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Patient-Centered Rehabilitation: From Philosophical Ideal to Measurable Practice

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INTRODUCTION

Patient-centered care (PCC) has evolved from an emerging ethical ideal to a policy cornerstone of contemporary healthcare, especially in rehabilitation. At its core, PCC ensures that clinical decisions are guided by each patient's preferences, needs, and values. Born partly as a corrective to paternalistic medicine, its ascent is driven by robust evidence linking patient engagement to superior functional outcomes, treatment adherence, and satisfaction—benefits that prove particularly vital in the prolonged, multifaceted journey of trauma rehabilitation.

Yet the term's ubiquity risks transforming it from lived practice into mere rhetoric. This editorial interrogates the chasm between PCC's theoretical and ethical promise and the institutional, cultural, and systemic barriers that hinder its routine enactment, especially in the resource-constrained arena of trauma recovery.

CRITICAL VIEWPOINT

The claim that patient-centered rehabilitation constitutes a comprehensive approach is, at best, premature; more accurately, it remains an unrealized potential. Although PCC is universally endorsed in rehabilitation frameworks, efficiency, protocol, and professional expertise routinely eclipse individual agency under system- or profession-centered paradigms.

True PCC demands shared decision-making in which the patient is an epistemic partner. In trauma rehabilitation, this means anchoring recovery goals in the patient's personal vision of a meaningful life post-injury—returning to a cherished hobby, caregiving role, or workplace—rather than solely objective metrics such as range of motion or gait velocity. Clinicians supply "what is possible"; patients define "what is valuable." This ideal, however, collides with three formidable realities.

First, acute and sub-acute settings impose structural and temporal constraints that favor pre-packaged, protocol-driven care. Heavy caseloads and payer-mandated treatment durations leave therapists scant time for the iterative, emotionally demanding conversations required to grasp a patient's values, social context, and psychological readiness. Current funding models do not reimburse the time required for genuine shared decision-making. This tension is starkly illustrated in 2025 traumatic brain injury (TBI) litigation literature, where adversarial legal processes exacerbate ethical dilemmas when person-centered support clashes with time-consuming procedural demands (1).

Second, professional power dynamics and organizational culture perpetuate subtle paternalism. Despite training, clinicians' technical authority can inadvertently marginalize patient input. Authentic PCC requires not only soliciting goals but embracing those that diverge from biomechanical ideals. For example, a trauma survivor prioritizing rapid pain relief and emotional stability over intensive physical therapy may be labeled "non-compliant" rather than recognized as exercising legitimate agency—a profound failure of the model. The 2025 literature's heightened focus on social isolation and loneliness among rehabilitation patients underscores the urgent need to shift from impairment-focused to participation-based care, exposing a persistent shortfall in holistic orientation (2).

Third, systemic inequities undermine the very premise of "patient-centered" service. A home-based plan tailored to an individual's environment, support network, and economic resources is inherently more person-centered than a generic protocol. Yet structural dysfunction ensures that rehabilitation quality remains contingent on socioeconomic status, insurance coverage, and geography. If the system itself is unequal, individualized care will disproportionately benefit the already advantaged. Prescription Digital Therapeutics (PDTs) are frequently marketed as "meeting patients where they are," promising scalable personalization for mental health and functional recovery (3). While conducted in chronic musculoskeletal conditions, these findings are highly relevant to trauma-related functional recovery; however, 2025 analyses stress that without rigorous psychometric validation and equity-focused implementation, such eHealth tools risk widening rather than bridging the digital divide. Until policy reform, interprofessional education, and funding structures reward therapeutic dialogue, patient-centered rehabilitation will remain a well-intentioned philosophy rather than a measurable, equitable practice.

CONCLUSION AND PATH FORWARD

Patient-centered care currently excels at eliciting participation but falls short of forging true partnership. The profession must transition from advocacy to systematic embedding and evaluation of PCC, attuned to 2025's technological and social shifts.

Future efforts should integrate the patient voice at every systems level—from policy formulation to co-design of virtual assessments and PDTs. Research must extend beyond clinical endpoints to metrics capturing therapeutic alliance quality, mutual decision-making depth, and goal congruence with patient priorities via patient-reported experience measures (PREMs). Journals and funders should mandate PREMs alongside PROMs in all rehabilitation trials by 2027.

The ultimate objective, as 2025 scholarship affirms, is a rehabilitation system that is participation-centered, trauma-informed, and equitably accessible—with PCC not as an add-on, but as its ethical and operational core. Only then will patient-centered rehabilitation cease to be aspirational and become the measurable, self-evident standard of trauma recovery.

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