Rethinking Informed Consent in the Age of Vaccine Misinformation

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Introduction

Patients rarely encounter medical information for the first time in the consulting room. Before speaking to a clinician, they may have searched their symptoms online, watched videos describing personal experiences with treatment, read challenges to public-health guidance or joined digital communities organised around particular health concerns.

This wider access to medical information can advance patient autonomy. It allows people to ask informed questions, seek second opinions and participate more actively in decisions about their care. Yet the same digital environment also enables false and misleading claims to circulate rapidly, often without the context needed to assess their reliability. In relation to vaccination, such claims may present routine immunisation as harmful, experimental or part of a wider institutional agenda. They do not simply offer a competing view of risk; they may also encourage distrust of the institutions responsible for producing and communicating medical knowledge (Metzler & Garcia, 2024; Denniss & Lindberg, 2025).

This creates a challenge for informed consent. In England and Wales, medical law has rightly moved away from a model in which doctors controlled what patients were told. However, the law remains focused primarily on disclosure within clinical encounters. I argue that the duty established in *Montgomery* is necessary but no longer sufficient as a complete account of meaningful autonomy. A patient may receive legally adequate information from a clinician while interpreting it through beliefs shaped by months or years of misinformation, algorithmic recommendation systems and institutional distrust.

The answer is not to weaken autonomy or permit clinicians to override decisions they regard as mistaken. Exposure to misinformation does not itself remove capacity, and an adult with capacity remains entitled to make an unwise decision. Instead, vaccine misinformation shows why the conditions supporting informed decision-making must extend beyond the consultation.

The Limits of Disclosure

In *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, the Supreme Court confirmed that a doctor must take reasonable care to ensure that a patient is aware of material risks and reasonable alternative or variant treatments. A risk is material where a reasonable person in the patient's position would be likely to attach significance to it, or where the doctor knows, or should know, that the particular patient would do so. The judgment recognised that medical decisions involve personal values and priorities, not clinical expertise alone.

This was an essential rejection of medical paternalism. It placed the patient, rather than the profession, at the centre of the decision. Yet the duty necessarily operates through dialogue between clinician and patient. It addresses what the clinician must explain; it cannot control the wider conditions in which the patient decides whether that explanation is credible.

Historically, the central concern of informed-consent law was information scarcity. Doctors possessed medical knowledge and could withhold facts they believed patients should not hear. The legal response was to require disclosure. In digital environments, however, the difficulty may be information saturation. Patients may be overwhelmed by a mixture of accurate, misleading, conflicting and decontextualised claims before an appointment begins.

Digital platforms have changed the patient's epistemic environment: the wider conditions that shape which information people encounter, which sources appear credible and how competing claims are evaluated. Social-media platforms do not operate as neutral libraries. Their systems personalise, organise and recommend content, often according to its predicted ability to retain attention. Repeated exposure, emotional intensity and endorsement within a trusted community can make a claim appear persuasive even where its evidential basis is weak. These effects may be reinforced by commercial incentives that reward content capable of attracting attention and engagement (Denniss & Lindberg, 2025). Although the evidence concerning algorithmic effects is complex, recommendation systems can reinforce existing social forces and patterns of engagement (Metzler & Garcia, 2024). A clinician cannot realistically undo this epistemic environment during a brief appointment.

This exposes a practical limitation rather than a defect that *Montgomery* could simply repair. The law can require careful disclosure and dialogue, but it cannot guarantee that the information provided will be trusted or interpreted as the clinician intends. A patient may therefore have received the legally required explanation of material risks and

alternatives while remaining misinformed about the evidence, institutions or motives behind that advice.

Trust and the Digital Clinical Encounter

The problem is not merely that a patient may believe a single inaccurate claim. Vaccine conspiracy theories can promote a broader worldview in which doctors are financially compromised, regulators conceal evidence and public health advice forms part of a coordinated deception. Once that worldview is accepted, a clinician's attempt to provide reassurance may itself be interpreted as further evidence of concealment.

Research on motivated reasoning and identity protective cognition helps explain why supplying more facts may not resolve the problem. People do not always assess information neutrally. Evidence may be interpreted in ways that protect existing values, loyalties and group identities (Kahan, 2017). Where attitudes towards vaccination become intertwined with membership of an online community, accepting clinical advice may appear to require rejecting the group through which the individual has come to understand the issue.

The clinician is therefore not necessarily correcting a simple informational deficit. They may be engaging with beliefs that also perform social and psychological functions. Dismissive correction can consequently be ineffective and may deepen suspicion of medical authority.

Institutional distrust, however, should not automatically be characterised as irrational. Some patients and communities have genuine reasons to approach medical institutions with caution. The Infected Blood Inquiry documented profound failures involving risk disclosure, testing, candour and the treatment of affected patients (Infected Blood Inquiry, 2024). Its relevance to informed consent is clear. Distrust can arise from actual breaches of transparency and autonomy rather than from ignorance alone.

Misinformation can exploit these histories by combining legitimate grievances with unsupported present-day claims. Recognising this does not validate vaccine conspiracy theories. It helps explain why messages that simply instruct people to "trust the experts" may fail, particularly among communities whose experiences of healthcare include neglect, racism, paternalism or institutional defensiveness (Schmidt-Sane et al., 2023). Trust cannot be demanded through additional disclosure. It must be supported through responsiveness, candour and a willingness to acknowledge uncertainty and past failures.

Nor should exposure to misinformation become a shortcut to a finding of incapacity. Section 1(4) of the Mental Capacity Act 2005 states that a person must not be treated as unable to make a decision merely because they make an unwise decision. Autonomy is not

conditional upon agreement with orthodox medical advice. A patient with capacity may refuse vaccination for reasons that a clinician regards as unreasonable.

The point is instead relational and practical. Meaningful dialogue requires some willingness to regard the clinician and the information they provide as credible. Where that minimum trust has broken down, compliance with a disclosure duty may not, by itself, create the conditions required for genuine engagement.

Individual Choice and Collective Harm

Vaccination makes this tension especially difficult because an individual decision can have consequences for others. Refusal may increase the risk of transmission to infants, people who cannot be vaccinated and those who remain medically vulnerable. Bodily autonomy remains fundamental, but vaccination decisions do not occur in a social vacuum.

The measles outbreak centred on Swansea in 2012 and 2013 illustrates how misleading information may contribute to collective harm. Public Health Wales recorded 447 confirmed cases, 64 hospital admissions and one death. MMR uptake in the area had remained historically low following widespread publicity about an alleged association between the vaccine and autism that was subsequently discredited (Public Health Wales, 2026). Research conducted in South Wales found that parents who declined MMR were more likely to report being influenced by newspapers, television, the internet and vaccine pressure groups (Walsh et al., 2015).

The outbreak occurred before the present social media landscape had fully developed, and it would be simplistic to attribute every refusal or infection to misinformation. Nevertheless, it demonstrates how decisions formed partly within a distorted information environment can accumulate into serious consequences for public health. This does not justify overriding individual autonomy, but it does explain why the conditions in which vaccination decisions are made matter beyond the individual patient.

Supporting Autonomy Beyond the Consultation

Responding to this problem does not require a return to the paternalism that preceded *Montgomery*. Allowing the state or the medical profession to determine which beliefs are acceptable would undermine the autonomy that informed consent is intended to protect. The better response is to strengthen the conditions in which people encounter and evaluate health information.

First, public health engagement must begin before a patient faces an immediate decision. Healthcare institutions should communicate risk and uncertainty in accessible, culturally sensitive and transparent terms. They should acknowledge mistakes openly and

respond to the concerns of particular communities rather than relying on generic messages. Clinicians also need sufficient time, training and reliable resources to discuss misinformation with empathy and without ridicule or confrontation. Listening is often a precondition for advice being heard.

Secondly, digital health literacy should be treated as a public health priority. Patients are routinely expected to distinguish anecdote from evidence, assess unfamiliar sources and recognise emotional manipulation. That burden cannot fall solely on individuals. Schools, public health bodies, healthcare institutions and civil society organisations all have a role in helping people ask who produced a claim, what evidence supports it, what remains uncertain and whether the claim has been independently scrutinised. The aim is not obedience to authority, but the ability to evaluate competing claims with greater confidence.

Thirdly, greater attention must be directed upstream. Individual clinicians cannot resolve an information crisis one consultation at a time. Platform design, recommendation systems and incentives based on engagement influence which health claims users encounter, trust and share. Effective responses should therefore combine the correction of false claims with digital literacy and proportionate scrutiny of the systems that facilitate their circulation (Denniss & Lindberg, 2025). This does not require the state to become an arbiter of acceptable belief. It requires transparency about how powerful information systems operate and scrutiny of whether their design facilitates the spread of harmful falsehoods.

These measures would not change the legal test for capacity, authorise compulsory treatment or alter the rules governing genuine emergencies. Their purpose is to support the patient's freedom to decide by improving the conditions in which that freedom is exercised.

Montgomery remains essential because it protects the individual's right to determine which risks to accept. Yet disclosure within a consultation cannot counter every influence operating beyond it. In an environment shaped by information saturation, online communities and contested institutional trust, meaningful autonomy requires more than respect for the patient's final choice. It also requires sustained attention to the conditions in which that choice is formed. This is not a departure from *Montgomery*, but a way of taking its commitment to patient autonomy seriously.

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