

PERSPECTIVES IN HYPERTENSION

Rehumanising hypertension: The wounded storyteller meets the digital clinician

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I have measured blood pressure thousands of times. In clinic, on wards, in research studies, and in community screenings. What I have measured far less often is the story that accompanies those numbers.

Hypertension is one of the most common conditions in medicine, yet one of the least humanly understood. We diagnose it by numbers, manage it through algorithms, and judge its success by whether systolic and diastolic values fall within predefined targets. In doing so, we have quietly transformed a deeply embodied, lived condition into a technical problem of measurement and control.

For patients, however, hypertension is rarely just a number.

I think of a woman in her forties who sat across from me clutching her blood pressure diary like a school report card. Her readings were high. She apologized before I could speak. "I tried," she said. "I really did." Her life was crowded with caregiving, financial strain, interrupted sleep, and quiet grief. Hypertension, for her, was not a defect of willpower. It was a mirror held up to an exhausted life.

Another patient, a retired schoolteacher, arrived with meticulously recorded home readings taken five times a day. He had memorized guideline thresholds. Each elevated value sent him into panic. "Doctor," he whispered, "what if today is the day I have a stroke?" He did not need another

antihypertensive. He needed reassurance, containment, and permission to stop surveilling his own body.

And then there was the man who refused medication altogether. He had been dismissed by doctors before. His side effects were minimized. His questions were brushed aside. He turned to herbal remedies not because he was ignorant, but because he no longer trusted a system that did not listen.

These patients were not "non-adherent." They were human. To rehumanise hypertension, we must begin not with better numbers, but with better listening.

Illness as Narrative

Arthur Frank's concept of the wounded storyteller offers a useful lens through which to understand hypertension.¹ He describes three narrative responses to illness: restitution, chaos, and quest.

The restitution story is the one medicine prefers: "I was sick, I took treatment, I am better." In hypertension, this becomes a pill, a normal number, and the hope of returning to who one was before the diagnosis.

The chaos story belongs to those overwhelmed by fluctuating readings, unexplained medication changes, side effects, and an unspoken fear of stroke or sudden death. Nothing makes sense. Control feels elusive.

The quest story is rarer but transformative. Here, hypertension becomes a turning point – a signal that reshapes priorities, identity, and meaning.

Modern hypertension care recognizes only the restitution story. We reward those whose numbers behave and quietly marginalize those whose stories do not fit the algorithm.

The anxious schoolteacher lived inside a chaos narrative.

The exhausted caregiver was being forced into restitution.

The resistant man had begun a quest for dignity outside medicine.

Beyond stories: how hypertension creates identities

Yet illness narratives alone do not fully capture how people learn to live inside medical systems. Over time, patients with hypertension also acquire identities – not as personality traits, but as adaptations to a form of care that moralizes compliance, rewards control, and quietly punishes deviation.²

These identities shape what patients disclose, what they hide, how they interpret their numbers, and how they relate to clinicians. To rehumanize hypertension, we must learn to recognize not only the stories patients tell, but the roles they have been taught to perform.

The moralization of blood pressure

Hypertension has quietly become a moral condition. Controlled blood pressure signals virtue. Uncontrolled blood pressure implies failure.³

Patients learn quickly what is rewarded. They perform adherence. They conceal missed doses. They apologize for their numbers.

The woman with the diary was not apologizing for physiology.

She was apologizing for her life.

The Human Faces of Hypertension

The Dependable Patient

“I do what I’m told. I don’t want to be difficult.”

Follows prescriptions even when struggling.
Hides side effects and fear to appear “good.”
Feels moral shame when BP remains uncontrolled.

The Stoic Patient

“Others have it worse. I shouldn’t complain.”

Minimizes symptoms and delays follow-up.
Normalizes fatigue and dizziness.
Endures silently at personal cost.

The Anxious Monitor

“Every number matters. I must keep checking.”

Compulsively measures BP.
Panics over single readings.
Loses trust in embodied experience.

The Resistant Patient

“I don’t trust this system. It doesn’t see me.”

Rejects medication for herbs or alternatives.
Feels unheard or culturally misaligned.
Protests through non-adherence.

The woman with the diary was a dependable patient.

The schoolteacher was an anxious monitor.

The man who rejected medication was resistant because he had been unheard.

These are not flawed personalities.

They are survival strategies.

I have come to recognize that chaos narratives are not merely psychological dispositions; they are often produced by care itself. A single rushed consultation, an unexplained medication switch, or a dismissive remark can undo months of careful self-management. Poor hypertension care does not simply fail to restore order – it actively generates chaos.

Adherence, in this context, is not a technical problem but a narrative one. The so-called “non-adherent” patient is often a dependable, stoic, anxious, or resistant human being whose life no longer fits the story medicine is asking them to live.

Digital medicine and the tyranny of numbers

Digital health technologies have intensified this dynamic. Home blood pressure monitors, smartphone apps, and wearable devices promise empowerment, yet often deliver anxiety.^{4,5}

The schoolteacher did not need five readings a day. He needed permission to live.

Numbers now follow patients into bedrooms, workplaces, and family meals. A quiet evening can be ruined by a transient systolic spike. Life itself becomes a risk factor.

Surveillance medicine does not merely observe hypertension. It reshapes identity around it.

In this emerging world, the clinician is no longer only a witness to suffering, but a curator of data – a digital clinician negotiating between algorithms and human stories.

A striking example of this digital turn is the recent FDA-cleared hypertension notification feature on the Apple Watch.⁶ Rather than directly measuring blood pressure in millimetres of mercury, the watch analyses vascular patterns over time and alerts users when readings are consistent with possible hypertension, prompting confirmation with a validated cuff and clinician review. This innovation has real public-health promise: it could identify millions of people with undiagnosed hypertension who might otherwise remain unaware of their risk.

Yet it is not a diagnostic tool, does not provide standard blood pressure values, and must not replace clinical assessment. Its value lies in awareness and screening, not in management decisions. For some patients it may empower; for others it may amplify anxiety or create false reassurance. The Apple Watch thus embodies both the promise and the peril of digital medicine: data without context can deepen surveillance while hollowing out meaning.

Gender, culture, and the silent burden

In low- and middle-income countries, and among women globally, these dynamics are amplified.⁷

The exhausted caregiver I met did not skip medication out of ignorance. She skipped it because her children needed school fees more than she needed tablets. She delayed follow-up because transport cost money. She minimized symptoms because no one had time to hear them. Stoicism becomes survival.

The resistant patient, too, must be understood culturally. In postcolonial contexts, distrust of Western medicine is not ignorance; it is historical memory.⁸ Herbal remedies are not superstition – they are parallel languages of care.

To rehumanize hypertension globally means recognizing that non-adherence is often a rational response to systems that do not listen.

What rehumanizing hypertension really means

Rehumanizing hypertension is not about being nicer. It is about changing what we count as success.

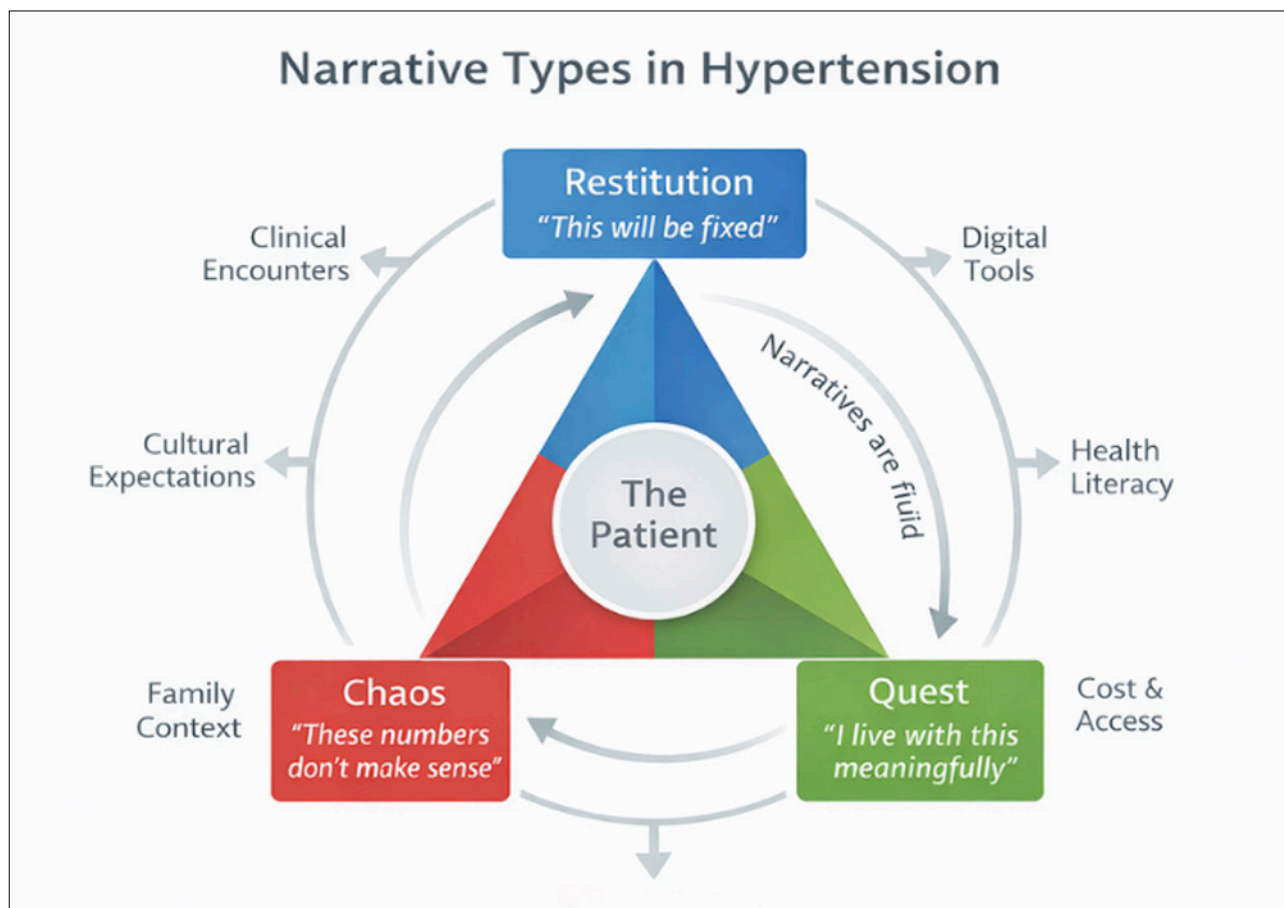
It means:

- Asking patients what hypertension means to them.
- Listening for restitution, chaos, or quest.
- Recognizing patient identities as adaptive roles.
- Valuing trust as much as pharmacology.
- Designing digital tools that reduce anxiety.
- Creating space for fear, resistance, and meaning.

Principles for Rehumanizing Hypertension Care

- Treat BP readings as signals, not verdicts.
- Ask narrative questions: “What has this changed for you?”
- Normalize fear and uncertainty.
- Recognize cultural and gendered dimensions.
- Resist moral language around compliance.
- Design care for people, not just populations.

Figure 1



A Closing Reflection

Hypertension will always be biological.

It will always require pharmacology, guidelines, and targets.⁹

But it is also human.

The woman with the diary, the anxious schoolteacher, the resistant man – none of them needed more algorithms. They needed to be seen. We do not need to choose between science and story. We need to hold them together.

To rehumanize hypertension is to remember that behind every systolic value is a life trying to make sense of itself. And that listening – truly listening – may be as therapeutic as any drug we prescribe.¹⁰

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