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Authors
George, Elizabeth
Richie, Megan B
Glastonbury, Christine M

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The Reply

Elizabeth George, MD[1], Megan B. Richie, MD[2], Christine M. Glastonbury, MBBS[1]

1 Department of Radiology and Biomedical Imaging, University of California San Francisco, San Francisco, California, USA
2 Department of Neurology, University of California San Francisco, San Francisco, California, USA

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All authors participated in the preparation of the manuscript.

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Corresponding Author:
Elizabeth George, MD
Department of Radiology and Biomedical Imaging
University of California San Francisco
505 Parnassus Avenue
San Francisco, CA 94143

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To the Editor:

We thank the authors <Yale et al, Letter to Editor> for their comments on our article on the clinical practice and cognitive errors associated with the diagnosis of facial paralysis.[1] We wish to address two points raised by the authors against our ~~proposition~~ proposal to replace the eponym Bell palsy with idiopathic facial nerve paralysis.

~~We agree with~~As the authors' ~~comment~~ state, that the eponym Bell palsy is deeply ingrained in medical literature. While a debate on whether all eponyms should be abandoned is beyond the scope of the article[1] and this letter, there are certainly arguments in support of and against its use as described in the point-counterpoint series of articles referenced by the authors.[2,3] However, current widespread use alone does not warrant continued use of this eponym in clinical practice, especially when it can be a source of diagnostic errors.[1] Furthermore, our proposition to abandon the use of the eponym does not diminish the contributions of Sir Charles Bell to the description of the condition and the function of the facial nerve.[4]

We also agree with the authors that accurate knowledge of the types of facial paralysis and its etiologies are crucial to diagnosis and inadequate knowledge base can be a source of diagnostic error.[5] Hence, educating clinicians on the types of facial paralysis is one of the goals of the clinical review section of the article.[1] We do not believe the error associated with misdiagnosis of facial paralysis is a linguistic error in definition as suggested by the authors, but rather a gap in knowledge that stems from a

fundamental misunderstanding of the need to consider secondary causes. ~~However~~Furthermore, medical error is often multifactorial in origin[5] and according to the theory of skill-, rule-, and knowledge-based levels of human performance,[6] knowledge alone does not prevent cognitive errors across the range of human functioning and behavior--shaping constraints and enablers can play a key role. Replacement of “Bell palsy” with *idiopathic* facial paralysis can serve as such a constraint, a forcing function, reminding clinicians to consider alternative etiologies. While we do summarize the literature on erroneous diagnosis of non-idiopathic causes of facial paralysis as “Bell palsy”, we acknowledge it is challenging to conduct a scientific study to demonstrate that abandoning the eponym will decrease diagnostic errors. Regardless, the authors’ acknowledge our assertion that descriptive terms should be preferred over eponyms, and we further expand that assertion to state that while differentiating peripheral from central ~~We also do not believe the error associated with misdiagnosis of facial paralysis is a linguistic error in definition as suggested by the authors. We are in agreement with the authors’ conclusion that descriptive terms should be preferred over eponyms. While differentiating peripheral from central causes of~~ facial paralysis is critical, presuming all peripheral facial paralysis is idiopathic and hence benign is a~~nother~~ major error. Hence, the accurate descriptive term for “Bell palsy” ~~would be~~ is idiopathic facial nerve paralysis.

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