

The Ethical Right to Remain Offline: A Policy Framework for Digital Refusal, Equivalent Access, and Continuity of Care in Patient-Centered Health Systems

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Abstract

Digital technologies increasingly mediate access to appointments, clinical communication, records, monitoring, and other healthcare functions. Their benefits, however, do not establish that patients should be required to participate digitally whenever health systems can deliver a service through digital channels. This normative policy analysis examines whether a patient may refuse a digital modality while retaining meaningful access to the underlying healthcare function. Using Prescriptive Design and Normative Policy Theory, the analysis distinguishes refusal of a delivery modality from refusal of care, and develops a function-based account of equivalent access. The central claim is conditional: health systems should preserve a practically usable non-digital pathway when making digital participation a condition of access would impose unjustified burdens, threaten continuity, or convert technological preference into an eligibility criterion for ordinary care. Equivalent access does not require identical delivery. Alternatives may legitimately differ in interface, timing, workflow, or staffing when essential clinical functions, safety, reasonable timeliness, and continuity remain protected. Digital support and navigation remain important, but assistance should expand genuine choice rather than become compulsory remediation before a patient can obtain care through another channel. The resulting policy position is therefore neither digital-resistant nor technology-neutral in an absolute sense. It requires health systems to justify modality-dependent differences according to the healthcare function at stake, the burdens imposed on patients, clinical risk, continuity consequences, and feasible institutional alternatives.

Keywords: Digital exclusion, Digital health equity, Patient autonomy, Healthcare access, Continuity of care, Digital health policy

Introduction

Digitalization now shapes access to routine healthcare functions rather than merely supplementing them. Appointment systems, communication portals, remote consultations, records access, monitoring technologies, and administrative processes can all make digital participation consequential for obtaining care. Contemporary evidence characterizes digital exclusion

as a multidimensional healthcare-equity problem involving access, skills, motivation, usability, institutional design, and social conditions [1]. The ethical problem therefore extends beyond whether a device or internet connection is available.

Digital health equity frameworks similarly locate exclusion across individual, organizational, community, service, and wider structural levels [2]. This matters because a formally available digital service may remain difficult to use, difficult to trust, poorly matched to a patient's circumstances, or unavailable in a functionally useful form. Systematic qualitative evidence on advancing digital health equity further shows that inclusion depends on implementation conditions rather than on technological availability alone [3]. A policy that treats digital deployment as equivalent to equitable

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access consequently risks confusing the existence of a channel with patients' practical ability to obtain the healthcare function carried through it.

The possibility of unequal benefit does not make digital innovation ethically suspect by definition. Informatics interventions may improve care overall while still generating inequality at the stages of access, uptake, adherence, or effectiveness [4]. The policy question is therefore not whether health systems should digitalize. It is whether they may make digital participation the ordinary price of obtaining functions that patients remain otherwise entitled to receive. Recent integrative work joining digital exclusion, ethical concerns, and implementation reinforces the need to treat these dimensions together rather than as separate technical and moral problems [5].

This article addresses that narrower question through Prescriptive Design and Normative Policy Theory. Its focus is the institutional rule that should govern situations in which a patient rejects a digital modality but still seeks the underlying healthcare function. The analysis does not assume a statutory legal right to an offline channel in every jurisdiction, nor does it claim that all digital and non-digital services must be identical. Instead, it asks what a patient-centered health system should preserve when digitalization changes the practical conditions of access. The resulting argument distinguishes three matters that are often collapsed: refusal of a technological modality, continued eligibility for care, and the degree of equivalence that an alternative pathway must provide. That distinction provides the basis for evaluating when digital refusal warrants accommodation and when safety, continuity, or institutional feasibility may justify differences in delivery.

Digitalization and the ethics of refusal

Digitalization becomes ethically significant when it changes the terms under which patients can exercise ordinary healthcare choices. Qualitative evidence shows that patients experience digitalization as part of healthcare itself, affecting interaction, access, and participation rather than merely administrative convenience [6]. A refusal to use a portal, application, video platform, or remote-monitoring interface can therefore concern the manner in which care is mediated without amounting to refusal of the underlying consultation, information, monitoring, prescription, or follow-up.

Health systems may reasonably respond to digital difficulty by offering support. Yet support and voluntariness perform different ethical functions. Primary-care evidence from England shows that digital facilitation is often inconsistent, passive, or dependent on local processes, demonstrating that assistance cannot be presumed simply because an online service exists [7]. Portal-use evidence likewise indicates persistent sociodemographic and socioeconomic differences in engagement [8]. A policy that makes digital assistance available can reduce avoidable barriers, but a policy that requires a patient to complete assistance or training before an alternative channel becomes available converts support into a condition of access. The former expands capability; the latter may narrow choice.

The distinction becomes sharper when the unit of analysis is the healthcare function rather than the platform. Observational evidence from the NHS App shows that patterns of use differ across particular functions rather than following one uniform digital divide [9]. Portal engagement disparities have also been observed within ordinary chronic-care populations [10]. These findings support a function-specific policy analysis: a patient may be comfortable receiving reminders electronically while declining video consultation, willing to access laboratory results online while preferring telephone scheduling, or able to use a portal intermittently while requiring a non-digital route during periods of illness or disability. Treating digital participation as a single all-or-nothing characteristic obscures those distinctions.

Formal availability also does not guarantee meaningful benefit. National survey evidence from Finland found that perceived benefits of online health and social-care services vary with socioeconomic, demographic, health, and information-technology factors [11]. Digital health equity scholarship consequently warns that innovation can reproduce existing social gradients unless equity is incorporated into design and implementation [12]. The normative implication is not that any unequal pattern invalidates digital care. It is that institutions cannot treat the burden of making a digital pathway usable as belonging entirely to the patient when the institution itself has made that pathway central to access.

This allocation of burden is especially important when patients are unable or simply unwilling to engage digitally. Work on the digital inverse care law explicitly argues for maintaining effective non-digital approaches for people who cannot, or choose not to, engage with

digital services [13]. At the same time, digital health literacy differs across populations and contexts [14]. These propositions must remain separate. A patient should not have to establish a deficit in literacy to make digital refusal ethically intelligible. Refusal may arise from privacy preferences, prior experience, disability, language, fatigue, technological distrust, practical burden, preference for interpersonal interaction, or reasons that the patient is not required to convert into a diagnostic explanation before requesting another channel.

The same restraint is necessary for age and functional vulnerability. Digital exclusion among older adults is heterogeneous and shaped by multiple interacting conditions [15]. Longitudinal evidence associating internet nonuse with cognitive outcomes illustrates why

changing functional circumstances may matter for digital participation [16], but such associations cannot support an inference that nonuse demonstrates incapacity in an individual patient. The relevant ethical presumption should therefore run in the opposite direction: digital refusal remains a modality decision unless there is independent reason to question decision-making capacity.

A function-based analysis produces several distinct ethical states of refusal. The critical question is not whether the patient has accepted the institution's preferred technology, but whether the underlying healthcare function remains clinically relevant, whether a reasonable alternative exists, and whether the burdens attached to obtaining that alternative are proportionate.

Table 1 summarizes the distinctions discussed above.

Table 1. Ethical status of digital refusal across healthcare functions and burden conditions

Digital-refusal situation	Healthcare function at stake	What the patient is refusing	Presumptive system obligation	When the alternative may legitimately differ	Principal limit on the refusal claim
Refusal of portal-based administration	Scheduling, registration, routine administrative exchange	Digital interface rather than healthcare eligibility	Preserve a practically usable way to complete the administrative function	Different hours, workflow, or staff process may be acceptable when access remains reasonably timely	Alternative need not reproduce every convenience feature of the portal
Refusal of digital information access	Results, instructions, records, care information	Electronic retrieval or notification channel	Provide access to clinically relevant information through another usable route	Format and speed may differ when urgency and comprehension remain adequately protected	Immediate electronic availability need not always be duplicated offline
Refusal of remote consultation	Clinical assessment or follow-up	Video or other remote encounter modality	Maintain access to an appropriate clinical encounter when the function can be delivered another way	Telephone or in-person care may differ according to clinical requirements	A requested modality can be declined when clinically unsafe or unsuitable
Refusal of app- or device-mediated monitoring	Monitoring and transmission of health information	Particular monitoring technology	Determine whether clinically necessary monitoring can be achieved through a workable alternative	Frequency, convenience, or location of monitoring may differ	Refusal cannot require an alternative that fails to provide clinically necessary surveillance
Temporary inability or unwillingness to use a digital route	Any ongoing function already incorporated into care	Current use of the digital pathway	Preserve continuity while allowing movement to another channel	Transitional arrangements may be time-limited where continuity is otherwise maintained	The claim does not guarantee permanent duplication of every channel
Acceptance of digital support without commitment to digital-only care	Access assistance and future modality choice	Exclusive reliance on the digital route	Offer support without treating successful training or enrollment as consent to digital exclusivity	Supported use may coexist with non-digital fallback arrangements	Institutions may still use proportionate digital defaults where alternatives remain genuinely accessible

Table note: The table presents the article's proposed normative synthesis. "Presumptive system obligation" denotes a policy starting point subject to clinical safety, continuity, proportionality, and feasible service design. Equivalent access concerns preservation of the healthcare function rather than identity of delivery format.

Equivalent access and continuity of care

Once digital refusal is distinguished from refusal of care, the next question is what an alternative pathway must preserve. Equivalent access should be understood functionally rather than as a demand for identical delivery. Large-scale evidence on office, video, and telephone visits with the same primary-care clinicians demonstrates that patients may receive care through different modalities while retaining the same professional relationship [17]. Yet telemedicine-access research also shows that completion and mode of remote care can vary according to age, language, race or ethnicity, income, and insurance characteristics [18]. The ethical standard therefore cannot be that every patient receives the same interface. It must ask whether the patient can obtain the clinically relevant function under conditions that preserve meaningful access.

Functional equivalence permits asymmetry. A telephone appointment may not reproduce all features of video, and an in-person route may require travel that a portal does not. Contemporary US evidence also shows that use of video and audio-only telemedicine differs across patient characteristics [19]. Infrastructure matters, but high-speed internet availability alone does not eliminate disparities in telehealth use [20]. A health system may therefore provide different routes without promising identical convenience, provided those differences do not convert one route into a predictably inferior form of access for patients who decline the preferred technology. The standard must also account for cumulative burden. A qualitative systematic review among culturally and linguistically diverse populations identified technology, design, language, culture, health, trust, and interpersonal interaction as interrelated influences on digital participation [21]. Intersectional analysis likewise cautions against treating sources of disadvantage as independent variables that can simply be addressed one at a time [22]. Equivalent access should therefore be evaluated from the standpoint of the pathway a patient must actually navigate. An offline option that technically exists but requires repeated travel, longer waits, separate registration, inaccessible communication, or repeated explanation of the same circumstances may preserve formal availability while undermining practical equivalence.

Disability provides another reason to separate digital availability from accessibility. International policy analysis has shown how digital health may increase inequalities for people living with disabilities when accessibility is insufficiently incorporated into policy and design [23]. At the same time, a recent equity analysis of remote patient-monitoring literature found inconsistent reporting across multiple equity parameters [24]. Institutions should consequently avoid declaring a pathway equitable simply because the technology is capable of reaching patients remotely. Accessibility is an empirical and experiential condition, not an intrinsic property of digitization.

Continuity adds a temporal dimension to equivalence. A patient who changes modality should not have to restart access to care as though changing channels were equivalent to leaving the healthcare relationship. Information, follow-up obligations, clinically significant communications, and pending decisions should remain attached to the patient across channel changes. This does not require every pathway to operate through the same staff, schedule, or interface. It requires the system to prevent modality switching from causing clinically significant loss of information, avoidable delay, or abandonment of an already established care process.

The resulting standard is deliberately more demanding than the existence of an offline contact point and less demanding than identical duplication. Equivalent access exists when a patient can still reach the relevant healthcare function through a practicable alternative, with burdens and delays that remain proportionate to the function at stake and with continuity protected across the transition. This distinction also marks the ethical limit of digital refusal: a patient may refuse the digital modality, but the refusal does not require a health system to provide an alternative that cannot safely perform the necessary clinical function. **Figure 1** represents this relationship between modality refusal, support, functional preservation, continuity, and justified limits.

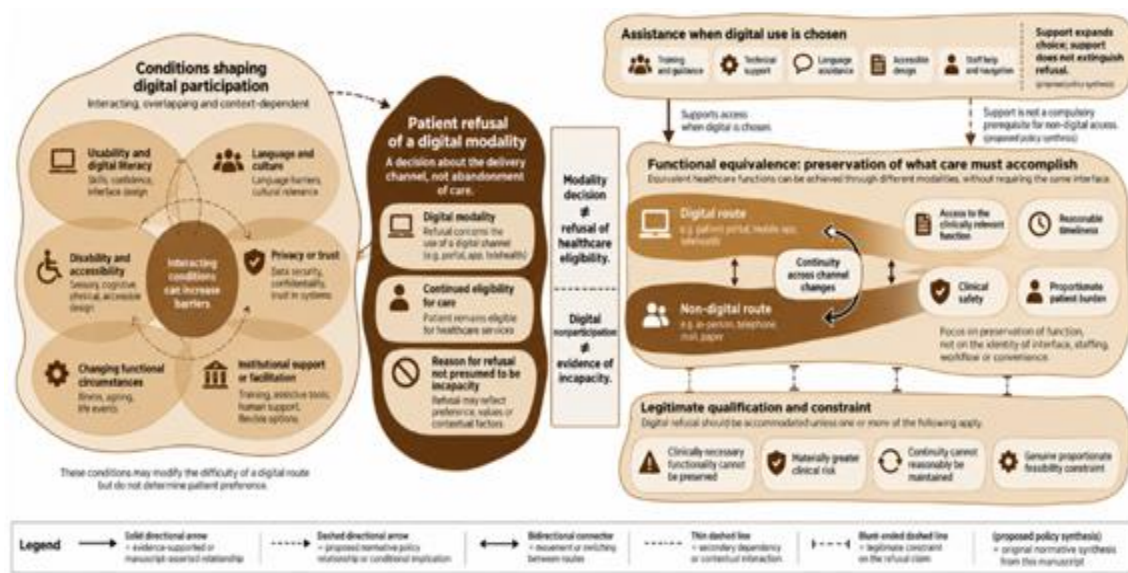


Figure 1. When refusing the channel does not mean refusing the care: the conditions that preserve patient authority across digital and non-digital access

A policy framework for the right to remain offline

A workable policy begins with a presumption that access to an eligible healthcare function should not depend unnecessarily on acceptance of one technological channel. Facilitated telehealth demonstrates that institutions can actively reduce practical barriers when patients choose digital care [25]. Such support should enlarge the range of usable options. It should not make successful enrollment, training, portal activation, or device use a prerequisite for receiving the underlying service through another clinically suitable route.

Responsibility for making digital care usable also cannot rest entirely with patients. Health-system implementation of multilingual digital navigation shows that organizations can assign personnel and workflows specifically to reduce access barriers [26]. A right to remain offline therefore sits alongside a positive duty to support patients who prefer digital care. These duties are complementary: one protects against compelled technological participation, while the other prevents nominal digital availability from becoming inaccessible through inadequate institutional support.

The design of alternatives should also be informed by people who encounter the burdens being regulated. Community-based organizations contribute contextual knowledge about how digital-health interventions interact with language, trust, local resources, and established service relationships [27]. Participatory input

is especially important when administrators are deciding whether a proposed non-digital alternative is practically equivalent. Formal availability observed from inside an institution may conceal transportation demands, repeated identification procedures, communication barriers, or delays that materially change accessibility for patients.

Resource use and service quality nevertheless constrain policy design. Greater telehealth use may increase access to clinician encounters while producing mixed patterns across quality and expenditure outcomes [28]. These trade-offs make a universal preference for either digital-first or offline-first care difficult to defend. Policy should instead examine the healthcare function, the risks attached to different modes, the burdens imposed on patients, and the feasible alternatives available to the institution. A digital default can therefore be permissible when it improves ordinary access and an adequate alternative remains practically obtainable.

Assessment of digital readiness may help identify patients who want additional support. The validated Digital Health Readiness Screener separates technical readiness from concerns about the quality of digitally mediated care [29]. This distinction matters because reluctance may reflect judgments about communication, privacy, clinical interaction, or perceived quality rather than inability to operate a device. Readiness assessment should consequently trigger assistance or discussion

rather than operate as a test of whether a person deserves a non-digital route.

Similar caution applies to digital health literacy. Research practice does not rely on one universally adopted definition or operationalization of health and digital health literacy [30]. A policy that conditions alternative access on proving inadequate literacy would therefore place excessive normative weight on a variable whose meaning and measurement differ across studies

and settings. The relevant decision is whether the patient can obtain the healthcare function safely and reasonably through available channels.

These relationships create a policy field in which channel choice, support, equivalent access, continuity, and institutional constraint interact rather than forming a simple progression.

Figure 2 illustrates the relationships discussed above.

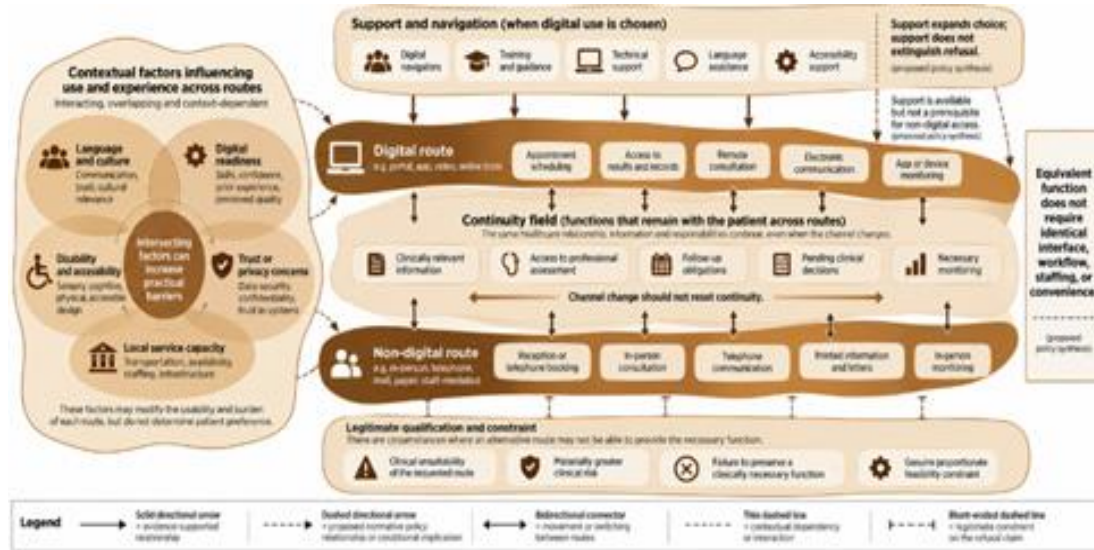


Figure 2. Keeping the healthcare function continuous when patients move between digital and non-digital routes

Institutional responsibility extends beyond the design of technological tools. Provider offer and encouragement materially shape whether patients gain access to portal services [31]. Patient “nonadoption” therefore cannot automatically be interpreted as an individual failure that releases the institution from responsibility. When a health

system makes a channel central to care, it also assumes responsibility for ensuring either that the channel is reasonably usable or that another adequate route remains available.

Table 2 summarizes the distinctions discussed above.

Table 2. Functional requirements for equivalent access across digital and non-digital care pathways

Healthcare function to preserve	Digital expression may include	Non-digital expression may include	What must remain equivalent	Differences that may be justified	Continuity failure to avoid
Entry into care	Portal, app, online scheduling	Telephone, reception, staff-mediated booking	Genuine ability to request eligible care	Workflow, hours, interface, degree of automation	Alternative exists formally but is practically unreachable
Clinical communication	Secure messaging, video, digital forms	Telephone, in-person communication, supported written exchange	Clinically sufficient opportunity to communicate relevant information	Mode and response process may differ according to urgency and staffing	Messages or concerns disappear when channel changes
Access to clinical information	Portal results, electronic records, digital instructions	Printed information, telephone explanation, staff-mediated access	Timely access to information needed for decisions and self-care	Format and immediacy may differ when clinically acceptable	Offline users receive incomplete or materially delayed information

Professional assessment	Video or digitally supported review	Telephone or in-person assessment	Appropriate clinical assessment for the presenting need	The clinically suitable modality may legitimately differ by condition	Refusal of one modality becomes de facto refusal of assessment
Follow-up and monitoring	App, device, portal questionnaire, remote review	Scheduled contact, in-person monitoring, alternative reporting process	Required follow-up remains active and clinically interpretable	Frequency, location, convenience, or technology may differ	Monitoring obligation silently terminates after channel change
Movement between channels	Digital reassignment or electronic handoff	Staff-mediated reassignment or booking	Relevant records, pending decisions, safety-netting, and responsibility travel with the patient	Administrative processes may differ	Patient must restart the episode of care after switching modality

Table note: Equivalent access concerns preservation of essential healthcare functions, clinically acceptable timeliness, continuity, and proportionate burden. It does not require duplication of every interface or convenience associated with another channel.

Health-system implementation

Implementation requires health systems to monitor actual patterns of access rather than assign permanent labels to groups presumed to be digitally excluded. Contemporary evidence shows that digital-health use varies with both individual and contextual factors, and patterns may not always follow a simple gradient of disadvantage [32]. Monitoring should therefore detect who is unable to use particular functions, who chooses another route, whether disparities are changing, and whether an alternative pathway is itself deteriorating.

Continuity must also extend beyond single encounters. Digital health services used by patients at home span multiple functions and service configurations [33]. Systems that permit channel switching need mechanisms for preserving records, pending actions, results communication, follow-up responsibility, and safety-netting when patients move between digital and non-digital routes. Administrative conversion should not become a clinically significant interruption.

Navigation and readiness support can be incorporated into this architecture without becoming mandatory remediation. Digital navigators may assist patients who

want help with enrollment or use [26]. Readiness assessment may identify whether a barrier concerns technology, communication, or perceived quality [29]. Neither mechanism should become a prerequisite for access to a clinically suitable alternative. Operational ownership is also necessary because facilitation and provider behavior influence whether patients can use available services [7]. Institutions therefore need identifiable responsibility for maintaining both route usability and cross-channel continuity.

Scarcity may prevent indefinite duplication of every service configuration. Infrastructure and service characteristics influence which pathways can realistically be maintained [20]. Evidence of mixed access, quality, and cost effects also cautions against assuming that maximizing any single modality will optimize the system as a whole [28]. Proportionate feasibility constraints can therefore justify differences in scheduling, staffing, location, or workflow. They should be explicit and function-specific rather than concealed inside a digital default that removes a necessary route without considering its consequences.

Table 3 summarizes the distinctions discussed above.

Table 3. Policy design principles for preserving offline access without converting parallel care into unrestricted duplication

Policy design principle	Operational trigger	Institutional action	What should be monitored	Unacceptable implementation drift
Preserve an access route to essential functions	A service function becomes primarily digital	Maintain or designate a clinically suitable alternative where required	Completion, delay, failed contact, unresolved requests	Digital enrollment becomes an unstated eligibility condition
Separate support from compulsion	Patient encounters difficulty or requests help	Offer navigation, training, interpretation, accessibility support, or assisted use	Uptake of support and unresolved barriers	Alternative access is withheld until remediation is completed
Protect continuity during switching	Patient moves from one channel to another	Transfer records, pending actions, follow-up duties, and safety-netting	Lost follow-up, repeated registration, duplicate assessment, missed results	Channel change resets the episode of care

Test functional equivalence	Digital and non-digital pathways differ substantially	Evaluate whether essential clinical and informational functions remain available	Timeliness, clinical suitability, communication completeness, patient burden	“Alternative available” is declared without examining practical usability
Use readiness measures for accommodation	Barriers to digital use are uncertain	Identify support needs without making readiness a gatekeeping score	Whether assistance resolves the barrier when desired	Low readiness becomes grounds for stigma or reduced entitlement
Assign accountable ownership	Access failures cross administrative and clinical boundaries	Allocate responsibility for escalation and route maintenance	Unresolved handoffs, repeated failures, responsibility gaps	Burden is repeatedly returned to the patient
Review justified constraints	Safety or resource limits restrict an alternative	Record the affected function and the proportional justification for the difference	Duration, affected population, alternatives considered	Temporary or function-specific limits become permanent digital-only policy

Table note: These principles are the article’s proposed prescriptive synthesis. They do not specify universal staffing ratios, waiting-time thresholds, or service volumes; implementation remains dependent on clinical function and local system conditions.

Results and Discussion

The ethical right to remain offline is best understood as a constrained institutional obligation to preserve patient access when technology becomes a dominant route into ordinary healthcare. It does not imply that digitalization is ethically undesirable. Digital services can reduce travel, increase flexibility, expand communication, and mitigate some traditional access barriers. The ethical concern arises when the advantages of a preferred system channel become grounds for transferring disproportionate burdens onto patients who cannot or do not wish to use it.

This account also avoids equating equivalent access with unlimited duplication. Modality-choice evidence shows that different channels may serve different patients and circumstances [17]. Infrastructure does not eliminate all access disparities [20], and system-level telehealth evidence demonstrates that access gains can coexist with other quality or resource trade-offs [28]. The relevant obligation is therefore preservation of the clinically important function under proportionate conditions. Identical staffing, interface, convenience, or timing is unnecessary when differences do not materially undermine access, safety, or continuity.

Context remains important. Language, culture, trust, disability, and community conditions can alter how a formally available route is experienced and used [21]. Disability-focused policy analysis further shows why accessibility cannot be treated as an automatic property of digital care [23]. Community organizations can identify burdens and implementation features that may be less visible to centralized system designers [27]. Consequently, the proposed policy principles require local specification while retaining the patient’s authority to choose among clinically viable routes.

Measurement should be used with comparable restraint. Equity assessments may be limited by incomplete reporting [24], and digital-readiness instruments themselves distinguish different sources of difficulty [29]. Digital health literacy also lacks a single uniformly applied research definition [30]. These tools can improve accommodation, service design, and monitoring, but they should not become proxies for whether a patient has earned access to another channel.

A final risk is that preservation of an offline pathway becomes merely symbolic. Institutions may maintain a telephone number or reception route while progressively reducing staffing, increasing delays, separating records, or excluding functions that remain easy to obtain digitally. Contemporary evidence that patterns of digital-health use can change across groups and contexts supports adaptive monitoring rather than static assumptions about who requires alternatives [32]. The proposed right therefore requires scrutiny of both sides of the system: exclusion from the digital pathway and degradation of the non-digital pathway. A health system respects digital refusal only when the alternative remains practically capable of carrying the healthcare function it claims to preserve.

Conclusion

Digital participation should not become an unexamined condition of ordinary healthcare access. A patient-centered system can promote digital services vigorously while preserving meaningful alternatives for patients who refuse the modality yet continue to seek care. The ethical requirement is functional: clinically necessary access, information, safety, follow-up, and continuity should survive a change of channel. Alternatives need not reproduce every convenience or workflow of digital care,

and legitimate clinical or proportionate feasibility constraints may justify differences. The right to remain offline is therefore strongest where digital compulsion would otherwise convert technological preference, vulnerability, or circumstance into loss of meaningful healthcare access, and it weakens where no alternative can preserve the necessary clinical function without disproportionate risk or burden.

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