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Values and Preferences of Korean Patients With Facial Palsy: A Cross-Sectional Survey

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ABSTRACT

Background: Facial palsy is a debilitating condition that can lead to significant functional, aesthetic, and psychosocial impairments. Thus, this study aimed to systematically explore treatment preferences and values among Korean patients with facial palsy and develop clinically applicable recommendations to enhance patient-centered care.

Methods: A cross-sectional questionnaire survey was conducted between June and July 2025 at a facial palsy clinic in a secondary referral hospital. A total of 51 patients with peripheral facial palsy completed a structured 21-item survey addressing preferences related to assessment and diagnosis, treatment modalities, multidisciplinary care, communication, information sources, and recovery concerns. The internal consistency of the questionnaire was evaluated using Cronbach's alpha (α).

Results: Participants (mean age 43.1 ± 12.4 years; 68.6% female) prioritized objective assessment methods and accurate prognostic information, favoring standardized tools and electrophysiological testing. Regarding treatment preferences, 82.4% supported active

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Disclosure

The authors have no potential conflicts of interest to disclose.

Author Contributions

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steroid therapy and 74.5% preferred combined steroid-antiviral treatment. Surgery was generally viewed as a last resort, with 51.0% favoring non-surgical rehabilitation even in chronic cases—those persisting for more than six months. Multidisciplinary care and clear, detailed communication were highly valued. The primary recovery concern was permanent facial sequelae (64.7%). Meanwhile, the internal consistency of the survey, which covered diverse and independent domains, was rather poor (Cronbach's $\alpha = 0.548$), reflecting the multidimensional nature of the patient preferences.

Conclusion: Korean patients with facial palsy express a strong fear of permanent sequelae, which shapes the preferences of patients toward objective information and treatments with high efficacy. Moreover, the patients were found to favor comprehensive multidisciplinary care, clear and transparent communication, and collaborative relationships with healthcare providers. These findings provide important insights for developing patient-centered clinical guidelines tailored to Korean patients with facial palsy.

Keywords: Facial Palsy; Bell's Palsy; Patient Preference; Patient-Centered Care; Cross-Sectional Study

INTRODUCTION

Facial palsy refers to the paralysis of the facial nerve, resulting in the sudden or gradual weakening of the facial muscles.^{1,2} The annual incidence of facial palsy ranges from 11 to 40 cases per 100,000 people,^{3,4} with approximately 90,000 cases reported in South Korea annually.¹ Bell's palsy, which is idiopathic, is the most common cause, accounting for approximately 51% of all cases.⁵ Meanwhile, other etiologies include identifiable causes such as head trauma, herpes zoster oticus, tumors, infections, and hemifacial spasms. Regardless of the underlying cause of facial palsy, approximately 85% of patients recover some degree of function, with more than 70% achieving complete recovery.⁶ However, 15–20% of patients experience incomplete recovery, highlighting the importance of utilizing an appropriate treatment to minimize long-term sequelae.

Facial palsy is a devastating condition with both functional and aesthetic consequences, leading to significant impairment in quality of life (QoL).^{7–9} Facial muscle movement is essential for interpersonal communication, emotional expression, and oral functions; however, patients with facial palsy often experience difficulties including facial asymmetry at rest, incomplete eye closure, reduced facial movement, problems with eating and drinking, and diminished taste sensation in the anterior two-thirds of the tongue.¹⁰ Furthermore, in terms of psychosocial distress, population-based data from Korea have shown that patients with facial palsy are at significantly higher risk for depression and anxiety.^{8,11,12}

Management of acute-onset facial palsy involves oral corticosteroid and antiviral therapy, along with eye protection.^{1,2,6,13} Transmastoid facial nerve decompression can be considered in patients with neural degeneration exceeding 90%.¹⁴ For those with poor outcomes, additional treatment options include physical therapy, transcutaneous electrical stimulation, facial nerve cable grafting, facelift procedures, botulinum injections, and facial reanimation surgery.^{15–18} However, the absolute effectiveness of these treatments remains controversial since large, prospective, randomized, and controlled trials are limited.^{15,19} Nevertheless, significant improvements in QoL have been reported in patients with facial palsy for various treatment modalities.⁴

Given the varying severity of symptoms among patients with facial palsy and the wide range of available treatment options, incorporating patient values and preferences into treatment decisions is essential for improving adherence, satisfaction, and treatment outcomes.²⁰ A collaborative process using a shared decision-making framework has also been shown to benefit patients with longstanding facial palsy by reducing decision conflict, improving overall decision quality, and minimizing costs.²¹

Despite the growing global burden of facial palsy, few studies have systematically examined patient values and preferences.^{22,23} The diversity of healthcare systems and cultural contexts limits the direct applicability of international findings to local settings. Therefore, this study aimed to investigate treatment preferences and decision-making factors among Korean patients with facial palsy, providing foundational data for the development of patient-centered and culturally appropriate clinical strategies.

METHODS

Study design and participants

We conducted a cross-sectional questionnaire survey from June 1 to July 15, 2025, in accordance with the STROBE guidelines.²⁴ Participants were patients with peripheral facial palsy who visited the Department of Otorhinolaryngology at a secondary referral hospital with an active facial palsy clinic. The inclusion criteria were as follows: 1) adults aged 19 years or older; 2) facial palsy as the chief complaint; 3) provision of voluntary informed consent; 4) the ability to complete the questionnaire independently. Exclusion criteria were: 1) central origin facial palsy; 2) cognitive impairment; 3) refusal to participate.

Study instrument

We developed a comprehensive patient preference questionnaire to support the development of evidence-based guidelines for managing facial palsy. The survey comprised 21 items across four distinct domains. Each item was designed to capture independent aspects of patient preferences, rather than measuring a unidimensional construct. The items included in the questionnaire were as follows:

1. Assessment and diagnosis preferences (6 items): preferences for assessment tools (Q1-1), important factors in assessment (Q1-2), preferences for the scope of diagnostic testing (Q2-1), priorities in diagnostic testing (Q2-2), electrophysiological test acceptance (Q3-1), and preferred formats for prognostic information (Q3-2).
2. Treatment modality preferences (10 items): preferences regarding steroid treatment (Q4-1), steroid treatment concerns (Q4-2), preferences for combined steroid and antiviral therapy (Q5-1), priorities in combined treatment (Q5-2), willingness to undergo surgical intervention (Q6-1), key considerations when deciding on surgery (Q6-2), preferences for rehabilitation therapy (Q7-1), preferred rehabilitation methods (Q7-2), preferences regarding surgical intervention in chronic facial palsy (≥ 6 months) (Q8-1), and priorities in chronic facial palsy treatment (Q8-2).
3. Multidisciplinary care and communication preferences (3 items): preferences for multidisciplinary care (Q9-1), priorities within multidisciplinary care (Q9-2), and preferred communication methods with healthcare providers (Q10).
4. Information sources and recovery concerns (2 items; Q11 to Q12)

Items Q1-1 through Q10 utilized single-choice responses with varying scales (3–6 options) tailored to each specific preference domain. Items Q11 and Q12 allowed multiple responses to capture a broad range of information sources and concerns. All items were developed through expert consensus and consultation with patient stakeholders to ensure content validity and clinical relevance.

The English translation of the questionnaire (**Supplementary Data 1**) and the original Korean version (**Supplementary Data 2**) are provided in the Supplementary Data.

Sample size calculation

The sample size was estimated using the formula for simple proportions. According to a study by Machetanz et al.,²² which used a survey to assess outpatient treatment satisfaction in patients with facial palsy, the reported score on the adapted Client Satisfaction Questionnaire (ZUF-8) was 24.59 ± 6.2 . Therefore, the standard deviation (SD; σ) of the measure was assumed to be 6.2.

$$n = (Z^2\sigma^2)/E^2, \text{ where } Z = 1.96 \text{ (95\% confidence interval [CI]), } \sigma = 6.2, \text{ and } E = 1.75.$$

The margin of error (E) was set at ± 1.75 , and the required sample size (n) was calculated to be 49. Thus, a total of 51 participants were recruited to accommodate a potential 5% attrition rate.

Statistical analysis

Although the survey was designed to measure independent preference domains rather than a unidimensional construct, we conducted a reliability analysis to evaluate the psychometric properties of the instrument. Internal consistency was assessed using Cronbach's alpha coefficient for the entire 21-item questionnaire. Item–total correlations were examined, and alpha values were recalculated with each item deleted to identify potentially problematic items.

For the multiple-response items (Q11 and Q12), only the first response was included in the reliability analysis to maintain consistency within the correlation matrix. Missing data were handled using listwise deletion. All analyses were performed in R version 4.3.0 (R Foundation for Statistical Computing, Vienna, Austria) using the 'psych' package (version 2.3.6).

Given the multidimensional nature of patient preferences, lower internal consistency values were anticipated compared to unidimensional scales. We interpreted Cronbach's alpha using conventional thresholds (≥ 0.70 indicating acceptable reliability), while acknowledging that lower values do not necessarily invalidate the utility of the survey for capturing diverse patient preferences relevant to clinical guideline development.

Ethics statement

The study was approved by the Institutional Review Board (IRB) of Hallym University Dongtan Sacred Heart Hospital (IRB No. 2025-03-004). Written informed consent was obtained from all participants before enrollment. All data were anonymized using coded identifiers, in accordance with the principles of the Declaration of Helsinki.

Table 1. Demographic and clinical characteristics of study participants (N = 51)

Characteristics	Values
Sex	
Male	16 (31.4)
Female	35 (68.6)
Age, yr	43.1 ± 12.4
19–29	8 (15.7)
30–39	13 (25.5)
40–49	18 (35.3)
50–59	7 (13.7)
≥ 60	5 (9.8)
Education level	
Graduate school or higher	3 (5.9)
College graduate	38 (74.5)
High school graduate	9 (17.6)
Middle school or less	1 (2.0)

Values are presented as number (%) or mean ± standard deviation.

RESULTS

Participant characteristics

Of the 51 survey respondents, 48 (94.1%) provided complete responses for the reliability analysis. The mean age was 43.1 years (SD = 12.4), and the study included 35 (68.6%) female participants (**Table 1**). Regarding educational attainment, 3 respondents (5.9%) had graduate degrees, 38 (74.5%) had undergraduate degrees, 9 (17.6%) had completed high school, and 1 (2.0%) had a middle school education or less.

Internal consistency and item analysis

The overall Cronbach's alpha coefficient for the 21-item survey was 0.548 (95% CI, 0.36–0.73), with a standardized alpha of 0.61. This relatively low internal consistency was expected given the design of the survey to capture independent preference domains rather than a unidimensional construct.

Item–total correlations ranged from –0.287 to 0.404, with most items showing weak to moderate positive correlations. The highest item–total correlations were observed for Q2-2 (priorities in diagnostic testing, $r = 0.404$), Q1-2 (important factors in assessment, $r = 0.353$), and Q3-1 (electrophysiological test acceptance, $r = 0.353$).

Notably, Q11 (information sources) demonstrated a negative correlation with the total score ($r = -0.287$), likely reflecting the distinct measurement of information-seeking behavior of this item rather than treatment preferences. Meanwhile, removing Q11 would increase the overall alpha to 0.59, representing the largest potential improvement among all items.

Analysis of the alpha-if-item-deleted values revealed that most items contributed similarly to the overall reliability, with values ranging from 0.50 to 0.59. Four items showed alpha values above 0.55 when deleted: Q11 ($\alpha = 0.59$), Q7-2 (preferred rehabilitation methods, $\alpha = 0.57$), Q4-2 (steroid treatment concerns, $\alpha = 0.57$), and Q12 (recovery concerns, $\alpha = 0.56$).

The low internal consistency reflects the intended purpose of the survey, which is to capture diverse and independent aspects of patient preferences across multiple treatment decisions. Each item addresses a distinct clinical decision point where patient preferences may vary independently of one another. For instance, the preference of a patient for objective

assessment tools (Q1-1) does not necessarily predict their willingness to undergo surgical intervention (Q6-1) or their preferred information sources (Q11).

This multidimensional structure is appropriate for informing clinical guidelines, where understanding the full spectrum of patient preferences across different decision points is more valuable than measuring a single underlying construct. The utility of the survey lies in its comprehensive coverage of preference domains rather than its psychometric properties as a unidimensional scale.

Assessment and diagnosis preferences

The key results regarding patient preferences for facial palsy assessment and diagnostic testing are summarized in Fig. 1.

Participants preferred objective assessment methods for facial palsy, with 41.2% favoring the use of standardized tools such as the House–Brackmann (H–B) scale²⁵ or the Sunnybrook Facial Grading System (SFGS),²⁶ and 31.4% preferring visual comparison using facial photos and videos. Subjective assessments exhibited very low preference among patients, such as “clinical observation alone by the physician is sufficient” (5.9%). The most important factors in assessment for facial palsy were the ability to track recovery objectively (58.8%) and the accuracy of assessment results (25.5%), indicating that participants value assessments that can objectively monitor treatment progress and the degree of recovery.

Regarding diagnostic testing, more than half of the participants (52.9%) preferred selective diagnostic testing tailored to the severity of facial palsy, whereas 39.2% favored comprehensive testing. When asked to prioritize factors influencing diagnostic test preferences, most respondents emphasized accuracy and reliability (70.6%), over other considerations such as rapid result availability (17.6%), safety (5.9%), and cost (3.9%).

In particular, 70.6% of participants considered electrophysiological testing, including electroneurography (ENoG), essential for detailed prognostic prediction and preferred to receive prognostic information in the form of exact numbers and probabilities (78.4%).

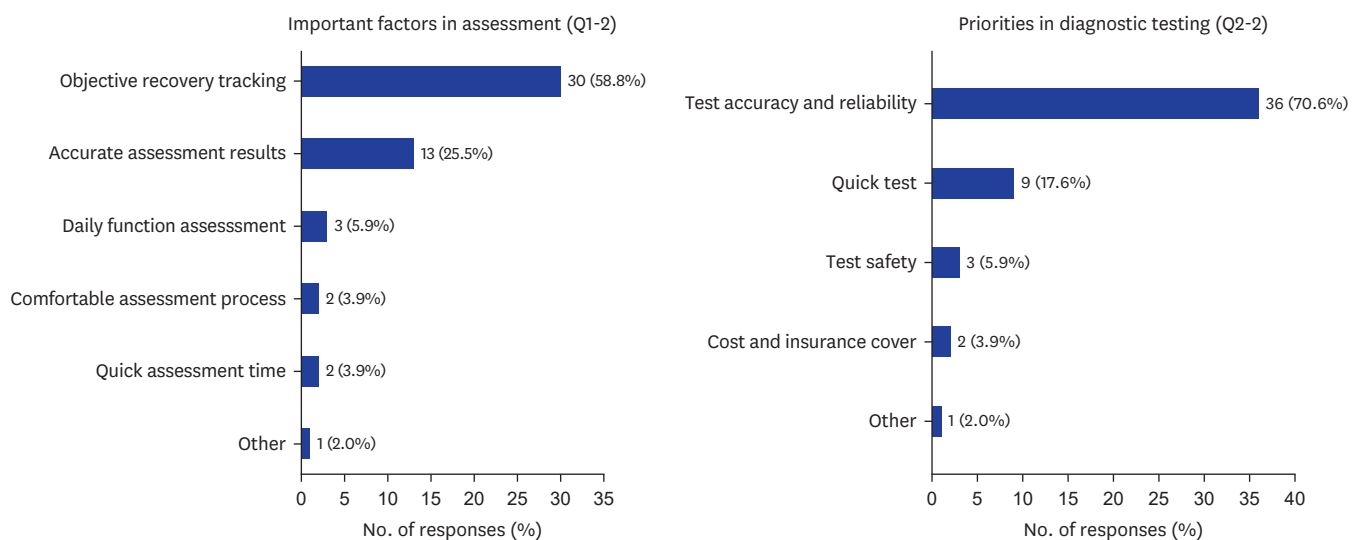


Fig. 1. Preferences for assessment and diagnostic testing among patients with facial palsy.

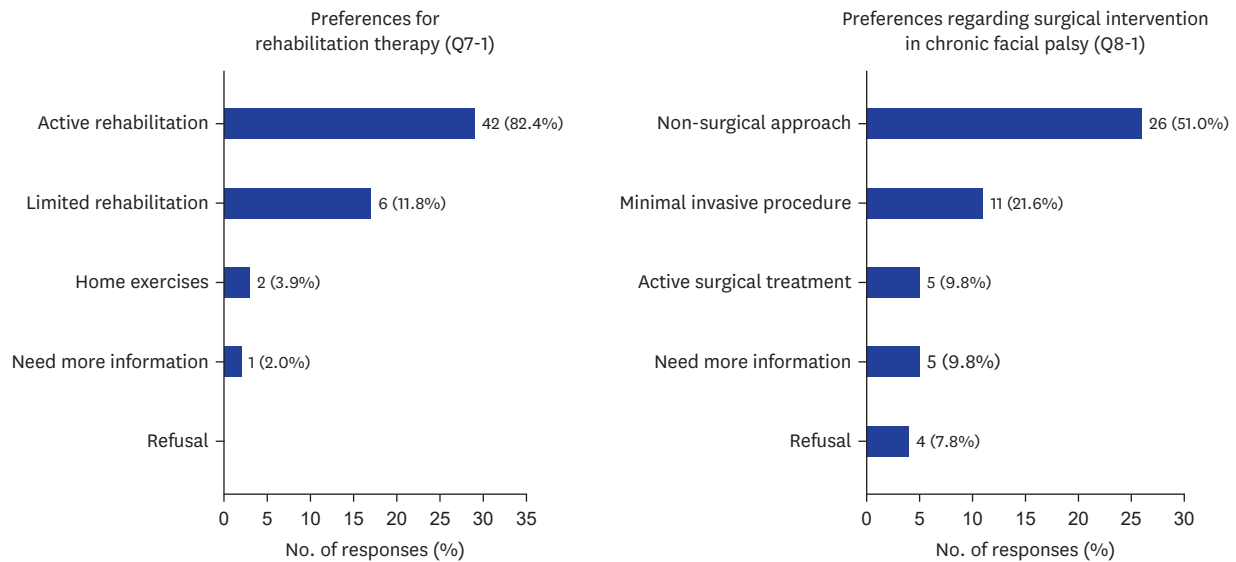


Fig. 2. Preferences for treatment modalities among patients with facial palsy.

Treatment modality preferences

Fig. 2 shows the key findings regarding the preferences of the patient for treatment modalities related to facial palsy.

In the acute phase of facial palsy, 82.4% of participants strongly favored active steroid treatment. Regarding steroid use, patients expressed concerns about long-term side effects (43.1%), such as reduced immunity or osteoporosis, and short-term side effects (23.5%), including gastrointestinal problems, insomnia, and hyperglycemia. Meanwhile, 19.6% reported no concerns.

For a combination therapy involving both steroids and antiviral drugs, 74.5% of participants preferred active combination therapy to increase the probability of recovery, with most participants (90.2%) citing the maximization of treatment effectiveness as the main reason for this preference.

In cases of facial palsy with severe nerve injury, approximately half of the participants (47.1%) considered surgery as a last resort, which was to be considered only after exhausting all non-surgical treatment options. Notably, many perceived the surgery as a final option and reported a lack of sufficient information about surgical procedures. The probability of postoperative recovery (80.4%) was identified as the most important factor influencing the decision of each patient to undergo surgery.

Regarding rehabilitation therapy, the majority of participants (82.4%) supported active engagement in rehabilitation, and some (11.8%) expressed interest in learning home-based physical therapy techniques. One-on-one physical therapy sessions with a specialist were the most preferred format (51.4%), followed by home exercise programs, facial massage with heat therapy, and electrical stimulation.

Even in cases of chronic facial palsy lasting more than six months, 51.0% of patients still favored non-surgical approaches involving continued rehabilitation, while only 9.8%

preferred active surgical intervention. For chronic cases, the primary concern was the functional restoration of facial movement (72.5%) rather than cosmetic symmetry (9.8%).

Multidisciplinary care and communication preferences

The main results regarding patient preferences for multidisciplinary care and communication are presented in Fig. 3.

More than half of the participants (60.8%) expressed favorable attitudes toward multidisciplinary care which involves various medical specialists, anticipating a more comprehensive approach to assessment and treatment. Key priorities within such collaborative care models included maintaining consistent treatment strategies across providers (56.9%) and ensuring effective interprofessional communication and information sharing regarding the condition of the patient (33.3%).

With respect to communication with healthcare professionals, 78.4% of respondents expressed a strong preference for receiving clear and detailed explanations concerning personalized treatment plans and prognostic outlook.

Information sources and recovery concerns (multiple responses)

Fig. 4 provides an overview of the information sources and concerns about recovery reported by the patients.

Patients most commonly obtained information about facial palsy treatment via internet searches (39.8%), followed by consultations with medical professionals (29.0%), social media (18.3%), medical literature (6.5%), and patient support groups (4.3%).

The greatest concern during recovery was the potential of permanent facial sequelae (64.7%). Additional concerns included those regarding impaired facial function (19.6%), psychological burden (11.8%), and challenges in returning to daily life (2.0%).

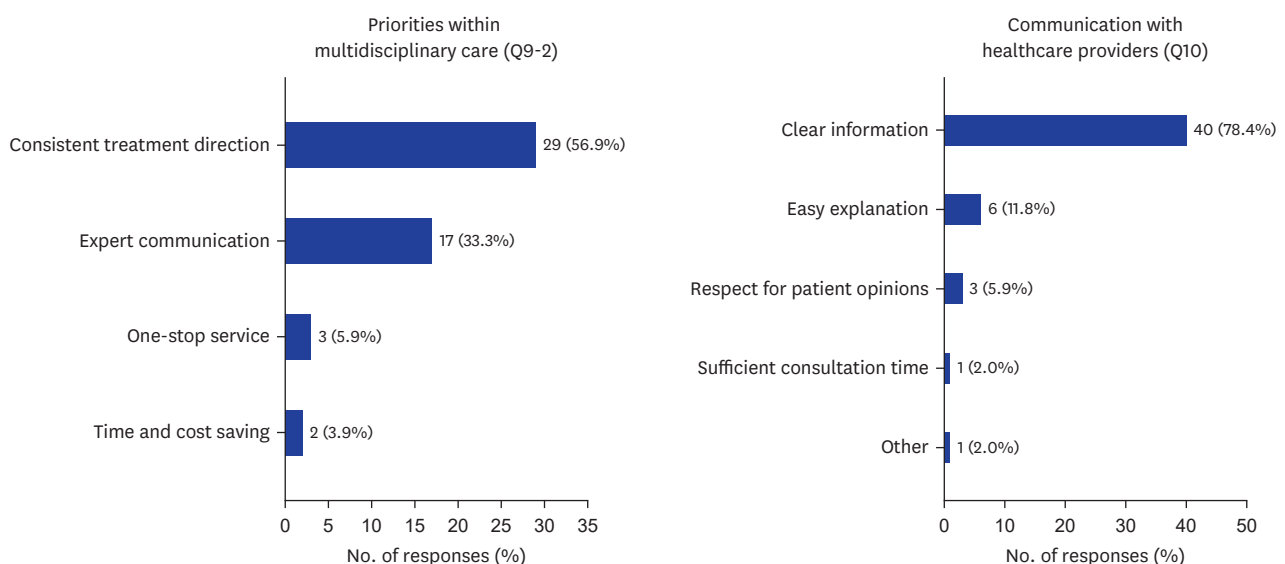


Fig. 3. Preferences for multidisciplinary care and communication among patients with facial palsy.

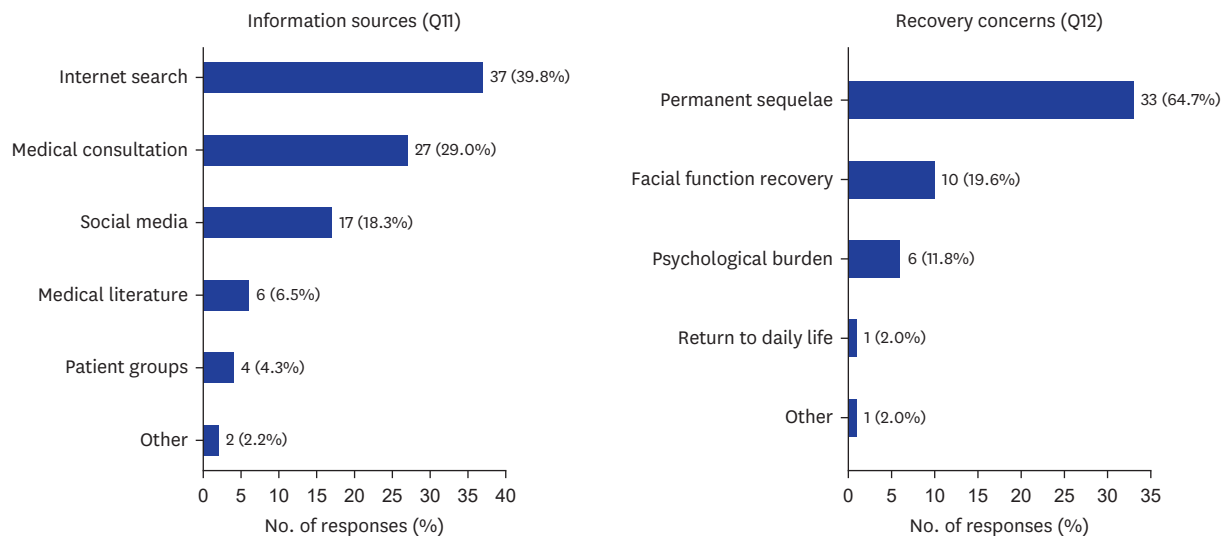


Fig. 4. Information sources and recovery concerns among patients with facial palsy.

DISCUSSION

To the best of our knowledge, this is the first study to systematically investigate treatment preferences and values among Korean patients with facial palsy, providing foundational data for patient-centered care. This analysis revealed that a profound fear of permanent functional and psychosocial sequelae lies at the core of patient preferences and decision-making processes. This fundamental anxiety appears to guide patients in establishing a consistent and rational value system throughout the course of treatment. Patients sought certainty through objective, specific, and quantifiable information, prioritizing the maximization of treatment efficacy in the pursuit of optimal recovery outcomes. Furthermore, patients favored a comprehensive and specialized multidisciplinary team (MDT) approach, placing high value on partnerships with healthcare providers based on transparent information sharing.

The mean age of the participants was 43.1 years, with women comprising twice the number of men, consistent with present epidemiological data on facial palsy. Given that the median age of onset is approximately 40 years and a higher incidence rate among women has been reported in the literature,⁵ this study population is considered representative of patients with facial palsy.

One of the most notable findings was that the primary concern of the patients during the recovery process (Q12) was the potential for permanent sequelae (64.7%). As facial palsy is not simply an aesthetic problem but also causes severe functional impairments, anxiety, depression, social withdrawal, and reduced QoL,^{8,27,28} the primary fear of the patients centers on the 'permanence' of the condition. The fear of irreversible changes to one's function, appearance, and identity serves as the central axis and shapes all other patient preferences. Moreover, this fear represents the key factor in explaining the reasonable trade-offs that patients are willing to make throughout their treatment course, regardless of psychological distress and financial burden. Therefore, healthcare providers and clinical practice guidelines should recognize and prioritize addressing the fears of patients regarding permanent sequelae from facial palsy.

In the section on assessment and diagnosis preferences, patients preferred objective tools that were accurate and reliable. Moreover, the patients favored prognostic information in the form of exact numbers and probabilities. The desire for objectivity is a direct response to the uncertainty of the disease, as patients seek visible evidence regarding their condition and treatment progress. However, observer-based analyses of facial function, such as the H-B scale or SFGS in actual use, do not correlate well with patient-reported QoL, particularly in the domain of social function.⁹ A systematic review reported higher associations between facial function and physical function than with social QoL.²⁹ Although patients pursue objective data as a means to manage any associated anxiety, these data are known to inadequately reflect the full extent of the suffering and psychosocial burden. Therefore, clinicians should not only provide the objective and quantifiable data requested by patients but also incorporate validated patient-reported outcome measures (PROMs), such as the Facial Clinimetric Evaluation (FaCE) Scale or Facial Disability Index,³⁰ and discuss these results collaboratively with the patient.

Regarding treatment modality preferences, the efficiency-centered preferences of the patients aligned with the evidence-based clinical guidelines. Notably, patients favored active steroid therapy, in combination with antiviral drugs, to maximize treatment effectiveness. According to clinical guidelines and systematic reviews, early corticosteroid treatment in facial palsy significantly increases the rate of complete recovery; meanwhile, the evidence for adding antiviral agents is relatively weak but suggests an additional benefit, thereby warranting consideration through shared decision-making.^{31,32} Rehabilitation therapy, particularly one-on-one individualized sessions with a therapist, was also highly preferred. Several studies have supported the efficacy of neuromuscular retraining, massage, and biofeedback training in managing peripheral facial palsy.³³ As for surgical approaches, patients generally regarded surgery as a last resort, to be considered only after all non-surgical treatment options had been exhausted, even in chronic cases. Facial reanimation surgery is a highly complex procedure that involves a wide range of techniques and various factors that must be carefully considered and evaluated. Surgical outcomes are variable, and even the best results achieved through nerve grafting often remain at H-B grade III.^{14,34} Therefore, surgical decision-making requires careful consideration of various factors, including the clinical condition, etiology, and prognosis of each patient.

Regarding the patient–healthcare provider relationship, patients highly preferred a MDT approach, accompanied by clear and detailed explanations of their treatment plans and prognostic outlook. The management of facial palsy is fundamentally multidisciplinary, involving otolaryngologists, neurologists, facial surgeons, physical therapists, psychologists, and other relevant professionals. This approach provides comprehensive care, reducing referral delays and thereby improving clinical outcomes and enhancing patient satisfaction.^{35,36} Additionally, patients valued a coordinated and coherent approach to care delivered by a MDT. For shared decision-making, clinical guidelines should be established to ensure the effective delivery of information, including the use of objective data, evidence-based discussions of treatment efficacy, and a well-defined overview of the treatment process. In a modern medical environment, newly diagnosed and distressed patients often become highly motivated, problem-focused information seekers using the internet or social media.³⁷⁻³⁹ However, readily accessible online information is usually of limited quality. Therefore, patients still value consultations with medical professionals. Meanwhile, healthcare providers should proactively inquire about the information patients have encountered online, be prepared to address any misinformation, and incorporate these discussions into the clinical consultations.

Finally, based on these findings, we propose the following clinical recommendations.

1. Preservation of long-term function: initiate all clinical consultations by acknowledging the primary concern of patients regarding long-term outcomes, and tailor treatment plans to address and minimize this risk specifically.
2. Clarity and objectivity: use standardized assessments that combine both clinician-rated scales (e.g., electronic, clinician-graded facial function scale) with validated PROMs (e.g., FaCE Scale). Share and discuss both results with the patient. Incorporate quantitative data (e.g., ENoG percentages, probability of recovery) into prognostic discussions.
3. Treatment efficacy: in shared decision-making about steroid treatment, clearly communicate the trade-off between the high risk of permanent sequelae and the low risk of typically mild and transient side effects.
4. Measured conservatism: develop standardized, evidence-based patient decision aids for surgical options that clearly explain the surgical procedure, realistic functional outcomes, associated risks, and available alternatives.
5. Interdisciplinary competence: establish MDT care as the standard approach for managing facial palsy. Define the composition of core team members and implement structured protocols for interdisciplinary communication and integrated care planning.
6. Partnership based on shared information: promote transparency in the delivery of information. Train healthcare providers to effectively explain complex treatment plans, prognosis, and evidence, facilitating informed partnerships.
7. Active information seeking: encourage healthcare providers to engage proactively with patients regarding any previously accessed information from online sources. Invest in developing and disseminating high-quality, accessible online resources within the healthcare system.

This study has several limitations. First, the single-center design and modest sample size limit the generalizability of the findings and restrict the feasibility of subgroup analyses. Second, the cross-sectional nature precludes causal inferences, and objective measures of treatment efficacy were not included. Future research should incorporate longitudinal, multicenter, and interventional designs, as well as the development of decision aids. Third, objective clinical measures, such as the initial H-B grade or electrophysiological tests, were not collected, which may have influenced the values and preferences of the patients. Lastly, the internal consistency of the 21-item questionnaire (Cronbach's $\alpha = 0.548$) was relatively low, reflecting poor reliability. However, this is expected, given that the questionnaire was designed to capture diverse, independent domains of patient preferences rather than a single unidimensional construct, highlighting the multidimensional nature of treatment evaluation in facial palsy.

In conclusion, Korean patients with facial palsy are most concerned about permanent functional and aesthetic sequelae, which strongly influence their treatment priorities. The patients were found to value objective assessment, evidence-based treatments, and multidisciplinary care, as well as clear communication and shared decision-making. Therefore, incorporating these patient values into clinical practice can improve adherence, satisfaction, and overall outcomes, underscoring the importance of patient-centered guidelines in the management of facial palsy.

SUPPLEMENTARY MATERIALS

Supplementary Data 1

Values and preferences of patients with facial nerve palsy: a cross-sectional survey

Supplementary Data 2

Values and preferences of patients with facial nerve palsy: a cross-sectional survey (Korean)

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