

OPINION

Medical stability is not recovery: a reflection on stroke rehabilitation and continuity of care short communication

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ABSTRACT

Acute stroke care has increased survival, and recovery following the acute admission requires coordinated rehabilitation and follow-up. Medical stability refers to the management of an acute physiological threat and the lack of an urgent requirement for acute intervention but not to a return of function nor to the conclusion of rehabilitation needs. This Opinion refers to a clinical example that has been anonymized to prompt discussion on transitions for people with stroke, including migrant workers and those with financial or administrative limitations. This Opinion does not assume a failure of care or lack of rehabilitation simply because there was a transfer/repatriation. The question is whether an appropriate and feasible rehabilitation pathway exists and is shared across settings. Early multidisciplinary assessment, functional needs to be documented, medication reconciliation, direct communication with receiving services, if possible, accessible patient and caregiver education and social and financial barriers to be assessed are recommended. These actions should be informed by a commitment to safe, person-centered transitions, but not as a substitute for recovery.

Keywords: Stroke, rehabilitation, continuity of care, health equity, migrant health, discharge planning.

Objective and Scope

This Opinion states that discharge and transfer planning following stroke should link medical readiness with an actionable plan for continued rehabilitation and follow-up. It's an ethics/health system view, not a case report or outcomes study. The clinical experience below is an example of discussing a transfer and does not reflect the incidence or impact of transfers like this.

Medical Stability, Function, and Continuity

Medical stability is a requirement for transition – risks and problems have been identified and no longer need to be addressed at an acute level. Functional recovery is a multi-faceted process that takes time, and includes mobility, self-care, communication and cognition, emotional status, and living with the condition. These are concepts that are related, not competing endpoints. Stabilization can facilitate the next level of care, and rehabilitation may be a lifelong process as long as it helps a person reach meaningful goals. Current guidance identifies specialist, multidisciplinary stroke rehabilitation; a shared care plan; communication of functional and medication needs; and timely follow-up after transfer as key [1,2,3,4].

Continuity of care accounts for the transfer of relevant clinical information, responsibilities and plans with a clear pathway for follow-up. Rehabilitation access involves making more than just nominal access to services possible, it requires that a person may reach, afford, understand, and participate in appropriate rehabilitation services. A planned transfer, including repatriation, can be compatible with continuity when the receiving pathway is assessed and coordinated. Conversely, an unplanned gap may arise even when transfer is medically appropriate.

A Clinical Experience as a Prompt

In one clinical experience, an adult migrant worker was treated for a severe stroke and was described by the treating team as medically stable for transfer

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to his country of origin. Completion of the available account indicated that this might have been the result of the time of transfer, which could have been due to employment, sponsorship, or financial reasons, among others, and these factors and their relative importance must be confirmed from the record and from the patient. Information regarding rehabilitation or follow-up after transfer and the outcomes that ensued are not available for this Opinion. It is therefore impossible to draw conclusions about the care that is received, about the patient's preferences, or about the motives of individuals or institutions.

This leaves the question of what was available and coordinated at the time of transfer to support further rehabilitation? There is nothing in the case which supports the concept that the person was refused rehabilitation or that it was an inappropriate transfer, or that there was a one-off issue which indicates it was part of a wider practice. Transfer may have been determined by the 'person being fit to travel', the person's knowledge and expressed wishes, their family situation, the policy within an institution, insurance, immigration or employment arrangements and the availability of services.

Equity and The Transition After Stroke

The need for rehabilitation is not uniform and access is influenced by capacity to provide rehabilitation services and by the way people can access rehabilitation services. A systematic review and meta-analysis identified socioeconomic disadvantage as a risk factor for poor functional outcomes following stroke and suggested that the pathways were multiple, and specific to context [5]. Access to rehabilitation is also reported to vary by socio-economic and geographical level as well as by the quality and reliability of the evidence for each group [6]. These results promote the focus on barriers, and are not conclusive evidence that an individual patient's results were due to their migration status or financial situation.

Potential barriers for migrants may be the cost, insurance or entitlement rules, language, lack of information, administrative complexity, lack of precarious legal or employment conditions, as well as separation from familiar support networks. WHO recommends migrant sensitive and inclusive health systems and documents these structural barriers [7,8]. There are only limited data available on access to post-stroke rehabilitation for migrant workers, and generalizations should be avoided. Assessment should be personalized, confidential and consider the person's preferences and supports.

Practical Recommendations

A few well-documented steps can help teams and health systems make the transition better:

- Initiate early rehabilitation screening and needs assessment, such as functional status, communication, cognition, self-care, equipment and goals.
- Consider disability/rehabilitation in transfer/discharge planning with medical fitness, not as a substitute.
- Before transfer, create a short clinical and rehab summary with diagnosis, function, precautions, medicines, rehab, goals, follow-up, etc. Reconcile medicines and give the summary in language and format that can be used by the patient and other team.
- Identify receiving clinician/service and discuss directly plans, timing, and who will be responsible for follow-up where possible and appropriate. If there is no confirmed receiving service, note that and provide the patient/family with practical contact and referral information.
- Provide advice regarding therapy, social work, and case management with regard to fees, insurance/eligibility, transportation, language, work, sponsorship and restriction, caregiver, and other resource restriction. Offer short-term substitutes in outpatient, community, or remote care when clinically feasible and attainable.
- Ensure education of patient and selected caregivers is easily accessible and contains warning signs, medication instructions, rehabilitation goals, equipment and safe assistance, and who to call. Verify rather than assume comprehension.
- At service level, set up protocols to transfer, set up a named coordinating role, secure information sharing, and built a process to ensure follow-up. Track access and outcomes for relevant social groups, without compromising privacy.

Limitations

This Opinion is based on one clinical experience only, but it does not contain a systematic case review, verified documentation of transfer arrangements or outcome data following the transfer. The account does not provide the reasons for the transfer (whether they were consensual or not), what rehabilitation was offered in the recipient country, or if there was continuous care. The evidence provided is aimed at general discussion on stroke rehabilitation, inequities in the social determinants of health and migrant health and does not establish causal effects for this person or directly quantify outcomes for migrant workers moved across borders.

Conclusion

Medical stability is a key accomplishment and a starting point for many transitions and not a measure of functional recovery. The transition itself should be part of a stroke service's care, noting function and the need for rehabilitation, explaining a realistic plan, and



addressing barriers that might prevent the plan from being followed. If the person is able to receive care in the receiving setting, the quality of the transfer/repatriation will vary depending on the type of transfer/repatriation that is appropriate. These recommendations aim to enhance the coordination of services while taking into account the clinical judgment of the health team, the patient's preferences, and the limitations of services.

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