
Editor Note on Epistemic Innovation and Academic Progression in the Rehabilitation Community

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Editor Note

I am writing this editor note as an 18 year veteran of clinical practice. 18 years as witness to the progress, innovation, and clinical development that forever changed how we treat patients. In that time the profession has experienced exponential growth as it relates to clinical innovation and academic investment. The profession of physical therapy has transitioned from ancillary work as a physician extender into the robust and scientifically validated field of science it is today. Clinicians graduating today can anticipate being well versed to tackle the economic and didactic challenges of clinical practice in the current healthcare market.

However, the business and operational environment in the field of rehabilitation has not been equally as progressive within the same timeframe. Provision of care over the last quarter century has followed a traditional formula of fee-for-service in the brick-and-mortar clinical setting. Mode of production has also remained unchanged, as has agency and the provision of clinical services. Economic pressures continue to shape the identity of the profession and indoctrinate clinicians into the arbitrary pursuit of remunerative success. Mechanism of provision of care has also stagnated on multiple levels. This attenuation is a direct result of the supply and demand model of rehabilitation. Universally, this model consists of three interested parties that help shape how care is rendered. Physicians, large healthcare providers, and finally the individuals pursuing care each have a unique investment in the delivery of our

product.

The pinnacle of the supply chain has always been the medical referral echelon consisting of physicians that refer patients for rehabilitation services. Referrals are made for several reasons, only one of which is the clinical necessity of rehab services. Referral volume tends to increase in geographic areas where there is an abundant availability of services, as well as in locations where physicians have a personal investment in the physical therapy business. Poorly defined and poorly understood practices parameters have left a substantial margin for interpretation as to when such referrals are warranted and initiated. Financial and economic interests in such a system often overshadow the primary objectives and fundamental responsibilities of the affected clinicians.

The next vested piece of the supply chain is the for-profit commercial enterprises known as “box store” clinics. Such clinics have effectively over-saturated the market and in some areas even cannibalized each other over the hunt for increased volume and utilization of patient visits. This had the unintended consequence of diluting the actual clinical efficacy of care delivery and clinical need of care. Commercialization of the industry has resulted in a shift from academic to entrepreneurial leadership. Therapists’ clinical growth has been systematically sacrificed for the persistent need for “productivity”. Clinicians' value to the employer is now a simple assessment of how “productive” they can be on the assembly line of patient visits. Industry leaders are currently business high-performers, which has resulted in academic and professional development as an afterthought. The last agent in care is the individual receiving care. Poor understanding and limited expectations from clinical exposure resulted in individuals receiving sub-par care. Patients who were referred to rehabilitation services had limited ability to reference the type/method of care that carried the greatest clinical evidence and validity. There is a need to increase volume and quality of clinical evidence to further validate rehabilitation. Patients, in turn, need to become “educated consumers”. Tracking and providing access to clinical outcomes can allow patients to employ the most “fit” clinicians with best clinical results related to specific diagnosis. By such standards, providers and consumers will carry greater incentive to standardize care. Keep standards in data collection, forming a local and national standard of care. Transparency in data and outcomes available to patients will result in a positive economic pressure to provide higher levels of clinical care related to the latest evidence-based practice.

Further opportunity arises with validating the long-term effect of rehab exposure. There is paucity of clinical outcomes reported beyond 6 months. The literature that is available often places physical therapy to be synonymous with conservative care. The growth potential lies in standardizing the general model of healthcare delivery in rehabilitation. Keeping track of outcomes beyond the standard period can provide insight into the clinical efficacy of physical therapy exposure. Establishing a baseline standard of what physical therapy is, related to other fields of research, can reduce the risk of bias. I challenge rehab professionals to establish an identity that goes beyond conservative care.

I am optimistic about the structure, clinical value and validity of our discipline. We can grow by embracing the standard of care, adapting to innovative technologies and modernizing the clinical product. I challenge my colleagues to embrace change, embrace technology and continue to work on

validating evidence-based interventions. We need to go beyond the traditional business model, into the one that focuses on value based clinical care. Value of care being encompassed in clinical outcomes, procedural interventions and professional accountability. Building and innovating healthcare technologies to improve patient compliance and improve outcomes. We can build bridges with innovative industries, promote camaraderie in shared effort to make healthcare more accessible, affordable and approachable. Adaptation to the clinical needs of the community can result in need-based utilization of care. Promoting innovation can incentivize individuals, clinicians and companies to grow beyond finite key performance indicators onto the infinite value driven professionalism and transformation.

Conclusion

I would like to challenge my colleagues to be open to change. Accept the challenges that the current economic and clinical climate brings. Adapt to adversity and grow from newly acquired knowledge. Modernize your practice, convert your established clinical beliefs and adapt to better serve others. Our trade will evolve and emerge to be best fit into the current healthcare model.