

Hospital Based Systemic Changes for Early Integration of Rehabilitation Specialists in Stroke Care

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DESCRIPTION

Stroke is one of the leading causes of disability worldwide, and while advances in acute medical care have significantly improved survival rates, the challenge of rehabilitation continues to be one of the most pressing concerns for patients, families and healthcare systems. Stroke rehabilitation must not be perceived as a discrete or optional component of recovery, but rather as the very core of what it means to rebuild a life after such a devastating neurological event. When a stroke strikes, it alters not only the vascular landscape of the brain but the entire trajectory of an individual's life, disrupting physical abilities, cognitive functions, and emotional stability. The rehabilitation process, therefore, is not merely about physical exercises or retraining motor skills, but about reestablishing identity, independence, and participation in society.

The first and perhaps most essential truth about stroke rehabilitation is that it begins almost as soon as the patient is stabilized. Every hour matters in influencing recovery outcomes, as early intervention can reduce complications such as muscle contractures, deep vein thrombosis and pressure ulcers. Beyond physical risks, early rehabilitation establishes the psychological foundation for recovery, signaling to patients and families that life, although altered, still holds possibility. This requires systemic changes in hospitals where rehabilitation specialists, including physiotherapists, occupational therapists, and speech therapists, are part of the initial care team rather than being introduced later.

Another important perspective is that stroke rehabilitation cannot adopt a one-size-fits-all approach. Every stroke is unique, depending on the part of the brain affected, the extent of damage, and the pre-existing health of the patient. This means rehabilitation must be personalized, tailored to the individual's functional deficits, goals and social context. A patient with right

hemispheric damage may struggle with spatial awareness and neglect, while another with left hemispheric involvement may face aphasia and difficulty with language. A uniform rehabilitation model would be inadequate to address these complexities. The future of stroke rehabilitation lies in individualized programs that use precision medicine principles, where therapies are chosen based on neurological imaging, biomarkers and functional assessments that guide targeted interventions.

The physical aspects of rehabilitation have long received significant attention and rightfully so, because regaining mobility and motor skills is central to restoring independence. Physiotherapy has evolved to focus not only on passive exercises but also on task specific training, neuroplasticity driven approaches and advanced technologies such as robotic assisted therapy. Exoskeletons, treadmill training with body weight support and functional electrical stimulation have transformed the possibilities for movement recovery. Human engagement, motivation and repetition remain at the heart of recovery and technology should serve as an adjunct rather than a replacement. The human connection between therapist and patient with its encouragement, feedback and adaptation, remains irreplaceable.

Equally important, though often undervalued, are the cognitive and emotional aspects of stroke rehabilitation. The cognitive deficits following a stroke can be subtle yet profoundly disabling, affecting memory, attention, problem solving and executive function. Emotional consequences such as depression, anxiety and loss of confidence further compound recovery challenges. A stroke does not just weaken muscles it can fracture the self. Patients may feel they are no longer the same person, struggling with identity and purpose. Psychological rehabilitation whether through therapy, peer support groups, or social reintegration programs is as crucial as any physical therapy.

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