Optimizing the geriatrician's contribution to cancer care for older patients

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Abstract

Cancer specialists and geriatricians can struggle to find the best form for their collaboration within geriatric oncology and do not always benefit optimally from the experience and knowledge the other has to offer. To optimize the yield of a geriatric consultation for older cancer patients, the geriatrician needs to know the specific purpose of the consultation, the expected disease trajectory, and some information on the potential benefits and risks of treatment options including best supportive care only. The geriatrician should subsequently focus primarily on the patient, their preferences and priorities with regards to oncologic and non-oncologic outcomes and assess their overall health status through a geriatric assessment that includes at minimum comorbidities, medication review, basic and instrument activities of daily living, mobility, falls, nutritional status, cognition, mood and social support. Reporting back to the cancer specialist should be concise, objective whenever possible and to the point. Within the multidisciplinary team, the geriatrician can contribute with information on health status and reserves, remaining life-expectancy and toxicity risks, and by creating awareness of the limitations of evidence regarding the older population. This will help in reaching a well-tailored treatment decision that balances cancer-related and patient-centred outcome measures and fits within the patient's own preferences for treatment.

Introduction

Over the past two decades, the field of geriatric oncology has grown rapidly. Cancer specialists increasingly recognize the value of geriatric assessment in the care for their older patients, supported by position papers from the International Society of Geriatric Oncology¹ and, more recently, the American Society of Clinical Oncology.² Some cancer specialists will choose to incorporate aspects of geriatric assessment into standard care pathways as provided by the oncology team while others will aim to achieve this through collaboration with geriatricians.

However, cancer specialists and geriatricians can struggle to find the best form for their collaboration or do not benefit optimally from the experience and knowledge the other has to offer.³ For both groups of specialists, geriatric oncology is often new and was not part of their training curriculum.^{4;5} Geriatricians may feel they lack knowledge on the wide range of tumour types and continuously evolving treatment options to give useful recommendations. Cancer specialists may not know what they can ask or expect from a geriatrician. When seeking a clear yes or no about the feasibility of treatment, the cancer specialist may be frustrated when instead receiving an elaborate, seemingly irrelevant geriatric descriptions of the patient's health status.³ In oncology, personalized treatment often begins with the tumour, its pathology, genetics and staging, which are incorporated in algorithms that yield treatment recommendations; the next step will then be to assess whether the patient is suitable for the treatment. A geriatric approach to personalized treatment often starts at the other end, with an emphasis on the patient's health status, individual goals of care and physical strengths and limitations; subsequently, it is assessed whether the treatment is suitable for the patient. Whilst this generalisation clearly does not do justice to individual differences between medical specialists, an underlying difference in how decision making is approached can complicate the collaboration process if not sufficiently acknowledged.

As cancer specialists and geriatricians are trying to discover the best ways to collaborate, they often go through the same process and encounter the same issues as others have before them. There could be significant benefit in learning from one another. Therefore, this paper aims to provide some guidance for specialists seeking geriatric oncology collaboration and focuses on three main questions. (1) What does the geriatrician need to know about the cancer and treatment options in order to optimize the yield of a geriatric consultation? (2) What should the geriatrician aim to provide for the patient and the referring physician? (3) And finally, how can the geriatrician contribute within the multidisciplinary team to optimize decision-making for older cancer patients?

What information does the geriatrician need regarding the cancer and treatment options

Oncology itself is generally not a mandatory component of the curriculum for geriatric fellows.⁴ A recent survey among geriatric fellowship directors showed that only 26% considered it very important for a geriatric fellow to 'broadly understand cancer therapies for most common cancers in older adults'.⁴ Although this may seem surprising, the average patient within geriatric medicine is much older, more frail and has significantly more multimorbidity than the patients the geriatrician will encounter within geriatric oncology.⁶ For geriatricians working in general geriatrics, knowing how to manage symptoms of and complications from cancer will be more relevant than knowing about cancer treatment itself.⁴ However, for a useful geriatric oncology consultation, the geriatrician will need some basic background information on the cancer and possible treatment options. Which information is most pertinent to decision making, will vary per case.

It will also depend on the reason why the patient is referred to the geriatrician (Table 1). Sometimes the purpose is to do a one-time assessment which can guide treatment decisions; there may be several viable treatment options or perhaps the consideration is whether to start treatment at all.¹ In other cases, the decision regarding treatment has already been made, and the purpose of the referral is to optimize the patient's health status prior to treatment initiation; in these cases, the request could be for on-going management by the geriatrician during the course of treatment.⁷ Sometimes the patient may have cognitive impairment, potentially affecting their ability to provide informed consent. Another reason may be that the patient is uncertain about treatment preferences, their own ability to tolerate treatment or the impact treatment may have on their cognitive and physical functioning.⁸ Finally, depending on the way palliative care is organised locally, geriatricians may have a role in the initiation and follow up of advance care planning.

When aiming to optimize the collaboration between geriatricians and cancer specialists, enhancing communication is the first and most important step. This begins with conveying to the geriatrician the reason for referring the patient and any questions the cancer specialist would like to have answered. The more specific these questions, the more specific the answer is likely to be. Also, providing some case-specific information regarding the cancer and treatment options under consideration will greatly help to optimize the yield of the geriatric consultation. Whilst some of this information is available from the patient's chart or electronic medical record, it may also be useful for a cancer specialist to discuss these issues with the geriatrician at the time of referral. Table 2 provides an overview of some specific issues that could be relevant.

First of all, it is important to understand how the cancer currently affects the general state of the patient. Is the cancer symptomatic or was it an incidental finding? Does the cancer explain any of the patient's current complaints and will this likely be alleviated by treatment? For example, if a small tumour in the colon is discovered by chance in a patient who is frail, the general state of the patient cannot be explained by the tumour, and is therefore unlikely to be positively affected by cancer treatment. However, if this tumour causes bleeding and recurring anaemia, which could subsequently lead to fatigue and deconditioning, the benefit of treatment may be quite different.

Similarly, it is important to understand possible trajectories of the disease, for example what complications may be expected from the cancer if left untreated and at which time-interval these might occur. While for many of these questions no clear-cut evidence-based answer will be available, it is likely that the educated estimation of an experienced cancer specialist will be more accurate than that of a geriatrician with much less practice in oncology. Discussing these issues will allow for a better estimation of both current and future risks as well as the likely time-to-benefit of treatment, that is, the time that needs to pass before a statistically significant benefit (such as less disease recurrence or improved survival) is observed in trials of people receiving the therapy compared to a control group without the therapy. It may also be relevant for the geriatrician to know how prognosis may be affected if cancer treatment is postponed, for example for prehabilitation before surgery or when choosing to wait with treatment until the cancer becomes (more) symptomatic. In some cases, this might be a reasonable option, while in others a timely start will significantly increase the likelihood of treatment success.

When a geriatric recommendation regarding treatment choice is requested, the geriatrician needs to know what would be considered standard treatment for the tumour type and stage that the patient has. In addition to standard treatment, any reasonable alternative treatment strategies are relevant

to know about, with some information about their intensity or toxicity and why they might be considered more or less viable than standard treatment. It is also useful to know of any specific organ system that is often affected by treatment, for example the kidneys or heart, as this may influence the treatment decision or offer an opportunity for pre-treatment optimization.

Finally, it should be clarified whether treatment options are given with curative or palliative intent. For treatment given with curative intent, some understanding of the likelihood of curation is important, as this may vary greatly across tumour types and stages. In particular, the geriatrician needs to realize that in some cases, curative intent implies that curation is a possibility rather than a probability. For example, in case of colon cancer with resectable liver metastases, surgical resection may be defined as having curative intent, but the likelihood that curation can be as low as 15%.⁹ In case of palliative treatment, it helps to know whether this is aimed at alleviating symptoms and/or prolongation of life, and if the latter, whether expected benefit should be thought of in terms of months or years. Novel treatment options may yield results that differ significantly from what the geriatrician has last heard about a particular cancer type – for example in case of immunotherapy for advanced stage melanoma, which has dramatically changed the prognosis in selected patients. Having up-to-date information will help the geriatrician's thought process regarding treatment options.

What the geriatrician should aim to provide

Table 3 provides an overview of ways in which a geriatric perspective can contribute to treatment decision-making and cancer care. Perhaps one of the important contributions a geriatrician can make to multidisciplinary decision-making regarding cancer treatment for older patients with cancer is ensure the focus remains on the patient. Several prior studies have demonstrated that information about comorbid conditions, the psychosocial context and the patient's priorities and values are often lacking or receive little attention within multidisciplinary oncology team meetings.¹⁰ This could lead to treatment recommendations that are tailored to the tumour's characteristics but not necessarily the patient's health status and reserves. The underlying assumption may be that optimal treatment of the disease equals optimal treatment of the patient, but in the older patient population, this is not always true.

Uncovering geriatric impairments

An important aspect of focussing on the patient is uncovering geriatric impairments which may have been missed in the standard oncology work-up.¹¹ One reason can be that these issues often do not come up unless they are specifically inquired after, or because of underreporting by the patient or caregiver. Sometimes a caregiver will take the lead in the conversation with the specialist, or patients might defer to their caregiver when a question is asked, leaving it unclear how much the patient has understood or remembered of the information that is given. A recent study also showed that when the patient does bring up concerns regarding geriatric impairments in a consultation with the cancer specialist, these are not always acknowledged¹² and often not recorded.¹³

Through a geriatric assessment, impairments relevant to oncologic treatment decisions can be uncovered. This assessment should at minimum include comorbidities, medication review, basic and instrumental activities of daily living, mobility, falls, nutritional status, cognition, mood and social support.¹ A systematic review published in 2018 showed that in a median of 28% of patients (range 8-54%), the initial oncologic treatment plan was altered after the results of the geriatric assessment were shared with the multidisciplinary team, generally resulting in a shift towards a less intensive treatment option.¹⁴

When considering comorbidities and their importance in decision-making, not only the number and type of comorbid conditions is relevant, but also their severity and if they are or can be adequately compensated with medication. Assessment of comorbidities provides an opportunity for optimizing overall health status. In addition, serious comorbidities can represent a competing mortality risk,¹⁵ which may sometimes limit the relevance of the current malignancy,^{16;17} particularly when the latter is asymptomatic. Furthermore, some comorbid conditions can be exacerbated by treatment, thus affecting treatment tolerance or benefit.

Having multiple comorbidities often also means having multiple types of medication, and polypharmacy renders patients more likely to undertreatment.¹⁸ Careful review of medication and any possible unwanted interactions or side-effects is a routine part of care for most geriatricians. For many cancer specialists, depending somewhat on their background, this review is not something they are comfortable with or have time for; even more so as new drugs are constantly becoming available, making it difficult to keep up.

The combination of performance status and comorbidity is often routinely used by cancer specialists to assess overall physical condition and shape clinical judgement, but previous research has shown that functional impairments in basic and instrumental activities of daily living can still be missed this way.¹⁹⁻²¹ Functional dependency is a predictor of postoperative complications, toxicity and increased mortality.^{1;22;23} Furthermore, gait speed and recent falls are fairly consistently associated with prognosis, treatment-related complications and functional decline after treatment, including institutionalisation.²⁴⁻²⁸ Treatment can also exacerbate mobility impairment, for example through polyneuropathy which may occur with some types of chemotherapy.

When analysing physical functioning, it is important but sometimes challenging to differentiate between dependency caused by intrinsic frailty or caused by symptoms related to the tumour, which might be reversible with treatment. Inquiring about the trajectory of the decline in functioning may give some clues about the likely underlying causes.²⁸ This will often need to be based on patient self-report or the assessment of the caregiver, as functional status is often found not to be recorded in clinical records.¹³

Malnutrition can be associated with increased psychosocial stress and poor quality of life in patients with cancer.²⁹ Eating and drinking together may help the patient feel connected to others, and even small amounts of food and drink can be important in a symbolic way. As both cancer and age may affect nutritional status and food intake, this is an important factor to address. Furthermore, nutritional status is highly associated with prognosis.^{1;23} There is some debate on whether this association is due to the fact that undernutrition itself leads to poorer survival, or if it is merely a proxy of a more aggressive or debilitating tumour type. Irrespective of it being due to the patient's intrinsic frailty or the cancer, undernutrition is consistently associated with adverse treatment outcomes, including toxicity and other treatment-related complications.²³ Of note, nutritional status

is often routinely assessed in a standard oncologic work-up and many times protocolled interventions will already be in place. However, no studies thus far have demonstrated that these nutritional interventions are able to reverse the negative impact of malnutrition on oncologic outcomes.

While less strongly associated with treatment outcome or mortality than physical functioning and nutritional status, psychosocial factors such as cognition, mood disorders and social support are important to include because they can affect decision-making capacity, compliance and the ability to tolerate treatment.^{22;30} These issues can also give opportunities for improving quality of life and the treatment trajectory. Ensuring that sufficient care and support are available to the patient – especially in case of cognitive impairment – is fundamental to care and treatment planning.

How to use the results of the geriatric assessment

When reporting on the outcome of the geriatric assessment, the geriatrician should aim to be concise and as specific as possible. It is useful to try to quantify the results, thereby staging the ageing. A conclusion along the lines of ‘this is a vulnerable patient with increased risk of complications’ is unlikely to contribute much to the decision-making process. In addition to highlighting any geriatric domains that are severely impaired, the cumulative illness burden can be described, for example by adding up the number of domains in which some impairment is present. It is also helpful to give an estimation of the reserve capacity the patient has. For example, if a patient has just enough physical and mental resources to live at home, a limited course of chemotherapy with some side effects that leads to a hospitalization could be the tipping point that results in significant care dependence or even a permanent nursing home admission. On the other hand, a highly functioning, very fit patient may have excellent reserves, but also has a lot more to lose compared to a patient who already has relevant impairment. These considerations could be a significant factor in treatment decisions.

Uncovering heretofore unnoticed geriatric impairments also allows for a more accurate estimation of prognosis aside from the current malignancy as well as the risk of toxicity of treatment. The CARG and CRASH scores, developed for predicting risk of grade 3 or higher chemotherapy-related toxicity, incorporate various specific geriatric factors,^{31;32} and the same applies to many tools used for estimating remaining life-expectancy.³³ When cancer is not (yet) symptomatic, cancer treatment is generally aimed at preventing future loss of well-being. This needs to be weighed against the short-term risk of significant toxicity or complications. Similarly, the likely time-to-benefit needs to be balanced with the remaining life-expectancy.

Recently, numerous publications have discussed the possibility of geriatric interventions and prehabilitation as a means of increasing treatment tolerance and oncologic outcome by decreasing the patient’s frailty.^{14;34;35} Although evidence shows that there will be short term gains, for example in exercise capacity or decreased length of stay in hospital, the effect on long-term outcomes is less clear.¹⁴ As frailty is the resultant of ageing processes that have been ongoing for decades, it makes sense that this cannot be fully reversed. Thus, while optimizing the patient’s health status and care should always be aimed for, it is important to be realistic about how much this will actually affect the patient’s ability to tolerate treatment. Rather, awareness of vulnerabilities is likely to allow for better tailoring of treatment. Ultimately, it is this that will increase the likelihood of completing the treatment as planned while decreasing treatment-related toxicity and complications.^{14;36}

Much of the research on geriatric assessment for older cancer patients has used assessments that were done by a researcher or the oncology team themselves, generally through having the patient complete a series of validated questionnaires that screen for the possible presence of impairments. When compared to the comprehensive geriatric assessment that is the essence of geriatric medicine, these questionnaire-based assessments were shown to be equally able to uncover geriatric impairment and to yield possible (protocolled) non-oncologic interventions.¹⁴ However, questionnaires that provide fixed scoring systems may be of limited value when aiming to maximize the output of a geriatric assessment. As always in clinical practice, questionnaires work best when combined with clinical skills, and the complete assessment needs to be summarized with a clear conclusion that incorporates scores and judgement. Although screening tools can pick up whether or not a patient is vulnerable, the benefit of a geriatrician performing the assessment is that they can pinpoint more clearly *why* the patient is vulnerable and how disease-related symptoms or treatment-related side-effects could impact upon this. Furthermore, the geriatrician is able to initiate treatment for many of the comorbidities and geriatric impairments that are uncovered, rather than this requiring further referrals to other specialists, and subsequently can follow-up on these non-oncologic interventions, making the geriatric assessment a process rather than a snapshot of the patient's health status at a single time point. Additional benefit lies in the fact that geriatricians often have more time available to discuss patient preferences and priorities as well as advance care planning; however, this may vary between countries and between hospitals, depending on how the care process is organised and financed.

Consider treatment options

The next step is to consider the various treatment options, including the option of best supportive care only, in the context of the patient's overall health status and the outcomes they find most relevant. This begins with understanding their priorities in life. What makes life worthwhile for them and which possible treatment outcomes do they consider most important? When trade-offs need to be made between longer survival, quality of life, burden of treatment and living independently, each patient may have their own personal reasons for prioritizing one or more over others.³⁷ Understanding these priorities will make it possible to select the treatment option most likely to result in an outcome that the patient will be content with.

This will often include non-oncologic outcomes such as maintaining current cognitive functioning or the ability to live independently.³⁸ Decisions on cancer treatment are inevitably uncertain. Even if data are available specific to older patients, this does not mean that the impact of treatment on the individual patient and tumour can be fully predicted beforehand. To deal with this uncertainty, being as well-informed as possible is essential. Understanding what cancer- and treatment-related issues the patient may experience, at which time intervals, and how these issues are likely to differ across treatment options including best supportive care, will help patients to come to decision and can prevent future decisional regret,³⁹ irrespective of outcome.

When discussing treatment options, it is important to address any misinformation or incorrect assumptions that the patient or caregiver may have about the risks or benefits of the potential therapeutic options and about the patient's ability (or lack thereof) to tolerate treatment.⁴⁰ Many patients will have heard stories about other (older) people who have had cancer treatments and may

extrapolate these experiences to their own situation, even when the treatment or their health status are quite different. In addition, patients appear to overestimate the likely benefit of treatment, particularly in a palliative setting; in a large cohort of patients receiving chemotherapy for incurable cancers, over two-thirds of patients did not appear aware that their treatment was unlikely to be curative.⁴¹ If not asked about their considerations regarding treatment, such assumptions may not be corrected and lead the patient to making choices they would otherwise not have made.

In the oncology community, discussions about acceptable numbers needed to treat and numbers needed to harm are on-going. As the evidence-base regarding optimal treatment regimens and dosing of individual agents is continuously evolving, these discussions will continue, especially now that many new treatment options are emerging.⁴² Not all geriatricians will be up-to-date on such evolving knowledge, particularly when just starting out in the field of geriatric oncology; if this is the case, they should therefore avoid making firm treatment recommendations to the patient unless well-informed beforehand by the cancer specialist on the available treatment options.

The geriatrician's contribution within the multidisciplinary cancer team (MDT)

To increase the likelihood of success of a geriatric oncology collaboration, we recommend starting first with those tumour types which are common in older patients and where the team acknowledges or at least is willing to explore the potential benefit of some form of geriatric involvement. This is not always the case, and some cancer specialists can be hesitant about having a new discipline join the team. Taking the first steps exploratory in seeking collaboration is much easier when there is a general interest from all parties involved. In starting out, it is helpful to develop on a shared understanding about the goals of the collaboration in terms of outcome goals and the roles each specialism will take in interactions with patients/families and the shared decision-making process. While formulating a basic outline of the geriatric oncology care pathway beforehand is helpful, it is likely that this will evolve over time, and will need to be periodically evaluated and adjusted. Once a collaboration is proven successful in one cancer care trajectory, this can remove some of the resistance that others may have, opening up opportunities for extending the collaboration to other cancer types and treatment modalities. Sometimes, it can be useful to develop the collaboration in the form of a (research) pilot, as this may win over colleagues more hesitant about having a new discipline join the team.

A useful place to begin geriatric oncology collaboration is by having a geriatrician be present at MDT meetings. This allows the geriatrician to become more aware of what issues are most pertinent in this particular MDT and where they could potentially contribute. Prior research shows that the contribution of the geriatrician will vary significantly depending on the tumour group and local treatment culture,¹⁴ and thus cannot be fully ascertained beforehand.

Current MDT meetings are often quite technical, focussing on tumour characteristics and the multidisciplinary application of guidelines.⁴³ However, these guidelines generally describe the optimal treatment of one illness and base their recommendation on research in which older patients and those with comorbidities were often not allowed to participate.⁴⁴ An important reason for this exclusion is that comorbidity - as a competing cause of death - and age-related limitations in the ability to tolerate treatment may result in less significant treatment effects compared to a younger, healthier population.⁴⁵ Subsequent guideline-recommendations and the potential gains suggested for various treatment options may therefore not apply to older patients: for example, two recent

studies showed significantly longer survival in trial patients compared to non-trial patients receiving the same oncologic treatment.^{46;47} Thus, there is a risk of overestimating treatment benefit based on extrapolation of data from younger populations.

In addition, there is a fear of undertreatment of older patients, with subsequent longer-term cancer-related sequelae.⁴⁸ Cancer specialists are generally well aware of how bad these complications can be; this makes it difficult to consider not giving a treatment that could potentially prevent them from occurring. For the geriatrician, it is important to acknowledge this fear, but to also mention that overtreatment can be just as harmful, particularly in the context of patient-centred outcome measures and the risk of functional or cognitive decline. Balancing over- and undertreatment is a significant challenge. For example, when considering the dosing of chemotherapy, the dose needed for cure is often high. If – based on patient’s potential vulnerability – one chooses to lower the dose or to use only one chemotherapeutic agent where combination therapy is the standard, this may lead to less side effects in the short-term, but could be at the price of a (much) less significant effect on the tumour. On the other hand, if the treatment that is given is too severe for the patient to tolerate given their health status, the severity of side effects can often mean that not all courses of treatment can be completed, resulting in the same decreased anti-tumour effect in addition to the treatment-related complications. This fine line oncologic benefit and risks of side-effects requires joint input from both the geriatric and oncologic perspectives.

Despite general consensus that age is not a useful marker for health status, treatment recommendations at MDTs are still often based on chronologic age, particularly if discussion of non-cancer aspects of the patient’s health status is limited,⁴⁹ and information regarding geriatric impairment and reserves is missing.^{10;50} Prior research shows that currently, the time devoted to discussing issues other than tumour-related factors at MDT meetings is only 14%.⁴⁹ In addition, while many cancer specialists and other health care professionals are increasingly aware that these non-disease aspects of the patient are relevant, they often lack proficiency in discussing them.⁵¹ Within the MDT, there is a shared knowledge of technical and medical terminology that can be used to describe cancer and comorbidity. In contrast, a recent study demonstrated that older patient’s health status is often described in non-objective and potentially ambiguous lay terminology such as ‘pretty fit’, or ‘not very good’, for which subtle intonation and context can markedly alter the meaning.⁵¹

Having performed a geriatric assessment, the geriatrician will be able to provide the MDT with much more objective information of the patient’s health status,⁴³ allowing for staging of the ageing process. Furthermore, by drawing attention to the potential lack of applicability of guideline recommendation or trial data to this particular case, and by prioritizing patient’s own preferences, the geriatrician could help provide a framework for discussing treatment including potential alternative options, a step in the decision-making process that is currently often omitted.^{38;43} This input has been shown to greatly increase the likelihood of reaching a treatment decision at the MDT conference.⁵²

Conclusion

To optimize the yield of a geriatric consultation for older cancer patients, the geriatrician needs to know the specific purpose of the consultation, the expected disease trajectory, and have some information on the potential benefits and risks of treatment options including best supportive care

only. The geriatrician should subsequently focus primarily on the patient, their preferences and priorities with regards to outcomes and assess their overall health status through a geriatric assessment. Reporting back to the cancer specialist should be concise and as specific as possible. Within the multidisciplinary team, the geriatrician can contribute with objective information about functional reserves, remaining life-expectancy and toxicity risks, and by creating awareness of the limitations of evidence regarding the older population. This will help in reaching a well-tailored treatment decision that balances cancer-related and patient-centred outcome measures and fits within the patient's own preferences for treatment.

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Table 1. Reasons for referring an older cancer patient to a geriatrician

- Ascertaining overall health status across physical, functional and psychosocial domains through a geriatric assessment
- Evaluating and weighing the potential risk and benefit of various treatment options in the light of the outcome of the geriatric assessment
- Optimizing a patient's health status prior to treatment initiation
- Assessing a patient's ability to provide informed consent
- Clarifying a patient's or caregiver's uncertainty regarding treatment preferences
- Initiating advance care planning

Table 2. Potentially relevant questions about the cancer and potential cancer treatment

- How does the cancer currently affect the patient's health status?
- What is the likely trajectory of the cancer with and without treatment?
- What would be the standard treatment for this cancer type and stage?
- Which alternative treatment strategies are available?
- What are the potential benefits and side-effects/complications for these treatment options?
- What is the likelihood that this particular patient will experience these benefits or risks?

Table 3. Geriatric contributions to decision making and cancer care

- Supporting a patient-focused vision within the multidisciplinary team
- Uncovering geriatric impairments
- Evaluating a patient's reserve capacity and ability to tolerate treatment
- Estimating remaining life expectancy with and without the cancer
- Estimating prognosis and risk of treatment-related toxicity and complications
- Managing and optimizing comorbidities and geriatric impairments
- Taking time to discuss and elucidate patient preferences and priorities

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