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What to Do With Sideline Guilt—Reply

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Reuben, David B

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COMMENT & RESPONSE

What to Do With Sideline Guilt

To the Editor The Physician Perspective by Reuben[1] 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 prepandemic 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 Reuben[1] 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 Reuben[1] 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 Berwick[2] 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.

Calvin S. Bruce, MD

Author Affiliation: Retired, Madison, Wisconsin.

Corresponding Author: Calvin S. Bruce, MD, Retired, 710 Baltzell St, Madison, WI 53711-1831 (cebruce@wisc.edu).

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To the Editor As the coronavirus disease 2019 (COVID-19) pandemic charges ahead, I too have felt the sideline guilt that David Reuben[1] described in his recent Physician Perspective. I retired from active patient care several years ago. Truth be told, it has been decades since I had acute-care skills that might be useful in today's intensive care units. Nevertheless, as a retiree, I am tormented by the undeniable horrors of the pandemic.

The COVID-19 pandemic has sharply clarified the structural flaws in US medical care and the inadequacy of our public health infrastructure. Even before the current economic recession, tens of millions in the US could not afford medical care while private corporations enriched themselves through expanding their roles in hospital management and ownership of physicians' practices.[2] With the pandemic's arrival and proliferation of massive unemployment, job-related medical coverage has become increasingly irrelevant. The modest benefits of the Affordable Care Act have largely evaporated, yet the profits of investor-owned insurance companies have soared to record levels.[3]

Retirement deepens my perspective about what must be done. Responding to Reuben's challenge, the most "efficient and ethical thing"[1] I can do is increase my advocacy for a fundamental change in how the US finances medical care and supports public health. I believe that the adoption of improved, expanded Medicare for all would be a great first step. For US physicians who may now find themselves on the COVID-19 sidelines, I recommend committing to improving the US health care system in ways that move us toward universal coverage and away from for-profit, corporate capture.

Henry S. Kahn, MD

Author Affiliation: Emory University School of Medicine, Atlanta, Georgia.

Corresponding Author: Henry S. Kahn, MD, Professor Emeritus, Emory University School of Medicine, 947 Blue Ridge Ave NE, Atlanta, GA 30306 (hkahn@emory.edu).

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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.

David B. Reuben, MD

Author Affiliation: Multicampus Program in Geriatric Medicine and Gerontology, Division of Geriatrics, David Geffen School of Medicine at University of California, Los Angeles.

Corresponding Author: David B. Reuben, MD, Multicampus Program in Geriatric Medicine and Gerontology, Division of Geriatrics, David Geffen School of Medicine at University of California, Los Angeles, 10945 LeConte Ave, Suite 2339, Los Angeles, CA 90095-1687 (dreuben@mednet.ucla.edu).

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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 al[1] found that the negative conversion rate in asymptomatic cases was higher than that in symptomatic cases, although to a statistically insignificant degree (Figure 1[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.[1] 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[1]).

Third, as there was no testing performed before day 8 and between days 10 and 14 of quarantine,[1] 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.

Ruiyuan Zhang, MM
Huiying Liang, PhD
Jinling Tang, PhD

Author Affiliations: Department of Clinical Data Center, Guangzhou Women and Children's Medical Center, Guangzhou Medical University, Guangzhou, China (Zhang, Liang, Tang); Guangdong Provincial Children's Medical Research Center, Guangzhou Women and Children's Medical Center, Guangzhou Medical University, Guangzhou, China (Liang); School of Public Health and Primary Care, the Chinese University of Hong Kong, Hong Kong Special Administrative Region, China (Tang).

Correspondence Author: Huiying Liang, PhD, Department of Clinical Data Center, Guangzhou Women and Children's Medical Center, Guangzhou Medical University, No. 9 Jinsui Rd, Tianhe District, Guangzhou, 510623, China (lianghuiying@gwcmc.org).

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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]