IIHMR UNIVERSITY

The IIHMR University, Jaipur

Institute of Health Management Research

MBA Health and Hospital Management, Batch 19th (2014-2016), 1st Year

Human Resource Management

CC-609 - Term Examination

Maximum Marks: 70 | **January 2015** | **Time Allowed: 3 hrs.**

Note: The Question Paper consists of three sections. Please strictly adhere to word limit.

Section A- Consists of 12 multiple choice/ one word/ true- false answer type questions. **Please attempt any ten questions** . All questions carry one mark each. Prefer to complete this part first in maximum 10 minutes. **Attempt this part in examination copy only . Write the series number, question number and WRITE your answer.**

Section B- Consists of short notes type answer. Attempt any four . (word limit – 150)

Section C - consists of 6 questions based on Personal Best (part reproduced here) . **Please attempt any 4 questions. Each question carries 12 maximum marks. (word Limit -500 words)**

SECTION B : Write short notes on any four **4x3 =12**

a) Potential appraisal
b) Employer Branding
c) HR Outlay and real-time availability of HR
d) Promotion, Demotion and Bumping
e) Principle of Natural Justice (postulates)
f) Fringe Benefits

SECTION C : Attempt any four questions **4x12 =48**

Assume that the Medical Council of India has mandated that "coaches" be hired in every hospital wherever life saving surgeries with high incidence of human error is reported as an effort to control the same. Answer the following question based on the case PERSONAL BEST

Q.1 a) What according to you should be the **job description(JD)** and **job specification(JS)** of the "Coach"? (Minimum 8 JD and 4 JS) (8)

b) Which method will you propose to **evaluate the money worth of the job** of a coach ? Why ? (4)

Q.2 a) What would/ should be the most appropriate **method(s) of recruitment** of a Coach in Healthcare? Why ? (4)

b) Based on the JD and JS what three/four step **selection system** will you propose for selecting the coaches ? Justify your choice. (8)

Q. 3 Identify ten major indicators on which you will propose to **appraise the performance** of a Coach along with the **method of measurement (scale)** . (12)

Q. 4.a) Comment on **career paths** of the author Dr Atul Gawande and his coach Dr Osteen (4)

b) If you are the HR head/ hospital administrator of a hospital contemplating the idea of hiring coaches, what method(s) would you adopt to **sensitize employees** towards coaching and also for ensuring readiness of employees to accept mentors in their professional journeys . (8)

Q.5 Design a week-long **induction and orientation** programme for the first batch of coaches in your hospital. Propose atleast 12 themes on which the coaches need to be oriented upon (you may use inputs from OB/ Communication Planning and management modules) (12)

Q. 6 On a strategic level, what could be the challenges faced by HR department with this new mandate of hiring "coaches" in the healthcare organizations. (atleast 4-6) (12)

PART ARTICLE RESPRODUCED: PERSONAL BEST

I decided to try a coach. I called Robert Osteen, a retired general surgeon, whom I trained under during my residency, to see if he might consider the idea. He's one of the surgeons I most hoped to emulate in my career. His operations were swift without seeming hurried and elegant without seeming showy. He was calm. I never once saw him lose his temper. He had a plan for every circumstance. He had impeccable judgment. And his patients had unusually few complications. He specialized in surgery for tumors of the pancreas, liver, stomach, esophagus, colon, breast, and other organs. One test of a cancer surgeon is knowing when surgery is pointless and when to forge ahead. Osteen never hemmed or hawed, or pushed too far. "Can't be done," he'd say upon getting a patient's abdomen open and discovering a tumor to be more invasive than expected. And, without a pause for lament, he'd begin closing up again. **(158 words)**

Year after year, the senior residents chose him for their annual teaching award. He was an unusual teacher. He never quite told you what to do. As an intern, I did my first splenectomy with him. He did not draw the skin incision to be made with the sterile marking pen the way the other professors did. He just stood there, waiting. Finally, I took the pen, put the felt tip on the skin somewhere, and looked up at him to see if I could make out a glimmer of approval or disapproval. He gave me nothing. I drew a line down the patient's middle, from just below the sternum to just above the navel."Is that really where you want it?" he said. Osteen's voice was a low, car-engine growl, tinged with the accent of his boyhood in Savannah, Georgia, and it took me a couple of years to realize that it was not his voice that scared me but his questions. He was invariably trying to get residents to think—to think like surgeons—and his questions exposed how much we had to learn.

"Yes," I answered. We proceeded with the operation. Ten minutes into the case, it became obvious that I'd made the incision too small to expose the spleen. "I should have taken the incision down below the

navel, huh?" He grunted in the affirmative, and we stopped to extend the incision. I reached Osteen at his summer home, on Buzzards Bay. He was enjoying retirement. He spent time with his grandchildren and travelled, and, having been an avid sailor all his life, he had just finished writing a book on nineteenth-century naval mapmaking. He didn't miss operating, but one day a week he held a teaching conference for residents and medical students. When I explained the experiment I wanted to try, he was game. He came to my operating room one morning and stood silently observing from a step stool set back a few feet from the table. He scribbled in a notepad and changed position once in a while, looking over the anesthesia drape or watching from behind me. **(511 words)**

I was initially self-conscious about being observed by my former teacher. But I was doing an operation—a thyroidectomy for a patient with a cancerous nodule—that I had done around a thousand times, more times than I've been to the movies. I was quickly absorbed in the flow of it—the symphony of coordinated movement between me and my surgical assistant, a senior resident, across the table from me, and the surgical technician to my side.

The case went beautifully. The cancer had not spread beyond the thyroid, and, in eighty-six minutes, we removed the fleshy, butterfly-shaped organ, carefully detaching it from the trachea and from the nerves to the vocal cords. Osteen had rarely done this operation when he was practicing, and I wondered whether he would find anything useful to tell me. We sat in the surgeons' lounge afterward. He saw only small things, he said, but, if I were trying to keep a problem from happening even once in my next hundred operations, it's the small things I had to worry about. He noticed that I'd positioned and draped the patient perfectly for me, standing on his left side, but not for anyone else. The draping hemmed in the surgical assistant across the table on the patient's right side, restricting his left arm, and hampering his ability to pull the wound upward. At one point in the operation, we found ourselves struggling to see up high enough in the neck on that side. The draping also pushed the medical student off to the surgical assistant's right, where he couldn't help at all. I should have made more room to the left, which would have allowed the student to hold the retractor and freed the surgical assistant's left hand.

Osteen also asked me to pay more attention to my elbows. At various points during the operation, he observed, my right elbow rose to the level of my shoulder, on occasion higher. "You cannot achieve precision with your elbow in the air," he said. A surgeon's elbows should be loose and down by his sides. "When you are tempted to raise your elbow, that means you need to either move your feet"—because you're standing in the wrong position—"or choose a different instrument." He had a whole list of observations like this. His notepad was dense with small print. I operate with magnifying loupes and wasn't aware how much this restricted my peripheral vision. I never noticed, for example, that at one point the patient had blood-pressure problems, which the anesthesiologist was monitoring. Nor did I realize that, for about half an hour, the operating light drifted out of the wound; I was operating with light from reflected surfaces. Osteen pointed out that the instruments I'd chosen for holding the incision open had got tangled up, wasting time.

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There was a moment in sports when employing a coach was unimaginable—and then came a time when not doing so was unimaginable. We care about results in sports, and if we care half as much about results in schools and in hospitals we may reach the same conclusion. Local health systems may need to go the way of the Albemarle school district. We could create coaching programs not only for surgeons but for other doctors, too—internists aiming to sharpen their diagnostic skills, cardiologists aiming to improve their heart-attack outcomes, and all of us who have to figure out ways to use our resources more efficiently. In the past year, I've thought nothing of asking my hospital to spend some hundred thousand dollars to upgrade the surgical equipment I use, in the vague hope of giving me finer precision and reducing complications. Avoiding just one major complication saves, on average, fourteen thousand dollars in medical costs—not to mention harm to a human being. So it seems worth it. But the three or four hours I've spent with Osteen each month have almost certainly added more to my capabilities than any of this.

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The patient was a woman with a large tumor in the adrenal gland atop her right kidney, and I had decided to remove it using a laparoscope. Some surgeons might have questioned this decision. When adrenal tumors get to be a certain size, they can't be removed laparoscopically—you have to do a traditional, open operation and get your hands inside. I persisted, though, and soon had cause for regret. Working my way around this tumor with a ten-millimetre camera on the end of a foot-and-a-half-long wand was like trying to find my way around a mountain with a penlight. I continued with my folly too long, and caused bleeding in a blind spot. The team had to give her a blood transfusion while I opened her belly wide and did the traditional operation.

Osteen watched, silent and blank-faced the entire time, taking notes. My cheeks burned; I was mortified. I wished I'd never asked him along. I tried to be rational about the situation—the patient did fine. But I had let Osteen see my judgment fail; I'd let him see that I may not be who I want to be. This is why it will never be easy to submit to coaching, especially for those who are well along in their career. I'm ostensibly an expert. I'd finished long ago with the days of being tested and observed. I am supposed to be past needing such things. Why should I expose myself to scrutiny and fault-finding? I have spoken to other surgeons about the idea. "Oh, I can think of a few people who could use some coaching" has been a common reaction. Not many say, "Man, could I use a coach!" Once, I wouldn't have, either.

Osteen and I sat together after the operation and broke the case down, weighing the decisions I'd made at various points. He focussed on what I thought went well and what I thought didn't. He wasn't sure what I ought to have done differently, he said. But he asked me to think harder about the anatomy of the attachments holding the tumor in. "You seemed to have trouble keeping the tissue on tension," he said. He was right. You can't free a tumor unless you can lift and hold taut the tissue planes you need to dissect through. Early on, when it had become apparent that I couldn't see the planes clearly, I could have switched to the open procedure before my poking around caused bleeding. Thinking back, however, I also realized that there was another maneuver I could have tried that might have let me hold the key attachments on tension, and maybe even freed the tumor.

"Most surgery is done in your head," Osteen likes to say. Your performance is not determined by where you stand or where your elbow goes. It's determined by where you decide to stand, where you decide to put your elbow. I knew that he could drive me to make smarter decisions, but that afternoon I recognized the price: exposure. For society, too, there are uncomfortable difficulties: we may not be ready to accept—or pay for—a cadre of people who identify the flaws in the professionals upon whom we rely, and yet hold in confidence what they see. Coaching done well may be the most effective intervention designed for human performance. Yet the allegiance of coaches is to the people they work with; their success depends on it. And the existence of a coach requires an acknowledgment that even expert practitioners have significant room for improvement. Are we ready to confront this fact when we're in their care?

* MBA (I YEAR) HRM * 19 January 2015 Roll No. ..... Series Q

Multiple choice/ one word/one line/ true false type Questions . Attempt any 10. MM 10

1. Which of these is **NOT** a dimension of Equity
   a) Internal equity ☐ b) External Equity ☐ c) Industrial Equity ☐ d) Individual Equity ☐

2. Which of the following is **NOT** a type of piece rate system

   a) Piece Rate with Guaranteed Time Rate ☐ b) Fringe Rate ☐ c) Straight Piece Rate ☐
   d) Differential Piece rate ☐

3. ..... are indirect compensation because they are usually extended as a condition of employment and are not directly related to performance.

4. Under ..... the eligible employees are allotted company's share below the market price.

5. The maximum (total) amount of gratuity payable to an employee shall not exceed ..... months' wage.

6. A labour Welfare Officer to improve labour administration should be appointed when the employer employs a) 100 persons ☐ b) 250 persons ☐ c) 500 persons ☐ d) 1000 persons ☐

7. Benefits offered to persons of small means by the government out of its general revenues, without any contribution from employees , is known as social insurance True ☐ False ☐

8. The ESI Act provides for medical help and unemployment insurance to industrial workers during their illness. True ☐ False ☐

9. To claim the maternity benefits , the woman employee must have worked for atleast ..... days in 12 months immediately preceding the day of her expected delivery
   a) 60 days ☐ b) 100 days ☐ c) 150 days ☐ d) 240 days ☐

10. ..... Implies collapsing salary grades into just a few wide levels of bands each of which contains a relatively wide range of jobs and pay levels.

11. Fair Wage is a dynamic concept , which grows in line with the growth of the national economy
    True ☐ False ☐

12. Which of the following is **NOT** a type of Grievance
    a) Imaginary ☐ b) Factual ☐ c) Disguised ☐ d) Gripe Boxes ☐

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* MBA (I YEAR) HRM * 19 January 2015 Roll No. ..... Series P

Multiple choice/ one word/one line/ true false type Questions . Attempt any 10. MM 10

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2. Fair Wage is a dynamic concept , which grows in line with the growth of the national economy
   True ☐ False ☐

3. Which of the following is **NOT** a type of piece rate system
   a) Piece Rate with Guaranteed Time Rate ☐ b) Fringe Rate ☐ c) Straight Piece Rate ☐
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IIHMR UNIVERSITY

The IIHMR University, Jaipur

Institute of Health Management Research

MBA Health and Hospital Management, Batch 19th (2014-2016), 1st Year

Human Resource Management

CC-609 - Term Examination

Maximum Marks: 70 **January 2015** **Time Allowed: 3 hrs.**

Note: The Question Paper consists of three sections. Please strictly adhere to word limit.

Section A- Consists of 12 multiple choice/ one word/ true- false answer type questions. **Please attempt any ten questions .** All questions carry one mark each. Prefer to complete this part first in maximum 10 minutes. **Attempt this part in examination copy only . Write the series number, question number and WRITE your answer.**

Section B- Consists of short notes type answer. Attempt any four . (word limit – 150)

Section C - consists of 6 questions based on Personal Best (part reproduced here) . **Please attempt any 4 questions. Each question carries 12 maximum marks. (word Limit -500 words)**

SECTION B : Write short notes on any four **4x3 =12**

a) Potential appraisal
b) Employer Branding
c) HR Outlay and real-time availability of HR
d) Promotion, Demotion and Bumping
e) Principle of Natural Justice (postulates)
f) Fringe Benefits

SECTION C : Attempt any four questions **4x12 =48**

Assume that the Medical Council of India has mandated that "coaches" be hired in every hospital wherever life saving surgeries with high incidence of human error is reported as an effort to control the same. Answer the following question based on the case PERSONAL BEST

Q.1 a) What according to you should be the **job description(JD)** and **job specification(JS)** of the "Coach"? (Minimum 8 JD and 4 JS) (8)

b) Which method will you propose to **evaluate the money worth of the job** of a coach ? Why ? (4)

Q.2 a) What would/ should be the most appropriate **method(s) of recruitment** of a Coach in Healthcare? Why ? (4)

b) Based on the JD and JS what three/four step **selection system** will you propose for selecting the coaches ? Justify your choice. (8)

Q. 3 Identify ten major indicators on which you will propose to **appraise the performance** of a Coach along with the **method of measurement (scale)** . (12)

Q. 4.a) Comment on **career paths** of the author Dr Atul Gawande and his coach Dr Osteen (4)

b) If you are the HR head/ hospital administrator of a hospital contemplating the idea of hiring coaches, what method(s) would you adopt to **sensitize employees** towards coaching and also for ensuring readiness of employees to accept mentors in their professional journeys . (8)

Q.5 Design a week-long **induction and orientation** programme for the first batch of coaches in your hospital. Propose atleast 12 themes on which the coaches need to be oriented upon (you may use inputs from OB/ Communication Planning and management modules) (12)

Q. 6 On a strategic level, what could be the challenges faced by HR department with this new mandate of hiring "coaches" in the healthcare organizations. (atleast 4-6) (12)

PART ARTICLE RESPRODUCED: PERSONAL BEST

I decided to try a coach. I called Robert Osteen, a retired general surgeon, whom I trained under during my residency, to see if he might consider the idea. He's one of the surgeons I most hoped to emulate in my career. His operations were swift without seeming hurried and elegant without seeming showy. He was calm. I never once saw him lose his temper. He had a plan for every circumstance. He had impeccable judgment. And his patients had unusually few complications. He specialized in surgery for tumors of the pancreas, liver, stomach, esophagus, colon, breast, and other organs. One test of a cancer surgeon is knowing when surgery is pointless and when to forge ahead. Osteen never hemmed or hawed, or pushed too far. "Can't be done," he'd say upon getting a patient's abdomen open and discovering a tumor to be more invasive than expected. And, without a pause for lament, he'd begin closing up again. **(158 words)**

Year after year, the senior residents chose him for their annual teaching award. He was an unusual teacher. He never quite told you what to do. As an intern, I did my first splenectomy with him. He did not draw the skin incision to be made with the sterile marking pen the way the other professors did. He just stood there, waiting. Finally, I took the pen, put the felt tip on the skin somewhere, and looked up at him to see if I could make out a glimmer of approval or disapproval. He gave me nothing. I drew a line down the patient's middle, from just below the sternum to just above the navel."Is that really where you want it?" he said. Osteen's voice was a low, car-engine growl, tinged with the accent of his boyhood in Savannah, Georgia, and it took me a couple of years to realize that it was not his voice that scared me but his questions. He was invariably trying to get residents to think—to think like surgeons—and his questions exposed how much we had to learn.

"Yes," I answered. We proceeded with the operation. Ten minutes into the case, it became obvious that I'd made the incision too small to expose the spleen. "I should have taken the incision down below the

navel, huh?" He grunted in the affirmative, and we stopped to extend the incision. I reached Osteen at his summer home, on Buzzards Bay. He was enjoying retirement. He spent time with his grandchildren and travelled, and, having been an avid sailor all his life, he had just finished writing a book on nineteenth-century naval mapmaking. He didn't miss operating, but one day a week he held a teaching conference for residents and medical students. When I explained the experiment I wanted to try, he was game. He came to my operating room one morning and stood silently observing from a step stool set back a few feet from the table. He scribbled in a notepad and changed position once in a while, looking over the anesthesia drape or watching from behind me. **(511 words)**

I was initially self-conscious about being observed by my former teacher. But I was doing an operation—a thyroidectomy for a patient with a cancerous nodule—that I had done around a thousand times, more times than I've been to the movies. I was quickly absorbed in the flow of it—the symphony of coordinated movement between me and my surgical assistant, a senior resident, across the table from me, and the surgical technician to my side.

The case went beautifully. The cancer had not spread beyond the thyroid, and, in eighty-six minutes, we removed the fleshy, butterfly-shaped organ, carefully detaching it from the trachea and from the nerves to the vocal cords. Osteen had rarely done this operation when he was practicing, and I wondered whether he would find anything useful to tell me. We sat in the surgeons' lounge afterward. He saw only small things, he said, but, if I were trying to keep a problem from happening even once in my next hundred operations, it's the small things I had to worry about. He noticed that I'd positioned and draped the patient perfectly for me, standing on his left side, but not for anyone else. The draping hemmed in the surgical assistant across the table on the patient's right side, restricting his left arm, and hampering his ability to pull the wound upward. At one point in the operation, we found ourselves struggling to see up high enough in the neck on that side. The draping also pushed the medical student off to the surgical assistant's right, where he couldn't help at all. I should have made more room to the left, which would have allowed the student to hold the retractor and freed the surgical assistant's left hand.

Osteen also asked me to pay more attention to my elbows. At various points during the operation, he observed, my right elbow rose to the level of my shoulder, on occasion higher. "You cannot achieve precision with your elbow in the air," he said. A surgeon's elbows should be loose and down by his sides. "When you are tempted to raise your elbow, that means you need to either move your feet"—because you're standing in the wrong position—"or choose a different instrument." He had a whole list of observations like this. His notepad was dense with small print. I operate with magnifying loupes and wasn't aware how much this restricted my peripheral vision. I never noticed, for example, that at one point the patient had blood-pressure problems, which the anesthesiologist was monitoring. Nor did I realize that, for about half an hour, the operating light drifted out of the wound; I was operating with light from reflected surfaces. Osteen pointed out that the instruments I'd chosen for holding the incision open had got tangled up, wasting time.

That one twenty-minute discussion gave me more to consider and work on than I'd had in the past five years. It had been strange and more than a little awkward having to explain to the surgical team why Osteen was spending the morning with us. "He's here to coach me," I'd said. Yet the stranger thing, it occurred to me, was that no senior colleague had come to observe me in the eight years since I'd established my surgical practice. Like most work, medical practice is largely unseen by anyone who might raise one's sights. I'd had no outside ears and eyes. Osteen has continued to coach me in the months since that experiment. I take his observations, work on them for a few weeks, and then get

together with him again. The mechanics of the interaction are still evolving. Surgical performance begins well before the operating room, with the choice made in the clinic of whether to operate in the first place. Osteen and I have spent time examining the way I plan before surgery. I've also begun taking time to do something I'd rarely done before—watch other colleagues operate in order to gather ideas about what I could do.

A former colleague at my hospital, the cancer surgeon Caprice Greenberg, has become a pioneer in using video in the operating room. She had the idea that routine, high-quality video recordings of operations could enable us to figure out why some patients fare better than others. If we learned what techniques made the difference, we could even try to coach for them. The work is still in its early stages. So far, a handful of surgeons have had their operations taped, and begun reviewing them with a colleague. I was one of the surgeons who got to try it. It was like going over a game tape. One rainy afternoon, I brought my laptop to Osteen's kitchen, and we watched a recording of another thyroidectomy I'd performed. Three video pictures of the operation streamed on the screen—one from a camera in the operating light, one from a wide-angle room camera, and one with the feed from the anesthesia monitor. A boom microphone picked up the sound.

Osteen liked how I'd changed the patient's positioning and draping. "See? Right there!" He pointed at the screen. "The assistant is able to help you now." At one point, the light drifted out of the wound and we watched to see how long it took me to realize I'd lost direct illumination: four minutes, instead of half an hour. "Good," he said. "You're paying more attention." He had new pointers for me. He wanted me to let the residents struggle thirty seconds more when I asked them to help with a task. I tended to give them precise instructions as soon as progress slowed. "No, use the DeBakey forceps," I'd say, or "Move the retractor first." Osteen's advice: "Get them to think." It's the only way people learn. And together we identified a critical step in a thyroidectomy to work on: finding and preserving the parathyroid glands—four fatty glands the size of a yellow split pea that sit on the surface of the thyroid gland and are crucial for regulating a person's calcium levels. The rate at which my patients suffered permanent injury to those little organs had been hovering at two per cent. He wanted me to try lowering the risk further by finding the glands earlier in the operation. Since I have taken on a coach, my complication rate has gone down. It's too soon to know for sure whether that's not random, but it seems real. I know that I'm learning again. I can't say that every surgeon needs a coach to do his or her best work, but I've discovered that I do.

There was a moment in sports when employing a coach was unimaginable—and then came a time when not doing so was unimaginable. We care about results in sports, and if we care half as much about results in schools and in hospitals we may reach the same conclusion. Local health systems may need to go the way of the Albemarle school district. We could create coaching programs not only for surgeons but for other doctors, too—internists aiming to sharpen their diagnostic skills, cardiologists aiming to improve their heart-attack outcomes, and all of us who have to figure out ways to use our resources more efficiently. In the past year, I've thought nothing of asking my hospital to spend some hundred thousand dollars to upgrade the surgical equipment I use, in the vague hope of giving me finer precision and reducing complications. Avoiding just one major complication saves, on average, fourteen thousand dollars in medical costs—not to mention harm to a human being. So it seems worth it. But the three or four hours I've spent with Osteen each month have almost certainly added more to my capabilities than any of this.

A determined effort to introduce coaching could change this. Making sure that the benefits exceed the cost will take work, to be sure. So will finding coaches—though, with the growing pool of retirees, we may already have a ready reserve of accumulated experience and know-how. The greatest difficulty, though, may simply be a profession's willingness to accept the idea. The prospect of coaching forces awkward questions about how we regard failure. I thought about this after another case of mine that Bob Osteen came to observe. It didn't go so well.

The patient was a woman with a large tumor in the adrenal gland atop her right kidney, and I had decided to remove it using a laparoscope. Some surgeons might have questioned this decision. When adrenal tumors get to be a certain size, they can't be removed laparoscopically—you have to do a traditional, open operation and get your hands inside. I persisted, though, and soon had cause for regret. Working my way around this tumor with a ten-millimetre camera on the end of a foot-and-a-half-long wand was like trying to find my way around a mountain with a penlight. I continued with my folly too long, and caused bleeding in a blind spot. The team had to give her a blood transfusion while I opened her belly wide and did the traditional operation.

Osteen watched, silent and blank-faced the entire time, taking notes. My cheeks burned; I was mortified. I wished I'd never asked him along. I tried to be rational about the situation—the patient did fine. But I had let Osteen see my judgment fail; I'd let him see that I may not be who I want to be. This is why it will never be easy to submit to coaching, especially for those who are well along in their career. I'm ostensibly an expert. I'd finished long ago with the days of being tested and observed. I am supposed to be past needing such things. Why should I expose myself to scrutiny and fault-finding? I have spoken to other surgeons about the idea. "Oh, I can think of a few people who could use some coaching" has been a common reaction. Not many say, "Man, could I use a coach!" Once, I wouldn't have, either.

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* MBA (I YEAR) HRM * 19 January 2015 Roll No. ..... Series P

Multiple choice/ one word/one line/ true false type Questions . Attempt any 10. MM 10

1. Which of these is **NOT** a dimension of Equity
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2. Fair Wage is a dynamic concept , which grows in line with the growth of the national economy
   True ☐ False ☐

3. Which of the following is **NOT** a type of piece rate system
   a) Piece Rate with Guaranteed Time Rate ☐ b) Fringe Rate ☐ c) Straight Piece Rate ☐
   d) Differential Piece rate ☐

4. Under ..... the eligible employees are allotted company's share below the market price.

5. ..... are indirect compensation because they are usually extended as a condition of employment and are not directly related to performance.

6. The maximum (total) amount of gratuity payable to an employee shall not exceed ..... months' wage.

7. A labour Welfare Officer to improve labour administration should be appointed when the employer employs a) 100 persons ☐ b) 250 persons ☐ c) 500 persons ☐ d) 1000 persons ☐

8. ..... Implies collapsing salary grades into just a few wide levels of bands each of which contains a relatively wide range of jobs and pay levels.

9. Benefits offered to persons of small means by the government out of its general revenues, without any contribution from employees , is known as social insurance True ☐ False ☐

10. The ESI Act provides for medical help and unemployment insurance to industrial workers during their illness. True ☐ False ☐

11. To claim the maternity benefits , the woman employee must have worked for atleast ..... days in 12 months immediately preceding the day of her expected delivery
    a) 60 days ☐ b) 100 days ☐ c) 150 days ☐ d) 240 days ☐

12. Which of the following is **NOT** a type of Grievance
    a) Imaginary ☐ b) Factual ☐ c) Disguised ☐ d) Gripe Boxes ☐

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Q. 4.a) Comment on **career paths** of the author Dr Atul Gawande and his coach Dr Osteen (4)

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Q.5 Design a week-long **induction and orientation** programme for the first batch of coaches in your hospital. Propose atleast 12 themes on which the coaches need to be oriented upon (you may use inputs from OB/ Communication Planning and management modules) (12)

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The patient was a woman with a large tumor in the adrenal gland atop her right kidney, and I had decided to remove it using a laparoscope. Some surgeons might have questioned this decision. When adrenal tumors get to be a certain size, they can't be removed laparoscopically—you have to do a traditional, open operation and get your hands inside. I persisted, though, and soon had cause for regret. Working my way around this tumor with a ten-millimetre camera on the end of a foot-and-a-half-long wand was like trying to find my way around a mountain with a penlight. I continued with my folly too long, and caused bleeding in a blind spot. The team had to give her a blood transfusion while I opened her belly wide and did the traditional operation.

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* MBA (I YEAR) HRM * 19 January 2015 Roll No. ..... Series S

Multiple choice/ one word/one line/ true false type Questions . Attempt any 10. MM 10

1. The maximum (total) amount of gratuity payable to an employee shall not exceed ..... months' wage.
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   a) Piece Rate with Guaranteed Time Rate ☐ b) Fringe Rate ☐ c) Straight Piece Rate ☐
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3. ..... are indirect compensation because they are usually extended as a condition of employment and are not directly related to performance.

4. Under ..... the eligible employees are allotted company's share below the market price.

5. Fair Wage is a dynamic concept , which grows in line with the growth of the national economy
   True ☐ False ☐

6. Which of these is **NOT** a dimension of Equity
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7. A labour Welfare Officer to improve labour administration should be appointed when the employer employs a) 100 persons ☐ b) 250 persons ☐ c) 500 persons ☐ d) 1000 persons ☐

8. The ESI Act provides for medical help and unemployment insurance to industrial workers during their illness. True ☐ False ☐

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10. ..... Implies collapsing salary grades into just a few wide levels of bands each of which contains a relatively wide range of jobs and pay levels.

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12. Benefits offered to persons of small means by the government out of its general revenues, without any contribution from employees , is known as social insurance True ☐ False ☐

IIHMR UNIVERSITY

The IIHMR University, Jaipur

Institute of Health Management Research

MBA Health and Hospital Management, Batch 19th (2014-2016), 1st Year

Human Resource Management

CC-609 - Term Examination

Maximum Marks: 70 **January 2015** **Time Allowed: 3 hrs.**

Note: The Question Paper consists of three sections. Please strictly adhere to word limit.

Section A- Consists of 12 multiple choice/ one word/ true- false answer type questions. **Please attempt any ten questions .** All questions carry one mark each. Prefer to complete this part first in maximum 10 minutes. **Attempt this part in examination copy only . Write the series number, question number and WRITE your answer.**

Section B- Consists of short notes type answer. Attempt any four . (word limit – 150)

Section C - consists of 6 questions based on Personal Best (part reproduced here) . **Please attempt any 4 questions. Each question carries 12 maximum marks. (word Limit -500 words)**

SECTION B : Write short notes on any four 4x3 =12

a) Potential appraisal
b) Employer Branding
c) HR Outlay and real-time availability of HR
d) Promotion, Demotion and Bumping
e) Principle of Natural Justice (postulates)
f) Fringe Benefits

SECTION C : Attempt any four questions 4x12 =48

Assume that the Medical Council of India has mandated that "coaches" be hired in every hospital wherever life saving surgeries with high incidence of human error is reported as an effort to control the same. Answer the following question based on the case PERSONAL BEST

Q.1 a) What according to you should be the **job description(JD)** and **job specification(JS)** of the "Coach"? (Minimum 8 JD and 4 JS) (8)

b) Which method will you propose to **evaluate the money worth of the job** of a coach ? Why ? (4)

Q.2 a) What would/ should be the most appropriate **method(s) of recruitment** of a Coach in Healthcare? Why ? (4)

b) Based on the JD and JS what three/four step **selection system** will you propose for selecting the coaches ? Justify your choice. (8)

Q. 3 Identify ten major indicators on which you will propose to **appraise the performance** of a Coach along with the **method of measurement (scale)** . (12)

Q. 4.a) Comment on **career paths** of the author Dr Atul Gawande and his coach Dr Osteen (4)

b) If you are the HR head/ hospital administrator of a hospital contemplating the idea of hiring coaches, what method(s) would you adopt to **sensitize employees** towards coaching and also for ensuring readiness of employees to accept mentors in their professional journeys . (8)

Q.5 Design a week-long **induction and orientation** programme for the first batch of coaches in your hospital. Propose atleast 12 themes on which the coaches need to be oriented upon (you may use inputs from OB/ Communication Planning and management modules) (12)

Q. 6 On a strategic level, what could be the challenges faced by HR department with this new mandate of hiring "coaches" in the healthcare organizations. (atleast 4-6) (12)

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