

RESEARCH

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Exploring the Role of HRM in Service Delivery in Healthcare Organizations: A Study of an Indian Hospital

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Executive Summary

The new service management school of thought acknowledges a set of new human resource management (HRM) practices, underpinned by the concept of satisfaction mirror between customers and front-line workers. HRM practices in the cycle of success include careful selection, high-quality training, well-designed support systems, empowerment, teamwork, appropriate measurement, rewards and recognition, and the development of a service culture. The model for achieving cycle of success in interactive service works is known as the high involvement work systems (HIWS). There is some research evidence about the positive influence of high involvement HR practices on effective service delivery.

This exploratory study examines the role played by HR practices in maintaining the quality of service delivery, in the context of healthcare services. It specifically studies the administrative factors and HR policies that aid effective service quality and the practices that bring down the quality of care provided in a private sector Indian hospital.

This being a relatively new area, an inductive approach was used. The study relied on semi-structured interviews for the purpose of data collection. Along with data collection, core theoretical concepts were identified and tentative linkages were developed between the theoretical core concepts and the data.

The findings show that the emphasis is more on supreme hospitality and patient amenities than medical treatment. The healthcare industry is witnessing a significant change. A consultant is no longer the 'king'; this position has now been taken by the patients. Of late the emphasis is on patient satisfaction in terms of the facilities provided rather than the nature of medical treatment given. This is primarily so for organizations such as this hospital which aim at providing world-class care and for which 'patient centricity' is the hallmark. HR specific issues such as standardization of nursing activities, appraisal systems, effective communication channels, and compensation structure, all affect the quality of service provided in a hospital.

Similar research can be conducted across other healthcare organizations to replicate and validate the findings regarding the changing scenario in the industry.

KEY WORDS

HRM in Services

Healthcare in India

Front-line Staff

Service Quality

HIWS (High Involvement Work Systems)

Healthcare organizations have been undergoing considerable restructuring since the past decade. Health reforms in the last 25 years have focused largely on structural change, cost containment, and introduction of market mechanisms while the importance of HR management has often been overlooked (Townsend & Wilkinson, 2010). One important aspect of improving and maintaining service delivery in hospitals is efficient management of HR function. In many cases, these changes can be best conceptualized as a movement away from the domination of healthcare organizations by professionals and professional knowledge (Freidson, 1984) through a simultaneous increase in 'customer' orientation and rationalization. The idea that 'the consumer is the king, rather than the consultant', is the key (Korczynski, 2002). Equal in significance to these 'customer' oriented policies have been systematic pressures to rationalize healthcare production, increase efficiency, and cut costs in many economies. Most hospitals intend keeping their staffing levels to a minimum without compromising on their 'quality of care'. Healthcare employees expect their employers to provide infrastructure, HR practices, and support, which they can link to improved performance especially in relation to patient care and service innovations. Counter-intuitively, effort is maintained towards immediate patient care when employee expectations remain unmet (Hyde et al., 2009).

There are some studies that address the healthcare sector in the Indian context but most of these feature either the rural or the public sector hospitals and healthcare facilities. The existing studies are mostly on healthcare facilities of rural India (Pathak, Ketkar, & Majumdar, 1981; Bhandari & Dutta, 2007; Sharma & Narang, 2011) and education about health in urban India (Bhandari, 2006). There are very few studies in the Indian public healthcare context which focus on influence of HR practices on doctors' work attitudes, including professional and organizational commitment (Maheshwari, Bhat, & Dhiman, 2007).

LITERATURE REVIEW

HRM and Effective Service Delivery

The language of the sovereign customer is increasingly embedded in a wide ranging series of organizational structures, practices, and technologies (du Gay & Salaman, 1992). He argues that the customer is used as a

key source of legitimacy within organizations. Management actions are justified in terms of following the dictates of the sovereign consumer, and restructuring of work is justified as necessary to give service to customers. There has been a gradual reduction in the bureaucratic ways of organizing work, and a rise in identities at work based on the idea of the enterprising self (Freidson, 1984). HRM in service work is a part of wider totalizing discourse of the enterprising self. In the healthcare sector, for instance, the front-line staff increasingly perceive themselves as an enterprising self. Meeting the expectations of the front-line staff can lead to a more effective patient care. According to Boaden et al. (2008), "Professional ideology enables performance that might otherwise not be achieved". Individual performance was concerned with how an individual does her/his work, which then leads to outcomes for patients. Organizational performance was perceived as being assessed using 'targets' that were seen by some to be in conflict with patient care – many individuals being unable to describe a link between their own individual performance and that of the organization.

The new service management school of thought (Korczynski, 2002) celebrates a set of new HRM practices, underpinned by the concept of the *satisfaction mirror* between customers and front-line workers. The production line approach to services leads to failure because its narrow, low-skilled jobs, and emphasis on the use of technology leads to workers either having a poor service attitude or leaving the firm through boredom and dissatisfaction. These in turn lead to customer perception of low service quality and to a lack of customer loyalty. A key stepping stone for a new set of HRM practices is the concept of workforce satisfaction mirror (Schneider & Bowen, 1985; Heskett et al., 1997). The idea behind the satisfaction mirror is that customers will receive higher quality service and be more satisfied when the front-line workforce themselves are satisfied in their jobs. A key part of the mirror is the inter-relatedness of the satisfaction of the two parties (Korczynski, 2002). Another aspect of reflective mirror is the argument that front-line workers feel more satisfied because they are able to satisfy customers.

To foster workforce satisfaction, new service management school prescribes the adoption of a range of HRM practices. 'Cycle of capability' HRM practices (Schlesinger, & Heskett, 1991) would include careful selection, high-quality training, well-designed support systems, empower-

ment, teamwork, appropriate measurement, rewards and recognition, and the development of a service culture. Climate for service and employee well-being are both highly correlated with the overall customer perception of service quality. Service climate includes incentives to reward service excellence, tangible evidence from the organization that customer service is critical, emphasis on the retention of existing customers, and support equipments and practices necessary for service delivery. The climate for employee well-being can be measured through worker perception of the following HRM practices: work facilitation, supervision, organizational career facilitation, organizational status, new employee socialization, and overall quality of HRM practices. However, the concept of satisfaction mirror has little research support.

Many service industries show systematic low wages, low training, restricted career paths, and high turnover. The model for achieving cycle of success in interactive service works is known as *high involvement work systems* (HIWS). It includes high relative skill requirement from the employees, jobs designed to provide the opportunity to use these skills, and an incentive structure in organizations to induce discretionary effort (Batt, 2000). HIWS is expected in many service organizations, especially in the ones that rely on the knowledge and ability of their workforce. The HR elements of this work system are careful selection, realistic previews of job and organization, focus on early job experiences of employees, employee empowerment and latitude, employees' awareness of their role in customer satisfaction and economic success, scorekeeping and feedback, integration of employees in a winning team, focus on aggregate labour costs instead of average wage levels, and concentration on quality at the service core. In a study of six organizations, Hyde et al. (2009), found frequency distribution of employees' expectations to be 22 percent for infrastructure, 45 percent for HR practices, and 33 percent for help and support. Expectations were remarkably consistent across organizations and job roles. Many expectations concern HR practices and other aspects of HRM, and so, HR function has an important role to play in developing, negotiating, and aligning expectations, especially as healthcare organizations and consequent expectations of staff are changing (McKee, Ferlie, & Hyde, 2008).

In order to establish a relationship between the human resource policies and the quality of service delivery, it is important to first identify the parameters of good quality.

Under the concept of HIWS, higher self-perceived service capability is expected. This self-perceived service capability can be understood in terms of *SERVQUAL* (Service Quality), a concept of quality that has five dimensions (Parasuraman, Zeithaml, & Berry, 1985) – Responsiveness, Assurance, Tangibles, Empathy, and Reliability (often termed as RATER).

Healthcare Service

The primary front-line staff (customer-facing employees) in the healthcare industry are doctors and nurses. The doctors have a more impersonal relationship with the patients while the nurses provide *tender loving care* (Korczyński, 2002). The interaction of the doctors is limited to the diagnosis and discussions related to the treatment and during the treatment. However, the nurses interact with patients throughout their stay as in-patients. They pay regular visits to the patient and help them with their needs. The pressure for efficiency and effectiveness is particularly pronounced in the hospital sector, which is the most resource-intensive component of the health care system (AIHW, 2005). Thus, maintaining *SERVQUAL* is the primary responsibility of the doctors and the nurses. They are entrusted with the task of patient satisfaction and it is their collective responsibility to ensure that patient needs are fulfilled. From the HR perspective, different HR practices and policies are required for doctors and nurses because they create different components in the service value chain. Therefore, while in the case of doctors, policies such as revenue sharing (for retention) would be of more importance, for nurses, training to help them perform dual objectives (of quality and quantity of service) would be of higher relevance.

The contradictions between the bureaucratic imperative to deliver healthcare efficiently and the desire of healthcare workers to give meaningful, personalized care to patients create the central tension of work (CoB – Customer-oriented Bureaucracy). The socially embedded relationship with patients provides a space for real pleasure and meaning for healthcare workers (Korczyński, 2002). A significant development in the healthcare sector has been the concept of 'primary care'. Primary nursing is patient-centred rather than task-centred and is characterized by each patient having a single, identified, qualified nurse who is responsible for their care during the entire period of their hospital stay (Wicks, 1998). Most profit-maximizing organizations, however, emphasize technical ratio-

nality and quantitative efficiency. The bureaucratic hyper-specialization of healthcare is the medical manifestation of the wider phenomenon of the dehumanizing effects of bureaucracies (Bauman, 1989). The analytical lens of the customer-oriented bureaucracy also highlights the contested nature of authority in healthcare. The idea that the 'consultant is king' clearly speaks about the dominance of the authority of medical knowledge. This prioritizes theoretical knowledge of medicine above the object (the patient) to which this knowledge is applied. This form of authority is in line with bureaucratic authority and is termed as 'medical rational authority' (Korczyński, 2002).

'Patient advocacy', where nurses act as the voice for the often voiceless patients (Korczyński, 2002) is a concept exclusive to the healthcare organizations, and something that contradicts the concept of medical rational authority. In the current scenario of healthcare sector, especially for the profit-maximizing hospitals, another distinct challenge to medical rational authority is the importance given to hospitality of the patients. The customers' needs and comfort are increasingly becoming very essential for the hospitals. The non-medical managers also in fact formulate HR and administrative policies keeping the patients in the forefront. Another facet of the medical professional that needs to be understood is that in this field, professional identification, commitment, and ethics are stronger in comparison with organizational identification, commitment, and ethics. The doctors and nurses are answerable to their profession first and their organization later. In any conflicting situation or otherwise, it is always their professional ethics that will drive them. These are instilled into the healthcare professionals even before they join any organization. This issue will be uncovered in depth at a later stage.

METHODOLOGY

Keeping in view the exploratory nature of the study, a qualitative approach has been adopted. One organization was studied for which data was collected through semi-structured interviews which also included open-ended questions. Before data collection in the field, several doctors were contacted to throw light on the core issues of service delivery in a private hospital. This way the researchers ensured that the questions being asked during field work were relevant and supported by the knowledge of the practitioners. The interviews were conducted in two phases. In the first phase, HR executives

were interviewed (refer to Exhibit 1) to understand the HR policies and practices at the hospital. Then, interviews with doctors and nurses were conducted (refer to Exhibit 2). The sample chosen was such that there was no representation bias. Care was taken to include doctors and nurses from all the departments (fields of medicine) of the hospital and all levels of experience. Thus, a mixed sample was obtained and the respondents were finally decided on these bases from the list provided by the HR department of the hospital. At the end of the first phase, six doctors, six nurses, and one Nursing Superintendent were interviewed (refer to Table 1). Of the six doctors, only one was a payroll doctor and the rest five were retainers of which again one was a Department Head. The nurses chosen were also a fair blend of females and males, young and experienced, and working in various departments. This ensured that a variety of front-line staff was covered to prevent any bias. There were separate questionnaires for the HR staff and the front-line staff. Direct observation was also involved in the research as a method of data collection. Roughly 50 hours of field observation and interviewing was done in the first phase of the research.

The responses of the interviewees were then collated and categorized under several heads to uncover patterns. However, there were certain contradictions amongst (a) the responses of different HR executives, (b) the responses of the front-line staff and the HR department information, and (c) the respondents' own answers. In order to get a clearer understanding of the practices and their effects on the quality of service, a second round of interviews was conducted spanning around 40 hours. This time, five more doctors (two Heads, one clinical associate, and two senior resident doctors) and four more nurses were interviewed. The hospital's HR department was once again contacted for information regarding the revenue sharing models and the like. During the second phase, some members of the top management were also interviewed for their views on the patterns obtained in the first phase.

The criterion for judging when to stop theoretical sampling is 'theoretical saturation' of the category or the theory. By this term, Glaser and Strauss (1967) refer to the situation in which "... no additional data are being found whereby the (researcher) can develop properties of the category. As (s)he sees similar instances over and over

Table 1: Profile of Doctors Interviewed

Code	Tenure	Designation	Specialization/Department
1	1.5 Years	Retainer	Cardiology Department and Cardio-Vascular Surgery
2	5 Years	Retainer	Gynaecology Department
3	4 Years +	Retainer	Gynaecology Department
4	2 Months	Permanent	Radiology Department
5	3 Years +	Retainer	Cardiology Department
6	2 Years +	Permanent	Cardiology Department
7	4 Years +	Retainer	Emergency (Surgeon)
8	Less than 6 months	Retainer	Radiology
9	3 Years+	Retainer	Emergency (Surgeon)
10	2 Years +	Empanelled	Internal Medicine Family Health Management
11	3 Years+	Retainer	Emergency Department
12	1.5 Years	Permanent	Nursing Superintendent
13	10 Months	Permanent	Medical Surgical Ward
14	3 Years +	Permanent	Orthopaedics
15	3 Months	Permanent	Orthopaedics
16	3 Months	Permanent	Orthopaedics
17	1 Year	Permanent	Neurology
18	2 Years +	Permanent	Orthopaedics
19	5 Months	Permanent	Orthopaedics
20	1 Year	Permanent	Orthopaedics
21	6 Months	Permanent	Orthopaedics
22	10 Months	Permanent	Neuro-Surgical Department

again, the researcher becomes empirically confident that a category is saturated ... when one category is saturated, nothing remains but to go on to new groups for data on other categories, and attempt to saturate these categories also". The need for taking more interviews was not felt after the second round of interviews with the doctors and nurses because the pattern of responses had started repeating (Yin, 2003) and with each new interview, the scope of getting additional information had reduced. Hence, 11 doctors, 10 nurses, and 1 Nursing Superintendent were considered sufficient to establish some of the findings discussed later.

Coding and memoing were used to analyse the data collected from these interviews. The thoughts and ideas of the researchers were collected throughout the process of data collection. Extensive memos were created while doing field observations and conducting interviews. Initially data was seen in minute details and some initial categories were developed. After this initial stage, coding was done more selectively and systematically with respect to the core concepts discussed earlier.

Organizational Background

The hospital under consideration was established in 1999 and within a time span of nine years, the group had 26 running hospitals (including 11 satellite/heart command centres) with several more in the pipeline. Currently, there are both multi-specialty and super-specialty hospitals (catering to different kinds of patients based on their medical condition) under the umbrella organization. It is a profit-maximizing organization and its customer segment is mostly "upper-middle class to rich, well-educated people" as indicated by a senior HR executive of the hospital. According to him, the image that this hospital has in the minds of the patients is that of an excellent health services and care provider. Patients come here for its high levels of hospitality and world-class facilities.

The hospital has adopted a business strategy of differentiation with a focus on patient amenities rather than technical quality of medical care. With a reputation of providing world-class patient care, it attracts affluent customers and offers quality services to them. This hospital is NABH (National Accreditation Board for Hospitals and Healthcare) accredited and HIS (Hospital Information

System) compliant. NABH accreditation means that its processes are compliant with the industry's safety and service norms. HIS compatibility means that technologically, it does not lag behind its competitors. The information system ensures that the patients' medical information is captured in a database for future reference. This helps the front-line staff provide better service since they have the medical history of the patients and details such as whom they were treated by on their previous visit, their allergy information, medications prescribed, etc.

The unit under consideration was established six years ago and today it is one of the prominent multi-specialty hospitals in Noida. Interviews with the Chief People Officer and Director of Capabilities Development of the hospital revealed that the sources of competitive advantage were the hospital's brand value, high quality facilities, and some 'star' doctors with very good reputation and expertise.

RESULTS

HR Policies

Based on the interviews with the HR executives, all the HR practices and policies followed at the hospital were studied. The policies for doctors and nurses were segregated because they had different implications for service quality.

HRM of Doctors

Figure 1 explains the career path of a doctor at this hospital. The lower three to four levels are strictly tenure- (time) based and as any doctor moves higher up the matrix, his/her promotion is based on performance. There are three categories of doctors namely; Empanelled Doctors, Retainers, and Salaried doctors (refer to Figure 2). Empanelled doctors (483 out of 6,132 doctors) are visiting doctors at each facility and they get their share of the doctors' fee in the surgeries performed. The salaried doctors (on Payroll) at this unit are fresh MBBS and MDs with little or no experience. They are regular, full-time employees who get salary and other fringe benefits each month. The retainers get a lump sum amount and are not entitled to benefits such as leaves, medical reimbursements, Provident Fund, etc. Majority of the doctors are retainers (refer to Figure 2) who work on a retainership fees instead of a salary or any other kind of revenue-sharing arrangement. Generally, senior consultants and empanelled doctors negotiate their own terms with the organization and work on varied revenue-sharing models. For the empanelled doctors, these revenue sharing models can be purely variable or a combination of fixed and variable components based on the doctors' demands and his/her negotiation with the employer. In case of the variable pay, for instance, the doctor is entitled to a lump sum share of the doctors' fees. Within these categories,

Figure 1: The Medical Matrix

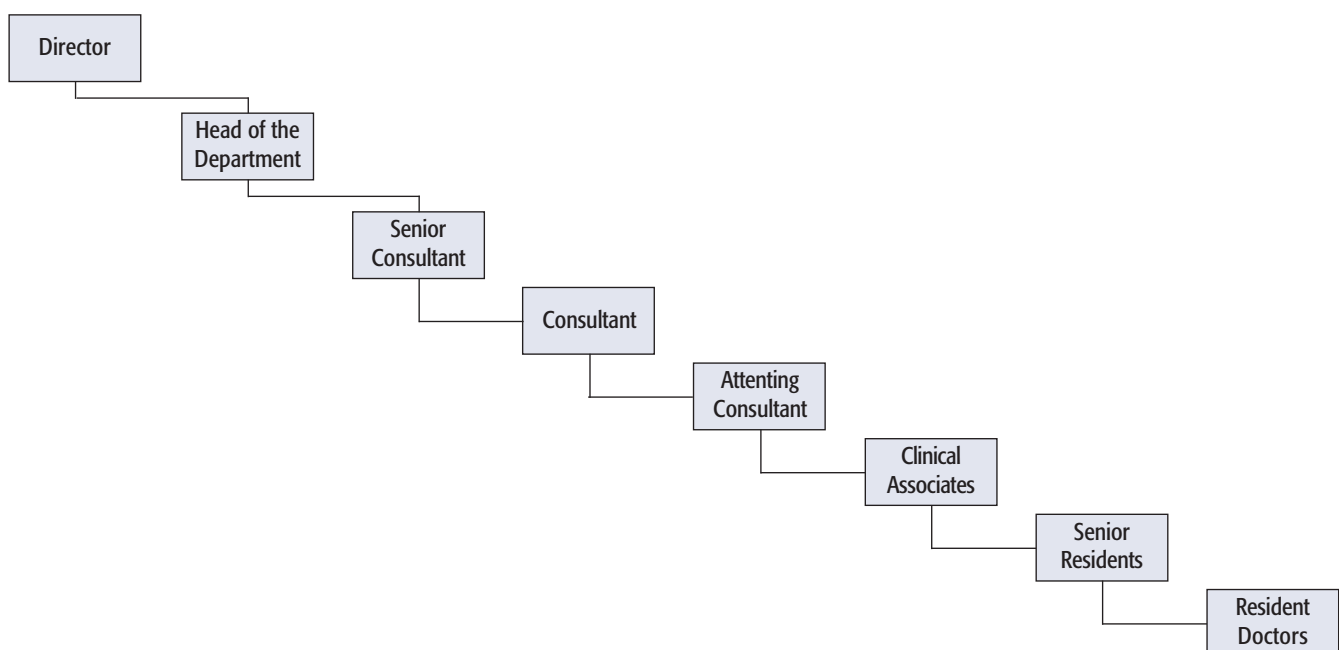
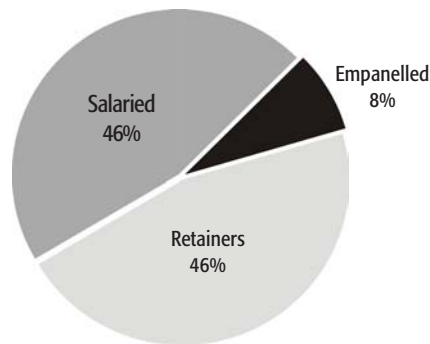


Figure 2: Profile of Doctors in the Hospital



there are 'star' doctors who can be on retainership or be empanelled with their own revenue-sharing model. They are responsible for attracting patients to the hospital owing to their reputation in the medical field. There are some widely recognized doctors who are the 'rain makers' for the organization. They are the chief revenue generators and several patients come owing to the fame of these 'Star' doctors. Clinicians Engagement Group (CEG) is a small body at the corporate level which ensures that the needs of these doctors, monetary or otherwise, are met and that they are retained in the organization. Thus, these star doctors have enough motivation to continue to deliver excellent services. They negotiate their own revenue models and often have profit-sharing arrangements, the terms of which vary on case-to-case basis. However, there are no such incentives for the other doctors.

The recruitment for doctors of all categories is mainly through referrals from senior doctors and poaching of reputed doctors from other hospitals. The selection process essentially comprises an interview of the relevant specialty taken by the Medical Superintendent, Head of the concerned department, and one HR Personnel. The criteria for selection are educational qualifications and previous work experience as told by a senior HR executive. All employees (doctors, nurses, and non-medical staff) at the hospital undergo a four-day induction programme.

There is an annual appraisal cycle in which doctors under all categories (including retainers and empanelled doctors) are rated on a scale of 5 on 18 parameters. These parameters primarily include the service aspects of patient care rather than medical outcomes (refer to Exhibit 3). There are a few columns for self-appraisal. In this section, doctors are asked to write about their achievements in terms of the academic papers presented, medical con-

ferences attended, and other research work. They are expected to write about their contributions to the hospital in the previous year. They are also asked to mention the key areas where they feel they need more training and guidance from a senior doctor. Once these subjective questions are answered, the appraisee has to rate himself on the parameters on a scale of 1-5 where 1 represents 'Unsatisfactory' and 5 stands for 'Outstanding'. The performance appraisal is done by the Head of the Department (HOD) in consultation with the senior doctors. The results of the performance appraisal are not directly linked with monetary or non-monetary rewards. After the appraisee has rated himself on the above, the form goes to the concerned appraiser who also rates the doctors on these parameters on a scale of 1-5 and offers his comments. The appraisal form finally goes to the reviewer for final assessment and comments. For a doctor, the appraiser is generally the HOD. The reviewer is also a person of a higher rank in the hospital. Once the process is complete, the forms are collected by the HR department and analysed.

According to one HR executive, there are four categories under which the performance of doctors is clubbed. These are:

- Below Expectations
- Mostly meets Expectations
- Fully meets Expectations
- Exceeds Expectations

Fitting the doctors into a normal curve, about 5-10 percent are found to fall in the first and the fourth category each. No increment in salary is given to employees who are rated in the 'Below Expectations' category. For all the other categories, there are suitable salary hikes ranging from 5-20 percent. In selected cases, salary correction may also be done according to the performance and worth of the doctors.

HRM of Nursing Staff

The Nursing staff at the hospital comprises 48 percent of the total 73 percent of the medical staff, which includes both doctors and nurses. Due to a high demand, nurses are invited for the recruitment process in the hospital every Tuesday. The vacancies are advertised through newspapers and the hospital website. There is one written test for the nurses comprising 42 questions, 5 of which are strictly patient-centric (emphasis on patient care and com-

fort) to ensure that incumbent nurses follow the hospital hallmark and maintain the high standards of quality. On clearing the test, (75% being the pass mark), the nurses are interviewed by the Nursing Superintendent along with one HR personnel. As per a senior executive of the HR department, during the interview, the answer to the question, "Why Nursing?" is of prime importance. Candidates highlighting aspects such as remuneration, future prospects, etc., are generally not preferred.

There are no contract-based or agency nurses (part-time) in the hospital. The nurses have to be registered at the Registration Council for Nurses. The hospital is strict about this qualification because it ensures elementary knowledge and skill level of nurses. There is a 7-day nursing induction programme for the nurses. As a part of their training, nurses are also taught basics of management (such as time management, documentation skills), leadership qualities, cost consciousness, waste reduction, etc. The objectives of these training sessions are to prepare the nurses for high quality nursing care and to make them understand the business much better. It also helps in identifying their competence to grow in the organization as future supervisors or floor in-charges.

The nurses are regular, full-time employees and receive their remuneration based on their past work experience and qualifications. The incentives for nurses include discounts on medical treatment of self and family, hostel facility on nominal rents and the like. Professionally, nurses can be promoted to supervisory posts based on performance. They are also eligible to work in intensive care departments such as Critical Care Units and with experienced doctors based on their performance. Apart from the above incentives, a performance-based annual increment is given to the nurses.

There is an annual appraisal for nurses on the basis of 20 parameters (refer to Exhibit 4). Like the doctors, the nurses are also expected to write about their contributions and their training and development needs in the appraisal form. The nurses also have to rate themselves on the parameters in the form on a scale of 1-5 where 1 represents 'Unsatisfactory' and 5 stands for 'Outstanding'. After the appraisee nurse has rated himself/herself on the above, the form goes to the concerned appraiser (can be a doctor, nursing supervisor or floor in-charge) who also rates the nurses on these parameters on a scale of 1-5 and offers his/her comments. The appraisal form finally goes to the

reviewer (Nursing Superintendent) for a final assessment and comments. Once the process is complete, the forms are collected by the HR department and analysed.

The nurses function on a standardized system (sequential activities carried out to perform each major task in the hospital) worked out by one of the top management consulting firms. They abide by the protocols and procedures that have been developed across the hospital as per NABH accreditation. There is a Nursing Forum (NF) that meets once in every quarter in one of the facilities to discuss any issues related to the facilities provided by the organization to the nurses.

ANALYSIS

HRM and Service Quality

The front-line staff at the hospital is not particularly satisfied with their working conditions (refer to Table 2). The paper discusses the main sources of dissatisfaction amongst doctors and nurses later. In this section, the effect of HR practices and policies on the day-to-day work of the doctors and nurses are discussed.

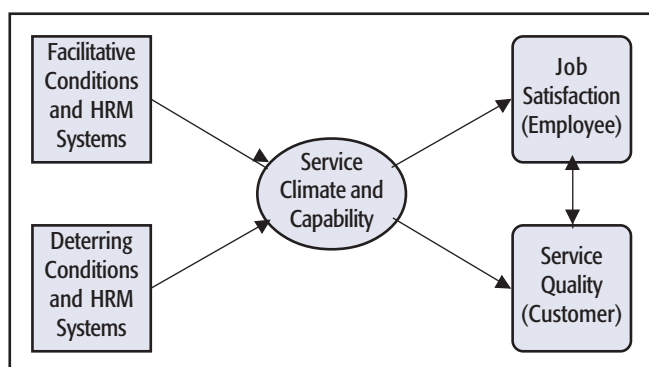
Several administrative practices are well accepted by the front-line staff and they tend to enhance (according to the front-line staff) their drive towards better service quality. The hospital is NABH-accredited which means that it has been attributed with a certification for maintaining excellent processes and facilities. The National Accreditation Board for Hospitals and Healthcare Providers is a constituent board of the Quality Council of India. NABH is an institutional member of the International Society for Quality in Healthcare (ISQUA). Being NABH accredited, the hospital maintains high quality of care and patient safety. The HR department devises strict regulations in order to consistently receive the accreditation renewal. As stated in the NABH official website, the patients get services by credential medical staff. Patient needs are respected and protected and their satisfaction level is surveyed by the means of a feedback form (Exhibit 5). Therefore, patients can feel confident about an NABH accredited hospital as opposed to one without this official recognition.

The medical staff of any NABH-accredited hospital feels satisfied as the accreditation provides for continuous learning, good working environment, and above all ownership of clinical processes. This was the opinion of seven

of the total respondents. As told by a doctor in the Emergency Department, NABH accreditation ensures that quality and safety targets are consistently met; 14 out of the 22 doctors and nurses interviewed were of a similar view. Accreditation to a hospital stimulates continuous improvement and enables it to demonstrate commitment to quality care. According to NABH website, "It (accreditation) provides opportunity to healthcare unit to benchmark with the best". There is circular causality between the performance of nurses and the NABH accreditation where one seems to be leading to the other. The variability of service due to varied backgrounds and work experience of the nursing staff is also minimized. A nurse said that NABH was a proof of the high quality delivered by them. The protocols are regularly adhered to and this ensures better quality service. Therefore, it is clear that the accreditation is well received by the front-line staff and it augments within them a feeling of superiority.

Thirteen respondents felt that the facilities for them were adequate. A resident doctor said that the medical equipments were "exceptional". A degree nurse, with many years of experience at several other hospitals, and who has served in the Orthopaedics department of this hospital for the last one year said, "the X-Ray machines are directly connected to the monitors and there is no need to develop wet films". He felt that this is a "significant way of reducing time of the nursing staff and, even for the doctors, it is easy viewing".

Figure 3: Representative Model



One of the nurses interviewed felt that the facilities (such as hostel accommodation, 10% discount for employees' treatment) at the hospital had a positive impact on the quality of their work. Some doctors interviewed felt that as compared to their previous workplace, the hospital offered much better facilities. In the above framework

(Schneider, White, & Paul, 1998), the facilities given to the nurses in fact provide facilitative conditions that can create a positive service climate and in turn lead to higher job satisfaction. And as per the satisfaction mirror concept, this job satisfaction of employees translates into better service delivered by them.

Three out of the total respondents contradicted this view; they felt that in order to become a world-class healthcare provider; the hospital had a very long way to go. They felt that the amenities for the doctors were still not up to the mark. A doctor from the Gynaecology department said that infertility treatment and test tube babies section was still not developed. She suggested that tertiary care centres should be developed at the hospital. Two doctors from the Emergency and Critical Care units felt that they were not provided with certain basic facilities. There was a taste of dissatisfaction in them; they said that lack of basic conveniences for them and provision of world-class facilities for the patients had led them to believe that their comfort was not important for the organization. They were of the view that this in turn affected the quality of care they delivered.

The most important factor in ensuring quality is the brand value that the hospital as a healthcare service provider, offers to its employees. For doctors and nurses, brand value means a valuable point on their resume (as told by 17 out of the 22 respondents) and thus better job prospects for the future. This helps them market themselves and enhances future employability. In order to sustain this image in the minds of the people, the doctors and nurses are expected to deliver first rate services.

Secondly, for ensuring quality of operations at the hospital, training programmes are conducted for the doctors and nurses. Training is related to both medical profession and management. It assists the staff to abide by the quality-related protocols. Management training on cost effectiveness, time management, etc., helps the nurses understand the corporate culture at the hospital and thus ensure that they maintain quality. The rewards and recognition policy of awarding 'Best Doctor/Nurse of the Month' also goes very well with the front-line staff. This award is given irrespective of the category of the doctor (salaried, retainer, or empanelled). The doctors and nurses commented that such initiatives taken by the management of the hospital motivate them to perform better. These awards act as drivers of improved service delivery and

patient care. The front-line staff feels that this way they are also assured that their performance is regularly monitored and that they have an incentive to strive for excellence.

Thirdly, quality is ensured by the voice mechanism provided by the HR department in the form of the hospital's Nursing Forum (NF). Whenever nurses have difficulty in performing their daily organizational activities or in delivering good quality service, they can approach their higher ups through NF. This forum holds one meeting every quarter in one of the hospital units. Nurses can share their grievances with their supervisors and superintendents who in turn communicate valid issues to the top management. However, this forum is currently not functioning at its fullest capacity as told by some nurses working with the hospital for a while. Nurses feel that often their issues are not resolved which further lessens their faith in the higher authorities. Also, as found during the research, there are no forums for the junior doctors or for doctors of the rank of a resident, senior resident and clinical associates. From the human resource management perspective, such forums are not just important as voice mechanisms but also serve as platforms for doctors for sharing the latest in the medical field and transferring best practices to others (knowledge sharing).

Several practices adopted at the hospital ensure quality. The patient-nurse ratio is such that a nurse is never overloaded with different and time-consuming patient expectations. She can give the required attention that a patient deserves, thereby ensuring quality of care. As per Korczynski (2002, p.208), "the nurses are said to be walking a "tightrope" where they have to maintain balance between closeness, stemming from their patient empathy and distance from the patient that stems from the bureaucratic imperative of efficiency". By keeping this ratio at its optimum levels, the hospital can ensure that its nurses ensure efficient operations as per standards and simultaneously customize according to the needs of the patients. Also, the appraisal forms for doctors and nurses (refer to Exhibits 3 and 4) emphasize on aspects related to quality. The distribution of parameters is such that discipline, empathy, and behavioural components are given equal weightage as aspects such as professional knowledge.

Quality Deterrents

There are several deterrents to effective service delivery. The HR practices, in particular, are not assisting the front-

line staff do a good job (refer to Table 2). Many practices have left the doctors and nurses discontented.

In this hospital, patient comfort and needs are emphasized and this is clear from their patient feedback form (refer to Exhibit 5). In a 30 item 'Out-Patient Feedback Form', there are 25 items that need responses on satisfaction with hospitality and services. Also, items such as "Your involvement in decision-making", "Response to your special/ personal needs", etc., highlight the fact that it is not really medical treatment that the hospital intends to seek feedback on. This is justifiable to a certain extent because the patients do not have much knowledge about complex medical procedures; and so, in any case, they may not be able to provide very objective assessment of medical treatment given to them. One doctor challenged the author during the interview to pick up any feedback form randomly and see that none would contain words of approval or appreciation for the treatment or the doctor. They would only contain praises about the cleanliness maintained in the premises, the white linen, a cafeteria with good variety of food items, and other hospitality related items.

Some of the doctors (4 out of 11 interviewed) felt that they did not mind being paid less or being given less facilities; however, they did mind commercialization of their profession. The status of the doctors in the system had greatly reduced and there was a feeling that the non-medicos (HR and administration staff) were all powerful in the organization. The HODs complained that their decision was overruled when some junior doctor was nominated for promotion. The HR department was blamed for taking their own decisions regarding salary payments, promotions, etc., without consulting the senior doctors. However, this argument was countered by an executive of the HR Department of the hospital. He informed that, on the contrary, the department heads and appraisers did not give a ranking or preference order for the promotions. He reasoned that the heads wanted to appease their juniors and stay clear of any controversies in future, and hence gave similar ratings and recommended a large number of doctors. Since it was not feasible to promote everyone, the HR department was forced to take such decisions.

The hospital is facing very high attrition, of both doctors and nurses: 56.5 percent for doctors and 45.2 percent for nurses. There is a wealth of research demonstrating that

Table 2: Issues related to Doctors and Nurses

Issue	Doctors	Nurses
Over-emphasis on hospitality-related aspects rather than medical outcomes	1, 3, 5, 6, 14, 16, 17, 18	7
HR department needs to get to the ground level, is not well-informed, and hence does a poor job	1, 2, 5, 6, 14, 16,18	9, 10, 11, 12, 20, 21, 22
The hospital is only bothered about its bottom-line, is a bad pay master, and does not take any step to retain good staff	2, 3, 4, 14, 15, 17	—
Dissatisfactory promotion policies and unfair appraisal system	1, 2, 5, 14, 16, 18	9, 10, 13, 20
Separate induction process for doctors and nurses	1, 2, 3, 4, 6, 14, 15,16, 18	8, 9, 10, 11, 21, 22
Inadequate availability of learning avenues	1, 2, 4, 5, 6, 14, 16, 18	7
NABH accreditation advantageous for the hospital and driver of quality	2, 3, 4, 14, 17, 18	7, 8, 10, 11, 13, 19, 21, 22
Standardization makes jobs easy	—	8, 10, 12, 13, 19, 20, 21
Standardization hindering professional independence	—	9, 11, 22
Staff is over-worked and shortage of staff is the main cause	2, 4, 5, 17	7, 8, 9, 10, 11, 12, 13, 19, 20, 21, 22
Doctors do not mind being paid less but need to be respected	1, 5, 6, 16, 18	—
Nurses: Lack of respect from the rest of the departments	—	8, 9, 10, 11, 12, 13, 20, 22
Appraisals not linked to salary hikes or promotions	1, 2, 5, 14, 16, 17, 18	11, 12, 22

hospitals throughout the world have been facing a nursing labour shortage for some time now (Buchan & Calman, 2004; Townsend & Allan, 2005). This is a problem for the hospital because they devote time and money in training these nurses. The nurses on the other hand treat the hospital as a training ground, post which they can easily get jobs as nurses or midwives abroad – Middle East, USA, UK, and Canada. They try and work with reputed doctors and in critical care units such that their resumes gain extra credibility making it easier for them to grab an international assignment. Such jobs may offer them salaries that are nearly impossible to match in India. Thus, there is little that the hospital can do to retain these nurses. According to the HR executive, the situation is especially critical because the schools in India providing the GNM (General Nursing and Midwifery) training are mostly sub-standard. The hospital invests a lot on their training starting from giving them the most elementary guidance such as administering an injection to these untrained nurses.

Due to the high attrition rates, there is a severe crunch in the hospital for nurses and junior doctors especially at the resident and senior resident level. Owing to the crunch for medical staff, the existing staff is over-worked. This can be fatal for quality of service delivery. The nursing staff stated that they exceeded their shifts by 2-3 hours every day. A doctor in the gynaecology department in-

formed that against the international working hour norms of close to 50 hours per week, doctors at the hospital worked for about 72-75 hours per week. Another reason why this is detrimental to the quality of service delivery is that since there are no monetary or non-monetary benefits for working extra, the front-line staff has no incentive to deliver good quality service.

There is a lot of documentation work that the nurses are expected to do as a part of the standardized processes advised by the management consulting company. The result of this is that they cannot fully concentrate on their core job. They treat the documentation activities as mandatory because it is a deliverable for them at the end of the day. After their shift gets over, they have to submit reports as a 'Handing Over' exercise. According to the nurses, this is where small hospitals give them the liberty to practice their profession fully and the hospital makes them do tasks that are stressful for them and in which patient care gets neglected.

Another problem associated with the nurses, who are the prime interfaces between the doctors and the patients and hence important drivers of quality, is that they are not respected by the rest of the departments (refer to Table 2). As told by Respondent 13, "... (we) feel very small in the entire system" and by Respondent 12, "There is no re-

spect for the nurses by the non-medicos". This lack of respect is not taken well by them and is reducing their loyalty towards the organization. This is leading to more dissatisfaction which either results in a compromise on the quality of work or attrition of the nurses.

Another quality deterrent is the insufficient learning opportunity at the hospital. Doctors feel that the basic facilities such as internet are not adequately available. Also, doctors are not encouraged to go for national/international conferences and symposiums. There is a contradiction in this regard because during the appraisal process, the doctors are encouraged to write about their professional achievements. But it is clear that these practices do not reflect in the salary hikes or promotions. Doctors are not sponsored for higher education and even indispensable certification courses such as ACLS and BLS are taken by them at their own expenses. Several doctors were keen on pursuing management courses such as Masters in Hospital Administration, but they grieved that they had to struggle to get leave in order to study further. Respondent 1 suggested that there would be far lesser administrative issues and better policy formulation if management employees at hospitals are medicos. Respondent 14 is also attending a course in hospital administration. However, the hospital is yet to take advantage of these career inclinations of the doctors. In the Indian public healthcare context, supportive training climate has been found to significantly influence doctors' commitment to the organization (Maheshwari et al., 2007); however, doctors reported poor training support in the same study.

Most employees of the hospital, including very senior doctors were dissatisfied with the compensation packages (refer to item 3 in Table 2). An HOD commented, "They (The hospital) are very poor pay masters". Yet another HOD commented, "The hospital knows how to extract more for less pay". In general, the doctors felt that their hard work and devotion was not adequately rewarded and this was a cause for frustration. This annoyance was apparent during the interviews; several doctors admitted that despite being in such a noble profession, they compromised the quality of their work at times and justified it as a very natural tendency on their part, as told by Respondent 5. Some doctors (Respondent 2, 3, and 16 in particular) acknowledged the fact that medicos indulged in activities like using influence for promotions and better salary packages which hampered the quality

of their work because they spent a great deal of time and effort in doing so.

Another reason of dissatisfaction amongst the doctors at the hospital was the great difference between their remuneration and that of the doctors at other facilities of the same organization. They confided that since Delhi patients (customers) had a higher paying capacity than Noida patients, there was a considerable disparity in the respective pay scales of the doctors. There also existed disparity at other levels at the hospital. There were department-related variations and compensation-related differences between some prominent doctors (essentially due to their "rainmaker" reputation) and the rest.

In the appraisal process carried out at the hospital, the appraisers are often not the people who have actually worked with the concerned subordinate. It was found that all doctors and nurses were appraised at the end of the financial year and were given ratings by the Heads of their Departments and Nursing Superintendent respectively, based on 20 parameters. Specific patient feedback, if any, was also taken into account. These parameters checked for medical knowledge, adherence to standards, service quality, hard work and dedication, aspirations, etc. However, the process is conducted quite casually at the hospital. There are 30 forms for the appraiser to appraise in a day and give respective comments. Already under a lot of work pressure, the appraisers can never perform this task judiciously. Even the appraisees do not take the process seriously. As told by an HOD, who is also the appraiser for several doctors and medicos in his department, there are many doctors who leave sections such as "Contributions to the hospital" and "Development areas/Training needed" blank. When asked, the doctors admitted and said that they had reasons for doing so. Many of them said that it was not as if they did not contribute to the hospital in their own ways or did not feel the need for specialized trainings, but were certain that mentioning them would be a sheer waste of time because these things were not important for the management.

During the course of the research, it was found that the doctors and nurses felt that filling their appraisal forms was just another documentation job assigned to them. This was told by Respondent 1 who was the appraiser of many doctors in the Cardiology department. Respondents told that the appraisals were not linked to either salary

hikes or promotions (refer to Table 3). The process seemed to be redundant and its relevance was still not clear to the employees. However, what came out in interviews conducted with the HR Staff was that performance was suitably rewarded as per the ratings awarded to the doctors and nurses. There is thus a contradiction between policies as stated by the front-line staff and the administrative employees.

DISCUSSION

The NABH accreditation and the brand value of the hospital act as motivators for the front-line staff to deliver better service to the patients. Another critical aspect of service quality in a healthcare organization is the standardization of processes. The nurses' activities, right from patient admission to his/her discharge are completely homogenized across the different hospital facilities by a process created by the consulting company. It is clear from the interviews that a majority of the nurses feel that the standardized procedures are very difficult to cope with initially but facilitate them in their work once they get accustomed to them. This goes against the concept of HIWS in this profession, which emphasizes the need for discretion to the front-line staff for superior productivity. The main pretexts on which HIWS functions are: (i) high skill requirements, (ii) work designed for discretion and opportunity and (iii) incentive structure to enhance motivation and commitment. The standardization of activities restricts the skill requirement and discretion to the employees. One nurse from the Orthopaedics department said that since all her activities were procedurized, she was "never at the risk of making a mistake". She said that this gave her the confidence regarding her quality of work. This way all nurses follow the same processes irrespective of their prior training and experience. Thus, the evenness of quality of service and care can be ensured.

However, there is a downside to this aspect. The nurses are expected to perform their set tasks for which the sequence and methodology is given. The nurses admitted that there were times when owing to the medical criticality of the situation; they ended up skipping a few steps or altering the chain of jobs. However, their actions were never interpreted as ones taken as per the need of the hour. The nurses at the hospital felt that this took away their commitment of patient care and turned their job into a mechanical set of duties (customer-oriented bureaucracy). There was a contradiction between efficiency and

care/customization of service delivery and they seemed to be two ends of a continuum, never co-existing. Some nurses, generally the ones more experienced, also felt that this came in the way of their professional independence (refer to Table 2). This independence at work was crucial for the quality of service delivery and therefore was something that should be encouraged at the hospital. Having said this, we would like to stress that by and large nurses have accepted standardization.

However, there are certain administrative practices that are either directly hampering service quality or are becoming a source of frustration amongst the doctors and nurses, thereby leading to reduced quality measures adopted. The way the healthcare industry has been changing is dramatic but nevertheless even in the present circumstances, it is essential to match the perceptions of quality of the doctors to that of the patients. Doctors at the hospital feel that the social concept of care is lost. What they are doing is merely enriching the bottom line of a corporate body and this corporate body is, in turn, ensuring that affluent, well-educated 'customers' are attracted to it for want of 'world-class' facilities elsewhere. Hospitality and patient needs are over-emphasized and it is important for the organization to keep its customers happy rather than its staff. A senior doctor said, "We have become the last priority". Owing to professional ethics, however, doctors never let their work-related dissatisfaction come in the way of their professional duties. This result conforms to findings in the Indian context that doctors working in public healthcare system at state and district levels have higher commitment to their profession than to the organization or the public healthcare department. Thus, despite reporting poor infrastructural support and weak human resource developmental policies, they are committed to the call of their duty (Maheshwari et al., 2007). However, contrary to these findings, evidence from the UK suggests that front-line hospital staff and administrative staff within organizations share certain common values (Hyde et al., 2009).

The healthcare industry is witnessing a significant change. A consultant is no longer the 'king' (Korczynski, 2002); this position has now been taken by the patients. Of late the emphasis is on patient satisfaction in terms of the facilities provided rather than the nature of medical treatment given. This is primarily so for organizations such as this hospital which aim at providing world-class care and for which "patient centricity" is the hallmark.

Patients, now-a-days, do not want unnecessary stress that they encountered before, in getting themselves treated. They are ready to spend money to get treated 'comfortably'. At most of the corporate hospital chains, patients know beforehand that they are in for a hefty bill but do not mind it since they get supreme facilities for the price. It is not surprising anymore to hear that a patient walked into one of the world-class care provider units for the facilities they offered rather than the treatment. The upside of this is that the 'customer' is satisfied.

There is an obvious downside of the present scenario as well. The consultants at these hospitals are disgruntled. Their professional excellence and deliverance of defect-free clinical outcomes (Khatri et al., 2006) have taken a backseat and they are increasingly expected to provide high quality facilities and generous hospitality. The doctors have been reduced to mere 'helping hands' (as told by Respondent 2) at a place like this hospital. This has left them dissatisfied with most of them feeling that it is only finance that matters to their organization. Their displeasure gets reflected in their work even though they would not want this to happen. Their sense of professional ethics would deter the doctors from letting their organization-related dissatisfaction overpower their professional commitments. However, three doctors' responses clearly showed that they found it difficult to empathize with their patients.

The HR practices followed at the hospital are also in line with the organization's vision and hallmark. Therefore, in most cases, they are unable to help the front-line staff. As a result, quality of service delivery has been suffering.

An unhappy front-line staff can severely affect the quality of care provided.

Limitations of the Study and Scope for Future

This study has certain limitations. The number of people interviewed during the research was 22 and even though most aspects included in the paper had consistent responses, some views may not have been echoed by all. The number was small but a need for more data was not felt as the responses had started stagnating in the second round of interviews. A significant problem faced was that all nurses interviewed being from Kerala, were not proficient in the language the interview was taken. Also, owing to their limited knowledge about HR practices, lot of probing had to be done and examples had to be cited to extract their response. And, because of this, there could have been inadvertent interviewer bias. As with the doctors, due to their busy schedules, some were not able to devote much time and thus could not give all the required information. Lastly, even though they were assured of confidentiality, many might not have come out with candid responses for the fear of their views being mentioned to their higher ups.


The study has a lot of scope for future. The same research can be conducted across the healthcare organizations to replicate and validate the findings regarding the changing scenario in the industry. Also, doctors and nurses who have worked in several hospitals can be interviewed to draw comparisons and observe the effectiveness of diverse HR practices. Some of the author's conjectures could not be tested due to lack of data. 

Exhibit 1: Schedule for the HR Head

1. What is the recruitment process at the hospital? How many rounds of interviews are conducted?
2. How are the job skills required for a particular job tested?
3. What type of personality tests are conducted in order to ensure that the employees fit into the hospital culture?
4. What is the Induction Process for the Healthcare front-line staff? How different is the process for Doctors and Nurses?
5. What is the nature of training provided to the nurses and care providers? Does this training include sessions on quality of service delivery, time management and other managerial aspects?
6. What are the measures taken in order to keep high motivation levels of the front-line staff?
7. Which type of appraisal system is followed to ensure that quality of service (and not just number of treatment related activities) is given due attention?
8. What measures are taken to retain Specialists/Star Doctors?
9. Owing to the community-oriented nature of the job, what kind of rewards and incentives work best for the healthcare providers?
10. How much standardization is involved in the treatment processes?
11. What are stress relieving mechanisms provided to the employees? Also, is there a voice mechanism where employees can voice out their work-related concerns?
12. There is a "tightrope" that the nurses have to walk. How is their balance ensured?

Exhibit 2: Schedule for the Front-line Staff

Section I

1. What are the issues/challenges you face in delivering excellent service at the hospital?
2. How does HRM help you in overcoming these issues/challenges?
3. What cooperation do you seek from other professional staff (e.g., nurses in the case of doctors and *vice versa*) in delivering better service? How do HRM practices help in invoking such cooperation?

Section II

4. How does the Recruitment and Selection process at the hospital help in getting the needed talent? What is it that attracts (or deters) doctors/nurses to the hospital?
5. According to your experience, do you think the hospital socialization/induction processes are sufficient to integrate a new employee?
6. How does the hospital appraisal system help you in delivering better service?

7. Are there enough learning avenues at the hospital that help you in improving service delivery?
8. What incentives at the hospital motivate you to give better performance?

Section III

9. What keeps you committed to the hospital? What are main reasons behind the high attrition rates? How can HRM help to reduce attrition?
10. How does HRM help to cope with the emotional labour associated with the job?
11. Who (doctors, nurses, patient or management/administration) is most influential in the system and has an impact on the service delivery?

Additional Question for the Nurses

1. Does standardization hamper the freedom of working style of the nurses?
2. Do you think this can be a potential cause for dissatisfaction amongst the staff?

Exhibit 3: Appraisal Form for The Doctors

Demographic details:

NAME
DESIGNATION
DEPARTMENT
LOCATION
DATE OF JOINING
EMPLOYEE ID
APPRAISER

Rank on the following parameters:

1. Clinical knowledge
2. Clinical assessment
3. Quality of patient care
4. Response time in case of emergencies
5. Adherence to clinical protocols
6. Completion of medical documentation
7. Rate of complications handled

8. Ability to connect with patients
9. Adherence to infection control practices
10. CMEs/Trainings attended
11. Participation in Organization's events
12. Displays leadership qualities, assertiveness and persuasiveness.
13. Academic focus
14. Requisite knowledge of drugs
15. Ability to optimally utilize resources
16. Personal grooming, dress code and neatness
17. Attendance and punctuality
18. Interpersonal Skills

Comments of the Appraisee:

Comments of the Appraiser:

Comments of the Reviewer:

Exhibit 4: Annual Nursing Performance Review

NAME
DESIGNATION
DEPARTMENT
LOCATION
DATE OF JOINING
EMPLOYEE ID
APPRAISER

Review Parameters

1. Groomed/turned out as per employee standards
2. Able to think logically, is alert and takes care of patient care standards
3. Courteous, tactful and considerate
4. Trustworthy and reliable
5. Attendance and punctuality

6. Is enthusiastic and takes initiatives
7. Displays leadership qualities, assertiveness and persuasiveness
8. Follows instructions and exhibits positive behavioural changes
9. Able to communicate effectively
10. Projects positive image of organization to patients and external customers
11. Follows departmental protocols, processes and policies
12. Able to elicit relevant health history of the patient, performs physical examination accurately
13. Able to plan, implement and evaluate outcomes
14. Has sound knowledge and adequate skills.
15. Demonstrates evidence of self- directed learning
16. Understands and interprets quality indicators of healthcare
17. Patient safety and infection control practices
18. Requisite knowledge of drugs and drug safety

19. Skillful in handling instruments and equipments
20. Identifies opportunity of health education and imparts health advices.

Areas worked in:

Observed improvement/development needs:

Suggested Action Plan:

- **What?**
- **By when?**
- **By whom?**

Comments of the Appraisee:

Comments of the Appraiser:

Comments of the Reviewer:

Exhibit 5: Out-patient Feedback Form

Dear Sir/Madam,

Thank you for giving us the opportunity to serve you. We value your opinions. We appreciate you taking time to complete this feedback form which will help us serve you better.

	Very satisfied		Very dissatisfied	
	1	2	3	4
Front Office				
Helpfulness & courtesy of staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting time at the front desk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ease of getting an appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctor Consultation (Speciality _____)				
Helpfulness & courtesy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time spent by the doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation about diagnosis & treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your involvement in decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintained privacy during consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information about health promotion & disease prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Services <input type="checkbox"/> Radiology <input type="checkbox"/> Pathology <input type="checkbox"/> NIC <input type="checkbox"/> Other				
Ease of getting an appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting time for investigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpfulness & courtesy of staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation about the investigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting time for reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pharmacy

- Helpfulness & courtesy of staff
- Availability of medicines
- Waiting time

Facilities

- Cleanliness
- Signages
- Seating arrangement
- Services at cafeteria
- Services and valet parking
- Courtesy of security staff
- Any other (_____)

Very satisfied	Very dissatisfied		
1	2	3	4

Extremely likely/ Very satisfied	Not at all likely/ Very dissatisfied		
1	2	3	4

Overall Experience

- Response to your special/personal needs
- Overall satisfaction with the care you were received at the hospital
- If required, I would be willing to come back or refer a friend/ relative to this hospital

Would you nominate any employee for the “Outstanding Service”

Name:

Area of work:

Reasons:

How can we make experience in the hospital even better for patients & their attendants?

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Date: _____

Name: _____ UHID: _____

Speciality of treatment: _____

Address: _____

Phone: _____

email: _____

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