



# Is It Necessary to Continue Wearing the Mask in a Medical Setting After COVID-19?

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As the COVID-19 public health emergency is lifted and the pandemic continues to recede, hospitals must decide how to de-escalate mitigation strategies to sustainable states. Decisions about modifying institutional strategies for infection prevention and control are complex and depend on regional and institutional factors (1).

The issue of masking in the community has been considered a controversial reduction technique in the course of the pandemic, to some extent due to the lack of high-quality proof reporting effectiveness and partly due to the political aspect of mask-wearing. There are methodological deficiencies in a majority of published studies dealing with mask effectiveness. Furthermore, mask-wearing adherence has been insignificant in nearly all the publications. Proving mask effectiveness is difficult when they are not worn constantly. While there is no access to gold-standard evidence, it is asserted that in spite of a dearth of clinical effectiveness studies (similar to the case of the extensively accepted practice of hand hygiene), it is necessary to take the issue of mask-wearing in interactions between patients and healthcare staff into serious consideration as a patient safety measure (1).

What clinical studies have not obtained has been achieved by laboratory investigations that indicated that surgical masks, and to a considerable degree, filtering facepiece respirators, are efficacious in restricting the spread of aerosols and droplets from those with infections of influenza, coronaviruses, and other respiratory viruses (1). Despite no 100% success, they significantly decrease the amounts of virus expelled in coughing or talking, thereby reducing the risk (2).

Actual global experience indicates mask-wearing efficacy in clinical settings. Healthcare staff has been at much greater risk of getting COVID-19 from individuals

than occupational exposures owing mainly to global mask-wearing and using other personal protective equipment (3). Patient-to-staff and staff-to-patient transmissions, in case both are masked, do take place; however, they are not prevalent (4).

Researchers reviewed three randomized trials and 21 observational studies to compare the effectiveness of those and cloth masks in reducing COVID-19 transmission." It is necessary to take the issue of mask-wearing in interactions between patients and healthcare staff into serious consideration as a patient safety measure.

They conclude that to return to the appearance and feeling of normalcy, and as institutions decide which mitigation strategies to discontinue, we strongly advocate not discarding this important lesson learned for the sake of our patients' safety.

Masks continue to lower the risk of catching the virus during medical visits, And there was not much difference between wearing surgical masks and N95 respirators in healthcare settings (1).

So, the use of masks in the clinical setting should continue to be studied for both benefits and untoward consequences. The most concrete pitfalls of masks, such as impeding communication and negatively affecting empathy, should become fodder for engineers and developers to improve or redesign masks to obviate these issues.

On balance, despite the limitations of existing masks, healthcare institutions functioned reasonably well during the pandemic. Some have argued that sustaining universal masking is impractical for patient care. During the early HIV/AIDS epidemic, some physicians said they simply could not—for a host of reasons—wear gloves even when situations were associated with likely exposure to blood or

bloody body fluids. Healthcare personnel has adjusted to this requirement, and glove use in such situations has now become the standard of care and is widely accepted as part of standard precautions.

#### Footnote

**Conflict of Interests:** There is no conflict of interest.

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