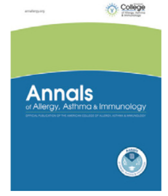
Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Ann Allergy Asthma Immunol 127 (2021) 5–6

Contents lists available at ScienceDirect



Perspective

Coronavirus disease 2019 fatigue in the allergy clinic

Joseph P. Forester, DO, FACAAI[*]; Sumana C. Reddy, MD[†]; J. Wesley Sublett, MD, FACAAI[‡]; Marissa R. Shams, MD, FACAAI[§]; J. Allen Meadows, MD, FACAAI[‖]

[*] *Department of Allergy and Immunology, 96th Medical Group, Eglin Air Force Base, Florida*
[†] *University of Mississippi Medical Center, Jackson, Mississippi*
[‡] *Family Allergy and Asthma, Louisville, Kentucky*
[§] *Emory University School of Medicine, Atlanta, Georgia*
[‖] *Alabama College of Osteopathic Medicine, Montgomery, Alabama*

A R T I C L E I N F O

Article history:
Received for publication February 16, 2021.
Received in revised form March 25, 2021.
Accepted for publication March 29, 2021.

In January 2020, the world became aware of a novel virus circulating in Wuhan, China. By March 2020, severe acute respiratory syndrome coronavirus 2 had spread across the globe prompting a pandemic declaration by the World Health Organization and shutdowns of varying degrees in almost every facet of life.[1] The health care industry was certainly not spared. Many in the specialty of allergy and immunology saw their practices adversely affected because patients were afraid to venture into clinical settings. Allergists were forced to modify their approach to patient care as they were unsure on how to keep their patients and staff safe. As time passed and more knowledge on coronavirus disease 2019 (COVID-19) was gained, safeguards and screening protocols were instituted to protect patients and staff as face-to-face care increased. However, for many, these safeguards have proven inadequate in the prevention of viral exposure in clinical settings. But, why have these measures failed?

"Normalization of deviance" was first described by sociologist Diane Vaughan when discussing the Space Shuttle Challenger accident.[2] In medicine, this term is frequently used when speaking on deviations to standard practice which generally are small but when taken collectively over a period of time can lead to errors or harm to patients. However, this same concept can be applied to the behaviors and actions of patients. For example, in summer 2020, in a community allergy practice, an established immunotherapy patient presented for routine injections. Per the protocol of that clinic, the patient was asked screening questions including high-risk travel, contact to persons with COVID-19, and whether they were experiencing any of the pathognomonic symptoms of COVID-19 to which they responded no. The patient was also afebrile; thus, immunotherapy was administered and the patient went to the waiting area where physical distancing and facemask use were enforced. The patient was discharged from the clinic after 30 minutes without complaint. However, after 3 days, the patient called the physician to inform them that they had been diagnosed as having COVID-19 and presumably caught the infection from their spouse who was diagnosed 7 days before and was isolating at home. When asked why they did not provide honest answers to the screening questions, the patient stated that they did not want to be turned away without receiving their immunotherapy and fall behind on their dosing schedule. As a result of the action of this patient, several patients and staff were potentially exposed to COVID-19. Unfortunately, this example is not an outlier and has become more common in the passing months. A recent study in *the Journal of Health Psychology* reiterates this sentiment after finding that several individuals concealed COVID-19–related health information including symptoms and engagement in social distancing and quarantine practices during the pandemic.[3] Irrespective of the reason for withholding health information, this deviance from standard protocols can have considerable impacts on the health of our patients, our staff, and the larger community.

Within the field of allergy and immunology, patients with a variety of ailments are frequent visitors to practices for immunotherapy, biologic medications, or chronic disease management. Because of

Reprints: Joseph P. Forester, DO, FACAAI, Department of Allergy and Immunology, 96th Medical Group, 307 Boatner Road, Eglin Air Force Base, FL 32542 E-mail: joseph.p.forester.mil@mail.mil.

Disclosures: Dr Forester reports serving as a speaker for AstraZeneca, Genentech, Inc, Merck, and Pfizer Inc. Dr Sublett reports being on a contracted research for Aimmune Therapeutics, ALK, AstraZeneca, Evidera, GlaxoSmithKline plc, LEO Pharma A/S, Novartis AG, Octapharma AG, Regeneron Pharmaceuticals Inc, Sanofi, Target, and Teva Pharmaceutical Industries Ltd; serving on the advisory board for Aimmune Therapeutics, Bryn Pharma, and Pfizer Inc; and serving as a speaker for Aimmune Therapeutics, AstraZeneca, Regeneron Pharmaceuticals Inc, and Sanofi. Dr Meadows reports serving as a consultant for Aimmune Therapeutics and Teva Pharmaceutical Industries Ltd and as a speaker for AstraZeneca, OptiNose, Inc, Pfizer Inc, Regeneron Pharmaceuticals Inc, and Sanofi. Dr Reddy and Dr Shams have no conflicts of interest to report.

Funding: The authors have no funding sources to report.

The opinions or assertions herein are private views of the authors and are not to be construed as reflecting the views of the US Department of the Air Force or the US Department of Defense.

https://doi.org/10.1016/j.anai.2021.03.027
1081-1206/© 2021 Published by Elsevier Inc. on behalf of the American College of Allergy, Asthma & Immunology.

these repeated interactions, patients become comfortable with staff members. Furthermore, because of the improvement in quality of life, disease control and symptom management resulting from these therapies, patients are motivated to remain compliant with their treatment. During this unprecedented time of the pandemic, this degree of comfort has at times placed undue burden on practices by increasing the potential risk of viral spread. One might wonder why those so comfortable with the staff would not be more forthcoming regarding their symptoms and exposures. Although no single reason can explain the concealment by some patients and even some staff members, fear of judgment for not complying with standard protocols could contribute to the lack of disclosure.[3] The question remains on how can we continue to provide the level of care our patients have grown to appreciate and at the same time keep our staff, patients, and our own families safe?

We should acknowledge that these situations are becoming more common and take proactive measures to maintain the safety of our practices. With the "return to normal" being largely centered on vaccination campaigns, educating our patients and dispelling misinformation on COVID-19 and vaccines are essential. Until a large portion of the population is vaccinated, it is in the best interest of our patients and staff to recognize the limitations of screening measures and to constantly seek improved methods. We should help our patients understand that providing honest and forthcoming information in response to screening procedures protects them and other patients and staff and ensures the ability to remain open and able to provide care. If we are unable to trust our screening procedures and protocols, our "return to normal" will be drastically impaired.

No-screening policy is foolproof, and failures are inevitable. When failures do occur, a nonpunitive fact-finding investigation should be initiated seeking improvement to the system. There is no "one size fits all" solution, and each practice must find the methodology and protocols that would best serve them and their patients. To help clinicians through this time, Habersaat et al,[4] on behalf of the World Health Organization, advocated for "10 Considerations" for effective management of COVID-19 transition and that physician practices would be well advised to keep in mind when developing their specific clinic policies. Of these considerations, 3 are balancing of individual rights with social good, prioritizing those with the highest risk of negative consequences, and providing support for health care staff. Our messaging to patients should convey their essential role in the "return to normal" and the overall health of the community. To address those most vulnerable and protect clinic staff, practices can consider undertaking measures, such as appointment schedule modifications (ie, seeing high-risk patients earlier in the day) and enforcement of personal protective equipment use, hand hygiene, and limiting aerosol-producing procedures.[5] Policies and procedures will vary across clinical settings and practices, but continued vigilance and open communication with our patients, staff, and colleagues will help ensure that we are all able to provide safe and effective care for our patients.

References

1. The American Journal of Managed Care Staff. A timeline of COVID-19 developments in 2020. Available at: www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020. Accessed February 8, 2021.
2. Price MR, Williams TC. When doing wrong feels so right: normalization of deviance. *J Patient Saf*. 2018;14(1):1–2.
3. O'Connor AM, Evans AD. Dishonesty during a pandemic: the concealment of COVID-19 information. *J Health Psychol*. 2020.
4. Habersaat KB, Betsch C, Danchin M, et al. Ten considerations for effectively managing the COVID-19 transition. *Nat Hum Behav*. 2020;4(7):677–687.
5. Amato A, Caggiano M, Amato M, Moccia G, Capunzo M, De Caro F. Infection control in dental practice during the COVID-19 pandemic. *Int J Environ Res Public Health*. 2020;17(3):4769.