

# Enhancing Student Engagement and Critical Thinking During Hospital Orientation for Level 1 CPE Students

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*Hospital orientation for Level 1 CPE unit is challenging due to the volume of information and the requirement to comply with hospital and regulatory policies. In contrast with the case based, experiential focus of CPE, hospital orientation is content-driven. This pilot project revised hospital orientation to align it with the action-reflection method using video scenarios. Effectiveness was evaluated by assessing student knowledge as well as student and faculty perceptions of the delivery method. Pre-test and post-test results found improved student knowledge in each of four areas studied. Students found the scenarios enhanced critical thinking but were more neutral in recommending them over other methodologies. In contrast, faculty and residents strongly recommended scenarios rather than content-only orientation methods.*

**ORIENTATION TO THE CLINICAL ENVIRONMENT** for students entering an initial Level 1 summer unit of clinical pastoral education (CPE) has become increasingly challenging for CPE supervisors and pastoral care managers. The majority of students have limited experience with, or understanding of, complex health care organizations such as the modern academic teaching hospital. There also is increased demand for compliance with external regulatory agencies such as the Joint Commission as well as state health departments. While the Scope of Practice for individual pastoral care departments may vary, it is common for chaplains to have a breadth of responsibilities in addition to the delivery of spiritual care to patients, families and staff, e.g., multiple hospital-wide programmatic protocols such as advance directives, decedent affairs and bereavement.<sup>1</sup>

The volume of information included in the CPE student handbook is considerable. Presentations from pastoral care and hospital staff are personnel intensive. The ability of students to capture and retain such information remains an ongoing challenge. The CPE orientation program at Virginia Commonwealth University Medical Center (VCUMC) employs five to

six pastoral care members, plus hospital staff, to deliver approximately twenty hours of Week One orientation. In Week Two orientation, students are introduced to the electronic medical records; they must complete four hours of training and pass a competency test. During these two weeks, students are exposed to complex information without adequate knowledge of the clinical context in which this information is applied. Thus they receive significant information needed to enhance their success while many are still trying to find their way around a hospital.

Student-centered teaching that emphasizes critical thinking is rooted in the tradition of case-based teaching. Instruction using the case method approach emerged as a distinct pedagogical method in the 1960s through the efforts of Harvard Business School, which sought to improve teaching by emphasizing instructor-student relationships. The guiding principles of this method are questioning, listening and responding; leading the discussion process; and nurturing critical thinking through the balancing of discussion direction versus discussion control.<sup>2</sup> These apply regardless of the content area.

CPE has a long history of process-centered teaching through the use of the teacher-learner interaction, which emphasizes critical reflection on case material. It began with Boisen's study of the living human document through student observation and continued when Cabot and Dicks introduced the verbatim as a method to study the actual helping process. Throughout its history, CPE has employed various case-based methods to assist students involved in learning through the actual practice of ministry. Reflection and critical thinking using cases encountered in the clinical experience are part of the varied methods currently employed in CPE. In addition to the verbatim, these methods may include case histories, critical incident reports, role playing with and without video, dual visitation and interdisciplinary clinical rounds.<sup>3</sup> More recently, interest in the use of standardized patients, a method long utilized in medical education, has emerged in CPE.<sup>4</sup>

## Project significance

Operational dilemmas confronted by CPE students often require immediate decisions about how to respond to clinically pressing requests for pastoral services. Such dilemmas impact organizational roles and generate conflicting demands, task ambiguity and work overload. Critical thinking requires students to demonstrate the following abilities:

- To conduct a needs assessment.
- To identify critical questions to ask and resources needed or available.
- To establish priorities.
- To meet regulatory or policy standards.
- To encourage collaboration.
- To manage conflict constructively.

The teaching and learning of these skills are embedded in the CPE process throughout the initial summer unit and beyond.

Mastery of orientation content by Level 1 students is necessary for them to be effective in their roles as hospital chaplains and for the continued effectiveness and compliance of the hospital with operational requirements. The critical thinking skills necessary to properly access and process content provided during the information-weighted orientation assist students in their ability to make timely and effective determinations that will lead to quality outcomes within the clinical context.

The VCUMC program has had a growing sense that the common process of delivering orientation is counter intuitive to the action/reflection model of teaching and the clinical method of learning inherent in CPE. For the most part, CPE training is problem based and case focused in its approach. In contrast, the traditional method of hospital orientation is content driven and "rules" oriented. While CPE values student engagement in the process of learning, hospital orientation typically lends itself to more passive learning.

Adult learning in CPE has long promoted the theory that learning occurs best when it is meaningful and applicable to the present context. Orientation tends to focus on information that has future and undetermined relevance. When combined with the expectation that CPE supervisors review program expectations and ACPE policies, the orientation process may significantly delay student opportunity to engage in patient care and supervisor opportunity to make early assessment regarding students' level of ability and comfort with the clinical setting. Students come into CPE already anxious about the unknown. Often, the volume of information delivered to new interns during orientation heightens anxiety at a time when the facilitation of student readiness to learn requires reducing it.

## Project

The primary objective of this project was to revise the orientation process in order to align it with the experience-based, action/reflection method already employed within the overall program. Corollary objectives included the following:

- Incorporation of a critical thinking component without increasing the length of orientation.
- Incorporation of a critical thinking component without sacrificing coverage of hospital/departmental policies and procedures.
- Assessment of the utilization of videotaped, case-based scenarios rather than didactic, content-focused delivery of information.
- Enhancement of student engagement in a shared learning experience.

To this end, the Program in Patient Counseling (PATC) at Virginia Commonwealth University (VCU) developed an experiential component through the use of videotaped multistage scenario role plays.

Role play scenarios were developed through focus group discussions with current interns, residents, hospital chaplains and department faculty. They were structured to provide for discussion based on relevant regulatory guidelines, related hospital and departmental policies, type of dilemma (conflict, ambiguity, overload), essential information or resources needed to address clinical situations and possible responses to these. See [Appendix A](#) for a sample scenario, "The Advance Directive." A content-based checklist was developed to assess student learning. While the original pre/post-test checklist included only agree/disagree options, the second post-test was revised to include a "reason" cell. See [Appendix B](#) for the revised post-test for "The Advance Directive." The role play scenarios, and pre/post-tests were piloted prior to use with summer interns.

The 20-hour orientation covered ten major topics. For the purposes of this study, the faculty selected four key components of orientation:

- Advance Directives.
- Ethics Committee and Ethics Consultation.
- Pastoral Care Scope of Practice.
- Pastoral Care in a Multi-faith Context.

The project faculty developed a case scenario for each of these, which included learning objectives, a role play with defined characters and discussion questions for facilitation of reflection on the role plays.

The role plays were conducted using faculty as standardized patients/family members and CPE residents as chaplains. They were videotaped and posted into a Blackboard course using new software available through a grant award from VCU's Center for Teaching Excellence. The project was submitted to VCU's Human Subjects Review Board, and approval was granted for the study with "exempt" status based upon its use of existing, standard educational methodologies. Students were informed of the voluntary nature of participation in the pre/post-test component as well as the potential risks and benefits associated with participation. Anonymity was preserved through the use of a numerical identifier selected by the student.

All eleven students enrolled in the 2008 summer intern program chose to participate in the study. None had previous CPE experience. All students had completed at least one year of theological education, with four already holding graduate degrees. They ranged in age from early twenties to

late forties. Eight students were female, three were male. Seven students were Caucasian, three were African American, and one was Asian American. Nine students were mainline Protestant, one was Roman Catholic, and one was Buddhist.

On the evening before each orientation topic was scheduled for review, students were directed to view the videotaped scenario online and to identify key content learned as well as key critical thinking issues raised in the role play. The following day, the faculty member responsible for each orientation component used this assignment to begin discussion. Using the role play as a shared experience backdrop, the faculty member engaged students around key content and critical thinking elements. (A sample video is available for viewing at the following site: [http://video.vcu.edu/ramgen/jlodge/patc/patc400/advance\\_dir.rm](http://video.vcu.edu/ramgen/jlodge/patc/patc400/advance_dir.rm) Access requires RealPlayer or other multimedia player; however, institutional computer security may prohibit downloading the necessary software).

## Assessment

Prior to orientation, students completed a content-based pre-test on each of the four selected orientation topics, with ten items related to each. Following each orientation discussion, students completed a post-test comprised of the same items as the pre-test. The students completed a second post-test during the tenth—and final—week of the program. Student evaluation of the use of videotaped scenarios also was conducted during the final week. Following the close of the summer program, five faculty and six residents also completed evaluation forms. The two primary faculty identified with this project did not complete evaluations.

One of the positive outcomes of the first post-test was the identification of information that was potentially ambiguous. In an effort to address this from both a content and critical thinking perspective, the faculty reviewed with students the most frequently missed questions at the end of program week 4. The second post-test was then modified to include a “reason” cell. This helped address the ambiguity factor and determine the thought process for each result.

One example of an ambiguous statement is Advance Directive question 2 ([Appendix B](#)): “In Virginia, an Advance Directive applies only if a patient has a terminal illness.” The initial assumed correct answer was “agree” as this is a true statement. However, one could also answer “disagree” and be correct as the statement is only partially true. A patient also has to lack “capacity,” and in Virginia’s Health Care Decisions Act a “persistent vegetative state” is included in the definition of terminal illness. As a result of these findings, the second post-test was modified to include a reason cell. This was added to address the ambiguity factor and to help determine the thought process for each response.

## Results

The effectiveness of this innovative hospital orientation was evaluated in two ways:

- Assessment of student understanding and knowledge of the four content areas.
- Student and faculty/resident perceptions of the effectiveness of the video scenario delivery method.

### ***Evaluation of understanding and knowledge***

The use of videotaped scenarios to introduce orientation topics demonstrated both immediate and sustained acquisition of new knowledge for clinical practice within the hospital setting. [Table 1](#) includes pre- and post-test results. Improvement is demonstrated by a decreased number of incorrect responses. Comparisons of test results show progressive improvement for the majority of students.

## Evaluation of video scenarios

The use of video scenarios represents a significant change in the delivery of hospital orientation content. Even if student knowledge and understanding of specific content was improved by the use of these scenarios, endorsement of this delivery method would be premature or questionable if it were perceived as ineffective or undesirable by students and/or by the faculty directly involved in the hospital orientation process.

Overall the students' evaluation was moderately favorable. The most favorable student responses were associated with the promotion of critical thinking and problem solving. Relative to content areas covered by the scenarios, students found the ethics consultations and multifaith scenarios most useful, the scenario focusing on prioritization moderately useful and the scenario on advance directives relatively less useful. However, students were less inclined to recommend video scenarios over other teaching methodologies.

In contrast with the students' perceptions of the video scenarios, the faculty/residents' overall perceptions of the video scenarios were more favorable (See [Table 2](#)). They strongly agreed that this methodology promoted an atmosphere of student engagement and student learning. In contrast to the students' relatively neutral view, faculty and residents strongly recommended video scenarios over content only delivery methods.

## Discussion

### ***Student Learning***

Relative to orientation topic content evaluated across the three points in time (one pre and two post-tests), the results point to improved student understanding in each of the four scenario content areas. Results of the second post-test demonstrate a sustained learning pattern. Also, the relative change recorded for students who initially had the lowest number of correct answers to the survey questions often was dramatic.

It is important to note that initial review of the results of the pre-test and first post-test suggested methodological problems related to the binomial (agree/disagree) response. Subsequent review indicated that a number of scenarios were ambiguous and complex; thus, incorrect answers on the first post-test might be attributed to critical thinking. Revising the second post-test to include a section for student rationale helped to determine the students' level of understanding as well as to reflect their critical thinking.

Further, the results may reflect differences in student learning styles. The scenario methodology posited that an interactive intervention would produce positive student outcomes. Yet, some adults learn more effectively using traditional didactic or reading interventions.

One limitation of this study is the lack of a control group. While orientation consistently has been the most critiqued element of the summer intern program, no data have been collected to evaluate the traditional didactic only method of presenting the content areas. Thus, it is difficult to assess the extent to which this was an improvement when compared to the traditional didactic/content-based orientation.

### ***Student and Faculty/Resident Assessment***

Two conclusions may be drawn from the subjective evaluations completed by these two groups. First, subjective student evaluation of the use of videotaped scenarios failed to reflect the extent of new and sustained student learning. While the reasons for this are open to interpretation, a few possibilities exist. As previously noted, this may well reflect differences in student learning styles. Student evaluations also may reflect consistency with historical feedback that orientation still contains too much information to absorb in a limited time frame. Information and new learning

opportunities may not be immediately identifiable without sufficient understanding of the applicability to the yet unknown clinical context.

Second, evaluation of the orientation initiative was more highly regarded by faculty than by students. This difference may be attributable to the former's inherent desire for the project to be successful. This possibility is mitigated by the fact that residents, who had considerably less investment in the initiative, also evaluated the project more positively. While no resident referenced his/her own experience of orientation to the hospital during the initial unit of CPE, it is noteworthy that four of the six residents who evaluated this process completed their initial units at VCUMC and thus were recipients of the more traditional didactic method of delivery.

A more optimistic interpretation of the discrepancy is that faculty was able to identify beneficial use of videotaped scenarios in the student intern learning that the students themselves had not consciously internalized. There is some support for the notion that process learning includes the development of learning how to learn.

The evaluation tools did not specifically request comments, another limitation identified in retrospect. Nonetheless, one resident wrote that the scenarios provided critical thinking opportunities that would later benefit the students. A faculty member who facilitated one of the orientation components noted that the new format stimulated significant student/faculty interaction. Students seemed interested in more information and were open to discussion of appropriate clinical responses to the patient care scenarios. The scenarios "allowed the students to project themselves psychologically into the scenarios and imagine their own potential actions and responses."

### **Planning for the future**

Relative to future efforts to incorporate scenarios into student orientation, four additional lessons were learned.

1. Greater attentiveness should be given to assure that the evaluation methodology is congruent with the objective of increased critical thinking. The initial use of binomial test responses counters the objective to increase student critical thinking and to promote greater recognition of the complexity of the topics covered. In addition, the evaluation tools likely would have produced more meaningful results had a narrative comment section been solicited.
2. Collection of data at multiple points in time is strongly recommended, both to evaluate the effectiveness of content delivery and to identify areas that need clarification.
3. Evaluation of pedagogical methodology from the perspective of both students and faculty/residents is strongly encouraged. Although the primary goal of the orientation scenarios was sustained student knowledge of specific content as well as enhanced student engagement, the faculty's perspective of the efficiency and ease of implementation is critical for sustaining this orientation delivery methodology in the long run.
4. Even with a change in delivery methodology, orientation still was information and timeframe driven. In retrospect, more attention could have been devoted to exploring dynamics of the pastoral interchanges in each of the scenarios. More extensive discussion around identification of pastoral needs and theological issues raised by the scenarios might have provided valuable opportunity for student reflection and supervisor assessment of future learning opportunities.

## **Conclusion**

Sufficient documentation of student learning as well as student and faculty/resident satisfaction with this initiative exists to support repetition and replication. In preparation for the 2009 cohort of

summer CPE interns, VCU faculty plan to make the adjustments noted in this report in developing videotaped scenarios and incorporating the critical thinking field into the pre/post tests. We also have approached colleagues at another academic teaching hospital with the possibility of replicating this study at their hospital-based CPE program. Finally, we invite inquiries and/or participation from others who may be interested in participating in a multicenter study. 🌟

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<sup>1</sup> Formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

<sup>2</sup> Louis B. Barnes, C. Roland Christensen, Abby J. Hanson, *Teaching and the Case Method* (Boston: Harvard Business School Publishing Division, 1994).

<sup>3</sup> David A. Steere, "Clinical supervision in pastoral care," in David A. Steere, ed., *The Supervision of Pastoral Care* (Louisville, KY: Westminster/John Knox Press, 1989).

<sup>4</sup> Alexander Tartaglia and Diane Dodd-McCue, "Use of standardized patients in CPE and Research at the VCU program in patient counseling," *ACPE Research Network Newsletters* 5, no. 2 (Winter 2007) [www.acperesearch.net/Newsletters.html](http://www.acperesearch.net/Newsletters.html).

## Appendix A: The advance directive

### **Training objectives**

- Understanding of the use of an advance directive including its component parts.
- Understanding of the role of hospital chaplains in facilitating completion of advance directives.
- Assessment of patient understanding of an advance directive.
- Recognition of the role other health care professionals may play in helping the hospital chaplain make determinations of patient understanding and patient competence relative to completion of an advance directive.

### **Video scenario**

Student chaplain background: You are the hospital chaplain paged for a patient wishing to complete an advance directive. You are called to Main 9W, the transplant unit. The nurse tells you that the patient is awaiting a liver transplant.

Role player background: You are a patient who does not appear to pay much attention to what the chaplain is explaining about an advance directive. In fact, when asked if you understand, you repeat back to the chaplain a number of fundamental errors. For example, you mistakenly say that your concern is about financial matters and that's why you want this done now. If the chaplain tries to help you understand, you cut him or her off by saying something like, "I don't have to hear any more of this, I'm ready to sign."

### **Discussion Questions**

- Did the chaplain raise the question of whether the patient understood what s/he would be signing?
- Did the chaplain ask the patient if the patient had discussed this with the person s/he would be designating as the medical power of attorney?
- Did the chaplain consider whether there would be a way to help the patient understand more clearly the intent of an advance directive?
- Did the chaplain consider using other resources, e.g., social worker, nurse, another chaplain, to facilitate understanding?
- Did the chaplain raise the question of, or consider, the patient's capacity or competency to complete an advance directive?

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## Appendix B: The advance directive – post-test 2

Identifier/ Last 4 digits of phone number	Date
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### **VCU Medical Center Summer Hospital Chaplain Intern Orientation**

Please indicate whether you agree or disagree with the following statements. Even if you do not “entirely” agree or disagree, please respond to the category which *most closely* reflects your perspective. Please do not omit any responses.

Also note: This survey is being used to evaluate the effectiveness of the hospital orientation program and is not being used to evaluate individual summer interns. Your individual results are confidential and individual identifiers are only used as a means of orientation evaluation.

	Agree	Disagree	Reason
The Advance Directive			
1. An Advance Directive is a legal document initiated by patients to address their financial obligations.			
2. In Virginia, an Advance Directive applies only if a patient has a terminal illness.			
3. A standard Advance Directive form is available in each patient care unit.			
4. Patients must complete a new Advance Directive each time they are admitted to the hospital.			
5. Hospital chaplains are seldom involved in helping patients with Advance Directives and usually only as witnesses.			
6. Confirmation of patient understanding is a prerequisite for proceeding with an Advance Directive.			
7. One way of evaluating patients’ understanding is by asking them to restate, in their own words, what an Advance Directive means.			
8. When there is a lack of clarity about a patient’s capacity to initiate an Advance Directive, legal counsel must be consulted.			
9. Patients should discuss the implications of an Advance Directive with the person who is their designated Medical Power of Attorney.			
10. Family members are no longer permitted to witness Advance Directive forms.			

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## Table 1: Student intern test results

Each of the orientation topic tests included ten items. (See [Appendix B](#) for sample.) All four were administered prior to orientation, immediately following the orientation discussion of each topic and during the last week of the internship. This table shows the number of incorrect answers for each.

	Students											
	A	B	C	D	E	F	G	H	I	J	K	
Advance Directives												
Pretest	2	3	4	2	3	1	3	3	3	2	3	
Post 1	0	1	3	1	1	1	2	0	1	1	1	
Post 2	0	0	1	1	1	0	0	0	1	2	1	
Ethics Committee and Consultative Services												
Pretest												
Post 1	4	4	4	2	4	3	5	1	6	5	5	
Post 2	3	2	4	1	1	0	4	1	2	2	0	
Post 2	2	0	3	1	4	0	1	1	0	0	0	
Pastoral Care Scope of Practice/Prioritizing												
Pretest												
Post 1	4	3	4	2	1	5	4	1	4	4	3	
Post 2	0	2	3	1	2	3	0	0	2	0	2	
Post 2	2	0	2	0	3	0	0	1	1	0	0	
Pastoral Care in Multifaith Situation												
Pretest												
Post 1	3	0	5	2	2	1	2	2	2	3	2	
Post 2	2	1	2	0	3	1	0	1	1	1	1	
Post 2	2	0	1	0	3	0	0	0	0	0	0	

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## Table 2: Evaluation of use of videos for orientation

The response range is 5 (strongly agree) to 1 (strongly disagree). Responses were received from eleven student interns and eleven faculty/residents.

Question	Student Responses		Faculty/Resident Responses	
	Range	Median	Range	Median
Increased knowledge of hospital policies	1-5	3	3-5	4
Helped to apply critical thinking to hospital scenarios	2-5	4	3-5	4
Helped to promote critical thinking	1-5	4	2-5	4
Emphasized criteria for problem solving	2-4	4	3-5	4
Emphasized possibility of several right answers	2-5	3	3-5	4
Promoted an atmosphere to enhance student engagement	1-5	3	3-5	5
Promoted learning	1-5	3	4-5	4
Recommended over other content-only method	1-4	3	2-5	5
Usefulness of scenarios in pastoral practice (students only)				
Advance directive	1-5	3		
Scope of practice/prioritizing	1-4	4		
Ethics consultation	2-5	4		
Multifaith situations	2-5	4		

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