between the president and Congress have never in history been resolved in court. Why start now?

The House's unprecedented lawsuit is thus unlikely to survive appeal. But the law governing who has standing to sue is malleable enough that the House could perhaps eke out a victory. The consequences of such a victory would be both severe and regrettable: more federal spending, pricier insurance, and fewer people with coverage. Maybe at that point, a chastened Congress would finally appropriate the money that it should have appropriated several years ago.

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1. 31 U.S.C. §1324.
2. Blumberg LJ, Buettgens M. The implications of a finding for the plaintiffs in *House v. Burwell*. Washington, DC: Urban Institute, 2016 (http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000590-The-Implications-of-a-Finding-for-the-Plaintiffs-in-House-v-Burwell.pdf).
3. 31 U.S.C. §1301(d).
4. Government Accountability Office. Principles of federal appropriations law. 3rd ed. January 1, 2004.
5. Raines v. Byrd, 521 U.S. 811 s(1997).

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The Sharing of Loss

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Just as the Friday evening efflux of staff begins, a patient with cancer whom I saw only days ago is reported to be not quite right. She may not think so, but I have always liked her. At her first consult, she flatly refused to mention her weight in front of her husband, causing me to wonder if she feared he would leave her. Far from it — though she was significantly overweight, he said, "I love her just the way she is," and I was touched by his ability to support her in the way she needed, then and later.

My 63-year-old patient is petrified of the surgeon, wary of her radiation oncologist, and restrained about seeing me too often. She has heard that oncologists can be "loose" with chemotherapy, and although she apologizes profusely for her caution around me, she conducts herself with simplicity, grace, and rationality when considering her options, which are, after all, palliative. And she has remained well for a long time, proof of the adage that more treatment isn't always better. Slowly, her wariness has given way to trust, but old habits die hard, and this time she has let her avoidance of doctors go too far. Her husband wheels her in clutching a plastic bag into which she retches. She strains to sit straight, and when he knocks her oversize wheelchair against my door, she growls — the first time I have seen her lose her temper. "I haven't eaten all week," she whimpers, "and my head kills. Please help me."

Dismayed, I admit her to the hospital, promising to get to the bottom of her surprising acute illness. Hours later, tests reveal not the brain metastases I had dreaded but unexpected organ dysfunction. On Friday night, deemed too unstable for the ward, she is transferred to the intensive care unit of another hospital.

"Can't you keep me here, under you?" she asks.

"I am afraid not," I say, "but they will look after you."

The first call from the ICU is a familiar one. The patient has unexplained sepsis, renal failure, liver failure, and early signs of disseminated intravascular coagulation. The question is polite, even circumspect. "How far do you want us to go?" The implied question screams, "What were you thinking when you sent her over?"

I am still grappling with how my patient with low-volume cancer and no recent chemotherapy went from being generally well to perilously ill, and the intensivist's implication raises my hackles because oncologists and intensive care physicians are well known to dance around the issue of therapeutic nihilism. There are the stereotypes of the oncologist who, unable to distinguish the forest from trees, won't let up on the dying patient and the intensive care doctor who turns the dial on the ventilator while muttering about the oncologist's appalling lack of perspective.

So I use more words and more energy than necessary to say, "For now, I'd like you to put her cancer aside and treat her like you would any other septic patient." I am mollified when she

says my input will assist in the handover to the weekend team, whose rolling eyes I can already conjure in my imagination.

All weekend, I fret over my patient's downfall, pledging that as soon as she improves, we must have a firm conversation about reporting symptoms earlier. I plan to visit her soon, so when the phone rings on Sunday evening, I brace myself for another round of advocacy. It's the senior intensive care physician. "I am sorry to interrupt your weekend," he says, "but we need to talk." He then relates one calamitous result after another. The creatinine is climbing, the bilirubin is skyrocketing, the patient is encephalopathic.

I listen silently, my own angst at the unmitigated disaster mingling with his clear chagrin that his meticulous care has not made an iota of difference. Between snippets of clinical information, we discuss the person behind the patient. I tell him about her active volunteering; he mentions her husband's vigil at her side. I mention her mistrust of doctors; he notes her gratitude when they first met.

"Do you think we should intubate?" he muses, his hesitation transparent.

I hadn't even considered it and am surprised.

"Would you?" I ask.

"It wouldn't reverse things," we say simultaneously, and with palpable relief.

The conversation lasts a long 10 minutes. I hang up, feeling sad but strangely calmed at this first opportunity to talk about her without needing to answer an urgent question or justify a thread of reasoning.

The patient's pain is palliated, and the next morning she breathes her last just as I swipe my card to enter her room. At her bedside, I find her husband, grief-laden questions tumbling from his lips. Should he have called the ambulance earlier? Could he have given her part of his liver? Did I think she suffered greatly? I reassure him that he performed a wonderful service and am gratified to note some consolation seep into his torment.

It turned out to be a call only to convey to another doctor the hollow feeling of losing a mutual patient, not knowing quite why or how, only that it was happening, and it was on our watch.

In the ensuing months, I hear about the fate of other patients through incidental means. In a labyrinthine hospital network, it's not uncommon to have a patient die one floor away but discover the news through a stale discharge summary, a dutiful relative, or a poignant obituary. Missed appointments and thank-you cards routinely serve as other notifications of death. Many times, I am left to rue a missed opportunity to offer solace to patient and family, wondering why, despite all our advances, we can't seem to get the simple things right.

In an era of instant messaging through ubiquitous devices, the ritual exchanges between doctors are incessant, even distracting. It is impossible to conduct a ward round without someone paying more attention to a screen than to the patient. We call to nab a quick consult; we text to find out if there is room on the bronchoscopy list; we e-mail to nail down that last clinical trial spot. But all these myriad exchanges actually boil down to the question of who can do what for whom. Like all oncologists, I receive numerous summons to elucidate a diagnosis, manage complications of chemotherapy, and guide fractious family meetings.

At the time, the intensivist's call seemed irregular, almost to the point of being awkward. I remember wondering "When will he get to the point?" as my mind worked furiously to prepare itself for the tricky question that I knew must lie in wait.

But it turned out to be a call like no other. A call only to convey to another doctor the hollow feeling of losing a mutual patient, not knowing quite why or how, only that it was happening, and it was on our watch. A call whose sole but worthy purpose was to say, "I feel powerless, and I know you do, too, so let's talk this over."

And yet it was an important gesture — one that allowed two physicians to share our mounting regrets, quell our internal conflicts, and reconcile to the inevitable. All too often, we announce our triumphs but camouflage our losses, as if the death

of a patient represents a personal failure. In hindsight, acknowledging the impending loss enabled appropriate palliation for the patient and timely pastoral care for her husband, something that is known to leave an enduring impression on surviving relatives.

Eventually, I express my gratitude to my colleague. Still curious, I ask what prompted the Sunday night call when he knew that the writing was on the wall and there was nothing I could add.

"I knew she would die," he says simply, "and it felt right to share the loss."

In a world awash with rituals, the routine sharing of loss barely rates a mention, but it is a gesture that our colleagues — and our patients — will thank us for making.

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