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BARRIERS AND STRATEGIES TO REDUCE MYOCARDIAL INFARCTION MORTALITY FROM THE LENS OF HEALTHCARE WORKERS IN KARACHI

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Abstract
One of the main causes of cardiovascular death is myocardial infarction (MI), which calls for quick action during the crucial "Golden Hour." Nursing personnel are essential to the early diagnosis and treatment of MI. In the context of MI management, there is a lack of local data that explicitly provides the reasons and strategies of MI mortality in Pakistan. This is qualitative research. The primary objective of this research is to investigate the barriers and strategies for reducing myocardial infarction. The sample is selected using a convenient sampling technique. The data was collected using semi-structured interviews from the sample of 12 nurses and patients/patients 'family. All the ethical considerations were followed using BERA framework. After the data collection, the data was analysed using thematic analysis. Deductive approach was used in the theme categorization. The major themes under the heading barriers to MI care were frontline competency gap, physician latency and commercialization in care. The prominent themes for strategies are workforce upskilling, permanent specialist presence, and ethical re alignment. The recommendations are to provide enough ECG machines. ACLS course

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certification should be mandatory for nurses in critical areas and ethical guidelines regarding patients' life safety must be moderated.
Keywords: Mortality, Myocardial Infarction, Barriers, Challenges, Nurses, Cardiologists.

INTRODUCTION

Myocardial Infarction (MI) is a leading cause of cardiovascular mortality, necessitating prompt intervention during the critical 'Golden Hour (Khandelwal, 2025).' Nursing staff play a pivotal role in the early recognition and management of MI, implementing life-saving protocols such as MONA (Morphine, Oxygen, Nitro-glycerine, Aspirin) and Advanced Cardiac Life Support (ACLS) (Sabbour, 2025). Their involvement is crucial in improving patient outcomes and reducing mortality rates (Alanazi, 2025). As one of the world's top causes of death, myocardial infarction (MI) is a major global health concern. It is mostly caused by the sudden stoppage of coronary blood flow, which frequently happens as a result of the rupture of atherosclerotic plaque (Kamalova, 2025) . MI still contributes significantly to cardiovascular disease (CVD) mortality despite improvements in treatment and management, especially in low- and middle-income nations where healthcare systems may be less prepared to handle such crises (Rafi, 2025) . .Over 15% of all deaths worldwide are caused by MI, with CVD accounting for about 4 million deaths in Europe alone (Siddique, 2025). Although rates are rising in emerging nations, MI is significantly more common in men of all ages (Ghafoor, 2026).The prevalence of type 1 MI, the most prevalent kind linked to atherosclerosis, is greatly influenced by these factors (Ng, 2026) .Among the most modifiable risk factors are: Obesity, hypertension, diabetes mellitus, smoking, and dyslipidemia (Aslam, 2026) .Roughly 30% of MI patients in low- and middle-income nations do not obtain early reperfusion, a problem made worse by delayed diagnosis and insufficient medical facilities (Savonitto, 2026) . Improving results requires putting in place efficient MI care services, such as telemedicine and education.

The Clinical Magnitude of MI

The promptness and precision of the initial nurse assessment and intervention have a major impact on the prognosis of a patient suffering from a myocardial infarction (MI) (Yu, 2025) . Since early symptom detection and management are essential for lowering MI-related morbidity and death, prompt and efficient nursing care can significantly improve patient outcomes (Araiza-Garaygordobil, 2025) .Nurses are essential in the prompt evaluation of MI symptoms, which involves keeping an eye on vital signs and doing electrocardiograms to look for arrhythmias (Organization., 2025) . In emergency rooms, following defined procedures for triage and treatment guarantees that patients receive prompt interventions, which are critical for raising survival rates (Pundkar, 2025) .In the acute period of managing MI, effective nurse interventions—like the administration of medicines and emotional support—are essential. Because it attends to both short-term and long-term requirements, a methodical approach to nursing care improves patient safety and fosters improved health outcomes (Abdollahifar, 2025) .On the other hand, postponing evaluation or action may result in more complications and a higher chance of death. Consequently,

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to maximize patient prognosis in the acute therapy of MI, the nursing role is essential (Yu, 2025).

Nurses must acquire several vital skills and abilities to serve as the first line of defence for patients with myocardial infarction (MI) in the emergency room or cardiac unit (Yaqoob, 2025) . In addition to improving patient outcomes, these capabilities guarantee prompt and efficient emergency care. To start therapies on time, nurses must promptly evaluate patients for MI symptoms, such as chest discomfort and ECG abnormalities (Gadafi, 2026).Understanding how to read ECGs is essential for spotting arrhythmias and other MI-related issues (Khatar, 2025).When providing emergency treatment under pressure, nurses should be skilled in conducting CPR and giving medication (Alenezi, 2025) . Effective emergency treatment requires the ability to make quick, well-informed judgments based on the patient's condition (Alimiri Dehbaghi, 2025). Coordinated treatment is ensured and patient safety is improved by effective communication with other healthcare professionals. When it comes to teaching patients and their families about MI, available treatments, and lifestyle changes, nurses are essential (Homem, 2025) . Improving the quality of care in MI situations requires addressing these problems with continued education and assistance.

The Importance of Evidence-Based Practice (EBP)

In Pakistan, treating myocardial infarction (MI) requires a multimodal strategy that includes prompt diagnosis, suitable treatment regimens, and post-discharge care (Bashar, 2025). Clinical recommendations, public awareness, and resource availability all have an impact on management techniques (Tian, 2024). 36% of patients arrive within two hours after the onset of chest pain, which is a large percentage of people. Thrombolytic treatment was only administered to 29% of eligible patients, suggesting a delay in prompt action (Lee, 2023) .Although this is the recommended course of treatment for ST-segment elevation myocardial infarction (STEMI), its application is hampered by a lack of funding and expertise (Crawshaw, 2025).Lipid testing, which is essential for secondary prevention, was only recommended for 13.8% of post-AMI patients (Burzyńska, 2026).

Lipid testing, which is essential for secondary prevention, is only recommended for 13.8% of post-AMI patients (Fitilev, 2025).Just 73% of patients are taking aspirin, and 67% are taking clopidogre, indicating poor adherence to therapeutic recommendations (Moawad, 2026) .Only 11.5% of patients who were on statin therapy reached their desired LDL levels (Abdul Wahab, 2026).This underscores the need for improved management techniques..It has been demonstrated that implementing standardized care pathways improves the quality of life and clinical results for individuals with AMI (Jasmshidbeigi, 2026).

Problem Statement: Myocardial Infarction is a major cause of death worldwide and especially in Pakistan (Usama, 2026) . The "Golden Hour"—the brief window for prompt diagnosis and treatment—is crucial to patient survival (Ayenew, 2026) . Significant systemic and human resource constraints prevent prompt care despite established clinical guidelines, which results in preventable deaths (Mario, 2026).

The lack of frontline nurse staff with advanced cardiovascular life support (ACLS) and ECG interpretation skills creates a severe diagnostic bottleneck in many clinical

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settings (Winkler, 2025) . The shortcoming leads to a risky dependence on doctor arrival, which causes therapeutic delays that jeopardize the viability of the heart muscle (Imeni, 2025). The provider-patient relationship has also changed as a result of the growing commercialization of healthcare, where a perceived preference for financial gain over professional ethics—often considering patients as "customers" rather than as people whose lives need to be saved—erodes the dedication needed for prompt, sincere intervention (Eze, 2025).

Finding the precise structural obstacles and necessary resources to reduce the gap between the start of symptoms and life-saving treatment is urgently needed (Stassen, 2025) . Despite improvements in medical technology, MI mortality rates have remained high, hence it is imperative to identify the gaps. To close the gap between the beginning of symptoms and life-saving care, it is imperative to determine the precise structural hurdles and necessary resources (Riaz, G., Khan, N., Haq, E. U., Kumari, S., Hussain, I., & Zada, S. , 2025). Finding the gaps is vital because MI mortality rates have remained high despite improvements in medical technology.

Research Objective: To investigate the practical challenges faced by nursing staff and identify specific training and resource interventions required to improve MI survival rates.

Research Question:

RQ1: What are the primary obstacles to effective MI care?

RQ2: What are the strategies for reducing myocardial infarction mortality ?

Literature Review:

Theoretical Framework:

Avedis Donabedian, a doctor and researcher, created the Donabedian Model in the 1960s and 1980s as a fundamental conceptual framework for assessing the calibre of medical care. It is predicated on the idea that three interrelated elements—structure, process, and outcome—can be used to gauge the quality of healthcare (Donabedian, 1986). Structure describes the environment in which care is provided, encompassing organizational structure, physical facilities, equipment, and human resources (qualifications, staffing levels). It stands for the "inputs" that make care possible. Process consists of all patient-provider interactions, such as diagnosis, treatment, and patient education. It focuses on the delivery of care and is seen to be the most immediate indicator of its quality. Evaluates how medical care affects a patient's health, including clinical outcomes (mortality, morbidity), patient behaviour, and patient satisfaction. The components are interrelated even if they are described in a linear fashion; a good structure raises the possibility of a good process, which raises the possibility of a good outcome. By examining these three areas together, the model serves as a guide to assess whether a system is fair, good, or bad in quality. The concept is quite adaptable and has been used in a number of domains, such as pharmacy, nursing education, and, more recently, the assessment of eHealth integration (Sreejith, 2026).

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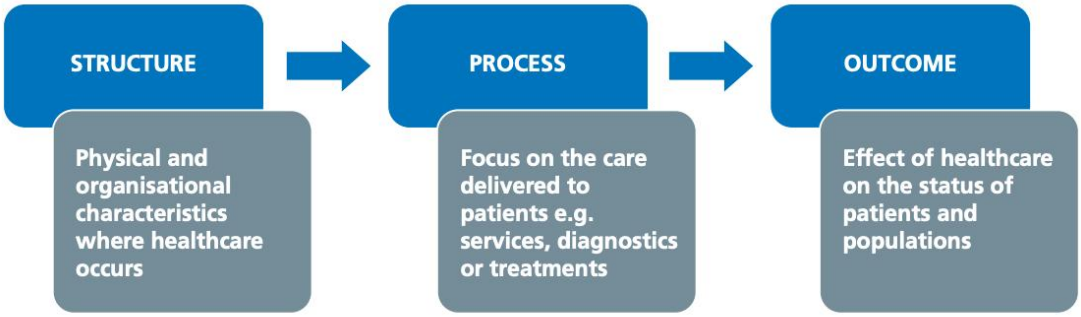

Fig 1: The Donabedian model for quality of care

Global and Local Burden of Myocardial Infarction (MI)

Significant improvements in cardiovascular care, especially in the treatment of heart failure and hypertension, are reflected in the most recent guidelines from important organizations like the American Heart Association (AHA) and the European Society of Cardiology (ESC). Both organizations prioritize evidence-based procedures while making adjustments in response to fresh research results, resulting in recommendations that are nuanced and meet the needs of a wide range of patients. To improve heart failure care, the 2022 ACC/AHA/HFSA guidelines emphasize customized therapy regimens that incorporate knowledge from current clinical trials (Alvi, 2026) . Using novel biological markers and imaging methods to better customize treatments to patient profiles is one of the main suggestions (Kim, 2026). The number of people diagnosed with hypertension increased dramatically when the 2017 ACC/AHA guidelines proposed a lower diagnostic threshold for hypertension (130/80 mmHg) (Jafari, 2026).In contrast, the 2018 ESC/ESH guidelines emphasized a more cautious approach to treatment beginning while maintaining the prior threshold of 140/90 mmHg (Bashar, 2025) (Zeniodi, 2026).The 2024 ESC guidelines support a multidisciplinary strategy that emphasizes lifestyle changes and risk factor management while offering useful suggestions for practical implementation (Ribeiro, 2026). The goal of this move toward patient-cantered care is to improve treatment coordination among medical professionals.

Research Methodology:

Research Design: The research design is qualitative phenomenological. The goal of phenomenological research, a qualitative approach, is to investigate and comprehend the core of human "lived experiences" with respect to a particular event (Chikobola, 2026). It aims to provide a comprehensive, subjective, and first-hand picture of people's reality by concentrating on how they see and understand events. This method looks for an experience's central significance.

Sampling Technique: A convenience sampling technique is used to select the sample. In qualitative research, convenience sampling is a non-probability technique that chooses participants based on their willingness to engage, ease of accessibility, and proximity (Dey, 2026). Because of its efficiency and low cost, it is perfect for pilot studies, exploratory research, and situations with limited resources. It is quick, cheap,

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and simple to use. It facilitates in-depth, rich data collection from available participants.Sample was nurses and patients families.

Data Collection Method: Semi-structured interviews were conducted to collect the data. Semi-structured interviews allowed for flexibility in responses while ensuring that the goals of the study were met.

Ethical Consideration: All the ethical guidelines were followed according to the BERA framework. The participants were asked permission prior to interview and consent forms were signed before the interviews. The participants were told that there are no anticipated risks related to this interview and their identity won't be revealed. The information will used solely for research purposes and the data will be disposed after 6 months.

Data Analysis: Data was analysed systematically and iteratively. Coding was done, which led to the generation. themes were generated. After a rigorous reading, the two major deductive themes led to sub-themes, which are as follows:

Thematic Analysis:

Barriers to Immediate Care:

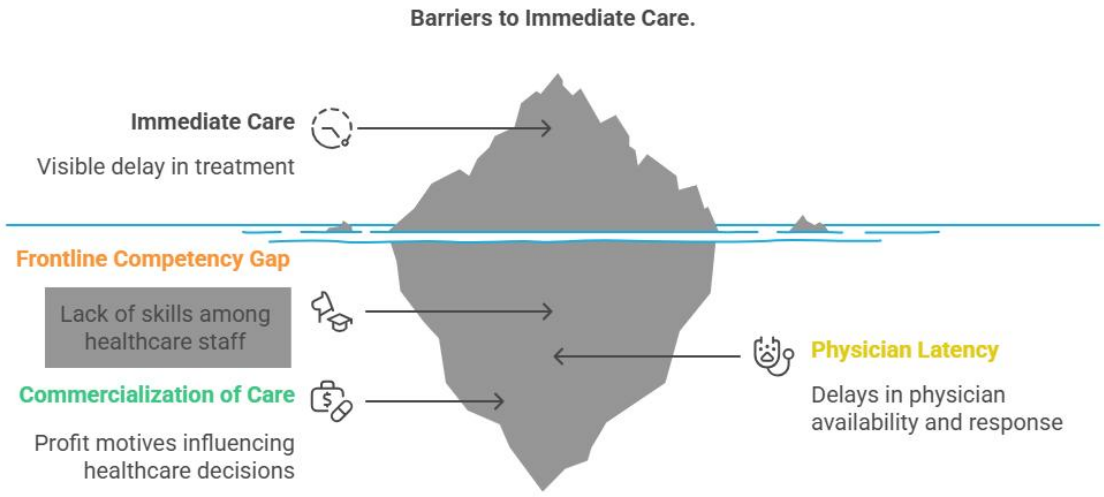

Fig 1: Barriers to Immediate Care in Myocardial Infarction

Frontline Competency Gap:

The term "frontline competency gap" in myocardial infarction (MI) describes the deficiencies in knowledge, skills, and quick decision-making abilities among medical professionals, particularly emergency nurses, paramedics, and first responders, who are in charge of the initial evaluation and treatment of patients suspected of having a heart attack (Zhan, 2025). This disparity directly contributes to care delays during the "golden hour" (the first sixty to ninety minutes), which can result in greater rates of deadly arrhythmias, significant heart damage, and increased mortality (Amuji, 2025; El-Atawi, 2025; Almutairi, 2025).

The immediate care of patients suffering from myocardial infarction (MI) is greatly impacted by the competency gap in ECG interpretation among nurses (Chen, 2026).

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Delays in diagnosis and treatment may result from this gap, which could eventually have an impact on patient outcomes (Faugno, 2025). Inadequate ECG interpretation abilities can lead to a delayed or incorrect diagnosis of MI, which is essential for prompt intervention (Varrassi, 2025) . Research shows that inadequate ECG proficiency among nurses is associated with increased fatality rates in MI patients as a result of treatment delays (Mariam, 2025). Only 26.1% of nurses say they are moderately confident in their ability to interpret ECGs (Khan, 2025). There is a strong demand for continuing education programs to improve nurses' skills, as evidenced by the numerous nurses who indicate a desire for further training (Stavropoulou, 2025). Delays in action can result in greater infarctions and worse prognoses, even though peak troponin levels may not change much (Armillotta, 2025).

P3:We are often the first to see the patient, but without formal ECG training, we are forced to wait for a doctor's review. We feel helpless as the patient is in critical condition.

As demonstrated by instances where staff misunderstand electrocardiograms (ECGs), the failure to identify ST-elevation myocardial infarction (STEMI) can result in substantial treatment delays (Vinay, B., Manohara, N., & Jain, A., 2025). This mistake is especially noticeable when it comes to ST-segment elevation in lead aVR, which is frequently disregarded, leading to longer door-to-balloon timelines and possibly worse patient outcomes (Rodríguez, 2025) .Another ECG appearance that emphasizes the possibility of mistake is the Aslanger pattern, which may show acute coronary blockage without fulfilling conventional STEMI criteria (Patel, 2025) .ST-elevation in lead aVR, which might indicate serious problems such left main coronary artery blockage, is often ignored by clinicians (Tareen, 2025) .Atypical ECG patterns are frequently overlooked in emergency medicine training, which leads to incorrect diagnoses (Kraik, 2025).

P1: I have witnessed cases where MI was delayed for around forty minutes as the staff on duty couldn't understand ST-elevation. They have ECG report in their hands, but they can't read it.

The lack of defined guidelines for ECG interpretation limits nurses' autonomy in emergency settings. Peer and workplace support are crucial for developing ECG skills, yet these systems are often lacking. Conversely, some argue that the integration of technology, such as automated ECG interpretation tools, could mitigate the effects of this competency gap, allowing nurses to focus on patient care while relying on technology for accurate readings. In order to address these issues, this viewpoint raises the possibility of a change in nursing practice and education.

Physician Latency

Physician latency, also known as "physician delay" or "referral delay" in the context of the larger pre-hospital delay, is the amount of time that passes between a patient's first medical contact (FMC), such as a visit to a clinic or general practitioner, and the referral or transport to a hospital that can provide definitive reperfusion therapy, such as PCI or thrombolytics (Xu, 2025) .This latency, which frequently results in delayed "door-to-needle" or "door-to-balloon" timings, is a crucial part of the overall, pre-hospital, and system-level delays that directly lead to increased morbidity and death (Almakaieel, 2025).

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Patient outcomes can be greatly impacted by the absence of a cardiologist in the emergency room (ER) at midnight, especially for patients who present with cardiac problems (Matter, 2025) . Patients with acute myocardial infarction who present after hours, notably at night, have longer treatment durations and greater short-term fatality rates (Gelain, 2025). Lack of access to specialized treatment makes this problem worse, increasing hospital hospitalizations and possibly worsening patient outcomes (Imeni M. N., 2025) . Patients with ST-segment elevation myocardial infarction (STEMI) who present after hours, particularly on weekends and at night, have a 6-7% higher short-term death rate (Özakın, 2025) .According to a long-term study, admissions made at night increased 30-day mortality rates by 0.6 percentage points, with weekend nights carrying the largest risk.Door-to-balloon delays are longer for patients who arrive after hours; for STEMI cases, the average wait is 14.8 minutes.Inadequate cardiology consultation can result in low- to intermediate-risk patients being mismanaged, which raises the risk of needless hospitalizations (Aggou, 2026).It has been demonstrated that implementing an off-hours cardiology consulting service greatly lowers inpatient admissions, enabling improved patient treatment in the emergency room (Chandra, 2026).According to this paradigm, the negative consequences of presentations made after hours can be lessened by prompt access to experts (Ciotlăuș, 2025).

P2: We reached at ER, but the cardiologist wasn't available .He was called and nurses on duty tried to contact him over the message but nothing worked. My patient was crying coz of pain and we had to rush to some other hospital and experienced the absence of cardio in ER there too.

Reactive healthcare systems can lead to inconsistent and delayed patient care, which can have a negative impact on patient outcomes, especially when it comes to myocardial infarction (MI) (Lessa Junior, 2025) . Due to delays in receiving timely reperfusion therapy, the absence of a proactive, well-organized system for managing ST-elevation myocardial infarction (STEMI) might increase mortality and morbidity (Organization., 2025). The main reason for this is that reactive systems typically lack the coordination and infrastructure needed to provide quick access to life-saving treatments like fibrinolytic therapy or primary percutaneous cardiac intervention (PCI) (Araiza-Garaygordobil, 2025) . Primary PCI, the recommended treatment for STEMI when administered promptly, is frequently significantly delayed by reactive systems (Mignatti, 2025). The advantages of PCI versus fibrinolytic treatment may be negated by these delays, which could result in increased death rates (Zhou, 2025).These delays may be made worse by geographical and structural obstacles in reactive systems, as patients might not be promptly referred to hospitals with PCI capabilities (Nawaz, 2025).There is a noticeable difference in the quality of care given in different areas, with better results typically being attained by facilities handling larger numbers of STEMI cases (Zeng, 2025). Reactive systems that lack coordination and defined protocols are characterized by this inconsistency.Because not all patients have equal access to high-quality emergency treatment, the lack of a coordinated, regionalized system of care can result in discrepancies in patient outcomes (Yaqoob E. K., 2025).

P5: The system is reactive, not proactive; we spend more time calling for a specialist than actually treating the patient. By the time the 'expert' arrives, the damage to the

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myocardium is often irreversible."
The limits of reactive systems can be overcome and adherence to life-saving recommendations can be enhanced by implementing regional protocols and making use of technology like telemedicine (Alotaibi, 2025) .Reactive healthcare systems provide many difficulties, but they also show how systemic adjustments could lead to improvement. Healthcare organizations can better manage acute cardiovascular events and enhance patient outcomes by switching to a more proactive, regionalized approach (Cook, 2026) . To guarantee fair and prompt access to care, this change necessitates investments in infrastructure, education, and collaboration among diverse healthcare stakeholders.

Commercialization of Care
The term "commercialization of care" describes the growing impact of market-driven tactics, investor-based ownership (such as private equity), and profit-driven motivations on the provision of heart attack therapy (Teron, 2026) . This tendency frequently entails moving away from strictly clinical, patient-centred, or public-sector care paradigms and toward an emphasis on financial efficiency, service consolidation, and revenue maximization. "Medicine has shifted from a calling to a corporation where patients are viewed as 'customers' to be billed (Tomes, 2025). The focus is no longer on the heartbeat, but on the credit limit of the person in the stretcher (Fasihi, 2025).
P7: The hospital focuses on increasing the bill of the patient rather than taking patient as a human being. Patients are just viewed as customers and they are trapped via delaying tactics.
A major, well-documented, and frequently discussed ethical dilemma in contemporary healthcare, especially in fee-for-service systems, is highlighted by the fact that some medical personnel may see cardiac emergencies through a lens of profitability rather than as a human crisis (Ungar-Sargon, 2025) .This viewpoint frequently results from a confluence of financial incentives, high technology expenses, and the commodification of treatment, according to research on ethical dilemmas in cardiac care. Financial incentives may encourage the overuse of diagnostic cardiac tests (such as angiography) and related treatments, putting patients at needless risk for bleeding and infection, according to concerns (Warren, 2025) . Sometimes, instead of concentrating on palliative or compassionate care, "slow-codes" (knowingly performing ineffectual resuscitation) or aggressive, pointless, and costly treatments are pursued in order to preserve money or prevent legal problems.

2.Strategies for Mortality Reduction

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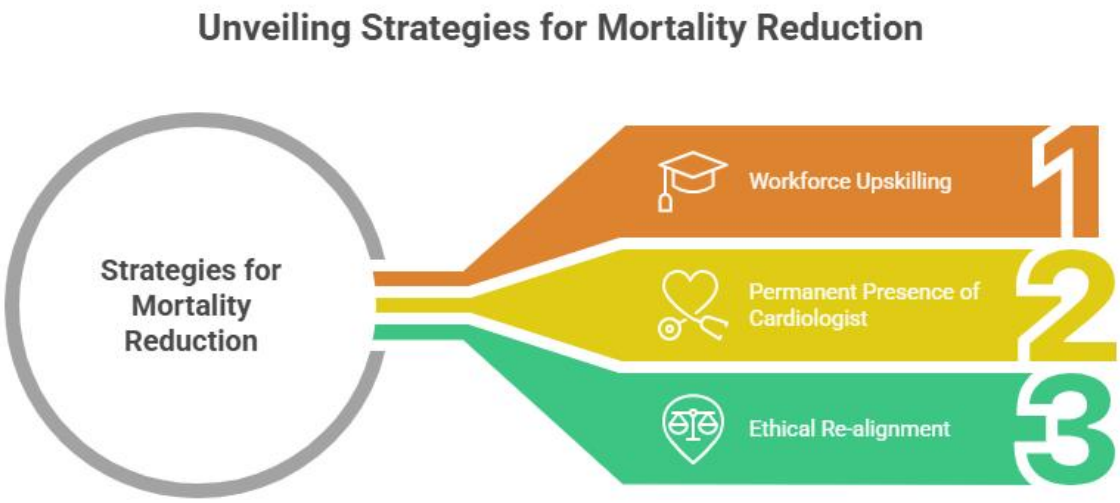

Fig 2: Strategies for Mortality Reduction

Workforce Upskilling

The process of training workers new, advanced skills or improving their current capabilities to boost productivity, satisfy changing industry expectations, and promote career advancement within their current responsibilities is known as workforce upskilling (Li, 2024). Through focused training, it serves as a "leveling up" technique to close skill gaps, raise output, and improve staff retention (Sousa, 2025).

P9: "Mandatory ACLS certification for every staff member on the floor would change everything instantly. If a nurse can diagnose and start the protocol, we save the twenty minutes usually lost to bureaucracy."

By improving survival rates and the standard of care given during cardiac emergencies, timely Advanced Cardiac Life Support (ACLS) certification has a substantial impact on patient outcomes in emergency scenarios (Peterson, 2026). ACLS certification increases the odds of patient survival and recovery by providing medical professionals with the skills they need to carry out efficient cardiopulmonary resuscitation (CPR), early defibrillation, and other vital procedures within the key time window (Thirunavukkarasu, 2026). ACLS training increased 24-hour survival rates for patients receiving CPR in the emergency room, but it had no discernible impact on survival to discharge (Okonkwo, 2026).Accredited advanced life support courses, such as ACLS, consistently improve outcomes including the recovery of spontaneous circulation and the survival to discharge of adult patients, according to systematic reviews (Okonkwo, 2026) .Timely ACLS intervention is essential for addressing respiratory arrest and heart rhythm abnormalities, which are frequent in electrical and lightning injury cases (Verma, 2026). Quick and efficient ACLS can greatly increase the likelihood of survival and avoid long-term problems. Because it offers vital interventions before to hospital admission, prompt prehospital ACLS is crucial for the best survival rates from cardiac arrest (Brown, 2026).

Participant 4: "We need to invest in 'ECG Literacy' as a basic requirement for

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employment, not an optional skill. When the frontline is empowered, the mortality rate naturally drops because the response is immediate."

Because of their vital role in providing rapid patient care, empowering nurses has a substantial impact on the death rates linked to myocardial infarction (MI) (Yilmaz, 2026). According to research, prompt nurse interventions can lower death rates by improving patient outcomes and response times (Tom, 2026).By carrying out duties like ECG monitoring and medicine administration, nurses play a crucial role in the early detection and management of MI (Chen Y. C., 2026). Nurses' participation in pre-hospital emergency care considerably reduces rescue delays and fatality rates (Roshanzadeh, 2026). A supportive work environment improves the quality of care (Cao, 2026) .Despite playing a vital role, nurses must deal with issues like heavy workloads and patient noncompliance, which can make it difficult to provide effective treatment (Yi, 2026).While empowering nurses is important, it's also critical to take into account how the larger healthcare system supports nursing practices (Rice, 2026) . Patient outcomes in MI management are also greatly impacted by variables like hospital policies, resource accessibility, and interdisciplinary teamwork (Naidoo, 2026).

Permanent Specialist Presence

Having certified emergency medicine specialists (EMS) or consultants physically present and working in the department around-the-clock, seven days a week, is referred to as having a permanent specialist presence in the Emergency Room (ER) (Saleem, 2026) .This guarantees that senior, board-certified, or residency-trained doctors may handle acute, critical, and complicated patients right away without having to be summoned from their homes or other departments.

P11 : A cardiologist presence 24/7 is pivotal for life saving of patient and to save first twenty minutes of the patient.

In emergency scenarios, the availability of on-site cardiology services has a major impact on patient treatment and mortality rates, especially for myocardial infarction (MI) and acute coronary syndrome (ACS) (Pool, 2026). Hospitals that have cardiac catheterization and surgical capabilities on-site typically offer more aggressive procedures, which may enhance short-term results (Samy, 2026) . Nonetheless, facilities with and without these treatments seem to have comparable long-term death rates. Percutaneous coronary procedures (PCI) and coronary artery bypass grafting (CABG) are more common at hospitals with on-site cardiac services (Heer, 2026) .Research shows that hospitals with and without on-site services do not significantly differ in their 1-year mortality rates (Vestergaard Jensen, 2026).

P 3: The investments should be on round -the-clock cardiac team availability then on marketing of the hospitals. Having a 24/7 availability of cardiologist is the only way to save patient and a guarantee to 30-minute door -to- balloon time.

Ethical Re-alignment

A fundamental change in structures and values is necessary to design healthcare systems that put patient survival ahead of financial considerations (George, 2026). A number of crucial tactics that prioritize systemic changes and patient-centred treatment can accomplish this (Di Giuseppe, 2026).Healthcare delivery can be aligned

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with patient outcomes rather than financial measurements by putting concepts like Porter's patient-centred model and Berwick's "Triple Aim" into practice (Farag, 2026).Patient welfare can be improved while preserving economic viability through a systematic redesign that integrates all tiers of care and encourages cooperation among stakeholders (Prete, 2026) .By ensuring that patient care takes precedence over corporate interests, a shift to a universal healthcare model can lessen the profit-driven motivations of existing systems (Brown, 2026). The financial obstacles that jeopardize patient access and safety can be lessened by enforcing price restrictions and transparency in healthcare pricing (Haendel, 2026) .Healthcare workers must advocate for moral behaviours that put patient care first, acknowledging their place in a system that frequently puts financial gain ahead of patient well-being (Wesp, 2026) .Although these tactics offer a method to create a healthcare system that is more egalitarian, there are still obstacles in the way of overcoming deeply ingrained financial interests and making sure that everyone involved is dedicated to putting patient survival first.

P12:It requires proper check and balance of all the doctors and hospital staff to ensure strict ethical alignment and transperancy

Restoring a mission-driven approach to patient care requires the implementation of stringent ethical oversight in the healthcare industry (Gile, 2026) . This entails encouraging a culture of moral behavior, incorporating moral values into clinical settings, and making sure medical personnel uphold the highest standards of professionalism (Liu, 2026) . Healthcare workers' moral anguish can be reduced by creating a culture that places a high priority on ethical issues, which will improve their job happiness and the standard of patient care (Kirby, 2026) . Employees that participate in ethical decision-making training programs are better equipped to handle challenging circumstances (Di Giuseppe, 2026) . Patient-centered care is maintained as a top priority when fundamental ethical principles—beneficence, non-maleficence, autonomy, and justice—are incorporated into day-to-day operations (Durdova, 2026) . Ethical norms in patient contacts can be reinforced by effective complaint resolution procedures that function as restorative justice mechanisms (Goldman, 2026) . Maintaining professionalism via open communication and collaboration promotes honesty and trust in patient relationships (Larasati, 2026) . Maintaining ethical standards in the face of changing healthcare challenges requires ongoing professional growth and mentoring (Elmi, 2026).

P 7: We are human beings not minting machines. Hospitals' primary goal should be patients 'survival not the bill.

In healthcare settings, being viewed as a profit-generating entity rather than a human being has significant and varied psychological repercussions (Roberts, 2026). Dehumanization, moral harm, and a loss of faith in the doctor-patient connection are all possible outcomes of this therapy paradigm (Bokek-Cohen, 2026) .Patients may lose their uniqueness and humanity since they are frequently treated like simply clients (Chanouha, 2026).

Practices that lessen empathy and encourage treatment mechanization worsen this dehumanization (Shepperson, 2026) . Patients may experience distress and feelings of worthlessness as a result of a lack of compassionate care brought on by the idea that they are sources of profit (Fedorowicz, 2026) . The tension between their

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professional ethics and the system's profit-driven goals causes moral harm to healthcare providers (Boretti, 2026). Because doctors find it difficult to balance their responsibilities as caregivers with their jobs as wage workers in a capitalist system, this conflict can result in burnout (Kim, 2026).A transactional rather than relational approach to care results from the emphasis on business undermining the trust necessary for successful doctor-patient relationships (Lee, 2026).Health disparities may worsen if patients feel alienated and are less inclined to seek critical medical care (Shane, 2026) .His viewpoint frequently ignores the negative psychological effects on patients and healthcare professionals, underscoring the need for a more compassionate approach in healthcare institutions.

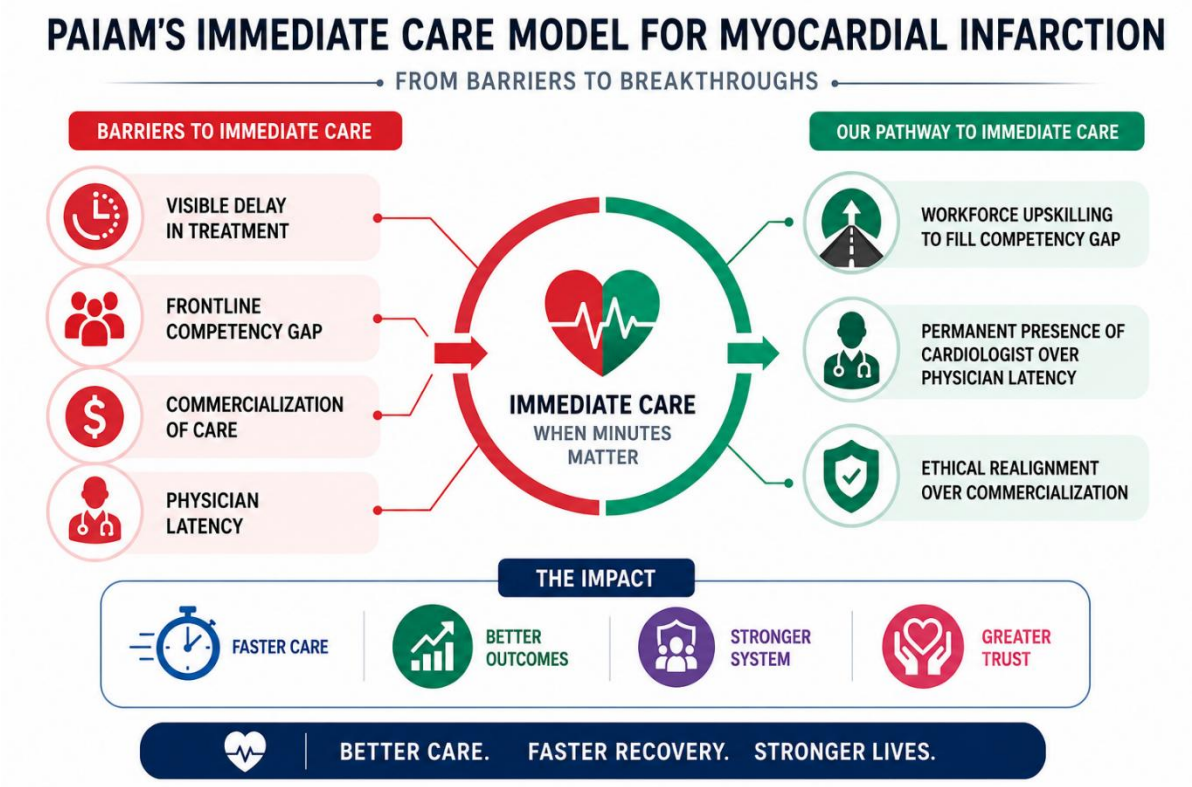

Fig 3: Paiam's Immediate Care Model for Myocardial Infarction.

Conclusion:

The study highlighted the biers that are acknowledged as important elements influencing patient outcomes based on studies on patient safety in cardiac treatment. indicates that hospital organizational priorities, nursing competency, and training have a major influence on patient safety. Many nurses are not well-versed in basic life support (BLS) and advanced cardiovascular life support (ACLS). Patient safety is directly endangered by inadequate knowledge, which raises the risk of complications, incapacity, or death. It is also found that nurses' performance is much enhanced by specialized training. It is concluded that educational programs can raise knowledge scores and raise practice levels.Hospital leadership frequently fails to prioritize cardiovascular disease preventive programs, placing more emphasis on quantity of care (numbers) than quality of care.Patient-centered care is limited by "job insecurity" for employees and an emphasis on performance monitoring based on the

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volume of activities documented in systems (such as the SIB system) rather than quality.A higher percentage of avoidable errors in cardiac care is caused by a lack of funding for appropriate staff, equipment, and training.The competence of the entire team—especially the nurses, who offer round-the-clock care—acts as the barrier to safety if they are not sufficiently trained to identify early issues, even though the presence of a doctor is crucial.

Recommendations:

1. The number of ECG machines should be increased to avoid time lapse.
2. ACLS course certification should be mandatory for nurses in critical areas.
3. Ethical guidelines regarding patient safety must be moderated.

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