To the Editor The Physician Perspective by Reuben1 on sideline guilt should strike a deep chord for many of us. I am a family physician, 72 years old, 6 years retired after an episode of ill health from which I have recovered. So I have my health, food in the refrigerator, enough money in the bank, and a spouse who still puts up with me. The only hardship we face is that coronavirus disease 2019 (COVID-19) has kept us from seeing our far-flung children and grandchildren and forced us to socialize distantly with our friends. Many of my pre-pandemic activities—working as a nursing home ombudsman, teaching medical students, serving on hospital committees—have been curtailed completely or relegated to virtual visits. That I, as a noncritical care specialist, could meaningfully replace a frontline worker is a dubious proposition at best. As Reuben1 points out, staying away from hospitals may be the most constructive thing some of us can do. But beyond the world of medicine, there is so much more to feel guilty about. The COVID-19 pandemic and current events have brought into sharp focus the long-standing racial and class inequities from which I and so many who might read this have undoubtedly benefited in one way or another. I would add 2 suggestions to those Reuben1 has proposed. First, allow yourself to experience gratitude if you float in the same guilty boat as I do: gratitude that you have the boat. Second, get angry about the state of the world and get motivated. The Viewpoint by Berwick2 on the moral determinants of health is a good place to start. There is much that those of us who are blessed not to be suffering in these difficult times can do to help make sure the new normal will better than the old.

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In Reply I would like to thank Kahn and Bruce as well as other retired physicians who contacted me directly for their reflections on sideline guilt.1 While acknowledging the guilt emotion described in the article, they seem less disturbed about not being on the front lines of the battle. Perhaps that is because this is no longer a possibility, as they stepped down from direct patient care roles before the pandemic. Yet these physicians remain engaged and remarkably energetic, channeling this energy into advocacy for health care financing reform (Kahn) and for a broader set of societal issues (Bruce). I am also struck by the expressions of how thankful they are.
for personally being spared infection by the virus. For them, gratitude rather than guilt is a more prominent emotion.

Most of the retired physicians reading JAMA Internal Medicine are no more than 2 decades older than me. They were peers of my teachers and personified the physician I aspired to be. For the most part, they loved their work and understood what being a physician was all about. They lived careers of service caring for patients, which, in turn, fostered their values about the sanctity of the human condition. As is true of physicians practicing today during the COVID-19 pandemic, for much of their careers, these physicians had limited therapeutic options for some of the most devastating diseases and were placed in roles of caring and comforting, often while watching illnesses run their destructive courses. There is much to be learned from them about turning empathy into action to improve the lives of many during the pandemic and beyond.

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Negative Conversion Rate of SARS-CoV-2 Infection

To the Editor: By September 11, 2020, there were more than 28 million people infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) worldwide (https://coronavirus.jhu.edu/). In a recent issue of JAMA Internal Medicine, an Original Investigation by Lee et al1 found that the negative conversion rate in asymptomatic cases was higher than that in symptomatic cases, although to a statistically insignificant degree (Figure 1). However, the negative conversion rate and its comparison between symptomatic and asymptomatic cases may be biased for the following reasons.

First, use of a single negative test result of reverse transcription-polymerase chain reaction as negative conversion may overestimate negative conversion rate, as a negative result may occur purely owing to failure in sampling of specimens.2,3 Previous studies suggest that at least 2 consecutive reverse transcription-polymerase chain reaction tests are needed for confirming negative conversion,4 and the China National Health Commission guideline also requires that the 2 consecutive tests be at least 24 hours apart.5

Second, 26 of 89 asymptomatic case patients received negative SARS-CoV-2 test results within 9 days (from March 6 to March 15) of quarantine and were released from isolation and counted as asymptomatic cases.1 However, research shows that it requires an average of some 15 days for asymptomatic patients to eventually develop symptoms.6 Thus, some of these 26 “asymptomatic cases” may later develop symptoms and should be counted as symptomatic cases. Misclassification of these cases will overestimate the conversion rate in asymptomatic cases and may thus partly explain the observation of the study that the conversion rate was higher in asymptomatic cases than in symptomatic cases (Figure 1).

Third, as there was no testing performed before day 8 and between days 10 and 14 of quarantine,7 the conversion time will be overestimated in those who turned negative before day 8 and between days 9 and 15. As a result, the median time from diagnosis to the first negative conversion may also have been overestimated in the study.

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In Reply We wish to thank Zhang et al for their comments on our Original Investigation.1 They considered the overestimation of the negative conversion rate owing to the use of a single negative result to define negative conversion. During the study, the Korean Center for Disease Control and Prevention also recommended that quarantined individuals should be released after 2 consecutive negative polymerase chain reaction results from the upper respiratory tract in a 24-hour interval,2 similar to the guidelines from the China National Health Commission.3 We defined the first negative conversion as the first negative result for both upper and lower respiratory tract specimens. In Kaplan-Meier curves of 2 consecutive negative conversion proportions of specimens from the upper and lower respiratory tract, we confirmed that negative conversion rates are not statistically different between symptomatic and asymptomatic patients in either upper respiratory or lower respiratory specimens.1