Medical Malpractice and Facial Nerve Paralysis

Daniel D. Lydiatt, DDS, MD

**Background:** Iatrogenic facial nerve paralysis is a devastating surgical complication that occasionally results in litigation.

**Objective:** To analyze litigation trends to better understand the causes and outcomes of suits involving facial nerve paralysis to prevent future litigation and improve physician education.

**Design:** Retrospective review.

**Setting:** All US civil trials.

**Participants:** All state and federal civil trials alleging malpractice and facial nerve paralysis were reviewed.

**Methods:** Jury verdict reviews from January 1, 1985, to December 31, 2000, were obtained from a computerized legal database and analyzed. Reviews compile data on defendants, plaintiffs, allegations of wrongdoing, and expert witness specialties, and provide case summaries. Fifty-three cases from 19 of the 50 states were obtained. Data were entered into a spreadsheet for analysis.

**Main Outcome Measures:** Verdicts and indemnity payments.

**Results:** Suits reviewed were as follows: cosmetic, 12 (23%); otologic, 13 (25%); nonneoplastic disease of the parotid or other benign conditions of the head and neck, 15 (28%); benign neoplasms of the parotid, 9 (17%); malignant neoplasms of the parotid, 1 (2%); and temporo-mandibular joint operations, 3 (6%) (percentages do not total 100 because of rounding). Allegations of negligence were frequently multiple and included lack of informed consent (16 [30%] of 53), failure to diagnose (10 [19%] of 53), and surgical misadventures (47 [89%] of 53). Excluding failure to obtain consent or to diagnose, 28 suits still alleged negligence based solely on a surgical misadventure. Of these suits, 12 (63%) resulted in plaintiff awards.

**Conclusions:** Surgeons must emphasize and document the likelihood and consequences of this devastating complication to all patients undergoing surgery in this area. Risk management goals include a thorough and timely examination and careful and thoughtful surgical approaches. However, patient rapport and bedside manner may be the only protection the surgeon has from litigation arising from this complication.

*Arch Otolaryngol Head Neck Surg. 2003;129:50-53*

**Original Article**

From the Division of Head and Neck Oncology, Department of Otolaryngology, University of Nebraska Medical Center, and the Methodist Hospital Cancer Center, Omaha.

Facial nerve paralysis is a devastating complication of many otolaryngologic, cosmetic, and oncologic procedures in the head and neck. The complication is well recognized, surgical procedures have been designed to find and/or avoid the nerve, and surgeons and patients are presumably well aware of the risks. Yet, the complication is so devastating that patients are unhappy and, although rare, occasionally sue their physicians. To better understand the causes, circumstances, and outcomes of these suits, I undertook a review of malpractice litigation involving patients with facial nerve paralysis. Litigation analysis and physician education are vital to reducing the number of malpractice claims. Medical malpractice has been studied for several cancers, and disease states, but little is known about litigation trends in patients with surgically induced facial nerve paralysis. The present study analyzes malpractice litigation trends by reviewing jury verdict reports from a 16-year period to determine the nature and outcome of these suits. It is hoped that a better understanding of these suits will aid in developing risk management strategies to avoid these injuries, or at least the resultant litigation.

**METHODS**

A computerized legal database (WESTLAW; West Publishing Co, St Paul, Minn) was used to search all civil trials that alleged malpractice and involved facial nerve paralysis. This database includes verdicts collected by 14 sources and searches of all federal and state cases from all 50 states. Cases were reviewed, and summaries of the verdict outcomes were obtained. Fifty-three cases from 19 states from January 1, 1985, to December 31, 2000, were found. Although suits that were settled or dropped before going to court cannot be obtained, this database includes all cases that were placed on a court docket. These are the cases attorneys evaluate.
for precedents, summary content, verdict outcomes, and size of judgments. Attorneys consider them strongly persuasive in terms of the summary content. Data were abstracted and entered into a spreadsheet (Quattro Pro; Corel Corporation, Ottawa, Ontario). Data included defendant name, age, and specialty; plaintiff name, age, sex, and occupation; the year, state, and outcomes of the trial; and alleged reasons for bringing the suit. Allegations specifically analyzed included failure to diagnose, lack of informed consent, and surgical or medical complications. Results were also evaluated according to the type of disease process or surgical category, and included otologic, cosmetic, benign neoplastic parotid disease, malignant neoplastic parotid disease, or other benign nonneoplastic parotid or neck disease. The specialty of the expert witness for the plaintiff and defendant was listed. Verdict outcomes and indemnity payments were obtained and analyzed.

**RESULTS**

Fifty-three cases from January 1, 1985, to December 31, 2000, representing 19 different states, were recovered from the database. These 53 cases were then divided into 6 surgical or causative categories: otologic, 13 (25%); cosmetic, 12 (23%); benign neoplasms of the parotid, 9 (17%); malignant neoplasms of the parotid, 1 (2%); nonneoplastic disease of the parotid or other benign conditions of the head and neck, 15 (28%); and temporomandibular joint operations, 3 (6%) (percentages do not total 100 because of rounding) (Figure 1).

The specialty of the defendant was known in 36 cases (Figure 2). Analysis of the plaintiff demographic characteristics revealed a mean age of 44 years (median, 42 years); the age of 12 plaintiffs was unknown. Plaintiffs’ sex was female in 28 cases (53%), male in 23 (43%), and unknown in 2 (4%).

The expert witness for the plaintiff was listed in 15 suits (Figure 3) and for the defendant in 14 suits (Figure 4). In 14 suits, the specialties of the plaintiff and the defendant expert witnesses were known, and in 13 of these 14 suits they both had the same specialty. In only 1 case was a plaintiff expert witness from a different specialty than the defendant or the defendant expert witness.

Final verdict outcomes are shown in Figure 5. Analysis of outcomes by causative categories revealed the following. In the otologic group (n=13), the suit concluded for the plaintiff in 5 cases (38%); settlement, 3 cases (23%); and the defendant, 5 cases (38%). In the cosmetic group (n=12), the suit concluded for the plaintiff in 4 cases (33%); settlement, 3 cases (25%); and the defendant, 5 cases (42%). In the benign neoplasms of the parotid group (n=9), the suit concluded for the plaintiff in 5 cases (56%); settlement, 1 case (11%); and the defendant, 3 cases (33%). In the malignant neoplasms of the parotid group (n=1), the suit concluded for the plaintiff in 5 cases (56%); settlement, 1 case (11%); and the defendant, 3 cases (33%). In the nonneoplastic disease of the parotid or other benign conditions of the head and neck group (n=15), the suit concluded for the plaintiff in 5 cases (33%); settlement, 5 cases (33%); and the defendant, 5 cases (33%). (Percentages may not total 100 because of rounding.) The 3 temporomandibular joint and 1 malignant neoplasm of the parotid suits were all concluded for the defendant. The average money paid for either plaintiff or settlement awards was $461'844 for the otologic group, $479'136 for the cosmetic group, $394'800 for the benign neoplasm of the parotid group, and $542'123 for the nonneoplastic disease of the parotid or other benign conditions of the head and neck group.

The mean award asked by plaintiffs was $794'485, and the mean plaintiff award given was $567'944. The
mean settlement award asked was $654,167, the mean defendant offer was $215,986, and the mean settlement award was $337,313. Defendant offers were listed 18 times, and were more common in the cosmetic group (7 [39%] of 18 cases).

Although 5 of the 6 million dollar outcomes were from the East Coast, no real difference could be found in outcomes for the 19 separate states. Award amounts varied considerably, but generally increased over the years. The mean and median awards from 1985 to 1990 were $309,000 and $194,000, respectively; and from 1995 to 2000, $549,000 and $338,000, respectively. The number of suits making it on a court docket also increased over time. The number of cases reviewed was 9 from 1985 to 1989, 17 from 1990 to 1994, and 27 from 1995 to 2000.

The allegations for bringing the suit were often multiple, and included failure to diagnose in 10 (19%), lack of informed consent in 16 (30%), and surgical misadventures in 47 (89%) of the 53 cases. Plaintiffs who alleged lack of informed consent were in the following categories: otologic, 5 (38%) of 13; cosmetic, 3 (25%) of 12; benign neoplasms of the parotid, 1 (11%) of 9; and nonneoplastic disease of the parotid or other benign disease in the neck, 7 (47%) of 15. All patients who alleged lack of informed consent also alleged a surgical misadventure, and even though 37 (70%) plaintiffs had no problems with consent, 31 (84%) of these patients thought a surgical misadventure was the result of their facial nerve paralysis. Plaintiffs who alleged consent problems won awards 50% (8/16) of the time, and those who had allegations other than consent problems won awards in 62% (23/37) of the suits.

Analysis of the group of 37 suits that did not have consent issues revealed that 9 (24%) alleged failure to diagnose and 1 (3%) alleged medical complications and failure to diagnose. Twenty-six of the remaining 28 could be classified, and were, as follows: cosmetic, 9 (35%); otologic, 7 (27%); nonneoplastic and benign disease, 4 (15%); and benign neoplasms of the parotid, 6 (23%). Age was unknown for 26 plaintiffs in this group; 17 (65%) were women. This group of 28 patients who had no complaints of consent, failure to diagnose, or medical complication alleged negligence because of excessive blood loss (n=1), procedure performed by a resident (n=1), operation performed beyond the scope of the surgeon (n=1), only the second time the surgeon had performed this type of operation (n=1), nerve monitor did not function (n=1), cautery burn and surgeon was incapacitated by cancer himself (n=1), poor surgical technique (n=2), and the surgeon did not immediately repair a known injury to the facial nerve (n=1). The remaining 19 suits had no other mitigating factors, and the plaintiffs simply alleged the surgeon had negligently injured the nerve. The median and mean age for plaintiffs in this group was 49 years. The outcomes of these 19 suits were as follows: plaintiff awards, 6 (32%); settlements, 6 (32%); and defense, 7 (37%) (percentages do not total 100 because of rounding).

We are in the midst of a malpractice crisis that began in the 1970s. A 1995 study by the General Accounting Office found that insurance premiums cost medical providers (hospitals, physicians, nurses, etc) between $4.86 and $9.20 billion annually, and that defensive medicine costs the health care industry from $4.2 to $12.7 billion a year. Tort reform holds tremendous promise to abate this crisis, but few in the health care industry have any realistic hopes for the foreseeable future. Physicians can become involved in the process. Litigation analysis and physician education can reduce malpractice claims, and risk management and prevention strategies can be developed from these studies. Medical malpractice in cancers of the breast, colon, and rectum has been studied. Surgical endocrine disease and laparoscopic cholecystectomies have also been studied, but, to my knowledge, litigation analysis of suits involving facial nerve paralysis has not been performed.

Two themes surfaced from analyzing these suits. First, despite the importance and concern for the facial nerve, patients allege in many cases that they were unaware of this complication. Second, even in the face of understanding the risk of this complication, patients sue, and frequently win, when left with this devastating complication, alleging a surgical misadventure.

Facial nerve paralysis is a primary concern of the surgeon, and it is unlikely that discussions on this dread complication were not held; why, then, did 16 (30%) patients believe they were not adequately informed? Studies have shown that patients recall only a small portion of information given to them preoperatively, with a range of 35% to 57% retention for patients receiving the information 7 days before testing. Hekkenberg et al, in a study of informed consent for patients undergoing head and neck surgery, found an overall rate of recall of 48% in patients undergoing thyroidectomy, parathyroidectomy, or parotidectomy. The risks discussed for parotidectomy included facial scar, greater auricular nerve paresthesia, Frey syndrome, and facial nerve weakness or paralysis. Patients were interviewed for recall 1 to 8 weeks after the informed consent. Recall was 27% for scar and Frey syndrome and 60% for greater auricular nerve injury; in contrast to the other complications, recall was 93% for facial nerve paralysis. Studies indicate that better recall is seen in better-educated and younger patients, and may be related to anxiety. Developing patient rapport and confidence in the surgeon would obviously be an important risk management consideration.

Godwin studied patients undergoing reduction mammoplasty and found that, although 97% believed the...
procedure of obtaining consent was adequate, retention of risk of complications was poor (25%). However, it matters little how much information is remembered later; it is more important that the patient understands the risks at the time of surgery to really make an informed decision to proceed or not. Although much discussion centers around the many reasons patients do not understand or remember warnings about surgical complications, it seems likely that many do understand the gravity and likelihood of facial nerve paralysis. Risk management goals may be met by listing the complication on the informed consent form the patient signs and providing a copy of the form to the patient. Other reasons to document this complication are the significant decline in information remembered over time, the extended time for litigation to conclude, and the potential of increasing the patient’s understanding of the procedure and complications. It also seems likely that patients not only have a better understanding after receiving written information but usually think it is a good idea. It has been suggested, and seems likely, that these patients would also be less inclined to seek legal redress for a perceived bad outcome.

What about the 37 (70%) who did not contest the fact that they understood they might have facial nerve paralysis as a result of the surgery? Of these patients, 31 (84%) of 37 still thought malpractice had been committed when their result was a known risk of the surgery. Plaintiffs won awards in 20 (65%) of the 31 suits through either plaintiff awards or settlement. Facial nerve paralysis rates vary, but the incidence for parotidectomy, rhytidectomy, and most elective otologic procedures is below 5%. All of these procedures have been refined over the years to identify, avoid, or otherwise protect and preserve the facial nerve. Proper training and careful surgical technique are indispensable, but facial nerve injuries happen to even the best surgeons. Dawes et al state that patients have a high expectation of a successful outcome and are more inclined to sue for an unsatisfactory outcome. A bad outcome is not evidence of malpractice, and negligence cannot be imputed from unsatisfactory results. Medical malpractice can only be upheld when all 4 elements of negligence are proved: the physician has a duty to the patient, there was a breach of that duty, the patient was damaged, and the breach of duty reasonably led to that damage. Certainly the surgeon has a duty to the patient, the damage is obvious to all, and when damage is discovered in the immediate postoperative period it would seem reasonable most often to assume this damage was the result of the operation. The breach of duty is the most nebulous area to prove. In medical malpractice, the layman cannot be expected to have adequate knowledge to understand the facts surrounding the case, and the courts and juries must depend on expert advice. The plaintiff has the burden of proof to show that the injury was negligently caused by the defendant and not just that there was injury caused by the defendant, irrespective of the testimony of other experts. This should be an onerous task. What negligent acts caused the facial nerve paralysis in these cases? Perhaps a case can be constructed for inadequate scope or training, errors in judgment made intraoperatively, and delays in diagnosis, but many (n = 19) of the suits seem to hinge on the poor outcome alone and testimony that negligence must have caused that outcome. Facial nerve paralysis is a devastating injury and doubtless makes a compelling sight in court. Awards and settlements can be large, and at least in this study occurred frequently (12 [63%] of 19 cases), and the verdict seemed to be primarily influenced by a bad outcome (facial nerve paralysis). This area seems ready for further study and possibly tort reform.

Surgeons must emphasize and document the likelihood and consequences of facial nerve injury to all patients undergoing surgery in this area. A thorough and timely examination of patients with head and neck masses should be a part of all algorithms and patient care guidelines. Careful and thoughtful surgical approaches should, of course, be used. When these are performed, good patient rapport and an honest bedside manner may be all surgeons have to protect themselves if this complication occurs.

Accepted for publication July 29, 2002.

This study was presented at the annual meeting of the American Head and Neck Society, Boca Raton, Fla, May 11, 2002.

Corresponding author and reprints: Daniel D. Lydiatt, DDS, MD, Methodist Hospital Cancer Center, 8303 Dodge St, Omaha, NE 68114 (e-mail: Dlydiatt@UNMC.edu).

REFERENCES