Ideas and Opinions
M23-0793
202306200
Early
202304180
Open
COVID
COVID-19
Health care
Health care policy
Hospital medicine
Infection control
Infectious disease epidemiology
Infectious diseases
Pathogens
Prevention, policy, and public health

Universal Masking in Health Care Settings: A Pandemic Strategy Whose Time Has Come and Gone, For Now

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During the COVID-19 pandemic in the United States, the use of facemasks has been mandated in all health care settings for individuals older than 2 years, whether present as health care personnel, patients, or visitors. In this commentary, a group of health care epidemiologists, infectious diseases physicians, and researchers argue for the withdrawal of the universal masking policy given the current status of the COVID-19 pandemic.

The use of facemasks for source control and as protection against exposure to infectious agents was well accepted in health care settings before the COVID-19 pandemic as part of both Standard Precautions and Transmission-Based Precautions. During the pandemic, expanded use of facemasks as part of "universal masking" for health care personnel (HCP), patients, and visitors in health care settings was implemented (as in most public settings) to reduce the risk for morbidity and mortality associated with the spread of a novel virulent pathogen. In the context of no population immunity, limited testing capacity, and no medical countermeasures (for example, vaccines, therapeutics), universal masking was a critical protective measure.

Health care settings remain one of the last environments where widespread masking requirements continue despite the evolution of the pandemic and transition to endemicity. Some health care facilities have maintained these requirements even after state and local health authorities have lifted them. Masking requirements in health care have continued longer than in the community because these settings have a higher proportion of individuals at high risk for complications of infection. However, the context and conditions of the pandemic have changed dramatically and favorably since masking requirements in health care were initially adopted (**Figure**), and evidence-based public health policy should also adapt in response (1).

In this commentary, we review the utility of universal masking in health care settings during the COVID-19 pandemic, the potential downsides of maintaining such policies, and why universal masking should not, as some have argued, be incorporated as a required component of Standard Precautions for all direct patient care encounters, regardless of symptoms or diagnosis (2). We also address future circumstances that could prompt reconsideration for masking requirements, beyond what are included in Standard Precautions and Transmission-Based Precautions. We advocate for considering masking requirements as a tool in our arsenal that can be deployed as part of a dynamic approach to infection prevention policy that adapts to changing circumstances.

Universal Masking in Response to the Pandemic: The *Why?*

Throughout the pandemic, widespread use of universal masking in health care settings was justifiable for reducing the risk for transmission among HCP, patients, and visitors and preserving the health care workforce to maintain operations during surges. Universal masking was one element of a larger bundle of strategies to limit transmission, which included restricting access to facilities, use of remote work, symptom screening, asymptomatic testing, and expansion of telemedicine. The implementation of masking along

with these interventions, as part of a framework often called the hierarchy of controls (3), were supported by public health guidelines and health care epidemiology experts (4). Although many of these interventions interfered with care delivery, they were appropriate and widely accepted during the early pandemic response given our limited knowledge about the pathogen and lack of preventive and therapeutic options.

Universal Masking During Later Phases: The *Why Not?*

The burden of SARS-CoV-2 has been mitigated over time through access to testing, substantial population-level immunity providing durable protection against severe disease, a series of less virulent variants, and widespread availability of medical countermeasures, which in combination have resulted in decreasing infection mortality rates. Both the World Health Organization and the U.S. federal government have announced an imminent end to the public health emergency. SARS-CoV-2 has transitioned to a more stable phase, during which the choice and intensity of mitigation efforts must be commensurate with the risk and align with management strategies for other endemic pathogens. Recognizing these changes, many pandemic interventions have been deimplemented. Masking requirements and other restrictions remain notable exceptions in health care settings.

Maintaining masking requirements for HCP during all direct clinical encounters may marginally reduce the risk for transmission from HCP to patient or from patient to HCP. Those potential incremental benefits, however, need to be weighed against increasingly recognized costs. Masking impedes communication, a barrier that is distributed unequally across patient populations, such as those for whom English is not their preferred language and those who are hard-of-hearing and rely on lip reading and other nonverbal cues. The increase in listening effort required when masks are used in clinical encounters is associated with increased cognitive load for patients and clinicians (5). Masks obscure facial expression; contribute to feelings of isolation; and negatively impact human connection, trust, and perception of empathy (6, 7).

Masking in Health Care: The *What Now?*

The time has come to manage SARS-CoV-2 as we generally manage other endemic respiratory viruses in health care settings, which is through correct and consistent application of Standard Precautions and Transmission-Based Precautions (pathogen-specific). Under Standard Precautions, HCP use a mask (and eye protection) to protect themselves from exposure when they are engaging in activities that could generate splashes or sprays to the face, regardless of patient symptoms. Respiratory hygiene, a component of Standard Precautions, means individuals with respiratory symptoms should use a mask for source control in health care settings. Finally, when caring for patients with suspected or confirmed respiratory infection, HCP should implement Transmission-Based Precautions, which include specific personal protective equipment and other interventions. These practices in combination effectively limit and minimize the risk for transmission of

pathogens in health care settings.

Moving away from universal masking policies should be accompanied by reconsideration of other pandemic-era strategies (for example, asymptomatic testing, resource-intensive contact tracing), which similarly have experienced a shift in their risk–benefit balance over the course of the pandemic.

Masking in the Future: The *What Next?*

Masking policies remain an important infection prevention strategy. Educating HCP, our patients, and others in health care settings on the rationale for ongoing policy reconsideration and changes will be essential. Future pandemics or significant localized outbreaks may justify more widespread or targeted masking policies, respectively, as part of a bundled response. High-quality epidemiologic data with frequent updates and regular reevaluation are needed to inform scale-up or scale-down decisions. The health care community needs focused research to quantify the incremental value of interventions under various epidemiologic circumstances and to support the development of a learning health care system. This is essential to allow active and ongoing local reassessment of utility to ensure requirements are not maintained longer than necessary and are reinstated when needed (8). Consistent with the principles of continued assessment of infection prevention interventions, the Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee is currently reevaluating existing approaches to Transmission-Based Precautions, which is likely to inform future considerations for health care transmission mitigation strategies (9, 10). Additional investigation to understand the transmission risks from infected individuals across a range of respiratory viruses and intensity of exposures during asymptomatic, presymptomatic, and symptomatic stages will also inform future policy.

Conclusion

Interactions between humans and pathogens are inherently dynamic and are constantly evolving, and we have achieved major advancements in the prevention and management of SARS-CoV-2 since the pathogen was initially identified in 2019. In recognition of these achievements, the time has come to deimplement policies that are not appropriate for an endemic pathogen when the expected benefits of such policies are low. Universal masking in health care is a policy whose time has come and gone ... for now.

Disclaimer: The views expressed are those of the authors and do not necessarily represent those of the U.S. Department of Veterans Affairs or the U.S. federal government.

Acknowledgment: The authors acknowledge Paul D. Biddinger, MD, and David A. Chambers, DPhil, for thoughtful review of the manuscript.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M23-0793.

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Figure. **Key milestones and contextual factors during the pandemic to endemic phases.** Transitions during the pandemic to endemic stages and linkage of key milestones and contextual factors to masking recommendations in health care and community settings are illustrated.