MDForLives

THE GLOBAL PULSE OF HEALTHCARE · SURGERY INSIGHT REPORT

Surgical Prehabilitation: Why It Still Isn’t Routine Before Major Surgery

A detailed view of how surgeons are using prehabilitation before major elective procedures, which patients appear to offer the strongest return, how risk is identified, what happens when time is short, why staffing and reimbursement remain central barriers, and how digital monitoring could change participation outside the hospital.

Context → Screening → Optimization → Surgery

83 Survey records	**6** Countries represented USA · UK · Canada · Italy · France · Germany	**81.9%** Completion rate

WHY THIS REPORT

Prehabilitation asks surgeons to improve readiness before the operation, but the value of that window depends on time, team capacity, and what can realistically change

Modern perioperative care increasingly looks upstream. The American College of Surgeons’ Strong for Surgery program includes prehabilitation among preoperative strategies used to identify and address modifiable risk before elective operations. ERAS pathways similarly emphasize the full perioperative journey, and the ERAS Society continues to update specialty-specific preoperative guidance. In 2025, the UK Centre for Perioperative Care published updated clinical and implementation guidance for prehabilitation in people living with cancer.

The evidence base is encouraging but not uniform. An ACS summary published in 2026 described a systematic review of 23 randomized trials involving more than 2,100 patients in which exercise- and nutrition-based prehabilitation improved aggregate postoperative outcomes. Other recent surgery-specific reviews, particularly in colorectal cancer, have found more consistent gains in functional capacity than in complications and have highlighted variation in protocols, adherence definitions, and study quality. Prehabilitation is therefore both clinically plausible and operationally complex.

The MDForLives survey examines that implementation problem from the surgeon’s perspective. It asks whether structured prehab is routine, which procedures appear to generate the strongest return, whether a single domain or multimodal program matters most, how intensive optimization is triggered, which barriers stop routine delivery, what happens when only 2–3 weeks are available, how well patients adhere at home, which digital tools could improve participation, and what system-level change would make prehab easier to standardize.

> **Methodology and data note.** Audience: surgeons. Survey ID 8944147. The source export contains 83 survey records, an 81.9% completion rate, and responses from the USA, UK, Canada, Italy, France, and Germany. The hidden country-punching item is used only for geography metadata. Administrative tracking, bad-ID, required-text, after-question, and honeypot fields are excluded from interpretation.

EXECUTIVE SUMMARY

Six signals that explain why prehabilitation is clinically familiar but operationally uneven

INSIGHT 01

Routine adoption has crossed the one-third mark

INSIGHT 02

Orthopedic and joint replacement surgery leads

36.8% describe formal prehabilitation as routine standard of care for all major elective surgical procedures.

perceived return

44.1% identify major elective orthopedic or joint replacement surgery as the population with the highest clinical return.

INSIGHT 03

Screening remains judgment-led

48.5% rely primarily on clinical judgment during routine preoperative consultation to identify patients needing intensive optimization.

INSIGHT 04

The multidisciplinary team is the limiting resource

35.3% name lack of dedicated multidisciplinary staff as the greatest barrier to routine implementation.

INSIGHT 05

Short timelines compress the intervention

47.1% focus only on medical optimization when the pre-op window is restricted to 2–3 weeks.

INSIGHT 06

Remote monitoring is the preferred digital bridge

39.7% see remote monitoring with direct nurse or therapist contact as the digital tool with the greatest potential to improve participation.

01

ADOPTION

Prehabilitation is established enough to be routine in some institutions, but not standardized enough to be the default everywhere

36.8% say formal prehabilitation is routine standard of care for all major elective surgical procedures.

CONTEXT

Prehabilitation has moved from a niche research concept into mainstream perioperative discussion. ACS Strong for Surgery explicitly includes prehabilitation in preoperative risk reduction, and ERAS pathways frame recovery as a process that starts before the operation. The implementation challenge is that a program requires more than surgeon buy-in.

WHAT THE DATA SHOWS

Routine use across all major elective procedures is the largest response at 36.8%. Selective implementation for high-risk or frail patients is 22.1%, informal surgeon-led recommendations 20.6%, no formal program 17.6%, and development or pilot testing 2.9%.

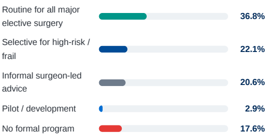
THE INSIGHT

The pattern describes partial institutionalization. A meaningful group has reached routine delivery, but nearly two-thirds report some degree of selectivity, informality, absence, or early development. Prehab is therefore not a fringe concept, yet access still depends on local infrastructure and pathway maturity.

WHY IT MATTERS

For surgeons, this means prehabilitation may function differently across operating lists. A standardized referral pathway can reduce variation, clarify which patients qualify, and allow optimization to start when the operation is scheduled rather than when deterioration or delay makes the need obvious.

Current adoption of formal, structured prehabilitation programs



02

PERCEIVED CLINICAL RETURN

Orthopedic and joint replacement surgery is where surgeons most clearly see the return on multimodal prehabilitation

44.1% identify major elective orthopedic or joint replacement surgery as the population with the highest clinical return.

CONTEXT

The opportunity for prehabilitation is shaped by procedure type and time. Elective arthroplasty commonly has a scheduled pathway, visible mobility goals, and established rehabilitation infrastructure. Major surgical oncology may carry equally compelling physiologic needs, but cancer timelines can constrain how long optimization can run before treatment.

WHAT THE DATA SHOWS

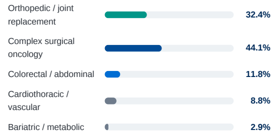
Major elective orthopedic or joint replacement surgery leads at 44.1%. Complex surgical oncology follows at 32.4%, colorectal and abdominal surgery at 11.8%, cardiothoracic and vascular surgery at 8.8%, and bariatric and metabolic surgery at 2.9%.

THE INSIGHT

These percentages capture perceived return, not comparative treatment effect. Still, they show where surgeons believe the combination of patient need, available time, functional goals, and program infrastructure creates the strongest case for prehab.

WHY IT MATTERS

Implementation may need to be specialty-specific rather than one-size-fits-all. An orthopedic pathway can emphasize conditioning, strength, mobility, nutrition, and expectations. A cancer pathway may need a faster multimodal model that protects oncologic timing while addressing nutrition, anemia, smoking, fitness, and psychological readiness.



Surgical population perceived to have the highest clinical return

---

03

PROGRAM DESIGN

Surgeons lean toward multimodal prehabilitation, but nutrition is the strongest single domain when one component must be prioritized

36.8% say multimodal integration is strictly necessary, while 30.9% choose nutritional optimization as the most critical single domain.

CONTEXT

Prehabilitation can address several modifiable risks at once: physical conditioning, nutrition and sarcopenia, anemia and medical optimization, smoking, and psychological preparation. The practical question is whether the program should be built around one high-yield component or around a coordinated bundle.

WHAT THE DATA SHOWS

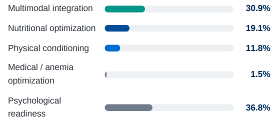
Multimodal integration leads at 36.8%. Nutritional optimization is 30.9%, physical conditioning 19.1%, medical and anemia optimization 11.8%, and psychological readiness 1.5%.

THE INSIGHT

The result suggests surgeons see prehab as more than preoperative exercise. Nutrition nearly matches the multimodal response, which is clinically relevant in patients with sarcopenia, cancer-related weight loss, poor intake, or high metabolic stress. Physical conditioning remains important, but it is not the dominant standalone choice.

WHY IT MATTERS

A practical pathway can be multimodal without being identical for every patient. Screening can identify the dominant modifiable risks, while the team decides which elements need immediate escalation. That is especially important when the pre-op window does not allow every component to be delivered at full intensity.



Most critical prehabilitation domain for reducing 30-day postoperative complications

04

RISK IDENTIFICATION

Clinical judgment remains the main doorway into intensive optimization, which keeps flexibility high but standardization low

48.5% use clinical judgment during routine preoperative consultation as the primary method for identifying patients who need intensive prehab.

CONTEXT

Surgeons routinely integrate comorbidity, functional reserve, frailty, nutrition, surgical magnitude, urgency, and patient preference. That makes clinical judgment central to operative planning. The question is whether it should also be the sole trigger for a multidisciplinary optimization pathway.

WHAT THE DATA SHOWS

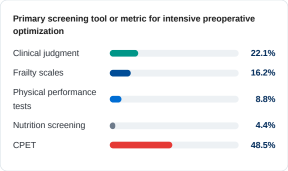
Clinical judgment leads at 48.5%. Standardized frailty scales are selected by 22.1%, objective performance tests by 16.2%, nutritional screening tools by 8.8%, and CPET by 4.4%.

THE INSIGHT

The survey suggests structured testing is used, but not as the dominant gatekeeper. That can be reasonable when resources are limited or procedure mix is broad, yet it increases dependence on individual recognition and local practice style.

WHY IT MATTERS

A hybrid model can preserve surgeon judgment while making risk recognition more consistent. Simple frailty, nutrition, and functional screens can trigger deeper evaluation or referral when needed, while CPET and more intensive testing remain targeted to selected patients and procedures.


Primary screening tool or metric for intensive preoperative optimization

05

IMPLEMENTATION BARRIER

The main obstacle is the workforce required to deliver prehab, followed by the way that work is financed

35.3% name lack of dedicated multidisciplinary staff as the greatest barrier, and 23.5% point to reimbursement or institutional funding.

CONTEXT

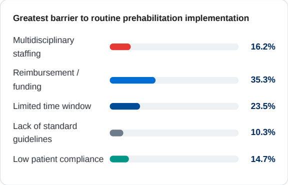
A multimodal program typically crosses professional boundaries. Exercise may require physiotherapy or exercise expertise, nutrition needs dietetic support, anemia and comorbidity optimization may involve anesthesia or perioperative medicine, and home delivery benefits from navigation and follow-up. The surgeon may initiate the process, but cannot operationalize every component alone.

WHAT THE DATA SHOWS

Multidisciplinary staffing is the leading barrier at 35.3%. Reimbursement or institutional funding is 23.5%, a limited time window 16.2%, lack of standardized guidelines across specialties 14.7%, and patient compliance or attendance 10.3%.

THE INSIGHT

Two infrastructure problems, staffing and financing, account for the top positions. Patient compliance is real, but it is not the leading explanation for why programs fail to become routine. The institution's ability to provide a service appears more limiting than the patient's willingness to engage.


Greatest barrier to routine prehabilitation implementation

WHY IT MATTERS

This shifts the improvement question from 'How do we convince surgeons to use prehab?' to 'Who owns the pathway, who is funded to deliver it, and how quickly can the patient access it after the operation is booked?' Those are governance and service-design questions as much as clinical ones.

06

TIME-SENSITIVE SURGERY

When only 2–3 weeks remain, prehabilitation becomes a triage problem rather than a full-program question

47.1% focus exclusively on medical optimization when urgent or cancer timelines compress the pre-op period.

CONTEXT

Time is one of the most clinically sensitive variables in prehabilitation. A surgeon may see clear benefit in optimization while also managing disease progression, symptoms, operating-room availability, and patient anxiety about delay. The shorter the window, the more the team has to distinguish interventions that can change risk quickly from those that require longer conditioning.

WHAT THE DATA SHOWS

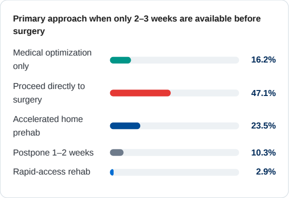
Medical optimization only is selected by 47.1%. Proceeding directly to surgery without delaying for prehab is 23.5%, an accelerated high-intensity short-course home regimen 16.2%, postponing surgery by 1–2 weeks 10.3%, and rapid-access outpatient rehabilitation 2.9%.

THE INSIGHT

The result reveals a hierarchy under pressure. When time contracts, surgeons prioritize interventions such as anemia treatment, smoking cessation, nutrition supplementation, and other medical optimization that may be easier to initiate immediately. Broader multimodal conditioning is more difficult to preserve.

WHY IT MATTERS

The right answer is not automatically to delay or not delay. The survey supports a rapid-assessment model in which surgical urgency, modifiable risk, likely time-to-benefit, and patient preference are weighed together. Institutions that want prehab to function in cancer and urgent elective care need a fast-start pathway rather than a program designed only for long elective runways.



Primary approach when only 2–3 weeks are available before surgery

---

07

HOME ADHERENCE

The home pathway is scalable, but the most common adherence estimate remains below 50%

36.8% estimate that only 25%–50% of surgical patients fully adhere to prescribed home-based exercise and nutrition regimens.

CONTEXT

Home-based prehabilitation is attractive because it reduces travel, can start quickly, and may fit patients who cannot attend frequent in-person sessions. It also transfers more responsibility to the patient and family, which makes adherence visible as a clinical variable rather than an administrative detail.

WHAT THE DATA SHOWS

The 25%–50% adherence band is the largest at 36.8%. Moderate-high adherence of 51%–75% is 32.4%, poor adherence below 25% is 13.2%, high adherence above 75% is 10.3%, and 7.4% are unsure or do not monitor home adherence.

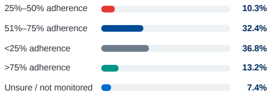
THE INSIGHT

Most respondents do not place their patients in the highest adherence category. That helps explain why digital monitoring and clinician check-ins rank strongly later in the survey. A home program without visibility can be difficult to distinguish from a recommendation that was never implemented.

WHY IT MATTERS

For surgical teams, the useful question is not only whether the patient received instructions. It is whether the program can detect missed sessions, declining activity, nutritional non-adherence, or new symptoms early enough to intervene before the operation.

Estimated proportion of patients fully adhering to home-based prehabilitation



08

DIGITAL SUPPORT

Surgeons prefer technology that keeps a clinician in the loop rather than technology that simply sends more reminders

39.7% see remote patient monitoring with direct nurse or therapist check-ins as the digital tool with the greatest potential to improve participation.

CONTEXT

Digital prehabilitation can support home exercise, nutrition tracking, education, symptom monitoring, and communication. The distinction is whether technology acts mainly as a content-delivery channel or as a connection between the patient and the perioperative team.

WHAT THE DATA SHOWS

Remote monitoring with direct nurse or therapist check-ins leads at 39.7%. Mobile health apps with guided exercise and nutrition logs are 29.4%, wearable activity trackers 26.5%, VR or gamified therapy 2.9%, and automated SMS or email reminders 1.5%.

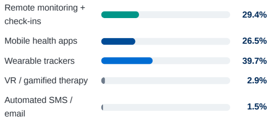
THE INSIGHT

The strongest option is the one that adds human oversight. That suggests surgeons value digital tools less for novelty and more for closing the feedback loop: is the patient doing the program, are they tolerating it, and does the plan need to change?

WHY IT MATTERS

This approach could also make adherence measurable. A home program becomes more actionable when the team can see activity, contact the patient, escalate nutrition or medical concerns, and document whether the intervention was completed before surgery.

Digital technology with greatest potential to improve participation



09

SCALING THE PATHWAY

Surgeons put reimbursement first, but the next priorities are workflow integration and accountability

33.8% choose mandatory insurance coverage and dedicated reimbursement as the systemic change most likely to establish prehabilitation as universal standard of care.

CONTEXT

A program becomes routine when the clinical pathway and the operating model reinforce each other. That includes payment, staffing, referral triggers, documentation, quality measures, digital access, and training. The survey's final structured question asks surgeons which system change would matter most.

WHAT THE DATA SHOWS

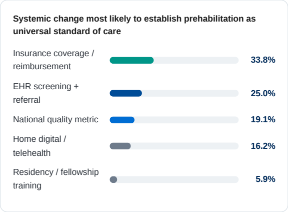
Insurance coverage and dedicated reimbursement lead at 33.8%. Full EHR integration of screening prompts and referral order sets is 25.0%, inclusion of prehab compliance as a national surgical quality metric 19.1%, expansion of home-based digital and telehealth programs 16.2%, and mandatory residency or fellowship training 5.9%.

THE INSIGHT

The top three answers address three different layers of standardization: finance the service, make it part of routine workflow, and measure whether it happens. That sequence is more structural than educational. Training matters, but respondents do not see knowledge alone as the main missing piece.

WHY IT MATTERS

Universal adoption is therefore unlikely to come from publishing another protocol by itself. Hospitals and payers would need to make prehab easy to order, possible to staff, financially sustainable, and visible in quality systems. Otherwise the pathway will continue to depend on local champions.


Systemic change most likely to establish prehabilitation as universal standard of care

OPEN-ENDED PERSPECTIVE

When surgeons describe the change they need most, the answer is not another isolated intervention. It is a better-supported perioperative system.

The open-ended item asked for the single most critical policy or surgical-workflow change needed to ensure high-risk patients are adequately optimized before entering the operating room. Most visible responses were substantive, with one response too unclear to support interpretation. Themes below are qualitative and are not assigned percentages.

Give the team time and people

Respondents ask for dedicated prehab staff, specialized personnel, a team-based approach, ancillary support, and enough provider time to counsel and optimize patients. This closely matches the structured finding that multidisciplinary staffing is the leading barrier.

Pay for the work

Insurance coverage and reimbursement appear repeatedly in the open text. The comments reinforce the structured system-change question, where dedicated coverage and billing are the most selected route to universal adoption.

Standardize identification and coordination

Respondents call for site- and specialty-specific protocols, better pre-op assessment, systems that identify high-risk patients without relying only on surgeon initiation, and better coordination between primary care, anesthesia, and surgery.

Make patient education part of the pathway

Several comments focus on patient education, clear information, adherence, and reducing misunderstanding about why prehabilitation matters. The theme adds nuance to the lower structured ranking for patient compliance: engagement may improve when the pathway itself provides better explanation and support.

What the qualitative responses add: surgeons are asking for a service model around prehabilitation. Their comments connect patient education, staffing, reimbursement, risk identification, provider training, and cross-specialty coordination into one implementation problem.

SURGICAL PREHABILITATION PRACTICE LENS

What a more workable prehabilitation pathway could look like before major surgery

The survey does not define one universal protocol. It does identify the points where surgical teams can reduce variation without replacing procedure-specific judgment.

Trigger optimization when surgery is booked

Use simple frailty, nutrition, functional, and medical risk screens to support surgical judgment and identify who needs a deeper prehab pathway early.

Match intensity to the time available

Build full multimodal pathways for longer elective windows and rapid-start versions for cancer or urgent surgery where delaying the operation may carry its own risk.

Make ownership explicit

Define which parts belong to surgery, anesthesia or perioperative medicine, physiotherapy, nutrition, nursing, and navigation so referrals do not stall between teams.

Monitor the home phase

Use remote check-ins, apps, or wearables when they help the team see adherence, respond to problems, and document whether the patient is actually progressing before surgery.

PEOPLE ALSO ASK

Frequently asked questions about surgical prehabilitation

What is surgical prehabilitation?

Surgical prehabilitation is a preoperative process designed to improve a patient's functional and physiologic reserve before an operation. Programs may include exercise, nutrition, medical risk-factor optimization, psychological support, and education.

How long does prehabilitation take before surgery?

There is no single duration for every operation. Programs can range from short preoperative interventions to several weeks, depending on surgical urgency, patient risk, procedure type, and local protocols. Cancer and other time-sensitive pathways may require compressed approaches.

What should a multimodal prehabilitation program include?

A multimodal program can combine physical conditioning, nutritional optimization, medical risk-factor management, smoking cessation, anemia management where appropriate, psychological preparation, and education. The exact mix should reflect the patient and planned surgery.

Which surgical patients benefit most from prehabilitation?

Potential benefit depends on the procedure, baseline functional reserve, frailty, nutrition, comorbidities, and available time before surgery. High-risk major elective procedures are common targets, but specialty-specific evidence and protocols vary.

How can surgeons identify patients who need preoperative optimization?

Assessment may combine clinical judgment with structured frailty scales, objective performance testing, nutrition screening, cardiopulmonary exercise testing in selected patients, and review of modifiable medical risks.

Can home-based or digital prehabilitation work?

Home-based programs can extend access and reduce travel burden, especially when paired with clear exercise and nutrition plans, monitoring, and clinician follow-up. Their effectiveness depends on patient selection, adherence, program design, and the type of surgery.

CLOSING PERSPECTIVE

Prehabilitation will become routine only when the perioperative system makes optimization as operationally real as the operation itself

The MDForLives data describes a surgical community that largely accepts the logic of preparing patients before major operations, but does not yet work inside one standardized implementation model. More than a third report routine formal prehabilitation, while others use selective pathways, informal advice, or have no formal program. The most visible gap is therefore not awareness. It is consistency.

The findings also show why consistency is difficult. Prehab spans nutrition, conditioning, medical risk, anemia, smoking, psychological readiness, and patient education. The largest group believes these components work best as a multimodal package, yet the primary screening gateway remains clinical judgment and the strongest implementation barrier is lack of dedicated multidisciplinary staff. That creates a familiar problem: the surgeon can identify risk, but the service needed to modify that risk may not be immediately available.

Time makes the problem sharper. In a 2–3 week window, nearly half of respondents narrow their strategy to medical optimization and almost a quarter would proceed directly to surgery rather than delay for prehab. This is not a contradiction of the broader multimodal preference. It is a reminder that surgical optimization always operates inside a competing-risk decision. The relevant question is which modifiable risks can be changed fast enough to matter without compromising the timing of definitive treatment.

The home phase introduces a second implementation gap. High adherence is not the norm in this survey, and respondents place the greatest digital potential in remote monitoring that includes direct nurse or therapist contact. Technology appears most useful when it makes participation visible and keeps the care team connected, not when it simply automates more messages.

Finally, the system-change question points toward what universal adoption would require. Surgeons rank reimbursement first, EHR integration second, and quality measurement third. The open-ended responses echo the same architecture with calls for dedicated teams, protected time, standardized protocols, better risk identification, patient education, and coordination between primary care, anesthesia, and surgery. The implication is clear: prehabilitation becomes standard when it is financed, staffed, triggered, monitored, and owned as a perioperative service.

1 · Screen early enough to act

Move risk identification to the start of the surgical pathway so optimization time is not lost after the operation date is fixed.

2 · Preserve multimodal thinking

Assess nutrition, function, medical risk, anemia, smoking, and psychological readiness even when only selected components can be intensified.

3 · Create a short-window protocol

Define what can be started immediately when there are only days or a few weeks before surgery, and when delay would be inappropriate.

4 · Fund the multidisciplinary team

Make the service deliverable through staffing, reimbursement, and clear ownership rather than leaving execution to individual surgeons.

5 · Measure participation, not just referral

Track whether home exercise, nutrition, and other interventions are actually completed and respond when adherence falls.

6 · Embed prehab in the surgical workflow

Use EHR prompts, referral order sets, and quality measures to make the pathway routine instead of dependent on local champions.

Help future surgical insights reflect what happens before the patient enters the operating room.

Share your perspective with MDForLives and help build a clearer view of prehabilitation, risk selection, perioperative optimization, surgical timing, patient adherence, and multidisciplinary care in real-world practice.

Join the Panel

Sources used for this report

1. **MDForLives Surgery Insight Survey_Aug, SGID 8944147.** Source survey report: 83 survey records, 81.9% completion rate, six countries, and question-level values used exactly as reported. Administrative and validation fields were excluded. Open-ended themes were interpreted qualitatively without coding percentages.
2. **American College of Surgeons.** Strong for Surgery. Preoperative checklists include nutrition, smoking cessation, prehabilitation, medication safety, pain control, and other modifiable risk areas. https://www.facs.org/quality-programs/qi-resources/strong-for-surgery/
3. **American College of Surgeons.** Prehabilitation, Strong for Surgery. Defines prehabilitation as improving functional capability before a surgical procedure to help patients withstand postoperative inactivity and decline. https://www.facs.org/for-patients/preparing-for-surgery/strong-for-surgery/prehabilitation/
4. **ERAS Society.** Guidelines. Includes specialty-specific enhanced recovery guidance and 2025 recommendations for preoperative care in elective colorectal surgery. https://erassociety.org/guidelines/
5. **Centre for Perioperative Care.** Prehabilitation for people with cancer: Clinical and implementation guidelines, updated 2025. Developed with perioperative, anesthesia, nutrition, cancer, and research partners to support implementation of prehabilitation services. https://www.cpoc.org.uk/guidelines-and-resources/guidelines
6. **American College of Surgeons.** Optimizing Exercise, Nutrition Before Surgery Boosts Patient Outcomes, April 29, 2026. Summarizes a systematic review and meta-analysis of 23 randomized trials of exercise- and nutrition-based prehabilitation. https://www.facs.org/media-center/press-releases/2026/optimizing-exercise-nutrition-before-surgery-boosts-patient-outcomes/
7. **Li X, et al.** The effectiveness of multimodal prehabilitation on functional capacity and clinical outcomes in patients undergoing elective laparoscopic colorectal cancer surgery: a systematic review and meta-analysis of randomized controlled trials. 2026. The review reported modest functional-capacity improvements, no significant complication reduction, and important study heterogeneity and risk-of-bias limitations. https://pubmed.ncbi.nlm.nih.gov/41872610/

MDForLives

The Global Pulse of Healthcare

MDForLives is a global healthcare insights platform where healthcare professionals, patients, and caregivers discover, share, and shape the future of healthcare. This report presents aggregated perspectives for professional insight and discussion. It is not clinical guidance, treatment advice, or a substitute for patient-specific judgement, approved product information, or local practice standards.

© 2026 MDForLives

A Borderless Access platform

Real Opinions to Insights. Validated by Data.