IIHMR UNIVERSITY

Institute of Health Management Research

MBA Hospital and Health Management

Batch-21st (2016-2018) First Year

Human Resource Management

Term Examination

Time - 3 Hour **MM-70**

The question paper contains 6 printed page. Please finish Section A in first 15 minutes. This section will be collected latest by 10:30 am. Out of Section B and C please **attempt maximum 60 marks** questions. You may not attempt more than 4 questions from Section B.

Section A *Separate Sheet Attached.* Please finish in first fifteen minutes

Section B Write Short Notes (Maximum 4) (10 marks each)

a) Issues of Human Resource Planning
b) Career Management Systems
c) Advantages and Disadvantages of any two external recruitment methods
d) Internal Mobility (Promotion, Demotion, Transfers)
e) Components of Salary in India including fringe benefits

Section C The questions are based on the article titled *The Heroism of Incremental Care* by Dr Atul Gawande published recently in The New Yorker and floated as a pre-read. The relevant parts of the article are reproduced here for ready reference.

Q. 1. How will the Job description and Specification for Incrementalists (General Practitioners / Doctors) differ from Specialists / Surgeons? (atleast 10) (20)

Q. 2. Propose atleast 10 qualitative indicators for appraising performance of the Incrementalists (General Practitioners/ Doctors). Also propose, with justification, the type of appraisal (rating scale-How to measure) you would recommend for them. (20)

Q. 3. Design a training programme for Incrementalists (General Practitioners / Doctors) for improving their efficiency. (only broad themes and contents to be proposed, minimum 6). Also, propose a method of evaluating the training. (10)

Q. 4. Based on observations of author on compensation of Incrementalists vis a vis the specialist, evaluate the job of incrementalists for upward rationalization. (10)

Part of the pre read article for reference ……..

……In her examination room, with its white vinyl floor and sanitary-paper-covered examination table against the wall, the fluorescent overhead lights were turned off to avoid triggering migraines. The sole illumination came from a low-wattage table lamp and a desktop-computer screen. Sitting across from her first patient of the day, Loder, who is fifty-eight, was attentive and unhurried, dressed in plain black slacks and a freshly pressed white doctor's coat, her auburn hair tucked into a bun. She projected both professional confidence and maternal concern. She had told me how she begins with new patients: "You ask them to tell the story of their headache and then you stay very quiet for a long time."

The patient was a reticent twenty-nine-year-old nurse who had come to see Loder about the chronic daily headaches she'd been having since she was twelve. Loder typed as the woman spoke, like a journalist taking notes. She did not interrupt or comment, except to say, "Tell me more," until the full story emerged. The nurse said that she enjoyed only three or four days a month without a throbbing headache. She'd tried a long list of medications, without success. The headaches had interfered with college, relationships, her job. She dreaded night shifts, since the headaches that came afterward were particularly awful.

Loder gave a sympathetic shake of her head, and that was enough to win the woman's confidence. The patient knew that she'd been heard by someone who understood the seriousness of her problem—a problem invisible to the naked eye, to blood tests, to biopsies, and to scans, and often not even believed by co-workers, family members, or, indeed, doctors.

She reviewed the woman's records—all the medications she'd taken, all the tests she'd undergone—and did a brief examination. Then we came to the moment I'd been waiting for, the moment when I would see what made the clinic so effective. Would Loder diagnose a condition that had never been suspected? Would she suggest a treatment I'd never heard of? Would she have some special microvascular procedure she could perform that others couldn't? The answer was no. This was, I later came to realize, the key fact about Loder's capabilities. But I didn't see it that day, and I was never going to see it in any single visit.

She started, disappointingly, by lowering expectations. For some ninety-five per cent of patients who see her, including this woman, the diagnosis is chronic migraines. And for chronic migraines, she explained, a complete cure was unlikely. Success meant that the headaches became less frequent and less intense, and that the patients grew more confident in handling them. Even that progress would take time. There is rarely a single, immediate remedy, she said, whether it was a drug or a change in diet or an exercise regimen. Nonetheless, she wanted her patients to trust her. Things would take a while—months, sometimes longer. Success would be incremental.

She asked the woman to keep a headache diary using a form she gave her to rate the peak level and hours of headache each day. She explained that together they would make small changes in treatments and review the diary every few months. If a regimen produced a greater than fifty-per-cent reduction in the number and severity of the headaches, they'd call that a victory.

……..How can anyone not love that? I knew there was a place for prevention and maintenance and incremental progress against difficult problems. But this seemed like the real work

of saving lives. Surgery was a definitive intervention at a critical moment in a person's life, with a clear, calculable, frequently transformative outcome.

Fields like primary-care medicine seemed, by comparison, squishy and uncertain. How often could you really achieve victories by inveigling patients to take their medicines when less than half really do; to lose weight when only a small fraction can keep it off; to quit smoking; to deal with their alcohol problem; to show up for their annual physical, which doesn't seem to make that much difference anyway

……..Not long ago, I was talking to Asaf Bitton, a thirty-nine-year-old internist I work with, about the contrast between his work and mine, and I made the mistake of saying that I had more opportunities to make a clear difference in people's lives. He was having none of it. Primary care, he countered, is the medical profession that has the greatest over-all impact, including lower mortality and better health, not to mention lower medical costs. Asaf is a recognized expert on the delivery of primary health care around the world, and, over the next few days, he sent me evidence for his claims.

He showed me studies demonstrating that states with higher ratios of primary-care physicians have lower rates of general mortality, infant mortality, and mortality from specific conditions such as heart disease and stroke. Other studies found that people with a primary-care physician as their usual source of care had lower subsequent five-year mortality rates than others, regardless of their initial health. In the United Kingdom, where family physicians are paid to practice in deprived areas, a ten-per-cent increase in the primary-care supply was shown to improve people's health so much that you could add ten years to everyone's life and still not match the benefit. Another study examined health-care reforms in Spain that focussed on strengthening primary care in various regions—by, for instance, building more clinics, extending their hours, and paying for home visits. After ten years, mortality fell in the areas where the reforms were made, and it fell more in those areas which received the reforms earlier. Likewise, reforms in California that provided all Medicaid recipients with primary-care physicians resulted in lower hospitalization rates. By contrast, private Medicare plans that increased co-payments for primary-care visits—and thereby reduced such visits—saw increased hospitalization rates. Further, the more complex a person's medical needs are the greater the benefit of primary care.

……"They walk out the door thinking you're a shaman," Asaf said, grinning. Everyone loves to be the hero. Asaf and his colleagues can deliver on-the-spot care for hundreds of conditions and guidance for thousands more. They run a medical general store. But, Asaf insisted, that's not really how primary-care clinicians save lives. After all, for any given situation specialists are likely to have more skill and experience, and more apt to follow the evidence of what works. Generalists have no advantage over specialists in any particular case. Yet, somehow, having a primary-care clinician as your main source of care is better for you.

Asaf tried to explain. "It's no one thing we do. It's all of it," he said. I found this unsatisfying. I pushed everyone I met at the clinic. How could seeing one of them for my—insert problem here—be better than going straight to a specialist? Invariably, the clinicians would circle around to the same conclusion.

"It's the relationship," they'd say. I began to understand only after I noticed that the doctors, the nurses, and the front-desk staff knew by name almost every patient who came through the door. Often, they had known the patient for years and would know him for years to come. In a single, isolated moment of care for, say, a man who came in with abdominal pain, Asaf looked like nothing

special. But once I took in the fact that patient and doctor really knew each other—that the man had visited three months earlier, for back pain, and six months before that, for a flu—I started to realize the significance of their familiarity.

For one thing, it made the man willing to seek medical attention for potentially serious symptoms far sooner, instead of putting it off until it was too late. There is solid evidence behind this. Studies have established that having a regular source of medical care, from a doctor who knows you, has a powerful effect on your willingness to seek care for severe symptoms. This alone appears to be a significant contributor to lower death rates.

Observing the care, I began to grasp how the commitment to seeing people over time leads primary-care clinicians to take an approach to problem-solving that is very different from that of doctors, like me, who provide mainly episodic care

.....Rose told me, "I think the hardest transition from residency, where we are essentially trained in inpatient medicine, to my practice as a primary-care physician was feeling comfortable with waiting. As an outpatient doctor, you don't have constant data or the security of in-house surveillance. But most of the time people will get better on their own, without intervention or extensive workup. And, if they don't get better, then usually more clues to the diagnosis will emerge, and the steps will be clearer. For me, as a relatively new primary-care physician, the biggest struggle is trusting that patients will call if they are getting worse." And they do, she said, because they know her and they know the clinic. "Being able to tolerate the anxiety that accompanies taking care of people who are sick but not dangerously ill is not a skill I was expecting to need when I decided to become a doctor, but it is one of the ones I have worked hardest to develop

.....Like the specialists at the Graham Center, the generalists at Jamaica Plain are incrementalists. They focus on the course of a person's health over time—even through a life. All understanding is provisional and subject to continual adjustment. For Rose, taking the long view meant thinking not just about her patient's bouts of facial swelling, or her headaches, or her depression, but about all of it—along with her living situation, her family history, her nutrition, her stress levels, and how they interrelated—and what that picture meant a doctor could do to improve her patient's long-term health and well-being throughout her life.

Success, therefore, is not about the episodic, momentary victories, though they do play a role. It is about the longer view of incremental steps that produce sustained progress. That, such clinicians argue, is what making a difference really looks like. In fact, it is what making a difference looks like in a range of endeavors.

.....None of this is entirely irrational. The only visible part of investment in incremental care is the perennial costs. There is generally little certainty about how much spending will really be needed or how effective it will be. Rescue work delivers much more certainty. There is a beginning and an end to the effort. And you know what all the money and effort is (and is not) accomplishing. We don't like to address problems until they are well upon us and unavoidable, and we don't trust solutions that promise benefits only down the road.

Incrementalists nonetheless want us to take a longer view. They want us to believe that they can recognize problems before they happen, and that, with steady, iterative effort over years, they can

reduce, delay, or eliminate them. Yet incrementalists also want us to accept that they will never be able to fully anticipate or prevent all problems. This makes for a hard sell. The incrementalists' contribution is more cryptic than the rescuers', and yet also more ambitious. They are claiming, in essence, to be able to predict and shape the future. They want us to put our money on it.

.....There is a lot about the future that remains unpredictable. Nonetheless, the patterns are becoming more susceptible to empiricism—to a science of surveillance, analysis, and iterative correction. The incrementalists are overtaking the rescuers. But the transformation has itself been incremental. So we're only just starting to notice.

.....This potential for incremental medicine to improve and save lives, however, is dramatically at odds with our system's allocation of rewards. According to a 2016 compensation survey, the five highest-paid specialties in American medicine are orthopedics, cardiology, dermatology, gastroenterology, and radiology. Practitioners in these fields have an average income of four hundred thousand dollars a year. All are interventionists: they make most of their income on defined, minutes- to hours-long procedures—replacing hips, excising basal-cell carcinomas, doing endoscopies, conducting and reading MRIs—and then move on. (One clear indicator: the starting income for cardiologists who perform invasive procedures is twice that of cardiologists who mainly provide preventive, longitudinal care.)

Here are the lowest-paid specialties: pediatrics, endocrinology, family medicine, H.I.V./infectious disease, allergy/immunology, internal medicine, psychiatry, and rheumatology. The average income for these practitioners is about two hundred thousand dollars a year. Almost certainly at the bottom, too, but not evaluated in the compensation survey: geriatricians, palliative-care physicians, and headache specialists. All are incrementalists—they produce value by improving people's lives over extended periods of time, typically months to years.

This hundred-per-cent difference in incomes actually understates the degree to which our policies and payment systems have given short shrift to incremental care. As an American surgeon, I have a battalion of people and millions of dollars of equipment on hand when I arrive in my operating room. Incrementalists are lucky if they can hire a nurse.

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Attempt any 10 questions. Each question carries 1 Mark.

1. Employees comply with rules out of an inherent desire to cooperate and achieve goals in _____
   a) Positive Discipline b) Negative Discipline c) Self Discipline d) Progressive Discipline

2. When each party is, uncompromising and take hard line the bargaining technique is:
   a) Armed Truce b) Conflict Based c) Power Bargaining d) Cooperative Bargaining

3. Boxes kept at prominent places in the prominent location in the factory for lodging anonymous complaints.
   a) Complaint Box b) Suggestion Box c) Gripe Box d) Tender Box

4. Employee disclosure of an employer's illegal, immoral or illegitimate practices to persons or organisations that may be able to take corrective actions is called as:
   a) Standing orders b) Corporate Governance c) Legal Complaining d) Whistle Blowing

5. The grievance which arise when legitimate needs of employees remain unfulfilled is:
   a) Imaginary b) Factual c) Disguised d) Spurious

6. In which of the following social security benefits contribution is neither been made by workers nor employers?
   a) Social Insurance b) Social Assistance c) Social Assurance d) Social Insolvency

7. Process of reducing, usually dramatically, the number of people employed by firm is:
   a) Dismissal b) Suspension c) Downsizing d) Discharge

8. How much time did supervisor get to redress the grievances of the employees?
   a) 7 days b) 48 hrs c) 3 days d) 42 hrs

9. Name the act which provides medical help and unemployment insurance to industrial worker during their illness.

   .....

10. Red Hot Stove Rule has four components. Tick the one that is not a component of Red Hot Stove Rule:
    a) Burns Immediately ☐ b) Provides Warning ☐
    c) Burns Personally ☐ d) Burns Impersonally ☐

11. Payment linked to number of year served is known as .....

12. Maternity leave can be availed upto:
    a) 16 weeks ☐ b) 10 weeks ☐ c) 20 weeks ☐ d) 26 weeks ☐