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An educational approach using interprofessional (IP) role plays and patient narratives to inculcate empathy and communication among undergraduates in breast cancer management

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Abstract

Background Interactive teaching methods such as patient narratives and role plays are effective tools in medical education. Incorporating the patient's perspective of the disease and standardized treatment in the teaching process helps the students become more empathetic and have better doctor-patient communication.

Methods An interactive module was conducted using role plays and patient narratives to teach communication skills and doctor-patient relationships to randomly chosen Seventy-seven final-year(4th year) medical students to address the various psychosocial problems faced by the patients with breast cancer. Participants' perspectives regarding the intervention were collected using pre and post-tests, session feedback, and interviews. The data were analyzed quantitatively and qualitatively, as appropriate. Observed Structured Clinical Examination (OSCE)stations with case scenarios to break bad news to simulated patients were used for the assessment.

Results Most participants felt that such interactive sessions were needed where they played the role of a doctor before facing an actual patient. While reading the narratives, they felt that the narrators' emotions were genuine and that they felt involved. Most of them could relate to the social and emotional aspects of the patient and understood the Interprofessional (IP) teamwork in the treatment of a breast cancer patient. 93.4% of the participants felt they gained competence in managing difficult communication situations with patients.

Conclusion Interactive teaching methods like narratives and role play may help enhance students' communication and empathy, which is vital for future doctors. They seamlessly integrate into existing curricula, offering practical experiences that deepen understanding and empathy without disrupting learning.

Keywords Role plays, Narratives, Medical education, Interactive teaching

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Introduction

Breast cancer is a highly prevalent cancer globally, and its diagnosis and treatment can be physically and emotionally taxing. The journey from diagnosis to survivorship involves a range of challenges, including fear, anxiety, and potential changes to one's sense of self and daily life. Support systems from family, friends, or the workplace play a crucial role in helping individuals navigate these difficulties [1, 2].

Effective communication between healthcare providers and patients ensures patient satisfaction and positive outcomes. The interpersonal aspect of healthcare experiences is increasingly recognized as influential in patients' overall well-being. Empathy, active listening, and effective communication are essential for healthcare professionals to provide holistic care [1, 2].

Traditional medical education often unintentionally leads students to believe in authoritarian physician roles during traditional training through the subtle messages they encounter during their clinical postings. The significance of building rapport and demonstrating empathy in patient care is frequently overshadowed by an emphasis on disease management rather than patient management. Additionally, students often encounter collaboration challenges within interprofessional (IP) teams. As medical educators, we must emphasize that effective communication and working with patients are required alongside medical knowledge to be proficient physicians. A well-balanced approach to patient care requires understanding patients' illnesses and their coping mechanisms in their own words [2, 3].

Combining role plays and patient narratives has proven effective for highlighting communication skills and strengthening doctor-patient relationships. These methods aid medical students in grasping patients' perspectives on their illnesses, including their psychosocial and emotional needs, throughout treatment. Consequently, students develop greater empathy and improve their communication skills with patients. This approach fosters an understanding of the interaction between diverse professionals involved in cancer patient care. The students learn teamwork and communication skills between various health care professionals through observation of the immersive theatre or videos or role-plays done by the IP team, followed by discussion and execution of role plays in smaller teams, thereby offering a dynamic approach to practicing communication, decision-making, and teamwork skills in a simulated environment. By immersing students in realistic scenarios, they engage in problem-solving and critical thinking, honing their ability to respond effectively under pressure [2–4].

In a similar study done by Katharina Luttenberger et al. [2] incorporating role plays in medical education, most students preferred playing the role of a doctor in a simulated environment as it helped them better understand the doctor-patient relationship. Shao-yin Chu et al. [3] found that the patient-centered frame is central to narrative medicine education, emphasizing healthcare professionals' ability to listen, understand, engage in narrative thinking, and convey patient-centric illness narratives. Cultivating a communicative rapport with patients is crucial for reflecting on their needs and providing tailored medical care. Milota MM [4] et al. reviewed 36 studies utilizing the Best Evidence in Medical Education Global Scale and Kirkpatrick Scale to evaluate assessment strategies and the effectiveness of narrative medicine programs. Their findings suggested that narrative medicine is an effective educational tool with a well-defined and replicable structure that positively influences participation, attitude modification, knowledge, and skill development [2–4].

Though there are several similar studies done on the use of role-play and narratives in medical education in the past, we selected a single topic of breast cancer and integrated the patient narratives from breast cancer survivors with interactive role-playing and video. The interprofessional team involved in breast cancer treatment planned the entire session. This study aims to integrate conventional teaching and the psychosocial and emotional aspects of patient experiences into the scientific curriculum, thereby highlighting the importance of collaborative, team-centered care in comprehensive breast cancer management [2–4].

Methodology

The study was conducted between the period May 2020 – Feb 2021 and began following approval from the institutional ethical committee and was conducted in two phases.

Phase 1

Involved the collection of narratives from patients with breast cancer and the preparation of a role-play and video by IP team members. Breast cancer survivors from India with diverse socioeconomic, educational, and cultural backgrounds were approached and briefed about the importance of the study. Ten consenting women were selected, and verbal consent was recorded. They were interviewed at their convenience for a 30–40-min narrative about their treatment experiences. Participants recounted their journey, beginning from the onset of concerns about their breasts, elaborating on internal conflicts, familial challenges, hospital encounters, and interactions with healthcare professionals, both positive and negative. Their narratives encompassed emotional dimensions, support structures, and adaptations

necessitated by their condition. The interviews were then transcribed verbatim and documented in a Word file. Each participant was sent the edited reader-friendly prose version of their narrative after removing the content features of the interview and repetitive statements, giving them a second opportunity to amend.

Analyzing the various problems faced by breast cancer patients in our narratives, a script was drafted by the authors for the role-play depicting the IP Teamwork and the SPIKES protocol of communication (Table 1). Anticipating unforeseeable problems, a video recording showing the difficulties faced by a breast cancer patient, doctor-patient communication, and interprofessional management of a breast cancer patient was also made. The roles played by various IP team members like Doctors (surgeon, oncologist, anaesthetist), nurses, yoga and physiotherapists, nutritionists, social workers, counsellors, lab workers, operating room and ward helpers were depicted in the role play and video were lasting for 15 min. While preparing the video, we considered the Interprofessional Education Collaborative (IPEC) framework. This framework provides a structure for integrating interprofessional education into the medical curriculum, thereby aiming to prepare future healthcare professionals for collaborative practice in diverse healthcare settings. It emphasizes the importance of teamwork, communication, and mutual respect among healthcare team members to improve patient care and safety. Four subject experts, including clinicians and medical educators, validated the script and the video.

Table 1 SPIKES protocol of communication

S	**Setting up the interview**
P	**Assessing the patient's perception**
I	**Obtaining the patient's invitation**
K	**Giving knowledge and information**
E	**Addressing the patient's emotions with empathetic responses**
S	**Strategy and summary**

Phase 2

Following approval from the Head of the institution and various department heads where the students were posted, Two batches of students (50 each) were enrolled in the study, but only Seventy-seven final-year medical students (4th year) could participate due to COVID-19 restrictions. They were divided into groups of 20–25 students, and each group attended sessions (sessions 1& 2) that lasted for 4 h.

A pre-validated questionnaire consisting of 14 questions by Katharina Luttenberger et al. [1] was taken and revised with seven closed-ended items on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree)to suit the requirements of our study and was used as the pre and post-test.

Session 1

An ice-breaking session was introduced as a game (blindfold obstacles), which helped the participants understand the role of teamwork and communication. The game aimed to emphasize that the patients are similar to

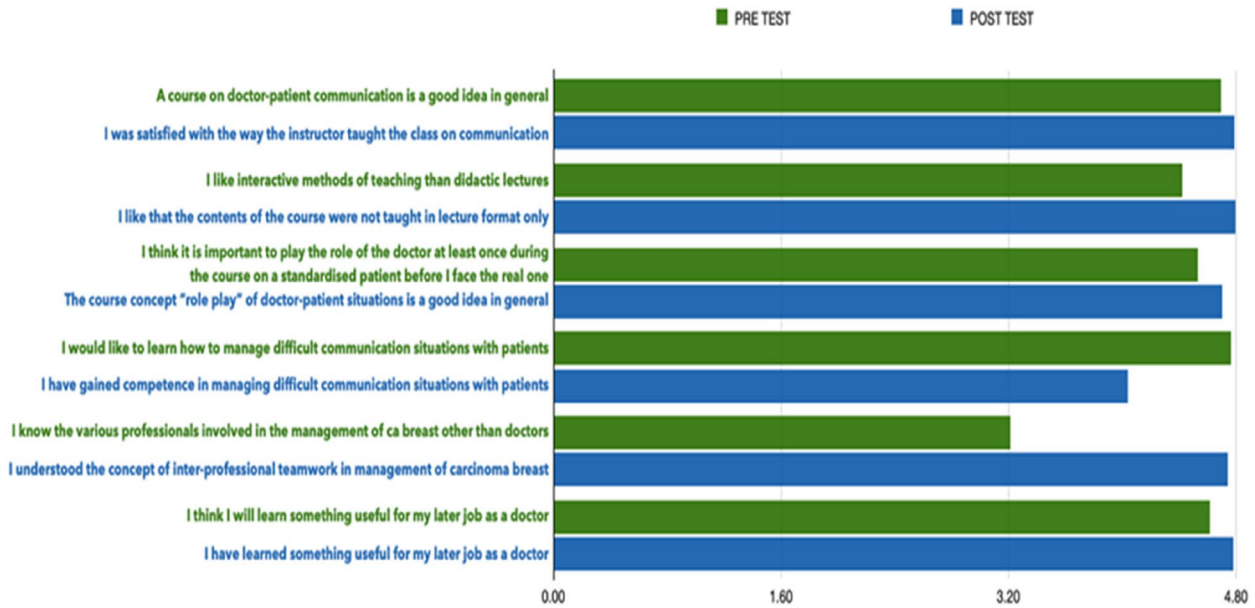

Fig. 1 Showing the comparison between pre and post test mean values

the blindfolded individuals, and our role as a team was to ultimately guide the patients through various obstacles in treatment to achieve holistic care. The pre-test was then administered to the students via Google Forms. Frequency analysis of the responses to the closed-ended questions was performed, and the results are expressed as the cumulative percentages of agree, strongly agree, disagree, and strongly disagree.

Each subgroup of students (5–6 students) was given a different patient narrative and was asked to reflect on the patients' problems, communication issues, and what could have been better using the THINK–PAIR–SHARE method. Each student was given 3 min to THINK or reflect on the narratives. They then PAIRED in their groups and discussed their feelings and the struggles encountered by the patients in the narrative. Each group summarized their narratives and SHARED their reflections with the rest of the groups, which were documented by a scribe. Following a brief session, the standard State Empathy Scale [5] test was administered to assess the level of empathy revealed by the narratives. This scale divides empathy into three categories (Table 1).

A) Cognitive empathy is understanding how a person feels and what they might think about. It makes us better communicators since it helps us relay information in a way that best reaches the other person.
B) Emotional empathy/affective empathy is the ability to share another person's feelings. Few have described it as "your pain in my heart." This type of empathy helps us to build emotional connections with others.
C) Compassionate empathy/associative empathy is the vicarious experience of another's circumstances and emotions as one's own.

Session 2

The session began with an activity to demonstrate teamwork and team dynamics (shoulder to shoulder- In this game the entire group of students had to follow the leader's commands and reciprocating exactly in teams of 2 or more as specified by the leader eg command 1: right shoulder of one person with right shoulder of other in teams of 2.). The participants were then briefed on the SPIKES protocol for breaking bad news, and this was further reinforced using the recorded video and role-plays performed by the IP team. The post-test was administered, which consisted of the same questions as that of the pre-test with few changes to match the present tense (action achieved); frequency analysis of the responses to the closed-ended questions was performed, and the results expressed as a cumulative percentage of agree, strongly agree, disagree and strongly disagree during result tabulation.

Assessment

Objective Structured Clinical Examination (OSCE) stations were used in the evaluation. The students were given a case scenario and asked to break the news about breast cancer to the simulated patient (The facilitator acted as a simulated patient). The Facilitators were provided with a checklist based on the SPIKES communication protocol (Table 1) for the unbiased assessment of the students. The entire session ended with session feedback and focused group discussion from the students. The interviews were transcribed verbatim and analyzed qualitatively by finding meaning units or "codes". Subsequently, the codes were subsumed into subcategories and collapsed into major themes finalized by consensus.

Phase 1: collection of patient narratives
Drafting of script for role play by the interprofessional team
Recording of a video by the interprofessional team

Phase 2: divided into session 1 and 2
Session 1:
77 medical students participated with consent
Divided into groups of 20–25 students
1. An ice-breaking session with a game
2. Pre-test
3. Students divided into subgroups of 5–6 students
4. Patient narratives discussion using the THINK PAIR SHARE method
5. State empathy scale administered
Session 2:
1. SPIKES protocol of communication explained
2. IP Video and role play were shown to the students and discussed
3. Post-test administered

Assessment –
Quantitative – scenario to break the diagnosis to a breast cancer patient given and students asked to play the role of the doctor and the IP team member played the role of patient. The assessment was done using a checklist for the SPIKES protocol
Qualitative–focused group interviews of students

Results

Session 1 results of the STATE EMPATHY scale (Table 2)

A) Cognitive empathy: 95% of the participants felt that the patients' emotions in the narrative were genuine, while 79% felt emotionally connected while reading/hearing the narrative. 82.9% could feel the patient's emotions, while 67% were in a similar emotional state as the character when hearing their narrative.
B) Emotional empathy/affective empathy: Most of our participants (94.7%) could see the patient's point of view. Most (89.5%) could recognize the patient's situation and understand what the character was going through in the message. 93.7% felt that the patient's reactions to the problem were understandable.

Table 2 State empathy scale (the word watched was replaced by heard in the study)

Dimensions	Items
Affective empathy	1. The character's emotions are genuine 2. I experienced the same emotions as the character when watching the message 3. I was in a similar emotional state as the character when watching this message 4. I can feel the characters emotions
Cognitive empathy	5. I can see the character's point of view 6. I recognize the character's situation 7. I can understand what the character was going through in the message 8. The character's reactions to the situation are understandable
Associative empathy	9. When watching the message, I was fully absorbed 10. I can relate to what the character was going through in the message 11. I can identify with the situation described in the message 12. I can identify with the characters in the message

Table 3 Comparison of the different types of narratives

	Mean	Std. Deviation	Result
Affective empathy	4.229	.810	
Cognitive empathy	4.530	.807	$p<0.001$
Affective empathy	4.229	.810	$p>0.05$
Associative empathy	4.146	0.917	
Cognitive empathy	4.530	.807	$p<0.001$
Associative empathy	4.146	0.917	

C) Compassionate empathy/associative empathy: 84.2% felt fully absorbed when hearing the narratives, while only 77.6% could relate to what the patient was going through in the message. 81.6% could identify with the situation described in the message, but only 56% could identify with the patient.

Comparison

The statictical analysis of the data was done using the SPSS23.0 software .Descriptive statistics was expressed using frequescy and percentage , mean , and standard deviation . comparison between the different types of empathy was done using the paired t test. A p value of <0.05 was considered statistically significant. A comparison of the different empathy scores was done using the paired t test (Table 3). The average affective empathy score is 4.229±0.810, cognitive empathy is 4.530±0.807 and associative empathy is 4.146±0.917. The comparison shows that cognitive empathy is significantly greater than affective and associative empathy. A comparison of affective and associative empathy revealed no significant difference (Table 3).

Section 2 results: comparison of pre-test and post-test (Fig 1)

Analysis of the pre-test results showed that most students (93.4%) felt that a doctor-patient communication course was a good idea at the beginning of the course, and 86.8% preferred interactive teaching methods to didactic lectures. Most participants (86.8%) felt the need to play the role of a doctor at least once during their course on a standardized patient before facing the actual patient.

A total of 94.7% felt that good communication skills helped to reduce the psychosocial trauma faced by cancer. 96% felt the need to learn how to manage complex patient communication situations. IP teamwork was known by a few participants (42.1%) in treating cancer breast cancer patients. Most students (67%) needed to understand what a narrative means. A total of 93.5% of the participants hoped that they would learn something useful for their role as a doctor at a later date.

At the end of the session (post-test analysis), 93.4% of the participants were delighted with how the session was planned on communication, and the majority (88.1%) felt the need for more such sessions on doctor-patient communication. 96% liked that the course contents were not taught in lecture format only. Following the session, 96.1% of the students could relate to the social and emotional aspects of the patient, and 93.4% completely understood the IPE teamwork in the treatment of a breast cancer patient. Postintervention, a more significant percentage (96%) of students felt that they learned something useful for their future role as a doctor than they did at the beginning of the course (93.5%). Approximately 93.4% of the participants felt they gained competence in managing difficult communication situations with patients. Most (94.7%) students thought the course's expectations were fulfilled and felt competent in the SPIKE communication protocol.

Figure 1 depicts the mean with standard deviation values of each component between the pre and post-test.

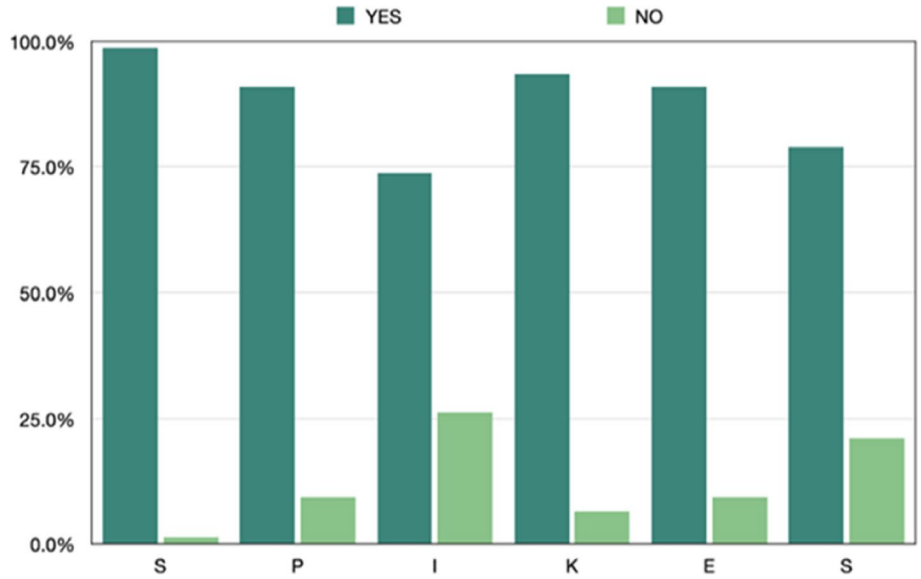

Fig. 2 Results of assessment of SPIKES format of communication by students using OSCE

We found a significant improvement in understanding interprofessional teamwork ($p < 0.001$), showing that participants gained a better grasp of teamwork concepts. However, we had a significant decrease in perceived competence in managing difficult communication situations between the pre and post-test ($p < 0.001$), indicating a drop in self-assessed competence. This suggests that students may require additional exposure to challenging communication scenarios as part of their curriculum to enhance their skills in this area. The comparison of agreement between males and females was performed using the Mann–Whitney U test. The analysis showed no significant difference in agreement on completing the learning objectives between male and female participants ($P > 0.05$).

Assessment

Assessment of the students on communication/breaking the news to a breast cancer patient was performed through OSCE using a structured checklist for SPIKES protocol. The students understood the SPIKES protocol well and the students could effectively communicate bad news to the simulated patient following the protocol (Fig. 2).

Qualitative results: student feedback and focused group discussion (Fig. 3)

A qualitative analysis of student feedback and interviews was performed. After removing the repetitive statements and assigning codes and categories, the following significant themes were finalized: problems faced by breast cancer patients, interprofessional teamwork, and session feedback.

Theme: problems faced by breast cancer patients: patients' perspectives

The analysis showed that the students had a good understanding of the problems faced by the patients, whether physical, emotional, social, financial, psychological, healthcare team-related, or family-related. The participants spoke about their opinions regarding the emotional framework of the patients, their support systems, the adjustments they had to make due to their disease, treatments, the lack of empathy of the health care team, the need for holistic treatment, etc. (Students were given an identity number S1, S2, etc.)

> *S1: "I realized that most of them go through painful treatments. It's easy to just prescribe from our side as doctors but never thought of the pain they go through."*

> *S5: "There is always a fear of death in their minds, a fear of treatment outcome, fear of surgery …I feel they are many times in constant denial".*

> *S14: "Cost of the treatment was a great worry in spite of the fact that most were working".*

> *S54: "Unless one is in their shoes, no one can understand their pain and what they go through."*

Fig. 3 Program photos (blurred to avoid identity)

S23: "Not being seen as a human being who has a problem and being thought about more like a case of breast cancer – I think we are going wrong".

S61: "These women were married and had nuclear families and kept being worried about the future and family."

Theme: problems faced by breast cancer patients: students' perspectives

The narratives gave them a better understanding of not only the symptomatology of the disease but also the problems that need to be addressed to provide holistic care to the patient. They learned to empathize with the patient and understood the need for holistic care for the patient. Reading the narratives helped them to empathize with the patients. The students understood that not only does the treatment at the hospital matter but also that a holistic approach is needed, which includes family and workplace support, rehabilitation, financial aid, etc.

S3: "Doctors might fail to see their uncomfortableness to expose their breast to random med students, other course students for whom they might be just a patient, but they are also humans with their own zone of comfort just because they have a finding."

S42: "I think we focus a lot on the disease part of it and take measures to treat that, but in a Ca.breast patient, after treatment, body dysmorphia is a common occurrence, so we should notice that as well".

S75: "We as doctors know how common the condition is and can be treated, and we forget that the patient is not aware of these facts and should console them."

S56: "We can change by proper counseling their life after managing the situation, their financial issues, family issues, etc."

S 32: "We need to give them a proper understanding and clear the stigmas and concerns, being empathetic of their small concerns, addressing their fears, etc."

Theme: interprofessional teamwork

The students understood what effective interprofessional teamwork meant. Concerning the problems faced by these patients, the students were sensitized to the issues that a patient experienced in poor communication. They learned about the various professionals involved in the treatment of a breast cancer patient as well as the need for good interprofessional teamwork to provide holistic care.

S22: "Interprofessional teamwork helps improve patient treatment with a multidisciplinary approach and teamwork and helps to enhance treatment outcomes".

S11: "There should be close communication between different disciplines to avoid confusion and further trauma to the patient."

S76: "Everyone is equal concerning their knowledge, not superior or inferior. We have to be creating good bonding and need to work properly to have an effective result."

S44: never realized that so many professionals work together for a single patient".

Theme: session feedback

The students felt that this interactive teaching method was entertaining and informative. They connected with the mentors better. The students thought they learned more from the patients' personal experiences than just reading a book. Most felt that the sessions helped them become better communicators. They believed that the need for more such sessions for various other diseases would help them become better physicians in the future.

S1:"Helped us view the patient as someone with feelings rather than just a case. Such sessions will help us interact with patients (our skills are lacking)."

S45: "It was fun...it was informative...and it was good to provide slightly more incentive to talk in a better manner to patients we go and take a case from...and to take it in stride when they are not compliant with us.."

S61: "I liked an interactive yet casual session that made it more interesting than a lecture. I learned a lot about breaking bad news and what a patient goes through after an unfavorable diagnosis."

S49: "It's great because, like me, I have a fear of talking. That can be improved with these sessions."

S58: "Not to just become a doctor or a treating physician but to be a part of a team in making this tough journey comfortable for the patient".

S23: We got to learn about the patient's point of view. The other side of the story."

S74: "On a regular basis – yes, it will help us be better practitioners".

Discussion

Breast cancer is the most common cancer among women worldwide. With tremendous advancements in the field of cancer management, women are now diagnosed with this disease earlier and live longer. The diagnosis of breast cancer is physically and psychologically quite traumatic, and its effects start with a distressing event from the communication of the diagnosis [1] and continue even after the completion of the treatment. A threat to life and physical disfigurement is significant, and the experience of pain and loss of social and occupational roles can trigger intense fear, helplessness, anxiety, or depression in many of these women [1]. Hence, a robust support system is needed to help them overcome this stressor, which most women look for from their families or the workplace.

Additionally, these survivors fear a recurrence of their cancer and the fear of not being able to return to their pre-cancer lives. One of the patients in our study quoted it as "the new normal". However, the feeling of being

a survivor after battling cancer has some positive life changes, with many reporting increased resiliency, emotional strength, and self-understanding as a result of their cancer experience.

A critical aspect of patient satisfaction with treatment is communication between healthcare staff and patients, and there is a growing emphasis on the interpersonal dimension of patients' experience with healthcare. The communication skills of health care providers have been associated with a range of medical and psychosocial outcomes, and poor communication has been suggested to affect both patients [1, 6] negatively. Over the years, medical education has emphasized the knowledge domain and clinical skills. Still, in the last few years, there has been an emphasis on the critical aspects of the affective domain, such as empathy, active listening, practical communication skills, and teamwork, have been identified. Not knowing these skills may lead students to undervalue the relationship between psychosocial and medical aspects of patient care. Based on these needs, several medical regulating bodies emphasized communication skills in the medical curriculum, which is otherwise taught as a hidden curriculum.

With the changes in the medical curriculum, the aim and focus have shifted to providing medical students with training that integrates knowledge and competencies by implementing clinical exposures. One of the main roles of an Indian Medical Graduate is they be a member and leader of healthcare teams. For this, they need to *"work effectively and appropriately with colleagues in an interprofessional health care team respecting the diversity of roles, responsibilities and competencies of other professionals."* This study demonstrated that students connected with patients better while reading their stories. Engaging with patients' narratives can help bridge the gap between medicine's general knowledge and the world of the patient, thereby contributing to newer aspects of breast cancer survivorship in both research and healthcare settings [6]. Practical teaching methods such as role-playing and videos further help to reinforce their communication skills. Our methods might play an essential role in helping the students become better doctors by training them in a safe, simulated environment before facing an actual patient. They understand what it is to feel with the patient and what it is to be a doctor.

Many studies have been conducted in the past that have assessed the use of role plays to introduce communication skills in the curriculum, with promising results [2, 7, 8]. Windish and Eboni [8] suggested that communication skills courses should be incorporated early in medical training because communication skills are related to clinical reasoning. It helps build a good rapport with the patients, helping the students have better communication skills. A few studies have incorporated role plays in the simulated environment and psycho-oncology, which helped them understand patients' emotional reactions through selected case studies, allowing them to know how to address such situations and communicate effectively [9].

Narrative medicine has been used as an innovative means of stimulating medical students' professional development by sensitizing them to approach their patients' experiences of illness with more understanding, empathy, and compassion [10]. Storytelling or narrative medicines help bridge the different worlds of patients, families, clinicians, health systems, policymakers, communities, cultures, and traditions, helping us understand how to create experiences and improve the lived experience of giving and receiving patient-centered healthcare [11]. Narratives enable students' self-exploration, reflection, and awareness of professional identity, helping them learn professionalism in clinical settings. Adopting patient narratives as an educational intervention in undergraduate medical education could significantly improve professionalism and patient communication skills [12]. Reading narratives positively impacted our students, with most of them understanding the patients' emotions and building a connection with them. IP role plays reinforced this, showing that teamwork and communication skills helped prepare patients for future encounters. Most students felt such sessions should be incorporated into the curriculum since they help them see the patient's perspectives.

According to the World Health Organization, "Interprofessional education occurs when two or more professions learn about, from, and with each other to foster effective collaboration and enhance health outcomes." We designed the role plays and videos using the Interprofessional Education Collaborative (IPEC) framework which integrates interprofessional education into the medical curriculum, thereby preparing future healthcare professionals for collaborative practice in diverse healthcare settings. It emphasizes the importance of teamwork, communication, and mutual respect among healthcare team members to improve patient care and safety. They aim to prepare future health professionals for effective team-based care, ultimately improving patient and population health outcomes [13].

Implications of the study

By highlighting the emotional and practical challenges faced by patients, such as those with breast cancer, we suggest that such immersive experiences can lead to a deeper understanding of patient needs and better prepare students for real-world interactions. Our study emphasizes the importance of interprofessional collaboration

in delivering comprehensive patient care. Our study supports the integration of teamwork-focused education into medical curricula as the students who participate in IPE are trained to understand and appreciate the roles of various healthcare professionals. The study also highlights the effectiveness of active learning methods, such as simulations and role-plays, in teaching complex communication skills and teamwork which may help in bridging the gap between theoretical knowledge and practical application.

Future research

To deepen our understanding of interprofessional education (IPEC), future research should be directed toward Longitudinal studies to evaluate how IPE interventions impact students' clinical practices and patient outcomes over time. Additionally, regular feedback from students and faculty about their experiences with IPE and how IPE affects professional collaboration in real-world healthcare settings can reveal valuable insights into its benefits, challenges, and opportunities for enhancement. These would help refine IPE approaches and promote more effective collaborative care in the healthcare field in India.

Conclusion

Interactive teaching methods like narratives and role play may help enhance students' communication and empathy, which is vital for future doctors. They seamlessly integrate into existing curricula, offering practical experiences that might help deepen understanding and empathy without disrupting learning. We recommend the use of interventions such as patient narratives along with traditional teaching of chronic illnesses such as cancer to teach students holistic management of such patients. This combined approach encourages students to view patients as whole individuals, considering their medical needs, psychosocial well-being, and quality of life. It teaches future healthcare professionals the knowledge, skills, and compassion necessary to deliver patient-centered care and support to individuals navigating chronic illnesses like cancer.

Limitations of the study

The study did not analyze the empathy score before the start of the study. Hence, it is difficult to gauge the change in different forms of empathy in a learner before and after the survey entirely.

Lessons learnt

Collection of the patient narratives helped the students learn from the patients, and the IP team members reflected a lot of positive impacts. There was a better bonding between the students and the facilitators during the session. However, such sessions need more workforce, elaborate planning, and ample time for execution, given the busy clinical schedule of the IP team.

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Authors' contributions

Caren, Supriya, Kishen Prasad: conducted study. Caren, Animesh Jain, Tatiyana, Ciraj : planning and editing the study. Caren - wrote manuscript. All authors reviewed the manuscript.

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Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due [: not included as a part of the manuscript as the voice recording of the narratives and the students focussed group discussions holds few personal details which cannot be shared in the manuscript] but are available from the corresponding author on reasonable request.

Data availability

The data that support the findings of this study are available with the authors, but cannot be publically shared in view of patient and students confidentiality. The data are, however, available from the authors upon reasonable request and with the permission of K S Hegde Medical Academy, NITTE deemed to be university and Manipal FAIMER international institute for Leadership in Interprofessional Education.

Declarations

Ethics approval and consent to participate

Informed consent to participate was obtained from all of the participants in the study. The ethical clearance was obtained from the institutional ethical committee, K S Hegde Medical Academy, Mangalore, India.

Consent for publication

No identifying images or other personal or clinical details of patients included in the study.

Competing interests

The authors declare no competing interests.

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