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The role of geriatric liaison teams in general surgery: a necessity, not an option

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As healthcare systems worldwide contend with an aging population, the demand for surgical services among older adults continues to rise. The National Health Service (NHS) data show a steady increase in hospital admissions for older patients,[1] with many presenting with complex general surgical conditions such as bowel obstruction, ischemia, perforation, and inflammatory diseases like diverticulitis and appendicitis. These patients often have multiple comorbidities, homeostenosis (reduced physiological reserve), and varying degrees of frailty, all of which contribute to higher postoperative complication rates, prolonged hospital stays, and increased mortality.[2] While adverse postoperative outcomes may be somewhat expected in this cohort, evidence suggests that we can and must do more to improve their surgical journey.[3] Historically, older patients were less likely to be offered surgical intervention due to concerns about poor outcomes. However, shifting attitudes and evolving societal expectations have led to more elderly patients undergoing surgery. While this change represents progress, it also exposes significant gaps in perioperative care for this vulnerable group. The traditional approach, where medical input is sought on an *ad hoc* basis from already overburdened registrars, fails to provide the continuity and specialized support these patients require.

A promising solution is the integration of geriatric liaison or frailty teams into surgical care, a collaborative model designed to optimize outcomes for older surgical patients. While geriatricians have long played a key role in managing frailty and multimorbidity, their integration into surgical pathways remains inconsistent outside of well-established orthogeriatric teams.[4] Yet, as outlined in joint guidance from the Centre for Perioperative Care and the British Geriatrics Society, embedding geriatricians within surgical teams should be standard practice across all surgical specialties.[5] Geriatricians bring a unique skill set that extends beyond traditional medical management. Their expertise in comprehensive geriatric assessment (CGA) allows for early identification of frailty, cognitive impairment, polypharmacy, and other key predictors of surgical outcomes. This enables tailored decision-making, not just determining whether a patient should undergo surgery, but ensuring they are optimized to withstand the physiological stress of the procedure.

In acute surgical emergencies, such as perforated bowel or ischemic bowel disease, time is of the essence. Here, geriatricians provide rapid assessment and risk stratification, helping to balance surgical urgency with the patient's overall health status. Preoperatively, they assist in stabilizing medical conditions, optimizing fluid management, and implementing delirium prevention strategies. Postoperatively, they play a crucial role in early rehabilitation, ensuring that frail patients regain function as swiftly as possible to avoid prolonged hospital stays and associated complications.

For elective cases, geriatricians focus on prehabilitation, an approach that enhances a patient's physical and cognitive resilience before surgery. Working alongside physiotherapists and dietitians, they implement exercise programs, nutritional strategies, and medication adjustments aimed at reducing postoperative complications. During the perioperative period, they collaborate with anaesthetists to tailor anaesthesia plans that minimize cognitive side effects and postoperative delirium. Additionally, they optimize chronic disease management, ensuring stable cardiovascular, renal, and glycaemic control; thereby reducing the risk of surgical complications such as myocardial infarction, acute kidney injury, and poor wound healing. Postoperatively, geriatricians facilitate early mobilization and rehabilitation, mitigating functional decline and promoting timely discharge. Too often, older patients experience a loss of independence following surgery, leading to higher readmission rates and institutionalization. By embedding geriatric expertise within the surgical pathway, these adverse outcomes can be significantly reduced.

A study in England observed the impact of an embedded geriatric surgical liaison service for patients admitted for gastrointestinal surgery.[6] The authors established a service in line with the estab-

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lished evidence base, including the orthogeriatric model of care, where elective patients would undergo a comprehensive geriatric assessment prior to surgery, and postoperative elective and emergency patients would benefit from twice-weekly joint medical-surgical ward round reviews as well as discussion at discharge planning meetings. Patients who were identified to have more complex medical complications or increased rehabilitation needs would have access to a geriatrician-led surgical rehabilitation ward. There was a significant reduction in the mean length of stay in emergency admissions and a trend indicating a greater reduction in length of stay with advancing age in patients admitted electively. The benefits of the implementation of similar services in other surgical specialties, such as urology[7] and vascular surgery[8] have been demonstrated.

One of the most compelling arguments for integrating geriatric liaison teams into surgical care is the financial burden associated with prolonged hospital stays. Older patients, particularly those who experience postoperative complications, often require extended admissions due to functional decline, medical instability, and delays in discharge planning. This increases healthcare costs and places additional strain on hospital resources, leading to bed shortages and the cancellation of planned surgical procedures. Studies have shown that comprehensive geriatric assessment and early intervention can significantly reduce length of stay, translating into substantial cost savings for healthcare systems. By investing in proactive perioperative care, hospitals can improve patient outcomes while simultaneously reducing expenditures associated with extended admissions.

Despite evidence supporting the benefits of geriatric liaison teams, several barriers continue to hinder widespread adoption:

1. Resource limitations: funding constraints, staffing shortages, and the time required to establish dedicated teams present significant challenges.
2. Organizational resistance: lack of leadership support and siloed hospital structures often delay the integration of multidisciplinary care models.
3. Cultural barriers: scepticism among surgeons about potential delays to decision-making, coupled with a lack of awareness about the benefits of geriatric input, can hinder collaboration.
4. Logistical issues: inadequate electronic health record integration and poor coordination between teams can create inefficiencies.

The value of integrating geriatricians into surgical teams remains underappreciated. Benefits include reduced complications, shorter admissions, improved functional outcomes, and more patient-centred care. Overcoming the barriers to implementation is crucial. Healthcare systems must move toward integrated models that reflect the needs of frail, multimorbid patients. The outdated divide between "medicine" and "surgery" must evolve into a holistic, collaborative approach that enhances surgical outcomes for the aging population.

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