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Access to new forms of public healthcare services: patient experiences from interpreter-mediated cardiac rehabilitation / Acceso a nuevos tipos de servicios públicos sanitarios: experiencias de pacientes de rehabilitación cardíaca mediada por intérpretes

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Abstract: 'Access to healthcare' is a complex concept involving dimensions such as service availability, degree of fit between services and service users, outcomes, and equity. Increased linguistic diversity poses challenges for conventional healthcare as well as for new forms of services, such as patients' Learning and Mastery Services (LMS). According to Norwegian legislation, all patients should have access to the services they need. In practice, the majority of LMS are offered only in Norwegian and are therefore not available for patients with limited proficiency in Norwegian unless interpreting is provided. There are exceptions such as the LMS course "Cardiac Rehabilitation Class–with Interpreting" (CRC-I), which is offered to multilingual groups of patients with serious heart disorders. In this context, this article discusses patient perspectives on interpreter-mediated communication in CRC-I and their experience considering different dimensions of access based on data from a qualitative study with fieldwork with participant observation and in-depth interviews with participants.

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Keywords: Access to healthcare; Cardiac rehabilitation; Patient perspectives; Interpreting in groups

Resumen: El concepto de “acceso a los servicios sanitarios” es complejo, y abarca aspectos como disponibilidad del servicio, idoneidad, resultados, y equidad. El aumento en la diversidad lingüística supone un reto tanto para los servicios de salud convencionales como para los de nueva creación, como pueden ser los servicios de formación del paciente (en inglés, Learning and Mastery Services o LMS). La legislación noruega establece que todos los pacientes tienen derecho a acceder a los servicios que necesiten. En la práctica, la mayoría de los LMS se ofrecen únicamente en noruego, de modo que quedan fuera del alcance de pacientes con un dominio limitado del noruego, a menos que haya interpretación. Existen, no obstante, excepciones. Una de ellas es el curso de formación del paciente “Rehabilitación Cardíaca con Interpretación” (CRC-I), que se ofrece a grupos multilingües de pacientes con anomalías cardíacas graves. En este contexto, este artículo analiza las percepciones de los pacientes sobre la comunicación mediada por intérpretes en el curso CRC-I y sus experiencias teniendo en cuenta distintas dimensiones de acceso basándose en los datos obtenidos en un estudio cualitativo con trabajo de campo en forma de observación de los participantes y entrevistas en profundidad con los mismos.

Palabras clave: Acceso a servicios públicos sanitarios; Rehabilitación cardíaca; Perspectiva de los pacientes; Interpretación en grupos

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1. Introduction

Providing access to public healthcare services is challenged by increased linguistic diversity in communities, as this often results in language barriers in encounters between service providers and users (Gil-Salmerón et al., 2021). This is the case of conventional healthcare as well as of new forms of services, such as those in focus in the present article: learning and mastery services (LMS). The goal of LMS is patient education that helps "facilitate self-reliance for people who have long-term health challenges, as well as that of their next of kin. The aim is to strengthen their mastering and to increase their quality of life" (Learning and Mastery Centers in Healthcare Institutions – below referred to as NK-LMH, 2018). In fact, for persons with long-term health challenges, "challenges linked to chronic disease, prolonged physical or psychological stress or disability" (NK-LMH, 2018), conventional healthcare services are often insufficient. Therefore, patient education on coping with health challenges in everyday life is needed.

Patient education has been a mandatory task for medical hospitals in Norway since 2001 (Specialist Health Services Act, 2001), and under Norwegian legislation, access to such services should be provided to all patients in need of them (Patients' and Users' Rights Act, 1999). Therefore, currently, LMS are organized in many different healthcare settings (NK-LMH, 2023). However, as most of these LMS courses are conducted in Norwegian, in practice, such services are not available for persons with limited proficiency in Norwegian (LPN). On the other hand, there also are some exceptions such as the LMS course "Cardiac Rehabilitation Class–with Interpreting" (CRC-I) (Hjerteskolen med tolk – lit. translation "Heart School with Interpreting"), which provides interpreter-mediated services to multilingual groups of cardiac patients.

The main purpose of our study is to examine patients' perspectives on this interpreter-mediated LMS course and their experiences in the light of a nuanced understanding of access, as a complex concept involving various dimensions (Gulliford et al., 2002), ultimately elucidating questions related to access to cardiac rehabilitation. This setting, including interpreter-mediated physical exercise and group-based patient education, is novel to interpreting studies.

As regards the data collection, the study is based on fieldwork with participant observation in CRC-I classes and interviews with participants. In the analysis, we pay special attention to patient experiences and reflections from participation in CRC-I and discuss the dimensions of access implicit in patients' accounts.

2. Background

2.1 Learning and mastery course: cardiac rehabilitation with interpreting

A wide range of LMS courses are delivered in Norway and many other countries (Stenberg et al., 2016, p. 1761). The LMS course we examine in this article is a version of a cardiac rehabilitation class (CRC). Medical literature explains that cardiac rehabilitation, with patient education and physical training as core components, is an evidence-based, multidisciplinary intervention, recommended by national and international guidelines for patients with ischemic heart disease (Ambrosetti et al., 2021; Ghisi et al., 2014; Pedersen et al., 2022; Peersen et al., 2021). It is documented that cardiac rehabilitation increases quality of life and reduces mortality and cardiovascular morbidity for this group of patients (Ambrosetti et al., 2021; Pedersen et al., 2022; Peersen et al., 2021).

Moreover, living with a serious chronic health challenge involves more than medication

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and medical treatment. It entails emotional and practical issues as well, and these are issues that the patients themselves and their families have the best insight into. Thus, user involvement is basic to all LMS activities (NK-LMH, 2018). Patient education in how to master living with a cardiac condition therefore encompasses learning from peer patients as well as from healthcare professionals.

Although many hospitals in Norway provide cardiac rehabilitation (Peersen et al., 2021), the course under scrutiny here, CRC-I, is unique as it has been adapted for cardiac patients with LPN. CRC-I is arranged in a hospital[1] located in a region with a linguistically diverse population (Statistics Norway, 2023). Like nearly all LMS courses (NK-LMH, 2018), CRC-I is group-based. However, in contrast to most LMS courses, the patient groups are multilingual. Each group consists of three to eight patients so that the group altogether represents up to eight different languages. Until now the course has been offered with interpreting in more than 15 languages.[2]

CRC-I was arranged for the first time in 2017. It was developed based on a course conducted in Norwegian that has been organized at this hospital since 2006. The same two healthcare professionals, one physiotherapist and one nurse, have been in charge of CRC-I from the start. It is offered four to five times a year. Each course lasts two days, from 09:00-14:00, spread over two weeks.

Interpreters for CRC-I are booked via the hospital's in-house interpreter service. Interpreters are typically engaged to interpret for the healthcare professionals and one, or sometimes, two patients, and occasionally their next of kin. As a rule, interpreters working in CRC-I are qualified according to Norway's newly enforced Interpreting Act (Interpreting Act, 2021). The Interpreting Act sets requirements both for public services and interpreters. Public services are obliged to use qualified interpreters while interpreters are obliged to follow ethical guidelines and to be registered in the National Registry of Interpreters (Interpreting Regulations, 2021). This is related to the current situation regarding the professionalization of interpreting in the public sector, which, in Norway, has been strengthened in recent years through undergraduate degrees (Sagli & Skaaden, 2023), interpreter accreditation, the National Registry of Interpreters (Interpreting Regulations, 2021), interpreter user training on how to communicate via interpreters (Felberg & Sagli, 2023) and, from 2022, the above-mentioned Interpreting Act (Interpreting Act, 2021).

In this CRC-I course, patient education is offered in a variety of ways, such as lectures on cardiac-related issues presented by the two healthcare professionals, as patient questions and answers, and as peer patient exchange of experiences and reflections. Physical training sessions comprise exercising and also physical exercise counseling.

As can be observed through the previous background, intrinsically, access to these basic components of CRC depends on efficient communication. This raises questions as to how interpreter-mediated patient education and physical training are experienced and reflected upon by patients who have participated in CRC-I.

2.2 Defining access

As a starting point for the discussion of access, we distinguish between four dimensions, following Gulliford et al. (2002), which will be used to analyze patients' accounts of participation in interpreter-mediated CRC:

[1] The name of the hospital is not disclosed to preserve the anonymity of the participants.
[2] Examples of languages: Albanian, Arabic, Chinese (Mandarin), Dari, English, Finnish, German, Greek, Pashto, Persian, Polish, Punjabi, Urdu, Russian, Sinhalese, Somali, Sorani, Spanish, Tamil, and Tigrinya.

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1) The first dimension is service availability. To be more precise, access to services requires sufficient provision of the service in question. With this meaning in mind, access to cardiac rehabilitation might be seen as achievable for cardiac patients in need of it if its provision exists in sufficient supply for patients all over the country. However, if the services are available only in Norwegian (without the provision of interpreting), one may wonder whether the services in practice are available for patients with LPN.

2) The second dimension of access relates to the actual use of services and to eventual barriers that limit the utilization of services. Gaining access is distinctly different from just the presence of supply. Barriers to gaining access might be personal, financial, and/or organizational. In this sense, access is seen as representing the degree of fit between client and services, i.e. how well the services and clients match each other. For example, language-discordant services, such as cardiac rehabilitation courses offered in Norwegian for LPN patients, might be regarded as representing an improper fit between service providers and clients. In the case of interpreter-mediated CRC, the provision of interpreting is introduced as a measure to decrease language barriers so that patients with LPN can gain access. In this vein, the question arises whether access can be gained by means of interpreting services in such complex communication settings as those found in CRC-I.

3) The third dimension underlines outcome. This understanding of access reminds us that the goal of access to healthcare is not simply the utilization of services but the promotion of health. When applied to the present topic, it inspires questions related to the outcome of participation in CRC-I.

4) The fourth dimension concerns equity and access and is associated with fairness and social justice. One widely used definition is “fairness in access for groups with equivalent needs” (Gulliford et al., 2002, p. 188). This aspect may be evaluated in the light of the other dimensions (availability, gaining access, health outcome) and may be seen as summing them up.

3. Literature review

Although interpreting in healthcare settings has received attention during the last two decades (e.g., Angelelli, 2004; Brisset et al., 2013; Fennig & Denov, 2021; Gavioli & Merlini, 2023; Hsieh, 2016; Kale, 2018; Krystallidou et al., 2021; Ng & Crezee, 2020), there are still several under-researched settings and topics. One such setting is *cardiac rehabilitation* represented through CRC-I. This complex course is designed for multilingual groups of patients where consecutive interpreting is conducted in parallel in different language groups both in classroom and physical exercises settings. To our knowledge, *parallel interpreting in different language groups* without the support of technical interpreting equipment is a new topic in interpreting research (Felberg & Sagli et al., 2024). In Norway, the gap in knowledge regarding interpreting in groups was recognized in 2015 when a hospital organized a workshop on interpreting in group-based treatment situations with the aim of “generating knowledge by documenting the participants’ own experiences and ideas” (Skaaden, 2017, p. 1).

Another topic requiring more research is patient perspectives on interpreter-mediated communication in healthcare. Although the body of research on this topic is growing (e.g., Edwards et al., 2005; Gerrish et al., 2004; Hadziabdic et al., 2009; Rhodes & Nocon, 2003; Walker & Sivell, 2022), to our knowledge, patient perspectives on access to group-based cardiac rehabilitation with interpreting has not yet been addressed.

Research on outcomes and patient experiences with learning and mastery courses (all without interpreters) is also in its infancy (for exceptions see Ghisi et al., 2014; Nossum et al., 2013; Pedersen et al., 2022). The existing research, as explained in a scoping review,

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shows that “group-based self-management patient education programs in different ways have been experienced as beneficial” (Stenberg et al., 2016, p. 1768). Patients report benefits and challenges categorized under the following general themes: 1) peer support and mutual learning; 2) hope for the future; 3) social support and network; 4) impact on health and quality of life; 5) learning to manage own health challenges; 6) cooperation between healthcare professions; and 7) challenging or negative experiences. Notably, the review did not address interpreter-mediated communication. Furthermore, the review revealed that what we know so far “is based on Caucasian samples” and stated that “studies with samples from different cultural, ethnic or socioeconomic backgrounds are needed to investigate and explore differences in outcomes and perceptions in participants’ experiences” (Stenberg et al., 2016, p. 1768). More recent research that focuses specifically on access to cardiac rehabilitation identifies language barriers as one of the main hindrances to access (Al-Sharifi et al., 2019; Carew Tofani et al., 2023; Vanzella et al., 2021).

This article is placed at the crossroads of the above-mentioned strands of research, and it is intended to contribute new knowledge relevant to them all.

4. Methodology

Our study draws on data from research carried out at a hospital in Norway in 2022-2023.[3] Data consist of participant observations at CRC-I and interviews with patients. Participant observations were conducted in all CRC-I’s learning activities, including physical exercises, throughout 12 all-day CRC course days.

As regards ethical considerations, the project was approved by the Norwegian Data Protection Agency (NSD no. 860748) and by the local hospital’s data protection official and the researchers signed a confidentiality declaration issued by the local hospital. Moreover, patients gave their written consent for participant observations in cardiac rehabilitation activities, interviews, and for interviews to be recorded. To ensure anonymity, all patients’ identifying traits have been removed, and the hospital is referred to simply as “the hospital”.

The actual interviewees were recruited at CRC courses where researchers explained the aims of the project via interpreters. Patients who did not have Norwegian as their mother tongue and who volunteered were later contacted for interviews. In-depth interviews were conducted with 13 patients, each interview lasting from 30 to 75 minutes. The interviews were conducted at the hospital or another place of the patient’s choice. Three interviews were conducted in English, two in Norwegian, and eight with interpreters in Albanian, Arabic (2), Dari, Punjabi, Sorani (2), and Vietnamese. Interviewing via interpreters required comprehensive planning, and all interpreters engaged were qualified with university-level education in interpreting (Interpreting Act, 2021; Interpreting Regulations, 2021).

The common element that connected all the patients was that they had recently been hospitalized and treated for a serious cardiac illness. Otherwise, the interviewed patients had diverse backgrounds regarding ethnicity, migration history, professional and educational background, family structure, socioeconomic status, cultural heritage, and experience with

[3]This article reports on a subproject within a larger research project about interpreting in healthcare carried out at a hospital in Norway during 2022-2023. The larger project has been conducted by an interdisciplinary group of researchers from OsloMet-Oslo Metropolitan University, Oslo, Norway, who collaborate in all phases of the research. The current article is informed by this collaboration. The research group is working on articles concerning different aspects of interpreting in the CRC-Is, for example, adaptations made to accommodate the course for interpreting based on participant observations and interviews with all participants: healthcare professionals, interpreters, and patients (Felberg & Sagli et al., 2024).

communication via an interpreter. Almost all the patients used several languages at home, at work, and in institutional encounters. Some patients used English as their second language. Most had some knowledge of Norwegian, however, not enough to communicate in healthcare settings. Some patients had a long migration history with longer stays in other countries before coming to Norway. The length of stay in Norway stretched from 2 to 30 years. The interviewees' mother tongues were Dari, Punjabi, Telugu, Arabic, Sorani, Vietnamese, Persian, Albanian, Tamil, and Pashto.

The questions posed to the patients in interviews included their use of languages in everyday life and their experience with communication via interpreters in different settings in the CRC course and elsewhere (see Appendix 1 for interview guide).

Researchers listened to the interview recordings several times, both individually and together and relevant parts of interviews were transcribed manually. The patients' comments related to the four dimensions of access (Gulliford et al., 2002) described in section 2.2 were identified and analyzed. Some patients provided short reflections while others provided much more elaborate and detailed answers and comments. When choosing the illustrating citations, we tried to present the breadth of the patients' reflections, including reflections represented by only one patient.

5. Results and analysis

Focusing on access, we examined the patients' experiences with and viewpoints on interpreter-mediated communication in CRC-I. Although these patients were not asked directly about their reflections on access or the outcome of the courses, in many cases, while commenting on interpreting they also included reflections on these topics.

With the four dimensions of access (Gulliford et al., 2002) as our point of departure, we explored which ones were implicit in patients' descriptions. We identified two dimensions as the most relevant: the degree of fit between patients and services and the outcome of access.

First, we will address the question of how interpreting functioned as a measure to obtain an appropriate degree of fit. We will do so by analyzing patients' experiences of interpreting in groups in two settings: the classroom (section 5.1) and the physical exercise setting (5.2). CRC-1 learning activities (lectures, patient reflection sessions, and physical training) take place in these two settings. In 5.3, we include patients' comments on the importance of engaging qualified interpreters. In 5.4, we explore the outcome dimension of access. Gaining access does not necessarily imply that patients achieve the desired outcome dimension; we therefore analyze patients' reflections on their benefits from the course.

5.1 Degree of fit: patient experiences with interpreting in groups in classroom settings

Classroom lectures by healthcare professionals and patient reflection sessions took place in designated classrooms at the hospital. The classrooms were relatively small, meant to accommodate approximately 15 people. The healthcare professionals arranged the desks in a fishbone pattern, with each "language desk" accommodating one or two patients, a next of kin, and one designated interpreter. There were four to eight language desks. Interpreters interpreted in a consecutive mode as agreed upon with the healthcare professionals in a pre-class meeting. Even though patients were not informed explicitly by the healthcare professionals about how the consecutive interpreting would be carried out, some of the patients described the process precisely, as in the following examples:

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> Patient 14: My interpreter, she is interpreting what I'm saying [into Norwegian], at the same time she is also saying what other patients are saying, and what was their answer to the question. So, everything is translated, what the group is saying, including my individual questions.
> Interviewer: So, it was not difficult to understand [communication via the interpreter]?
> Patient 1: No, no, no – because they [healthcare personnel] did always wait, did you notice? About 30, 40, 50 seconds [for interpreting]? They talk, and then wait for 15 seconds, and then talk and then wait for 15 seconds. Then it is so clear!

Given the complex communication setting where all interpreters interpret at the same time creating potentially disturbing noises, we were surprised that this situation was described as "clear". We would have expected patients to complain about challenging conditions with noise in a constricted space. However, overall, the patients expressed a high degree of satisfaction with the interpreting.

Moreover, when prompted to say something about interpreting in groups under these conditions, several patients explained that they disconnected from other languages and listened only to the language they understood:

> Patient 2: Then I only listened to my interpreter and didn't listen to the others.
>
> Patient 3: My mind is giving priority to *my* language so that I don't catch the other things. Maybe one person is talking here and there, but I can get the information.

Although one patient expressed that he was, in fact, distracted from time to time, due to many different voices and limited space in the classroom, this patient concluded that it did not seriously hamper his ability to follow the lectures:

> Patient 4: There were some occasions when everybody would be talking, and it could be somewhat distracting, because you have several different people with several different languages. When their interpreters start talking and they have to speak to interpret, and there are so many different voices, and you have to struggle to catch the voice of the person next to you.
> Interviewer: And all the different voices, as you said, did it hamper your ability to catch the information?
> Patient 4: No, not necessarily. It was somewhat distracting. I would physically get closer to my interpreter. So, I sort of block all that other noise, but it's difficult to block the noise, if you're sitting literally 20 centimeters from one another.

Ultimately, despite the number of languages being parallelly interpreted in a consecutive mode in very small rooms, without technical interpreting aids, communication seemed to function well. This impression was supported by both our observations and patients' reflections. Interpreting, thus, contributed to adjusting the degree of fit between the patients and the services.

5.2 Degree of fit: patient experiences with interpreting in groups – physical exercise setting

Another setting where the patients also encountered group-based interpreter-mediated communication was the physical exercise sessions. Physical exercise is a core component

[4] To preserve patients´ anonymity we did not use patients´ names or languages; we used numbers following the order of first-time appearance in this article. The translations from Norwegian (interpreted from other languages) to English were carried out by the authors while the three interviews conducted in English were not translated.

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of each course day. From this point of view, the healthcare professionals had told the group that regular physical training and increased physical activity in everyday life were important to improve their heart health, and they aimed to instruct the patients on how to exercise to achieve cardiovascular benefits in a safe manner. However, for cardiac patients "burdening their sick heart with physical exercise", to use their own words, was not an instinctive act. In fact, many patients who experienced life-threatening heart issues and underwent surgery for their condition tend to fear that physical activity can exacerbate their heart's health. In this vein, one patient stated that the heart attack was always at the back of his mind:

> Patient 4: One is always conscious of the fact that I've recently had a heart attack. And then, should I be moving this fast, this intensely? That is in the back of your mind.

Most days, the exercise training took place in a gym attached to the physiotherapy department; sometimes it took place in the hospital corridors and sometimes outdoors. The physical training in the gym resembled an aerobics class accompanied by music but adapted to match the physical status of the group.

Interpreters were informed in a pre-class meeting with the healthcare professionals that the CRC-I program included physical training. The interpreters were encouraged to participate in the training, but they did not receive any detailed instructions on how they were expected to fulfill the task of interpreting while exercising. Accordingly, the intensity of the interpreters' participation in the exercises varied. Most participated, but not so intensely that their interpreting was affected. Most, but not all, of the interpreters placed themselves close to the patient they were interpreting for. Most patients did not comment on this issue, but one patient, cited below, voiced a clear expectation about the interpreters' positioning:

> Patient 4: The nature of the exercise, is that they [the interpreters] have to [do the exercise] and at the same time explain, because the instructions are being given in Norwegian still, aren't they? When the lady [the physiotherapist] says start jumping or lift your hand up or move to the left and move to the right, the very minimum they [the interpreters] should be at least very close to their client, interpreting every single word.

One of the healthcare professionals, usually the physiotherapist, was in charge of the training. She placed herself in front of the group and demonstrated how the exercises should be conducted. For some patients, it was enough just to see what the physiotherapist did, but for others, it was important to also understand what the physiotherapist said to be able to perform the exercise correctly. As exemplified by the following citation, some of the patients explained that they liked having the instructions interpreted:

> Patient 5: I think it [the physical training] went very well since the interpreters were there because Norwegian was spoken. We could see what they [the healthcare professional] were doing, and that what [the instructions] was interpreted, helped us.

The communication that took place during the physical training did not only concern instructions on how to carry out the exercises. It also comprised physical activity counseling. Moreover, the healthcare professionals monitored the group and assisted individuals who needed support. For example, when some patients showed and expressed signs of anxiety while exercising, one of the healthcare professionals would then come to talk to that patient. Furthermore, healthcare professionals deemed it important that the patients learned to be

able to differentiate between body sensations that may be harmful and sensations that are side effects of exercise. This is important to sort out so that physical exercise can continue at the hospital and at home. In all these communicative situations interpreting was crucial, affecting the perception of the situation by the group. Thus, how situations of this kind were dealt with was also perceived as good, not only for the individuals but for the whole group:

> Patient 4: There was one occasion when somebody ran out of breath and had to sit down. Again, he had an interpreter with him, so one of the nurses, who was helping to lead the session, she went over and started talking to them. So, all in all I think it was a good experience for everybody.

The training sessions were also effective because they provided patients with opportunities to experience training as beneficial for them in a safe environment. As the course was only two days long, the patients were not expected to obtain aerobic benefits. Instead, sessions were meant to give a "taste" of appropriate exercises, according to the healthcare professionals. Therefore, physical activity counseling, as well as encouragement to exercise, become even more crucial for motivation purposes. Some of the patients, in interviews, specifically pointed to the motivating effect of having everything that the instructors said interpreted:

> Patient 1: It [the interpreting during physical exercise] is not disturbing me, it was encouraging me… Encouraging – that kind of feeling comes when she [the physiotherapist] was doing something, then she [the interpreter] was translating, and that was giving some encouragement.

Thus, encouragement was important at both individual and group levels as recognized by some patients in their reflections. Some patients recognized the importance of understanding even the smallest comments made by healthcare professionals – which was possible only via interpreting. This was expressed very clearly by one patient:

> Patient 4: You can visually see what the person is doing. But in between the lady who was showing these instructions, she would make small remarks, small jokes to sort of lift the mood up and get everybody to start exercising. You can sometimes find people in a group that are shy, that need more encouragement. I think the persons [the healthcare professionals] giving these instructions may notice that some patients may try to say something, and they try to make that person [patients] involved, or specifically address them. In that case, that loss of a phrase here or a sentence there could mean a huge difference. For somebody who's a little shy and would rather stay in their cocoon than be encouraged to come forward and take part. (…) What they're [the healthcare professionals] saying is for a purpose.

In sum, although the physical exercise sessions were unfamiliar communication settings for most of the interpreters and the patients, several positive aspects were suggested. Besides instructions on how to do the exercises, communication also involved encouragement and physical activity counseling. Healthcare professionals focused on instructing patients on how to do exercises to achieve cardiovascular benefits, addressing patients' reactions while doing exercises, encouraging them to increase their physical activity and finding ways to integrate training into their everyday lives. This meant that communication and therefore, the work of the interpreters, played a crucial role during exercising, and that communication concerned issues of vital importance for patients.

5.3 Degree of fit: the importance of professional interpreters

Many patients pointed at interpreters' professionalism as a prerequisite for interpreting being so successful in all learning activities. Most patients gave examples of previous negative experiences with interpreters in healthcare and explained it as a contrast to the interpreters used in CRC-I. They praised the interpreters and referred to them as "professional" or "experienced" interpreters, as shown by Patient 6:

> Patient 6: I will be honest with you: now I have experienced a different type of interpreter, after I have started here at CRC-I, the interpreters they use here are professional. All interpreters used so far are professional, all that have been used. Everyone is professional, no one to complain about.

In their descriptions of what "professional" meant to them, some patients highlighted the importance of accuracy both while interpreting technical details related to medication and while interpreting communication concerning feelings.

> Patient 7: It's very important to use a professional interpreter because if you don't use a good interpreter, if you don't use an interpreter during the doctor's consultation, it will lead to you being misunderstood and given the wrong medication (…) this is not valid only for me, it applies to everyone who uses interpreters.

> Patient 8: If I were to talk about feelings or what I feel, I would have wanted there to be a professional interpreter, who could tell everything that I feel and who would be able to pass it on to the doctor. Because, maybe, I lack some language areas and things that have a lot of different names. Then I might need a professional interpreter.

Despite all the challenges, and as illustrated above, data from patients' interviews in combination with our observations of patients' comments and interactions in CRC-I classes, indicate that interpreting was satisfactory, as the interpreters engaged were professionals. Ultimately, interpreting enabled patients and healthcare professionals to communicate, and thus, interpreting served as a measure to achieve an appropriate degree of fit between patients and services.

5.4 Outcome dimension of access: support and learning

In this section, we address another dimension of access: the outcome dimension. In this context, this dimension was related to what patients experienced as benefits from participation in CRC-I. Patient exchange of reflections and experiences and thus, opportunities for mutual learning, is another basic component of the cardiac rehabilitation with patient education, documented as creating better health outcomes (Ambrosetti et al., 2021; Ghisi et al., 2014; Stenberg et al., 2016).

Such sessions were conducted in a classroom setting. For patients to share their experiences, trust must be established in the group, through willingness to share personal experiences and reflections and through openness to seeing other patients' questions and answers as potentially relevant and useful for oneself. Trust building and group belonging is not easy to achieve in any group, and one may assume that in the CRC-I group, it may have been even harder to obtain since the group consisted of patients with different cultural backgrounds. For example, not all patients were used to sharing private information in a group. Patient 2 commented that hearing about other patients' families, and not only about their illness, was not to the patient's liking:

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> Patient 2: I understood what was said, but one day someone started talking about his family, and not directly about the topic of the heart, and I didn't like that very much.

However, according to our observations, most of the patients willingly participated in sharing their experiences, and the group setting as a resource was explicitly mentioned by some patients such as, for example, Patient 4:

> Patient 4: So, having all those different people with different backgrounds but with the same problem. With the same health issue but not identical with yours, you know. Because everybody is different, their bodies are different, they raise different questions in their own personal situations. And they ask those questions, and there is definitely a wealth of information that you get from other people asking those questions, something that is perhaps on the tip of your tongue, but you are not quite sure whether to ask it or whether it is an appropriate question to ask. And then it gets asked, and then it gets answered, and you realize, okay, that is useful to know.

To facilitate communication, healthcare professionals posed questions such as: "Do you feel healthy now? How did your heart problem change your life? What do you have to do differently now?" Interpreting in several language groups added to the complexity in this setting. This is how Patient 4 described his experiences in reflection sessions:

> Patient 4: They [healthcare professionals] asked the patients around in the room. When that question [are you sick or healthy?] was asked, everybody answered quite honestly [about their personal feelings and experiences]. And again, because it was being translated at the same time, from their language to Norwegian, my interpreter would listen to the Norwegian version of it and interpret it back to me in my language. So, there wasn't much lost in that translation, even though it was translated from one language to another and then from that to the second!

While observing these peer group sessions, we noticed that communication was surprisingly smooth. Although there were some instances where everybody was speaking at the same time and interpreters did not have good conditions to interpret, group-based exchange of reflections resulted in several outcomes. In fact, according to the patients they experienced a feeling of being together, relativization of one's own situation, and learning to manage their own health challenges inspired by the other patients and the healthcare professionals.

From this point of view, some patients underlined the importance of being together "with other people, from other countries, with other languages" and the opportunity to hear their stories and they expressed that they were able to obtain insight into other patients' situations and feel empathy, as the following examples illustrate:

> Patient 9: Whatever the other patient is saying, they [interpreters] try to explain the discussion so that I got some info about other patients, like what they have undergone, how they're feeling now.

> Patient 4: You hear their stories, they hear yours. There is this bonding, or some level of empathy, unspoken empathy for one another. Because you are all suffering from the same ailment, it's something that you take away with you, when you go home. On your way home, you think about it, or when you go to sleep that night, you are mulling these things over, and it just makes you realize the importance of life. It is precious, not just for you, but for others as well. You're not alone in this; it could happen to anybody. So, in that sense I think it's a good thing.

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Other patients underlined that group feeling was achieved via interpreting, which connected them and made them feel like they were speaking the same language:

> Patient 9: If I didn't understand what another person was saying, there could have been disconnection between the people, but thanks to the interpreter we understand whatever the person is saying. Because of that, we feel like we're all talking in the same language.

Patient 4 compared his own situation with that of the others and saw it from a new perspective, which helped him relativize his own situation:

> Patient 4: There were people who've had it worse than I did. There was a guy who I was talking to, he's had an open-heart surgery where they had to cut open his chest, you know (…) And it just makes you realize that everything is relative. Your bad day could be somebody's good day. It also makes you feel grateful in a sense.

The above examples illustrate that patients learned from each other; however, they also gave examples of learning from healthcare professionals. Some underlined that they benefited from the information given in lectures or during physical exercises, signaling that they had had access to it:

> Patient 7: Yesterday we also benefited from being there. Because we got a lot of information that we didn't have access to before. Got benefit from it.

> Patient 9: I think I learned a very nice thing to be able to do push-ups against the wall.

In sum, despite the vulnerability of the peer group learning situation, which included sharing intimate issues such as personal feelings, pains, and bodily sensations, the communication was seemingly satisfactory. Patients reported that they understood what the other participants were saying, felt support by being together in a group, and learned aspects that were useful for their own health situation from both their peers and the healthcare professionals. Thus, overall, this indicates that the outcome dimension of access was feasible in the interpreter-mediated reflection sessions.

6. Conclusion

The novelty of this research includes the study of a new healthcare service, namely learning and mastery services, applying a nuanced approach to access, as well as examining patient perspectives on interpreter-mediated communication in group settings such as physical exercises.

We studied a CRC-I through interviews with patients and fieldwork participant observations. LMS are radically different from conventional services such as medical treatments in that they focus on patients' learning how to cope with chronic diseases. Considering our examination of access to a CRC-I for patients who have limited proficiency in Norwegian through the four dimensions indicated by Gulliford et al. (2002) (availability, degree of fit between patients and services, outcome of the course, and equity), our analysis showed that the degree of fit and outcome dimensions were the most relevant. Data from two CRC-I settings, a classroom and physical exercise, indicated that interpreting served to achieve a satisfactory degree of fit despite a complex communication setting with several

languages being interpreted simultaneously. In a broader context, which is beyond the scope of this study, the availability of cardiac rehabilitation courses to patients with LPN has not been achieved, as courses with interpreting are scarce. Consequently, the equity dimension of access has unfortunately not yet been achieved.

However, we have shown that LMS goals, such as access to group-based peer patient learning and participation in physical exercise, may be achieved even in multilingual patient groups if it is based on communication via interpreting. Although there are still obstacles (such as a shortage of supply of interpreter-mediated services), CRC-I improved the situation for patients with LPN.

Moreover, through interviews, patients expressed that they acquired new knowledge and a better understanding of their own health issues through lectures, physical exercise, and peer-patient exchange, and that communication via interpreters “functioned well”. A prerequisite for the success of the course, according to the patients, is that the interpreters engaged are professional. However, more research is needed to make further claims concerning the validity of the results for a wider population of LMS participants.

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Appendix 1

Themes and questions in patient interviews

Introductory questions about language use

- Can you tell us a little about which language, or languages, you usually use in various contexts?
- What's your mother tongue?
- Do you speak other languages? Which ones?
- Which language do you usually use in everyday life? At home (with whom)? In working life? In other social contexts?
- How long have you lived in Norway?
- Can you tell us a bit more about how you experience living in Norway and not speaking Norwegian? Examples?
- Anything else that you think is important?

Language use in health care encounters: Experiences with/without an interpreter

- Can you say a little about what usually happens with regard to language and communication when you are at the doctor's or in a hospital or elsewhere in the health service?
- Do you have concrete examples of how communication challenges have been sorted out? (Interpreter? Other ways?)
- Do you have previous experience of communicating via an interpreter?
- In what contexts?
- Can you give examples of healthcare encounters with and without an interpreter?
- Special challenges? Misunderstandings?
- What makes you think "I would like an interpreter in this conversation"?
- If applicable, have you ever said that you would like an interpreter? Have you got an interpreter? Or not?
- What do you think are the advantages and disadvantages of using an interpreter?

Experiences and reflections from the Cardiac Care Class with Interpreting (CCC-I)

If you have attended a CCC-I:

- What are your experiences about participating in a group where there are many languages and many interpreters?
- How do you experience interpreting in contexts such as: 1) group conversations, 2) lectures, 3) workouts, 3) individual conversations, and 4) other activities?
- Based on your experiences, what advice would you give the interpreters to improve their approach to you as a patient?
- What do you experience as the main problems in interpreting various activities, including the workout sessions?

Advice for healthcare professionals:

- Healthcare professionals are responsible for ordering an interpreter. Do you have any advice/thoughts for them about what assessments should be taken into account when deciding whether an interpreter should be selected or not?
- Please give concrete examples!
- What do you think should determine whether engaging an interpreter is necessary or not?

Self-assessment of Norwegian skills

- How well do you speak Norwegian? (1 = not at all, 2 = not well, 3 = well, 4 = very well).

- Followed up with: When you are with the doctor or at the hospital, if you could choose freely—in an ideal world—would you prefer to communicate with health personnel in your mother tongue (i.e., via an interpreter or native-speaking healthcare personnel) or in Norwegian?
- Would you benefit from attending the CCC without an interpreter?

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