JHR NARRATIVE REFLECTION

Who Gets Sent to Heal? Lessons From a Rehabilitation Hospital

By Aardhra Venkatachalam, MPH

On my third week as a medical student at Shepherd Center in Atlanta, Georgia, I watched a young man take three steps between parallel bars.

At first, this seemed unremarkable. His movements were uneven, his balance uncertain, and his physical therapist remained close enough to assist at any point. Yet as he moved forward, the atmosphere shifted. A few feet away, his mother stood with one hand over her mouth, as if even a small sound might interrupt what was unfolding.

When he reached the end, she began to cry. The sound was quiet and restrained, carrying the weight of something that had been held back for days, perhaps longer. Later, I learned that only a short time earlier he had required maximal assistance to stand. The injury had been severe, and the trajectory uncertain. Within that context, those three steps represented something far greater than physical progress.

The moment stayed with me, not only because of what I saw, but because of what I began to understand afterward.

What I Carried With Me

Before this rotation, I thought I understood what rehabilitation looked like. My exposure had come through coursework and research; I had read about social determinants of health, and about the ways insurance status and geography shape who reaches post-acute care. I arrived at Shepherd Center believing I had a working picture of the system. What I had not done was stand in the room where fundamental rehabilitation could only happen for some.

What the research had not prepared me for was the texture of it: the discharge planning conversations where factors far beyond clinical need quietly shaped what came next—the weight of what care teams navigated that never appeared in a chart. It was not a single moment that shifted my thinking. It was the accumulation of those conversations, what was said and what went unsaid, that began to make visible something the data had always described but never fully shown me.

Published online 17 NOVEMBER 2026 at jhrehab.org

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Inequality of Access

Traumatic brain injury (TBI) disrupts lives in an instant, but recovery unfolds unevenly and is shaped by unequal access to rehabilitation resources that are not equally available to all.[1-3] During my time as a medical student at Shepherd Center, I witnessed patients relearn how to move, communicate, and rebuild a sense of self after catastrophic injury. I came to understand a quieter truth: not every patient with the same need reaches this level of care.

Post-acute rehabilitation placement is often framed as a logistical endpoint of acute care; in reality, it reflects a complex interplay of insurance structures, language access, family advocacy, geography, and assumptions about rehabilitation potential. This narrative reflection explores a moment that challenged my understanding of recovery and reframed how I think about access, responsibility, and my future role in medicine.

The Patients I Could Not See

As I spent more time on the unit, I began to understand that the path to the therapy gym was neither simple nor guaranteed.

- It required survival from the initial injury, referral to a specialized rehabilitation center, medical stability sufficient for participation, and insurance approval or successful appeal.
- It also depended on bed availability, geography, family involvement, and a coordinated team that believed in the potential for recovery.

Initially, I saw this sequence as the system working as intended. Over time, it became clear how conditional it was.

The realization expanded beyond the patients in front of me. For each individual I encountered in the post-acute rehabilitation setting, I began to imagine another person with a similar injury who might never reach a setting like this. Differences in resources, language access, family capacity, and system navigation could alter the course of care long before treatment, and dictate whether rehabilitation would become an option for that individual.

These patients remained invisible within the hospital environment. Their absence did not interrupt rounds or appear in documentation, yet the notion of it carried weight. It changed how I interpreted recovery, shifting it from something expected to something contingent. The presence of one patient implied the absence of another.

When Injury Is Misunderstood

Even with a referral to specialized rehabilitation, there are still barriers to treatment that I did not anticipate. Traumatic brain injury often defies easy prediction and challenges clinical assumptions. Patients may appear physically intact while struggling with memory, attention, or judgment. Fluent speech can obscure cognitive deficits, and apparent confidence may mask a lack of insight.

Earlier in my training, the visible aspects of illness felt easier to recognize and treat. A diagnosis of TBI challenged that assumption by requiring attention to

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what could not be immediately seen. Behaviors that might be labeled as noncompliance, irritability, or disengagement often reflected underlying neurologic injury.

In the rehabilitation setting, these distinctions—between apparent and non-apparent deficits, between aberrant behaviors and their underlying neurologic sources—were central to care. Not every environment is equipped to interpret them in the same way, and that difference can influence both placement decisions and long-term outcomes.

Recovery also proved iterative, emotional, and often nonlinear. Patients were not simply regaining abilities; they were relearning how to exist in bodies and minds that no longer felt like their own.

I observed individuals using notebooks to compensate for memory loss, practicing emotional regulation in the face of unpredictable responses, and developing strategies to navigate previously innocuous environments that had now become overwhelming. What appeared to be small gains were often foundational, representing significant steps toward independence, communication, and a reconstructed sense of identity.

Within that context, the young man's three steps were not purely movement-based progress. Those steps reflected the possibility of rebuilding a life—one interrupted by traumatic injury and now painstakingly reclaimed.

What Families Carry

Recovery after TBI extends beyond the individual, often reshaping the lives of those closest to them. Families assume roles that blend caregiving, advocacy, and emotional support, often without preparation.

The mother whose story opened this piece returned to therapy with her son each day, observing closely, asking questions, and learning alongside him and the clinical team. Her presence reflected a level of engagement that is not always possible. Work obligations, distance, financial strain, language barriers, access, and privilege all influence what families can offer by way of support and assistance to their injured loved ones.

We often describe patients as having or lacking support, but this binary view obscures meaningful variation. Support exists along a spectrum defined by capacity, and when systems rely on families to bridge gaps in care, those differences and inequities become consequential.

Learning to Ask New Questions

The moment between a mother and son that I witnessed in the therapy gym initially appeared to be a straightforward success. Over time, it became something more complex. Reflection prompted a question that I had not previously considered: without access to this level of care, would those steps have occurred?

The answer remains uncertain. Recovery might have unfolded differently, been delayed, or may not have occurred at all. Before this experience, I did not fully consider how access shapes possibility. Now, it is difficult to separate the two.

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As a medical student, I observed that discussions about post-acute care often focused on logistical considerations, including bed availability, insurance approval, and family capacity. While these considerations are necessary, the prioritization of these factors reflects the constraints of the system rather than recognizing the full scope of patient needs. A different question emerged.

Instead of asking whether a patient qualifies for rehabilitation based upon existing constraints and parameters, it may be more meaningful to ask: What does this individual require to rebuild a life after injury?

This shift reframes rehabilitation from a limited resource to a responsibility—one shared by clinicians, systems, and policymakers alike.

After traumatic brain injury, patients are not seeking extraordinary outcomes. They seek the ability to function in ways that restore a sense of normalcy: remembering conversations, navigating daily environments, returning to work, and engaging meaningfully with others. And yet, in the context of rehabilitation, what is foundational is also aspirational; patients must work extraordinarily hard for what others take for granted. These goals are both basic and, given the terrain of recovery, remarkable.

What I Carry Forward

I entered this rotation expecting to learn clinical techniques that facilitate recovery. I left with a deeper awareness of the systems that determine access to that recovery.

My experience at Shepherd Center did not provide definitive answers, but it clarified the importance of the questions we ask. As I continue my training, I hope to approach decisions about care with an awareness of both system constraints and patient potential.

In another therapy gym, another patient is working toward their first steps after a catastrophic injury. Whether that opportunity exists is determined not by their injury alone, but by the intrinsic and external systems and structures that act to support or limit recovery.

Of the many questions pertinent to rehabilitation trajectory and prognostic potential, one worthy of weighty consideration is no longer solely whether recovery is possible, but who is afforded the opportunity to pursue it.

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