MDForLives

THE GLOBAL PULSE OF HEALTHCARE · NURSING INSIGHT REPORT

Health Misinformation in Nursing: When Patient Education Competes With Care

A detailed view of how often nurses confront health misinformation, which claims dominate patient conversations, how much correction work is absorbed into the shift, what preserves trust during disagreement, where nurses feel less than fully prepared, and which organizational supports could make evidence-based education easier at the point of care.

Misinformation → Trust → Education → Care

317	6	80.8%
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate

WHY THIS REPORT

Nurses are increasingly asked to correct health claims in the same moments they are delivering treatment, explaining risk, and trying to preserve trust

Health misinformation is no longer confined to public-health campaigns or online debate. It can enter a medication round, a vaccine conversation, discharge teaching, symptom triage, or a family discussion about whether recommended care is necessary. That makes misinformation a nursing workflow issue as well as an information-quality issue.

The external context is clear about the pressure on frontline communication. The World Health Organization's 2025 analysis describes frontline workers as both affected by infodemics and important sources of credible guidance, while misinformation can erode trust in health systems. The International Council of Nurses in 2026 emphasized nurses' role in translating science into care and the need to ensure they have time and resources for person-centred communication. WHO has also called for training health workers to identify and address misinformation and for accessible information that can be used quickly.

The MDForLives survey examines what this looks like inside nursing practice: how frequently misinformation appears, what type of claims nurses encounter, how correction affects shift workflow, which communication strategies preserve trust, how confident nurses feel when patients refuse evidence-based care, which sources create the greatest barrier, what prevents effective education, and what support nurses would most value from their organizations.

> **Methodology and data note.** Audience: nurses. Survey ID 8949821. The source export contains 317 survey records, an 80.8% completion rate, and responses from the USA, UK, Canada, Italy, France, and Germany. The hidden country-punching item is used only for geography metadata. Administrative tracking, bad-ID, required-text, after-question, and honeypot fields are excluded from interpretation.

EXECUTIVE SUMMARY

Six signals that show how health misinformation is becoming part of the nursing workload

INSIGHT 01

Misinformation is a daily reality

46.9% encounter unverified or misleading health information multiple times per shift or daily.

INSIGHT 02

Medication and vaccine misconceptions dominate

52.2% most frequently encounter misconceptions about prescription medicines, side effects, or vaccine safety.

INSIGHT 03

Correction work consumes nursing time

56.1% describe a moderate workflow impact because extra patient education is required during visits.

INSIGHT 04

Trust is protected before facts are corrected

57.6% prefer acknowledging the concern first, then pivoting to evidence-based guidance.

INSIGHT 05

Short-form social media leads the source problem

44.8% identify TikTok, Instagram Reels, YouTube Shorts, or similar short-form platforms as the greatest source barrier.

INSIGHT 06

Time is the limiting resource

47.8% name lack of time due to workload or staffing ratios as the biggest obstacle to effective patient education.

01

EXPOSURE FREQUENCY

For many nurses, health misinformation is part of the shift rather than an occasional exception

46.9% encounter unverified or misleading health information multiple times per shift or daily.

CONTEXT

A nurse may hear a misleading claim while giving a medication, checking discharge understanding, discussing vaccination, or responding to a family member who has searched online. The conversation arrives inside existing care rather than in a protected education slot.

WHAT THE DATA SHOWS

Multiple-times-per-shift or daily exposure leads at 46.9%. A few times a week is 37.7%, a few times a month 12.5%, and rarely or never 2.9%.

THE INSIGHT

The distribution makes misinformation a recurring communication demand for most respondents. The frequency is high enough that correction skills, escalation routes, and patient-facing resources need to function as routine workflow tools, not special-case interventions.

WHY IT MATTERS

Repeated correction work compounds. A single conversation may be manageable, but several during one shift can add documentation, reassurance, family discussion, and source-checking to an already crowded workload.

Frequency of encountering unverified or misleading health information

- Multiple times per shift / daily · 46.9%
- A few times a week · 37.7%
- A few times a month · 12.5%
- Rarely or never · 2.9%

02

CONTENT OF MISINFORMATION

The claims nurses correct most often are attached to medicines, side effects, and vaccine decisions

52.2% most frequently encounter misconceptions about prescription medications, side effects, or vaccine safety.

CONTEXT

Medication teaching is embedded throughout nursing care: what a drug is for, how to take it, what side effects to watch, when to seek help, and why adherence matters. Vaccine counseling can involve similar risk-benefit conversations. Misinformation in these areas can therefore move quickly from belief to action.

WHAT THE DATA SHOWS

Medication, side-effect, or vaccine-safety misconceptions lead at 52.2%. False information about disease cause, self-diagnosis, or prognosis is 25.4%; supplements, detoxes, or alternative wellness therapies 17.3%; and misleading advice on acute symptoms or post-discharge recovery 5.1%.

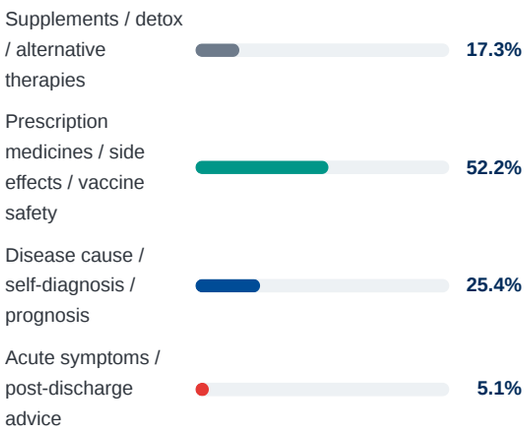
THE INSIGHT

The dominant category sits directly beside nursing tasks with safety implications. Nurses are not simply correcting broad wellness claims; they are frequently addressing information that can affect medication acceptance, adherence, monitoring, and preventive care.

WHY IT MATTERS

When the misinformation touches a medicine or vaccine, the nurse often has to connect evidence with the immediate clinical plan. That raises the value of fast, current, patient-friendly materials that reinforce the explanation without turning the interaction into a prolonged debate.

Most frequently encountered type of health misinformation



03

WORKFLOW BURDEN

Most nurses can absorb misinformation counseling into the workflow, but doing so still consumes clinical time

56.1% describe a moderate workflow impact that requires extra education time during visits.

CONTEXT

Patient education is part of nursing practice, but misinformation changes the nature of the task. Instead of explaining a plan from a shared starting point, the nurse may first need to identify the claim, understand its source, rebuild trust, correct the misconception, and confirm understanding.

WHAT THE DATA SHOWS

Moderate impact leads at 56.1%. Major impact is 26.2%, minor impact 17.0%, and no impact 0.7%.

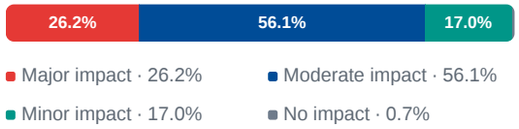
Impact of addressing misinformation on workflow and care delivery

THE INSIGHT

The word “moderate” can sound reassuring, but in a shift context it still means additional work. More than one in four respondents describe substantial time consumption and potential delay to necessary care, while almost no one says misinformation has no workflow effect.

WHY IT MATTERS

This is why workload and staffing appear later as the leading education barrier. Communication quality cannot be separated from the time available to deliver it, especially when the patient is hesitant, upset, or refusing care.



04

TRUST-PRESERVING COMMUNICATION

Nurses favor a communication move that reduces defensiveness before introducing evidence

57.6% choose “Validation + Pivot” as the most effective strategy for maintaining trust.

CONTEXT

Correcting a patient in front of family, during an anxious moment, or after the patient has spent hours consuming reinforcing content can quickly become a relationship problem. A response that begins with “that is wrong” may be factually direct but still fail if the patient disengages.

WHAT THE DATA SHOWS

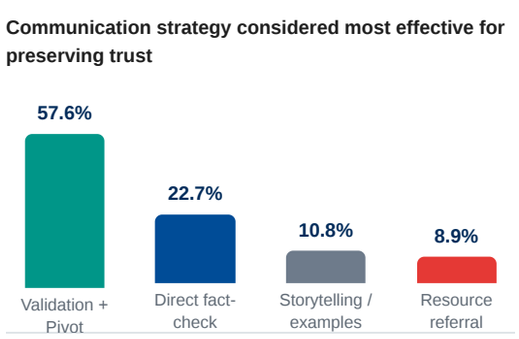
Validation + Pivot leads at 57.6%. Direct fact-checking is 22.7%, storytelling or examples 10.8%, and referral to verified external resources 8.9%.

THE INSIGHT

The leading choice suggests respondents separate acknowledgment from agreement. Recognizing where a concern came from can create a conversational opening, after which the nurse can introduce evidence, explain the clinical recommendation, and check whether the patient has understood it.

WHY IT MATTERS

This approach aligns with health-literacy practice that emphasizes clear, non-shaming communication. AHRQ’s teach-back method, for example, checks understanding by asking the patient or caregiver to explain key information in their own words rather than simply asking whether they understand.



05

DE-ESCALATION CONFIDENCE

Confidence is high enough to manage many difficult conversations, but it is more often moderate than complete

63.2% say they are moderately confident de-escalating refusal caused by online misinformation.

CONTEXT

A refusal conversation is more demanding than routine education. The nurse may be balancing autonomy, immediate risk, family dynamics, emotional escalation, and the need to involve a physician, charge nurse, or ethics resource when the situation exceeds bedside resolution.

WHAT THE DATA SHOWS

Moderate confidence leads at 63.2%. Extreme confidence is 24.2%, slight confidence 11.2%, and no confidence 1.5%.

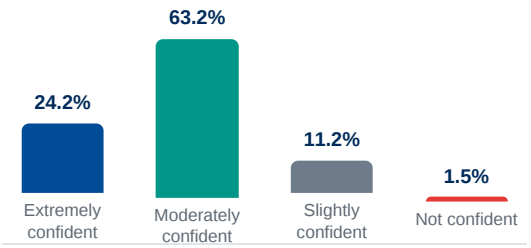
THE INSIGHT

Most respondents do not describe themselves as unprepared. Instead, the modal experience is competence with a cost: the survey wording for moderate confidence explicitly notes that these conversations can be emotionally draining.

WHY IT MATTERS

Organizations should therefore think beyond basic fact sheets. Nurses may benefit from de-escalation language, motivational interviewing, escalation pathways, and opportunities to hand off prolonged counseling when it begins to compete with other patient-care responsibilities.

Confidence de-escalating refusal due to online misinformation



06

WHERE MISINFORMATION COMES FROM

Short-form social media is the leading source barrier, but nurses are also negotiating family influence, forums, and AI

44.8% identify short-form social media as the source posing the greatest barrier to effective patient care.

CONTEXT

The information environment around patients is fragmented. A claim may come from a thirty-second video, a support group, a family member, an influencer, or an AI-generated answer. Each source carries a different kind of authority in the patient's mind, which changes how the nurse has to respond.

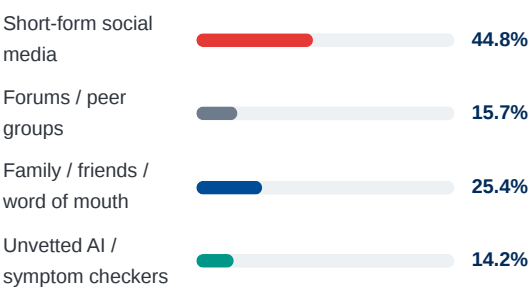
WHAT THE DATA SHOWS

Short-form social media leads at 44.8%, followed by family, friends, or word-of-mouth influencers at 25.4%, online forums or peer groups at 15.7%, and unvetted AI chatbots or automated symptom checkers at 14.2%.

THE INSIGHT

The result is not a social-media-only story. Almost half select another source category, including close personal networks and emerging AI tools. Nurses may therefore need to ask where a claim came from rather than assuming the patient encountered it on a single platform.

Source of misinformation posing the greatest barrier to effective care



WHY IT MATTERS

Source-aware communication can improve efficiency. If the concern comes from a family member, the family may need to be included. If it comes from AI or a social feed, showing the patient how to compare the claim with a trusted clinical source may be more useful than repeating a correction without addressing the source.

07

EDUCATION BARRIER

The biggest obstacle is not knowing what to say; it is having enough time to say it well

47.8% name lack of time during patient interactions because of workload or staffing ratios as the single biggest obstacle.

CONTEXT

A nurse can know the evidence and still be unable to deliver a high-quality correction if the patient requires a long conversation during a high-pressure shift. Time determines whether the nurse can explore the belief, answer questions, involve family, use teach-back, and return later if the patient is not ready to decide.

WHAT THE DATA SHOWS

Lack of time leads at 47.8%. Patient entrenchment or mistrust is 32.8%, absence of quick patient-friendly visual materials 13.4%, and lack of formal training 6.0%.

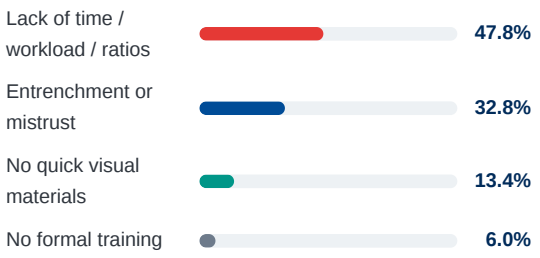
THE INSIGHT

The barrier hierarchy matters. Training is selected least often as the single biggest obstacle, while time and mistrust dominate. That does not make training unimportant; it suggests training alone is unlikely to solve the problem if the workflow still gives the nurse no room to use the skill.

WHY IT MATTERS

A workable response needs both communication capability and operational support. Rapid-access materials can shorten explanation, educators can absorb longer counseling, and escalation pathways can prevent one difficult conversation from consuming disproportionate nursing time.

Single biggest obstacle to educating patients about health misinformation



08

ORGANIZATIONAL SUPPORT

Nurses prioritize patient-facing tools and dedicated educators over training alone

35.2% say patient-facing digital or printed toolkits would best empower them to combat misinformation at the point of care.

CONTEXT

When the leading barrier is time, the most valuable support is likely to be something that makes the next conversation faster, clearer, or easier to hand off. The survey asks nurses to choose the organizational support with the greatest potential to help at the point of care.

WHAT THE DATA SHOWS

Patient-facing toolkits lead at 35.2%, dedicated patient educators or health-literacy specialists at 31.1%, formal hospital training at 17.2%, and EHR-integrated educational discharge templates at 16.5%.

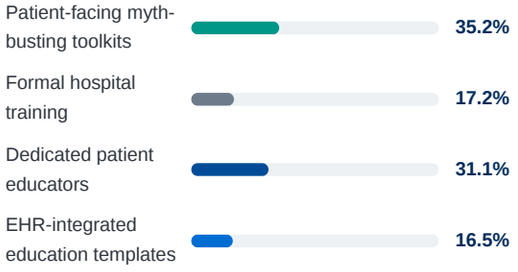
THE INSIGHT

The top two responses solve different parts of the same workload problem. Toolkits give the bedside nurse something immediately usable; dedicated educators create another destination for complex or prolonged counseling. Together they suggest a preference for support that changes the workflow, not only the nurse's knowledge.

WHY IT MATTERS

The strongest implementation model may be layered: a quick bedside resource for common myths, an EHR-linked version for discharge, training for difficult conversations, and a clear referral route when the patient needs more time than the shift can reasonably provide.

Organizational support nurses say would help most



09

OPERATIONAL SYNTHESIS

The survey describes a mismatch between how much trust-building work nurses are doing and how much protected capacity they have to do it

The leading barrier is time, while the leading supports are tools and people that can reduce or redistribute counseling work.

CONTEXT

Across the survey, the same pattern repeats: misinformation arrives frequently, often touches high-stakes medication or vaccine decisions, and usually requires additional education. Nurses feel capable of responding, but the conversation is not frictionless, especially when a patient is entrenched or refusing care.

WHAT THE DATA SHOWS

Lack of time is selected by 47.8% as the biggest obstacle. The two leading requested supports are patient-facing toolkits at 35.2% and dedicated educators or health-literacy specialists at 31.1%. Separately, 57.6% prefer a trust-preserving Validation + Pivot approach, which itself requires attention and conversation.

THE INSIGHT

The issue is therefore not a simple knowledge deficit. Nurses already have strategies and a strong sense of how to preserve trust. The operational gap is whether the system makes those strategies usable at the speed of real care.

How the leading barrier and requested supports fit together

47.8%
Lack of time is the leading obstacle

35.2%
Patient-facing toolkits are the leading requested support

31.1%
Dedicated educators are the second requested support

57.6%
Validation + Pivot is the leading trust-preserving strategy

WHY IT MATTERS

If organizations want more reliable misinformation correction, the most direct opportunity is to reduce the amount of reinvention at the bedside. Standardized resources, clear escalation and referral routes, and accessible specialist support can turn an individual communication burden into a shared care process.

OPEN-ENDED PERSPECTIVE

When nurses describe the myths they actually face, the problem becomes more personal, more varied, and harder to solve with one script

The open-ended item asked nurses to describe a bizarre, dangerous, or frustrating health myth encountered recently and how they handled it. Usable responses included medication and vaccine myths, alternative-remedy claims, misunderstandings affecting treatment adherence, and beliefs shaped by social media or AI. Several entries were too brief, ambiguous, or unrelated to support interpretation. Themes below are qualitative and are not assigned percentages.

Medication and vaccine fears can directly alter care decisions

Responses included claims linking vaccines with autism or cancer, beliefs that morphine kills patients, and misunderstandings about continuing medicines after major cardiovascular treatment. These are the kinds of myths that can move quickly from conversation into refusal or non-adherence.

Alternative remedies compete with evidence-based treatment

Several responses described patients substituting home remedies, prayer, or other non-standard approaches for recommended treatment. The nursing task in these cases is not only to correct a fact but to understand what the alternative means to the patient and whether it creates immediate risk.

Digital authority is expanding beyond social media

Open-text examples included a patient treating AI as a doctor and another relying on Facebook content for a claimed memory remedy. These comments add texture to the structured finding that unvetted AI and short-form social platforms are already part of the information environment nurses encounter.

Handling the myth often means returning to trusted evidence

Respondents described explaining the evidence, pointing patients to official medical resources, providing facts, and talking through the risks and benefits. The approaches vary, but the recurring objective is to replace an unsupported claim with information the patient can understand and act on.

What the qualitative responses add: the same communication skill can be required across very different beliefs. Nurses need enough flexibility to address the source, the emotion, the clinical risk, and the patient's level of readiness rather than relying on a single generic correction script.

NURSING PRACTICE LENS

What a more workable point-of-care misinformation response could look like

The survey does not define one universal communication protocol. It does identify where nursing teams and healthcare organizations can reduce friction without replacing professional judgment.

Protect the first minute of the conversation

Start by identifying the specific claim and where it came from. Acknowledge the concern without endorsing misinformation, then move toward the evidence and the immediate care decision.

Put myth-specific resources within reach

Use short, patient-friendly materials for common medication, vaccine, and disease misconceptions so nurses do not have to rebuild the same explanation from scratch during every shift.

Create a clear escalation and handoff route

Define when the bedside nurse should involve a physician, charge nurse, pharmacist, educator, interpreter, or ethics resource, especially when refusal or misunderstanding creates meaningful clinical risk.

Check understanding before the conversation ends

Use plain language and teach-back or similar techniques to confirm that the patient can explain the plan in their own words, particularly after correcting a high-stakes misconception.

PEOPLE ALSO ASK

Frequently asked questions about health misinformation in nursing

What is health misinformation in healthcare?

Health misinformation is false, inaccurate, or misleading health information that can shape how patients understand symptoms, treatments, medicines, prevention, or recovery. It may come from social media, websites, family networks, AI tools, or other informal sources.

How can nurses correct health misinformation without damaging trust?

A useful approach is to acknowledge the concern, ask what the patient has heard or believes, respond with clear evidence in plain language, and check understanding. The aim is to correct the claim without turning the conversation into a confrontation.

Why does social media health misinformation spread so quickly?

Short-form and highly shareable content can spread faster than careful clinical explanations. Repetition, emotional stories, algorithms, and familiar influencers can make inaccurate claims feel persuasive even when the underlying evidence is weak.

What is the teach-back method in nursing?

Teach-back asks patients or family members to explain key information or next steps in their own words. It helps nurses check whether an explanation was clear and identify misunderstandings that need correction.

How can nurses address medication or vaccine misinformation?

Start by identifying the exact concern, use current evidence and trusted clinical resources, explain benefits and risks in understandable terms, and avoid dismissing the patient. Escalation may be appropriate when refusal creates significant clinical or ethical risk.

How can healthcare organizations support nurses dealing with misinformation?

Useful support can include ready-to-use patient education materials, health-literacy and communication training, access to educators or specialists, EHR-linked resources, and workflows that give nurses enough time to address high-risk misconceptions.

CLOSING PERSPECTIVE

Health misinformation is becoming part of the nursing workload, but the burden should not remain an individual bedside problem

The report describes nurses working at the intersection of evidence, trust, and time. Misinformation appears frequently, often concerns medicines, side effects, or vaccines, and is usually manageable only because nurses absorb extra education into the flow of care.

The strongest communication response is not an aggressive correction. It is an acknowledgment of the concern followed by a pivot to evidence. That choice is clinically sensible because it protects the relationship, but it also takes time, especially when the patient is anxious, entrenched, or refusing treatment. The survey's most common confidence level reflects that tension: nurses generally feel able to handle the conversation, yet many describe it as emotionally draining.

The system-level opportunity is to make good communication easier to deliver. The leading barrier is workload-related time, while the leading requested supports are ready-to-use patient materials and dedicated educators or health-literacy specialists. Those findings point toward a shared model: give nurses fast evidence-based tools for common myths, build escalation routes for high-risk or prolonged conversations, integrate useful education into discharge workflow, and provide specialist backup when bedside counseling begins to compete with other essential care.

Misinformation will continue to change its form, from familiar vaccine and medication myths to new claims generated by influencers, peer groups, or AI. The nursing response therefore has to be durable rather than platform-specific: listen, identify the belief, preserve trust, explain the evidence, check understanding, and know when to escalate. The critical organizational question is whether nurses are given the capacity to do that consistently.

Make reliable information immediately usable

Prepare short, plain-language materials for recurring myths so correction does not begin from zero each time.

Support the conversation, not just the facts

Train teams in non-confrontational communication, motivational interviewing, teach-back, and de-escalation where appropriate.

Share ownership of complex counseling

Use educators, pharmacists, interpreters, physicians, and ethics resources when the issue exceeds what one nurse can resolve during the shift.

Design around time pressure

Build patient education into workflow and discharge processes so misinformation correction is not treated as optional extra work.

Bring your nursing perspective to the global healthcare conversation

Share how patient education, misinformation, trust, and workflow pressures shape care in your practice.

Join the Panel

Sources used for this report

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2. World Health Organization. WHO policy brief: COVID-19 infodemic management. 2022.
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