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Dialogic interactions among multi-professionals in the context of online sessions: The use of *Mederu* to understand *Moyatto* experiences

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Abstract

This study discusses professional love in the context of online sessions where healthcare professionals employ a dialogic framework to reflect on or explore how discomfort arises in their interprofessional practices. The goal of this study is to provide frontline practitioners and educators with insights into what constitutes professional love in dialogue and to suggest avenues of support for the development of continuous health profession education through such dialogue. We took a reflective writing approach based on observations of dialogic practices. This essay represents a reflective writing conducted by the first author as he explored, in his own practice, love in dialogic interactions among professionals in online sessions. He established a Study Group in 2014, aiming to improve interprofessional collaboration through dialogue on Moyatto, which is defined as emotional, cognitive, and physical distress experienced when individuals face conflicting communication with people who have different viewpoints and interests. We describe actual events that occurred in sessions and interactions that continue even without direct conversations after the conclusion of the session.

The results indicate that the first step for professionals to experience love in their professional practice is to share the Moyatto experiences without any quid pro quo in response to the other's narrative. Even after the session's conclusion, the participants continued to feel something that could not be verbalized because of the other's alienness. Therefore, the interactions comprising the exchanging of Moyatto experiences can continue even without direct conversations, and such experiences can motivate participants to inquire about perspectives hitherto unknown to them. We postulate that this process can be regarded as Mederu, a Japanese sense of loving used by people to willingly observe and care for the diverse elements of others or materials. This transitional learning that transcends professional and disciplinary boundaries may need to recur at various points in a professional's career, requiring more sustainable and stable educational resources.

Keywords: Health Professionals, Love, Interprofessional Collaboration, Interprofessional Education, Continuing Education, Dialogue, Online meeting

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Introduction

This paper discusses healthcare professionals' experiences of love in their professional practice with other professionals in the context of interprofessional dialogue and collaboration (education). This love is shared among healthcare professionals rather than between patients and their caregivers. Healthcare professionals' main goal in their practice at a university or medical institution is to implement interprofessional collaboration for the benefit of patients or to teach trainees. Little is known about dialogue and love in interprofessional collaboration, which is considered important but difficult to achieve in healthcare settings. Specifically, we discuss professional love and dialogue in the context of online sessions in which healthcare professionals employ a dialogic framework to reflect on or explore the emergence of discomfort (*Moyatto* in Japanese) in their interprofessional collaboration or education. Through this article, we share our insights into what constitutes professional love in interprofessional dialogue. The goal of this study is to provide frontline practitioners and educators with insights into what constitutes professional love in dialogue and to suggest avenues of support for the development of continuous health profession education through such dialogue.

For that purpose, the reasons for discussing professional love and dialogue are first presented using the first author's experience. Second, we discuss the concept of love and examine previous literature

about how the concept of love has been explored in healthcare settings. The reviewed literature clearly showed that several studies consider professional experiences of love between healthcare professionals and patients (Novick, & Novick, 2000), but there are no studies of professional experiences of love among healthcare professionals. Third, we describe the methods used to analyze the interactions of the dialogic online sessions among healthcare professionals. We adopted a reflective writing approach in this paper; reflective writing refers to writing for reflection and is a widely used method of considering things or seeking a deeper understanding of something (Jasper, 2005). We illustrate specific examples of the online sessions with vignettes and examine what was happening there, using the perspectives of professional love and dialogue. Finally, we discuss how the experiences of professional love and dialogue described in this paper can contribute to the education and practice of professionals, with reference to the norms of conventional healthcare ethics.

The current situation in healthcare

Growing demand for interprofessional dialogue

Recently, it has been reported that 50% of the general population in developed nations live with chronic conditions, and their needs are numerous and complex (Boersma, 2020; Public Health Agency of Canada, 2020). A similar situation can be seen in Japan, where this study was conducted (Mitsutake et al., 2019). Furthermore, in mental healthcare settings (where the first author works), professionals must often deal with not only health issues but also social issues, such as interpersonal problems (bullying, abuse, violence, etc.) and controversial issues (gender, race, ethnicity, etc.) (Lalande et al., 2023). The patients' needs are often amplified because cases are dealt with simultaneously in several branches of the welfare system involving a variety of actors. In other words, collaboration with "alien others" from different disciplines and professions is essential to address a range of issues (Tajima, 2020; Tajima, 2021). As a psychiatrist, the first author (IS) routinely encounters patients with complex needs in hospitals that provide adult psychiatric care. The following case is one of the examples showing the complexity of care and the necessity for collaboration among healthcare professionals:

> Patient A., a depressed man in his 40s, was admitted to IS's psychiatric hospital. A's father said the mother couldn't live with A because she was worried, anxious, and depressed all the time because of A's problems. A's partner, on the other hand, was willing to move in with him, hoping to eventually marry him once his condition improved. Additionally, she understood that her support played an important role in the mental health treatment journey, but said it was not feasible. She has two children with her ex-husband. While raising them, she also cared for her elderly father at home. She also ran a boarding house for college students in her home to make a living. Patient A. had also been helping with the boarding house, which was very helpful to her. However, she stated that while she could provide him with housing, she could not afford to pay him a salary or hire anyone else. When A. was discharged from the hospital, he woke up at 5:00 a.m. to make lunch boxes for the college students at the boarding house, even though he had not fully recovered from his illness. He also had to provide three meals every day to the college students. His partner was distressed, "I feel sorry for A., but I have no choice but to ask him to work at the boarding house." On the other hand, she preferred traditional medicine and was adamantly opposed to putting A. on Western medications, saying it would "rob him of his fertility." When he lived with his partner, he often became depressed due to chronic fatigue. He had repeatedly interpreted his depression as being caused by his medications and discontinued them, which further exacerbated his condition.

If various healthcare professionals are involved in this case, we could imagine how each specialist interprets this case from their own perspective. For example, psychiatrists focusing on neurobiology may attribute A's poor antidepressant response to dysfunction in the prefrontal cortex. Psychologists with an

emphasis on cognitive science may suggest that certain cognitive processes exacerbate A's negative mood. Pharmacists may want to know why patients choose to deviate from drug treatment. Family therapists would say that family therapy is particularly helpful when family distress is present as a component of depression, as in the case of A. Social workers may use a public health approach, looking at structural social factors (class, gender, poverty) rather than individual ones.

On the other hand, A and his partner may focus on the realm of existence, personal meaning, and spirituality, which professionals tend to leave aside. All of these methods and approaches can be useful but may not be appropriate in every situation. The problem itself can change, and new aspects of the problem may emerge. If these practitioners do not collaborate to share information and expertise, they cannot obtain all relevant information to meet patient's needs. Preventable errors will continue to occur at a high rate and cause patient harm, unwanted hospitalisation, longer stay in the hospital, and even fatality (Sassoli et al., 2020). Furthermore, interesting and creative solutions for complex problems usually come from combining insights, information, and challenges that these different professionals have. Professionals need to clarify how to understand and approach various aspects in different conditions and different circumstances through ongoing dialogue. In summary, we believe addressing patients with such complex needs requires a dialogic collaboration among specialists across different fields (Geese et al., 2023; Thistlethwaite et al., 2013).

Difficulties in initiating dialogue

Notably, it is difficult to initiate such dialogue in healthcare settings (Reeves & Lewin, 2004; Reeves et al., 2009). The healthcare settings are busy environments, and many obstacles hinder interprofessional engagement. Moreover, there is no time or space for professionals to get to know each other and engage in dialogue. For example, IS often has experiences like the following:

> *IS is a psychiatrist with 18 years of experience, working in a 318-bed psychiatric hospital in central Japan. In addition to himself, 15 doctors and 150 nurses are engaged in inpatient and outpatient services, including psychologists, pharmacists, nutritionists, occupational therapists, social workers, radiologists, and laboratory technicians. Patients receiving inpatient services had a variety of acute medical problems; some were treated and discharged, while others were treated ineffectively and stayed longer. Physicians working at this hospital also provided outpatient care. In other words, discharged patients were treated by the physician as outpatients, and if hospitalization was deemed necessary, the same physician was also in charge of inpatient care. Therefore, with about 20 patients in seven wards at any given time, IS treated about 100 outpatients a week. The hospital was divided into zones to include seven wards and an outpatient zone. The outpatient zone includes offices for professionals, such as physicians and psychologists.*
>
> *IS frequented three of the seven wards; two of them housed acute patients, while the other housed subacute patients. Each ward had retained a traditional arrangement of 50 beds. About 10 patient rooms were single-bed rooms, and the remaining 10 were multi-occupancy rooms (mostly four-bed rooms). The nurses' station was located near the wards' entrances. It was separated from the ward by a large clear acrylic window that enclosed a small space containing chairs, desks, and equipment. Valuables and medications were also stored there, and the entrance and exit were locked to keep patients from going in. The nurses' station was used as the meeting place for the concerned professionals, where they talked, wrote records, and made phone calls. At the nurses' station, nurses often talked about non-work topics, for example, their families. The ward included two patient day rooms, several seclusion rooms, three examination rooms, a utility room, a family waiting room, bathrooms, toilets, washroom corners, and a laundry. Each ward was staffed with 15 to 20 nurses, with half of them present in the ward at all times. In*

IS's hospital, the attending doctor was in charge of each patient. Each doctor had patients in various wards, and patients under their care were admitted wherever a bed was available. Therefore, many doctors regularly visited each ward to see their patients, mainly in between outpatient visits. Psychologists, pharmacists, and social workers were similarly stationed in offices located in the outpatient zone. Sometimes, they would visit the wards in response to requests from the patients or the nurses.

One morning, IS entered the ward to check on his patient. She stayed in one of the patient day rooms and requested to be seen in an examination room; thus, IS took her there, talked with her for about 15 minutes, and entered his notes in the electronic medical record. Her symptoms improved, and she wanted to be discharged, so IS went to the nurses' station and informed B. nurse, who was in charge of her discharge. B. inquired about a post-discharge outpatient appointment, and IS explained that he had already made one for the patient. However, during this conversation, B's cell phone rang, and she answered it. IS, therefore, sat down next to her, waiting to complete the discharge paperwork, but soon, another nurse called him to ask if he would come to the outpatient zone to handle a disturbed outpatient. At that time, B. was at the counter handling inpatients. IS then spoke to another nurse who happened to be standing next to him (she was new, and IS didn't remember her name) and handed her the discharge papers. Upon receiving the papers, the nurse stated that she would meet with the family of the newly admitted patient and leave the nurses' station. By this time, a young physician had entered the nurses' station and was checking with B. about the condition of the patient in his charge.

While interprofessional dialogue is important, several barriers impeded its occurrence in the case described above. First, the wards are busy environments (Reeves et al., 2009). At any given time, a wide variety of people (patients, family members, and many professionals) can be in or pass through the ward. Interprofessional collaboration in this environment comprises simple and formal task-related interactions, usually initiated by a doctor providing information or instructions to a nurse (Reeves & Lewin, 2004). These interactions are business-like, focus on the patients' matters, and provide few opportunities for professionals to express their expertise. Many exchanges are initiated abruptly and without social niceties, such as addressing others by their name/designation or greeting them, and there is little emotional interaction. Sometimes, professionals interact without knowing the other person's name or specialty. In other words, if they have a query, they usually look around the ward and ask professionals who are performing other tasks but might be able to answer it. Interprofessional interactions rarely include small talk; social interactions occur only when the ward is quiet, that is, when it does not delay the completion of tasks. Several studies have reported that these terse, task-oriented interactions between physicians and nurses are central to interprofessional exchanges in hospital wards (Reeves & Lewin, 2004; Reeves et al., 2009). In comparison, the exchanges among the nurses are quantitatively and qualitatively richer (Reeves & Lewin, 2004). Emotional exchanges are relatively frequent within the nursing group, particularly in nurse stations where there are no patients (Reeves & Lewin, 2004).

A second possible explanation for the difficulty in initiating interprofessional dialogue is differences in professional roles. Professional roles are prescribed sectorally, shaping the identities of professionals who practice different tasks. For example, the training culture of physicians differs from that of nurses and focuses more on actions and outcomes than on relationships (Hall, 2005). Therefore, in physicians' work practice, they prioritize methods of work that are task-oriented, have clear outputs, and separate the public and private (Fletcher, 1998). Conversely, tasks such as interprofessional dialogue and team building are often coded as private-sphere feminine activities that are outside the definition of work and competence (Fletcher, 1998). For this reason, nurses may find it difficult to dialogue with physicians, even though they can do so with other nurses (Reeves & Lewin, 2004).

Third, neoliberalism, which has been the dominant ideology in healthcare settings since the 1970s, is considered one of the factors that redefine professional roles and impede the expansion of interprofessional dialogue (LaGuardia & Oelke, 2021). Neoliberalism is a form of capitalism characterized by deregulation, austerity, and individualism, on the assumption that if markets were allowed to function without restraint, they would be able to serve all economic needs and generate full employment for all those who wish to work (Harvey, 2005). Neoliberal reforms in healthcare have led to more direct surveillance and performance evaluation of frontline practitioners by senior managers and increased competition within and outside organizations (Moth, 2020). In addition, frequent service restructuring has led to staff reductions and colleagues competing for fewer posts. Some reports indicate that neoliberalism has contributed to competition, inequality, and oppression rather than collaboration and dialogue between healthcare professionals (Cohen, 2016).

As a result, interactions in the wards are dominated by "conversations" limited to technical terms among peers who mutually believe they share task-related knowledge and experience. Bakhtin called these mental states "automatization" (Bakhtin, 1979/1984). Automatization refers to mental states in which speakers exchange their intentions without a conscious sense of controlling language with partners whom they believe share knowledge with them (Tajima, 2021). Automatization does not make people aware of the ambiguity of language, and conversations may become superficial. Such a conversation is reported as a common mechanism in complex, busy hospital environments because it allows work to be performed efficiently and is not interrupted by unrelated topics of conversation (Reeves & Lewin, 2004).

However, in recent years, reports have emerged about the unintended harm caused by prioritizing professional conversations about complex problems that essentially require a dialogue with others (Humphris, & Hean, 2004; Laming, 2003; The Bristol Royal Infirmary Inquiry, 2001). In exchanges where professionals are expected to communicate without critiquing existing ideologies, the uniqueness of each perspective is less likely to be respected. Consequently, such professional groups are prone to groupthink, which can lead to a lack of diversity and innovation or rare but fatal accidents (Kaba et al, 2016; Janis, 1991). Healthcare professionals require dialogic collaboration where they work together at a deeper level to address the complex needs of patients in the healthcare field. In collaboration with other professions and institutions, one's ideas or ideologies may be criticized or denied. Such criticism is needed to encourage professionals to think differently about the ideologies that are automatically accepted in comfortable environments (Tajima, 2017).

Theoretical frameworks and the literature review

In the following sections of the paper, we explore what it means for professionals to "show love in professional settings" to other professionals in the context of online sessions that require the use of a dialogic framework. First, we define the concepts of dialogue and love in this essay. Based on the definition and previous literature on love in healthcare settings (Novick & Novick, 2000), we develop a theoretical lens for analyzing the interactions of dialogic online sessions among healthcare professionals. The concept of love is discussed in various contexts and disciplines. There is some overlap between English and Japanese understandings of love, but not in all cases. Therefore, we review the types of love in dialogue, the discourse on love in Japan (research setting), and then explain the significance of discussing love in healthcare.

Dialogue

According to the Russian literary researcher and philosopher Bakhtin, dialogue is a form of communication with others (Bakhtin, 1979/1984). It refers to critical communication with others that allows participants to investigate fixed and opposing ideologies from various perspectives to create a new ideology for coexistence (Tajima, 2021). This process of dialogue, which Bakhtin calls "estrangement," involves

bilateral investigations of authoritative ideologies rather than unilateral attacks on them (Bakhtin, 1975/1981; Tajima, 2017). Speakers criticize others' ideologies but also welcome others' criticisms of their own thinking ambivalently in the context of Bakhtin's use of estrangement. In conversations with peers, on the other hand, it is expected that speakers will understand each other without the need for deliberate verbalization because they share ideologies and values (Tajima, 2021). Speakers in dialogue need to verbalize meanings that could be omitted as shared knowledge among their peers, clarify responses to criticism, and be conscious of linguistic expressions deemed acceptable by the other party (Tajima, 2021). Only then can the profession examine ideologies from each speaker's ambivalent perspective, independently of their affiliated communities, and gain novel perspectives on complex issues (Tajima, 2017). Therefore, professionals who seek to collaborate effectively need to shift from an automatization-based conversation to an estrangement-based dialogue.

The shift from automatization-based conversation to estrangement-based dialogue requires participants to assume that others are criticizing them (Tajima, 2021). Bakhtin states that dialogue with others inevitably causes emotional pain because the speaker's view may be criticized or negated (Bakhtin, 1990). Participants must manage negative emotions related to criticism, which is easier said than done. When overwhelmed by negative emotions, participants may struggle to contain themselves and appropriately deal with their emotional load. They may also find it difficult to divert their attention away from the source of their emotional upset. The inability to reign in automatic negative thoughts and anxieties can lead to a lack of openness and creativity, disrupting the participant's dialogue. They have to leave the situation if they are overly emotional. In such stressful situations, verbal exchanges between speakers require the following type of affection.

Love

Love in this paper is referred to in the context of dialogue, which excludes love that is idealized religiously[1] or considered psychopathological[2]. Moreover, this section does not aim to review the vast amount of research on love but to introduce existing discourses and studies on love that are relevant to the objective of this research and to clarify its academic contribution. The objective is to provide frontline practitioners and educators with insights into what constitutes professional love in dialogue.

During a dialogue, a safe and familiar environment for the speaker is often invaded by the external world. Bakhtin used the word "transgression" to refer to outsideness, suggesting an invasion of safe and familiar environments from the outside world (Bakhtin, 1990). In addition, Bakhtin proposed acquired emotions such as love as factors for overcoming the pain accompanying the critical transgressions that inevitably arise in dialogue with others (Bakhtin, 1990). According to Tajima (2021), "love" in this context refers to the affection that accompanies the verbal exchange between speakers. He further argued that enabling critical self-examination may require a relationship based on mutual trust in which both parties can enjoy exchanging criticisms in a way that makes each other wiser and is more beneficial (Tajima, 2021; Tajima, 2023). It may also be helpful for individuals to listen without jumping to conclusions, easily

[1] Religious types of love describe the relationship between God and human beings. For example, a distinction of the love which has been taken for granted in many Christian contexts worldwide is drawn from Anders Nygren (1953). He argued that eros is the term for Platonic, self-centred love that strives for union with the divine realities, while agape, denoting the Christian concept of love, is the free, divine movement towards human beings (Tollefsen, 2021). Agape is unselfish and is not motivated by any value in the recipient.

[2] Pathological love is the uncontrollable behavior and attitude of caring for a partner that results in neglecting the needs of the self (Stravogiannis et al, 2018). Romantic relationships provide a variety of positive effects, such as companionship, passion, and intimacy, but they can also be a source of great sorrow and suffering. The psychopathology of love and romantic relationships has historically received attention in psychiatry and clinical psychology because of its potential to lead to significant impairments and distress (Berscheid, 2010). In these fields, many love scholars define love as an attitude, a predisposition to think, feel, and behave in positive ways toward another. However, most laypersons and some love scholars, including us, prefer to think of love as an emotion (Berscheid, 2010).

interpreting what is heard and immediately believing that they are correct. These behaviors allow for listening while acknowledging that the other party may be right in some areas.

Bakhtin discussed two types of love in dialogue (Bakhtin, 1990): (1) domestic love, which involves monologic interactions that transfer existing ideologies from parents to children without any critique, and (2) love toward non-family members, which involves dialogue comprising mutual critiquing of each speaker's perspective. He tended to be critical of the automatic acceptance of ideology, which could lead to fixed conventional identities in each group (Tajima, 2021). Children are offered love and care by their parents, but they have difficulty separating them from parental ideology. Of course, no family relationships exist without authority, although overly authoritarian parental love sometimes creates an oppressive environment for children. However, moderately authoritative discourse provides a basis for autonomous self-consciousness. Healthy young people can question the ideologies fostered by their parents as their own consciousness develops. They come into conflict with domestic love. Tajima called this natural affection for one's family "homophonic love" (Tajima, 2021). The other is an acquired affection for the alien other, and Tajima referred to it as "polyphonic love" in relation to "philia," that is, the Greek concept of friendship love (Tajima, 2021). The latter helps us overcome the pain accompanying the transgression in the online sessions. Critical discourse without polyphonic love may result in unilateral attacks and the rejection of others' perspectives. Polyphonic love is discussed in this paper.

The discourse on love in Japan

In Japan, people often avoid saying the word "love" directly (Yamane, 2008). Expressions such as "I love you" are rare, not only among friends but also between partners. Indeed, love is a key attribute of God in Christianity. In the New Testament, God's love for humanity or the world is expressed in Greek as agape (ἀγάπη) (Tollefsen, 2021). However, Japanese culture, which is polytheistic, does not assume an absolute and unchanging existence. Consequently, the use of the word "love" in Japan makes the people feel strongly about the existence of only one Christian God (Yamane, 2008). The word "love" has been deified and idealized as an attribute of God, and the Japanese word love (愛 *Ai*) has come to imply ostentation and seriousness. Therefore, when this word is used in everyday interpersonal relationships, it can appear as a superficial and insubstantial lie, or have an eerie seriousness that often makes the listener suspicious (Yamane, 2008). However, this does not imply that the Japanese do not feel love. The expression "affection" (愛情 *Aijou* or 情 *Jou*) is often used to refer to the same feeling.

Second, the Japanese word for love connotes an emotion (desire) that a person has for an object. It is often considered to be a longing or craving for something that is not one's own. When Japanese people use the word affection (情 *Jou*)—an everyday term for love—they express it as "affection comes up in me (情が湧く *Jou ga waku*)" or "Affection is transferred to the other person（情が移る *Jou ga utsuru*）" through interactions. It does not mean that "I" as the subject "love" the object, but that "I" as one of the components of the system is affected, and "affection" dwells within "me" or is transferred to others and affects them. Affection (情 *Jou*) embodies this dynamic Japanese view of the system, but love (愛 *Ai*) does not. Hence, in Japan, we say "affection (情 *Jou*) comes up in me," and not "Love (愛 *Ai*) comes up in me." People tend to perceive themselves as components of a bigger system, that is, as within nature or as a part of the cosmic tide of time, where one influences and is influenced by many other components (Togashi, 2009). This way of perceiving oneself may prevent everyday use of the word "love." However, the reasons for the daring to use the theoretical lens of love in this study are discussed below.

Previous research on love in the healthcare field

In the healthcare field, some people have a sense of responsibility, are high performers, and display proper behavior. In addition, such people are resilient, passionate, have a sense of initiation, and are described as loving their profession (Bolandian-Bafghi et al., 2022). Some studies have discussed this love

for one's profession (Adib-Hajbaghery et al., 2021; Bolandian-Bafghi et al., 2022). Particularly, in Japan, "the state of wellbeing that arises from devotion to activities one enjoys, which also brings a sense of fulfillment" is called *Ikigai*, which means "purpose in life" (Kumano, 2018). Among life's activities, work-specific happiness and fulfillment are called *Yarigai*, and Nishigori (2020) introduced this as a necessary component of a physician's professionalism. How to love the physician's profession and make it *Ikigai* or *Yarigai* has become an important topic for many physicians. However, when it comes to the love that physicians have for people rather than their profession, the discussion becomes more delicate.

As mentioned earlier, in healthcare settings, emotions such as love have been disparaged as illegitimate forms of knowledge (seen as both gendered and unscientific) in contrast to reason (McNaughton, 2013). Consequently, there have been fewer contributions from perspectives beyond the biosciences and psychology in medical education, further diminishing the visibility and feasibility of emotions in educational and professional contexts (McNaughton, 2013). Of course, discussions about emotions such as love are not absent in the medical field (Emakpor et al., 2010; Rykkje et al., 2015; Watson, 2003); love in the doctor-patient relationship has been examined in detail by psychoanalysts, such as Freud (Chatterjee, 2022). However, even though there is much discussion about the patient's love for the physician, there is little discussion about the physician's love for their patients/colleagues (Novick & Novick, 2000).

According to Novick & Novick (2000), in psychoanalysis, love from the patient for the doctor has historically been considered the object of analysis. Some patients create a "false connection" between their desires and the physician, placing the physician at the center of emotions that belong to the patient's past. Freud called this phenomenon transference (Freud, 1961). In these cases, the physician can focus directly on and work with the conflict in the "here and now" of the therapeutic relationship, thereby allowing the patient to immediately confront his or her emotions. Additionally, by working in and with transference, the patient and the physician can gain differentiated insight into the essential issues of the extratherapeutic relationship (Hobson & Kapur, 2005). By contrast, love from the doctor to a patient is conceptualized as relatively negligible (Novick & Novick, 2000). Love was unavoidable and intense in therapy and plagued most analysts, and some female non-medical analysts found therapeutic significance in it (Szasz, 1956; Shulman, 2016). However, the dominant view was that the doctor's reciprocal response was understood to be as unreal as the patient's, cast as the doctor's transference to the patient, and this countertransference was to be excluded from the analysis and instead examined through self-analysis or a return to personal treatment (Novick & Novick, 2000). This idea of transference and countertransference provides physicians with theoretical and technical tools to withstand the temptations inherent to all situations of power and authority. However, the love that physicians had since Freud's era has been, at best, illegitimate, outside the realm of debate, and often considered an ethical breach, and most physicians have been unable to express such love, for reasons linked to medical ethics (Lothane, 2000).

The most famous example of a doctor–patient relationship in the history of psychoanalysis is that between Sabina Spielrein (1885–1941) and Carl Gustav Jung (1875–1961). This relationship included sexual intercourse, which is unthinkable today. For many years, this case has been considered a prime example of an ethical breach of the boundary between healthcare providers and patients during the treatment process, which may have influenced the subsequent taboo on the topic of love among healthcare providers (Lothane, 2000).

Reasons for discussing love in healthcare settings

There are several reasons for discussing professional love. First, there has been little research on the kind of love that professionals, especially medical professionals, have. Only specific aspects of the categorization of love as a form of countertransference have been examined (Novick & Novick, 2000), and

within a limited doctor–patient relationship. To our knowledge, this is the first paper to discuss healthcare professionals' experiences of love in their professional practice with other professionals. Second, given the assumption that such healthcare providers have a need for love, there is even less discussion on how these needs are to be met. The reciprocal needs of healthcare professionals may be met directly by patients, but others may be met by colleagues (Shapiro et al., 2019). Moreover, it is not sufficient for the need for love to be met for a limited period. Interprofessional dialogue on any one complex issue is not the endpoint of the patient care journey. Professional love may be needed at various points in a professional's career. For example, medical students and junior postgraduate trainees are already aware of the complex and ambiguous nature of healthcare settings (Khatri et al., 2020; Neve et al., 2017). Small reflective groups might help students navigate these challenges that essentially require dialogue and love with others (Collett et al., 2017). However, it is not clear what kind of dialogical place professionals need and how they incorporate love and develop mutual trusting relationships through dialogue. We do know that senior clinicians also experience uncertainty and complexity following their transition to independent specialty practice (Smith et al., 2018).

This study aims to discern love in dialogic interactions among healthcare professionals by describing the pain that accompanies transgressions and emotions in mutual interactions during online sessions. Moreover, we explore and describe our study group regarding interprofessional distress (*Moyatto* in Japanese) and consider how such a group is being used to inform interprofessional practice (education). Our overall goal is to provide frontline healthcare practitioners and educators with insights into what constitutes professional love in dialogue and to suggest avenues of support for the development of continuous health profession education through such dialogue.

Method

Context

We developed online sessions as a strategy to facilitate open dialogue by reducing or removing some barriers. We found that the online sessions provided a sense of separateness that allowed professionals to detach themselves from the barriers in official healthcare settings (e.g., busy environments, neoliberalism). Furthermore, online sessions create a dialogic space that requires professionals to temporarily move into a different role or identity from their official one (Kumagai et al., 2015). Participants had to agree to remove themselves from professional roles and identities to some extent. Under these circumstances, the dialogic space is defined not by physical locale, time spent, or even physical isolation from other activities (Kumagai et al, 2015). Instead, it is defined by the intention to designate this time, this place, and this conversation as involving reflection and dialogue about the professional's experience of themselves in the context of interprofessional collaboration. The first author, IS, began such online sessions in 2014, aiming to improve interprofessional collaboration through dialogue on discomfort in healthcare settings. A project designed to articulate the theoretical underpinnings of its educational interventions ran from February 2022 to September 2023. This was a unique opportunity to explore love in interprofessional dialogue. IS participated in the project and took reflective notes during and after the online sessions. In this study, these notes were used as information sources. Nine multidisciplinary professionals participated in the project.

Through practice in healthcare settings, IS had considered that interprofessional discomfort could facilitate dialogue and provide an opportunity for improved collaboration. IS, therefore, decided to call the discomfort *Moyatto*, a Japanese adverb (or noun) representing distress that cannot be simply described by its discrete cause, an accompanied sense, and an emotion (Sano et al., 2021). In the interprofessional practice, professionals experience *Moyatto* when something taken for granted from a professional perspective is criticized or denied by a professional from other disciplines. *Moyatto* (or *Moyamoya*) originally

means “misty, foggy, or murky,” and is often used to describe a sense of uncertainty (Iida & Nishigori, 2021). This word also has positive connotations, suggesting a situation full of anticipation before the fog lifts and a new world arrives. When a conversation suddenly goes awry among peers who mutually believe they share knowledge and experience in the healthcare setting, they are keenly aware that the person in front of them is an alien other and may feel *Moyatto*. In other words, *Moyatto* offers a turning point for professionals who seek to collaborate effectively and need a shift from an automatization-based conversation to an estrangement-based dialogue. Studying the phenomenon of *Moyatto* provides an opportunity to understand different perspectives and views through dialogue and to learn from each other by accepting critical evaluation. The first author called the group, which was established in 2014 and studied the phenomenon, a study group on *Moyatto* (SGM) (Sano et al., 2023).

The dialogue in the SGM focused on group members’ experiences at work. Throughout 2024, during the process of writing this manuscript, nine multidisciplinary professionals from several institutions continued to meet once a month for a one-hour online session after work. Professionals who have participated in SGM are nurses, psychiatric social workers, physicians, pharmacists, and medical clerks, and they work in a variety of settings, including educational institutions (colleges, universities), medical institutions (clinics, hospitals), and government organizations. They were encouraged to temporarily leave their workplaces and participate in one-hour online sessions once a month (Sano et al., 2023). After the online sessions, the first author continued to make SGM accessible and responsive to participants: When participants consulted the SGM with questions or concerns, each would be invited to use social media to respond in a timely manner and with a thoughtful response that addresses their issues. Additionally, the SGM hosted recurring in-person events (organizing workshops, attending trips, meals, and conferences) and actively encouraged participation to create a strong sense of community among participants. According to the 2023 data, the average duration of participation in the SGM was 2.7 years (Sano et al., 2023).

In the actual online sessions, each participant shared their *Moyatto* experiences, which were mindfully viewed by all and reconstructed by using a new perspective that was provided by a member from another discipline (Sano et al., 2023). For example, a doctor who interprets patients’ poor antidepressant responses from a neurobiological perspective may be at odds with pharmacists, nurses, and social workers in a healthcare setting but can gain new perspectives from members in the online session. In addition, participants can enjoy exchanging criticisms of each other’s professional culture (e.g., values, beliefs, attitudes, customs, behaviors) in a way that makes them wiser and more beneficial to each other. The online session began with the facilitator inviting a participant to share a *Moyatto* experience. Those willing to share their experiences went first and invited other participants who have had similar experiences to share their stories. Each participant then shared a relevant experience so that the session provided a multifaceted view of the experience. The goal behind such sharing of experiences was not to solve the problem described in the shared *Moyatto* experience but to help the participants to understand the situation in which the problem that led to the *Moyatto* experience occurred, gain new insights and perspectives, and reconstruct their own experiences.

In SGM, when a speaker shared their *Moyatto* experience, listeners tried to understand the entire experience in a climate of openness so that the speaker felt welcome to share. They made a conscious effort to hear the speaker’s words and absorb the complete experience being communicated. They attempted to walk in someone else’s shoes and gained a good understanding of how the speaker had experienced *Moyatto* and how they had felt. This method of understanding the individual differs from that which occurs during consensus-building skills, where participants ask clarifying questions and paraphrase what they have heard to ensure understanding. These skills involve “who–why” questions and are often used to investigate causal relationships analytically and linguistically; this method is not suitable for understanding *Moyatto*, which could not be simply described by its discrete cause, accompanying senses, or emotions. In contrast, SGM participants often attempted to react to one another through responses, such

as gestures and onomatopoeias, that evoked certain images in the speaker's mind. The synchronization of images and body movements among participants and the use of onomatopoeias and gestures that evoke certain images have been vigorously studied in fields such as traditional Japanese dance (Douglah, 2021; Keevallik, 2015; Yasui, 2023). According to these studies, using imagery and body movements to build connections between people strengthens the intimacy between speakers and listeners or between listeners and serves as the basis for subsequent loving relationships.

Data collection and analysis

To analyze the interactions of the dialogic online sessions among healthcare professionals, we took a reflective writing approach. Reflective writing refers to writing for reflection and is a widely used method of considering things or seeking a deeper understanding of something (Jasper, 2005). The strength is in the capacity for reflective writing to develop the writer's critical thinking and analytical abilities, contribute to their cognitive development, enable creativity and unique connections to be made between disparate sets of information, and contribute to new perspectives being taken on issues (Jasper et al., 2005). This method was adopted in this study because it can help the writer develop an understanding of how an idea or theory, such as professional love in dialogue, works in practice from an "insider" source. Using this method, the first author began the research in 2022. A total of nine professionals affiliated with the SGM (see Appendix A) were recruited for the research study. All agreed to participate in the study and carry out the project to clarify the theoretical underpinnings of SGM. They were six nurses, two social workers, and one doctor (the first author) working in colleges, universities, hospitals, and national government organizations. All had more than 10 years of professional experience, including one ward manager, two professors and one chief physician. The first author reflected on his own experiences of activities, made notes, and collected data from February 2022 to September 2023. The notes were analyzed using the concepts of love and dialogue described in the section "Theoretical frameworks and the literature review," and relevant parts were identified for further reflection and analysis. To ensure that the research findings were trustworthy, we used member checks, made thick descriptions of our data to ensure the solidity of our findings, and maintained a detailed research record. To avoid self-indulgent reflection, IS deliberately interacted with others throughout the research. He held seven in-depth conversations with the research team (MM and HN, both co-authors of this article) and worked in collaboration with them on the data collection and interpretation, as well as the writing of this paper.

We also show the position IS has chosen to adopt within this research study for the reader to assess the effect of the researcher's identity on the research process and results. IS is an experienced psychiatrist working towards completing a PhD degree in critical reflective dialogue. IS's clinical experience has guided the choice of his research topic and research question. As a medical student, IS participated in an experiential learning course in community medicine. Remarkably, the collaborative work between the physicians, nurses, therapists, clerks, and care coordinators consisted of interactions that were generally more friendly, less rushed, and often involved a more in-depth discussion of patient care than it is common for interactions of such nature in hospital settings. The interactions that IS participated in during the above-mentioned collaboration also often included information on patients' social problems, humor, and laughter. These interprofessional and social interactions provided the involved professionals with an opportunity to understand different perspectives and views through dialogue and to learn from each other by accepting critical evaluation. Being individual agents, the healthcare providers appeared to conduct everyday resistance to the institutional environment in municipal healthcare sector, which Bakhtin called "automatization." IS became a psychiatrist but sometimes felt it difficult to initiate such a dialogue in hospital settings. Over time, in these clinical settings, IS became frustrated with the lack of opportunity to explore the institutional environment of healthcare and critically reflect on the social structures due to an emphasis on practicing under professional control. IS decided to establish the SGM in 2014, with the aim

to enhance interprofessional dialogue provision and thereby improve clinical decision-making and staff well-being. IS's clinical and personal background has continued to shape the research he is undertaking.

Findings

This section includes six cases from representative episodes that were drawn from the reflective writing notes and reconstructed as vignettes to exemplify the themes in each subsection and share various dialogic practices with the reader. We then highlighted areas where the realities of love in dialogic interactions among professionals were more nuanced than the research team initially anticipated based on reading the existing literature. We were interested in exploring IS's experiences of love in online sessions and how emotions such as love may work as factors for overcoming the pain that accompanies the critical transgressions that inevitably arise in dialogue with others. We also focused on identifying IS's and other participants' reactions and attitudes to these pains and processes through IS's perspective.

The following three subsections describe the SGM participants' attempts to understand others in online sessions. These attempts could serve as a basis for loving relationships between participants and encourage them to overcome difficult emotions, such as anger and pain, that were generated by their dialogues. After these subsections, we discuss how the participants separated their experiences from others' experiences. They were in tension between standing their ground on their own experiences and being profoundly open to others and other experiences. In other words, they were able to choose their level of involvement in the dialogue, engaging fully in it or not listening too much. Their own experiences could be given to other participants without any quid pro quo. In this situation, they just presented their experiences and did not immediately seek solutions. Finally, this study showed that the interaction in such online sessions had a long-lasting impact on the participants' professional experience.

The following six cases have been chosen as they allow us to explore how love and dialogue among healthcare professionals with different backgrounds emerged. The comprehensive discussion following the six cases deepen our understanding of love and dialogue in interprofessional collaboration and education.

Attempts to understand others

First, we present a typical scene from one online session as representative of this study's findings. This scene illustrates how participants attempt to understand others; such repeated attempts to understand others are interpreted as providing the basis for a loving relationship. In the interprofessional dialogue, SGM participants attempted to walk in someone else's shoes and gain a good understanding of how the speaker experienced *Moyatto* and how they felt.

Figure 1: IS's gestures and body movements at the SGM

Social worker C. shared her experience. IS responded with gestures (Fig.1) and onomatopoeic Moyatto: "Oh, really? It (C's story) was exactly an experience of Moyatto!"

Onomatopoeias, in this case, are "sensory words" that evoke vivid, visual, and perceptual images in an imitative fashion; they are also known as mimetics or ideophones, such as bang or splash in English (Akita, & Dingemanse, 2019; Dingemanse, & Akita, 2017; Kita, 1997). In this study, these onomatopoeia often co-occurred with gestures and other body movements (Fig.1), and similar results have been shown in several studies (Dingemanse, 2013; Hosoma, 2012). We also observed "active responsive understanding by the listener (Bakhtin, 1986)" involving gestures and onomatopoeia. Bakhtin (1986) said "From the very beginning, the utterance is constructed while taking into account possible responsive reactions, for whose sake, in essence, it is actually created. As we know, the role of the others for whom the utterance is constructed is extremely great. . . From the very beginning, the speaker expects a response from them, an active responsive understanding. The entire utterance is constructed, as it were, in anticipation of encountering this response (Bakhtin, 1986, p.94)." Therefore, we interpreted the direct cognitions of the listener's active response through gestures and onomatopoetic expressions as promoting the sense of trust, which in turn promoted critical dialogues.

Furthermore, these methods not only allowed the participant to show the speaker that they were listening but also avoided defining the other's experience externally or appropriating their words. Onomatopoeias and gestures could give the receiver the power and freedom to create, allowing participants to accept unexplainable things as they are. In other words, they evoke images in an imitative fashion, but it is the receiver, not the user, who creates this perceptual image. Communication in SGM was always unfinished, fluid, and shape changing. Therefore, it was always at the borderline between that which participants can control (or explain) and that which they cannot. Communication in SGM was a process that shaped the participants as much as they shaped it. Therefore, SGM participants avoided communication that overly shaped others or externally defined their experience, especially at the beginning of the dialogue. Bakhtin held that people have a unique and irreplaceable perspective and interpret the external world from that perspective (Bakhtin, 1979/1984). He also called this uniqueness of perspective "excess (Surplus) of vision" and pointed out that no other person can fully define it. Thus, we interpreted the SGM participants as creating a dialogic space by permitting candid criticism of each ideology arising from the unique "excess of vision."

The synchronization of images and body movements as a basis for loving relationships

Second, we show that these repeated attempts to understand others cause images and body movements to synchronize. This study suggests an attempt to understand others eventually encourages participants to feel several emotions related to love through the synchronization of images and body movements. We describe the impact of the images and body movements of SGM participants on interpersonal connections and love.

Nurse D. said listeners perceive Moyatto when they hear about the speaker's experience of Moyatto. Nursing faculty E. agreed and stated that just listening to others' experiences makes her feel as if she is experiencing the other person's Moyatto. Indeed, IS observed they often said things like, "It makes my body hot" or "I am burning up!" Furthermore, IS found that when listeners respond with gestures and onomatopoeias, they often evoke specific images and body movements, not only for the speaker but also for other participants. Nurse D. pointed out that such interaction is common in SGM and described it as "Moyatto being contagious," as images and body movements related to Moyatto spread from person to person.

D. and E. expressed their excitement and *Moyatto* through the metonymies of increased body temperature and stated that these images and body movements related to *Moyatto* spread from person to

person. Therefore, we interpreted the SGM participants as having felt several emotions related to love, such as linking, friendship, and respect, through synchronizing images and body movements.

However, IS does not always feel these positive emotions. Like most meaningful interactions, interactions in SGM are often characterized by a complex mix of emotions, which can include both positive feelings and negative ones, such as anger and pain.

The pain accompanying the critical transgressions

In the SGM, participants share their own experiences, but most of the session time is spent listening to other participants' experiences. When listening to others, IS sometimes felt as if he was being affirmed or criticized for his shared experiences and himself (even though others have no intention to do so). We describe this as a moment of what Bakhtin called transgression when the speaker (who becomes the listener after speaking) feels that their safe and familiar environment has been invaded by the outside world.

> *In IS's experience, a situation that is difficult to overcome in interprofessional dialogue relates to professional "guises." For example, in an online session, Nursing faculty F. stated that once some doctors judged that an elderly patient had cognitive decline, they often did not ask the patient to make treatment decisions. Indeed, doctors tend to choose not to disclose a diagnosis of dementia if the diagnosis is uncertain or effective treatment is lacking. Of course, there is a general consensus among physicians that patients have a right to know and understand their diagnosis and treatment. However, many doctors do not inform dementia patients of their diagnosis because they do not want to cause the patient emotional distress. Doctors then tend to focus on the "outcome" rather than the "process" of communicating a diagnosis and consider themselves "out of a task" if they find the diagnostic disclosure or treatment ineffective. They do not express their own guilt of not being able to do anything because they believe it is their "official" role to do so. This faculty member was not directly criticizing IS's behavior. However, when IS thought she criticized his way of working as a physician, which is task-oriented, has clear outputs, and is split between public and private, IS experienced pain due to the transgression; he thought he was being denied the guise of a physician. Interestingly, Nursing faculty F. seemed completely unaware that IS was experiencing such distress. She did not comment on IS's reaction. She mentioned the doctor's guise to share her experience, and as a result, she accidentally caused IS distress.*
>
> *Furthermore, the pain that accompanied these transgressions often triggered a variety of emotional responses. At times, IS almost dismissed other professionals' displays of emotion as unprofessional behavior or tried to hide his experience of pain accompanying a transgression. Despite his efforts, the distress lasted for some time, and as one participant after another shared their experiences, his emotions changed abruptly. It was an entirely accidental change. IS felt a connection and respect for the experience of Nurse G., which diverted his attention from the pain. But IS again felt anger and pain for Social worker C. The pain changed, but another pain was created and then disappeared. After a while, IS became obsessed with the idea of sharing the experiences he had recalled.*

Professional roles, identities, and practices are a part of the professional guise, and the pain accompanying the transgression is more likely to intensify when criticisms in the dialogue are directed under these guises. However, physicians are not always accustomed to dealing with emotions, such as anger and love, which are usually hidden under their professional guise. In this study, IS felt as if he was personally being affirmed or criticized by Nursing faculty F. and Social worker C. This may be partly due to the medical education that IS received. In medical education, Cartesian dualities, such as mind/body and reason/emotion, are partially perpetuated (McNaughton, 2013).

Furthermore, with the added effects of scientific and technological developments, physicians discover early on that "emotion is a corruption of reason that needs to be transcended" (McNaughton, 2013, p.72). Therefore, physicians tend to think: To be a good doctor, one must evacuate emotion from reason. Expressions of emotion are to be avoided, and if they cannot be avoided, they must be disguised (MacLeod, 2011). Such individuals may be so preoccupied with suppressing emotions that they may have difficulty investigating and critically examining their guises.

"Not listen too much"

In a session, three participants, C., F., and IS connected with participant E. through imagery and body movements and strived to walk in each other's shoes, sharing their own experiences. In this section, we describe this process.

> *In the session, Nursing faculty E. described her experience of Moyatto in a psychiatric ward when she accompanied a student as a practical training supervisor. That ward housed a patient with borderline personality disorder. The ward nurses were supposed to consult with a specific nurse when they were approached by that patient rather than making decisions by themselves. The students seemed to question this rule. The student wondered why most nurses did not make decisions since she believed that an ideal team would be one in which all team members know how to respond and provide the same nursing care no matter who responded. Asking the student more specifically, the nursing faculty member learned that the student wondered why each role was determined and why the nurse did not listen to the patient kindly when requested to do so. This student seemed to see the role of the nurse as offering kindness, compassion, love, and respect with all her being to the needy person in front of her.*
>
> *In response to these narratives, Social worker C. in SGM offered the following team perspective: "The ward nurses are not just sharing information, they are sharing the responses. This is a form of team response, in my opinion. Does this mean that it was not sufficiently "team-like" for that student to have one person making decisions? The student assumed that the nurses should be an ideal team, but in reality, the ward nurses had already developed the usual team. What does it mean to be sufficiently team-like?" Nursing faculty F. spoke about professional boundaries and pointed out the following: "Professionals think they are being helpful by taking on patients' problems, even though they are the patients' problems, not their own. Then, they cannot refuse all requests. They are at the mercy of their sense of duty to listen. And by overstepping their boundaries as nurses, they disrupt the team." In addition, from the perspective of the professionals' vulnerability, Nursing faculty F. expressed the following opinion: "The ability to maintain professional boundaries depends on one's awareness of personal vulnerabilities. Strategies that aim to understand patients and families from the professional's personal perspective often end in excessive attention to the professional's reactions, thereby impairing the professional's ability to help. The question is whether we have the strength not to overstep boundaries. It is necessary to be aware of one's vulnerability, which is at the mercy of the patient."*
>
> *IS was reminded of another Moyatto experience. The topic of professional boundaries and vulnerability triggered him to recall his own experience with the handling of death in his medical education. Medical education separates life from death, often pushing death into the private sphere. Of course, it does deal with "medical death." Conceptualizing death as biomedical death, separate from the professionals themselves, allows physicians to maintain an "appropriate" distance from death. As a result, physicians learn how to handle death medically, but not how to handle death in their personal lives. Yet, like love, death is clinically unavoidable and intense, and it haunts most physicians. The difficulties in dealing with a dying patient seem to be intensified when the patient reminds them of someone close to them who has died. IS shared his memory*

> *of when one of his psychiatric patients committed suicide. "There was little opportunity in medical education to consider how death in the healthcare field affects physicians or their personal side. I was unprepared for the emotional toll of a patient's suicide. I was heartbroken by my patient's suicide; I mourned him. But as a physician, I could not do it publicly. I wanted to attend the funeral, but my supervisor stopped me. I was not allowed to do that."*

In the SGM, participants C., F., and IS experienced a sudden urge to share their own experiences, and they did so, one after another, while simultaneously trying to understand Nursing faculty E. When these participants recalled their *Moyatto* experiences elicited by others' narratives, they tended to leave their experience as it was without pondering its nature. They did not consider whether the experience was useful to others. In education for health professionals, attentive listening rather than impulsive assertion is implicitly valued as assertions are seen as more confrontational (Fook & Askeland, 2007). We interpreted SGM participants as focusing both on attentively listening, and on not listening too much so that the session does not end up being just one person's shared experience.

The key point here is that participants resist the dominant ideologies in healthcare settings, such as problem-solving and attentive listening. As individual agents, SGM participants conducted everyday resistance to ideologies automatically accepted in accustomed environments, which Bakhtin called "automatization." If more time and effort are devoted to one person, the other participants strive to play a role in helping the speaker solve a patient-related problem. If all participants aim to solve the problem, they come to regard situations where the problem remains unresolved (*Moyatto*) as abnormal; they also become preoccupied with eliminating only the prominent parts of the complex problem. However, that problem is *Moyatto* because it cannot be solved immediately. If the problem can be solved in a short time, it is less *Moyatto*. Hence, in the SGM, the speaker impulsively starts and continues speaking, whether the participants are listening or not. The goal is not to solve the problem but to understand the situation in which the problem occurred, gain new perspectives, and reconstruct one's own experiences (Sano et al., 2023). This one-sided attitude often gives the listener freedom to choose whether to listen or not. Participants can listen hard to put themselves in the other's shoes, or they can surrender themselves to the urge to share their experiences. In other words, the implicit rule, "Not to listen too much," removes the burden and role of listening and problem-solving for one person from the participants.

Giving without expecting anything in return

As previously mentioned, love in Japan is generally defined as a longing or craving for something that is not one's own. In other words, love is the motivation to acquire something owned by another person, but SGM participants express a different kind of love.

> *IS initially attended this session with the intention of sharing his Moyatto experience prepared in advance. However, once other participants shared their experiences, IS became obsessed with the thought of sharing the experience of patient suicide that he had recalled at that very moment. In other words, IS unintentionally tried to respond to the narratives and cries of others. However, the thoughtlessness of this crying seemed to go beyond what was acceptable. As for Moyatto, IS did not cause that Nursing faculty E. distress. IS was not obligated by legality or common sense to help her. IS had no supervisory relationship with the nursing student or a therapeutic relationship with the patient. IS was not to be blamed or punished for sharing another experience that he had prepared for in advance. However, as much as IS tried to shake off his responsibility, IS was compelled by the cry to share that very obsession. In other words, IS shared his experiences of the patient's suicide for the sake of others.*

Levinas described this impetus to action as "compulsion" when the other makes me, and only me, ethically responsible for the other's *Moyatto* (Levinas, 1974/1981). For Levinas, responsibility is bestowed

on us, unasked. It is a sort of scream, a cry, that cannot be denied, even if one wants to (Welten, 2020). IS responded to the narratives and cries of others and shared his *Moyatto* experiences. More precisely, he was compelled to share. This finding suggests that it is love that forgives, even if a part of themselves is taken away. In this way, the first step for professionals to experience love in their professional practice is to give without expecting anything in return. The participants who were given love may have liked others' experiences and gained insights from them.

According to Nurse D., this situation is described as "having their experience drawn out by others," "leaving one's own experience 'there' without knowing how it will be used and by whom," and "taking from 'there' any experience of others that one favors as well." The term "there" does not simply refer to a physical online space but to a specific place named by certain people (in Japanese, "*Ba*"). A *Ba* connotes the transformation of space into a different place, depending on the participants and the experiences shared at that time (Kajimaru et al., 2021). Each participant shares their own experiences and perspectives, and they take away whatever they resonated with from that *Ba*. However, rather than "sharing" one's experience, it is more accurate to describe it as "giving away" a part of one's self because experiences are "drawn out" and "taken" by others.

"Loving" in SGM

At the end of this section, we describe other participants' experiences that IS loved for a long time after the SGM.

> *In the SGM, IS shared his experience of one of his patient's suicide in response to Nursing faculty E's narrative. Once IS began talking about his own experiences, the other's alienness (which Levinas calls altérité) that had been compelling and obsessing him so strongly suddenly became less palpable. Now the experiences of the nursing faculty became "his," which he used to share his experiences. They became tools for his activities and temporarily lost their alienness.*
>
> *However, the others' alienness that haunted him during this session was very impressive. The impressive alienness was, in Levinas' words, an "enigma," and it left him with the sense that he had encountered an unprecedented intelligence (Levinas, 1987). IS could understand some of the words spoken in the SGM, but still could not understand most of them. Then, suddenly, seven months after the session, IS finally understood the meaning of the experience shared by Nursing faculty E. It was an experience wherein IS was guided by the facts pointed to by Nursing faculty E's alienness, and IS's experience illuminated the depths of Nursing faculty E's alienness.*
>
> *Six months after the SGM concluded, the experience first manifested in the healthcare setting, where IS also works. It occurred when one of the young residents suspected the onset of a new physical illness in a patient admitted to the psychiatric ward. He delayed in referral to another physician, and the patient's condition worsened, prompting the ward nurse to complain. IS happened to overhear two ward nurses at the nurses' station saying, "What the hell! It's too late to write a letter of referral now, isn't it?" and "He's wishy-washy." Indeed, this resident had a strong sense of responsibility and believed that he alone was ultimately responsible for his patients. Furthermore, he was ashamed of his lack of knowledge and was not good at seeking advice from others. As a result, he sometimes made decisions on his own and missed opportunities to intervene. This resident seemed to be struggling with the gap between "what he should ideally do as a doctor" and "what a doctor actually does in the field." From the perspective of this gap, IS was suddenly reminded of the experience shared by Nursing faculty E. regarding the nursing student: it could be understood as a gap between "what she should ideally do as a nurse" and "what a nurse actually does in the field." Yet, "something" more seemed to "appear without appearing" in the Moyatto of the resident and nursing student. According to Levinas, "enigma" is*

like this something: "a way for the Other to call for my recognition while preserving its incognito" (Levinas, 1949/1998, p.209).

The second was when IS attended a conference seven months after the SGM's conclusion. Again, "something" was on the tip of his tongue, but IS was puzzled and at a standstill, not knowing what that "something" was. Haruta and his colleagues made the following points at the conference (Haruta et al., 2023). Healthcare professions students are allowed to review and renew their stereotypes of professionals (e.g., doctors as superheroes) after entering school (Green, 2015). This gives students a realistic understanding of the profession but little opportunity to understand the professional conduct and practice expected by specific others (Haruta et al., 2023), in part because medical and other healthcare students are rarely directly observed and given feedback during their clinical placements (Burgess, & Mellis, 2015). In addition, students, especially in their early years, do not fully understand their profession (Tong et al., 2020). According to Bebeau and Monson (2011), during this period, most healthcare students conceptualize their professional identity as meeting concrete profession-specific role expectations. For example, first-year nursing students may view their nursing identity as only carrying out nursing-specific duties correctly. In comparison, students in their later years develop a greater understanding of how the roles and responsibilities of their own and other professions contribute toward client-centered care, which aligns with the purpose of interprofessional education. As they mature, they come to self-define the profession by understanding the professional conduct and practice expected by specific others (Rees et al., 2019).

From this perspective, the nursing student may have been allowed to rethink their nursing identity, which had been viewed as only carrying out nursing-specific duties correctly. On the other hand, the resident, though troubled, was already at the stage of going out into the clinical field and understanding what was expected of them as physicians by specific others, such as ward nurses. From the perspective of professional identity formation, IS got a better understanding of the experiences of the nursing student and resident.

Thus, even after the conclusion of the SGM, IS kept recalling others' experiences that they favored. Here, the feeling of "favored" is a positive evaluation of others and/or others' experiences and cannot be distinguished from the temporary feeling of "liking" (i.e., fondness). Furthermore, positive evaluations of these may continue after the SGM, such as "the experience shared at that session was good," and so on. However, such "continuous liking" and "loving" seem to be different. The former is merely an ongoing evaluation of others and/or others' experiences, whereas the latter refers to the process in which the emotional experience persists. In other words, the process itself is the emotional experience of love, such that one's evaluation becomes positive or negative because they are no longer sure what this positive or negative experience is about but they still decide to remain committed to this experience (Yamane, 2008). The process by which IS remained committed to something was, indeed, a loving experience.

Consequently, IS was able to exchange his *Moyatto* experiences through interactions without direct conversations after the conclusion of the SGM. The other's alienness that IS experienced during the SGM mandated that he leave a part of himself behind, and after the SGM's conclusion, it continued to give him something that might always be an enigma. It took seven months after the online session for that something to turn out to be related to professional identities. Initially, IS thought he was giving, but he was actually receiving. At the beginning of the SGM, IS shared his *Moyatto* experience without any quid pro quo. Perhaps this is because this kind of enigma gave IS something. Similarly, other participants might have been able to give without seeking something in return because they were given something else by someone else. Without that something, it would have been difficult to continue giving love through self-sacrifice.

Discussion

In this study, we explored the experiences of love in online sessions and how emotions such as love may work as factors for overcoming the pain, which accompanies the critical transgressions that inevitably arise in dialogue with others. Furthermore, this section focuses on areas where the realities of loving *Moyatto* experiences in dialogic interactions among professionals were more nuanced than the research team initially anticipated based on reading the current literature. The research question here is whether love as a factor in overcoming the pain accompanying the critical transgressions that inevitably arise in SGM dialogue can be explained by polyphonic love, and if not, what can explain it.

This study revealed that participants used their body gestures or onomatopoeia and understood others through trying to avoid defining the other's experience externally or appropriating their words. In other words, participants permitted candid criticism of each ideology arising from the unique "excess of vision." This attempt to understand others could serve as a basis for loving relationships between participants and encourage them to overcome difficult emotions, such as anger and pain, that were generated by their dialogue. Moreover, we discussed how the participants separated their experiences from others' experiences. They were in tension between standing their ground on their own experiences and being profoundly open to others and other experiences. In other words, they were able to choose their level of involvement in the dialogue, engaging fully in it or not listening too much. By focusing both on attentively listening and on not listening too much, participants routinely resisted the dominant ideologies in healthcare settings. Their own experiences could be given to other participants without any quid pro quo. In this situation, they just presented their experiences and did not immediately seek solutions. This had a long-lasting impact on the participants' professional experience.

Furthermore, the analysis of the interaction in the SGM revealed the appearance of love through which the professionals forgive, even if a part of themselves is taken away. Participants C., F., and IS responded to the narratives and cries of others and shared their *Moyatto* experiences. In other words, the first step for professionals to experience love in their professional practice is to share their *Moyatto* experience without any quid pro quo and in response to others' cries. When participants recalled their *Moyatto* experiences elicited by others' cries, they tended to leave their experience as it was without pondering its nature. Participants C., F., and IS experienced a sudden urge to share their own experiences, and they did so, one after another, while simultaneously trying to understand Nursing faculty E. They did not consider whether the experience was useful to others. Participants may have liked others' experiences and gained insights during the session. Even after the session was over, the other's alienness continued to give IS something that could not be verbalized, referred to as "enigma." It took seven months after the online session for that something to turn out to be related to professional identities. Therefore, the interactions comprising the exchanging of their *Moyatto* experiences could continue even without direct conversations, and those experiences could motivate participants to inquire about perspectives unknown to them.

This process may be partially explained by polyphonic love as a factor for overcoming the pain accompanying the critical transgressions that inevitably arise in dialogue with others (Bakhtin, 1990; Tajima, 2021). Indeed, SGM participants felt several emotions related to love through the synchronization of images and body movements. Three participants, C., F., and IS connected with participant E. through synchronization; they strove to walk in each other's shoes while sharing their own experience, a process that can be explained by polyphonic love. Such polyphonic love, that is, acquired affection for the other, helped SGM participants overcome the pain accompanying the transgression in the online sessions. In contrast, there were no situations that required homophonic love or monologue interactions in which professionals transferred existing ideologies without criticism.

In this study, however, professional love is not a longing or craving for something that is not one's own, but something that comes up in response to others' cries, as in the case of affection (情 *Jou*). This type of love does not take away but instead forgives even if a part of the individual is taken away. Furthermore, while Bakhtin believed that estrangement originated in communication, the SGM participants focused on something that caused estrangement both in the dialogue between speakers and in the recalled narratives. Nursing faculty E's alienness was experienced by IS during the SGM and continued to give him something related to professional identities after the SGM's conclusion. The process of remaining committed to such something was, indeed, a loving experience, but it is difficult to explain the process only in terms of polyphonic love.

The process of these actions can be regarded as *Mederu,* a Japanese sense of loving with which people are willing to observe and take care of the diverse elements of others or objects with passion. It is a sense that comes up in response to others or objects in the same way as affection (情 Jou). IS's *Mederu* also began by responding to the narratives and cries of others and sharing his experiences. IS observed Nursing faculty E's alienness that IS experienced during the SGM and continued to do so for seven months after the SGM's conclusion in an attempt to gain something (enigma) from its diverse elements. *Mederu* (愛でる) is a Japanese verb meaning "to adore a person, animal, plant, or other object" or "to admire its beauty or loveliness." The kanji for 愛 *Ai* is identical to the character for *Aisuru* (愛する), meaning to love (verb), and the two have very similar meanings. However, while *Aisuru* connotes taking a part of others as one's own, causing them to lose their alienness (Levinas calls this "possession"), *Mederu* has a different meaning. Instead, it is a way of loving that maintains their alienness, keeping a certain distance from an object and observing or watching its various aspects. This seems consistent with the practice of SGM, which aims to understand others without appropriating their words, but gaining new perspectives on their *Moyatto* by keeping a certain distance even after the sessions are over.

Unlike loving, *Mederu* allows us to perceive the fleeting beauty in an experience that cannot be identified or denoted by a single moment or image. The other's alienness in SGM was so impressive that it had compelled and obsessed IS but was so fragile that once it became "his," it suddenly became less palpable. This kind of fragile beauty is called "*Mono no Aware*" and creates a powerful experience for the observer because it must be fully enjoyed in a specific period (Prusinski, 2012). We can also feel "*Wabi-sabi*" by admiring (*Mederu*) the object (Prusinski, 2012). *Wabi-sabi* depicts a crude or often-faded beauty that correlates with a dark, desolate sublimity. Nursing faculty F. noted that there is a hidden sense of duty in the unprofessional act of crossing professional boundaries. She also argued that such awareness of one's vulnerability can lead to strength in not overstepping boundaries. In this way, *Moyatto* experiences often shine a light on both the dark and desolate side of healthcare and on the sublime professionalism and commitment of the professionals who work there.

According to Prusinski, Japan has always been a nation focused on beauty in all realms of culture, such as poetry and calligraphy, manifesting through rituals such as ancient tea ceremonies (Prusinski, 2012). Indeed, the oldest extant collection of poetry in Japan, *Man yoshu*, also describes *Mederu*, the act of admiring beautifully colored landscapes (Vovin, 2017). Even today, people in Japan admire (*Mederu*) flowers and pop idols (Fumio, 2023; Kakin, 2019). Here, beauty does not lie in the object itself but in the entire experience, transformation, and timespan in which the object is present and changing (Prusinski, 2012). Nursing faculty E's alienness that IS experienced during the SGM continued to give him something (enigma) for seven months after the SGM's conclusion. During that time, unexpected encounters with young physicians and researchers in clinical and academic settings revealed that this something was related to professional identities. In other words, the object of beauty that IS admired (*Mederu*) was present and changing. IS admired (*Mederu*) the beauty of the whole experience, transformation, and timespan in which the enigma was present and changing. In this way, the view of beauty as temporary and unstable rather than eternally fixed and spatial. It cultivates the Japanese sensitivity to beauty, which is called situational

beauty (Takashina, 2018). Such long-term admiring (*Mederu*) for situational beauty may be possible because the SGM participants continued their dialogue with the same participants for several years, even if it was for an hour each month.

Finally, we discuss how the SGM, as a place to admire (*Mederu*) experiences, can contribute to health profession education. We argue that the SGM provides dialogic places where people can be receptive to and responsible for others through sharing *Moyatto* experiences. The responsibility here is a sort of cry that requires us to respond to other's alienness and to share our *Moyatto* experiences. The SGM can provide an ideal opportunity for critical reflection on the context of patient care, the busy healthcare environment, professional attitudes towards collaboration, educational backgrounds, and the dominant ideology in healthcare. We have little opportunity for critical reflection on these social structures, and rather than viewing the current state of healthcare as non-dialogic (e.g., "in our society, health services are increasingly run for profit and that society makes dialogue difficult"), we seem to have already internalized non-dialogic beliefs (e.g., "A person's success in life is determined by his or her personal rather than by society and dialogue is not helpful to its success") (Card & Hepburn, 2023). In contrast to the worldview of healthcare, which often divides emotions and pains into separate categories and refers to them as something that must be overcome logically and objectively in the private sphere, the SGM emphasizes a dialogic framework that deals with professional love for overcoming the pain accompanying the critical transgressions. The SGM can provide more sustainable and stable educational resources, as this professional love may be needed at various points in a professional's career. Moreover, the SGM can facilitate the transitional learning across professional and disciplinary boundaries that is necessary for excellent patient care (Sano et al., 2023).

We suggested that the online sessions allowed professionals to detach themselves from preexisting professional roles, identities, and practices in the "official" healthcare settings. Specifically, the following rules were created and adopted to make it easier for participants to take a break from their professional roles. 1) Keep the group size appropriate; SGM participants are recruited for the workshops when needed. 2) The participants decide the content and timing of the workshops. 3) Each participant is free to withdraw or suspend membership. 4) Other healthcare providers can participate in SGM only once, but in this case, all members of the SGM must approve the participation. 5) Each person is referred to by the name that they wish to be called. However, honorific titles such as "sir" that create a hierarchical relationship should be prohibited. 6) The lead author assumes the role of the organizer, but everyone takes turns as the facilitator and secretary of each meeting. 7) Information on interprofessional collaboration (education) is shared via social media or e-mail. These educational designs may have allowed SGM participants to take a break from the "official" healthcare field and engage in a cycle of giving and receiving each other's experiences as they interact with others and the environment.

The professional self is also born as a dynamic entity within this cycle and is, therefore, both interdependent and dependent on developmental pathways. In other words, the self appears differently depending on who and how individuals meet. This is not a view that assumes a rational self and pushes an aspect of the self into the private sphere, but one in which people have more than one "self:" one self in the healthcare field, one self in the SGM, and one self at home. Consequently, there is no contradiction between being a doctor who does not express emotions in the healthcare field and a participant who speaks enthusiastically about *Moyatto* in the SGM. Ikegami (2005) referred to the "publics," i.e., communicative sites that emerge at the points of connection among various networks and argued that they are places where these various "I's" can grow. During the Edo period (1603–1868), Japan already had many publics wherein multiple people gathered to create art forms such as poetry (Tanaka, 1986). People from various social backgrounds - from commoners to retired emperors - could participate in these group gatherings regardless of status. Individuals participated in these publics using multiple names and, thus, mastered the talents of embodying multiple "I's." The SGM can also be regarded as a publics that is free from official

order, where people of various backgrounds can associate on an equal footing, engaging in a dialogue characterized by *Mederu*.

To create an estrangement-based dialogic place, we argue that participants need to be given freedom and power by other participants. Participants are only freed from their professional guise by leaving not only the healthcare practice but also the specific other who expects them to wear it. By using onomatopoeia and gestures, participants can give the recipient the freedom and power to create various perceptual images. They can create loving, safe, and familiar connections by exposing vulnerable bodies that are often excluded in healthcare settings and synchronizing their images and first-body movements. Participants release themselves from the attentive listening that is valued in education settings for healthcare professionals and engage in impulsive assertions that are seen as more confrontational because participants respond compulsively to other people's narratives and cries. However, participants share their *Moyatto* experiences because they accidentally happen to be there, and they are specifically free to share or not. Such freedom and empowerment can foster multiple I's: "I" who blame myself for not being able to prevent my patients' suicides as a psychiatrist, "I" who wanted to go to a funeral that would allow me to properly mourn and grieve over the loss of my friend, and "I" who should follow the advice of the supervisor closely as a supervisee. Each "I" has different emotions: anger, sadness, and respect.

The conflicts (*Moyatto*) between the multiple I's are specific to the person. Furthermore, the "I" then and the "I" now are not necessarily the same. Even when performing the same act of talking about a patient's suicide, the first author transforms into a very differing 'I' and have very different emotions based on the situation. This accidental and collective engagement of these highly unstable multiple "I's" creates an estrangement-based dialogue (Bakhtin, 1979/1984). For professionals who intend to step into the estrangement-based dialogic place, the Japanese concept of the publics and the *Mederu* Japanese way of loving presented here will be helpful.

Limitations and further research

The use of reflective writing brings forth both limitations and advantages of the study (Jasper et al., 2005). We acknowledged at the outset that what is presented relates and purports to the experiences and perceptions of the first author. Reflective writing is, by its very nature, written in the first person and is, therefore, essentially subjective. This nature draws attention to the fact that there is no one objective reality that every presentation is a construction of that reality, according to the writer (Jasper et al., 2005). It can also be seen as an asset for the use of reflective writing in research in that it makes visible aspects of the researcher that might otherwise be hidden, such as emotional pain and dialogue with oneself.

However, to properly understand dialogue and love as a mutual act, it may be necessary for further research to know what they are for the participants. All data types must be triangulated within the process of constructing understanding to enhance credibility (Scanlon et al., 2002). For example, ethnomethodology aims to study the ways people coordinate and make sense of their everyday activities, including dialogue and love (Ten Have, 2004). It could produce significant knowledge about how professionals interact in online sessions, clinical settings, and everyday life and how these interactions are constituted as being dialogue and love. According to Ten Have (2002), "by following professional practices in detail, ethnomethodology can show that and how a professional practice is embedded in quite ordinary competences, and also elaborate that and how it is special, in the sense of being part of a particular local version of a more generalized professional culture." Unfortunately, this study only covers reflective data during and after the online sessions and does not follow professional practice in detail.

Concluding remarks

This study revealed the love of healthcare professionals for colleagues, while previous studies talked about the love of patients for doctors. Through this study, we argued that the love of healthcare professionals for colleagues could be considered and discussed more. Although the love between patients and doctors has been one of the topics in medical education, the love among healthcare professionals is a new perspective to the field. In addition, our study could provide a new perspective and new knowledge about how we could explore ways of relating and communicating with others. The Japanese concept of the publics and the *Mederu* Japanese way of loving will be helpful, especially for professionals seeking to step into the estrangement-based dialogic place. To develop a community into this dialogic place, we argued that professionals need to detach themselves from preexisting professional roles, identities, and practices and give freedom and power to each other.

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APENDIX A: Demographic Characteristics of Research Participants

Participant	Gender	Age	Profession	Institution	Status	Years in professional (faculty) career*1
C	Female	66	Social worker	NGO*2	Staff	28
D	Female	54	Nurse	Hospital	Ward manager	20
E	Female	46	Nursing faculty	University	Staff	21 (14)
F	Female	63	Nursing faculty	College	Professor	42 (21)
G	Female	37	Nurse	Hospital	Staff	16
H	Female	50	Social worker	Hospital	Staff	17
I	Female	50	Nursing faculty	College	Professor	25 (21)
J	Female	56	Nursing faculty	College	Staff	35 (2)
IS*3	Male	44	Physician	Hospital	Chief physician	18

*1 "Years in professional career" refers to the period from professional qualification to the present (September 2022), while those in faculty career refer to the period during their working life in an educational institute.
*2 NGO: National Government Organization,
*3 IS: First author