

Change of Ideal and Practice on Patient Education in the Postwar Period

Kiyoka Niiya¹⁾

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ABSTRACT

This research outlined how the nursing education of patients grew from the end of World War II to the 1980s, and examined its various implications using documentary research methodologies centered on collecting, interpreting, and analyzing archives. From the standpoint of patient education, I aimed to establish a more effective setup within continuing practice, emphasizing the basic principle of moving from a nurse-centered to a patient-centered approach and incorporating an interdisciplinary methodology combined with practical thinking centered on behavioral sciences and self-care. This is the process of moving from the provision of abstract and generalized to specific and individualized information; teacher-taught to mutually supportive relationship; unidirectional leadership to practice based on behavioral science; and issue resolution to clarification. By adapting to practical action in this way, patient education has grown methodologically both from an interdisciplinary perspective and as an independent field of study.

Introduction

Nursing in Japan was once not established as an independent work. It was only sought as subsidiary work under doctor's guidance. Under this situation nursing reforms initiated by members of the American occupation forces after the Second World War became a strong promoter of improving it. The Occupation Administration reformed public health, nursing service, and nursing education. It also made efforts to improve patient education as a subset of nursing reform. Yet, medical treatment was given priority over education in nursing at that time, therefore, there were few nurses who recognized the necessity of patient education.

The transformation from cure-centered medicine to care-centered medicine in the 1970s, however, questioned the practice of nursing education by making patient needs involved deeply in medical care. The question to be asked about nursing education was not about the enlargement of nurse's role awareness and area of interest on it but about how nurses incorporated their own perspective of nursing practice into helping for patients.

Patient education from the perspective of nursing was introduced from the United States into Japan's nursing community in the 1970s and the 1980s. Following books were such examples: Machiko Takeyama's *Kanjya kyouiku no puroseseu (The Process of Patient Teaching in Nursing)* (1971), Fumikazu Sato's, *Seijin-byo kanjya kyouiku no jissai (The Actual Situation of Education for Patients of Adult Diseases)* (1971), Hikaru Horiuchi and others, *Tounyoubyou kanjya kyouiku no riron to jissai (Theory and Practice of Education for Diabetic Patients)* (1981), Misako Kojima's *Kanjya kyouiku no tame no jissenteki apurouchi (Practical Approaches to Patient Education)* (1986), and Yuko Minami's *Mansei shikkan o ikiru (Chronic Illness and the Quality of Life)* (1987). These books which were published at the exact moment of the appearance of patient education in Japan were highly conscious of the importance of patient education on nursing.

Teruko Kawaguchi and Chieko Kawada were often mentioned as representative scholars who conducted an essential study of patient education. They delved into the new intellectual

sphere of patient education through a critical examination of conventional practice of patient education. For instance, it was discussed from the perspective of learning support model (Yoshida, Kawaguchi, and Kawada 1992), the perspective of problem-solving learning (Miyasaka and Kawada 1984), and the perspective of behavioral practice (Hinohara and others 1987: 179), and self-care perspective (Noguchi 1983: 46). At first glance the practice of patient education appears to have spread since the 1980s but we must not forget that there were attempts to construct "patient-centered" approach of nursing by predecessors and the accumulation of practice aimed for "the support of self-reliance" before the 1980s.

This research is aimed to understand patient education from a standpoint of nursing but it is insufficient to introduce "problem-solving methods" and "the method of support" for clarifying it. As long as it is taken for granted that the formulation of a problem as "patient education = nursing speciality", a variety of things related to patient education such as the role of nurses, their relationship with patients, how to practice it, and how it is perceived remain to be seen. Therefore, it is necessary to reexamine what was problematized and how it went through changes by analyzing actual cases of patient education. Some studies such as the works of Moriyama (2011) and Yamaguchi (2008) which reviewed the historical transition of patient education partly share the concerns of this study but they do not examine how the meanings and theories attached to nursing practice affected patient education.

Therefore, this research examines how patient education for nurses had spread through the readings of a variety of meaning attached to patient education by reviewing the transition of patient education for the postwar period from 1945 to the 1980s. For this purpose I focused on (1) the transition from nurse-centered educational view to patient-centered educational view, (2) the transition from teaching practice to behavioral scientific practice, and (3) the transition from problem solving to problem clarification. Educational views and practice are examined through these perspectives for the following reasons: (1) "patient-centered" was not understood as a monolithic meaning on the transition from nurse-centered- to patient-centered-educational views. The meaning of "patient-centered" was evolved into the universal value through the process of nursing practice. (2) On the transition from teaching- to behavioral-practice nurses were asked to get newly involved as study supporters when patient-

1) Faculty of Nursing, Hiroshima International University

Corresponding author. Tel.: +81 823 73 8395; Fax: +81 823 73 8992.
E-mail address: k-akutag@ns.hirokoku-u.ac.jp

centered patient education is conducted. This involvement was based on behavioral scientific practice. It has been the core of educational methods until now. (3) Problem solving shows that the question of “which solution is good?” can be answered only through educational practice from the nurses’ standpoint. On the other hand, problem clarification which tries to answer the “why” questions such as “why do patients make questions?,” “why do patients think so,” addresses the way how patients become self-reliant. In other words, it can be understood that it needs to clarify problems from the standpoint of patients for thinking about patient education from the perspective of nursing.

Based on these perspective it is examined what kinds of educational principles derived from practice and how they were linked to nursing practice?

I. Research Methods

This research collects, classifies, reads, and analyzes relevant literature as a clue to know the practice of patient education. The following literature was examined: Monographs on health education, hygiene education, and patient education, related legal documents on Ministry of Education, Culture, Sports, Science and Technology (MEXT) and Ministry of Health, Labour and Welfare (MHLW), academic journals of medical care and nursing, and nursing journals: *Kangogaku Zasshi* (1946-), *Iryo* (1947-), *Byoin* (1949-), *Kango* (1949-), *Kango Gijyutsu* (1955-), *Kango Kyoiku* (1960-), *Sougou Kango* (1966-), *Kango Kenkyu* (1968-), *Rinsho Kango* (1975-), *Kango Tenbo* (1976), *Gekkan Nursing* (1981-), and *Kango MOOK* (1982-).

Due to the shortage of papers and the GHQ’s control of publication few nursing journals was published from 1945 to the 1950s. The journals listed above are therefore characterized as crucial historical materials for clues about nurses’ educational philosophy of patient education and their practice. The investigation of historical facts were conducted by looking through all nursing journals cited above and examined the authenticity of historical documents and historical facts by cross-checking more than one articles. *Kangogaku Zasshi* was especially an important journal because it is the nursing journal which was published first, and not only nurses but also officials in the Ministry of Health and Welfare contributed articles to this journal (Kaneko 1994). Members of the editorial board of *Kangogaku Zasshi* was also writing articles in *Koto Kangogaku Koza*, the first Japanese textbook of nursing, therefore, I referred to this journal many times for checking the authenticity of historical facts.

According to Japan Academy of Nursing Science (2005), patient education aims to help a patient to learn the knowledge, techniques, and attitudes for disease management and life adjustment by himself/herself. In this research historical transition of patient education is examined, therefore, the words - *Eisei Kyoiku* (hygiene education), *Kenko Kyoiku* (health education), and *Hoken Kyoiku* (preservation-of-health education) which encompass the meaning of patient education were treated as parts of patient education for making disease management and life adjustment for patients.

II. The Transition of Educational Philosophy and Practice of Patient Education

How did educational philosophy and practice of patient education evolve? This article examines it from the perspectives

of (1) the transition from nurse-centered educational view to patient-centered educational view, (2) the transition from teaching practice to behavioral scientific practice, and (3) the transition from problem solving to problem clarification.

1. The Transition from Nurse-centered Educational View to Patient-centered Educational View

Few nurses perceived the importance of patient education from 1945 through the 1950s because medical care was a primary intervention in patients. On nursing service Mizuno (1955) noted that “all nursing service were for doctors and nurses were primarily asked to serve doctors,” showing doctors’ domination and nurses’ subordination during this period. It is undeniable that his view is a rough generalization because he ignored the cases of nurses who stood on the side of patients even against doctors or had more medical knowledge and experience than average doctors. Yet, it is also undeniable that hierarchy in medical community in the pre-war period continued to exist after 1945. Nursing reform after 1945 aimed for nursing service which tried to improve the health of patients with a help of doctors and sought nurses who were good educators for attaining this goal (Inoue 1951).

Yet, as Kaneko (1959) notes, “nurses can provide care to patients but cannot educate them very much. This is because they are not good at taking a leading role.” That is, it is pointed out that the main problems of nursing education is the lack of knowledge and leadership on patient education. Patient education was primarily conducted on tubercular patients at the behavioral level such as the teaching of the knowledge of tuberculosis and personal hygiene (Nakamichi 1951; Tsukahara 1957). Nurses taught standard cautions on diet, sleep, and activities to patients. They might be helpful for preventing expected complications and promoting medical care but its content was so abstract and general that it was totally detached from individual lives and experience of patients. The word *information* has been used widely since the 16th century. Its original meaning was the “teaching” by those who have knowledge but it began to have the meaning of “inform” and “convey” information, notices, or reports (Terasawa 1997). Patient education also offers information in the sense that it teaches the knowledge of diseases, informs what a doctor says, and conveys the information of medical treatment.

Educational relationship between a nurse and a patient is also based on the role relationship between the one who teaches and the one who are taught, implying that it is deliberate teaching relationship conducted between them. The nurse must possess knowledge and technique necessary for a patient and the patient must acquire it. Phrases such as “nurses teach...” and “patients are asked to do...” were often found out in literature review, suggesting that nurses become the central figures of patient education.

During the 1960s and 1970s the aging of population and the increase of those who had chronic diseases enhanced the role of nurses on patient education. Ministry of Health and Welfare also noted in its examination of expanded role of nurses that “medicine is not only the relationship between doctors and patients but also the relationship between nurses and patients. These human relationship is, so to speak, educational relationship and it is obvious that both doctors and nurses exist for patients” (1964). It was a major advance in patient education because the autonomy and self-reliance of

nurses was shown for the first time.

There was also a change of nurse's perception on patient education. It was originally recognized as a part of care but it has become more important as a tool to support the lives of patients as a result of the increase of the aged who had chronic diseases. For example, Yamagata, technical official at Ministry of Health and Welfare, showed the importance of patient education not only as the diffusion of knowledge on adult disease prevention but only from the counseling for patients with adult diseases (Yamagata 1961). Takahashi also noted the necessity of patient education from the perspective of livelihood support (Takahashi 1963).

Subjects of patient education were also expanded from tubercular patients to patients with adult diseases (Hinohara 1961; Hirayama, et al. 1967; Yajima 1967). The increase of educational practice prompts us to revise the standardized "teaching" methods. The following statements that "in order that each patient may understand and solve his/her own health problem we must support him/her indirectly" (Matsumoto 1969) or "nurses must give guidance to patients not with vague generalities of textbook knowledge but with specific and concrete details" (Hinohara 1971) suggest that a new method of patient education tailored to each individual patient is sought after by nurses. During the 1950s "teaching" was meant to tell patients general and abstract things but by asking concrete practice as individuality nurses have begun to notice a universalistic idea of "nurse-centered." That is, they have asked themselves a variety of "teaching" matters such as "who do they teach?," "where do they teach?," "when do they teach?," and "how do they teach?" through the practice of "teaching," making it a trigger to ask the educational view of "patient-centered."

Moreover, "l'education permanente" which Paul Lengrand preached at UNESCO in 1965 affected many educational scenes by prompting the study of adult development whose keyword is "lifelong learning." Its educational significance lies in the thoughts of "the power of self education" and the concept of "linkage" in which family education, school education, and social education should be conducted effectively (Lengrand 1971). In Japan the policy report titled "About the Role of Social Education Dealing with the Changes of Rapid Social Structure" which mentioned the role of the government on lifelong learning and its importance was submitted by Social Education Council in 1972 (the Ministry of Education 1971). The policy report of Central Council on Education titled "About Lifelong Learning" (the Ministry of Education 1981) also claimed that "adult education and learning can be matured only after each individual have enough motivation and autonomy to enlighten and improve himself/herself," emphasizing the importance of self-reliance and autonomy among each individual and of creating better educational environment and teaching skills for supporting it.

Lifelong learning has been conducted in a variety of places such as homes, schools, workplaces, and communities under the government's promotion. There is a thought of "learner-centered" under the basis of these wide range of learning activities. This transformation of educational views contributed to develop a new strategy in the field of health sociology and health education, making this principle a trend to affect educational practice profoundly as "a new perspective of patient education" on nursing. For instance, Iwasaki (1985) asserted that patients should not be regarded as subjects of medical cases but as human beings who engage in learning

by their own will. Ito (1987) viewed educational practice in which a patient learn by himself/herself with a focus on the differences in learning style between adults and children. Miya and Kawata (1985) also emphasized patient's autonomy and self-reliance. They notes that "patient education is to help a patient to acquire necessary knowledge for cure for disease and social rehabilitation, have an ability to use decision-making skills for medical treatment and social rehabilitation, and to possess attitudes and energy to work actively for physical and social recovery. In this way patient education had no choice but to have "patient-centered" awareness by a critical retrospection when patient education was grasped from the "learner-centered" perspective.

As a "patient-centered" approach the practice to promote self-control by developing learning materials and methods for encouraging patients' participation, such as the teaching of insulin self-injection (Seto 1985) and the introduction of educational hospitalization programs (Suenaga 1984) has been conducted. New patient education of "patient-centered" approach is also peculiar in that it tries to grasp psychology and behavioral process of each individual. Noguchi (1983, p.50) noted that we need to provide psychological help to patients in order to make them have human relationship that can express their own feelings freely, become aware of themselves, and notice what they have to do by themselves, so that they would become proactive about their own health. Kadekaru (1983) notes that it is important to understand how nursing involvement and practice contribute to the improvement of patient's daily life activities through the analysis of the facts of their behavioral process in a logical way.

Nurses must change consciously from educational practitioners to learning supporters in patient-centered learning. It is asked not only to tell necessary information to patients but also to teach how to learn it, necessitating behavioral science theory as a basis of this practice.

2. The Conversion of Teaching Practice to Behavioral Scientific Practice

In the 1970s and the 1980s the practice of health education which analyzes observable phenomena became very popular under the influence of the behavioral paradigm. For example, Hinohara et al. (1987) promoted self-monitoring of blood pressure and the 24-hour urine collection test toward local residents. In this case doctors initiated to make them check their own blood pressure and urine collection by themselves in order to induce them to form a good habit. A behavioral science approach has shown that direct experience is more effective as a new educational method than knowledge acquisition because it brings about high motivation and behavioral transformation (Hinohara 1987: 203).

In this way educational practice of behavioral science treats the questions of how health problems are solved as the process of "problem solving" between patients and healthcare practitioner and "mutual cooperative ties between those who help and those who are helped" (Munakata 1991). In "problem solving" approach patients are perceived as actors who take actions to improve their own health, therefore, medical experts are expected to help them in order to make their health behaviors effective. For that reason, there are many reports which set the goal of patients' behavioral transformation and examined how to help them to solve their own health problems by themselves in the practice of patient

education. Kumazoe, et al. (1987), for instance, reports that their behavioral therapy for patients with anorexia nervosa was effective in improving their eating habits. Kaneko (1987) also carries out an exercise therapy program as a method of problem solving for improving patients' lifestyle. The main goal of these practice is patient's behavioral transformation, so that they are expected to learn by themselves (e.g., "a patient can do something," or "a patient did something.>").

Japan Nursing Association (1973) proclaimed that "relationship between a nurse and a subject is considered to be an interactive process as a collaboration between them in order to achieve a particular goal." This proposal contributed to change the relationship between a nurse and a patient from "educational relationship" to "relationship for mutual cooperation." Iwata (1986) notes that nurse's emotions and languages have great effect on the construction of interactive relationship between a patient and a nurse. Nakagawa and Nakashima (1987) also state that nurses should listen to patients' complaints patiently and be sensitive to their emotions in order to construct mutual cooperative ties with patients.

Relationship between a nurse and a patient had been usually shaped vertically (those who teach → those who are taught) but in mutual cooperative ties based on behavioral science theory patients aspire to discuss and deal with problems by themselves. Therefore, the terms "help" and "support" are more likely to be used than the term "educate" in this practice. Fukase (1987) notes that it is "not patient education but support or help. It is not taught from the top but relies on horizontal relationship. That is, education nurses conduct here is to help patients by constructing informal relationship between them." In this way she explained the significance of using the terms "help" or "support" their study instead of the term "educate." Some may think that the terms "help," "support," and "promote" which are used for expressing educational activities would degrade the value of "education." But in mutual cooperative relationship they are useful for reexamining the importance and appropriate ways of "education" through the analysis of educational practice by using these terms.

Reflection on the practice of patient education has been practiced on a variety of individual and organizational activities. It has been influenced by learning and analytical views focusing on behavioral science, questioning the practice of "those who educate – those who are educated." Asking this question has contributed to situate the significance of behavioral science approach on the field of patient education and clarify practical meanings of patient education.

Behavioral scientific practice has contributed to develop patient education by bringing about a new approach but some practice has been ineffective in causing behavioral changes of patients by just applying theoretical prescriptions to patients without contextual considerations. There was a tendency to evaluate its utility by checking whether it can be useful as a means to contribute to behavioral changes, thereby theoretical foundations of behavioral scientific practice is rarely problematized. Some people also raised questions about the basis of behavioral science (Watabe 1985: 61).

Practical methods that focus on behavioral change in patients tend to focus more on their behaviors than on nonbehavioral aspects of their livelihood, so that we tend to be unconscious of the latter. Therefore, we failed to direct our attention on nurses' limited understanding of the questions of "what is patient education?" or "why do we have to engage in patient

education?". In order to think about the meaning of an act of patient education we must look through the significance of patient education from the standpoint of nursing. The purpose of patient education is deeply committed not only to the solving of health problems but to patient's needs and self-reliance. The important perspective on this point is patient education captured from the perspective of self-care.

3. The Transformation from Problem Solving to Problem Clarification

The concept of self-care has existed since the era of Florence Nightingale and has been utilized in clinical nursing. Hildegard E. Peplau also used the term "self-care" in the 1950s but one of the most active promoter of "self-care" is Dorothea E. Orem. She noted in her book titled *Nursing: Concept of Practice* (1971) that adults are independent and are expected to take responsibility for well-being of their own and of those who depend on them and self-care is the practice which should be pursued by their own initiative in order to maintain and promote their own life, health, and well-being. She also talked about teaching skills for assisting subject's self-care behaviors. Primary Health Care was declared (Declaration of Alma-Ata) in 1978 and self-care activities through one's own efforts and responsibility started to be pursued actively in Japan (Inada 1987). Health and Welfare Ministry announced in its *The Mid Term Report of General Task Force of National Health Service* that "it starts to put through reforms in a direction to focus on the perspective of self-care that one's own disease must cure by himself/herself, hence contributing to enhance the interests of self-care (Health and Welfare Ministry 1987). The term - "self-care education" in place of patient education has also been used. Lowell S. Leving made distinction between them (1978):

- ① Patient education is aimed at patients but self-care education does not presuppose their existence.
- ② The goal of patient education is the treatment for disease whereas the goal of self-care education is expected behavior against risk.
- ③ Patient education is carried out by means medical experts constructed whereas self-care education is conducted by learner's needs.

In other words, the most distinct element between them is that the former gives rise to dependence while the latter creates self-reliance. If the purpose of self-care education is to make a care receiver "independent", a learner must decide which action he/she should (or should not) take and get responsible for his/her own actions.

Yet in Japan patient education from the perspective of self-care has not been developed in a way that patients who receive care are asked to bear a responsibility. Behavioral scientific approach has tended to be educator-oriented and to lose sight of the essence of problems, therefore, we must revisit patient education by contemplating the reasons "why we conduct patient education." Inaoka (1983) pointed out that people's health behavior is influenced not only by their rational orientation but also mental and emotional ones but conventional behavioral scientific approach tended to ignore the latter. Sekito (1983) also noted that nurses tended to be accustomed to patient's passive behaviors, so that they failed to encourage their active participation, therefore, it is necessary for them to realize the significance of self-care in patient education.

Behavioral scientific approach was originally intended to reflect on one's own life, notice the existence of its foundations, and attempt to engage in behavioral change but patient education conscious of self-care put emphasis on the support of patient's self-reliance (Kimura 1982). "Self-reliance" here refers to the situations in which a patient who has a disease attempts to control his/her life again in a new way.

Support of self-reliance presupposes that patients acquire necessary knowledge and techniques for their own livelihood through learning. Directional approach is actually practiced here, implying that it does not necessarily deny "teach-taught" learning perspective. For instance, Narumi, et al. (1983) reported that there was a stage of practicing directional approach in the process of the development of self-care behaviors among patients. Watabe also noted that it is important to support patients according to human views that patients observe their own existence deeply and have the will to change in a good direction, therefore, it sometimes takes the form of teaching and order for them (1985: 59).

Patient's self-reliance is concerned with his/her individual life, therefore, nurses could not prescribe its content. However, patients who do not have professional knowledge also cannot prescribe it alone. Therefore, it is not appropriate for a patient to act just as he/she likes even if he/she wants to be self-reliant. Nurses must judge what each patient needs from a professional perspective and encourage him/her to deal with one's own learning needs and health problems by themselves. In this way directional approach is used as educational practice.

Behavioral scientific approach tends to delay in taking action because it tries to offer solution for achieving a goal of behavioral change after health problems occur. When a problem is not solved, it tries to consider a new solution. In other words, behavioral scientific approach tends to focus only on a solution to problems without clarifying the nature of problems. Therefore, it is sought to answer the questions of "what is the best solution?," "what purposes should we seek?," and "what is the best means?" without problematizing the goals of patients. On the other hand, practice of patient education from the perspective of self-care problematizes what are problems for patients who try to be self-reliant. It tries to answer functional questions such as "why does a patient ask a question?" and "what does a patient think about?". Nurses should not presuppose the goals of patients in patient education. Instead, they should aspire to help patients to be self-reliant even if they are not healthy with a perspective of how to understand patients. Seen in that light, it is a method of practice not focusing on problem solving but on problem clarification.

III. Discussion

Human relationship between a nurse and a patient had occurred only when medical treatment and procedure are performed until the 1950s. Here a nurse plays a role as the aid of medical treatment but it is only a function "dependent" on doctors in which he/she "carries out doctor's order." Therefore, educational relationship between a nurse and a patient is merely vertical relationship in which the former tells the latter about knowledge under a doctor's guidance. Knowledge offered to patients was mainly the one for preventing complications but it was merely the provision of abstract and generalized information detached from patient's living experience. This relationship could be effective as long as patient education

was functioned as the supplement of medical treatment.

Yet, vertical relationship between a nurse and a patient has not need to be inevitable since the increase of lifestyle-related diseases and the transition from treatment-centered to care-centered medical procedure. The pillar of educational practice among patients was teaching skills of nurses whose educational principle is patient-centered. It was influenced by learner-centered lifelong learning and was started from nurses' practice of patient education, whose practice was patient-centered. Patient education from the patient-centered perspective emphasized the use of interdisciplinary methods and practical thinking and verification of theory based on behavioral science and self-care.

Practice based on behavioral science has redefined a variety of educational methods such as educational content, educational materials, learning environment, individual study, and group study for solving patients' health problems. At the same time, leadership qualities and abilities of nurses has also been emphasized, necessitating the improvement of their teaching skills as educators. In particular, nurses made efforts to polish their teaching skills through enlarging educational relationship between a nurse and a patient. To day this, patient education based on behavioral scientific approach is still practiced as the core of educational methods.

Practice based on the assistance of patients' self-reliance is aspired in the practice of patient education from the perspective of self-care. Whenever patients' self-reliance becomes the main goal, we face the problems of "how to think about a variety of experiences and difficulties," "what kinds of care they expect to receive," and "how to engage in practice in accordance with one's needs." In this case it is important to clarify the problems of "what a patient wants," and "what a patient expects." Nurse's continuous attempts to ask patients about whether nurse's efforts really contribute to patient's self-reliance can be called the practice which is conscious of the clarification of problems instead of the resolution of problems.

The validity of patient education has been proved by the analysis of practice based on the patient-centered ideas which had been conducted from 1945 through the 1980s. Research on patient education accumulated its knowledge through methodological aspects in line with practical facts. This has changed from the provision of abstract and general information to concrete and distinct content, from the relationship between a teacher and a student to the mutually cooperative ties, from unilateral guidance to behavioral scientific practice, and from the problem-solving to the clarification of problems. Then, the meaning of "what is patient education?" has been questioned repeatedly through its practice. Nurses' attempts to question the practice of patient education have contributed to rediscover the significance of patient education, opening a new methodological possibility. In other words, patient education has deepened its methodological approach and expanded its interdisciplinary possibility as nursing research through practice.

Yet, there have been few studies focusing on the essentials of patient education (e.g., "what is patient's self-reliance?" or "where is the possibility of patient education?") although there are many articles on the function and methodology of patient education. Researches on asking the essence of patient education has focused on the understanding of adult learners and informed consent since the 1990s.

Research on patient education has expanded and has become more complex, whose goal is to make patients live a

humane life. Therefore, it is important to continue to answer the question of how human beings live as human being and examine human problems accompanied by becoming a patient in order to construct new patient education.

Conclusion

Medical care in Japan was based on human relationship between a doctor and a patient whereas nurses were merely helpers to doctors and family members took care of patients for a long period of time. The postwar nursing reform enlarged the roles of nurses and patient education was one of them. But there were difficulties to pursue patient education due to nurses' long-term dependence on doctors. In spite of these difficulties, the role of nurse's patient education was enlarged from 1945 through the 1980s.

To be sure, the basis of patient education were mainly inductive but there were attempts to establish the original knowledge and techniques of nursing with the aid of theories developed abroad and in other disciplines. It can also be said that patient education has become a distinct discipline by enlarging interdisciplinary field from a methodological aspect.

On the other hand, only the number of practical research of patient education has increased due to the reduced length of stay and the promotion of streamlining in medical policy, hampering the study of the essence of patient education. When thinking about patient education it must be linked to its essential characteristics (e.g., "how do we see patients as human beings?" and "how do we think about patients' self-reliance?"). Practical aspects such as part of treatment or behavioral transformation has been emphasized but what is more important is how to see patients as persons who possess rights and how to grasp self-reliant persons. These standpoints would help us to rethink its methodology and the way to capture patient education.

In any case, researches on patient education is still developing. I hope further studies on this field would be accumulated and this study would contribute to it.

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