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LETTER TO THE EDITOR

ON MAKING A DIFFERENCE: THE CASE OF SELF-MANAGEMENT EDUCATION AND PHYSICAL AND REHABILITATION MEDICINE

We very much appreciate the comments of Gutenbrunner, one of the editors of the *White Book of Physical Rehabilitation Medicine*, on our article "Physical and rehabilitation medicine and self-management education: a comparative analysis of two approaches" (1–3). It gives us the opportunity to deliberate more intensively on the purpose, nature and results of our comparative analysis of physical and rehabilitation medicine (PRM) and self-management education (SME) (4). We are aware that the theoretical background that our analytical work draws upon (discourse analysis and actor network theory) is little-known in rehabilitation research, although there are inspiring examples of such analysis in the field of PRM (5–7). Nevertheless, it seems to us that Gutenbrunner does not completely understand the essence of our comparative work. With this letter to the editor we hope to convince the reader that it is through grasping differences and similarities between diverging approaches that any dialogue (or other type of interaction) between them may be productive.

Firstly, it must be explained that our analytical approach is not merely a linguistic method. Instead, it must be considered as a content analysis that studies "reality" as it is formed within *material* semiotic networks. We approach science as a set of complex practices, of which the appropriateness of its terminology in any specific site is not to be taken for granted, but rather is open for investigation (8, 9). That is why the contents of PRM and SME was not explored in predetermined definitions of (International Classification of Functioning, Disability and Health (ICF)) terminology, but instead as a set of linguistic and material entities that mutually inform each other. This sociologically informed way of what science and medicine are and do moves away from traditional conceptions of science in which certain analytical privileges are granted, such as unity of language and research method.

Thus, the aim of our article was not to *replace* the discussion of PRM contents, as Gutenbrunner seems to suggest, but to *add* to that discussion from a very different scientific angle. By detailing differences and similarities in language, predecessors, material and social set up, we were able to examine issues that otherwise would have remained hidden. We agree with Gutenbrunner that PRM is a conglomerate of many principles and practices, and SME is, at most, a conglomerate of a few. However, this "inequality" did not hinder us in disclosing previously neglected issues related to the content of the *White Book on Physical and Rehabilitation Medicine in Europe*, such as social (learning) theory. It is true that current models used by rehabilitation, such as the ICF, do address the importance of involvement in a life situation. Nevertheless, they do not adequately address issues such as the role of environment, the nature of the community, the importance of meaning and choice when thinking about life situations, and changes in abilities across the life course in the chronic stage (10).

PRM is "interested" in SME for reasons such as; making the transition to the home-environment less difficult and striving for long-term independency of patients (11). However, our point is that discussions on the relationship between PRM and SME are too general; they lack specificity. Take Gutenbrunner, who articulates the benefits of SME in terms of cost-efficiency, as do many other policymakers and researchers. Based on a recent, as yet unpublished, study, we can say that in rehabilitation practice, next to cost-efficiency ideals, many self-management ideals prevail, such as patient's autonomy and dealing with the boundaries accompanying a chronic disease. Thus, by articulating differences (in this study between PRM and SME), a more detailed picture emerges, which can help to improve rehabilitation practice as well as research (12).

To examine another example highlighted by Gutenbrunner, it goes without saying that neural plasticity research has shown that functional and even structural changes in the nervous system are strongly related to behaviour, and that behavioural learning is part of it. This, however, does not automatically imply that behavioural self-management and problem-solving capacities are of course included in PRM, as Gutenbrunner suggests in his commentary. It is, for instance, important to differentiate between problem-solving capacities focused on motor learning and those focused on social learning. An improvement study on prosthetic rehabilitation revealed that in task- and context-specific training patient's problem-solving capacities are deployed to teach them the necessary *motor* skills, whereas in self-management education such capacities are offered to provide patients with the *psychological* skills to manage the complexities of life with a chronic illness (13). Thus, by articulating differences and exploring how co-existing approaches interfere with one another, blind spots and specificities come to the surface that need to be addressed in PRM. The detail that Gutenbrunner qualifies these blind spots in note 1 as (minor) misinterpretations of the authors demonstrates the drawback of a too-general stated view on PRM.

Finally, we cannot agree more with Gutenbrunner that SME needs to be integrated into all aspects of rehabilitation and prevention, with this remark that such an education needs specification in the different processes. Our metaphor of the relay race illustrates this statement clearly. We make a strong plea that patients should learn how to self-manage during rehabilitation, in the areas of physical as well as social and psychological functioning, and obtain the necessary skills to make the transition to their home environment as smooth as possible. However, the process should not stop there, but should have a slightly different content. If functional recovery is no longer the primary focus, then the focus must shift to patients having to deal with the impact of their changed body and the social environment on personal factors such as

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defining their identity in relation to the waxing and waning of their chronic condition. If the illness or disability develops beyond the boundaries of control of individuals and their self-management capabilities across the course of their lives, they should have the opportunity to hand the baton back for a while to PRM or other professionals. In other words, a more productive interaction between rehabilitation and chronic disease management models is necessary.

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