Near-peer mentoring: a reflection on the benefits and
difficulties from both sides of the table. A discursive
piece from a mentor and four learners

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Abstract

Medical students are more and more involved in informal near-peer mentoring schemes. At Plymouth University
Peninsula Schools of Medicine and Dentistry (PUPSMD), a programme has been set up to encourage fifth-year
medical students to mentor fourth-year students towards their final-year exams. This reflective piece analyses the
experiences of one group of learners and their mentor during their near-peer mentoring journey. Group size, mentor
personality, diversity of learners, content and style of sessions, frequency of sessions and evaluation processes all
play an important role in the benefits and challenges reported by this group. There is not a one size fits all for near-
peer mentoring but we hope that these reflections provide some transferrable insights into the challenges and benefits
from all involved.

Keywords: Near-peer mentoring., Undergraduate medical education., Feedback., Integrated Structured Clinical
Examinations., Role-play,

Introduction

Medical students are increasingly interested, and encouraged, to hone their teaching skills as near-peer teachers with
demonstrable benefits to themselves, their learners and in turn, their patients (Ross, 2007). This impetus to evolve
medical students into early career medical educators is highlighted by the General Medical Council's Guidance,
‘Tomorrow’s Doctors’ (GMC, 2009).
Every June at Plymouth University Peninsula Schools of Medicine and Dentistry (PUPSMD), eighty-six fourth-year students sit their medical school finals, the Integrated Structured Clinical Examinations (ISCEs).

In preparation for these examinations, the PUPSMD student-led mentoring society allocates fourth-year students to a mentor or a group of mentors by random. The mentor tends to be a student in their fifth, and final, year of medical school. The programme is entirely informal in nature, and groups can decide on the frequency of sessions, content and evaluation process.

This short piece dissects some of the experiences of this near-peer mentoring programme from the points' of view of the mentor, Katherine Stevenson, and the group of fourth-year learners; Ian Bugg, Merina Kurian, Kirushthiga Naguleswaran, and Charlotte Patmore. It has been written collaboratively with the aim to best portray the issues from both sides of the metaphorical (and literal) table.

Allocation to mentor and group size

The PUPSMD student-led mentoring society emails all fifth-year medical students at the beginning of the academic year to invite fifth-year students to volunteer themselves as mentors. Interested fifth-year students are allocated between two to four fourth-year students. The allocation process is entirely random and voluntary.

What Katherine has to say:

As an individual who is passionate about teaching, with additional experience from an intercalated Masters in Clinical Education, it may be fair to say that I am not the average near-peer medical student mentor. The beginning of 2016 marked my final year as a medical student, and my final opportunity to remain involved with the PUPSMD mentoring society. By this time, I had volunteered as a mentor for several years and was well accustomed to the process and organisation involved in setting up mentoring sessions; I was excited to get back to mentoring and implement some of the theory I had learnt about education into my teaching practise.

I was initially allocated three learners, but my zealousness for teaching ensured that throughout the process I adopted several other learners. In turn, this meant that our group evolved from three to seven. In hindsight, I can only reflect upon how the group size affected the group dynamics. In terms of nomenclature, near-peer mentoring technically refers to a teacher to learner ratio of 1:1 or 1:3 (Topping, 2005), but our group had expanded way beyond the norm. Learner involvement tends to be maximised within smaller groups, and learners tend to be more readily able to express any uncertainties and ask questions. This meant that some learners would at times remain quiet and unnoticed, thereby limiting the utility of our programme of sessions for those students.

What Kirushthiga, Merina, Ian and Charlotte have to say:

We appreciated how the random nature of the allocation process minimised bias of individual ability. Diversity within the group created an opportunity to work with members of the year group that we had not previously worked with. As a group we were diverse in strengths and weaknesses so were able to learn not only from our mentor, but also from one another.

Much research has gone into the analysis of what makes a good teacher, including elements of personality (Illic, 2016). And this is no different with near-peer mentoring, the combination of enthusiasm, experience and creativity of the mentor definitely attributes to the success of the mentoring.
However, her over-enthusiasm to let other learners join the group meant that we were effectively an oversized group. Discussing our mentoring experiences with fellow students highlighted that the size of the group was a significant factor in influencing the quality of our learning.

**Style and content**

Integrated Structured Clinical Examinations (ISCEs) comprise of a circuit of stations in which each student is observed interacting with a patient by an examiner on an individual basis, students rotate through the stations, with a different examiner at each station (Harden, 1975).

At PUPSMD, the ISCEs consist of six separate forty-five minute stations in which the student is observed by an examiner to take a history from and examine a ‘real’ or ‘simulated’ (actor) patient. They are then expected to orally present the case back to the examiner, including their differential diagnoses, chosen investigations and their subsequent management plan.

The ISCEs are multi-faceted examinations and many different elements can be learnt and practiced in preparation for the examinations. Many of the near-peer mentoring groups choose to practice history taking, physical examination skills and oral case presentation.

**What Katherine has to say:**

What I have discovered through years of mentoring for ISCE examinations is that many of the PUPSMD students are highly skilled at taking histories and performing clinical examinations from an early stage. However, many struggle with the more complex skill of orally presenting their case back to an examiner.

Oral case presentation (OCP) is the language used by doctors to convey relevant patient information to a specific medical audience in an efficient manner. There exists a recognised OCP structure comprising of; a summary, report of the history, examination findings, differential diagnosis, investigations and management plan which should be adapted in length and style dependent on audience, purpose and urgency (Green, 2009). A case should be presented succinctly, engagingly and extemporaneously making it an intimidating task for any medical student who has yet to learn how to sift, extract relevant details, compose and present a captivating OCP (Chan, 2015).

Medical students are typically expected to learn OCP skills through practise and feedback, without any prior instruction on the structure of OCP which by default means that they will be ineffective presenters at the debut of their clinical years. The use of role-play, simulation, and storytelling techniques have been shown to help improve these skills (Hammer, 2011).

From the outset of the programme, I was a strong advocate for the use of role-play to simulate the ISCE examination. A topic would be chosen in advance of the session, for example, ‘cardiovascular’, and a mock scenario, for example, ‘a sixty-five year old lady with a year long history of angina’ would be written up by myself or by one of the learners. One learner would volunteer to play the role of the patient and another the role of medical student. The medical student would take a focussed history, examine and present in real-time and observers and myself, would feedback on the learner’s performance.

As a group we spent time focussing on not only the content of the OCP and the learners’ clinical reasoning skills but also the overall organisation, flow, style, engagement with the examiner, pace and ability to answer questions. I would often iterate how not only clinical acumen but also storytelling skills and confidence contribute to overall
ISCE performance.

What I had failed to notice, however, is that instead of listening to my learners’ and being guided by their chosen methods of learning, I had been so involved with my method that I failed to listen to their ideas.

**What Kirushthiga, Merina, Ian and Charlotte (learners) have to say:**

Our mentor provided a variety of varied role-play histories to enact in each session and with each session running once a week, a routine was quickly established. However, as a group we shared similar goals but we all had our individual preferences on the way we like to learn, and we sometimes found that this was not always addressed in mentoring. As aforementioned, our sessions were predominantly revolved around role-playing, ideal for those more inclined towards auditory learning but less useful for those who prefer the visual methods.

Despite simulating the exam situation, the exercise involved prolonged periods of passively listening to a fellow colleague take history and present their management plan. Although this provided insight into how a variety of ways patients can be managed effectively, we noted that there are still limitations to observational learning particularly when trying to practice the communication skills integral to a good OCP.

A reflection on the programme as a whole was that it was in fact too exam-specific, concentrating too heavily on the ISCEs, which limited the transferability of skills acquired. However, our mentor aimed to share advice on other extraneous issues which may affect us in the fifth-year.

**Feedback and evaluation**

There is no formal method from the mentoring programme on how to feedback to learners on their progress nor how to feedback to mentors on their teaching style.

**What Katherine has to say:**

We quickly established that it was important as a group to firstly allow the learner to critically analyse their own progress, and subsequently allow other members’ of the group to contribute to this feedback. After each role-play we would try to go through this process altogether in a timely and constructive fashion.

At the end of the programme I collected formal anonymous feedback from all my learners in a bid to improve myself as a near-peer mentor. From this I began to write a short diary of reflections on near-peer mentoring which formed the basis of this piece.

What I have gleaned from the ISCE mentoring programme is that despite the mentoring being exam-specific, I have been able to work alongside my peers in a relaxed manner, sharing ‘nuggets’ of information relevant to their prospective final year at medical school. In many ways, as a near-peer mentor you are not just a teacher but an individual who can provide pastoral support for your learners.

**What Kirushthiga, Merina, Ian and Charlotte have to say:**

We felt that the on-the-spot constructive feedback from both the mentor and peers provided direction on which areas to focus on for the future. Receiving and delivering this constructive feedback equipped us with greater knowledge on how to critique our own history taking outside of mentoring. This demonstrated the synergistic
relationship between near-peer, peer-to-peer mentoring and independent learning. Our mentoring group created an open forum for knowledge transfer not only through verbal feedback but also via exchanging useful resources outside of the sessions. Through observing our mentor, we were able to witness many of the personal and professional qualities that are required of a doctor.

**Take Home Messages**

- **Size is not everything.** Smaller groups may be conducive to improved mentor-learner relationship and learning in near-peer mentoring.
- **Mix it up.** Aim to have as diverse a group as possible, everyone brings something to the table.
- **Listen to the learners.** As a mentor you may be super-enthusiastic about one topic or style of teaching but this is irrelevant if the learners do not share this.
- **Nurture the learner.** Near-peer mentoring can act as a platform not only for examination preparation but for pastoral care.
- **Reflect and evaluate.** Allow yourself to reflect upon your progress, both as a learner and a mentor, and allow others to contribute to this reflection.

There is not a one size fits all for near-peer mentoring but we hope that these reflections provide some transferrable insights into the challenges and benefits from all involved.

**Notes On Contributors**

Dr Katherine Stevenson, BMBS, MScClinEd, is a Foundation Year 1 Doctor at Southmead Hospital, North Bristol NHS Trust. Her main interests are undergraduate medical education, communications skills training and widening access to Medicine.

Kirushthiga Naguleswaran, Merina Kurian, Ian Bugg and Charlotte Patmore are all final year medical students at Plymouth University Peninsula Schools of Medicine and Dentistry.

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Appendices

Declaration of Interest

The author has declared that there are no conflicts of interest.