BRITISH JOURNAL OF HOSPITAL MEDICINE

EDITORIAL

Medical Rehabilitation for Life Changing Conditions

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Introduction

…the experienced doctor thinks in larger units of time, not just backward to cases in the past but, more interestingly, forward, trying to see into the patient's indeterminate future. (Sennett, 2008, p247)

…the meanings of stories are found, and from them people draw both moral and practical guidance on how to carry on. (Ingold, 2011, p210)

What makes a condition life changing? Lasting physical impairment is one answer. Another, perhaps less obvious, is the disruption of two vital functions that serve as life's maps and compass. Respectively, imaginative functioning conjures what we could do, while our ethical functioning evaluates what we should (Jesudason, 2025). On this view, illness becomes life changing when it disables the prospective imagination with which we normally create our lives. Retrospection and interoception take over as we interrogate the past for causes and the body for threats (Horhota et al, 2012; Fani et al, 2024; Opdensteinen et al, 2025). Preoccupied, we struggle to envision a future, losing trust in it. Ethical evaluations then curdle into recriminations, as we lose our sense of the right way to turn.

Being creative and evaluative, these two functions shape what we make of our other capabilities, so their disruption by illness is of wide consequence, particularly when seeking to rebuild. Despite this importance, such imaginative and ethical dysfunction is commonly just medicated, labelled respectively as anxiety and low mood. Alongside talking therapies, these generic approaches can leave patients with troubling and particular medical concerns.

This editorial argues, instead, for the specific rehabilitation of imaginative and ethical functioning, using expert medical counsel from specialists in Physical and Rehabilitation Medicine (PRM). While medical specialties often focus on minimising mortality and morbidity, PRM advocates a broader view of life, with emphasis on *functioning* as a key marker of health (Stucki and Bickenbach, 2017). Pursuing health rather than just the limitation of disease, the specialty uses the World Health Organisation's International Classification of Functioning, Disability and Health (ICF) to work across the range of human capabilities, from biophysical to psychosocial (World Health Organization, 2001).

Imaginative and Ethical Dysfunction

To consider how we accomplish this medical rehabilitation, let's first flesh out the problem. When life-changing illness disrupts such top line functioning, it diverts our imagination toward interoception (Fani et al, 2024). Embodied sensations

How to cite this article:
Jesudason EC. Medical Rehabilitation for Life Changing Conditions. Br J Hosp Med. 2025. https://doi.org/10.12968/hmed.2025.0667

lead to our "script writing" new dystopian horror stories creatively conjuring what else might now be going wrong inside us (Opdensteinen et al, 2025). Alongside, imagination can get stuck in retrospection, in regretful re-narrations of the past, and wishful "if onlys" (Horhota et al, 2012). In contrast, in this post-acute period, prospective imagination, the function with which we normally create our lives, can often dry up; sometimes stuck on the forlorn hope things will magically go back to normal (Jesudason, 2025). Such imaginative dysfunction also perturbs our trust in ethical self-evaluations. No longer confident in what we could or should do, we can become stuck, losing sense of the right direction. Combined, these two dysfunctions impede rehabilitation of physical functioning too. Often labelled loosely as anxiety or depression (Valeiro et al, 2025), these experiences can be treated differently if we attend to them as imaginative and ethical functioning. On this view, anxiety is often a product of excessive interoceptive and retrospective imagination. Sensations and fears of recurrence keep people feeling they shouldn't exercise functions, despite being capable of doing so. Similarly, low mood often relates to perturbed ethical evaluations. No longer able to trust ourselves to accomplish what we should, can leave us feeling useless and unworthy. Of note, this common ethical dysfunction (self-blaming loss of perspective/feeling somehow wrong in ourselves) is quite distinct from ethical failure (wrongdoing).

Rehabilitating Imaginative and Ethical Functioning

In response, rehabilitation needs us to reignite prospective imagination and restore a balance to life's ethical self-evaluations. This is relevant for anyone capable of appreciating their condition is life changing. While one might imagine this work is best suited to psychology, expert medical counsel addresses cardinal uncertainties arising from pasts, present and futures of the underlying conditions.

In overview, work with patients and families, on pathogenesis, diagnosis and prognosis, helps patients retrieve imaginative functioning from excess of retrospection and interoception, turning it again toward life-creating prospection. Treating patients' medical quandaries also helps shift their ethical evaluations from self-blaming resignation toward self-compassionate hope. Medical humanities develop the quality of such counsel: from advertising to politics, apt metaphors move minds, good narratives encourage; holistically, they help future health feel possible and worth pursuing once more.

Let's detail these steps further. PRM can create a healthier space for patients' *prospective* imagination, by carefully interpreting symptoms rather than ticking them off algorithmically. This involves (i) diagnosing disease-driven symptoms from their distressing, and distress-driven, *interoceptive* mimics; (ii) guiding patients and families on how they might learn to differentiate these in everyday life; and (iii) teaching on the pathogenesis of each set of experiences to settle patients' *retrospective* trawling of their past for causes. This allows PRM physicians to release interoceptive and retrospective "contractures" of the imagination, allowing the latter once more to turn forward and outward, in life-creating prospection. Such medical counsel relies on experience with pathogenetic mechanisms and diagnostic reasoning.

For rehabilitation of ethical functioning, the aim is to sketch out feasible futures that patients judge worthwhile and within reach. In this aspect, PRM specialists blend prognostic reasoning with psychological techniques, such as building self-compassion and behaviour-change. Such rehabilitation is also a creative art, where PRM draws upon medical humanities and, in particular, metaphor and narrative.

Metaphor, from political slogans to adverts, moves minds (Bleakley, 2023). Key is that metaphors are memorable, even visceral, such that patients can resort to them readily, even when far from clinic. Their rehearsal and inclusion in patient correspondence can assist this talismanic effect.

Narrative moves hearts, allowing patients to value themselves again as ethical agents in biographies of meaning and purpose (Kleinman, 1988; Charon et al, 2017; Bleakley, 2023). From fairy tales onward, we're used to sensing the "moral of the story". But we can lose that plot when distressing illness disables prospective imagination. Discouraged, we shrink from the world and its social supports. Creating forward-looking narratives that again feel ethically valuable benefits from a prospective imagination that's reignited by defusing its competitors. This re-storying blends skills in the arts and prognostication. The arts lend stories to emulate, perhaps of acceptance or overcoming (Aaltola, 2018). Prognostication, here, uses stories rather than probabilities; "plan B" narratives of the form, if this happens then we still have options to value. Classically, within PRM, this can involve discussion of mitigations for foreseeable future impairments. Often on patients' minds, these uncertainties can be soothed by weighing options. Such counsel can still be strongly therapeutic even if, ultimately, it's anticipating the choice to say "enough", and seek a sufficiency of care and symptom relief at the end of life.

Finally, another exercise for rehabilitating ethical dysfunction plays on Kant's "ought implies can" (Kohl, 2015). In rehabilitation, there's seldom conflict over doing what we can and ought; likewise, when avoiding what we neither can nor ought. But conflict smoulders when the two are in friction—where we can't do what we ought—or feel we oughtn't do what we're assured we can. Pinpointing such ethical conflicts can light paths toward resolution. In such work, PRM specialists respect that, when navigating these new mysteries within their moral universe, patients draw on myriad resources, ranging from religion and prayer, to online gaming and cannabinoids.

The case has been made for PRM to target rehabilitation of imaginative and ethical functioning. These top-line functions shape use of our others and their improvement distinguishes rehabilitation of the self from the sometimes production-line repair of the body. Otherwise, patients can feel like objects, signposted sideways from silo to silo. Fraught and frustrated, they can get discharged prematurely, judged curtly as "not engaging" or as reaching a "plateau". Patients, families and doctor-less multi-disciplinary teams (MDTs) may then call upon busy general practitioners who respond, understandably, with anxiolytics or antidepressants. Instead, by seeding PRM expertise within MDTs, we can facilitate rehabilitation of imaginative and ethical functioning. Rather than just medicating patients stalled by illness, PRM moves hearts and minds to foster *becoming*: a return to a wayfaring life, under renewed construction; a life that feels imaginable and valuable once more (Ingold, 2011).

Rehabilitating the Academy

To meet this opportunity, physicians deserve education, from undergraduate level onward, in not just the sciences of repair, but also the humanities needed for relationship-building and rehabilitation. Universities also benefit from integration between arts and sciences, if focused more on practical participation than narrowing novelty (Jesudason, 2022; Bleakley, 2023). Detailed reforms are beyond the scope of this editorial, but historical and relational perspectives may help; reminding us how, long before trying to "fix" life via science and "free" it via autonomy, we took consolation from participation in relationships and communities. Arguably, much of that effort falls now to health professionals over-employed to assess and objectify suffering, but under-equipped to relate to or console it. This risk rises as we expand the pathological to include more of what was once seen simply as life's travails. Finally, if integration of science and humanities feels unimaginable, one can be encouraged by the best randomised controlled trials. These bastions of the scientific method are now characterised by great ethical consideration, often developed via imaginative partnerships with patient groups.

Conclusion

Healthcare is being asked to do more with more; to promote health and a more holistic response to suffering, but with more science-specialised staff, arguably less rounded in the humanities. Remediation of this gap, through education, could help clinicians console patients and encourage recovery, rather than the costly alternative: perpetually labelling suffering, then medicating and/or referring it onward. Blending of science with humanities, within the practice of PRM, prioritises health, not just disease, and recognises how it's our imaginative and ethical functionings that, like maps and compass, guide us through life's sometimes unlucky and uneven landscape.

Key Points

- Rehabilitation often focuses on physical interventions with varying degrees of psychological support.
- Life changing conditions also require medical rehabilitation due to disruptions of imaginative and ethical functioning.
- These functions, creative and evaluative, shape thoughts of what one could and should do and are vital to recovery.
- Imaginative dysfunction, typified by fear of demise, is rehabilitated by diagnosing ongoing symptoms and defusing concerns over pathogenesis.
- Ethical dysfunction, typified by loss of heart and direction, is rehabilitated by addressing prognosis and what really matters.
- Such medical counsel uses both science and humanities, including metaphor to reframe predicaments and narrative to nurture hope.

Availability of Data and Materials

Not applicable.

Author Contributions

All elements of this paper were carried out by the author ECJ who read and approved the final manuscript, has participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

Not applicable.

Acknowledgement

The author would like to thank the many patients and families who attend clinics and participate in thought-provoking discussions of their life changing conditions. Their expertise and their trust is greatly appreciated.

Funding

This research received no external funding.

Conflict of Interest

Edwin C Jesudason is serving as one of the Editorial Board Members of this journal. We declare that Edwin C Jesudason had no involvement in the review of this article and has no access to information regarding its review. The author declares no conflict of interest.

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