



The Double-Edged Sword of Defensive Nursing: Safety or Overcaution?

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Dear Editor,

The nursing workforce in Iran faces numerous challenges in the clinical field that demand attention. One such challenge, which has recently garnered significant interest, is defensive nursing—a phenomenon closely related to defensive medicine but distinct in its application to nurses' roles. Defensive medicine broadly refers to healthcare practices where providers, primarily physicians, alter their clinical behavior to reduce the risk of malpractice claims, often through unnecessary tests, procedures, or avoidance of high-risk cases. Defensive nursing, by contrast, adapts these principles to the nursing context, where nurses—often in subordinate roles to physicians—engage in actions primarily to shield themselves from legal liability rather than focusing exclusively on optimal patient care. This includes excessive documentation, over-reporting, or evading certain responsibilities to minimize exposure to allegations of negligence (1).

In Iran's high-stakes healthcare environment, where legal claims and lawsuits are an undeniable reality due to resource constraints, heavy workloads, and rising patient expectations, nurses increasingly adopt defensive practices. Studies indicate that defensive behaviors are highly prevalent among Iranian healthcare professionals; for instance, among general practitioners in Southeast Iran, positive defensive medicine (actions of commission, such as ordering extra tests or documentation) occurs in 99.8% of cases, while negative defensive medicine (actions of omission, like avoiding high-risk patients) is seen in 79.2%. Although data specific to nurses is limited, similar patterns emerge, with factors like work experience and awareness of colleagues' lawsuits significantly influencing these behaviors (2). Defensive nursing in Iran is often a response to the profession's demanding conditions, including fear of litigation stemming from past experiences, workplace violence, and perceived high legal risks. For example, nurses may meticulously document every patient interaction or request additional consultations not strictly necessary, driven by the worry that incomplete records could lead to accusations of negligence (3).

It is crucial to distinguish between system-imposed documentation—mandatory reporting required by organizational policies, regulatory bodies, or national health guidelines in Iran, such as those from the Ministry of Health and Medical Education—and fear-driven documentation or avoidance (4). System-imposed burdens contribute to overall administrative overload but are intended to ensure standardization and patient safety. In contrast, fear-driven practices involve excessive, redundant documentation beyond these requirements or outright avoidance of tasks, motivated by personal liability concerns rather than systemic mandates. This differentiation highlights how defensive nursing exacerbates systemic burdens, turning necessary protocols into overcautious rituals that divert time from patient care (5).

Examples of defensive nursing can be anchored to core defensive medicine principles of commission versus omission. Acts of commission include performing unnecessary interventions, such as ordering extra vital sign checks or over-documenting routine procedures, to create a robust legal defense trail. Acts of omission might involve avoiding high-risk patients—such as those with complex comorbidities or litigious histories—or declining to participate in potentially contentious decisions, like end-of-life care discussions, to evade blame. In Iran, where nurses often report burnout linked to defense mechanisms (e.g., denial or projection in response to stress), these practices are compounded by occupational factors. A study of 318 nurses in Sari, Iran, found significant correlations between immature defense mechanisms and higher burnout rates, suggesting that defensive behaviors may serve as coping strategies but ultimately harm well-being and care quality (6). Nursing's subordinate role in treatment decisions further shapes defensive behaviors differently than in medicine. Unlike physicians, who have primary authority to diagnose and prescribe, Iranian nurses typically implement orders under hierarchical structures, limiting their autonomy. This subordination can amplify defensive practices focused on self-protection, such as hyper-vigilant reporting to superiors or excessive charting to

“cover” for potential physician errors, rather than initiating independent actions like extra tests. It may also foster a culture of blame-shifting, where nurses prioritize documenting compliance over advocating for patients, potentially eroding interprofessional trust and patient-centered care (7).

Defensive nursing impacts patient care in multiple ways. Positive practices (commission) may inflate healthcare costs and prolong hospital stays through unnecessary tasks, while negative practices (omission) can compromise access to timely care, leading to disparities—particularly in Iran's resource-strained public hospitals. Excessive focus on fear-driven documentation reduces time for direct patient interactions, weakening therapeutic relationships and trust. For instance, nurses might spend disproportionate time on paperwork instead of bedside support, diminishing empathy and holistic care (2).

Addressing defensive nursing in Iran requires a multifaceted approach emphasizing organizational culture, education, and support. Fostering a patient safety culture through open communication and robust legal protections can alleviate nurses' litigation fears. Practical training in conflict de-escalation and legal literacy could empower nurses to manage risks without resorting to defensive extremes. Simplifying documentation *via* digital tools aligned with Iran's health policies would balance legal necessities with efficient care, reducing administrative burdens. Ultimately, distinguishing defensive acts from systemic challenges will strengthen efforts to prioritize safe, compassionate nursing while protecting professionals (4).

Defensive nursing, while a protective response, risks evading core responsibilities and undermining patient-centered care in Iran. By understanding its roots in fear and subordination, stakeholders can develop solutions that safeguard both nurses and patients.

Conflicts of Interest

There are no conflicts of interest among the authors of this article.

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