



Original Article

Lived Experiences of Patients with Coronary Artery Disease: A Qualitative Study from a Cardiac Center of a Regional Hospital in Mauritius

Ananya Shukla¹, Satvik Jain¹, Nihal Mohammed¹, Tasneem Hussain¹, Indrajit Banerjee², MBBS, MD

¹Final Year MBBS Students, Sir Seewoosagur Ramgoolam Medical College, Belle Rive, Curepipe, Mauritius, ²Department of Pharmacology, Sir Seewoosagur Ramgoolam Medical College, Belle Rive, Curepipe, Mauritius.



***Corresponding author:**

Indrajit Banerjee,
Department of Pharmacology,
Sir Seewoosagur Ramgoolam
Medical College, Belle Rive,
Curepipe, Mauritius.

indrajit18@gmail.com

Received : 09 November 2021

Accepted : 02 December 2021

Published : 24 December 2021

DOI

10.25259/GJMPBU_21_2021

Quick Response Code:



ABSTRACT

Objectives: Coronary artery disease (CAD), also known as ischemic heart disease or atherosclerotic cardiovascular disease (CVD), is one of the major causes of morbidity and mortality globally and has contributed to about 80% of sudden deaths. There have been advancements in the diagnosis and treatment of CAD, some of which are still going on to improve patient care, however, there is a dearth of information regarding the various challenges the patients go through after being diagnosed with CAD and so a qualitative study was conducted on cardiac patients in Mauritius to shine a light on the various aspects of life affected by CAD. This is the first qualitative study conducted on cardiac patients in Mauritius.

Material and Methods: A phenomenological qualitative study was performed on 12 patients who were diagnosed with CAD, at the Cardiac Unit of Victoria Hospital, Mauritius. By the use of NVivo 12 (Windows) Plus software, after it was transcribed, codes/nodes and themes were generated.

Results: Twenty-five different codes were inferred from the study done and from the respective codes, eight main themes were established. The main themes drawn from the study were as follows: Emotional factors, risk factors, optimistic factors, support, awareness of your health, consequences, lifestyle modifications, and the healthcare system.

Conclusion: An event of CAD is an experience with multifaceted influences on innumerable aspects of the patient's life. The study illuminated the immense sufferings and emotional bearings of those patients who were living with heart disease. They expressed their overbearing, insecurities, and a loss of control over various aspects of their lives. This study provided various thought-provoking themes that emerged after transcribing the qualitative interviews. It also highlighted the various challenges faced by patients and how the beliefs of patients with CAD were vital to sustaining them. Family support is a vital aspect in keeping the patient both motivated to follow their treatment and emotionally grounded.

Keywords: Coronary disease, Hermeneutics, Indian Ocean Islands, Psychological phenomena, Psychosocial support systems

INTRODUCTION

Coronary artery disease (CAD), also known as ischemic heart disease or atherosclerotic cardiovascular disease (CVD), is one of the major causes of morbidity and mortality globally and has contributed to about 80% of sudden deaths. According to the WHO estimates, in 2019, a total

This is an open-access article distributed under the terms of the Creative Commons Attribution-Non Commercial-Share Alike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

©2021 Published by Scientific Scholar on behalf of Global Journal of Medical, Pharmaceutical, and Biomedical Update

of 17.9 million people died from CVD, representing about 32% of total global deaths. Heart attack and stroke epitomized 85% of these deaths. Over three-quarters of which took place in low- and middle-income countries.^[1] According to the World Health Report 2001, CVDs accounted for 9.2% of the total deaths in the African region as of 2000 compared with 8.15% in 1990. The burden of CVD is increasing rapidly in Africa, and it is now a public health problem throughout the African region.^[2]

In Mauritius, 89% of the deaths are due to non-communicable diseases and out of which 33% are being contributed by CVDs.^[3] According to the health statistics report of Island of Mauritius, 2019, a total of 3451 patients were treated in the cardiac center out of which 1014, that is, 29.4% were of chronic heart disease. In the past 10 years, an increasing trend has been observed in mortality rates from 595 per 100,000 population in 2019 compared to 474 in 2010.^[4]

One of the reasons for increased CVDs worldwide is the increase in aged populations, coupled with the risk factors such as for overweight, physical inactivity, unhealthy eating, and smoking tobacco. The prevalence of which varies differently among different countries. Hypertension is the main physiological risk factor for CVD.^[5,6] It is estimated that more than 20 million people are affected in the African region, mainly in urban areas. Prevalence ranges from 25% to 35% in adults aged 25–64 years. Some studies have revealed a clear relationship between the level of blood pressure, salt and fat consumption, body weight, and CVDs. Studies in Ghana, Mauritius, South Africa, and Zimbabwe show an increase in stroke mortality that could be related to increasing levels of hypertension, obesity, tobacco use, and diabetes.^[2] Exposure to various modifiable risk factors is responsible for at least 75% of all the CVD. As a result, most countries do not have national programs or strategies to address CVDs.^[1] A positive family history increases the risk of early diagnosis.^[6]

From a gender perspective, CVD is the major cause of death in women globally and the risk is often underestimated due to the misperception that females are protected against CVD as it is assumed that exposure to endogenous estrogens during the fertile period of life delays the manifestation of atherosclerotic disease in women. The low recognition of heart disease and differences in clinical presentation in women has led to less aggressive treatment strategies and a lower representation of women in clinical trials.^[7]

There have been advancements in the diagnosis and treatment of CAD and are still going on to improve patient care, however, there is a dearth of information regarding the various challenges the patients goes through after being diagnosed with CAD and thus a qualitative study was conducted on cardiac patients in Mauritius to shine a light on the various aspects of life affected by CAD. This is the first qualitative study conducted on cardiac patients in Mauritius.

MATERIAL AND METHODS

Study design and participants

A phenomenological qualitative study was performed on 12 patients who were diagnosed with CAD, at the Cardiac Unit of Victoria Hospital, Mauritius. There are a total of five public and three private hospitals with a cardiac unit in the country of Mauritius.^[8,9] Victoria Hospital was chosen for the study as it is one of the largest and oldest centers providing cardiac care in the country and is the primary public hospital for region 5 of Mauritius.^[10] Victoria Hospital receives patients from 30% of the country, and it is providing healthcare facilities to the patients from the district of Plaine-Wilhems and Black River district. It covers the towns, namely, Rose Hill, Quatre Bornes, Vacoas, Phoenix, and Curepipe, and the villages of Dubreuil, Flic en Flacq, Tamarin, Case Noyale, La Gaulette, Le Morne, and Chamarel. That is why it was selected as a place of study for this research.^[9] Data were collected and recorded by the means of a thorough in-depth interview. The participants were selected based on a random sampling technique and verbal consent was obtained from each of the patients.

Data collection

The data were obtained by conducting thorough, bedside interviews of the participants in the cardiac unit. The study was conducted from September 1, 2019, to September 15, 2019. The interview particularly aimed at having a brief look into the mind of a person suffering from CAD and understanding the impact and consequences of it at an emotional level. The participants were explained as to how these interviews would be conducted and used and were given assurance of utmost confidentiality and anonymity. The interview was recorded at each patient's bedside using digital audio recorders and mobile phones. It was broadly based on, but not limited to a questionnaire. The recordings were then transcribed using NVivo 12 (Windows) Plus software and also by manual means, to the letter. All the authors cross-checked the recorded interviews with the transcripts to ensure the utmost precision of the text.

Questionnaire design and validation

A semi-structured open-ended questionnaire was designed to conduct the interviews. The questionnaire was validated by five subject experts. The content and construct validities were ascertained by five subject experts.

Face validity

A pilot study was conducted on four patients with CAD. The questionnaire was modified based on the results of the pilot study.^[11]

Inclusion criteria

The authors intended to minimize any bias in terms of participants and hence both males and females who were more than 45 years old and suffering from obstructive, non-obstructive, or microvascular CAD were included in the study.

Exclusion criteria

Patients who were unwilling to give informed and verbal consent were excluded along with those reluctant to participate. Patients having debilitating illnesses were also excluded on moral grounds.

Sample size calculation

The study was conducted on a total of 12 patients while keeping in mind the immensely important question, "What is Qualitative in Qualitative Research?"^[12] Data were collected according to the guidelines of Glaser *et al.* and the interviews were conducted until data saturation was achieved and no new codes could be generated from interviews.^[13-15]

Outcome variable

Sentimental, lived experiences of patients with CAD were the outcome variable.

Explanatory variable

The diagnosis of the patients, age, gender, and address was the explanatory variables.

Ethical approval

The research was conducted after a thorough reading and understanding of the Declaration of Helsinki, 64th World Medical Association, General Assembly, Fortaleza, Brazil, October 2013, Helsinki – Ethical Principles for Medical Research involving Human Subjects guidelines.^[16]

Data management and statistical analysis

The interviews were recorded for 4 days after which the authors transcribed the data verbatim by manual means as well as using speech to text translation applications. Transcribed scripts were then scrutinized by the authors again to maintain accuracy. Scripts were then equally divided among the authors who generated codes/nodes by manual analysis as well as using NVivo 12 (Windows) Plus software. These codes/nodes were then merged and complied with after several meetings and deliberation among the authors to determine the best ones and to identify and eliminate the repetitive codes/nodes. The remaining codes/nodes were then merged to form a codebook to derive themes.

Generation of themes and data analysis was done after a thorough understanding of thematic analysis.

RESULTS

Out of the total 12 patients (P1-P12), the male: female ratio is 1:1, with these patients of a wide range of age groups, from the early 40s to late 70s, with different diagnoses such as acute MI, arterial blockages, and different types of angina pectoris [Table 1]. Table 2 depicts twenty-five different codes/nodes which were generated from the study [Table 2].

Codes/Nodes

Pain (P4)

"I felt immense pain at the area where my heart is, which made me rush to the hospital"

The pain was described by the data as a sharp dull pain, which became a negative code.

Comorbidity (P2)

"I have diabetes and now a cardiac problem as well"

Comorbidity was described by the data as: I have other illnesses as well and now this. The participant was speaking about how this is now another added burden to him. This code later on allowed for the development of risk factors as a theme.

Multiple problems (P2)

"My heart is a little good but now my problem is my feet"

This code was described by the data as saying she was having problems with her foot as well. This code in particular was overlapping and synonymously associated with the previous code.

Positive mindset (P6)

"I am alone like this but I tried to think I don't have a cardiac problem"

A positive mindset was described by the data as saying it would help tackle the illness. This code allowed for the establishment of the theme of optimistic factors, on the positive side of the end.

Friends (P1)

"Yes, I got some friends fortunately helping me to tackle this illness."

This code was described as: Having friends can be helpful in more than 1 way, having as a source of support and comfort.

Normal (P2)

“I want to be normal, no I don’t want to live like this”

Normalcy was described as saying: the patient just wants to live a normal life and do the things of everyday life on his own. She had lost her power to do routine things of everyday life and lost control over various aspects of her life, which she wanted to revert to normal if she had the option to do so.

Compliance (P8)

“I take my medicine and concentrate on my medicine.”

Compliant was described as saying the patient takes their medicine and treatment and is not scared of this illness anymore.

Sad (P12)

“Yes, I feel a little sad.”

This code was described as Yes, everyone feels sad from time to time; at the back of their minds. After much contemplation and deliberation, the patient answered this question with slight hesitation.

Enjoyment (P4)

“Every Monday, Wednesday, Friday I go to my club and then I feel good”

Enjoyment was described as saying: A little bit of recreation and fun activities help alleviate the mood. The patient puts in a conscious effort to care for his mental well-being in the midst of all this.

Happy (P4)

“I take care of myself like everybody else, I am happy”

Happiness was described as saying: Many patients try and keep a positive outlook and are happy and it should be our responsibility regarding it.

Physical limitations (P7)

“Before I climbed mountains but now I cannot.”

This code was described by saying: Inability to perform normal physical activity. The after-effects of getting to know about your diagnosis took a major toll on people’s minds and bodies.

Fear (P3)

“I take care I don’t want to die.”

This was described by saying: Everyone is afraid of dying and losing their life. So anybody would be apprehensive of losing their life.

Yoga (P7)

“I want to do yoga but I don’t have time if I get time, I will do it”

This code was described by saying: The patient is looking to improve and adopt changes that will help with the condition.

Spiritual (P10)

“No meditation, I go to church, I pray”

Most people tend to become more spiritual in adverse or morbid conditions.

Faith in doctors (P5)

“Yes, everybody here is a good doctor there is no problem.”

The patients need to have faith in their doctors which helps them in following the treatment properly.

Family support (P6)

“My family, my brother, my mother, and all gave me courage.”

Table 1: Demographic details of patients.

S. No.	Gender	Age	Address	Diagnosis
P1.	Female	46	Rose Hill, Mauritius	Acute myocardial ischemia left anterior descending artery block
P2.	Male	77	Unknown, Mauritius	Acute myocardial ischemia left anterior descending artery block
P3.	Female	59	Port Louis, Mauritius	Unstable angina, triple vessel blockage
P4.	Male	62	Port Louis, Mauritius	Classical angina
P5.	Male	65	Port Louis, Mauritius	Acute myocardial ischemia left anterior descending artery block
P6.	Female	48	Quatre Borne, Mauritius	Unstable angina
P7.	Female	58	Quatre Borne, Mauritius	Classical angina
P8.	Male	67	Candos, Mauritius	Acute myocardial ischemia left anterior descending artery and circumflex artery block
P9.	Female	76	Rose Hill, Mauritius	Unstable angina
P10.	Male	67	Quatre Borne, Mauritius	Acute myocardial ischemia left anterior descending artery block
P11.	Female	59	Port Louis, Mauritius	Unstable angina, triple vessel blockage
P12.	Male	55	Rose Hill, Mauritius	Acute myocardial ischemia left anterior descending artery block

This code was described by saying: Family provides huge moral support, being a huge relief in terms of support and comfort that too at times like these would be helpful beyond measure.

Health improvement (P3)

“I was not able to go for long walks but after one year of operation I was ok.”

This was described by saying: The patient experienced an improvement in stamina after surgery. This take was rather unique and different amid negative comments during a time like this.

Stress (P1)

“I am married I have 2 children now; I am stressed a lot.”

Table 2: Codebook framework.

Codes/nodes	Description	Narrative
Pain	Pain at the pectoral region led the patient to come to the hospital	“I feel pain in my body where my heart is.” (P4)
Comorbidity	The patient has other illnesses	“I have diabetes and now a cardiac problem.” (P2)
Multiple problems	The person is having problems with his foot also	“My heart is a little good but now my problem is my feet.” (P2)
Positive mindset	A positive mindset is often helpful in tackling the illness	“I am alone like this but I tried to think I don’t have cardiac problem.” (P6)
Friends	Having friends can be helpful in more than 1 way	“Yes, I got some friends.” (P1)
Normal	Many patients just want to live a normal life and do normal things without being limited by this condition	“I want to be normal, no I don’t want to live like this” (P2)
Compliance	The patient is focused on the treatment and not afraid of the illness anymore	“I take my medicine and concentrate on my medicine.” (P8)
Sad	Everyone tends to feel sad at the back of their minds	“Yes, I feel a little sad.” (P 12)
Enjoyment	A little bit of recreation and fun activities help alleviate the mood	“Every Monday, Wednesday, Friday I go to my club and then I feel good” (P4)
Happy	Many patients try and keep a positive outlook and are happy	“I take care of myself like everybody else, I am happy” (P4)
Physical limitations	Inability to perform normal physical activity	“Before I climbed mountains but now I cannot.” (P7)
Fear	Everyone is afraid of dying and losing their life	“I take care I don’t want to die.” (P3)
Yoga	The patient is looking to improve and adopt changes that will help with the condition	“I want to do yoga but I don’t have time if I get time, I will do it” (P7)
Spiritual	Most people tend to become more spiritual in adverse or morbid conditions	“No meditation, I go to church, I pray” (P10)
Faith in doctors	The patients need to have faith in their doctors which helps them in following the treatment properly	“Yes, everybody here is a good doctor there is no problem.” (P5)
Family support	Family provides a huge moral support	“My family, my brother, my mother and all gave me courage.” (P 6)
Health improvement	The patient experienced an improvement in stamina after surgery	“I was not able to go for long walks but after one year of operation I was ok.” (P3)
Stress	The burden of responsibilities and the fear of losing your life makes a person very stressed	“I am married I have 2 children now; I am stressed a lot.” (P1)
God	The creator of everything.	“I have faith in God.” (P 9)
Expensive health care	The private sector health care is very expensive	“We are middle-class people we can’t afford to go to clinics, in Mauritius, the clinics are very expensive.” (P3)
Change in routine	The doctor’s advice is to make changes in daily lifestyle to help and ameliorate the symptoms	“He advised me to take precautions and medications were given and not to eat much and I had to do exercise like not too hard but like 20 min a day.” (P 7)
Acceptance	The patient has accepted the condition	“I have to live with this.” (P 6)
Panic	People generally tend to panic when they get to know about a chronic, possibly fatal illness	“I felt panicked” (P 11)
Work pressure	After having such a debilitating condition, it is difficult to manage work	“There was work pressure.” (P1)
Dietary changes	Some patients switch to a healthy diet after finding out about the condition	“I don’t eat junk suppose there is a fruit I eat I will have that but I don’t eat junk food I don’t even drink Coke or Pepsi.” (P 8)

Table 3: Different themes were laid out during the thematic analysis.

Emotional factors	Pain Sad Fear Stress Worrying Panic
Risk factors	Comorbidity Multiple problems Work pressure
Optimistic factors	Positive mindset Normal Enjoyment Happy Spiritual Health improvement
Support	Acceptance Friends Family support God
Awareness of your health	Compliance Follow-up Precaution
After effects/consequences	Physical limitations Teetotaler/non-smoker Spiritual Financial crisis
Lifestyle modifications	Yoga Change in routine Self-control Exercise Dietary changes
Health-care system	Faith in doctors Expensive health care

This was described by saying: The burden of responsibilities and the fear of losing your life make a person very stressed. Making it an added weightage on the shoulders, being a liability was tough to be dealt with for the patient.

God (P9)

“I have faith in God.”

This was described as The creator of everything, a positive take on the whole scenario as such rather than a negative approach to the whole situation.

Expensive health care (P3)

“We are middle-class people we can't afford to go to clinics, in Mauritius, the clinics are very expensive.”

This was described by saying: The private sector health care is very expensive. After learning about the diagnosis, patients tend to be more focused and careful about spending their resources.

Change in routine (P7)

“He advised me to take precautions and medications were given and not to eat much and I had to do exercise like not too hard but like 20 min a day.”

This code was described as Doctor's advice to make changes in daily lifestyle to help and ameliorate the symptoms.

Acceptance (P6)

“I have to live with this.”

Acceptance was described as by saying: The patient has accepted the condition, living with the results, accepting the nature and reality of the situation.

Panic (P11)

“I felt panicked”

This code was described as saying: People generally tend to panic when they get to know about a chronic, possibly fatal illness.

Work pressure (P1)

“There was work pressure.”

This code was described by saying: After having such a debilitating condition, it is difficult to manage work. Repercussions of finding out about this disease affect them on the work front as well.

Dietary changes (P8)

“I don't eat junk suppose there is a fruit I eat I will have that but I don't eat junk food I don't even drink Coke or Pepsi.”

This code was elaborated by saying: Some patients switch to a healthy diet after finding out about the condition. Following the revelation of the diagnosis, patients make a conscious decision to switch from their existing diet to a more balanced and maintained diet.

Themes

From the different codes eight main themes were established as shown in Table 3. The main themes drawn from the study were: Emotional factors, risk factors, optimistic factors, support, awareness of your health, consequences, lifestyle modifications, and the healthcare system. The main codes were drawn from the interviews.

Theme 1: Emotional factors

The codes that were generated were of different ends of the spectrum of human feelings pain, sadness, fear, stress,

worrying, and panic lead to the development of this theme. These are human emotions leading to the feelings and state of mind that affect us both mentally and physically.

Theme 2: Risk factors

The codes that were generated were of comorbidity, work pressure, and multiple problems. These factors should be identified and must be properly avoided so that later in it may not provide to be a problem in the future.

Theme 3: Optimistic factors

The codes that were generated were of a positive mindset, normal enjoyment, happiness, spirituality, health improvement, and acceptance. These factors provide much-needed relief during times like these, which itself also is of pivotal importance.

Theme 4: Support

The codes that were generated were of friends, family, and God. Certainly, during times like these to have something and help to receive like comfort is to be cherished.

Theme 5: Awareness of your health

The codes that were generated were compliance, follow-up, teetotaler/non-smoker, precaution. The theme awareness of the disease means what the patient's attitude toward the disease is, his knowledge toward the disease, and how the patient has gone through a tremendous change during these difficult times as a direct result of the disease. Knowledge about the disease such as its causes, prevention, or any information about the disease together generated the theme of awareness. Awareness is very important as it helps in coping with the situation and it brings about awareness for future cases.

Theme 6: Consequences

The codes that were generated were of physical limitations, spiritual, and financial crisis. Regret is something no man should experience and should make the most out of life that is given to him. Repercussions can be of a positive impact as well as be leading a better life ahead.

Theme 7: Lifestyle modifications

The codes that were generated were of yoga, change in routine, self-control, exercise, and dietary changes. This theme refers to the alterations implemented in their daily life schedule to bring about a change in their life following the aftermath of knowing about this diagnosis.

Theme 8: Healthcare system

The codes that were generated were of faith in doctors and expensive healthcare. Good care embodies great physicians, as well as the interpersonal skills and communication the staff and doctors have and develop with the patients both during the course and after the diagnosis, is learned.

DISCUSSION

In the preceding study, following the thematic analysis, a total of eight themes were devised. Each theme focused on the various stages that a patient goes through after being diagnosed with CAD, how they have dealt with them, as well as what changes they have brought in their lives.

CAD, being a chronic condition, serves as a basis for deeply analyzing and comprehending the disease's long-term consequences, as it enables us to understand what challenges the patient faces and how we can improve patient care more effectively. Patients have displayed a wide range of emotions. Fear and worry were among the most common reactions following the first session.^[17] According to Lukkarinen and Kyngäs, fear is related to their recovery status, recurrences of the episode, as well as about bringing changes in daily life routine.^[17]

A wide range of risk factors has been identified and classified as non-modifiable and modifiable. Modifiable factors include age, gender, and family history, while non-modifiable factors include diabetes, smoking, dyslipidemia, hypertension, and obesity.^[18] Workplace stress has arisen as a substantial risk factor, alongside other risk factors such as hypertension, poor diet, and so on, as a result of the fast-paced lifestyle of the 21st century.^[19] These are not the only risk factors; comorbidities such as obesity, chronic renal disease, and heart failure are also present.^[18] Emotional changes, such as stress, have also been linked to the development of CAD,^[20] and not paying attention to early symptoms and recurrence of the condition after doing intense workouts are risk factors.^[19]

Patients strive to maintain a positive attitude about their health even after the occurrence of CAD. As one of the patients stated, "I am alone like this but I tried to think I don't have cardiac problem" and make an effort to be happy "I take care of myself like everybody else, I am happy." Some have even come to terms with their condition, saying, "I have to live with this."

As CAD is a stressful disease, patients have received a lot of emotional and physical support from their family members and friends, which include monitoring the patient's conditions, providing care, and sharing their emotional reactions, as one patient stated, "My family, my brother, my mother, and all gave me courage."

However, in some cases, the patient's relationship with friends may change, affecting social support as contacts outside the

family decrease.^[20] It has also been observed that patients have become much more spiritual, and their devotion to God has grown, as one patient stated, “I used to pray to God daily, but these days I pray more.” According to Momennasab *et al.*, the patients had felt a deep connection with God since their first episode and this belief made them calm and filled with hope.^[21]

It has also been observed that after the development of CAD, patients paid much more attention to their lifestyle by incorporating exercises such as yoga, walking, changing their dietary habits such as avoiding fatty foods, eating more vegetables, stress management helped to lower stress levels with, and adhering to their medications with the inclusion of regular follow-ups.^[19]

In terms of lifestyle changes, one patient stated, “He advised me to take precautions and medications were given and not to eat much and I had to do exercise like not too hard but like 20 minutes a day,” and another stated, “I don’t eat oily food, I eat only vegetables.”

CAD has an impact on the various aspects of individual lives. Patients have reported limitations in physical activity which led to failure to live a normal life, as stated by a patient “Before I climbed mountains but now I cannot.” The other aspect is in terms of finance. Since the treatment of CAD is extensive and costly thus is not easily affordable to patients from low or middle socioeconomic status. It was expressed by a patient, who stated that “We are middle class people we can’t afford to go to clinics, in Mauritius the clinics are very expensive.”^[20]

Patients felt that having a healthcare care provider in such situations was comforting and felt relieved and considered them as their rescuers and considered as their close relatives.^[21] However, the downfall of the healthcare system is that the treatment of CAD leaves the patient in financial crisis and some of them even cannot afford it, one of the participants stated that the treatment is costly in a private hospital, but it is good that treatment in government hospitals is free Mauritius.

CONCLUSION

An event of CAD is an experience with multifaceted influences on innumerable aspects of the patient’s life. The study illuminated the immense sufferings and emotional bearings of those patients who were living with heart disease. They expressed their overbearing, insecurities, and a loss of control over various aspects of their lives. This study provided various thought-provoking themes that emerged after transcribing the qualitative interviews. It also highlighted the various challenges faced by patients and how the beliefs of patients with CAD were vital to sustaining them. Family support is a vital aspect in keeping the patient both motivated to follow their treatment and emotionally grounded.

Acknowledgment

We extend our appreciation to Prof. Dr. Namrata Chhabra (principal In-charge, Sir Seewoosagur Ramgoolam Medical College, Belle Rive, Mauritius) for guidance, help and support to conduct the study and Mr Jared Robinson, Final Year Medical Student, Sir Seewoosagur Ramgoolam Medical College, Belle Rive, Mauritius for extensive assistance in language and grammar editing of the manuscript.

Authors contribution

All the authors have contributed equally in this Research.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. World Health Organization. Cardiovascular Diseases (CVDs). Geneva: World Health Organization; 2021. Available from: [https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-\(cvds\)](https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)) [Last accessed on 2021 Nov 09].
2. Regional Committee for Africa, 55. Cardiovascular Diseases in the African Region: Current Situation and Perspectives: Report of the Regional Director; 2011. Available from: <https://apps.who.int/iris/handle/10665/1871> [Last accessed on 2021 Nov 09].
3. Mauritius. Risk of Premature Death Due to NCDS (%). Available from: https://www.who.int/nmh/countries/mus_en.pdf?ua=1 [Last accessed on 2021 Nov 05].
4. Health Statistics Report 2019. Ministry of Health and Wellness. Available from: <https://health.govmu.org/Documents/Statistics/Health/Mauritius/Documents/HEALTH%20STATISTICS%20REPORT%202019.pdf> [Last accessed on 2021 Nov 09].
5. Moran AE, Forouzanfar MH, Roth GA, Mensah GA, Ezzati M, Flaxman A, *et al.* The global burden of ischemic heart disease in 1990 and 2010: The Global Burden of Disease 2010 study. *Circulation* 2014;129:1493-501.
6. Khan MA, Hashim MJ, Mustafa H, Baniyas MY, Al Suwaidi SK, AlKatheeri R, *et al.* Global epidemiology of ischemic heart disease: Results from the global burden of disease study. *Cureus* 2020;12:e9349.
7. Maas AH, Appelman YE. Gender differences in coronary heart disease. *Neth Heart J* 2010;18:598-602.
8. The Hospitals Republic of Mauritius. Available from: <https://govmu.org/EN/infoservices/healthandmedicalservices/Pages/>

- hospitals.aspx [Last accessed on 2021 Nov 09].
9. Cardiology and Cardiothoracic Surgery. Available from: <https://www.wellkinhospital.com/medical-specialities/cardiology-cardiothoracic-surgery> [Last accessed on 2021 Nov 09].
 10. Victoria Hospital and Princess Margareth Orthopaedic Centre Candos. Available from: <https://health.govmu.org/Pages/Services/Hospitals/Victoria.aspx> [Last accessed on 2021 Nov 09].
 11. Banerjee I, Robinson J, Mohabeer P, Kashyap A, Shukla A, Sathian B. COVID-19: Lockdown and its impact on medical students: A cross-sectional study from a medical school in Mauritius. *Nepal J Epidemiol* 2021;11:1006-22.
 12. Aspers P, Corte U. What is qualitative in qualitative research. *Qual Sociol* 2019;42:139-60.
 13. Glaser BG, Strauss AL. *Discovery of Grounded Theory: Strategies for Qualitative Research*. Milton Park, Abingdon-on-Thames: Routledge Publishers; 2017.
 14. Kashyap A, Banerjee I, Thakur A, Notwani V, Raghuvanshi M. Experiences of cancer patients on their visit to cancer outpatient department: A qualitative study from a regional hospital in Mauritius. *J Clin Diagn Res* 2020;14:XC01-5.
 15. Vasileiou K, Barnett J, Thorpe S, Young T. Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over 15 years. *BMC Med Res Methodol* 2018;18:148.
 16. WMA Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects. 64th WMA General Assembly, Fortaleza, Brazil, October 2013. Available from: <https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects> [Last accessed on 2021 Nov 09].
 17. Lukkarinen H, Kyngäs H. Experiences of the onset of coronary artery disease in a spouse. *Eur J Cardiovasc Nurs* 2003;2:189-94.
 18. Sekhri T, Kanwar RS, Wilfred R, Chugh P, Chhillar M, Aggarwal R, *et al.* Prevalence of risk factors for coronary artery disease in an urban Indian population. *BMJ Open* 2014;4:e005346.
 19. Mojalli M, Karimi Moonaghi H, Khosravan S, Mohammadpure A. Dealing with coronary artery disease in early encountering: A qualitative study. *Int Cardiovasc Res J* 2014;8:166-70.
 20. Januzzi JL Jr., Stern TA, Pasternak RC, DeSanctis RW. The influence of anxiety and depression on outcomes of patients with coronary artery disease. *Arch Intern Med* 2000;160:1913-2.
 21. Momennasab M, Moattari M, Abbaszade A, Shamshiri B. Spirituality in survivors of myocardial infarction. *Iran J Nurs Midwifery Res* 2012;17:343-51.

How to cite this article: Shukla A, Jain S, Mohammed N, Hussain T, Banerjee I. Lived experiences of patients with coronary artery disease: A qualitative study from a cardiac center of a regional hospital in Mauritius. *Glob J Med Pharm Biomed Update* 2021;16:11.