Invited Perspective

The Rehabilitation Model of Care: When Old Becomes New

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The key to our future is found in the values of our past. As physiatrists, we have consistently deployed through rehabilitation care what is becoming the mainstream of health care and needed now more than ever. Today, physiatrists have the opportunity to lead the way. Yes, we are a small specialty, but one with a big idea.

Recall the beginning of physical medicine and rehabilitation (PM&R). The polio epidemic had swept the country. Young men, catastrophically injured, survived a world war to return home. With the advent of antibiotics and improved acute medical care, suddenly the population became filled with survivors—people with disabilities. However, the health care providers of the time were unprepared to help people in that predicament. A change from the traditional model of medical care was needed. That change was the development of specialists who could help people living with disabilities to live their lives with quality and dignity, to participate in family and community life, and to contribute once again to society. These specialists became known as physiatrists, and the specialty known as PM&R was born.

The foundation of PM&R had a number of basic tenets. Physiatrists focused on peoples’ abilities—and possibilities—no matter what type of injury or disease a person may have experienced. Seeking ways to improve function and quality of life was key, and the focus was not on traditional medical diagnosis and treatment alone but on a view of the individual, that individual’s role in society, and ways that individual could participate. This philosophy freed physiatrists from the limits of medical knowledge because finding or developing a means for someone to participate in society can be limitless! This approach was certainly exciting for physiatrists and the people we treat but not well understood by those physicians (and patients) wedded to the “cure” mentality. Physiatrists are in the luxurious position of having an armamentarium of the breadth of traditional medical knowledge plus the rehabilitation “know-how” and science. Thus, if anyone should question the resiliency of this specialty, my response would be, “Of course, we will carry on indefinitely into the future!”

One of our greatest strengths was articulated by Dr. Stuart Weinstein in his editorial in this journal [1]. He described a “tolerance for uncertainty” in our specialty. This is both a salient principle and a physician behavior that describes our path and supports our direction. In the physiatric model of care, there is almost always something we can do to help each person we see, often in the absence of a classical curative treatment plan. We often “create” options for people with impairments and disabilities, and through our tolerance for the uncertainty of their future plus our own creativity, coupled with the creativity of our rehabilitation teams, our outcomes are often beyond what could have ever been expected. This tolerance for the uncertainty also makes us highly adaptable as specialists. We are the “chameleons” of medicine and can apply what we do to almost any condition.

The basic tenets of our specialty are timeless, very applicable today, and will carry us into the future. These include person-centered care, a focus on wellness and prevention, teamwork, functional outcomes, and independent living and quality of life.

PERSON-CENTERED CARE

The primary role of the physiatrist is to restore individuals to the most optimum level of social participation from their current status, including addressing their already diagnosed acute and chronic medical concerns, but beyond these medical conditions, formulating an
WELLNESS AND PREVENTION

The traditional medical model of “sickness care” places the physician as the leader, paternalistically dictating treatments, and by default, fostering dependency on the physician. When a “patient” visits a “doctor,” this automatically creates a message: “I am sick. The doctor will take care of me.” However, the health care delivery system as it exists can no longer afford for the providers to be solely responsible for people’s health. The rehabilitation model of care offers another model, one that is more “maternalistic,” promoting personal autonomy, empowerment, personal accountability, and independence. This model can be highly successful; as a prime example, one simply has to view the masterpiece of the successful evolution of spinal cord injury care. Because of wellness and prevention, most young people who sustain a traumatic spinal cord injury today will live a near-normal life expectancy. This has happened through promotion of vigilant wellness and healthy behaviors in addition to preventive care medicine. Similarly, we know that wellness and prevention pay off for many musculoskeletal problems and are key for the long-term management of cardiovascular disease, diabetes mellitus, and obesity.

With our focus on person-centered care, we need to teach the members of our society who seek our advice that they are ultimately responsible for themselves, their care, and their health—the current health care system can no longer afford to solely bear this burden. But how do we learn and then train self-reliance, health, wellness, and prevention to today’s individuals and tomorrow’s society? If physiatrists truly believe in a maternalistic, wellness model of care, then we have to prove that we can make this model work.

TEAMWORK

True interdisciplinary teamwork allows for the care of an individual to be extended beyond the physiatrist’s office. Actuating all goals to restore an individual to his or her optimum level of function takes a team. The heart of the interdisciplinary care team is the transfer of power that occurs, by definition, from team member to team member, thus allowing the person being cared for to remain the centrum of that team. Another innate advantage is that the team can extend to as many members as needed for the care of that individual. The team is flexible, ideally fluid, and responsive to the person and family.

Physiatrists have an uncommon ability to “work well with others.” This will be especially critical in the future of health care delivery as new models are formed. Because of our training in teamwork and coordination of care, we are particularly well-suited to lead teams in discussions of new models of care and help with reorganization of health care delivery systems. Physiatrists must take pride and ownership in this ability and assert ourselves to assure that we are included in these discussions. Discussions of the future of health care at the moment include medical homes (soon patients will be linked to a center that supervises their care) and accountable care organizations. In my opinion, physiatrists are very well-trained to take on leadership of these types of initiatives. However, we are at risk of being excluded, as we will not be readily thought of as adding value to these discussions, unless we educate others about our value using our teamwork skills.

FOCUS ON FUNCTIONAL OUTCOMES

PM&R has been described as a specialty without an “organ system,” but within the ranks of the specialty, “function” is often considered our organ system. Consider that the chief complaint of many of the people we treat is often phrased in a statement of function, for example, “I can’t walk” or “I can’t dress.” In addition, the concept of function is gaining traction in the wider medical community. In fact, functional measurement is a required component of clinical trials. However, the objective measures for such assessments are often difficult to apply reliably and efficiently in our daily clinical practice. Many functional outcome measurement tools are available, often specific to a disease entity, yet physiatrists have for many years applied global tools that allowed measurement of function regardless of diagnosis. Therefore, a key to our future growth, and frankly survival as a specialty, will be the ability to objectify that rehabilitation is valid and cost-effec-
tive in the long term. Similarly, these outcome tools should facilitate the design of clinically and financially better models of care. Hence, it behooves all physiatrists to work together to build consensus on tools that are clinically applicable and that can be standardized across different types of conditions and institutions.

INDEPENDENT LIVING AND QUALITY OF LIFE

The Americans with Disabilities Act emerged from the desire of people with disabilities to live independently and be treated with greater respect by the traditional medical community. With this came the development of Centers for Independent Living throughout the country. Human nature is to feel a sense of self worth and to be part of a community. As physiatrists, we are very familiar with working within communities and creatively using community-based resources to help restore those we treat to participate in their chosen role in society. This approach is certainly one that will be increasingly necessary in the future. Part of this movement will include the increasing level of technological innovation from simple devices to virtual reality that will allow us to reach those we treat in their homes and also allow groups of individuals with similar conditions, for example spinal cord injury, to interact and learn from each other. The opportunities to reduce expenditures associated with in-hospital or clinic expensive care, to bring health care to people geographically removed from such centers, and to work together with them to help assure adherence to self-care programs (eg, exercise, amputee residual limb management, neurogenic bladder management) will be significantly enhanced. Technology is facilitating behaviors that empower individuals to be responsible for their own health.

THE FUTURE

The challenge of chronic disease management is an increasingly prevalent concern to all areas of medicine. Yet, despite our knowledge and training, it is difficult to communicate the concept of management versus cure to our medical colleagues and payers who are immersed in the traditional model of sickness care. Certainly, some specialists embrace this concept: oncologists have discovered “survivorship” and “palliative care”; gerontologists have discovered “independent living”; and many specialists actively study the importance of exercise in modifying the course of a chronic condition, eg, diabetes or heart disease. Unfortunately, physiatrists have found it difficult to fully implement a model of care that implies taking more time with patients and working as a partnership. Therefore, for physiatrists to “participate,” we have had to adopt many of the traditional medical system’s practices, behaviors, and terminology. However, this is a double-edged sword. Physiatrists have become adept at making key diagnoses, especially in the musculoskeletal and neurologic arenas; have significantly escalated involvement in procedures such as image-guided musculoskeletal injections, electrodiagnostic studies, and intrathecal pump management for spasticity and pain; and have moved to more outpatient clinic visits that address individual organ system problems. However, the time devoted to addressing the person in the context of their family, work, and society is becoming increasingly shorter. Further, physiatric research very often deals with individual organ systems rather than the whole person, albeit as a result of the challenges of study design and sources of funding, but this detracts from the idea of promoting management of chronic disease versus searching for the elusive cure. Today, with health care reform looming, there is a grand opportunity to move the physiatric philosophy into the mainstream if we can once again rely on the principles of our beginnings.

What will our role be in the future? It has been said that if everyone brushed and flossed their teeth, we would never need dentists. Similarly, if all medical providers learn to not only treat their patients but care for the whole person, will we still need physiatrists? Could this specialty ever become extinct? The answer is “not likely.” In new models of health care delivery, I foresee that physiatrists will become more and more integrated with other providers and will no longer exist in departments or stand-alone practices but as members of teams of providers serving certain patient populations. What we offer is still unique: prevention or correction of additional disability, enhancement of body systems and intact capabilities unaffected by the pathologic condition, use of adaptive equipment, modification of the social/vocational environment, and psychological techniques to enhance performance and education are all part of the PM&R armamentarium. To remain an active participant in this health care delivery team, physiatrists must stay current regarding changes in health care reform and actively participate by offering our ideas of new models of care that are truly “person-centered” and “interdisciplinary.” We must provide high-quality, cost-effective care. We clearly have to pilot new models of care that incorporate our valued tenets and partner with payers to support these pilots. We need to accomplish and promote research that demonstrates the value of our services and publish as much as we can in the journals of other specialties so they recognize our value to them. Physiatric research needs to refocus on increasing levels on health care provision to those with chronic disease and aging as insufficient numbers of spinal cord-injured and brain-injured patients exist for us to survive caring only for people with these highly specialized needs. Aging, osteoarthritis, chronic diseases (including cardiovascular disease and diabetes), and social conditions (such as lack of access to good education, literacy, poverty, and access to medical care) should all be incorporated into our research. We need to share our specialty with others ranging from our congressional representatives to members of our communities. We need to be assertive and
capitalize on our teamwork skills to participate with those developing medical home and accountable care models, to develop new models of care that incorporate our values.

Also imperative as a small field is the importance of joining forces together, bringing all rehabilitation providers together at the table to systematically address the strategies that we will need to grow and promote our specialty well into the future. We need a forum to share our successes, failures, and options for new care delivery models with each other. Key to our success will be to work for the people we serve, to better society. We can not and should not simply look at this from the standpoint of survival of our specialty alone. Our passion for patient care will carry us forward. If we hold to our basic tenets, we will be here long into the future. In 1925, William Mayo said “Rehabilitation will be a master word in medicine” [4].

Our time has come.

REFERENCES