Implantable cardioverter defibrillators (ICDs) have become an essential tool for primary and secondary prevention of sudden cardiac death. Traditionally, defibrillation threshold (DFT) testing is part of the "lege artis" ICD implantation. Taking into consideration that the absolute mortality reduction in primary prevention trials is estimated around 8% and in secondary prevention trials around 7%, it is only in these patients that an acceptable DFT is expected to affect survival. Using a high-energy ICD, the likelihood of obtaining an inadequate DFT is about 2.5%. Thus, the number of patients needed to be subjected to DFT testing in order to avert one potential death is about 500. Application of antitachycardia pacing for rapid ventricular tachycardias further reduces the percentage of patients dependent on reliable ICD defibrillation capability. Thus, the mortality rate that can be prevented by DFT testing is below 0.2%. This contrasts a 0.4% risk of life-threatening complications and a low but not negligible mortality risk owed to the procedure. Although in light of these data the balance between DFT-related risk and benefit seems to tilt toward the former, insights gained from prospective randomized trials will clarify whether the abandonment of routine DFT testing can be claimed on a rightful basis.