

Review Article

How do we include geriatricians in geriatric oncology? The geriatrician's perspective

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A B S T R A C T

Older adults represent most patients with cancer, yet geriatric expertise remains underrepresented in oncology practice. This review explores practical strategies to integrate geriatricians throughout the continuum of cancer care, from diagnosis to survivorship and palliative care. We discuss models of interdisciplinary collaboration, optimal timing of geriatric involvement, and innovative solutions to address the global shortage of geriatricians. Evidence demonstrates that comprehensive geriatric assessment enhances treatment tolerance, quality of life, and survival among older adults with cancer [1–5]. Despite widespread endorsement, implementation barriers persist due to workforce limitations, time constraints, and lack of institutional support. Emerging strategies include task-shifting, telehealth-enabled assessments, and education programs that empower oncologists and allied health professionals to apply geriatric principles in daily practice [6–10]. Integrating geriatricians into multidisciplinary oncology teams is essential to deliver equitable, personalized, and value-based care for aging populations. We advocate for structured collaboration models, institutional prioritization of geriatric oncology, and policy-level initiatives that reinforce the indispensable role of geriatricians in modern cancer care.

1. Introduction

The global population is aging at an unprecedented rate, and the burden of cancer in older adults continues to rise accordingly. More than half of all new cancer diagnoses, and many cancer-related deaths, occur in individuals aged 65 years and older [1]. Despite this demographic reality, oncology services worldwide often lack the systematic integration of geriatric expertise. Older adults with cancer present unique challenges, including multimorbidity, polypharmacy, frailty, functional decline, and cognitive vulnerability, all of which profoundly influence treatment tolerance and outcomes [2,6].

Comprehensive geriatric assessment (CGA) is widely recognized as an essential tool for optimizing care in this population, informing decision-making, tailoring interventions, and improving both quality of life and survival [7,11,12]. However, implementation in routine oncology practice remains inconsistent, and geriatricians continue to be underrepresented within oncology teams [3,4,13]. Multiple barriers contribute to this gap, including time and resource constraints, limited training in geriatric principles among oncology providers, lack of clear pathways to integrate CGA findings into clinical decision-making, and uncertainty regarding reimbursement for the additional time and personnel required. In addition, time constraints within oncology clinics

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and concerns about delays in treatment initiation further limit the adoption of CGA. Clinicians often perceive geriatric assessment as time-intensive, potentially disrupting workflow and competing with urgent oncologic decision-making timelines. These operational challenges highlight the need for streamlined scalable models that integrate CGA without compromising treatment efficiency. Structural limitations and workforce shortages further hinder collaboration between geriatrics and oncology, often leaving oncologists to manage complex age-related syndromes without specialized support [5].

This paper examines the inclusion of geriatricians within oncology from the geriatricians' perspective, emphasizing their unique value and the need for sustainable, person-centered models of care that effectively integrate geriatric principles into the oncology care pathway.

1.1. Integrating Geriatricians Within the Oncology Care Pathway

As the global population ages, most older adults with cancer will live in low- and middle-income countries (LMICs), where resources to provide CGA remain limited. At the same time, the geriatrics workforce is insufficient in many regions—including parts of the United States—where growth has not kept pace with population needs [8]. In this context, primary care plays a pivotal role in the identification and management of frailty, serving as a critical entry point to geriatric services and geriatric oncology. Health systems with strong primary care infrastructures have demonstrated improved outcomes and cost-effectiveness through early identification of at-risk individuals [9]. Accordingly, frailty screening should be incorporated into the routine evaluation of older adults with suspected or confirmed cancer, as early detection of vulnerability allows timely referral for further assessment and intervention. Several validated screening tools are available to support this process, including patient reported outcome tools like the Geriatric-8 (G8), the Vulnerable Elders Survey-13 (VES-13), Clinical Frailty Scale (CFS), incorporated within guideline-recommended frameworks to identify older adults who may benefit from comprehensive geriatric assessment [10,14–17]. As a screening tool, G8 is designed to identify patients at risk (typically ≤ 14), who should then be referred for comprehensive geriatric assessment, highlighting its role as an initial triage step rather than a standalone evaluation.

To optimize the use of limited resources, a structured, stepwise approach can be adopted: (1) initial frailty screening using validated tools (e.g., G8, VES-13, CFS) to identify patients at risk; (2) targeted CGA for those screening positive, evaluating domains such as function, cognition, comorbidity, nutrition, and polypharmacy; (3) implementation of CGA-guided interventions, including treatment modification, prehabilitation, medication optimization, and supportive care; and (6) longitudinal follow-up to monitor response and adapt care plans. This approach enables efficient resource allocation while ensuring that vulnerable individuals receive appropriate, multidimensional care [18].

Once vulnerable individuals are identified, integration into secondary and tertiary oncology settings allows for a more comprehensive evaluation and targeted intervention. However, the cultural appropriateness of assessment tools developed and validated in high-income settings remains a concern when applied to diverse populations, particularly in LMICs, where differences in socioeconomic status, literacy, and cultural context may limit their applicability [18,19]. In such settings, locally adapted tools that retain the core domains of CGA may offer a more feasible and context-relevant approach, as demonstrated by adaptations developed in countries such as India [18,20].

Limited access to CGA is not restricted to LMICs but is also observed in high-income settings due to workforce shortages and system-level constraints. Historically, oncologic decision-making has relied heavily on performance status measures such as the Eastern Cooperative Oncology Group (ECOG) scale; however, these tools lack sensitivity to age-related vulnerability [18,19]. Multidisciplinary tumor boards with geriatric input—bringing together oncologists, geriatricians, and allied health professionals—are increasingly recognized as an optimal

framework for individualized care. Through this collaboration, treatment plans can be adapted to minimize toxicity, address comorbidities, and align interventions with patient priorities [8].

In real-world practice, these collaborative principles are implemented through structured geriatric oncology models, including consultative, co-management, and embedded clinic approaches, where geriatricians work alongside oncology teams to provide targeted assessments and recommendations [21,22]. A practical example of this approach can be seen in geriatric oncology programs where all patients aged ≥ 70 years undergo initial frailty screening using tools such as the G8. Patients identified as vulnerable are referred for same-day or rapid CGA, with findings discussed in a multidisciplinary setting. CGA-driven recommendations—including treatment modification, prehabilitation, and supportive care interventions—are then implemented collaboratively by oncology and geriatrics teams, with ongoing follow-up to reassess functional status and treatment tolerance.

Beyond initial treatment planning, a particularly important extension of CGA-guided care is prehabilitation, which aims to improve physiological reserve before initiating therapy. Prehabilitation programs incorporating physical exercise, nutritional optimization, and psychosocial support have been shown to enhance post-operative outcomes, functional recovery, and tolerance to chemotherapy and radiotherapy, although evidence remains heterogeneous [23,24]. By linking CGA findings to prehabilitation planning, clinicians can deliver interventions that address specific deficits and improve readiness for treatment. These principles are reflected in the implementation of geriatric oncology models, which vary across health systems and resource settings, reflecting differences in workforce capacity, infrastructure, and access to geriatric expertise (Fig. 1).

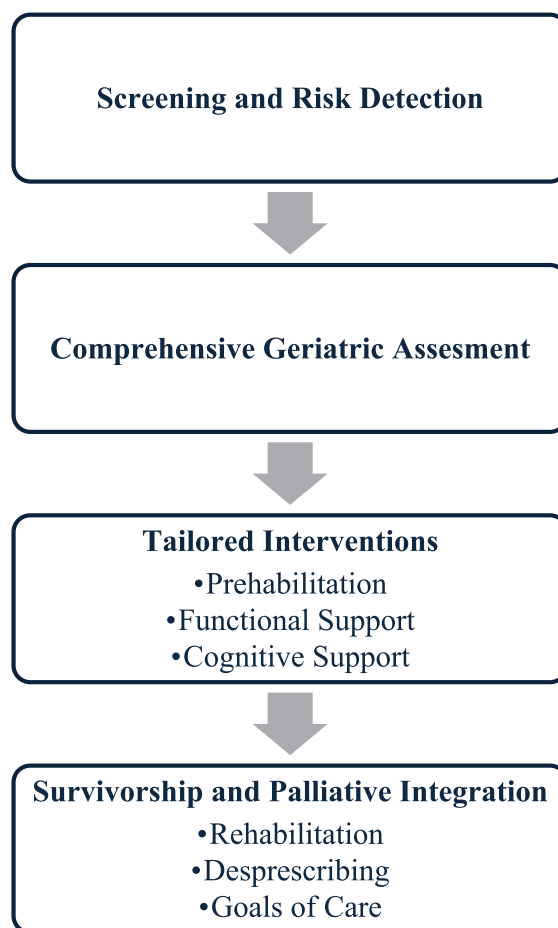


Fig. 1. Conceptual model for geriatric integration across the cancer continuum.

Four predominant models have been described: shared-care, consultative, embedded, and telehealth-based approaches. In shared-care models, oncologists and geriatricians collaborate longitudinally throughout the patient's treatment course, providing continuous multidisciplinary input. Consultative models involve targeted CGA assessments with recommendations that are implemented by the oncology team. Embedded models integrate geriatricians directly within oncology clinics, enabling co-management and real-time clinical decision-making. Telehealth-based approaches extend access to CGA and follow-up care, particularly in underserved or resource-limited settings [25,26]. Each model presents distinct advantages and limitations. Shared-care models offer comprehensive, longitudinal management but require substantial coordination and resources. Consultative models are more scalable but rely on the oncology team to implement recommendations. Embedded models facilitate timely decision-making and improve uptake of geriatric interventions, although they are resource intensive. Telehealth and digitally supported models—including remote monitoring and virtual assessments—represent promising strategies to expand access to geriatric expertise while maintaining efficiency [27]. Across models, evidence supports the role of GA-guided interventions in reducing treatment-related toxicity, improving treatment adherence, and preserving functional outcomes, although survival benefits remain less consistent [28–30]. Selecting the most appropriate model depends on local resources, system organization, and patient needs, highlighting the importance of flexible, context-adapted approaches to deliver equitable, age-sensitive cancer care.

Integration of geriatrics into oncology also naturally extends to palliative care. Older adults represent most patients requiring symptom control, functional preservation, and quality-of-life management; however, early palliative care remains underutilized in the cancer trajectory. Incorporating geriatricians within palliative teams allows a multidimensional understanding of frailty, multimorbidity, malnutrition, sarcopenia, cognitive impairment, and polypharmacy—all of which influence treatment tolerance and mortality. Practical integration can occur through joint geriatric–palliative clinics, early palliative involvement triggered by CGA findings, and coordinated deprescribing strategies to reduce treatment burden [31,32]. Additionally, caregiver support initiatives help align family expectations with patient-centered goals, reducing distress and improving communication. A progressive model of care—where CGA identifies vulnerability and palliative involvement increases as complexity grows—ensures timely, goal-concordant, and patient-centered management throughout the disease trajectory [31,33]. Additional examples include geriatric oncology clinics embedded within tertiary cancer centers, where geriatricians participate in routine oncology consultations and multidisciplinary tumor boards, facilitating real-time decision-making and improving implementation of CGA-based recommendations. See Table 1 for a comparative description of different models. Although screening plays a central role in identifying patients who may benefit from CGA, it does not require specialist-level expertise and can be performed by trained healthcare staff.

2. Expanding the Role of Geriatricians Across the Cancer Care Continuum

The role of geriatricians extends across every stage of cancer care—from the moment of clinical suspicion to long-term survivorship. Early integration ensures that diagnostic and treatment decisions are proportionate to patients' physiological reserve, functional status, and personal goals, helping to prevent both overtreatment and therapeutic nihilism. In the pre-diagnostic phase, clinicians face a dual challenge: avoiding the under-referral of fit older adults based solely on chronological age, while preventing the over-investigation of frail individuals unlikely to benefit from invasive procedures. Incorporating geriatric principles at this early stage helps mitigate both risks. Systematic screening for geriatric “red flags”—such as unexplained weight loss, functional decline, cognitive changes, or polypharmacy—should precede extensive diagnostic workups. Abnormal screening results should not exclude patients from oncologic evaluation; rather, they should prompt referral for more comprehensive, multidimensional assessment, enabling a better understanding of overall health status and guiding appropriate diagnostic strategies [34]. Embedding this triage process within primary care, emergency, and oncology settings can improve referral pathways, promote equity, and ensure that robust older adults are not denied evaluation, while frail patients are spared unnecessary interventions. By stratifying patients according to vulnerability, clinicians can tailor diagnostic intensity and therapeutic planning to align with realistic outcomes and patient-centered goals [35].

2.1. Geriatric Integration During Active Treatment

Once an older adult begins active cancer therapy, the integration of geriatric expertise becomes pivotal in shaping treatment selection, reducing toxicity, and maintaining independence. In surgical oncology, preoperative geriatric assessment—including domains such as functional capacity, cognition, nutrition, and comorbidities—has proven to be a strong prognostic indicator. It predicts postoperative complications, length of hospital stay, and the likelihood of requiring institutional care after discharge. [36] In medical oncology, CGA-based risk stratification informs treatment intensity and drug selection. Tools such as the Cancer and Aging Research Group (CARG) and the Chemotherapy Risk Assessment Scale for High-Age Patients (CRASH) estimate chemotherapy-related toxicity risks and support shared decision-making between clinicians and patients [37]. These instruments enable geriatricians and oncologists to individualize therapy by balancing efficacy and tolerability while promoting transparency about expected outcomes. However, the value of geriatric integration extends beyond treatment initiation. Continuous monitoring of geriatric syndromes—including malnutrition, delirium, depression, and fall risk—is essential throughout therapy. Failure to address these issues can lead to treatment interruption, unplanned hospitalization, and diminished quality of life. Embedding geriatricians or geriatric-trained team members within oncology services enables timely interventions that sustain treatment feasibility and functional independence [38]. This approach represents a paradigm shift—from a tumor-centered model to a function- and goal-oriented approach to care—prioritizing disability-

Table 1
Models of Geriatric Oncology Care Delivery.

Model	Description	Advantages	Limitations
Consultative Model	Targeted CGA upon oncology request	Flexible; resource-efficient	Limited continuity; dependent on referral
Embedded Model	Geriatrician integrated in clinic/tumor boards	Real-time input; team culture	Requires institutional resources
Co-Management Model	Shared ongoing responsibility between oncology and geriatrics	Comprehensive care; improved outcomes	Labor-intensive; workforce dependent
Tele-Geriatric Oncology	Remote CGA and follow-up	Expands access; benefits rural and underserved populations	Technology and training barriers

References: [17, 27–29, 63, 65–67]. CGA, comprehensive geriatric assessment.

free survival and quality of life alongside oncologic control [39].

2.2. Role in Preparedness and Pre-habilitation in Surgical Oncology

In surgical oncology, preoperative geriatric assessment—including domains such as functional capacity, cognition, nutrition, and comorbidities—serves as a key tool for risk stratification and perioperative planning. It has been shown to predict postoperative complications, length of hospital stay, and the likelihood of requiring institutional care after discharge [36].

Importantly, CGA allows for the identification of modifiable deficits, enabling targeted prehabilitation interventions—such as physical therapy, nutritional optimization, medication reconciliation, and psychological support—aimed at improving physiological reserve prior to surgery. As mentioned earlier, though prehabilitation is a promising strategy, evidence to its usefulness in real practice remains heterogeneous. Nevertheless, incorporating CGA findings into prehabilitation planning can go a long way in personalizing perioperative care and enhance treatment tolerance.

2.3. Functional and Cognitive Impairment

Cognitive impairment in older adults with cancer is a major barrier to effective care, affecting decision-making, treatment adherence, independence, and quality of life. Importantly, a substantial proportion of patients present with baseline impairment, while treatment-related cognitive decline may further worsen outcomes. Up to 30–40% of older adults with cancer exhibit cognitive impairment prior to treatment, and chemotherapy-related cognitive impairment (CRCI) can affect 50–80% during therapy and persist in 25–35% of patients long term [40]. Despite this high prevalence, routine cognitive screening remains limited in many oncology settings, particularly in resource-constrained environments. In addition, literacy, language, and cultural factors may further complicate assessment. Early identification through appropriate, context-adapted screening is therefore essential. Incorporating caregiver input can help capture functional decline that may not be readily apparent during clinical encounters. Management requires a multidisciplinary approach, including treatment adaptation, supportive interventions, and close monitoring throughout the cancer trajectory [41–43].

2.4. Monitoring Late Toxicities and Age-Related Conditions

Older survivors frequently develop delayed complications, such as cardiotoxicity, neuropathy, or endocrine dysfunction. Geriatricians monitor these late effects while simultaneously managing age-related syndromes like falls, sarcopenia, and polypharmacy. CGA-derived indicators, such as comorbidity burden and functional reserve, are predictive of future toxicity and hospitalization risks, supporting risk-adapted follow-up [44]. Integrating geriatric principles into survivorship ensures that cancer care transitions seamlessly into chronic disease management. CGA-guided programs improve communication between teams, reduce adverse events, and align long-term care with patients' values and priorities. Survivorship, in this context, is not merely about extending life but about preserving autonomy, function, and dignity [45].

2.5. Multidisciplinary Collaboration

Geriatricians play a coordinating role within multidisciplinary survivorship care. Collaboration with primary care physicians, oncologists, rehabilitation specialists, nutritionists, and social workers ensure continuity and holistic management [46,47]. CGA findings inform personalized rehabilitation plans—combining physical, cognitive, and nutritional support—to maximize recovery and autonomy [48,49]. See Table 1 for detailed information.

2.6. Geriatricians in Cancer Survivorship Care

Older adults now represent the fastest-growing group of cancer survivors, particularly those aged 75 years and older. Advances in early detection and treatment have improved survival; however, many patients experience long-term complications that threaten independence and overall well-being. Common late effects include fatigue, neuropathy, cognitive decline, depression, and functional impairment [50–52]. In addition, older survivors are at increased risk of secondary malignancies, cardiovascular disease, osteoporosis, and frailty-related decline [53]. Despite these challenges, survivorship research and care models remain largely oriented toward younger populations. Geriatric-informed survivorship care addresses this gap by prioritizing functional recovery, monitoring late toxicities, and managing chronic comorbidities, with the goal of preserving autonomy and quality of life in older adults.

3. Addressing the Global Shortage of Geriatricians

A major barrier to the widespread integration of geriatrics within oncology is the global shortage of trained geriatricians. In the United States alone, the American Geriatrics Society has projected a shortfall of more than 27,000 geriatricians by 2025, with only around 7300 certified specialists currently practicing [54], with similar shortages are evident across Europe, Asia, and Latin America, where the specialty is often under-developed or not formally recognized [55]. This scarcity has profound implications for the care of older adults with cancer, demanding innovation. Furthermore, many geriatricians may feel insufficiently trained in oncology-specific decision-making, contributing to the emergence of onco-geriatric subspecialisation and potentially exacerbating workforce gaps [56], this highlights the need for structured oncology training within geriatric curricula and innovative models that extend geriatric expertise beyond traditional workforce constraints [56].

3.1. Delegation and Task-Shifting

Given the limited number of geriatricians, training non-geriatric clinicians to perform basic screening and interventions has become an essential strategy. Interprofessional education programs—targeting nurses, oncologists, and primary care physicians—equip healthcare providers with the skills to conduct geriatric assessments and manage common geriatric syndromes [56,57]. Initiatives such as the Competency Framework for Interprofessional Comprehensive Geriatric Assessment have successfully improved the capacity of health systems to deliver age-appropriate care [58].

In parallel, standardized and regionally adapted tools and use of electronic comprehensive geriatric assessment (e-CGA) platforms have facilitated efficient triage and follow-up of older adults [58]. These digital tools support early identification of frailty, cognitive impairment, and functional decline, enabling timely referral for comprehensive evaluation. Embedding such screening tools in oncology workflows ensures that geriatric-informed decision-making becomes routine, even in the absence of on-site geriatric specialists [57].

The integration of geriatric principles into oncology fellowships and continuing education programs further support sustainability. Oncologists trained in recognizing frailty, multimorbidity, and cognitive vulnerability are better prepared to tailor treatments, manage complex polypharmacy, and engage in shared decision-making with older adults and their caregivers [55,59]. Caregivers, patient representatives, and community organizations can also play a critical role in extending geriatric oncology care, supporting monitoring, adherence, and health education.

3.2. When Specialist Consultation Is Essential

Despite the value of delegation, certain clinical situations clearly

warrant direct geriatrician involvement. These include complex polypharmacy and multimorbidity, where the risks of drug–drug interactions and treatment toxicity are heightened; cases involving cognitive impairment, frailty, or functional decline; and high-stakes therapeutic decisions in frail older adults, where balancing survival benefits against quality of life requires nuanced judgment [57–59]. In addition, collaboration with organ-specific specialists—such as cardiology, nephrology, and endocrinology—is often required to address treatment-related complications and comorbid conditions in older adults with cancer. Geriatricians are also essential in managing ethical dilemmas surrounding treatment limitations, advanced care planning, and end-of-life decision-making. Their expertise in navigating these discussions ensures that interventions align with patient values and realistic outcomes [60].

3.3. Optimizing Human Resources and System Design

Sustainable integration of geriatrics into oncology requires more than workforce expansion—it necessitates re-designing care delivery models to maximize existing expertise. Several system-level strategies have emerged to address this challenge. Actionable recommendations would be to develop hybrid geriatric oncology models integrating telehealth with in-person CGA by geriatricians. This would entail training of staff (geriatric and oncology) and caregivers in digital literacy and culturally sensitive artificial intelligence (AI) tools [61]. Further, multilingual apps and simplified interface specifically for older population can go a long way to achieve these goals. In summary, digital health, AI, and telehealth can revolutionize geriatric oncology with special focus on hybrid models—combining technology with culturally and practically appropriate human-centered care [61,62].

3.4. Interdisciplinary Team-Based Care with Geriatrician Oversight

Embedding geriatricians within multidisciplinary teams (MDTs) allows them to guide treatment planning, align cancer therapies with patients' functional status and goals, and reduce avoidable hospitalizations. In resource-limited settings, nurse practitioners, pharmacists, and allied health professionals can deliver components of CGA under geriatrician supervision, ensuring continuity and scalability [62,63]. Structured communication pathways, standardized protocols, and shared accountability frameworks support the effectiveness of these task-sharing models.

3.5. Digital Tools and Artificial Intelligence

Integration of e-CGA platforms into electronic medical records provide standardized data collection and facilitate longitudinal monitoring of geriatric domains such as mobility, cognition, and nutrition [64]. Emerging AI-supported triage systems can identify patients at risk for treatment-related complications by analysing CGA datasets and clinical records. Combined with tele-monitoring and wearable sensors, AI can assist in early detection of decline, enabling proactive interventions without increasing clinician workload [61]. While promising, these technologies are meant to augment—not replace—clinical judgment.

3.6. Hybrid and Telehealth Models

Hybrid models combining in-person assessment with virtual follow-up are particularly useful in regions with limited geriatric coverage. Initial in-person CGA establishes baseline status, while telehealth enables ongoing monitoring, symptom management, and caregiver support. Programs such as the GAIN-S trial in Brazil have shown that telehealth-based geriatric assessment and supportive interventions can improve function, symptom control, and quality of life among older adults with advanced cancer [62]. These approaches also facilitate access for rural and underserved populations, allowing geriatricians to manage larger caseloads while maintaining oversight.

3.7. Strategic Leadership and System Advocacy

Beyond direct patient care, geriatricians play an essential role as system leaders and advocates for age-responsive cancer care. Their expertise in managing complexity, aligning interventions with patient goals, and evaluating risk–benefit trade-offs position them to shape institutional policies and quality frameworks. Geriatricians can contribute to governance committees, lead guideline development, and advocate for equitable access to geriatric-informed oncology services [55,63]. A summary of integration pathways is provided in Table 2.

4. Future Directions

Future research in geriatric oncology should prioritize the evaluation of cost-effectiveness, feasibility, and scalability of different models of care across diverse healthcare settings, including both high- and low-resource environments. Attention should be given to implementation strategies that can be adapted to real-world constraints, especially in LMICs. Developing standardized competencies and structured training pathways in geriatric oncology for physicians, nurses, and allied health professionals will be essential to expand workforce capacity and ensure consistent, high-quality care. Addressing existing gaps in oncology-specific training among geriatricians should also be considered a key priority. Digital innovations—including artificial intelligence–assisted frailty prediction, telehealth-based CGA, and remote monitoring of symptoms and functional status—offer promising opportunities to extend geriatric expertise beyond tertiary centers and improve access in underserved regions. However, their implementation must consider barriers such as digital literacy, infrastructure, and equitable access. Collaborative international efforts between oncology and geriatrics societies, including the International Society of Geriatric Oncology (SIOG), region-specific societies like The Asia-Pacific Geriatric Oncology Society (AGOS), and geriatric oncology societies in Europe and the United States, will be critical to harmonize best practices, promote data sharing, and support the development of globally applicable, context-sensitive care models.

5. Conclusion

Integrating geriatrics into oncology is no longer a conceptual challenge but an implementation imperative. As the global population ages, the complexity of cancer care increasingly depends on the ability to assess and manage frailty, multimorbidity, and functional decline—domains that are central to geriatric expertise. Geriatricians play a critical role in aligning cancer treatment with patient-centered outcomes. However, given the persistent shortage of specialists,

Table 2
Graphical Summary of Geriatric Integration Across the Cancer Continuum.

Phase	Key Geriatric Actions	Expected Benefits	Potential Challenges
Screening & Diagnosis	Use of G8, VES-13, CFS tools to detect frailty	Early detection of vulnerability	Limited screening resources
Treatment Planning	CGA-based decision-making and prehabilitation	Tailored therapy; reduced toxicity	Time and workforce constraints
Active Treatment	Ongoing monitoring of geriatric syndromes	Improved adherence; fewer complications	Integration with oncology workflow
Survivorship & Palliative Care	Rehabilitation, deprescribing, and goal-of-care discussions	Enhanced QoL and autonomy	Communication and system barriers

References: (34, 35, 38, 39, 45, 50, 63, 68)
CFS, clinical frailty scale; CGA, comprehensive geriatric assessment; G-8, Geriatric-8; QoL, quality of life; VES-13, vulnerable elders Survey-13.

meaningful integration will depend on pragmatic and scalable solutions, including task-sharing, digital innovation, and interdisciplinary collaboration. The future of geriatric oncology lies in health systems that not only recognize the value of geriatric principles but actively embed them across the entire cancer continuum—from early detection and treatment decision-making to survivorship and palliative care. Ultimately, advancing the field will require a sustained commitment to translating evidence into practice through global collaboration, innovation, and the systematic inclusion of geriatric perspectives in all aspects of oncology care.

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Declaration of competing interest

The authors declare no competing interests.

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