## Editorial



## Embodying Resilience in Retina Specialty Care

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Medicine is a profession that demands much from its practitioners—intellect, skill, compassion, and above all, endurance. Each day, clinicians confront challenges that test their resolve, from the emotional weight of patient care to the ceaseless march of scientific progress and the labyrinthine bureaucracy of modern healthcare systems. Resilience—that underappreciated cornerstone of human character—enables physicians to navigate these demands while maintaining their sense of purpose and humanity.

The Oxford English Dictionary defines resilience as the ability to "bounce back" from difficult situations, hardships, or setbacks and to adapt positively to challenges. Resilience is not simply about "toughing it out" or enduring hardship without faltering. Rather, it is a dynamic, adaptive process, allowing individuals to recover, learn, and grow from adversity. In medicine, where the stakes are profoundly high and failure can carry devastating consequences, resilience becomes a necessity—not just for excellence but for survival.

Few professions immerse individuals in the human condition as deeply as medical practice does. Physicians are privileged to witness life's most profound moments: the first breath of a newborn, the tearful relief of a life-saving diagnosis, and the quiet dignity of a life well lived coming to its end. Yet this privilege is often paired with sorrow. We share in the grief of families who lose loved ones and shoulder the frustration of diseases we cannot yet cure.

Consider the retina specialist who addresses blinding eye conditions daily, the ocular oncologist who delivers terminal diagnoses weekly, or the emergency physician managing catastrophic injuries in the wake of a tragedy. These moments, although intrinsic to the job, take a toll on the psyche. Unaddressed, such emotional burdens can lead to burnout, compassion fatigue, and even moral injury—a condition in which a clinician's deeply held values and ethics conflict with the realities of his or her work.

"The 7 C's of Resilience" is a framework developed by Kenneth Ginsburg, MD, MSEd, that includes competence, confidence, connection, character, contribution, coping, and control—each a factor of an individual's ability to bounce back from adversity. Resilience acts as a buffer by allowing physicians to engage deeply with patients, providing empathetic care while maintaining their own mental health. Building resilience is not about becoming desensitized; it's about developing the capacity to process emotions constructively. Practices such as mindfulness, reflective journaling, and peer support can be invaluable tools in this endeavor.



Photo courtesy of Kevin Caldwell Photography.

Medicine is perpetually in flux, driven by advances in technology, shifting societal expectations, and evolving disease patterns. The COVID-19 pandemic underscored this reality in stark terms. Clinicians found themselves on the front line of a global crisis, adapting to rapidly changing protocols, grappling with inadequate resources, and enduring the personal risk for infection. For many, the resilience cultivated in quieter times proved essential.

Yet the pace of change in medicine extends beyond pandemics. Innovations in artificial intelligence, genomics, and telemedicine are reshaping how care is delivered. Although these advances hold great promise, they also introduce uncertainty. Physicians must continuously update their knowledge and skills, often in environments in which time and support for professional development are limited.

Resilience in this context is about embracing adaptability. It requires a mindset that views challenges not as insurmountable obstacles but as opportunities for growth. Resilient physicians are lifelong learners, unafraid to ask questions, seek mentorship, or even admit when they do not have all the answers.

Medicine is rarely practiced in isolation. Whether in operating rooms, clinics, or inpatient wards, healthcare delivery relies on cohesive, multidisciplinary teams. The resilience of these teams can be as crucial as that of any individual member.

A resilient team fosters an environment in which members feel safe to express concerns, admit mistakes, and offer constructive feedback. Such cultures are built on mutual respect and trust—qualities that must be actively cultivated. Physicians can play a leading role in this process by modeling vulnerability and openness. For example, sharing personal stories of overcoming challenges can normalize discussions about resilience and encourage colleagues to seek support when needed.

Institutional support is also critical. Hospitals and healthcare organizations must recognize the value of resilience training and provide resources such as mental health services, wellness programs, and structured debriefings after high-stakes events. These measures are not luxuries; they are investments in the well-being and effectiveness of the workforce.

The antithesis of resilience is burnout—a condition marked by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. Alarmingly, studies suggest that nearly half of all physicians experience symptoms of burnout at some point in their careers.

Burnout is not merely an individual issue; it has systemic consequences. Physicians experiencing burnout are more likely to make medical errors, have lower patient satisfaction scores, and even leave the profession prematurely. In an era of physician shortages, this exodus compounds the challenges facing healthcare systems worldwide.

Building resilience is one of the most effective antidotes to burnout. It begins with self-awareness—a recognition of one's limits and an acceptance that even the most dedicated clinicians cannot do everything. Physicians must prioritize self-care, which can take many forms, such as regular exercise, meaningful connections with loved ones, or even the simple act of taking a deep breath between patients.

Although the scientific foundation of medicine is ever expanding, the art of medicine remains timeless. This art—rooted in empathy, communication, and human connection—thrives in resilient practitioners. A burned-out physician may struggle to engage fully with patients; however, a resilient one approaches each encounter with curiosity and compassion.

Take, for example, the internist who spends an extra 5 minutes with an anxious patient, reassuring them with kindness and clarity. Or the surgeon who, despite a grueling schedule, takes time to explain a procedure thoroughly, easing a family's fears. These moments may seem small, but they are the essence of what makes medicine a calling rather than just a career.

Those of us who are senior physicians (having received the Vit-Buckle Society Senior Award—given with a *cane*, mind you) bear a responsibility to nurture resilience in the next generation of clinicians. Medical students and residents enter the profession with enthusiasm and idealism, but the rigors of training can erode these qualities if the teaching environment, training, and mentorship are not carefully managed.

Mentorship is a powerful tool in this regard. By sharing our experiences—both successes and failures—we can offer invaluable perspectives to those just beginning their journeys. We must also advocate for structural changes to medical education, ensuring that curricula address not only clinical skills but also the emotional and psychological challenges of the profession.

Resilience is not innate; it is learned. By teaching young physicians how to cultivate resilience early in their careers, we equip them with tools to face the inevitable challenges ahead.

## In This Issue

Leung et al<sup>1</sup> begin our original manuscripts with an evaluation of the race-based incidence of ocular hypertension after dexamethasone implant pleacement as a treatment for diabetic macular edema (DME). They found no significant differences. Of note, 118 patients were included, but bilaterality increased the treatedeye number to 145. The small sample, inclusion of bilateral eyes, and mixed entry points may limit the applicability of this study and reinforce the importance of inclusion and exclusion criteria. Nonetheless, the sample identified no statistically significant difference between the self-identified White patients and Black patients.

Patel and colleagues<sup>2</sup> evaluate the Duke experience with the socioeconomic impact on diabetic retinopathy (DR) using ZIP codes as a surrogate for income. Low-income ZIP codes were associated with greater DR scores, higher DME prevalence, and a greater need for treatment from their retina specialist. This implicates additional barriers to care in lower socioeconomic classes.

Ni et al<sup>3</sup> describe the Yin-Yang staining technique using triamcinolone acetonide followed by indocyanine green dye placement. This paper furthers the importance of the internal limiting membrane (ILM) flap in macular hole (MH) closure, noting 28 of 31 large MHs closed with a single procedure.

Kavoussi<sup>4</sup> describes infrared video imaging to identify and grade macula-involving symptomatic vitreous opacities. He proposes a grading system based on the percentage of the macula obscured and presence of foveal obscuration more than 50% of the imaging time. As surgical management is being considered more often, we as retina specialists need better imaging documentation to quantify and qualify symptomatic vitreous opacity.

Gunawardene and colleagues<sup>5</sup> direct our attention to patient information access for retinal conditions and focus on the scientific accuracy of information on online social media platforms. Using the Reddit platform, the authors identified 118 posts and 289 comments; 40.8% of the statements assessed for accuracy were judged inaccurate, and inaccuracies were associated with all identified classes of respondents.

The ASRS has played a significant role in patient education through its Retina Health Fact Sheets. Perhaps a curated presence in the online community would be a way to further disseminate accurate, timely information.

Wilkins et al<sup>6</sup> evaluate ocular screening with systemic fungemia, supporting recommendations from the American Academy of Ophthalmology that screening could be focused on patients with signs or symptoms of ocular involvement. In this study, 291 consecutive patients with fungemia were identified, while 93 patients were nonverbal and excluded from symptomatic analysis. In the entire cohort, 7 of 291 patients (2.4%) had identified ocular involvement, while 2 of 93 (2.2%) were noted in the nonverbal (intubated) cohort. The authors recommend that all visually symptomatic inpatients have an ophthalmic evaluation, while chronic fungemia in a nonverbal patient should also prompt evaluation. The authors suggest that erring on the side of overscreening within an evidence-based approach should minimize incidental disease.

Ozturk and colleagues<sup>7</sup> evaluated 55 eyes that had combined phacoemulsification/vitrectomy or phacoemulsification alone and reported the refractive outcomes for axial length and intraocular lens (IOL) power determination in eyes with a dense vitreous hemorrhage. This series supported the ability to determine IOL power in eyes with a dense vitreous hemorrhage having phacoemulsification with vitrectomy and noted a postoperative spherical equivalent of -0.72 D compared with a nonvitrectomized cohort with a postoperative spherical equivalent of -0.75 D using preoperative ultrasound biometry.

Sharma et al<sup>8</sup> present the BRESER study, comparing realworld outcomes for the biosimilar ranibizumab, Ranieyes (Lupin, Ltd). They predominantly focus on DME, choroidal neovascularization, and retinal vascular occlusion. There were 474 injections performed in 268 eyes of 254 patients. There were no severe adverse events, and the authors report a predicted clinical efficacy similar to that of the reference molecule.

Gibson and colleagues<sup>9</sup> present a retrospective review of 94 eyes receiving intravitreal (IVT) methotrexate (MTX) compared with 161 eyes treated with standard of care for complex retinal detachment (RD). The MTX treatment was typically 3 to 5 postoperative injections of a 200  $\mu$ g dose, which resulted in a single surgical success rate of 74% vs 41% for standard of care.

The authors note many caveats to these findings, primarily in the study's nonrandomized design. Further exploration of MTX in complex RD has the potential to alter our standard of care, enabling improvement in both anatomic and visual success in these high-risk patients.

Nawrocka et al<sup>10</sup> present data on switching from chronic treatment with bevacizumab to aflibercept and note improved visual outcomes. The antivascular endothelial growth factor (anti-VEGF) switch also incorporated a shortened IVT injection treatment interval, confounding the agent's potential role but clearly supporting the potential for improving outcomes for these complex patients. Again, undertreatment appears to be a major predictor of compromised visual outcomes for patients requiring IVT anti-VEGF.

Day and colleagues<sup>11</sup> report staged vs simultaneous placement of the 4-point fixated Akreos AO60 IOL (Bausch + Lomb). In the 98 studied eyes, both the 82 eyes in the combined group and the 16 eyes in the staged group, the authors noted that hypotony was the only statistically significant outcome associated with combined IOL placement. The anatomic and visual success rates were similar and comparable to those in other studies evaluating the use of this IOL.

Beginning our case focus, Light et al<sup>12</sup> report 2 adults with short telomere syndrome and describe the retinal vascular alterations that are a critical focus for this life-shortening disease. Shah and colleagues<sup>13</sup> present macular atrophy in the setting of a *COL2AI* mutation with Stickler syndrome. This reiterates the importance of genetic screening for atypical pediatric retinopathies and the impact of diagnostic accuracy in predicting the lifelong risk for RD at approximately 70%, with bilaterality in 50% of these children.

Dameron et al<sup>14</sup> describe the impact of belzutifan, an HIF-2 $\alpha$  inhibitor that has revolutionized the care of complex vascular manifestations of von Hippel-Lindau disease. In this 63-year-old patient with bilateral juxtapapillary retinal hemangioblastomas, treatment with oral belzutifan reduced tumor size, decreased ME, and improved vision over a treatment course of 6 months.

Bayram-Suverza and Ramírez-Estudillo<sup>15</sup> present a 70-yearold woman and describe the importance of multimodal imaging in this atypical case of nonhereditary foveomacular retinoschisis.

Husain and colleagues<sup>16</sup> report documentation of delayedonset multiple evanescent white-dot syndrome (MEWDS) after traumatic choroidal rupture. They suggest that compromise of the immunologically privileged subretinal space may be causative while highlighting the overlap between MEWDS and acute multifocal placoid pigment epitheliopathy.

Dias Lopes Urzedo and colleagues<sup>17</sup> present a 41-year-old man with dengue fever who developed a sub-ILM hemorrhage that responded to neodymium:YAG laser hyaloidotomy. This rare presentation focuses on the concomitant thrombocytopenia/anemia that may have factored into the hemorrhagic presentation.

Petrash and Lane<sup>18</sup> report the unplanned injection of tattoo ink into the suprachoroidal space. In this 40-year-old man, bilateral scleral tattooing was performed in a single setting, leading to decreased vision at 3 months. On examination, extensive black ink was seen in the peripheral retina as well as subretinal fibrosis. The authors postulate that the immune privilege of the subretinal/suprachoroidal space may have protected further ocular damage.

In our last case report, Vemulapalli and colleagues<sup>19</sup> discuss a 40-year-old woman with bilateral, sequential ophthalmic vascular occlusions. They remind us of the legacy of HIV-associated ocular disease, including vasculopathy as well as infectious and inflammatory retinitis/choroidopathy.

Fortunately, aggressive systemic treatment has virtually eliminated these vision-threatening complications but as in virtually all of our retina specialty care, our patients must play an active role in their treatment. This highlights the critical nature of patient compliance and its importance in preserving both anatomic and visual function.

Ultimately, resilience is the quiet force that sustains us as physicians through the highs and lows of our careers. It enables us to adapt to change, process adversity, and maintain our commitment to the patients we serve. In a field as demanding and vital as medicine, resilience is not merely desirable it is essential.

As we reflect on our own resilience, let us also recognize the need to foster it in our colleagues, teams, and institutions. By doing so, we honor the legacy of our profession and ensure that medicine remains a source of hope, healing, and inspiration for generations to come.

I often think of Maya Angelou's focus on resiliency as a battle to incorporate change without being diminished by adversity. "I can be changed by what happens to me," she said, "but I refuse to be reduced by it."

Nelson Mandela's focus on resiliency surpassed traditional concepts of success. He famously said, "Do not judge me by my success; judge me by how many times I fell down and got back up again."

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