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Fulfilling a Sense of Purpose in Medicine

Medicine, at its core, is a profession rooted in service, compassion, and the relentless pursuit of alleviating human suffering. Although technological advances, evidence-based practices, and rigorous scientific inquiry form the foundation of modern healthcare, a sense of *purpose* infuses the medical profession with its deepest meaning and highest aspirations.

Purpose in medicine is not merely about personal fulfillment; it is central to ensuring that the practice of medicine remains patient-centered, ethical, and compassionate. Over the past decade, significant threats to retina specialty care have focused on redefining the physician as a healthcare team member, classifying patients as *clients*, and limiting personalized physician care under the auspices of "evidence-based medicine." These insidious changes directly affect purpose in retina specialty care but rarely enter the peer-reviewed literature, and they often take place without input from the actual physician.

The history of medicine is a testament to humanity's enduring commitment to heal and nurture. From the ancient Hippocratic Oath, which emphasizes doing no harm and prioritizing patient welfare, to the compassionate-care philosophies of Florence Nightingale and Dr. William Osler, medicine has always been a vocation defined by purpose. This purpose has traditionally been centered around serving others, reducing suffering, and advancing human well-being. Such a legacy serves as a moral compass, guiding practitioners through the complex ethical landscapes of modern healthcare.

In the contemporary medical landscape, purpose is more relevant than ever. The practice of medicine is fraught with challenges—high-pressure environments, emotional fatigue, and the burden of difficult decisions. In such a demanding context, a clear sense of purpose can provide practitioners with resilience and motivation. Physicians who are deeply connected to their purpose are more likely to exhibit empathy, maintain ethical integrity, and persevere through adversity.

Purpose also enhances the quality of care. When healthcare professionals are driven by a genuine commitment to healing and patient advocacy, they are more attentive, compassionate, and patient-centered. Studies have shown that physicians who maintain a strong sense of purpose experience lower rates of burnout and higher levels of job satisfaction. This not only benefits the practitioners themselves but also leads to better patient outcomes because compassionate care is closely linked to improved recovery rates and patient trust.

Purpose in medicine is intrinsically linked to the ethical practice of healthcare. Ethical dilemmas are an inevitable part of clinical decision-making, from end-of-life care to resource allocation. A strong sense of purpose can help clinicians navigate these dilemmas by providing clarity and grounding. It serves as an ethical anchor, ensuring that decisions are made with integrity and in alignment with the core values of the profession.

Photo courtesy of Kevin Caldwell Photography.

Furthermore, purpose reinforces the commitment to equity and justice in healthcare. A purpose-driven approach encourages practitioners to recognize and address disparities in access, treatment, and outcomes. It promotes advocacy for marginalized populations and fosters a healthcare environment in which every patient is treated with dignity and respect.

Despite its importance, maintaining a sense of purpose in medicine has its challenges. The corporatization of healthcare, administrative burdens, and systemic inefficiencies can erode the sense of meaning that initially draws individuals to the profession. Physicians and nurses often find themselves overwhelmed by paperwork, metrics, and bureaucratic constraints, which can detract from direct patient care.

The emotional toll of witnessing suffering, navigating loss, and managing high-stakes responsibilities can lead to compassion fatigue and burnout. These experiences can distance practitioners from their sense of purpose, creating a risk for depersonalization and emotional exhaustion.

To address these challenges, healthcare institutions must prioritize purpose as a cornerstone of professional development

and organizational culture. This involves creating supportive environments in which practitioners can reconnect with their motivations, share their experiences, and find meaning in their work. Mentorship programs, reflective practice, and wellness initiatives can all contribute to sustaining a sense of purpose within the medical community.

The cultivation of purpose should begin early, during medical education and training. Aspiring physicians must be encouraged to reflect on their motivations and values, fostering a deep understanding of why they chose to enter the field. Medical curricula should incorporate discussions on ethics, empathy, and the humanistic aspects of medicine, ensuring that technical proficiency is matched by moral and emotional intelligence.

Exposure to diverse patient populations, community engagement, and service-learning opportunities can also reinforce a sense of purpose. By witnessing the profound impact of compassionate care, students can develop a lasting commitment to serving others. Educators and mentors play a crucial role in modeling purposeful practice, demonstrating how dedication to purpose enhances both professional fulfillment and patient outcomes.

Leadership in healthcare institutions plays a critical role in fostering and sustaining purpose among practitioners. Leaders must champion values of compassion, integrity, and service, embedding these principles into organizational missions and policies. Purpose-driven leadership involves recognizing and addressing the emotional and ethical challenges faced by healthcare workers, and creating space for reflection, dialogue, and support.

Leaders also should be advocates for systemic changes that alleviate unnecessary burdens and allow clinicians to focus more on patient care. By streamlining administrative processes and promoting interdisciplinary collaboration, leaders can help reduce burnout and preserve the intrinsic motivation that drives compassionate care.

Purpose has a transformative power that extends beyond individual practitioners to influence the entire healthcare system. When a culture of purpose is nurtured, it fosters environments in which empathy, ethical practice, and patient-centered care flourish. Such environments not only enhance patient outcomes but also contribute to the well-being of healthcare providers, creating a more sustainable and humane healthcare system.

Purpose also acts as a catalyst for innovation and progress. Practitioners driven by a deep commitment to improving lives are more likely to engage in research, advocate for systemic reform, and contribute to advances in medical knowledge and practice. In this way, purpose serves as both a stabilizing and propelling force, ensuring that the practice of medicine continues to evolve in alignment with its highest ideals.

In This Issue

Critical to the survival of any academic journal are its peer reviewers. Jung and colleagues[1] present a *JVRD*-focused analysis describing essential aspects of the peer-review process and highlighting best practices for our reviewers.

Stevanovic et al[2] review all phase 3 randomized clinical trial data evaluating the treatment of neovascular age-related macular degeneration (nAMD). Not surprisingly, their analysis highlighted the concerns related to serious adverse events with brolucizumab and abicipar pegol while noting the increased efficacy in the reduction of central retinal thickness for faricimab and brolucizumab. As with all treatment regimens, individualized care focused on complications, drug response, and cost/availability remains at the foundation of retina specialty care.

Weng and colleagues[3] evaluate a Duke University cohort of patients with AMD and look at conversion to neovascular nAMD stratified by dopamine antagonist use. They note significantly higher conversion associated with 3-year or longer use of a dopamine antagonist.

At 3 years, despite a significant number of patients lost to follow-up, conversion to nAMD occurred in 27.3% of patients on dopamine antagonists vs 6.8% of unexposed patients. This finding is intriguing but highlights potential issues in electronic medical record–based retrospective review.

Wakabayashi et al[4] evaluate the management of submacular hemorrhage associated with polypoidal choroidopathy in 47 patients and note better visual outcomes for those treated with intravitreal (IVT) aflibercept combined with pneumatic displacement vs aflibercept alone. Concerning was the 4% incidence of retinal detachment (RD) in the combined therapy group compared with 0% in the monotherapy-treated eyes.

Drummond and colleagues[5] evaluate the outcomes and cost of delivering panretinal photocoagulation (PRP) in the clinic vs the operating room; 82 eyes of 53 patients were treated at relatively similar costs ($5658 clinic vs $5887 operating room). Snellen-equivalent visual acuity (VA) was 20/40 for the clinic and 20/113 for the operating room. At a minimum, this study suggests the utility of operative treatment for PRP.

Bomdica et al[6] evaluate the timing of secondary epiretinal membranes (ERMs) after uncomplicated RD repair and report on 55 cases over a 7-year period. Fifty-one eyes developed a visually significant ERM associated with pars plana vitrectomy (PPV) with or without scleral buckling (51/2598 [1.96%]), while 4 eyes after scleral buckling alone developed a similar ERM (4/292 [1.37%]); 93% of all eyes developed an ERM in the first 3 postoperative months. Surgical repair achieved a significantly better visual outcome for eyes operated on within 6 months of the initial RD repair.

Adelberg and Parsons[7] use wavefront aberrometry to document an objective and significant reduction in higher-order aberrations for pseudophakic patients having PPV for bothersome, persistent floaters.

Uy and colleagues[8] evaluate 55 eyes having PPV with a 20 000 cuts-per-minute (cpm) probe, which they compare with a previous report on a 10 000 cpm vitrectomy probe. The authors conclude that the 20 000 cpm, 25-gauge, beveled cutting probe required fewer instrument exchanges without compromising the vitrectomy procedure or its outcome.

Yuan et al[9] report the clinical presentation, management, and outcomes for 18 eyes with a delayed diagnosis of an intraocular foreign body. Uniquely, eyes with a delayed diagnosis often present with relatively good vision and self-sealed wounds. Although the final mean VA was 20/26, the authors highlight the importance of early management to avoid siderosis, RD, or endophthalmitis.

Lee and colleagues[10] evaluate patient satisfaction in the setting of remote scribes. Between March 2022 and September 2023, 23 physicians converted to using remote scribes, while 2 physicians continued with in-person scribes. No decrease in patient satisfaction was noted, and remote scribing decreased overall patient wait times.

González et al[11] reported a marked decrease in melanoma tumor mortality for gene expression profiling class 2 tumors treated while the tumor apical heights were under 2.5 mm for small melanomas and under 5.0 mm for medium melanomas. Historically the 5-year metastatic rate for class 2 melanomas has been 72% irrespective of tumor size.

Reclassification of GEP 5-year outcomes now shows a metastatic incidence of 47.9%. This study shows a metastatic incidence decrease to 4.8% for small melanomas and 14.3% for medium (small) melanomas. These results support the ongoing transition to earlier uveal melanoma treatment.

Li et al[12] report the incidence of ERM in eyes with choroidal melanoma and note a rate of 34% in eyes with melanoma vs 12% in the controlled (fellow) eye. Risk factors included the radiation treatment dose along with RD at tumor presentation.

Enger and colleagues[13] report 3 patients with delayed-onset endophthalmitis after IVT dexamethasone implantation. These patients presented with severe visual loss between 2 and 5 weeks. All 3 patients had IVT antibiotics followed by vitrectomy. The final VAs were 20/60, 20/100, and hand motions, respectively.

Hill et al[14] report bilateral granulomatous uveitis in a 79-year-old woman receiving IVT faricimab for bilateral diabetic macular edema. The patient was treated with PPV early in the right eye and delayed in the left eye, followed by high-dose systemic oral steroids. At 6 weeks, the VA had improved from hand motions OD and 20/400 OS to 20/30 and 20/25, respectively.

Goldburg and Li[15] report a 53-year-old woman with multiple bilateral branch retinal artery occlusions with a known triple-positive antiphospholipid syndrome on systemic anticoagulation who died from complications of a stroke. The authors note the known high mortality rate and reiterate the importance of multidisciplinary care.

Apel and Li[16] present a 54-year-old man with rheumatoid arthritis who underwent supplementation with long-term, low-dose oral prednisone with a Janus-associated kinase (JAK) inhibitor (upadacitinib). Three weeks after JAK inhibitor treatment, the patient experienced painless superior field loss in the left eye.

On examination, the right eye was unremarkable, and the left eye revealed a localized extrafoveal amelanotic lesion, retinal hemorrhages, and inferior RD. The patient had an aggressive uveitis workup and received IVT foscarnet and oral valaciclovir. The JAK inhibitor was not repeated and the patient remained on oral steroids. The uveitis workup was negative. Imaging studies were consistent with central serous chorioretinopathy, and 16 months later, the patient reported that the symptoms had improved.

Kokame and colleagues[17] present topical medical therapy with prednisolone acetate and 0.07% bromfenac, leading to resolution of myopic macular retinoschisis and a macular hole in their 72-year-old patient.

Latasiewicz et al[18] discuss the operative use of a bandage contact lens as an alternative to temporary keratoprosthesis to enable vitrectomy with concomitant corneal opacity. When a temporary keratoprosthesis was unavailable for the 72-year-old man with monocular vision, the authors sutured a 14-mm bandage contact lens to enable surgical viewing in the patient's only functional eye.

Arnold et al[19] report cancer-associated retinopathy secondary to follicular thyroid carcinoma in a 68-year-old woman. Six months after presenting in the right eye, the condition developed in the fellow eye and the patient was started on high-dose steroids. Serology was positive for anti-enolase, anti-HSP60, and anti-glyceraldehyde-3 phosphate dehydrogenase consistent with an autoimmune retinopathy. A thyroidectomy was performed for invasive follicular carcinoma. At last follow-up, the VA was 20/150 OD and 20/40 OS.

Maywood and colleagues[20] present a 47-year-old healthy woman with acute-onset scotoma in her left eye. An examination showed anterior uveitis with parafoveal retinitis. An anterior chamber paracentesis revealed cytomegalovirus via polymerase chain reaction testing but was negative for herpes simplex virus, varicella zoster, and toxoplasmosis. Oral valganciclovir was instituted with intravenous foscarnet and ganciclovir. The authors discuss the importance of diagnostic testing, aggressive treatment, and consideration of long-term ongoing prophylaxis for potential recurrent disease.

Teru et al[21] describe another rare case of Purtscher-like retinopathy in a 72-year-old woman with acute ischemic colitis. The authors suggest the importance of a broad differential beyond classic trauma or pancreatitis for this micro-occlusive vasculopathy.

Abbas and colleagues[22] present a 97-year-old woman with acute unilateral serous choroidal detachment. Classic unilateral dilated episcleral vasculature prompted neuroimaging with cerebral angiography. A Barrow type D carotid-cavernous fistula was diagnosed. Neurosurgery recommended conservative treatment, and the choroidal detachments improved over the next 4 months. At 6 months, a vitreous hemorrhage occurred; however, the patient elected to defer surgical management. VA recovered from 2/200 to 20/80.

Seela et al[23] present a 36-year-old man with a 5-year history of worsening peripheral vision and compromised night-vision. Imaging was classic for an advanced rod–cone dystrophy even though previous genetic testing yielded normal results. Repeat inherited retinal disease testing (using a broader "panel") located variant mutations, including involvement of the *SGSH* gene associated with mucopolysaccharidosis type IIIA. The authors address the potential limitations of narrow genetic testing and the benefit of coordination with a genetic counselor experienced in ocular disease.

In an era marked by rapid technological advancement, complex ethical dilemmas, and systemic challenges, the importance of purpose in medicine cannot be overstated. Purpose is the foundation that sustains compassion, guides ethical decision-making, and nurtures resilience among practitioners. It is the force that transforms medicine from a technical endeavor into a profound expression of human service and solidarity.

For retina specialists to thrive and maintain their moral compass, healthcare institutions, educators, and leaders must prioritize the cultivation and preservation of purpose. By doing so, they can ensure that medicine remains not only a science and an art but also a vocation driven by a steadfast commitment to healing and human dignity.

"Efforts and courage are not enough without purpose and direction."
—John F. Kennedy

"The purpose of life is not to be happy. It is to be useful, to be honorable, to be compassionate, to have it make some difference that you have lived and lived well."
—Ralph Waldo Emerson

Timothy G. Murray, MD, MBA, FASRS, FACS
Editor-in-Chief
Journal of VitreoRetinal Diseases

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