiences lived on a daily basis.

2.2. Sociological look at the medical profession

First, the constitution of a strong professional body, such as the Order of Physicians, exerts a major influence on professional practices, and significantly affects the quality of training, the regulation of the field of expertise and its development, while strengthening professional identity by ensuring the development and recognition of practitioners. Following this logic, the absence of a real public health policy can weaken the community of physicians and lead to a disqualification of medical practice. Indeed, studies have shown that beyond strict technical competence, the "social difficulties" that health personnel face, their value systems, their individual experiences, the specificities of their corporation interfere with care practices and influence the quality and nature of medical provision (Sardan et al., 2003). This issue is all the more crucial in the medical profession, which is a profession of human interaction and therefore "work on others, for others, and with others".

Applying the principles of sociological analysis of professions proposed by DUBAR, TRIPIER and BOUSSARD (Tripier et al., 2013, pp. 334-336) to the medical profession, we see that the professional group of physicians is not "unified"; when sociologists look closely at this field, they discover a multitude of segmentations, differentiations and fragmentation processes.

Furthermore, the medical profession of residents is not "uniform" but rather a spectrum of roles and responsibilities that vary according to specialties, institutions and stages of training. Residents navigate a diverse set of professional segments, each with its own distinct expectations, norms and power dynamics. There is no "objective"

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profession but dynamic relationships between institutions or organizations of training, work management, and individual trajectories, paths and biographies within which professional identities are constructed (and destroyed), both "social" and "personal".

In this sense, becoming a specialist physician is not a predetermined path but rather a series of individual journeys shaped by personal aspirations, career goals and life circumstances. Residents evolve in this landscape through a combination of formal training and informal learning, continually adapting their skills and knowledge to meet the demands of their specialty and social demand. The professional recognition of resident physicians is often uncertain and depends on multiple factors, such as trainers' evaluations, exam results and peer perception.

In this regard, OSTY believes that with the dissolution of traditional conformity groups, the diversification of work forms and professional trajectories, professional identity is becoming collective and more and more individual. "Experience now compensates for the definition of status in the organization or socio-professional class, while tinkering becomes the driving force behind a more contingent and evolving identity" (Osty, 2005, p. 328)

When a person's work is not recognized, the resulting injustice is not merely material: it also harms the emotional dimension of their experience — their pride, frustration, indignation, and exhaustion. In *Affective Injustice in Healthcare*, Bogaert shows that healthcare professionals are largely expected to communicate their expertise in a non-personal way, which often involves suppressing their affects in order to appear professional or objective. She also notes that "healthcare providers have been encouraged to hide or minimize their affects in order to encourage effective communication and relationships (Bogaert, 2025, p3-5). Within the medical context, she argues, affects are devalued because institutions prioritize neutrality, objectivity, and technical competence. As a result, the emotions of healthcare providers are ignored, avoided, or treated as obstacles.

3. Method and Materials

3.1. Methodological approach

This study employed a qualitative research design to explore the experiences and perceptions of medical residents at Bejaïa University Hospital regarding recognition at work. Data were collected through semi-structured interviews, allowing participants to express their views freely while ensuring that key topics were systematically addressed.

The interview guide focused on several dimensions: residents' representation of the medical profession and motivations for entering it, daily professional activities (tasks, challenges, and responsibilities), perceptions of their medical specialization, and interactions with various hospital actors, including teachers, peers, administrators, and nurses.

Interviews also examined residents' relationships with patients, the forms and sources of recognition or non-recognition they experience, and their expectations and needs regarding professional recognition. The qualitative approach was chosen to capture rich, context-specific, and nuanced insights that quantitative methods cannot provide.

Data were analyzed using thematic content analysis, which identifies recurring themes and patterns in participants' narratives. Coding was conducted in three stages: open coding to detect emerging concepts, axial coding to organize codes into thematic categories, and selective coding to integrate themes into a coherent analytical framework.

Ethical considerations were rigorously followed: all participants provided informed consent, participation was voluntary, and all identifying information was anonymized. The study protocol was approved by the relevant ethics committee at Bejaïa University Hospital.

3.2. Corpus and empirical materials

The study included twelve resident physicians selected through purposive sampling to ensure diversity in gender, specialty, and year of residency. Among the respondents, seven were women and five were men. Residents were distributed across different years of training: first year (3 residents: psychiatry, pediatrics), second year (3: internal medicine, pediatrics, pneumology-phthisiology), third year (4:

cardiology, ophthalmology, gynecology), and fourth year (2: occupational medicine, intensive care).

Participants' marital status varied: eight were single, two were married with one child, one was married without children, and one was married with two children. Ages ranged from 27 to 36 years (see Appendix 1 for detailed demographics).

The interviews lasted between 40 and 90 minutes and were conducted from February 25 to May 10, 2024, across the departments of Bejaïa University Hospital. Established in 2009, the hospital comprises 22 departments across three establishments in Bejaïa city: Khelil Amrane Hospital, Frantz Fanon Hospital, and Targa Ouzemmour Hospital.

This design, combining purposive sampling, in-depth semi-structured interviews, and rigorous thematic analysis, ensures a comprehensive understanding of recognition experiences among medical residents, capturing both individual and collective perspectives.

4. Results and Discussion

4.1. Representations of the profession and projection of the self into the future

Residents' testimonies reveal that the choice of the medical profession was based on several motivations. These include childhood aspirations, a passion for medicine, the intrinsic qualities of the profession, the influence of the family and social environment, a high average in the baccalaureate paving the way for this career, the presence of a doctor parent, the social desirability of the profession, and the prospects for social promotion that it offers.

"I didn't see myself as anything other than a doctor." Respondent No. 2

"A childhood dream." Respondent No. 9

"To save lives and help the sick." Respondent No. 12

It is worth noting that a choice motivated by passion does not necessarily exclude pragmatic reasons,

"To make a career and money." Respondent No. 4

The decision to specialize in medicine appears to be a natural step for doctors who have graduated in general medicine, and is often seen as a logical progression in their career. Medical specialization generally confers more recognition within the medical community; in addition, it opens doors to new professional opportunities and allows the acquisition of specialized clinical and/or surgical expertise, which can translate into improved financial prospects.

It should be noted that preparation for the residency competition begins at the internship stage for many medical students. The testimonies of the respondents revealed that interns, future residents, pay particular attention to this competition, sometimes to the detriment of their practical training during the various internship rotations (medicine, surgery, paediatrics, and gynecology-obstetrics). While many young doctors even, opt for a preparatory year at the end of their internship in order to focus entirely on preparing for this competition, in order to maximize their chances of specializing in the discipline of their choice. Failure to access residency training is experienced as “a narcissistic injury.” The choice to remain a general practitioner is seen as a default choice. Some residents have struggled to pass their competitive exams; however, it is not uncommon to see residents resign from their positions or be excluded after two failures in the residency course.

" I worked as a general practitioner for three years... I had to work for financial reasons... that's why I only got my residency after 3 attempts." Respondent No. 10

The residency competition is an element of classification, but the ranking is not the only criterion for the choice of specialty by the winners. Personal preferences, professional and financial prospects of the specialty, as well as the social conditions of the candidate (marital status, sex, family responsibility, etc.), determine the choice of specialty. It even seems that the choice of medical specialty is gendered.

"Generally, women prefer medical specialties, or surgical-medical. Some specialties are almost exclusively male, such as purely surgical specialties, or urology." Respondent No. 10

"It depends on the candidate's skills, for example someone who likes reasoning, exploration and develops good relationships with patients and prefers to work in a calm environment chooses a medical specialty, only people who are able to manage stress and deal with emergencies can shine in surgical specialties." Respondent No. 2

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The respondents agree in describing the conditions of residency in the establishments annexed to the UHC as deficient. Among the obstacles hindering the smooth running of their training, they mention the insufficiency of material resources within the UHC, as well as the absence of modern technical means. They also note the insufficient training opportunities, the disorder in the management of certain services, and the overload of care tasks to the detriment of research activities. Our respondents cite other difficulties: constraints related to travel, lack of services at the hospital (catering, rest rooms, etc.), an unsatisfactory salary, and personal difficulties related to family and domestic responsibilities. In addition, relational dynamics within medical teams can act as additional obstacles. Cases of unfair competition and favouritism have been reported, jeopardizing the recognition and professional opportunities of residents.

"There is a very poor distribution of tasks, because the resident doctors do all the tasks, we often do the work of the nurses, sometimes we are even forced to clean... an honest and passionate doctor pays dearly for the carelessness of other colleagues without conscience". Respondent No. 11

"Only single residents living in the same region manage to reconcile training and private life, the majority find themselves faced with difficult compromises". Respondent No. 4

"We should not expect quality training from the professor, he is overloaded, and the majority of them treat the resident doctors badly". Respondent No. 3

Medical education itself faces major challenges, including a lack of rigor in the transmission of knowledge and failure to monitor scientific advances. This shortcoming compromises the ability of physicians to remain at the forefront of contemporary medical practices. The first years of medical school favour competition and the accumulation of knowledge more than the development of the interpersonal skills needed to establish instructive relationships with patients.

"Fortunately, there are elders who guide us, who give us their files." Respondent No. 1

We got used to learning on our own. From the preclinical cycle, we already started doing volunteer internships, shifts." Respondent No. 6

"We don't learn how to interact with patients. The patient is not a pathology...you have to know how to question them, speak to

them in their language, understand their mentality." Respondent No. 11

"During training, we learn competition but not collaboration between doctors...team spirit is crucial between doctors, it's during internship and residency that we find ourselves confronted with this kind of situation that is sometimes very difficult to manage." Respondent No. 2

Medical studies are among the longest in the higher education system. The length and intensity of medical studies require significant personal sacrifices. Night shifts, hospital internships, and exam preparation leave little room for extracurricular activities.

"Women often choose medical specialties to have time for family and domestic tasks." Respondent No. 3

"A very long and tedious path, and taking... long years, sacrifices, stress throughout the training especially during the ranking exams... We do not fully benefit from our youth." Respondent No. 6

"You have to develop certain qualities to hold on. You have to be hard-working, curious, passionate, and thirsty to learn and above all know how to manage your stress and cope with the difficulties of studies." Respondent No. 5

"After 12 years of studies, we will not have our diploma directly, you are still asked to repay the State's debts and provide a civil service that lasts four in the north and obtain this "acquittal" paper. Respondent No. 9

Our respondents explain that being a medical student is not simply an academic path but a true vocation that requires total commitment and continuous preparation for the professional and personal challenges that a medical career presents. This model of total commitment proves to be exhausting on a daily basis.

"Practicing medicine is not choosing a career, it's choosing a lifestyle, studies above all" Respondent No. 12

"Putting the interests of patients before your own" Respondent No. 10

"Medicine is not easy, I'm almost 30 and I've done nothing with my life but study" Respondent No. 6

All our respondents express the desire to leave public hospitals immediately after completing their specialist training and the compulsory civil service period. However, this desire is also linked to

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the expectation of suitable opportunities. Aspirations after obtaining the specialist diploma and completing the civil service include:

"Looking for a suitable position in a private clinic". Respondent No. 10

"Opening a private practice". Respondent No. 11 and Respondent No. 1

"Emigration". Respondent No. 8

"The public hospital is educational, but anarchic and unprofitable" Respondent No. 4

"I plan to go to France after my DEMS (specialized medical studies diploma) ... it's better after residency to directly access the PE (specific health course) competitions, after the internship you have to take PACES and it's an even longer path". Respondent No. 9

Regarding the emigration of Algerian doctors, the study by ZEHNATI (Zehnati, 2021) shows that they seem to display a strong disposition towards expatriation. Their preferred destination remains primarily France for historical and cultural reasons. Financial motives alone cannot justify the decision to emigrate. "It is likely that this is the result of interactions between individual motivations, professional aspirations, and contextual elements of a political, economic, and social nature".

4.2. Forms and signs of recognition and non-recognition at work

The recognition of resident physicians is a dynamic and multidimensional process established at the heart of human relationships and is not limited to formal evaluations or official rewards. In what follows, we first explain the nature of social relationships with this "other" according to the different fields of recognition established by (Brun & Dugas, 2005). Then, based on the testimonies of our respondents, we deduce the signs of recognition and/or denial of recognition experienced and the marks of recognition sought.

At the institutional level, formal recognition is manifested in hospital governance, where powers are concentrated at the level of the general management. Our respondents highlight dysfunctions in the management of hospital resources, directly affecting the quality of care provided. Management will be a source of recognition for only a few, mainly based on subjective criteria such as personal affinities

(favouritism, clientelism) rather than objective criteria like skills and commitment. Our respondents report a lack of recognition related to autonomy at work, the transversality of missions, technical support, and, finally, the recognition of the individual as such.

"It's a disaster, there is no coordination between the departments, each department lives in its own world, resource management is catastrophic" Respondent No. 6

"Everyone suffers from the lack of organization: the patient, the nurse and the doctor" Respondent No. 5

"The resident doctors' room is gradually collapsing, we filed a complaint over a year ago but to no avail, and the budget is wasted on secondary expenses" Respondent No. 3

"Very often, arbitrary decisions are made against the doctor...we are short of nurses and we find ourselves doing the work of nurses, doormen, security is not ensured and resources are not available." Respondent #4

"There are supplies that we need that are not provided to us, for example, the telephone is not available and we have to go in person, the computer system is not available, there is no special room to archive patient files." Respondent No 2

The financial compensation of residents is unsatisfactory, from the point of view of our respondents:

"The salary is barely enough to rent and eat." Respondent #5

"In Mauritania, a single night shift is equivalent to our monthly salary here at the hospital." Respondent No 6

Currently, residents are paid between 50,000 and 63,000 Algerian dinars per month. For a shift from 16:00 to 8:00 the next day, they are paid between 2,800 and 3,400 dinars. Although paid activities outside the hospital setting are formally prohibited, it is observed that some medical residents engage in informal practices. These practices are often motivated by the need to support themselves financially, the acquisition of practical experience, and exposure to the realities of the professional world, particularly in its entrepreneurial aspects. These behaviours are widely known and tacitly accepted, representing, in some way, a hidden consensus within the medical community in reaction to the modest remuneration offered.

In this regard, MEBTOUL states that the lack of recognition of their expertise by administrative and political authorities, who hold decision-making power in the field of health, is a primary factor in the

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disenchantment of doctors, far beyond the shortcomings in technical and therapeutic means (Mehtoul et al., 1998). Faced with this situation, doctors are often led to establish a superficial therapeutic relationship with users, for whom only the technical act can give a positive meaning to medical activity.

At the vertical level, formal recognition is evident in the training team, which is composed of professors and assistant professors and constitutes a significant field of recognition. The team's mission is to assess the level of qualification and technical skills of residents. Their assessment is primarily based on the valorisation of research results, teaching skills, and analytical capacity demonstrated during annual examinations, which vary according to specialties. Clinical results, however, are the subject of more discreet recognition.

Our respondents report formal recognition from the training team, but this recognition is discreet, not displayed ostentatiously, and often unequal in a professional environment characterized by practices of favouritism and a lack of fairness in the valorisation of residents' efforts and skills. On the relational level, respect for higher-ranking individuals by those of lower rank is emphasized as an indisputable standard of conduct.

"It all depends on the people: some professors collaborate and treat with respect, others in an arrogant manner." Respondent No. 10

"You have to run after the masters and be at the service of the master, to coax to gain his trust and benefit from his teachings and his protection." Respondent No. 12

"There are always residents favoured by the professor who spend more time in the operating room and others confined to routine tasks." Respondent No. 2

"There is no 100% fairness, there is always a favourite of the professor." Respondent No. 4

"I have personally never received recognition from the professor, the gratitude of the patients is enough for me." Respondent No. 3

At the horizontal level, peer recognition is expressed between peers (resident doctors) but also towards other doctors at the UHC. This horizontal recognition is all the more important as it comes from people who have witnessed the quality of the work carried out. According to the Algerian code of medical ethics: "Doctors must maintain good fellowship among themselves and foster feelings of loyalty, esteem, and

trust" (Article No. 59 of the code of medical ethics) (Executive Decree No. 92-276 establishing the code of medical ethics, 2012).

"Relations are generally good, but sometimes there are misunderstandings due to the distribution of tasks." Respondent No. 5

"Relations are good with some, and bad with others, but for the sake of the patient, all tensions must be overcome." Respondent No. 11

"There are problems, especially with regard to shifts, many women do not want to stay at night because of their family situation, which puts a lot of pressure on us men." Respondent No. 4

"There is competition in terms of academic success and gaining experience." Respondent No. 2

"Sometimes preparing for classes can lead to verbal arguments, but this is resolved through discussion and negotiation." Respondent No. 6

"There is unfair competition, for example, they will tell the head of department things to show that they are the best, leave before the scheduled time, etc." Respondent No. 11

The resident is often under the merciless scrutiny of extreme demands from their peers; social relations between them, according to the testimonies, oscillate between cooperation and tensions. Cooperation mainly occurs when the workload is heavy, during the communication of information about patients' conditions in consultations, while scientific exchanges remain limited.

All respondents agree that most conflicts concern rotations and on-call duties, sometimes the diagnosis and protocol presented to the patient, or misunderstandings during the exchange of information about the patient, negligence at work, professional errors, differences of opinion and ideas, or the excessive workload. These disputes are often resolved during "weekly seminars" through dialogue, the intervention of the head of department, and rarely by filing reports with management. Respondents highlight the impact of these "incidents" on their work and self-confidence, leaving lingering sensitivities and discomfort.

Inter-professional relationships between doctors of different grades are characterized by complex dynamics and show limited collaboration in providing consultations on patients' conditions.

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"They provide assistance in case of emergency or direct responsibility; if they are not directly involved, they do not offer their help". Respondent No. 9

The forms of recognition preferred by peers are centred on the recognition of work practices and investment in work. This can be reflected in a motivated and involved team, expressions of thanks, encouragement, mutual aid, moral support, and appreciation, sometimes shown through affectionate gestures. Qualities such as stress management in difficult situations and teamwork for the benefit of the patient are particularly valued. The above includes testimonies from our respondents, revealing the signs of recognition at work coming from peers.

*"Congratulations and appreciation of my work by colleagues".
Respondent No. 10*

*"Simply little sincere and affectionate moments together".
Respondent No. 8*

"I am often asked to give my opinion on cases, I consider that as a sign of recognition". Respondent No. 2

Recognition of learners and paramedics emerges in the working relationships between doctors and nurses, which present conflicting aspects according to the testimonies of some respondents. These conflicts arise when the nurse does not fulfill their obligations towards the patient, whether by delaying essential treatment, failing to administer medication, neglecting medical tests, or refusing to perform certain tasks.

"Tensions sometimes arise when the doctor makes a request and the nurse delays or refuses to do so, even in the event of an emergency or neglect of the patient." Respondent No. 7

*"Some nurses lack professionalism. They have an inferiority complex." Respondent No. 12 "The paramedical team told me that they felt much more motivated since I arrived, that I had given them the desire to get involved and work again."
Respondent No. 2*

The relationship between doctors and nurses is also influenced by various factors, including the seniority of the nurse within the team. Accumulated experience gives the nurse authority and influence, which they can use to affect the work dynamics, particularly in their interactions with less experienced doctors.

As for the relationships between resident doctors and internship students, our respondents emphasize that they are based on mutual respect, supervision, and support. Some as a burden that further increases their responsibilities see the task of educational support.

Recognition from internship students is perceived as incidental and of no major importance. In other words, although compliments or expressions of gratitude from students may be appreciated, they are not considered essential or decisive in the context of their own professional assessment. Formal and institutional recognition, as well as respect and support from colleagues and superiors, are considered much more significant for their professional development and well-being at work.

At the external level, social recognition of patients is central to a doctor's intervention, which is based on two main axes: a technical axis and a subjective axis consisting of taking care of unique individuals with particular emotional and psychological demands (Dubet, 2017, p. 5). In a context where medical information is abundant thanks to the internet, patients' expectations have evolved; they are more informed and more active in managing their health, and they expect care that is centred on the person and adapted to their individual needs. This makes the doctor-patient relationship even more delicate. Here are how our respondents describe their relationships with patients:

"A normal relationship between a doctor who has medical knowledge and a patient requiring medical treatment." Respondent No. 11

"Generally the relationship is positive, it is in the emergency department that some patients can show aggression upon arrival." Respondent No. 9

"Some patients can be reluctant from the beginning of their interaction with the doctor. Often it is the patient's family who poses a problem and disrespects the doctors." Respondent No. 4

"It is the private sector and the press that make patients turn against doctors in public hospitals." Respondent No. 5

"In gynecology, it is the medico-legal aspect that is scary, the doctor is not protected, we know colleagues who have been to prison..." Respondent No. 11

Patient recognition is certainly important because it is a direct testament to the work done. It is expressed in the form of thanks, kind words, "prayers to God," gratitude, and praise—in other words, positive feedback on the work done and a favourable reputation among patients.

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"When a patient or family thanks you for your excellent work." Respondent No. 3

"Resuscitation is a thankless specialty, all the praise goes to the surgeon." Respondent No. 10

"Patients' recognition of the listening and time I give them, my kindness, and my humanism." Respondent No. 11

"My greatest success is when I see my patient healed." Respondent No. 2

"Prayers to God for me "daawat el khir; May God give your health, May God protect your children, for me they are worth more than money." Respondent No. 7

"Saving lives makes me proud of myself." Respondent No. 12

"A former patient brought me two liters of olive oil, it's very touching." Respondent No. 8

The testimonies, therefore, reveal that the success of medical interventions (clinical and/or surgical) is the main source of recognition at work, even surpassing salary or statutory recognition. The form of recognition that prevails here is that of recognizing the results of the residents' medical practice. This is primarily recognition of the expertise and effectiveness of their medical interventions but also includes more relational aspects such as their availability, empathy, "humanity," their ability to communicate effectively, and the time they devote to each patient.

Although one field of recognition cannot replace the other, the self-recognition of the resident doctors surveyed is essentially based on the results of their work. It is the medical act in its technical dimension that constitutes the central element of their professional identity.

This focus on technicality allows residents to reassure themselves about their skills and find a source of personal satisfaction in the face of an uncertain professional environment. While these strategies of retreating into self-recognition can offer some psychological comfort, they also have limitations. Indeed, excessive focus on technicality can narrow the resident physician's perspective and prevent them from developing other essential skills, such as communication, teamwork, and empathy.

5. CONCLUSION

Resident physicians in Algeria, who are responsible for multiple duties—patient care, research, supervision, and evaluation—operate within a failing professional framework and demanding but incomplete training, all part of an environment marked by a medical professional culture that favours self-training. With institutional recognition lacking, peer recognition, although "partial" and "contextual," as well as formal and discreet recognition by trainers, are not enough. In this context, patient recognition is becoming increasingly important, serving as a palliative to the need for recognition in a professional environment that values performance and technique.

Faced with these challenges, residents develop strategies of withdrawal, where personal recognition, based on the results of their work—particularly in the technical dimension of the medical act—becomes a central element of their professional identity and the main source of their quest for recognition at work.

Finally, it is crucial to recognize the challenges faced by resident physicians in Algeria that can hinder their learning opportunities, such as limited resources and infrastructure (medical equipment, supplies, and personnel), heavy workload, weak supervision, and limited training opportunities.

It is important for hospitals and other healthcare institutions to create a culture of recognition where resident physicians feel valued and respected. Such measures could help reduce the feeling of insecurity and uncertainty among residents and promote more balanced and fulfilling professional development.

Appendix

Table 1. Respondent Identification

Respondent N°	Gender	Age	Marital Status	Medical Specialty	Year of Study
Respondent N° 1	W	28	Single	Psychiatry	1st
Respondent N° 2	M	30	Single	Cardiology	3rd
Respondent N° 3	W	32	Married, one child	Psychiatry	1st
Respondent N° 4	M	30	Single	Internal Medicine	2nd

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Respondent N° 5	M	34	Married, one child	Occupational Medicine	4th
Respondent N° 6	W	29	Single	Ophthalmology	3rd
Respondent N° 7	W	35	Married, two children	Paediatrics	2 nd
Respondent N° 8	M	28	Single	Paediatrics	1st
Respondent N° 9	W	27	Single	Pulmonology	2 nd
Respondent N° 10	M	36	Single	Intensive Care	4th
Respondent N° 11	W	33	Married	Gynaecology	3rd
Respondent N° 12	W	31	Single	Cardiology	3rd

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