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Is all defensive medicine morally impermissible?

Mapping the ethical spectrum.

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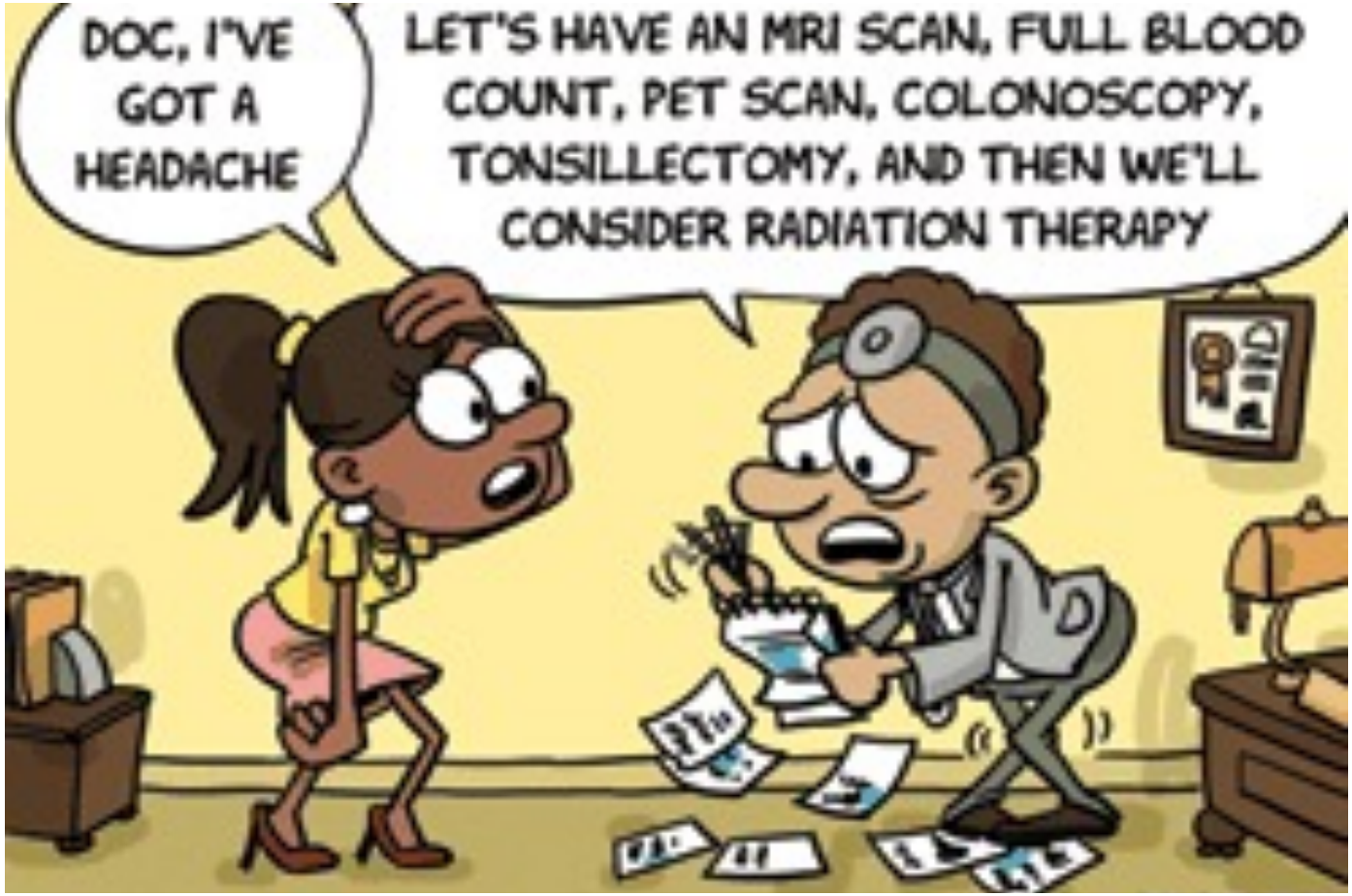

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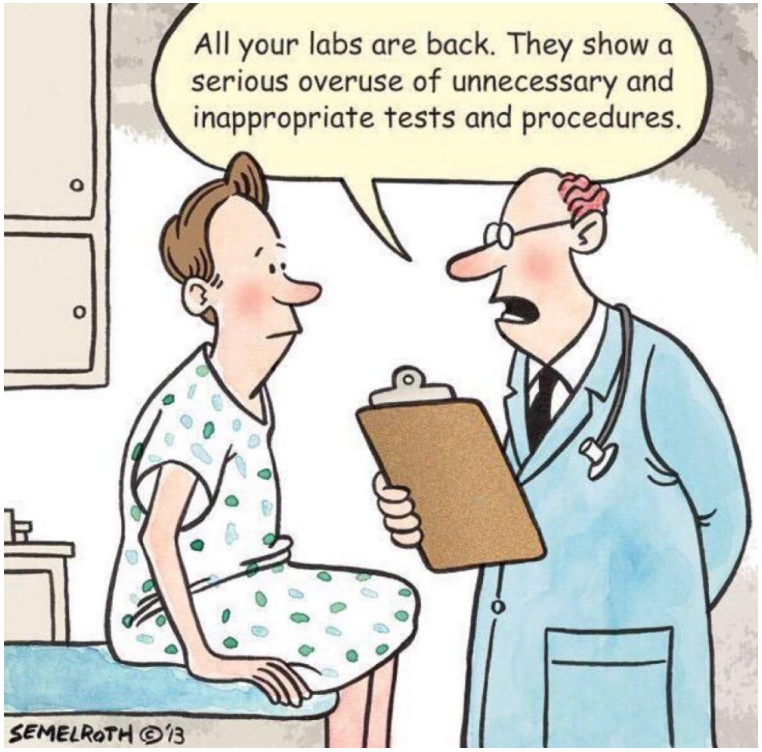
Unnecessary Care



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Defensive practice

*Primary motivation is **self-defence** for the benefit of the practitioner rather than patient, seeking to avoid potential adverse consequences (1)*

- Studies in the US indicate that 80-90% of clinicians report defensive behaviours (2)
- 43% of Australian doctors reported increased referral rates and 55% ordered more tests owing to medicolegal concerns (3)

Positive	Negative
Actions that lack medical indication and provide no benefit to patient outcome.	Avoiding high-risk interventions that are medically indicated and could benefit the patient.

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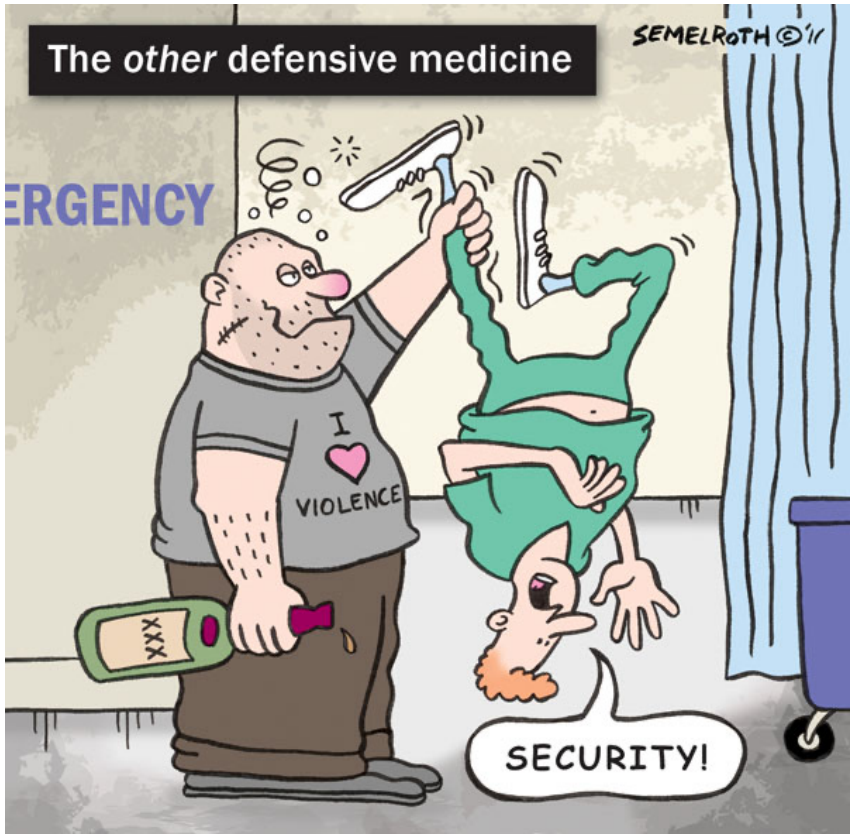
Motivations behind defensive practice

- Legal threat
- Physical threat
- Career/reputational threat
- Social threat
- Financial threat
  Psychological threat



Could defensive practice be ethically permissible?

If so, what kind of practices, and are there certain criteria that would contribute to a threshold measure of acceptability?

Aim:

- Examine the ethical permissibility of different defensive medical behaviours and distinguish which practices may be more, or less, morally acceptable.
- Develop and apply a criteria-based ethical framework to assess defensive behaviours and guide clinical decision-making.

Hypothesis:

1. Defensive practice sits on a spectrum of ethical justifiability, with permissibility varying according to the nature and severity of the threat to the clinician.

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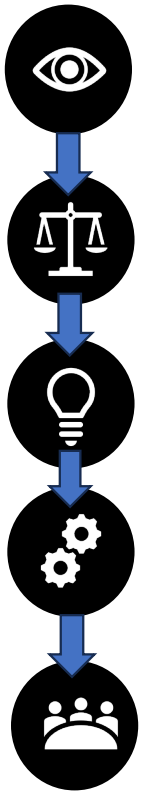
Methods



1. Review current literature on unnecessary practice, defensive medicine and the motivations behind these.
2. Collate cases of defensive practice for theoretical analysis, to identify relevant arguments for and against ethical justifiability.
3. Develop criteria to assess the moral permissibility of defensive clinical behaviours.
4. Propose an ethical framework fulfilling these criteria.
5. Recommend how this framework can be applied in practice when approaching defensive clinical decisions, and address objections to the new model.

Ethical analysis

Self-defence

Ethics, law, and professional guidance recognise a qualified right to self-defence.

Philosophical justifications (4)

- Lesser-evil
- Liability-based defence
- Agent-relative prerogatives

Proportionality constraint: defensive behaviour must be a genuine lesser evil, permitting minimal harm to protect clinician safety while ruling out measures that excessively compromise patient welfare. (4)

Case study: Iranian cardiologist, Dr Masoud Davoodi (5)

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Ethical analysis

Non-maleficence

- Physical harms: low-level risks from minimally invasive positive defensive practice (e.g., radiation, pain, infection), but serious harm when negative defensive practice denies necessary treatment and breaches non-maleficence.
- Emotional harms: psychological distress, anxiety from incidental findings, and erosion of trust in the clinician–patient relationship.
- Financial burdens: costs of extra tests and consultations, travel expenses, and lost income from time off work.
- Time burdens: disruption to work, family responsibilities, and meaningful daily activities.

Case study: Over-documentation

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Ethical analysis

Justice

Resource Allocation

- Defensive medicine wastes resources through unnecessary tests, costs, and environmental burden.
- It creates opportunity costs, diverting time, beds, and staff away from patients with genuine clinical need.
- Practising defensively may also reduce system strain by preventing burnout, litigation burden, and workforce loss, by reducing the emotional and logistical toll of patient complaint.

Equality of Opportunity

- Defensive care can favour more vocal or litigious patients, undermining equitable access based on clinical need.
- Clinician withdrawal from high-risk specialties or underserved areas worsens healthcare inequities, reducing access for vulnerable populations.

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Ethical analysis

Public trust

- Public trust is essential to effective care, enabling openness, adherence, and meaningful patient engagement.
- Defensive medicine undermines trust because its self-protective motives and subtle forms of deception (e.g., exaggerating severity) compromise honesty and transparency.
- From a deontological perspective, such practices erode professional integrity and can damage not only individual therapeutic relationships but trust in the healthcare system broadly.

Case study: exaggerating seriousness of patients' health conditions to manage expectations

Ethical analysis

Autonomy & Informed Consent

- Informed consent requires transparency and undisclosed defensive motives violate autonomy.
- Could we rectify this with open disclosure of defensive motivations?
    - May not understand the risks of defensive care
    - Power imbalance in doctor-patient relationships
- Undermines both procedural autonomy (i.e. lack of full information) and relational autonomy (i.e. subtle pressure and loss of partnership), treating patients as tools for risk management rather than autonomous decision-makers.

Discussion

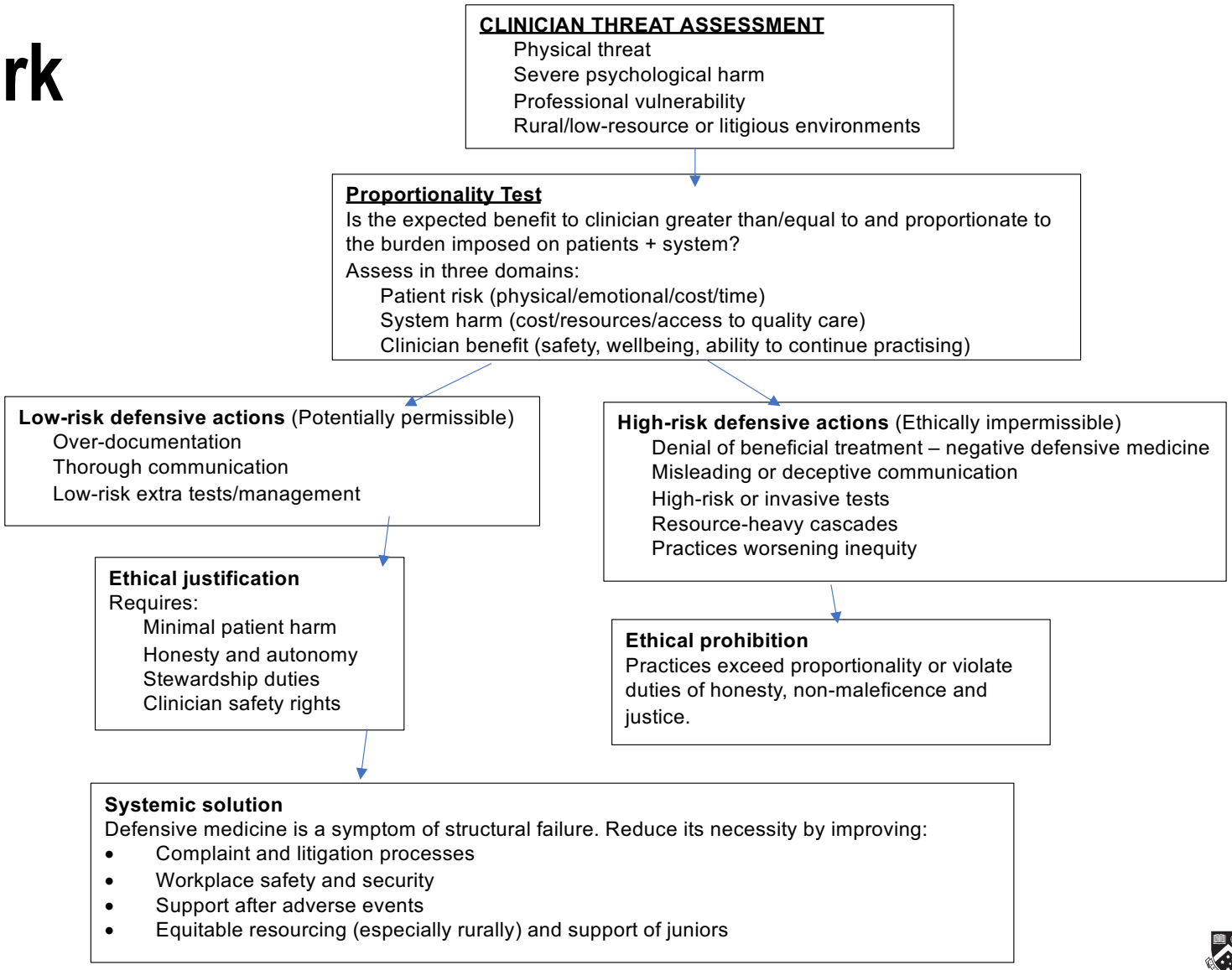
National survey of Iranian physicians:

- 35% regarding defensive medicine as morally justifiable
- 40% believed clinicians have a right to practise it, particularly those in high-risk procedural specialties

Proportionality: defensive actions are permissible only when the clinician's protection is proportionate to the minimal burden imposed on patients, colleagues, and the health system.

Consequentialism, deontology, and virtue ethics all reject unnecessary or harmful defensive acts, but may recognise a narrow moral right to self-defence in cases of serious physical, psychological, or professional threat, e.g. particularly in rural or under-resourced settings.

Framework



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Conclusion

- Defensive medicine is not ethically uniform.
- Most defensive medicine is ethically impermissible, yet a narrow subset may be justifiable in specific, high-risk contexts.
- Context and proportionality matter: defensiveness is acceptable only when it (a) responds to genuine harm and (b) imposes proportionate, low-level burdens.
- A narrow right to clinician self-defence supports wellbeing and retention, especially in rural, under-resourced settings, while harmful “negative” defensiveness remains impermissible.
- Systemic reform is required to reduce the drivers of defensive medicine, including fair complaint processes, workplace safety, and post-adverse-event support.

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Recommendation

- Systems must support clinicians to minimise the risks that lead them to practice defensively.
- Professional organisations and guidelines must help define justified defensive practice.

Objections

- May increase defensive practices in low-litigation or low-risk contexts, exacerbating resource allocation issues
- May incentivise demanding or threatening behaviour from patients

Further research

- Determine the threshold of justified self-defence
- Test framework against greater breadth of cases to ensure universality
- Couple with empirical research to compare public and clinician opinion to ethical analysis.

Thank you for your attention!

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