Background In Kuwait, coronary artery disease (CAD) has a mortality rate of 30% (World Life Expectancy, 2020). In Kuwait, weather, food, cultural and social norms can act as influencing factors in developing CAD.

Methods A one-to-one semi-structured interviews were used to explore in depth the perception of CAD patients regarding their disease, and their experience in cardiac rehabilitation programme (CR). It also aims to investigate the role of culture in improving quality of life (QoL) and to investigate the facilitators and barriers that may affect improvement in QoL.

Results Twenty participants were interviewed; ten from each of the two study groups. Thematic analysis produced six main themes with their associated subthemes: conception of life before and after the cardiac event (sub-themes; ‘I was free’, life before CAD, and Impact of CAD); lifestyle modification (sub-themes; the aftermath of CAD, activity level, physical activity, habit change, the influence of others, and living in Kuwait); visiting the cardiologist (standard medical care); experiences of attending CR programme (sub-themes; benefits of the CR programme, facilitators to the adhering to the CR programme, and understanding limits); barriers to lifestyle modification (sub-themes; lack of social support, work commitment, cultural barriers, lack of self-efficacy, and anxiety and fear of reoccurrence); and future health (sub-themes; no concern, supporting self, need for more knowledge, and losing weight).

Conclusion Appropriate information regarding exercise can increase awareness of the importance of behavioural change and being physically active, leading to improvement in QoL. In addition, some cultural, social, and religious factors may act as barriers against wider use of CR. These findings show that more innovative, individualistic and culturally sensitive strategies are needed in Kuwait.

Background Cardiac events can be serious and life-changing. Whilst the physical or bodily (corporeal) effects of a cardiac event are well-researched, little research investigates psychosocial impacts, especially when the two recovery trajectories differ.

Methods Ethnographic research, undertaken with people having experienced a cardiac event and their significant others (n=17), explored the cardiac patient journey through participant observation, repeated semi-structured interviews, and reflexive journaling. Bourdieu’s sociological theoretical framework provided a powerful lens through which to analyse data. Written informed consent was obtained from all research participants and from non-participants present during observations. Ethical approval was obtained from NHS Research Ethics Committee and Health Research Authority (Ref: 19/YH/0183).

Results Whilst the NHS cardiac rehabilitation model includes exercise and psychosocial support, these sub-fields of health care are often only accessed by those whose habits (dispositions, attitudes, values that shape perceptions and actions) and capital (different resources) support their participation. This is made more difficult by the habitus-shaking effect of ill-health; thus, recovery journeys can be highly complex. Notably, prevailing societal discourses post age- ing as decline, making serious ill-health particularly psychosocially difficult to reconcile.

Conclusion Physical and psychosocial recovery support are already core components of cardiac rehabilitation. However, it is important to acknowledge the complexity of support. This requires health professionals to discuss with patients personalised, socio-culturally informed, flexible approaches to exploring a multitude of interventions and agreeing care plans.