Some Days You Can't Save Them All

This is where you say goodbye, I needed to let her mother know.

No matter how many times I had done it before, the task never got any easier. The circumstances varied. Every mother or father, son or daughter, husband or wife reacted in a different way. What I knew for certain was that whichever words I chose and however I chose to say them, they would always bring forth much suffering. And so, after mustering enough conviction, infused with whatever amount of compassion that was left for the day, I said my piece with a straight face:

"*Nanay, pasensya na po. Wala na po kaming magagawa para sa anak ninyo. Kahit po operahan namin siya ngayon, wala na pong mabuting maitutulong sa kanya.*"

It was both an explanation and an apology, wanting to temper expectations and provide comfort, but likely fulfilling neither in the sea of emotion.

The mother in her late 30s gave out an agonizing cry, silencing the ordinarily raucous pediatric emergency room (ER) as she tugged on my polo.

"*Dok, please Dok. Gawan ni'yo po ng paraan, Dok! Parang awa ni'yo na, Diyos ko.*"

She wiped the flood of tears with the ruffles of her *daster*, clasped her hands and bowed her head, as if in prayer. I was her only hope and she begged.

Across the room her daughter lay, dying. Eyes frozen, hands and feet full of puncture marks, a tube in her mouth to force air into her lungs. They were unable to afford the cost of renting a mechanical ventilator. If the father were to stop manually deflating the Ambu bag, she would stop breathing altogether.

"*Kung ooperahan pa po natin siya ngayon 'Nay, baka lalo lang pong mapadali ang buhay niya.*"

Her blood pressure would plummet from the anesthetic and her heartbeat would become erratic, I thought of saying, but she would not comprehend, and the science would not matter at this time. I put my hand on her back.

"*Tabihan mo na lang ang anak mo. Yakapin mo. Kausapin mo habang kasama mo pa siya.*"

She took another crescendo of inhales, paused, and let out a wail that echoed a mother's sadness and anger and regret.

They were a family of scavengers. Earlier that day, her only daughter Ofelia, who had been playing hide and seek in a cemetery, slipped and fell from a topmost tomb, breaking her skull in several areas. A massive blood clot accumulated inside her head and she rapidly lost most of her brain function. Ofelia would die, regardless of what we did.

"*Pasensya na po, 'Nay. Hanggang dito na lang po tayo.*"

Would these words alleviate her pain, even by a tiny bit? Or was the token apology only a means to exculpate myself? To shake off guilt for knowing what could have been done and yet being unable to do anything. What good was understanding the pathophysiology of brain injury, or being able to enumerate the steps in evacuating an intracranial hemorrhage, if in the end the patient would die anyway just because her family could not get to the hospital in time? The sleepless nights that stretched all the way back to medical school, endured in the hope of being able to save every valuable life, suddenly became worthless.

"*Ganyan talaga ang buhay*," the callous would say with a shrug.

I thought about my mother. Put in the same situation, she would have cried harder. She would have gone hysterical. She would have thrown blood specimen vials and kicked the ER's waiting chairs, refusing to be restrained or pacified. In all likelihood, she would pass out.

I should call her in the morning. She had to be reminded to bring my scrub suits and white coats for the week, and if possible, to come late at night so I could have dinner with her and have time to ask about how my brother and sisters were doing.

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I was training to become a neurosurgeon in Philippine General Hospital (PGH). Neurosurgery residency was a five-year program, until 2012 when it was extended to six. I entered the program in 2010 and was thus mercifully spared from this ruling.

First year consisted of quarterly rotations under the trauma and general surgery divisions, where I learned the basics of suturing and wound care, assisted in opening up people's abdomens or taking out their cancerous breasts and inflamed gallbladders, and even performed appendectomies and chest tube insertions on my own. That was the highlight reel.

The rest was mostly scut work, carrying out orders from the consultants, the team captain (i.e., general surgery resident on the final year of training), and mid-level residents called vice chiefs. Some of the things I did every day:

1. Push stretcher beds from the ER to radiology and back
2. Sprint between the blood bank and the operating room complex with packs of red blood cells and fresh frozen plasma

3. Ensure patients scheduled for elective surgery had the medical clearance and supplies they required
4. Persuade the hospital's social service unit to waive fees for diagnostic exams
5. Pilfer antibiotics and sutures for patients who could not afford to buy them
6. Dress infected wounds and change bottle drains before ward round every morning
7. Repeat #1 and #2 while waiting for the outcome of #4

The inefficiency of processes in the hospital called for unquestioning diligence among the junior residents, otherwise it would take a long time for patients to move along the care pathway.

For example, it would take no less than five steps to get a chest x-ray in the middle of the night for a patient with difficulty of breathing. Imagine how much more effort it entailed to bring a patient to the operating room for emergency surgery. To get the unanimous approval of the chief surgeon, chief anesthesiologist, and chief nurse, you needed to move mountains. You could choose to do it with reason, charm, force, or any combination of the three, for as long as the job was accomplished and you were willing to deal with the consequences of your actions. Unfortunately, a few would resort to deceit. When uncovered, you would get the residency equivalent of being sent to the principal's office.

After one year of general surgery, I was surrendered to my home department—the section of neurosurgery—where I would spend every day of the remaining four years learning to operate on the human brain and spinal cord.

The day always began at 5:30 in the morning on weekdays and 7 o'clock on weekends. Vacation leaves and holidays did not exist. A pile of computed tomography (CT) and magnetic resonance imaging (MRI) films tucked underneath my right arm and held close like they were

my most valuable possessions, I would walk past the charity wards and dining hall of PGH, and make my way to morning rounds at the Neurosurgical Special Care Unit (NSSCU), an eight-bed intensive care unit (ICU) on the second floor dedicated to the most critical neurosurgical patients. That was, if I had not chosen to stay there overnight.

As a first year neurosurgery resident, I was a denizen of the NSSCU. Whenever I was the resident-on-duty (ROD), that was where I took phone calls, filled out patient forms, and ate my meals at unpredictable times. In the refrigerator, I (somewhat illegally) stored my 1.5-liter Coke bottle that kept me running on sugar.

During the wee hours, in between answering referrals from other departments and accomplishing assigned tasks for my 48-hour duty shift, I would choose an empty patient bed where I could lie down and take a nap, grateful for finally getting a chance to rest my back. Never mind if a patient had just died on the same bed an hour earlier. Nothing that couldn't be remedied by a generous wipe of 70% alcohol on the mattress. If the NSSCU happened to be fully occupied, I requested for hospital linen from the nursing aide on duty. I would spread the linen on the floor behind the head nurse's desk, a two-square-meter cubicle walled off from the patient beds and nurses station by an accordion divider. I used my bag as pillow, set multiple alarms ten minutes apart, and lathered mosquito-repellent lotion before retiring to my makeshift nest.

That way, if any of our patients from NSSCU or the surgical ward deteriorated overnight, the nurses would no longer need to look for me all over the hospital. One of them simply woke me up. I resuscitated the patient, facilitated an emergency CT scan, updated my team captain of the events, and went back to sleep after the patient had been stabilized. Every minute of rest was precious. The cacophony of cardiac monitor bleeps, mechanical ventilator alarms, and slurping

sounds of the suctioning machine lulled me to sleep. The unit had airconditioning, and after being in the hospital for days on end, that was all an ROD needed.

Sometimes, I slept all the way through 5:30. The nurses doing their endorsement rounds would interrupt my dreaming with gentle taps on my shoulder, pity and embarrassment in their eyes, "*Sir, pinapagising na po kayo ni* Powix (the chief resident)."

I would sit up startled.

Kamote! Ano pa ba ang mga hindi ko nagagawa?

Kamote was hardly a good way to start a day.

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There is never enough time when you belong to one of the busiest neurosurgical services in the country. The neurosurgery residents are in charge of all eight NSSCU beds and 22 beds in the adjacent Ward 6. At any given time, there are 30 to 50 referred patients from neurology, pediatrics, and trauma. In addition to the charity patients, there are 30 or more patients admitted under the consultants, in the private floors of the hospital's central block. Their consciousness levels ranged from the vegetative and insentient, barely meeting the minimum definition of alive, to the fully awake and rambunctious, hurling expletives as if it were as necessary as breathing. If any one of these patients needs attention, or if a new patient turns up at the ER, it is the neurosurgery ROD who gets called.

"*Dr. (author's name) po ako sa neurosurgery. Kami po ang mga nag-oopera sa ulo. Kung sakaling kailangan kang operahan, kami po ang mag-oopera sa iyo*."

I would see anywhere from 5 to 15 new patients on an average duty day, on top of the patients I would examine in the outpatient clinic during Wednesdays and Fridays.

I had interviewed them all: the wife who would tentatively promise to procure operating room needs for her husband with a clot in his brain from uncontrolled hypertension, the loud mother demanding that her toddler who fell down the stairs be seen right away, the drunken bastard who crashed his motorcycle into another vehicle, and the clueless *bantay* who could not even tell me where his patient's blue card was.

After the first hundred patient encounters, I learned that the least useful question in our institution was "*Bakit ngayon lang kayo kumonsulta, eh* (insert time frame) *na pala niyang nararamdaman iyan?*"

The answer was painfully predictable ("*Eh kasi Dok, wala ho talaga kaming pera*"), like a broken record on an infinite loop, albeit in a different voice each time. The question had neither diagnostic nor therapeutic value. It served no purpose other than to bare a physician's indifference to his or her patient's socioeconomic circumstances, so as a trainee I abandoned asking the question early on.

When I asked them, "*Bakit sa PGH niyo pa po dinala ang pasyente?*" (counting the number of public and private hospitals they passed along the way), they answered the same thing.

Occasionally, they said, "*Dito kasi sa PGH Dok, alam namin nandito ang mga magagaling.*"

Reflexively, I would clear my throat and chuckle.

"*Naku, nagbobolahan na tayo dito*," I would say.

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"*Kamusta ka?*"

"*Maayo naman,*" said the ten-year-old boy with a flash of his cavity-laden teeth. I began to tickle Eric in the stomach and was satisfied to see him giggle and move about in his metal stretcher bed because of what I was doing. At least, he was awake and playful. With a tumor the size of a five-peso coin in his cerebellum, the hindbrain, he would not be able to celebrate his next birthday if he did not undergo surgery soon.

Of course he did not know this. He did not have to. My senior resident and I had just disclosed the diagnosis to his mother, and the only response we got was a meek crying, as if mourning for her still living child.

Eric was the youngest of seven children. His parents brought him to PGH from Masbate because they noticed that he had difficulty walking and would often fall to the ground whenever he attempted to run. Understandably, his parents were shocked to find out that what they thought to be a quick orthopedic problem turned out to be something more sinister. At the rate it was growing, his tumor would compress his brainstem, which controlled his heart rate and breathing, in a few months' time, weeks even.

He would die without knowing he was dying, taking with him whatever potential he had and whoever he was meant to be.

"*Matalino ka ba?*"

He sniggered (No facial asymmetry, good), and turned his head away, refusing to reply.

"*Eh anong* favorite subject *mo?*"

"*Filipino po.*"

"*Ayaw mo ng math?*"

"*Hihihi. Ayaw.*"

I stopped my neurologic examination and looked at his mother, who began to run her fingers through the gaunt child's brown hair in gentle, sweeping strokes. My mother used to do that when I had fever as a child; I was reminded of the feeling of security and warmth it always gave. The same doting gesture was this mother's apology to her son. She was giving up.

"*Wala po kaming pera pampaopera, Dok.*"

"*Hindi po puwedeng ganun 'Nay. Gawan po ninyo ng paraan.*"

I urged her to contact all her friends and relatives, borrow money if she needed to.

"*Anak ni'yo po iyan. Kapag namatay iyan, wala nang bawian 'yun.*"

She continued to cry, wiping her tears with her dirtied Good Morning towel.

"*Dok, wala po kaming kakilala dito sa Maynila.*"

"*Ano bang trabaho ng asawa mo?*"

"*Nagtatanim lang po ng mais at kamoteng kahoy.*"

"*Magkano po ang dala ni'yong pera nung pumunta kayo dito?*"

"*Isanlibo lang po, Dok. Nabawasan na kasi bumili pa ako ng mga gamot kanina.*"

I ran through the numbers in my head:

> *Operating room needs: 20,000 pesos*
>
> *Anesthesia needs: 7,000 pesos*
>
> *Serial cranial CT scan: 5,000 pesos*
>
> *Antibiotics and medications: 15,000 pesos*
>
> *Laboratory workups: 5,000 pesos*

> *Mechanical ventilator: 2,000 pesos + 400 pesos/day*

Our neurosurgical team could defray the cost of operating room needs by using other patients' excess medical supplies. We could even pay for his post-op imaging. But taking out the tumor was just the beginning. To treat his brain cancer comprehensively, in all likelihood he would need chemotherapy and radiation therapy immediately after surgery. Otherwise, the tumor would recur and that would mean having to start from square one again. We had not even discussed the possibility of surgical complications.

"*Iuuwi na lang po namin siya, Dok,*" she said, not looking at me, but at her son who remained blithe and oblivious to the somber conversation.

To begin with, children do not belong in a hospital. They are meant to watch Batibot, play *Agawang-Base* and *Langit-Lupa*, get into fights deciding "*Sino ba talaga ang taya?*", bring out their parents' slippers when they arrive, and help set the dining table every night. They are not supposed to be bedridden, intubated, catheterized, injected with, or operated on. They cannot fight battles on their own, and nothing is more disheartening than to hear their parents refuse to fight for them.

"*Gusto mo nang umuwi?*" I asked Eric in resignation.

"*Opo, Dok. Wala na kaming peh-raaaa… kahit piiiii-so.*"

He just had to do the last bit in a singsong. I smiled with a sigh.

We had lost this child.

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When you first walk along the hallways of Philippine General Hospital, what you notice right away is how dimly lit they are, regardless of time of day. Doctors, medical students, utility workers, and watchers scurry in all directions with their patients being pushed or pulled in unpadded metal stretchers and wheelchairs, under the faint glow of fluorescent lamps grey and quivering as an old man's eyes. The chipped floor tiles, cracks on the wall, and gaps in the moldy drop ceiling only add to the gloom that insinuates itself into every cubic meter of airspace.

The minimal lighting is, in fact, an austerity measure, but often I wonder if the darkness were intentional, an attempt to conceal sorrow that has accumulated over decades, from countless men, women, and children who have shed tears on the death of their loved ones due to sheer poverty, or just the natural course of their patients' illnesses. They cry in narrow corridors, hollow corners, and empty stairwells, in the dead of the night with only the mute walls to listen. Patients move in and out of the hospital, for better or for worse, but the tears remain. In the dark, melancholy refuses to be wiped away.

To many, PGH is a hospital of despair. Yet, that has never deterred patients from arriving at PGH's doorsteps.

It is the hospital that taught me the ability to see. No more than a few minutes with a patient, and I saw the unequal pupils, the raccoon eyes, the facial asymmetry, the leg weakness, the irregular breathing, and the purulent wound discharge. The full spectrum of neurosurgical disease in the national university hospital necessarily sharpened one's clinical eye. A cursory look at the ER, and I could pick out which patient might die if nothing was done immediately.

But, more important, PGH also taught me to *un*-see. I saw the greasy hands, the mismatched slippers, the old stab wound, the faux eyelashes, the eagle tattoo, the forearm track

marks, the plastic rosary, the torn t-shirt, the fancy dress, the mobile phone kept intact by a rubber band, the Saudi gold, and the Rolex, and I treated them all the same.

I can say that from day one, I knew what I was getting into. As a clinical clerk and a medical intern, I saw how my PGH residents then struggled to provide the best possible care to patients despite the hospital's limited resources.

When I signed my appointment papers that officially designated me Medical Officer III, I was prepared to spend the next five years inside PGH, not knowing when I would be able to eat, shower, sleep, or study. I consented to put my life outside of the hospital in a state of suspended animation. That was the price I would have to pay for wanting to be a neurosurgeon, and the wealth of experience that could only be gained by training in a public hospital.

The temptation to quit was a traitor. It would not barge in boldly during the peak of my workload; often I was too preoccupied to contemplate on the dismal state of my personal life. Instead, it would sneak in during that silent minute in between surgeries, as I slumped on the floor and waited for the next patient to be brought in. It stared at me from a corner as I waited for the elevator doors to open, me holding both stretcher bed and oxygen tank and it's only an hour past midnight. It would whisper in my ear, to wake me up from a nap on the first Sunday afternoon that I got to spend at home in a long time. It would hold open my apartment door, as I donned my white coat, grabbed my keys, and rushed to morning ward rounds.

I survived by taking things one day at a time. However unrelenting, each day ended soon enough.

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On Friday mornings we girded our loins. At either 7 or 8 o'clock, the neurosurgery residents would do bedside rounds with the consultant of the week. The medical interns tagged along, occasionally at the receiving end of questions. Patients awaiting surgery were presented by the junior residents, post-operative patients by their respective surgeons. The mortality and morbidity conference followed at ten in the neurosurgery office, where the rest of the consultants waited.

On Fridays we were made accountable for all our actions and decisions during the week. One by one, the neurosurgery residents would stand in front of the negatoscope where the CT and MRI films were displayed, facing the consultants who sat around a long table, ready to interrogate after each patient was presented. A large white board on the far left listed the order in which the cases were to be discussed. The section secretary knew there had been carnage when the conference lasted till two in the afternoon.

It was the time to come clean. We confessed our blunders, explained why we did what we did, pointed out where we thought our surgeries went wrong. Ignorance was inexcusable. Everybody made mistakes, but to commit an error and not recognize it—or worse, to refuse to admit it or lie about it—these were capital sins. To be incorrigible was to dig your own grave.

Nobody minced words during the Friday conference.

> *Naoperahan mo na at lahat, hanggang ngayon hindi mo pa rin alam kung bakit?*
>
> *How come you still don't know this? This is not rocket science. Even monkeys can be taught to operate. Are you a monkey?*
>
> *Siraulo ka ba? Anong naisip mo nung nakita mo ang pasyente? Ang hirap sa inyo hindi na kayo nag-iisip.*

> *What made you think you could take all the tumor out? Now you've paralyzed your patient… for something that is not even malignant! Do you know the meaning of the word hubris?*
>
> *When did the patient deteriorate? How soon was the CT scan done? What time did you see this patient? Who was the senior on duty? You know what, just get the chart.*

Having gone through the same training program, the consultants demanded only two things: honesty regardless of consequence and uncompromising commitment to perfection. Every Friday the neurosurgery residents were measured up. Knowledge, skill, attitude—everything was on the table. The consultants kept tabs, and Fridays largely influenced whether a resident would be promoted in January, retained in the same year level, or kicked out of the program. Nobody was indispensible, that's what our training officer always said.

The impulse is to study out of fear: fear of being humiliated, looked down upon, punished with Sunday duties, banned from the operating room, or removed from the program too soon. Eventually, fear gives way to shame: embarrassment for failing to master a technique required at a certain level, for disappointing consultants who expected you to know better. Much later comes guilt. It may not be rocket science, but at stake are lives of real people, who have spouses and children, jobs and vocations, pasts and futures.

If one of my patients died or developed a complication, the conference ensured that I left the neurosurgery office knowing I was at fault, and that I needed to do better. I had a moral obligation to study my cases and develop my surgical skills, because this wasn't a video game where I could just press the restart button and instantly I would regain all the lives I began with. Remorse is a powerful thing.

Thus, neurosurgery residents spent Thursdays looking for misplaced CT and MRI films, reviewing medical charts for the correct temporal sequence of events, and re-examining our patients as we scribbled cheat notes in haste. We crossed our fingers tight and prayed to the gods that none of our patients would deteriorate or die on a Thursday night. We made a mental accounting of the things we did wrong, hoping they were outnumbered by the things we did right.

In the morning I always woke up with a throbbing tension headache, or chest pain from gastric reflux, symptoms that only abated after I had presented all my cases for the week.

Friday's only saving grace was the followup clinic in the afternoon, when we got to see our patients who eased our inner wounds with boxes of buko pie and black forest cake. On Saturdays the residents started anew, each one a phoenix rising from the ashes.

"We are not here to do what is easy. We are here to do what is right."

These were the words my chief resident Powix lived by, words that tided me over the worst Fridays, when—out of survival instinct—in fleeting but no less discomforting moments, I would infrequently catch myself more concerned about what the consultants would say, rather than what difficulties lay ahead for my patients because of my errors, and subsequently, I felt I could not be a more terrible human being.

That was how I learned, that was how I lived for four years.

Nobody talked about quality of life during neurosurgery residency. In those days, I too believed it was necessary sacrifice.

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I once promised an eight-year-old boy that he would not die.

His name was Pipoy.

I had just taken out his brain tumor, in a marathon operation that lasted almost eight hours, and I was waiting for him to wake up in NSSCU. Standing next to his bed, I leaned forward to whisper in his ear while I gently tapped his chest.

"*Pipoy, gising na, tapos na ang operasyon.*"

His eyes fluttered, and slowly, he turned his head to me.

"*Naaalala mo ba kung sino ako?*"

Through his transparent face mask that delivered oxygen, a faint reply.

"*Opo, Dok.*"

"Very good. *Tapos na ang operasyon ha?*"

What he said next, I did not expect.

"*Dok, ayaw ko pa pong mamatay… Gusto ko pa pong makapaglaro….*"

In Pipoy's eyes, I saw fear that was innocent and raw and delicate all at the same time, tremble apparent in his soft voice. It cut through me and sent a shudder. Even my adult patients were rarely this articulate right after their operations. Was it the anesthetic?

I gently squeezed his right hand, and said, "*Tapos na ang operasyon, Pipoy. Nandito na sa tayo sa* ICU. *Pramis, hindi ka mamamatay.*"

I held his gaze as I tried to reassure him.

"Relax *ka lang, nandito lang ako 'tsaka ang Nanay.*"

I told him he could sleep if he wanted to.

"*Huwag mo lang hihilahin 'yung tubo na nakakabit sa likod ng ulo mo, ha?*"

"*Opo, Dok,*" he nodded.

“*Huwag kang mag-alala, hindi kita papabayaan.*”

He was the politest child I have I ever had as a patient, and he died two months later from overwhelming infection and tumor recurrence. In PGH Ward 11. Under my care.

I broke my promise to a little boy who only wanted to live, and several years henceforth, I still did not know how to forgive myself.

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As I ascended the residency ladder, the amount of scut work declined, but with it was a disproportionate increase in responsibilities and expectations. The surgeries I was allowed to do became more complex, and critical decisions involving life and death now fell into my hands. The recoveries became more dramatic, but conversely, the deteriorations, more devastating. No longer was I responsible just for my actions; I now had to look after my junior residents as well.

I wish I could say that I had it all figured out, but past the halfway mark, I did not handle the pressure well. I became unforgiving of my failures, intolerant of the junior residents’ shortcomings, and generally impatient at most things—whether it was in the transport of a patient to the operating room, or waiting to be served breakfast in a fast-food restaurant. I became the senior resident who cursed at my juniors from across the hallway when they failed to do an errand or when a patient worsened on their watch. Even teaching the medical interns, once a fulfilling task, became just another chore to tick off. I hardly saw my family, and perhaps unnecessarily, I severed ties with the few friends I had. Most days I would find myself anxious, flustered, or downright angry.

Idealism and drive dwindled. Underneath the confident stride, the assertive tone, and the decisive actions—often perceived as arrogance—I was just going through the motions. Burnout was a looming eventuality.

The medical student who aspired to perform life-saving brain operations would only recognize fundamental fragments of his self in the senior neurosurgery resident. I can pinpoint the exact instant this thought occurred to me. It was the first month of my final year. I was in Singapore for a four-day course and I had one free day before going back to Manila. I chose to spend most of it in Singapore Zoo.

As I stood in the amphitheater where patrons could see the resident polar bear Inuka through a thick glass wall, I didn't know which amazed me more: that I was seeing, for the first time, an actual polar bear swimming in circles in ice cold water, or that I did not have to do anything at that moment, except appreciate the hypnotic, elegant movements of the arctic animal. No phone calls or text messages about patients from co-residents and consultants. Manila was distant and inconsequential. Lost in thought, I felt that I had put on twice the actual number of years since I started training. I learned neurosurgery, but did I like the person I had let myself become?

I was not sure.

A five-year-old boy with chinky eyes and hair resembling a coconut husk tugged the lower end of the neurosurgery resident's untucked polo, as the latter remained fixated on the swimming polar bear.

"*Para ka namang nagfi*-field trip. *Ang tanda-tanda mo na,*" the boy said. "*Wala ka bang kailangan gawin?*"

"*Wala.*"

“*Saan ka pupunta pagkatapos?*”

“*Hindi ko pa alam. Bahala na.*”

Inuka continued to paddle with serenity and grace. I was flailing and out of breath, unable to break the surface.

. . . .

“*Anong kuwento mo sa akin ngayon?*”

I was talking to Karl, a patient in his early 20s who once made a prudent request to have his operation expedited, just because his blurred vision made it difficult for him to attend classes and study. It was Friday afternoon in the outpatient clinic. I sat across him in my cubicle.

“*Ga*-graduate *na po ako Dok, sa wakas.*”

“*Talaga? Anong* course *mo?*”

“Marketing *po.*”

I instructed him to cover one eye, and then the other, as I checked his visual fields. I could not resist a smile because his vision had improved remarkably since his surgery months earlier.

“*Sana makapagtrabaho na po ako. Para makatulong na po ako sa mga magulang ko.*”

That should not be problem, I told him. I advised to repeat his MRI in a year and offered my congratulations. He responded with an invitation to visit his family in Pampanga when the time came to celebrate.

“*Anong kuwento mo sa akin ngayon?*” I asked another patient, a nine-year-old kid named Mimi.

“*Nililoko ko po ‘yung isang kaibigan ko na hindi ko siya naaalala.*”

“*Ha? Bakit mo naman ginagawa ‘yun?*”

“*Wala lang po, gusto lang namin gawin ng isa pang kaibigan ko.*”

She giggled at her antics, embarrassed and amused in equal measure.

One month earlier, I almost lost Mimi when her brain tumor bled just before her schedule for surgery. I rushed her to the operating room, not knowing whether she would wake up from coma. But there she was now, telling me about her little prank. A witty one, too. Her bald head made the amnesia more convincing, and I could only feel pity for the playmate.

“*Anong kuwento mo sa akin ngayon?*”

> *Nakakapaglakad na po ako, Dok.*
>
> *Nag-Top 9 po ako sa klase ko.*
>
> *Dok, naaalala ko na paisa-isa ang mga recipe ko.*
>
> *Ginawan kita ng painting, Dok.*
>
> *Gusto ko na po uling makapag-dive, Dok. Hinahanap na ako ng mga katrabaho ko.*
>
> *Mag-isa lang akong nag-commute ngayon. Kaya ko na, Dok.*

A myriad answers to a simple question, which, I discovered, had an unparalleled power of making my patients and their families feel important, especially when they had travelled for four hours and waited in a queue for four more, enduring hunger, humidity, and the perspiration of their compatriots. By veering from the standard “*Ano po ang masakit sa inyo?*” I learned much more about the people I served and worked hard for.

In a hospital where everyone always seemed to be in a hurry to do something or go somewhere else, I made it a point to sit down and greet my patients with the most important question in clinic:

"*Anong kuwento mo sa akin ngayon?*"

At their responses I nodded in agreement, wrinkled my forehead in disbelief, laughed heartily, or remained speechless, amazed at the rate of their progress. But mostly, I just listened to their stories. As they spoke of past pains relieved and soon to be forgotten, of present thrills whether frivolous or life-changing, and of future possibilities waiting to be lived with renewed excitement, I gained a deeper understanding of the reciprocal relationship between patient and physician in a public hospital.

To be heard is a human need. To listen is where compassion begins.

In my patients' narratives, told with enthusiasm, pride, and gratitude, accompanied by animated gestures, and sometimes, tears of joy, I found meaning and purpose.

Some days, you could not save them all, but my patients—with their promise of a good story—reminded me that I should not stop trying.