

Translation from English into Croatian Language "Problems and Challenges in Translating Texts of Different Genres"

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UNIVERSITY OF RIJEKA
FACULTY OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF ENGLISH

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TRANSLATION FROM ENGLISH INTO CROATIAN LANGUAGE
“PROBLEMS AND CHALLENGES IN TRANSLATING TEXTS OF
DIFFERENT GENRES”

Submitted in partial fulfilment of the requirements for the B.A. in English Language and
Literature and Pedagogy at the University of Rijeka

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ABSTRACT

The purpose of this thesis is to implement all the translation skills acquired during the study of English Language and Literature. The most appropriate technique to master the translation skills is by translating the texts of various genres as it is done in this thesis. Moreover, the focus is put on overcoming all the various obstacles that we encounter while translating.

The thesis is divided into five main sections. The first section of the thesis is the introduction part and it includes the main principles of the translation process. What is more, this part contains brief reviews of the source texts. The following sections include the source text, corresponding translation as well as the commentary and analysis. In the commentary and analysis the recipient of the translation gets the insight into the translation process, which includes the analysis of the text based on the twelve main points (genre, source, audience, purpose of writing, authenticity, style, level of formality, layout, content, cohesion, sentence patterns and terminology of the subject) and particular observations on various issues encountered while translating. The last section of this thesis is the conclusion and its purpose is to summarise the most relevant conclusions regarding the translation of the texts of various genres.

The source language of the texts is English, while the target language is Croatian. The source texts include three different genres: research in the field of medicine, overview of the health care system in the United States and an interview regarding the space travel.

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1. INTRODUCTION

Translation is a process that can be defined with multiple definitions, and different authors provide their own explanation of the term. One of the simplest clarification of this expression is that „*translation is transferring the meaning of the source language into the receptor language*“ (Larson, 1984:3). In other words, translation is a process in which the translator repeats the author's words and ideas in different language. The aim of this thesis closely relates to this definition. By translating three texts of different genres, the significance was put onto transferring the authors' ideas into Croatian language without altering the meaning of the main ideas, basic facts, style and structure.

In order to fully understand what translation really is, it is important to explain the role of the translators and what is expected of them. Due to the fact that language is like a living organism and it is changing on a daily basis, the role of the translator can be quite demanding. Every language is unique, having its own specific metaphors, expressions, phrases and idioms, so translating from the source language to the target language can be quite a challenging task. That is why the translator needs to be an expert regarding the source language, but even more proficient when it comes to the target language. Furthermore, the translator can stumble upon various obstacles while translating. When it comes to the vocabulary usage, various terms have multiple meanings and the translator needs to focus on the surrounding text while translating in order to keep the original meaning of the word and the sentence. Besides that, translator has to be careful when it comes to style and tone of translation because these elements should correspond to the source language. Translator needs to pay attention to the formality level of the text as well. If there is a high level of formality, translator needs to avoid colloquial expressions. What is more, translator needs to bear in mind that the translation needs to correspond to the original text, taking into consideration the

context of a text, the culture of the source language and the recipients of translation. These are just some of the elements which need to be taken into account while translating.

When dealing with few texts of the same genre, some of these elements can be easily omitted and that is why the main focus in this thesis is put on three texts of different genres and contexts. Prior to the beginning of the translation process, every text needs to be read and analysed in the interest of getting a complete overview of the topic. Due to the fact that these three texts belong to different fields of matter, before the translation of every text, it is necessary to read several Croatian articles on similar topics in order to get acquainted with the terminology and the style of writing. After thorough analysis of the genre, terminology, style and structure, the translation process can start.

The first source text “Perspectives on reasons of medication nonadherence in psychiatric patients“ is a research analysis and it belongs to the field of medicine. Due to the high level of formality the translator’s role is to translate the text trying to convey the meaning of the original work by translating the official terminology of the source language into the corresponding terms of the target language. Medical terminology has a vast range of complex expressions and that is why the translator needs to use medical dictionaries or even consult an expert of that field.

The second source text “Overview of the U.S. Health Care System“ belongs to the field of health care and the level of formality is not that high as in the first text due to the fact that it is a summarised overview of the United States’ health services written for general population. The translation of this text can be considered complex because the translator needs to bear in mind that the original text is written for the population that has a different culture than the target language. Besides that, the translator needs to transfer the original names of

programmes into the target language which can be quite challenging because some of these terms do not exist in the target language.

The third text “Being the first man on the Moon“ is an interview with Neil Armstrong and it is mostly focused on the space exploration and Armstrong’s life. This text is quite informal due to the great number of colloquial expressions.

Translation of every text is followed by the commentary and analysis. In this part, translator analyses the texts according to the previously selected points such as genre, source, style, content, etc. Besides that, translator explains the process of translating, guiding the recipient of the translation through different steps of transferring the meaning of the source language into the target language. In this part of the thesis, translator specifies the issues of the translation process, provides a thorough explanation of several translated terms and in some cases brings up a list of examples found in various text and articles.

In the conclusion, translator reflects on the overall course of translating.

While translating, the translator needs to focus on all the elements mentioned in the first part of the introduction. The translator is not just a person who transfers the meaning of source language into the target language. The translator is basically an author and a creator because the aim of translating is to create something new. Even though the essence of the translated text needs to correspond to the original text, the translator has to improvise and conduct a thorough exploration in order to make the translation valid. As Roger Chriss (2006) stated, translators are “*language professionals. They are applied linguists, competent writers, diplomats, and educated amateurs*”.

2. SOURCE TEXT I:

Perspectives on reasons of medication nonadherence in psychiatric patients

Derya Güliz Mert

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Purpose: This study was carried out to evaluate factors resulting in medication nonadherence within 6 months before admission to the psychiatric service of our hospital for bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other psychiatric diseases.

Patients and methods: Two hundred and three patients admitted to the Psychiatry Service of the Medical Faculty were included in this study. Sociodemographic parameters and clinical findings within 6 months before admission and patients' views on reasons of medication nonadherence were examined.

Results: Patients were classified into four groups according to their diagnosis: bipolar disorder (n=68, 33.5%), schizophrenia/schizoaffective disorder (n=59, 29.1%), depression (n=39, 19.2%), and others (n=37, 18.2%). The ratio of medication nonadherence was higher in the bipolar disorder group when compared to the groups with schizophrenia/schizoaffective disorder, depression, and other disorders (12.1%, 18.2%, and 24.2% vs 45.5%); however, the ratio of medication nonadherence was similar in schizophrenia/schizoaffective disorder, depression, and the others group. In logistic regression analysis, irregular follow-up (odds ratio [OR]: 5.7; 95% confidence interval [CI]: 2.92–11.31) and diagnosis (OR: 1.5; 95% CI: 1.07–1.95) were determined to be important risk factors for medication nonadherence. The

leading factors for medication nonadherence were: “not willing to use medication”, “not accepting the disease”, and “being disturbed by side effects” in the bipolar disorder group, “not accepting the disease” in the schizophrenia/schizoaffective disorder group, “feeling well” in the depression group, and “being disturbed by side effects” in the other diseases group.

Conclusion: Medication nonadherence is an important problem in psychiatric patients and should be dealt with by taking into account the diagnosis, attendance to follow-up appointments, and the patient’s attitude. Ensuring regular attendance to follow-up appointments, adjusting the management plan according to the diagnosis, and improving their thoughts about resistance to medication can be beneficial in terms of medication adherence.

Keywords: bipolar disorder, schizophrenia, schizoaffective disorder, depression, patient’s attitude

Introduction

The World Health Organization has reported the ratio of medication adherence as around 50% in people with a chronic disease. Nonadherence to treatment is a major problem in psychiatric patients; a recent review has stated a ratio of 20%–60% in psychiatric patients. Treatment nonadherence can be in the form of not taking the medication at the recommended dose and frequency, not taking the medication at all, and irregular attendance to follow-up appointments or not attending at all. The most important and highly encountered form of medication nonadherence is where a patient does not follow the recommended dose and frequency. The ratio of nonadherence has been reported as 40%–60% for antipsychotics, 18%–56% for mood stabilizers, and 30%–97% (63% on average) for antidepressants. Moreover, in studies evaluating medication adherence based on diagnosis, the ratio of nonadherence to medication has been shown to be 12%–64% in patients with bipolar

disorders, 11%–80% in patients with schizophrenia, and 30%–60% in patients with depression.

There are many factors leading to medication nonadherence in psychiatric patients, including lack of insight into having an illness, distress associated with side effects, disturbing side effects affecting quality of life, lack of family and social support, insufficient information on the disease and treatment, and substance abuse or addiction. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-V describes many conditions for medication nonadherence, including overweight or obesity, malingering, wandering associated with a mental disorder, and borderline intellectual functioning. Medication nonadherence is one of the major avoidable reasons causing relapses and morbidity. For this reason, reasons of nonadherence should be examined while evaluating patients. History of nonadherence, alcohol or substance use during symptom-free periods, medication doses, multiple medication use, side effects, and therapeutic alliance should be investigated in detail. As medication nonadherence frequently causes exacerbations, relapses, harmful behavior to oneself or one's environment, suicide and rehospitalization, it has negative impacts both on patients and their family and society. Hospitalization can be associated with medication nonadherence in 20% – 25% of psychiatric patients.

Studies on medication nonadherence, which has an important role in the treatment of psychiatric diseases, and factors associated with nonadherence usually address a single diagnosis group. In the literature, there are an insufficient number of studies comparing different diagnosis groups in terms of medication nonadherence. Moreover, studies assessing the contribution of patients' features and disease-related factors to medical nonadherence are not sufficient either. Results to be obtained on reason of medication nonadherence may have a great impact on inpatients' treatment and outpatient follow-ups. In the present study, factors

resulting in medication nonadherence within 6 months before admission to the psychiatric service of our hospital for bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other psychiatric disorders were evaluated from a multidimensional approach.

Patients and methods

Study population

The present cross-sectional study was conducted on patients hospitalized at the psychiatry clinic at our hospital for bipolar disorder, schizophrenia and schizoaffective disorders, depression, and other psychiatric disorders. Before the study was conducted, the approval of the Human Research Ethics Committee was obtained. All patients receiving treatment between October 2013 and February 2014 were asked to participate in the study, and those willing to participate were included in the study upon receiving consent. The term covering 6 months before the study was evaluated. Those with a psychiatric comorbid diagnosis, mental retardation, and illiterate patients were excluded from the study. Axis I disorders were assessed using the Structural Clinical Interview Diagnosis I (SCID-I) research version. Patients included in the study were classified into bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other disorder (such as adjustment disorder, anxiety disorder, dissociative disorder, substance abuse, or impulse control disorder – not otherwise specified) groups.

Data collection tools

A special form was prepared to collect demographic and clinical data. Patients were asked to fill in the form on the day they were discharged from the psychiatry service. Sociodemographic features (sex, age, education level, marital status, employment status, place

of residence, and household); clinical features and those affecting the course of disease (onset of complaints, number of hospitalizations, presence of axis II diagnosis, additional physical disease, and cigarette/substance addiction); attendance to follow-up appointments within 6 months before admission; and reasons of medication nonadherence (not willing to use medication, not accepting the disease, being disturbed by side effects, feeling well, not knowing how long the medication would be taken, being not aware that the medication would be taken regularly, and other reasons) were examined through the said form. Not taking any medicine for at least 1 week during the 6-month term before the study was regarded as medication nonadherence. This data was supported by the data gathered from first-degree relatives and patient files. Non-attendance of at least 20% of the appointments during the 6 months before the study was regarded as not attending the regular polyclinic follow-ups. This data also was supported by the data gathered from first-degree relatives and patient files.

Statistical analysis

Data were presented as mean $\pm$ standard deviation (SD) and percentage and statistically evaluated by SPSS software (v22; IBM Corporation, Armonk, NY, USA). After descriptive analysis, independent variables thought to affect the dependent variable medication nonadherence, namely age, sex, marital status, education status, smoking, household, place of residence, irregular follow-up attendance, and diagnostic parameters, were analyzed by logistic regression test. The distribution of the items selected by the cases in a seven-item question – multiple answer questions answered as yes/no – examining the reasons of medication nonadherence was evaluated using multiple response analysis. $P < 0.05$ was regarded as statistically significant.

Results

The average age of the patients was 36.7 ± 13.2 years. Sociodemographic features are shown in Table 1. Ninety-six (47.3 %) of the patients were married, 78 (38.4%) were primary school graduates, and 145 (71.4%) were unemployed. One hundred and thirty (64.0%) of the patients were residing in downtown, while 97 (47.8%) were living with their mother/father/sibling.

Table 1 Sociodemographic parameters

Sociodemographic characteristics	n (%)
Sex	
Female	90 (44.3)
Male	113 (55.7)
Marital status	
Married	96 (47.3)
Single	75 (36.9)
Divorced	22 (10.8)
Widow	10 (4.9)
Education status	
Primary school	78 (38.4)
Secondary school	40 (19.7)
High school	59 (29.1)
University	24 (11.8)
Employment status	
Unemployed	145 (71.4)
Employed	58 (28.6)

Place of residence	
Village	39 (19.2)
County	34 (16.7)
City	130 (64.0)
Households	
Spouse/children	82 (40.4)
Mother/father/sibling	97 (47.8)
Nursery	5 (2.7)
Alone	17 (9.0)
Other	2 (0.1)

The median length of total hospitalization at the psychiatry service was 2 days (range: 0–20), while the mean period for initiation of complaints was $2,776.5 \pm 1,012.3$ days. There were 45 (22.2%) cases with comorbid physical disease, 23 (11.3%) patients with axis II diagnosis, and 20 (9.9%) patients with lifelong substance abuse. Cases having a history of substance abuse stated that they had not used any substance during the 6-month term before hospitalization. Twenty-four (61.1%) of the cases stated that they were smokers.

It was found that 104 (51.2%) of the patients took their medicines regularly during the last 6 months, while 99 (48.8%) patients experienced medication nonadherence. Patients were studied under four groups: bipolar disorder (n=68, 33.5%), schizophrenia/schizoaffective disorder (n=59, 29.1%), depression (n=39, 19.2%), and other (n=37, 18.2%). The other disorders group was composed of cases having adjustment disorder (n=7, 3.2%), anxiety disorder (n=4, 2.8%), dissociative disorder (n=7, 3.2%), substance abuse (n=6, 2.7%), and impulse control disorder – not otherwise specified (n=10, 5.0%).

Medication nonadherence of the study subgroups defined as bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other disorders are shown in Table 2. Medication nonadherence was significantly higher in the bipolar disorder group when compared to other diagnostic groups (12.1%, 18.2%, and 24.2% vs 45.5%; $P<0.05$).

Table 3 yielded the following results: items 2, 3, and 1 in bipolar disorder cases, item 2 in schizophrenia/schizoaffective disorder cases, item 4 in depression cases, and item 3 in cases diagnosed with other disorders were found to be significantly important in medication nonadherence.

When the effects of important demographic and clinical parameters listed in Table 4 were studied by regression analysis by taking medication nonadherence as the dependent variable, it was found that age, sex, marital status, education status, smoking, living with others, and place of residence had no significant effect on medication nonadherence ($P>0.05$), while irregular follow-up attendance (odds ratio [OR]: 5.7; 95% confidence interval [CI]: 2.92–11.31) and diagnosis (OR: 1.5; 95% CI: 1.07–1.95) had increasing effects on medication nonadherence ($P<0.05$).

Table 2 Medication nonadherence in bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other disorder groups

Medication nonadherence	Bipolar disorder (n=68)	Schizophrenia /schizoaffective disorder (n=59)	Depression (n=39)	Other (n=37)	Total
Present	45 (45.5%)	24 (24.2%)	12 (12.1%)	18 (18.2%)	99 (100%)
Absent	23 (22.1%)	35 (33.7%)	27 (26.0%)	19 (18.3%)	104 (100%)

Notes: Medication nonadherence was significantly higher in the bipolar group when compared to the other diagnostic groups ($P<0.05$).

Table 3 Feedback related to the reasons of medication nonadherence in bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other diagnostic groups

Items	Bipolar disorder (n=45)	Schizophrenia/ schizoaffective disorder (n=24)	Depression (n=12)	Other (n=18)
Item 1: Not willing to use medication	19 (23.2%)	6 (15.85%)	5 (17.9%)	7 (25.9%)
Item 2: Not accepting the disease	23 (32.9%)	9 (23.7%)	5 (17.9%)	6 (22.2%)
Item 3: Being disturbed by side effects	22 (26.8%)	4 (10.5%)	5 (17.9%)	8 (29.6%)
Item 4: Feeling well	11 (13.4%)	5 (13.2%)	8 (28.6%)	3 (11.1%)
Item 5: Not knowing how long the medication would need to be taken for	1 (1.2%)	4 (10.5%)	1 (3.6%)	0
Item 6: Not being aware that the medication needed to be taken regularly	0	6 (15.8%)	2 (7.1%)	2 (7.4%)
Item 7: Other	2 (2.4%)	4 (10.5%)	2 (7.1%)	1 (3.7%)

Notes: Answers in each diagnostic group are shown as the number and percentage of cases representing each answer. The distribution of the items selected by the cases in a seven-item question – multiple answer questions answered as yes/no –

examining the reasons of medication nonadherence was evaluated using multiple response analysis. The table yielded the following results: items 1, 2, and 3 in bipolar disorder cases, item 2 in schizophrenia/schizoaffective disorder cases, item 4 in depression cases, and item 3 in cases diagnosed with other disorders were found to be significantly important in medication nonadherence.

Table 4 Odds ratios of the selected demographic and clinical parameters that may affect medication nonadherence

Dependent variables		P-value	Odds ratio	95% confidence interval
Age		0.86	1.0	0.97–1.04
Sex		0.44	1.3	0.65–2.73
Marital status		0.77	0.9	0.61–1.44
Education		0.09	0.3	0.08–1.21
Smoking		0.50	1.3	0.63–2.58
Living with others		0.37	0.8	0.58–1.23
Place of residence		0.55	0.9	0.59–1.32
Irregular	follow-up	0.001	5.7	2.92–11.31
attendance				
Diagnosis		0.01	1.5	1.07–1.95

Notes: Logistic regression analysis revealed that diagnosis and irregular follow-up attendance were the variables had significant effects on medication nonadherence.

Discussion

In the present study, cases hospitalized at the psychiatry clinic of our hospital were classified into bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other disorder groups, and medication nonadherence ratios during the last 6 months were examined together with the clinical factors affecting medication nonadherence. Sociodemographic features were found to have no effect on medication nonadherence. In the study group, the cases had bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other disorders. The ratio of medication nonadherence was found to be higher in bipolar disorder group when compared to the schizophrenia/schizoaffective disorder, depression, and other disorder groups. Schizophrenia/schizoaffective disorder, depression, and other disorder groups had similar ratios in terms of medication nonadherence. Not willing to use medication, not accepting the disease, and being disturbed by side effects in the bipolar group; not accepting the disease in schizophrenia/schizoaffective disorder cases; feeling well in depression cases; and being disturbed by side effects in other disorder cases were the factors effecting medication adherence more when compared to other factors. In general, all the diagnostic groups were similar in terms of the ratio of preferring the other items. In logistic regression analysis, age, sex, marital status, education status, smoking, living with others, place of residence, irregular follow-up attendance, and diagnosis were evaluated as variables having the potential to effect medication adherence; of these irregular follow-up (OR: 5.7) and diagnosis (OR: 1.5) were found to be the only factors increasing medication nonadherence. The other variables were found to have no effect on medication adherence.

In a study conducted by Scott and Pope, the ratio and reasons of medication nonadherence (in mood stabilizers) were evaluated in 98 bipolar disorder cases. The authors reported the medication nonadherence ratio as 50% in the previous 2 years and stated that past

history of nonadherence, lack of insight, and greater duration of using a medication were the factors significantly increasing medical nonadherence, while side effects were not as good as attitudes and behaviors in predicting medication nonadherence. Arvilommi et al studied clinical features with respect to their effects on medication nonadherence in an 18-month prospective study conducted on 168 in- and outpatients with bipolar disorders I and II. The authors found that half of the cases had medication nonadherence and reported that the main reasons for medication nonadherence were side effects, lack of motivation, and a negative attitude. Similar to the literature, we found that nearly half of the bipolar patients in our study had medication nonadherence. When the results of the above mentioned studies on bipolar disorders are taken into account, the reasons for medication nonadherence could be affected by various clinical parameters. In a review in which factors associated with adherence to treatment were comprehensively examined in bipolar patients, Leclerc et al classified the reasons of poor adherence as follows: patient-related factors (eg, younger age, male sex, low level of education, and alcohol and drugs comorbidity), treatment-related factors (eg, side effects of medications and effectiveness), and disorder-related factors (eg, younger age of onset, severity of BD, insight, and lack of awareness of illness). In our study we also aimed to evaluate the diagnostic groups as factors possible to be associated with medication nonadherence, the patient-related factors defined by Leclerc et al were not evaluated based on diagnostic groups but as independent variables in logistic regression analysis of the whole study group. Nonetheless, consistent with literature, in bipolar patients, not willing to use medication, not accepting the disease, and being disturbed by side effects came into the forefront in our evaluation.

In a comprehensive review of recent literature, Lacro et al found a mean nonadherence rate of 49.5% in patients with schizophrenia. In our study, the ratio of medication nonadherence was found to be 24.2% in patients with schizophrenia. This could be related to

difference in the study populations, methodology used in terms of definition and measurement of adherence, and period of time over which adherence was assessed. The ratio of regular medication use is higher in schizophrenia patients when compared to bipolar disorder patients (50%–60% vs 35%). Similarly, in our study, the ratio of medication nonadherence was higher in bipolar disorder cases when compared to schizophrenia patients. In our study, the ratios of those denying their disease were 32.9% and 23.7% in bipolar and schizophrenia/schizoaffective disorder patients, respectively. Unal et al stated that 50% of the patients lost to follow-up after discharge or those having an irregular attendance to follow-up appointments did not have sufficient knowledge of their disorder. In another study, 68.5% of the patients were found to stop medication without physician approval due to experiencing side effects, believing the medication would not help them recover, and feeling well.

We examined the reasons of medication nonadherence comprehensively, and observed that lack of insight was the major factor in those having bipolar disorder and schizophrenia/schizoaffective disorder (32.9% and 23.7%, respectively). In previous cross-sectional studies, it has been reported that patients with superior insight had better medication adherence when compared to those with no insight into their illness. Increasing insight has been shown to improve medication adherence. There may be varying levels of disease awareness, especially in psychotic patients. In another study, it was found that treatment compliance is not related to awareness of mental diseases but is related to an increased awareness of clinical symptoms.

It has been reported that one out of every three patients (34.2%) having a chronic psychiatric disorder attends follow-up appointments regularly. Low socioeconomic status, younger age, low educational level, history of irregular follow-up, substance abuse, low functioning, serious psychiatric problems, problems with communication with their physician,

and living far away from treatment centers have been found to be associated with irregular follow-up. Not attending follow-up appointments after the first episode can be an indicator of medication adherence. Medication adherence can be controlled by asking patients to bring their medications with them to the follow-up appointments. The results obtained in our study and in previous studies suggest that follow-up appointments contribute to patient–physician relations and support medication adherence by increasing insight into illness.

The strengths of our study are having several diagnostic groups and analyzing medication adherence from multiple perspectives. Moreover, a different point of view is presented by studying the history of medication nonadherence in inpatients. Limitations of our study include: the number of cases in diagnostic groups being relatively less than the number of characteristics studied, having a population composed of only inpatients, and being a cross-sectional study. Starting out from this point, further prospective studies conducted on outpatients, having a larger study population where the patients are followed-up for a longer time, and including a control group are suggested to be performed.

In conclusion, the ratio of medication nonadherence is high in patients hospitalized at a university hospital setting for bipolar disorder, schizophrenia/schizoaffective disorder, depression, and other disorders. Medication nonadherence affects treatment success significantly more in bipolar disorder and cases with irregular attendance to follow-up appointments. Views of psychiatric patients on medication nonadherence may contribute to determining strategies to increase medication adherence and to organize trainings for patients and families to decrease medication nonadherence. In the present study, medication nonadherence was evaluated through self-report, statements of relatives, and information on patient files. It is recommended to evaluate medication adherence in future studies through more specific methods such as pill counting and biochemical analysis along with the methods

used in the present study. Also, further studies are needed that score medication nonadherence in bipolar disorder, schizophrenia/schizoaffective disorder, and depression patients using a new scale specific for psychiatric patients and in terms of giving direction to the practice of reducing the medication nonadherence.

Acknowledgments

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Disclosure

The authors report no conflicts of interest in this work.

2.1. TRANSLATION OF THE SOURCE TEXT I

Pregled razloga nepravilnog uzimanja lijekova kod psihijatrijskih pacijenata

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Cilj istraživanja: Ovo istraživanje provedeno je kako bi se procijenili čimbenici koji utječu na nepravilno uzimanja lijekova unutar šest mjeseci prije prijema na psihijatrijsku skrb naše bolnice zbog bipolarnoga poremećaja, shizofrenije/shizoafektivnog poremećaja, depresije te ostalih psihijatrijskih bolesti.

Pacijenti i metode: U istraživanje je bilo uključeno dvjesto trideset tri pacijenata zaprimljena na psihijatrijsku skrb Medicinskog fakulteta. Proučavali su se sociodemografski parametri i klinički nalazi unutar šest mjeseci prije prijema te gledišta pacijenata na razloge nepravilnog uzimanja lijekova.

Rezultati: Pacijenti su bili razvrstani u četiri skupine u skladu s njihovim dijagnozama: bipolarni poremećaj (broj ispitanika = 68, 33.5%), shizofrenija/shizoafektivni poremećaj (broj ispitanika = 59, 29.1%), depresija (broj ispitanika = 39, 19.2%) i ostali (broj ispitanika = 37, 18.2%). Omjer nepravilnog uzimanja lijekova bio je veći u skupini bipolarni poremećaj u odnosu na skupine sa shizofrenijom/ shizoafektivnim poremećajem, depresijom te ostalim poremećajima (12.1%, 18.2% i 24.2% u odnosu na 45.5%), dok je u svim ostalim skupinama

omjer bio sličan. Analizom logističke regresije utvrđeno je kako su neredovito praćenje (omjer izgleda [OR]: 5.7; 95% interval pouzdanosti [IP]: 2.92-11.31) te dijagnoza (OR: 1.5; 95% IP: 1.07-1.95) važni čimbenici rizika kod nepravilnog uzimanja lijekova. Vodeći čimbenici povezani s nepravilnim uzimanjem lijekova su: „nije voljan uzimati lijekove“, „neprihvatanje bolesti“ i „smetnje uzrokovane nuspojavama“ u skupini bipolarni poremećaj, „neprihvatanje bolesti“ u skupini shizofrenija/shizoafektivni poremećaj, „osjeća se dobro“ u skupini depresija te „smetnje uzrokovane nuspojavama“ u skupini ostalih poremećaja.

Zaključak: Nepravilno uzimanje lijekova značajan je problem kod psihijatrijskih pacijenata i njime bi se trebalo baviti uzimajući u obzir dijagnozu, pohađanje termina praćenja te pacijentov stav. Osiguravanje redovitog pohađanja termina praćenja, prilagođavanje plana vođenja tretmana prema dijagnozi te poboljšanje njihovog razmišljanja u svezi opiranja uzimanja lijekova može djelovati blagotvorno na pridržavanje uzimanja propisane terapije.

Ključne riječi: bipolarni poremećaj, shizofrenija, shizoafektivni poremećaj, depresija, pacijentov stav

Uvod

Svjetska zdravstvena organizacija izvijestila je da je omjer nepravilnog uzimanja lijekova kod ljudi s kroničnim bolestima oko 50%. Odbijanje liječenja ozbiljan je problem kod psihijatrijskih pacijenata, na što nas upućuju podatci dobiveni nedavnim istraživanjem u kojem je utvrđen omjer odbijanja od čak 20-60%. Odbijanjem liječenja smatra se nepravilno uzimanje preporučene doze lijekova te neučestalost uzimanja istih, odbijanje uzimanja lijekova uopće te neredovito pohađanje termina praćenja ili nepohađanje termina uopće. Najvažniji i često susretljiv oblik nepravilnog uzimanja lijekova predstavljaju nepravilno uzimanje preporučene doze lijekova te neučestalost uzimanja istih. Omjer nepravilnog

uzimanja lijekova je 40%-60% za antipsihotike, 18%-56% za stabilizatore raspoloženja i 30%-97% (u prosjeku 63%) za antidepressive. Nadalje, u istraživanjima koja proučavaju nepravilno uzimanje lijekova s obzirom na dijagnozu, omjer nepravilnog uzimanja lijekova je 12%-64% kod pacijenata s bipolarnim poremećajem, 11%-80% kod pacijenata sa shizofrenijom te 30%-60% kod pacijenata koji boluju od depresije.

Postoje mnogi čimbenici koji vode k nepravilnom uzimanju lijekova kod psihijatrijskih pacijenata, uključujući nesvjesnost o postojanju bolesti, štetni učinak lijekova, ometajuće nuspojave koje utječu na kvalitetu života, nedostatak podrške obitelji i društva, nedovoljna informiranost o bolesti i liječenju te zloupotreba lijekova ili ovisnost. Dijagnostički i statistički priručnik za mentalne poremećaje (DSM)-5 opisuje mnoga stanja koja utječu na nepravilno uzimanje lijekova, uključujući prekomjernu težinu ili pretilost, simuliranje, lutanja uzrokovana mentalnim poremećajem te granične intelektualne sposobnosti. Nepravilno uzimanje lijekova jedan je od neizbježnih razloga koji utječe na vraćanje bolesti ili čak smrtnost pacijenata.

Iz tog razloga, tijekom procjenjivanja pacijenta trebaju se ispitati uzorci nepravilnog uzimanja lijekova. Potrebno je detaljno proučiti povijest nepridržavanja, konzumiranje alkohola ili lijekova za vrijeme perioda bez simptoma, doziranje lijekova, višestruko uzimanje lijekova, nuspojave te terapijsko povezivanje. Budući da nepravilno uzimanje lijekova učestalo uzrokuje pogoršanje, vraćanje bolesti, ponašanje štetno za sebe ili okolinu, samoubojstvo ili ponovno bolničko liječenje, ono ima negativan utjecaj na pacijenta, njegovu obitelj te društvo. Kod 20%-25% psihijatrijskih pacijenata bolničko liječenje povezano je s nepravilnim uzimanjem lijekova.

Istraživanja o nepravilnom uzimanju lijekova koja imaju važnu ulogu u liječenju psihijatrijskih bolesti te čimbenici povezani s nepridržavanjem obično upućuju na

pojedinačnu dijagnostičku skupinu. U literaturi ne postoji dovoljan broj istraživanja koja uspoređuju različite dijagnostičke skupine u odnosu na nepravilno uzimanje lijekova. Povrh toga, nedovoljan je i broj istraživanja koja procjenjuju utjecaj osobina pacijenata i čimbenika povezanih s bolešću na nepravilno uzimanje lijekova. Dobiveni rezultati o razlozima nepravilnog uzimanja lijekova mogu imati značajan utjecaj na bolničko liječenje pacijenata te praćenje vanjskih pacijenata. U ovom istraživanju čimbenici koji rezultiraju nepravilnim uzimanjem lijekova unutar šest mjeseci prije prijema na psihijatrijsku skrb naše bolnice zbog bipolarnog poremećaja, shizofrenije/ shizoafektivnog poremećaja, depresije i ostalih psihijatrijskih poremećaja vrednovani su višedimenzionalnim pristupom.

Pacijenti i metode

Ispitanici

Ovo unakrsno istraživanje provedeno je na pacijentima koji su zaprimljeni na bolničko liječenje u psihijatrijsku kliniku zbog bipolarnog poremećaja, shizofrenije i shizoafektivnih poremećaja, depresije te ostalih psihijatrijskih poremećaja. Prije provođenja istraživanja dobiveno je odobrenje Etičkog odbora za istraživanja koja se vrše na ljudskim ispitanicima. Svi pacijenti liječeni između listopada 2013. i veljače 2014. godine pozvani su da sudjeluju u istraživanju, a oni koji su bili voljni sudjelovati uključeni su u istraživanje na temelju dobivenog pristanka. U istraživanju se promatrao period od šest mjeseci prije početka studije. U istraživanje nisu bili uključeni pacijenti s višestrukim psihijatrijskim dijagnozama, intelektualnom onesposobljenošću te nepismeni pacijenti. Poremećaji po osi I procjenjivani su korištenjem istraživačke tehnike strukturiranog kliničkog intervjua za poremećaje po osi I (SKID- I). Pacijenti uključeni u istraživanje bili su razvrstani u skupine s obzirom na bipolarni poremećaj, shizofreniju/shizoafektivni poremećaj, depresiju te ostale poremećaje (kao što su

poremećaj prilagodbe, anksioznost, disocijativni poremećaj, zloupotreba lijekova ili poremećaj kontrole poriva, nije drugačije specificirano).

Instrumenti prikupljanja podataka

Za prikupljanje demografskih i kliničkih podataka pripremljen je poseban obrazac. Od pacijenata je zatraženo da obrazac popune na dan otpuštanja sa psihijatrijske skrbi. Pomoću navedenog obrasca proučavale su se sociodemografske karakteristike (spol, dob, stupanj obrazovanja, bračni status, zaposlenje, prebivalište, kućanstvo), kliničke te one karakteristike koje utječu na tijek bolesti (početak žaljenja zbog bolesti, broj bolničkih liječenja, prisustvo dijagnoze po osi II, dodatna fizička bolest te ovisnost o cigaretama ili drugim supstancama), pohađanje termina praćenja unutar šest mjeseci prije prijema te razlozi nepridržavanja uzimanja lijekova (odbijanje uzimanja lijekova, neprihvatanje bolesti, smetnje uzrokovane nuspojavama, osjeća se dobro, neupućenost o dužini perioda uzimanja lijekova, neosviještenost o redovitom uzimanju lijekova te drugi razlozi). Nepravilnim uzimanjem lijekova smatra se ne uzimanje bilo koje lijeka najmanje jedan tjedan unutar 6-mjesečnog perioda prije istraživanja. Ovi podatci upotpunjeni su informacijama dobivenima ispitivanjem rođaka u prvom koljenu te pomoću medicinskog kartona pacijenta. Neprisustvo na najmanje 20% termina praćenja tijekom šest mjeseci prije nego što je istraživanje započelo vodi se kao ne pohađanje redovitog kliničkog praćenja. Ovi podatci su također upotpunjeni informacijama dobivenima ispitivanjem rođaka u prvom koljenu te pomoću medicinskog kartona pacijenta.

Statistička analiza

Podatci su prikazani kao prosječna $\pm$ standardna devijacija (SD) i postotak te su statistički procijenjeni pomoću SPSS programa (verzija 22, IBM korporacija, Armonk, NY, SAD). Nakon opisne analize testom logističke regresije analizirali su se dob, spol, bračni status,

stupanj obrazovanja, pušenje, kućanstvo, prebivalište, neredovito pohađanje termina praćenja te dijagnostički parametri, što sve spada u nezavisne varijable za koje se smatra da utječu na zavisnu varijablu nepravilnog uzimanja lijekova. Raspodjela stavki po predmetima temeljila se na pitanjima sa sedam točaka (pitanja s višestrukim da/ne odgovorima). Na taj način ispitali su se razlozi nepravilnog uzimanja lijekova, dok se procjena vršila koristeći višestruku analizu odgovora. $P < 0.05$ se smatra statistički značajno.

Rezultati

Prosječna dob pacijenta je 36.7 ± 13.2 godina. Sociodemografske karakteristike prikazane su u Tablici 1. Devedeset šest (47.3%) pacijenata je u braku, 78 (38.4%) ih je završilo osnovnu školu dok ih je 145 (71.4%) nezaposleno. Sto trideset (64.0%) pacijenata živi u centru grada dok ih 97 (47.8%) živi s majkom/ocem/braćom.

Tablica 1. Sociodemografski parametri

Sociodemografske karakteristike	Broj ispitanika (%)
Spol	
Ženski	90 (44.3)
Muški	113 (55.7)
Bračni status	
U braku	96 (47.3)
Slobodan	75 (36.9)
Rastavljen	22 (10.8)
Udovac	10 (4.9)
Stupanj obrazovanja	
Osnovna škola	78 (38.4)

Srednja škola	40 (19.7)
Gimnazija	59 (29.1)
Fakultet	24 (11.8)
Radni status	
Nezaposlen	145 (71.4)
Zaposlen	58 (28.6)
Prebivalište	
Selo	39 (19.2)
Predgrađe	34 (16.7)
Grad	130 (64.0)
Kućanstvo	
Žena/djeca	82 (40.4)
Majka/otac/braća	97 (47.8)
Odgajalište	5 (2.7)
Sam	17 (9.0)
Drugo	2 (0.1)

Prosječno trajanje cjelokupnog bolničnog liječenja na psihijatrijskoj skrbi bilo je 2 dana (raspon: 0-20), dok je prosječan period za upućivanje žalbi bio $2,776.5 \pm 1,012.3$ dana. Bilo je 45 (22.2%) slučajeva komorbiditeta psihijatrijskih poremećaja, 23 (11.3%) pacijenata s dijagnozom po osi II te 20 (9.9%) pacijenata koji dugoročno zloupotrebljavaju opojne droge. Slučajevi s poviješću zloupotrebe opojnih droga izjasnili su se kako nisu koristili opojne droge unutar 6-mjesečnog perioda prije bolničkog liječenja. Dvadeset četiri (61.1%) slučajeva potvrdilo je da su pušači.

Otkriveno je kako je 104 (51.2%) pacijenata redovito uzimalo lijekove unazad šest mjeseci, dok 99 (48.8%) pacijenata nije. Pacijenti su bili proučavani unutar četiri skupine: bipolarni poremećaj (broj ispitanika = 68, 33.5%), shizofrenija/shizoafektivni poremećaj (broj

ispitanika = 59, 29.1%), depresija (broj ispitanika = 39, 19.2%) te skupina ostalih poremećaja (broj ispitanika = 37, 18.2%). U skupinu ostalih poremećaja bili su uključeni poremećaj prilagodbe (broj ispitanika = 7, 3.2%), poremećaj anksioznosti (broj ispitanika = 4, 2.8%), disocijativni poremećaj (broj ispitanika = 7, 3.2%), zloupotreba lijekova (broj ispitanika = 6, 2.7%) te poremećaj kontrole poriva, nije drugačije specificirano (broj ispitanika = 10, 5.0%).

Nepravilno uzimanje lijekova kod proučavanih podskupina koje su određene prema vrsti poremećaja prikazano je u Tablici 2. Nepravilno uzimanje lijekova bilo je značajnije u skupini bipolarni poremećaj uspoređujući rezultate s ostalim dijagnostičkim skupinama (12.1%, 18.2% te 24.2% u odnosu na 45.5%; $P < 0.05$).

Tablica 3. prikazuje sljedeće rezultate: otkriveno je da su kod nepravilnog uzimanja lijekova izrazito važne stavke 2, 3 i 1 u slučajevima bipolarnog poremećaja, stavka 2 kod slučajeva shizofrenije/shizoafektivnog poremećaja, stavka 4 u slučajevima depresije te stavka 3 u slučajevima koji su dijagnosticirani kao ostali poremećaji.

Proučavajući utjecaje važnih demografskih i kliničkih parametara navedenih u Tablici 4., uzimajući nepravilno uzimanje lijekova kao zavisnu varijablu, regresijskog analizom utvrđeno je kako dob, spol, bračni status, stupanj obrazovanja, pušenje, suživot s drugima te prebivalište nemaju značajan utjecaj na nepravilno uzimanje lijekova ($P > 0.05$), dok neredovito pohađanje termina praćenja (omjer izgleda [RO]: 5.7; 95% interval pouzdanosti [IP]: 2.92-11.31) te dijagnoza (RO: 1.5; 95% IP: 1.07-1.95) imaju povećan utjecaj na nepravilno uzimanje lijekova ($P < 0.05$).

Tablica 2. Nepravilno uzimanje lijekova kod bipolarnog poremećaja, shizofrenije/shizoafektivnog poremećaja, depresije te ostalih poremećaja

Nepravilno uzimanje lijekova	Bipolarni poremećaj (broj ispitanika =68)	Shizofrenija/ shizoafektivni poremećaj (broj ispitanika =59)	Depresija (broj ispitanika =39)	Ostali poremećaji (broj ispitanika =37)	Sveukupno
Prisutno	45 (45.5%)	24 (24.2%)	12 (12.1%)	18 (18.2%)	99 (100%)
Odsutno	23 (22.1%)	35 (33.7%)	27 (26.0%)	19 (18.3%)	104 (100%)

Napomena: Nepravilno uzimanje lijekova bilo je značajnije u skupini bipolarni poremećaj uspoređujući rezultate s ostalim dijagnostičkim skupinama ($P<0.05$).

Tablica 3. Povratna informacija o razlozima nepravilnog uzimanja lijekova kod bipolarnog poremećaja, shizofrenije/shizoafektivnog poremećaja, depresije te ostalih dijagnostičkih skupina

Podatci	Bipolarni poremećaj (broj ispitanika=45)	Shizofrenija/ shizoafektivni poremećaj (broj ispitanika =24)	Depresija (broj ispitanika =12)	Ostali (broj ispitanika =18)
Stavka 1: Odbijanje uzimanja lijekova	19 (23.2%)	6 (15.85%)	5 (17.9%)	7 (25.9%)
Stavka 2: Neprihvatanje bolesti	23 (32.9%)	9 (23.7%)	5 (17.9%)	6 (22.2%)
Stavka 3:Smetnje uzrokovane nuspojavama	22 (26.8%)	4 (10.5%)	5 (17.9%)	8 (29.6%)
Stavka 4: Osjeća se dobro	11 (13.4%)	5 (13.2%)	8 (28.6%)	3 (11.1%)
Stavka 5: Neupućenost o dužini perioda uzimanja lijevkova	1 (1.2%)	4 (10.5%)	1 (3.6%)	0
Stavka 6: Neosviještenost o redovitom uzimanju lijevkova	0	6 (15.8%)	2 (7.1%)	2 (7.4%)
Stavka 7: Drugi razlozi	2 (2.4%)	4 (10.5%)	2 (7.1%)	1 (3.7%)

Napomena: Odgovori u svakoj dijagnostičkoj skupini prikazani su kao broj te postotak slučajeva za svaki odgovor. Raspodjela stavki po predmetima temeljila se na pitanjima sa sedam točaka (pitanja s višestrukim da/ne odgovorima). Na taj način ispitali su se razlozi nepravilnog uzimanja lijekova, dok se procjena vršila koristeći višestruku analizu odgovora. Tablica prikazuje sljedeće rezultate: otkriveno je da su kod nepravilnog uzimanja lijekova izrazito važne stavke 2, 3 i 1 u slučajevima bipolarnog poremećaja, stavka 2 kod slučajeva shizofrenije/shizoafektivnog poremećaja, stavka 4 u slučaju depresije te stavka 3 u slučajevima koji su dijagnosticirani kao ostali poremećaji.

Tablica 4. Omjer izgleda odabranih demografskih i kliničkih parametara koji mogu utjecati na nepravilno uzimanje lijekova

Zavisne varijable	P-vrijednost	Omjer izgleda	95% interval pouzdanosti
Dob	0.86	1.0	0.97–1.04
Spol	0.44	1.3	0.65–2.73
Bračni status	0.77	0.9	0.61–1.44
Stupanj obrazovanja	0.09	0.3	0.08–1.21
Pušenje	0.50	1.3	0.63–2.58
Suživot s drugima	0.37	0.8	0.58–1.23
Prebivalište	0.55	0.9	0.59–1.32
Neredovito pohađanje termina praćenja	0.001	5.7	2.92–11.31
Dijagnoza	0.01	1.5	1.07–1.95

Napomena: Analizom logističke regresije otkriveno je kako su dijagnoza i neredovito pohađanje termina praćenja varijable koje imaju značajan utjecaj na nepravilno uzimanje lijekova.

Rasprava

U ovom istraživanju slučajevi zaprimljeni na bolničko liječenje u psihijatrijsku kliniku naše bolnice bili su razvrstani u nekoliko skupina, bipolarni poremećaj, shizofrenija/shizoafektivni poremećaj, depresija te ostali poremećaji, dok su se omjeri nepravilnog uzimanja lijekova tijekom posljednjih šest mjeseci proučavali pomoću kliničkih čimbenika koji utječu na nepridržavanje. Otkriveno je kako sociodemografski čimbenici nemaju utjecaj na nepravilno uzimanje lijekova. U ispitivanim skupinama nalazili su se slučajevi s bipolarnim poremećajem, shizofrenijom/shizoafektivnim poremećajem, depresijom te ostalim poremećajima. Omjer nepravilnog uzimanja lijekova bio je veći u skupini bipolarni poremećaj uspoređujući rezultate s ostalim skupinama. Shizofrenija/shizoafektivni poremećaj, depresija te ostali poremećaji imaju sličan omjer u pogledu nepravilnog uzimanja lijekova. U usporedbi s ostalim čimbenicima, na nepravilno uzimanje lijekova najviše utječu odbijanje uzimanja lijekova, neprihvatanje bolesti te smetnje uzrokovane nuspojavama u skupini bipolarni poremećaj, neprihvatanje bolesti u skupini shizofrenija/shizoafektivni poremećaj, osjećaj zdravlja u skupini depresija te smetnje uzrokovane nuspojavama u skupini ostalih poremećaja. Općenito, sve dijagnostičke skupine imale su sličan omjer uzevši u obzir odnos utjecaja ostalih stavki. Analizom logističke regresije procijenilo se kako su dob, spol, bračni status, stupnja obrazovanja, pušenje, suživot s drugima, prebivalište, neredovito pohađanje termina praćenja te dijagnoza stavke koje potencijalno mogu utjecati na uzimanje lijekova. Od navedenih stavki utvrđeno je kako su neredovito pohađanje termina praćenja (OV: 5.7) te dijagnoza (OV: 1.5) jedini čimbenici koji utječu na povećanje nepravilnog uzimanja lijekova. Utvrđeno je kako ostale varijable nemaju utjecaj na uzimanje lijekova.

U istraživanju provedenom od strane Scotta i Popea procjenjivali su se omjer te razlozi nepravilnog uzimanja lijekova (stabilizatora raspoloženja) u 98 slučajeva s bipolarnim

poremećajem. Autori su izvijestili kako je omjer nepravilnog uzimanja lijekova u protekle 2 godine iznosio 50%. Također tvrde kako su povijest nepravilnog uzimanja lijekova, nedostatak uvida u bolest te dulje uzimanje lijekova čimbenici koji značajno utječu na povećanje nepravilnog uzimanja lijekova. S druge strane, nuspojave nisu značajne kod predviđanja nepravilnog uzimanja lijekova, dok stavovi i ponašanje jesu. Arvilommi i suradnici proučavali su kliničke karakteristike s obzirom na njihov utjecaj na nepravilno uzimanje lijekova u 18-mjesečnom prospektivnom istraživanju provedenom na 168 unutarnjih i vanjskih pacijenata s bipolarnim poremećajem stupnja I i II. Autori su otkrili kako se kod polovice slučajeva javilo nepravilno uzimanje lijekova te su zaključili kako su glavni razlozi za to nuspojave, manjak motivacije te negativan stav. Slično kao i u literaturi, u ovom istraživanju otkrili smo kako polovica bipolarnih pacijenata lijekove ne uzima pravilno. Kada se uzmu u obzir rezultati gore navedenog istraživanja o bipolarnom poremećaju, razlozi nepravilnog uzimanja lijekova mogu biti pod utjecajem raznih kliničkih parametara. U ispitivanju u kojem su se iscrpno proučavali čimbenici povezani s pridržavanjem tretmanima kod bipolarnih pacijenata, Leclerc i suradnici grupirali su razloge lošeg pridržavanja tretmanima prema čimbenicima povezanim s pacijentom (npr. mlađa dob, muški spol, niži stupanj obrazovanja te komorbiditet zloupotrebe alkohola i droga), čimbenicima povezanim s liječenjem (npr. nuspojave te učinkovitost lijekova) te čimbenicima povezanim s poremećajem (npr. mlađa dob kod početka bolesti, jačina bipolarnog poremećaja, uvid u bolest te nedostatak svijesti o bolesti). Također, našim istraživanjem htjeli smo procijeniti dijagnostičke skupine kao čimbenike koji bi se mogli povezati s nepravilnim uzimanjem lijekova. Čimbenici povezani s pacijentom, koje su definirali Leclerc i suradnici, nisu bili procjenjivani na temelju dijagnostičkih skupina već kao nezavisne varijable analize logističke regresije cijele ispitivane skupine. Ipak, u skladu s literaturom, bipolarni pacijenti koji

odbijaju uzimati lijekove, ne prihvaćaju bolest te su ometeni nuspojavama stavljeni su u prve redove tijekom procjenjivanja.

U sveobuhvatnom pregledu nedavne literature, Lacro i suradnici odredili su srednju stopu nepravilnog uzimanja lijekova od 49.5% kod pacijenata sa shizofrenijom. U ovom istraživanju omjer nepravilnog uzimanja lijekova kod pacijenata sa shizofrenijom bio je 24.2%. To se može pripisati razlikama u ispitivanoj populaciji, metodologiji korištenoj u definiranju i mjerenju nepravilnog uzimanja lijekova te periodu u kojem se nepravilno uzimanje procenjivalo. Omjer redovitog uzimanja lijekova bio je viši kod pacijenata sa shizofrenijom u usporedbi s bipolarnim pacijentima (50%-60% naspram 35%). Na sličan način, u ovom istraživanju, omjer nepravilnog uzimanja lijekova bio je viši u slučajevima bipolarnog poremećaja u usporedbi s pacijentima sa shizofrenijom. Ustanovili smo kako je omjer onih koji poriču bolest bio 32.9% kod bipolarnih pacijenata odnosno 23.7% kod pacijenata sa shizofrenijom/shizoafektivnim poremećajem. Unal i suradnici tvrde kako 50% pacijenata koji nisu dolazili na praćenja nakon otpuštanja iz bolnice ili oni koji su dolazili neredovito imalo nedovoljna saznanja o svojoj bolesti. U drugom istraživanju, 68.5% pacijenata prestalo je uzimati lijekove bez dozvole liječnika zbog nuspojava, vjerujući kako im lijekovi neće pomoći u oporavku te kako se zbog njih neće osjećati bolje.

Pomno proučavajući razloge nepravilnog uzimanja lijekova uočili smo kako je nedostatak uvida u bolest jedan od vodećih čimbenika kod pacijenata s bipolarnim poremećajem te shizofrenijom/shizoafektivnim poremećajem (32.9% te 23.7%). U prethodnim unakrsnim istraživanjima utvrđeno je kako se pacijenti koji su svjesniji svoje bolesti dosljednije pridržavaju terapiji u odnosu na one koji nemaju saznanja o bolesti. Pokazalo se kako povećano saznanje o bolesti poboljšano utječe na uzimanje lijekova. Razine svijesti o bolesti mogu varirati, osobito kod psihotičnih pacijenata. U jednom drugom

istraživanju uočeno je kako prihvaćanje liječenja nije povezano s osviještenošću o mentalnoj bolesti već ovisi o povećanom shvaćanju kliničkih simptoma.

Utvrđeno je da je redovito pohađanje termina praćenja prisutno kod jednog od tri pacijenta (34.2%) koji boluju od kroničnih psihijatrijskih poremećaja. Loš socioekonomski status, mlađa dob, niži stupanj obrazovanja, povijest neredovitih dolazaka na tretmane praćenja, zloupotreba opojnih droga, niski stupanj funkcioniranja, ozbiljni psihijatrijski problemi, problemi komuniciranja s liječnikom te udaljenost mjesta stanovanja od mjesta gdje se vrši praćenje neki su od čimbenika koji se povezuju s neredovitim dolascima na termine praćenja. Nedolazak na termine praćenja nakon prvog termina može biti indikator nepravilnog uzimanja lijekova. Nepravilno uzimanje lijekova može se kontrolirati tako da se pacijenta zamoli da na termine praćenja uzima svoje lijekove. Rezultati dobiveni u ovom, ali i prošlim istraživanjima, ukazuju na to kako dogovoreni termini praćenja doprinose stvaranju odnosa između pacijenta i liječnika te potiču uzimanje lijekova kroz povećanje svijesti o bolesti.

Vjerodostojnost ovog istraživanja očitava se u korištenju nekoliko dijagnostičkih skupina te u multidimenzionalnom analiziranju nepravilnog uzimanja lijekova. Povrh toga, proučavanjem povijesti nepravilnog uzimanja lijekova kod bolesnika koji se liječe u bolnici prikazana su različita gledišta o uzimanju lijekova. Ograničenja ovog istraživanja uključuju unakrsno provođenje istraživanja te relativno manji broj slučajeva u dijagnostičkim skupinama negoli broj proučavanih čimbenika. Također, u istraživanje su bili uključeni samo pojedinci koji su se liječili u bolnici.

S tog gledišta, buduća prospektivna istraživanja trebala bi biti provedena na pacijentima koji se ne liječe u bolnici. Također, istraživanje bi trebalo imati veću studijsku populaciju koja uključuje pacijente praćene kroz duži period te bi se u istraživanje trebala uključiti kontrolna skupina.

U zaključku, omjer nepravilnog uzimanja lijekova kod pacijenata koji se liječe u sveučilišnoj bolnici zbog bipolarnog poremećaja, shizofrenije/shizoafektivnog poremećaja, depresije te ostalih poremećaja smatra se visokim. Nepravilno uzimanje lijekova znatno više utječe na uspješnost tretmana kod pacijenata s bipolarnim poremećajem te kod slučajeva koji neredovito pohađaju termine praćenja. Gledišta psihijatrijskih pacijenata na nepravilno uzimanje lijekova mogu doprinijeti određivanju strategija za povećanje pridržavanja uputa za uzimanje lijekova te organiziranju treninga za pacijente i članove obitelji kako bi se smanjilo nepravilno uzimanje lijekova. U ovom istraživanju nepravilno uzimanje lijekova bilo je procjenjivano pomoću izvještaja pacijenata, izjava rođaka te pomoću medicinskog kartona pacijenata. Kako bi se procijenilo uzimanje lijekova u budućim istraživanjima, preporučuju se posebne metode kao što su brojanje tableta te biokemijska analiza, uključujući i metode korištene u ovom istraživanju. Također, potrebna su daljnja istraživanja koja bilježe nepravilno uzimanje lijekova kod pacijenata koji boluju od bipolarnog poremećaja, shizofrenije/shizoafektivnog poremećaja te depresije koristeći novu ljestvicu specifičnu za psihijatrijske bolesnike. Uz to, buduća istraživanja trebala bi rezultirati davanjem uputa za proceduru smanjivanja nepravilnog uzimanja lijekova.

Zahvale

Autori žele zahvaliti svim pacijentima te medicinskom osoblju uključenom u istraživanje.

Priopćenje

Autori navode kako u ovom radu nema sukoba interesa.

2.2 COMMENTARY AND ANALYSIS

SOURCE TEXT I: Perspectives on reasons of medication nonadherence in psychiatric patients

Genre: Medical research

Source: Journal of Patient Preference and Adherence

Reference: Mert, D.G., Turgut, N.H., Kelleci, M., Semiz, M. (2015). *Perspectives on reasons of medication nonadherence in psychiatric patients*. Journal of Patient Preference and Adherence

Audience: Medical community (psychiatrists, doctors and the rest of the medical staff)

Purpose of writing: The research is conducted in order to familiarise the medical community with reasons of medication nonadherence in psychiatric patients. As it is stated in this text, there is insufficient number of research dealing with this topic. Extensive knowledge about medication nonadherence can be used to encourage psychiatric patients to take the prescribed medication.

Authenticity: Considering the fact that the research was conducted by the experts in the field of medicine, we can conclude that this work is authentic. This claim can be supported with a few more confirmations. The text was published in a well-known medical journal “Patient Preference and Adherence“ and the company Dove Medical Press, specialized in scientific and medical research, confirmed the authenticity of the text.

Style: Writing style of this text is expository. The authors explained how the research was conducted without giving their own personal opinion. Furthermore, they used a great deal of

supporting details, facts and figures in order to validate the obtained results. There is no jargon and cliché vocabulary, and the tone of the text is rather formal.

Level of formality: Highly formal (academic writing; writing methods follow all of the accepted language principles; no colloquial expressions; appropriate for academic setting)

Layout: A standard research layout. At the beginning there is a short summary of the research (purpose, patients and methods, results, conclusion and keywords). Summary is followed by an introduction and the main part of the research. At the end of the text the authors extricated the results of the research and compared them with other similar research in the discussion section. The main sections are visibly separated from the rest of the text by using larger font and bold letters in the titles. Subtitles are also written in larger font but without usage of bold letters. After the discussion there is a part which includes acknowledgments and disclosure. At the end of the text the authors have cited the sources used in their work.

Content: The first part of the text includes the short summary statement (purpose, patients and methods, results, conclusions and keywords). After the short summary, there is an introduction section. In this section the reader gets familiarised with the basic facts about the topic. In the main section (“Patients and methods”) the authors provide additional information about the study population, data collection tools and statistical analysis. The last part of the text includes the results and discussion sections. In the results section the authors interpret the outcome of the research, while in the discussion section they compare their results with other similar research.

Cohesion: The whole text is well integrated. The authors use the same terminology throughout the text. The key terms (such as “medication nonadherence”) are used in the same

context from the beginning to the end. With this repetition of the same terminology, the authors create the lexical cohesion of the text.

Sentence patterns: The text is composed mostly of compound and complex sentences. Sentences are written according to the specific rules and standards of academic writing (appropriate vocabulary, correctly used punctuation, subject-verb agreement, etc.). Authors avoid using ambiguous references in their sentences (such as this or they) and they follow all the grammar rules. They use past tense while reporting due to the fact that the research was conducted in the past.

Terminology of the subject: Medical terminology (such as “medication nonadherence”, “bipolar disorder”, “schizophrenia/schizoaffective disorder”, “depression”, etc.). Besides medical terminology, the authors use a few terms connected with statistics (“logistic regression analysis”, “confidence interval”, etc.). In the discussion part the authors use a Latin abbreviation “et al”, which means “and others”. The terms used in this research are closely related to the topic.

The translation of this research was quite a demanding task. Some of the terms used in this research were troublesome to translate due to the fact there are no equivalent expressions in the target language. In order to transfer the authors’ ideas properly into the target language, it was necessary to consult various medical dictionaries and articles with similar topics. It was particularly important to translate all the medical expressions accurately because there is a repetition of the same terminology throughout the whole research. If only one term is used in the wrong context, the whole translation loses its value.

The topic of the research is medication nonadherence. While translating this term, I came across a few difficulties. We cannot translate the term as “neuzimanje lijekova” because there

is no such expression in the medical literature. Croatian experts in the field of medicine mostly use the terms “neuredno uzimanje lijekova”, “nepravilno uzimanje lijekova”, “nepridržavanje uzimanja lijekova”, “neprimjereno uzimanje lijekova”, “nepridržavanje uputa o pravilnom uzimanju lijekova”, etc. I choose the second term because I think it is the most suitable one for this context. The last term “nepridržavanje uputa o pravilnom uzimanju lijekova” is rather too long and its usage could be inappropriate because the term is used repeatedly throughout the whole text.

Furthermore, authors have focused on just few disorders while conducting this research. I was already familiar with some of the terms such as bipolar disorder and depression, but the term schizoaffective disorder was new to me. In order to use the appropriate Croatian equivalent, I consulted the “MSD priručnik dijagnostike i terapije”.

Besides few terms closely related to the field of medicine, translation of some other phrases was problematic as well. The authors listed few factors for medication nonadherence such as “not accepting the disease”, and “being disturbed by side effects”. I translated those terms as nouns (“neprihvatanje“, “smetnje uzrokovane nuspojavama“). On the other hand, translating the phrase “feeling well“ as a noun phrase would be inadequate (for example: “osjećaj zdravlja“; “osjećaj boljitka“) so I decided to use the verb phrase instead (“ne osjeća se dobro“) because it fits in the context of the text. Another debatable phrase to translate was “follow-up appointments“. In Croatian language there is no single expression that could convey the meaning of the original phrase. In the interest of transferring the correct meaning, but respecting the tone, style and the formality level of the text, in the first version of the translation I used the phrase “dolazak na termine praćenja“. Since this is a highly formal text, I have decided to use more appropriate phrase - “pohađanje termina praćenja“.

Translating requires special effort when it comes to translating the names of organisations, books, etc. For example, when we are translating the term “The World Health Organization“, we should bear in mind that in the source language there is a capitalisation of every word in the names of some organisations. But that is not the case in the target language because the appropriate translation is “Svjetska zdravstvena organizacija“ (only the first letter is capitalised). There is a similar case with the names of books. For example, in the source language the name of the manual is “Diagnostic and Statistical Manual of Mental Disorders (DSM)-V“ (we can notice the capitalisation) while in the target language only the first word is capitalised (“Dijagnostički i statistički priručnik za mentalne poremećaje (DSM)-5“). While translating the name of this manual, I stumbled upon a few different translations of the title (“Dijagnostički i statistički priručnik za duševne poremećaje“, “Dijagnostički i statistički priručnik za psihičke poremećaje“ and “Dijagnostički i statistički priručnik za mentalne poremećaje“). The terms “duševni poremećaj“, “psihički poremećaj“ and “mentalni poremećaj“ have the same connotations, but I have decided to use the last example (“Dijagnostički i statistički priručnik za mentalne poremećaje“) because I discovered that in a few different articles, books and dissertations the staff of the University of Zagreb School of Medicine use this translation of the title. Considering the fact that they are the experts in the field of the medicine, I took over their translation of the manual.

Moreover, in order to improve my translation I decided to examine several articles with similar topics. The purpose of this examination was to use the same terminology in my translation as it was used in all the other studies. For example, I have found that the translation of the phrase “study population” is “ispitanici”, and that the “purpose” cannot be translated as “svrha istraživanja” but as “cilj istraživanja”. Besides that, this examination gave me an insight into the style and tone of academic writing of the target language.

Apart from medical terminology, authors used statistical terms while explaining the method of data processing. Some of the used terms are “Structural Clinical Interview Diagnosis I (SCID-I)“, “logistic regression test“, “odds ratio, “confidence interval“, etc. I have encountered some of these terms for the first time and in order to translate them as correct as possible I consulted various texts of similar topics written in the target language. I translated the name of the interview with the help of “Vodič za korisnike za Strukturirani klinički intervju za poremećaje s Osi I iz DSM-IV, klinička verzija“. While studying the materials of Faculty of Economics & Business Zagreb and other related faculties, I came across the translation of the term “logistic regression test” as “analiza logističke regresije”.

The term “odd ratio” and its abbreviation were quite tricky to translate. While examining the statistical terms of the target language, I came across the translation “relativni omjer”, “omjer vjerojatnosti” and “omjer izgleda”. Due to the fact that my knowledge of the statistical terms was not so extensive, I consulted Biochemia Medica “The journal of Croatian Society of Medical Biochemistry and Laboratory Medicine”. In one of the published works, I have found that the term is officially translated as “omjer izgleda” (“...omjer izgleda (engl. odds ratio, OR) je jedan od nekoliko statističkih testova...”). Throughout this work the authors used the English abbreviation of the term so I decided to do the same in my translation. Consulting the same journal, I have found the translation of the term “confidence interval”.

Another obstacle I have stumbled upon while translating was the abbreviation “*p*”. Reading through the articles of the similar topics in the target language, I came across the same abbreviation, but there was no explanation of its meaning. Some authors use only the abbreviation, while others use “*P vrijednost*”. Professor Ozren Polašek explains that the meaning of the abbreviation is probability of the accuracy of the obtained result. In English language “*p*” stands for probability and its usage is the same both in the source and the target language.

In the translation process, translation of some terms can be quite confusing. For example, while translating the terms “overweight and obesity” I was not sure which word denotes which meaning because both terms refer to the weight higher than the average. After consulting few health articles, I found out that the term “overweight” indicates having 10% more pounds than your optimal weight should be, while the term “obesity” includes everything above that percentage.

Due to the fact that this is a highly formal text, the structure of sentences is quite complex. While translating it was difficult to adhere to the original structure of the sentence. For example, while translating the sentence “ The distribution of the items selected by the cases in a seven-item question – multiple answer questions answered as yes/no – examining the reasons of medication nonadherence was evaluated using multiple response analysis.” I decided to detach the part after the hyphen as a separate sentence because it is unusual to combine two sentences with a hyphen in the target language.

Besides that, I often used inversion in my translation because the sentence patterns of the source language are not the same as the sentence patterns of the target language. One of the principles of translating is to adhere to the original text, but if the structure of the sentence is uncommon or it sounds odd, the translator needs to adapt the translation to the target language. It means that he or she is allowed to use an inversion or even divide one sentence into two separate parts, but he or she needs to bear in mind that the meaning of the translated sentence should correspond to the meaning of the original one.

3. SOURCE TEXT II:

Overview of the U.S. Health Care System

Written by Kao-Ping Chua

AMSA Jack Rutledge Fellow 2005-2006

February 10, 2006

INTRODUCTION

The U.S. health care system is the subject of much polarizing debate. At one extreme are those who argue that Americans have the “best health care system in the world”, pointing to the freely available medical technology and state-of-the-art facilities that have become so highly symbolic of the system. At the other extreme are those who berate the American system as being fragmented and inefficient, pointing to the fact that America spends more on health care than any other country in the world yet still suffers from massive uninsurance, uneven quality, and administrative waste.

Understanding the debate between these two diametrically opposed viewpoints requires a basic understanding of the structure of the U.S. health care system. This primer will explain the organization and financing of the system, as well as place the U.S. health care system in a greater international context.

ORGANIZATION OF U.S. HEALTH CARE SYSTEM

As with all other countries, there are both private and public insurers in the U.S. health care system. What is unique about the U.S. system in the world is the dominance of the private element over the public element.

In 2003, 62% of non-elderly Americans received private employer-sponsored insurance, and 5% purchased insurance on the private non group (individual) market. 15% were enrolled in public insurance programs like Medicaid, and 18% were uninsured. Elderly individuals aged 65 or over are almost uniformly enrolled in Medicare.

Public Health Insurance

- Medicare

- o Basics: Medicare is a federal program that covers individuals aged 65 and over, as well as some disabled individuals.

- o Administration: Medicare is a single-payer program administered by the government; single-payer refers to the idea that there is only one entity (the government) performing the insurance function of reimbursement.

- o Financing: Medicare is financed by federal income taxes, a payroll tax shared by employers and employees, and individual enrollee premiums (for parts B and D).

- o Benefits: Medicare Part A covers hospital services, Medicare Part B covers physician services, and Medicare Part D offers a prescription drug benefit. [Medicare Part C refers to Medicare Advantage – HMO's that administer Medicare benefits].

- There are many gaps in Medicare coverage, including incomplete coverage for skilled nursing facilities, incomplete preventive care coverage, and no coverage for dental, hearing, or vision care. Because of this, the vast majority of enrollees obtain supplemental insurance. Overall, seniors pay about 22% of their income for health care costs despite their Medicare coverage.

- Medicaid

- o Basics: Medicaid is a program designed for the low-income and disabled. By federal law, states must cover very poor pregnant women, children, elderly, disabled, and parents. Childless adults are not covered, and many poor individuals make too much to qualify for Medicaid.

- States have the option of expanding eligibility if they so choose. For example, states can choose to increase income eligibility levels.

- o Administration: The states and the District of Columbia are responsible for administering the Medicaid program; as such, there are effectively fifty-one different Medicaid programs in the country.

- o Financing: Medicaid is financed jointly by the states and federal government through taxes. Every dollar that a state spends on Medicaid is matched by the federal government at least 100%. In poorer states, the federal government matches each dollar more than 100%. Overall, the federal government pays for 57% of Medicaid costs.

- o Benefits: Medicaid offers a fairly comprehensive set of benefits, including prescription drugs. Despite this, many enrollees have difficulty finding providers that accept Medicaid due to its low reimbursement rate.

- Other public systems

- o S-CHIP: The State Children's Health Insurance Program (S-CHIP) was designed in 1997 to cover children whose families make too much money to qualify for Medicaid but make too little to purchase private health insurance. S-CHIP and Medicaid often share similar administrative and financing structures.

o VA: The Veteran's Administration is a federally administered program for veterans of the military. Health care is delivered in government-owned VA hospitals and clinics. The VA is funded by taxpayer dollars and generally offers extremely affordable (if not free) care to veterans.

Private Health Insurance

- Employer-sponsored insurance

o Basics: Employer-sponsored insurance represents the main way in which Americans receive health insurance. Employers provide health insurance as part of the benefits package for employees.

o Administration: Insurance plans are administered by private companies, both for-profit (e.g. Aetna, Cigna) and non-for-profit (e.g. Blue Cross/Blue Shield).

- A special case is represented by companies that are “self-insured” – that is, they pay for all health care costs incurred by employees directly. In this case, the company contracts with a third party to administer the health insurance plan. Self-insured companies tend to be larger companies such as General Motors.

o Financing: Employer-sponsored insurance is financed both through employers (who usually pay the majority of the premium) and employees (who pay the remainder of the premium). In 2005, the annual private employer-sponsored insurance premiums averaged \$4,024 for single coverage and \$10,880 for a family of four.⁵

- o Benefits: Benefits vary widely with the specific health insurance plan. Some plans cover prescription drugs, while others do not. The degree of cost-sharing (co-pays and deductibles) varies considerably.
- Private non-group (individual market)
 - o Basics: The individual market covers part of the population that is self-employed or retired. In addition, it covers some people who are unable to obtain insurance through their employer. In contrast to the group market (employment-based insurance), the individual market allows health insurance companies to deny people coverage based on pre-existing conditions.
 - o Administration: The plans are administered by private insurance companies.
 - o Financing: Individuals pay an insurance premium out-of-pocket for coverage. Risk in the individual market depends only on the health status of the individual, in contrast to the group market, in which risk is spread out among multiple individuals. As such, low-risk, healthy patients will have a low premium, whereas the opposite is true for high-risk, sick patients.
 - o Benefits: Benefits vary widely with the specific health insurance plan.

FINANCING OF THE U.S. HEALTH CARE SYSTEM

The financing of health care centers around two streams of money: the collection of money for health care (money going in), and the reimbursement of health service providers for health care (money going out). In the United States, the responsibility for these two functions is shared by private insurance companies as well as the government, both of which are known in policy terms as “payers.” As such, the United States can be thought of as a “multi-payer” system.

- Individuals and businesses

- o Taxes: Both individuals and businesses pay income taxes to the government. In addition, there is a payroll tax on employers and employees to finance Medicare.

- o Premiums: Businesses pay all or most of the premium for employer-based insurance for employees, and employees pay the remainder. On the individual market, individuals pay for all premiums out of pocket. Employer-based insurance premiums and individual insurance premiums are collected by private insurers.

- o Direct or out-of-pocket payments: This is a direct payment to a provider for health care services (e.g. a co-payment).

- Government

- o Medicare, Medicaid, S-CHIP, and the VA: The government uses money generated from taxes to reimburse providers who take care of patients enrolled in these programs.

- o Public employees' premiums: The government also uses tax dollars to pay private insurers a health insurance premium for federal employees and other public employees.

- o Tax subsidy: There is a tax subsidy of employer-based insurance (not shown in the graph) that represents a major cost to the government (on the order of \$100 billion). Employees receive health insurance benefits as tax-free compensation, and employers are able to deduct health insurance benefits as a cost of doing business. [Since employers are only taxed on profits, defined as any income above the cost of doing business, being able to deduct health insurance benefits as a cost of doing business is a tax subsidy for employers].

- Private insurers

- o Private insurers accept premiums from individuals, businesses, and the government.

In turn, they reimburse providers for taking care of patients with private insurance.

- Health service providers

- o Providers (doctors, allied health professionals, hospitals, and other health care facilities) take care of individuals. They are reimbursed for their services by private insurers and the government.

In 2002, government expenditures accounted for 44.9% of healthcare costs in the United States, and private expenditures accounted for the remaining 55.1%.⁶ The U.S. spent \$1.7 trillion on health care expenditures in 2003. Of the \$1.7 trillion used on health care, the majority went to hospital care and physician/clinical services.

THE U.S. HEALTH CARE SYSTEM IN AN INTERNATIONAL CONTEXT

[Note: This is taken directly from “OECD Health Data 2005: How Does the United States Compare”⁷].

Health spending and financing

The United States spent 15% of its GDP on health care in 2003, the highest percentage in the OECD (an organization of industrialized countries). The average percentage of GDP spent on health care in OECD countries was 8.6%. The United States also spends more on health care per capita than any other OECD country. In 2003, total health spending per capita was \$5,635 US dollars (adjusted for purchasing power parity), more than twice the OECD average of \$2,307 US dollars.

Between 1998 and 2003, health spending per capita in the United States increased in real terms by 4.6% per year on average, a growth rate comparable to the OECD average of 4.5% per year.

The public sector is the main source of health funding in all OECD countries, except for the United States, Mexico and Korea. In the United States, 44% of health spending is funded by government revenues, well below the average of 72% in OECD countries.

In the United States, private insurance accounts for 37% of total health spending, by far the largest share among OECD countries. Canada, France, and the Netherlands also have a relatively large share of funding coming from private insurance (more than 10%).

Resources in the health sector (human, physical)

- In 2002, the United States had 2.3 practicing physicians per 1000 population, below the OECD average of 2.9 per 1000 population.
- There were 7.9 nurses per 1000 population in the United States in 2002, below the OECD average of 8.2 per 1000 population.
- The number of acute care hospital beds in the United States in 2003 was 2.8 per 1000 population, below the OECD average of 4.1 beds per 1000 population.

Health status and risk factors

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In the United States, life expectancy at birth increased by 7.3 years between 1960 and 2002, which is less than the increase of 14 years in life expectancy in Japan, or of 8.4 years in Canada. In 2002/3, life expectancy in the United States stood at 77.2 years, below the OECD

average of 77.8 years. Japan, Iceland, Spain, Switzerland and Australia were among the top 5 countries registering the highest life expectancy among OECD countries.

Infant mortality rates in the United States have fallen greatly over the past few decades, but not as much as in most other OECD countries. In 2002, the infant mortality rate in the U.S. was 7 deaths per 1,000 live births, above the OECD average of 6.1. Among OECD countries, infant mortality is the lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway), which all have infant mortality rates below 3.5 deaths per 1,000 live births.

In the United States, the proportion of smokers among adults has fallen from 33.5% in 1980 to 17.5% in 2003, the lowest rate among OECD countries along with Canada and Sweden. In the United States, the obesity rate among adults (30.6% in 2002) is the highest in OECD countries, followed by Mexico (24.2% in 2000) and the United Kingdom (23% in 2003).

3.1. TRANSLATION OF THE SOURCE TEXT II

Pregled sustava zdravstvene skrbi SAD-a

Napisao: Kao-Ping Chua

AMSA Jack Rutledge Fellow 2005.-2006.

10. veljače 2006.

UVOD

Sustav zdravstvene skrbi SAD-a u velikoj je mjeri predmet polarizirajuće rasprave. S jedne strane nalaze se oni koji tvrde kako Amerikanci imaju „najbolji sustav zdravstvene skrbi u svijetu“, ističući tako slobodno dostupnu medicinsku tehnologiju te najmodernije objekte koji su postali simbolima njihovog sustava. S druge strane nalaze se oni koji ljutito kritiziraju američki sustav zbog fragmentiranosti i neučinkovitosti, na što ukazuje činjenica kako SAD troši više na zdravstvenu skrb negoli bilo koja druga zemlja na svijetu, a ipak se još uvijek bori s golemim brojem zdravstveno neosiguranih pojedinaca, neravnomjernom kvalitetom te administrativnim gubitcima.

Kako bi razumjeli raspravu između ova dva dijametralno oprečna stajališta, potrebno je osnovno predznanje strukture sustava zdravstvene skrbi SAD-a. Ovaj uvodni članak će objasniti organizaciju i financiranje sustava, kao i mjesto sustava zdravstvene skrbi SAD-a u internacionalnom kontekstu.

ORGANIZACIJA SUSTAVA ZDRAVSTVENE SKRBI SAD-a

Kao i u svim ostalim zemljama, sustav zdravstvene skrbi SAD-a sastoji se od privatnih i javnih osiguravatelja. Ono što američki zdravstveni sustav izdvaja od ostalih zemalja svijeta je prevlast privatnog nad javnim sektorom.

Privatno osiguranje pod pokroviteljstvom poslodavca 2003. godine primilo je 62% Amerikanaca mlade dobi, dok ih je 5% kupilo osiguranje na privatnom, negrupiranom (pojedinačnom) tržištu. U programe javnog osiguranja kao što je Medicaid (op.prev. naziv programa) bilo je uključeno 15% pojedinaca, dok ih je 18% bilo neosigurano. Osobe od 65 i više godina gotovo su podjednako uključene u program Medicare (op.prev. naziv programa).

Javno zdravstveno osiguranje

- Medicare

- o Osnove: Medicare je savezni program koji uključuje pojedince od 65 i više godina, kao i pojedine osobe s invaliditetom.

- o Administracija: Medicare je program pod upravom Vlade, a djeluje na principu samo jednog obveznika, što se odnosi na ideju da postoji samo jedan entitet (Vlada) koji obavlja funkciju nadoknade osiguranja.

- o Financiranje: Program Medicare se financira putem saveznog poreza na dohodak, to jest putem takozvanog poreza na isplatne liste poslodavaca i zaposlenika te putem individualnih premija za individue uključene u plan zdravstvenog osiguranja (za dijelove B i D).

- o Prednosti: Dio A Medicare programa pokriva bolničke usluge, Dio B Medicare programa pokriva liječnike usluge dok Dio D Medicare programa puža naknadu za lijekove na recept [Dio C Medicare programa odnosi se na „Medicare Advantage

plan“ (op.prev. naziv djela programa) organizacije zdravstvene zaštite koja upravlja pogodnostima Medicare programa].

- Postoje mnoge nedostaci Medicare programa, uključujući nepotpunu pokrivenost za kvalificirane domove za njegu, nepotpunu preventivnu skrb te neobuhvaćanje zdravstvene skrbi za njegu zubiju, sluha te vida. Upravo zbog toga velika većina individua uključenih u plan zdravstvenog osiguranja želi se izboriti za dopunsko osiguranje. Sve u svemu, ljudi treće životne dobi plaćaju oko 22% od svojih prihoda za troškove zdravstvenog osiguranja unatoč činjenici da su uključeni u Medicare program.

- Medicaid

o Osnove: Medicaid je program osmišljen za osobe s invaliditetom te niskim prihodima. Po saveznom zakonu države moraju pokrivati osiguranje za osobe slabijeg imovinskog statusa, što uključuje trudnice, djecu, starije, osobe s invaliditetom te roditelje. Odrasli bez djece nisu pokriveni programom, dok mnogi pojedinci slabijeg imovinskog statusa zarađuju previše da bi ostvarili pravo za Medicaid.

- Ako to žele, države imaju mogućnost proširenja ispunjavanja uvjeta. Na primjer, države mogu odlučiti o povećanju razine prihoda koji su potrebni za ispunjavanje uvjeta.

o Administracija: Države te okrug Columbia odgovorne su za administriranje Medicaid programa te sukladno tome u zemlji učinkovito djeluje pedeset jedan različit Medicaid program.

o Financiranje: Medicaid je financiran zajednički od strane država te federalne vlade putem poreza. Svaki dolar koji država potroši na Medicaid, federalna vlada

upotpunjuje s najmanje 100%. U siromašnijim zemljama, federalna vlada upotpunjuje svaki dolar s više od 100%. Sveukupno federalna vlada plaća 57% troškova Medicaid programa.

o Prednosti: Medicaid nudi prilično sveobuhvatan skup pogodnosti, uključujući lijekove na recept. Unatoč tome, mnoge individue uključene u plan zdravstvenog osiguranja susreću se s poteškoćama u pronalaženju davatelja usluga koji prihvaćaju Medicaid zbog niske stope naknade.

- Ostali javni sustavi

o S-CHIP: The State Children's Health Insurance Program (S-CHIP) (op.prev. naziv programa) osmišljen je 1997. godine kako bi se osigurala djeca onih roditelja čija su primanja iznad razine za ostvarivanje prava na Medicaid, ali istovremeno zarađuju premalo za kupnju privatnog zdravstvenog osiguranja. S-CHIP i Medicaid često dijele slične administrativne i financijske strukture.

o VA: The Veteran's Administration (op.prev. naziv programa) je vladin program za vojne veterane. Zdravstvena skrb se pruža u bolnicama i klinikama državnog vlasništva za VA programe. VA se financira od strane poreznih obveznika i u pravilu pružaju izuzetno povoljnu (ako ne i besplatnu) zdravstvenu skrb za veterane.

Privatno zdravstveno osiguranje

- Osiguranje pod pokroviteljstvom poslodavca

o Osnove: Osiguranje pod pokroviteljstvom poslodavca predstavlja glavni način na koji Amerikanci primaju zdravstveno osiguranje. Poslodavci pružaju zdravstveno osiguranje kao dio paketa pogodnosti za zaposlenike.

o Administracija: Planovi osiguranja upravljani su od strane privatnih tvrtki, kako za profitne (na primjer: Aetna, Cigna) tako i za neprofitne organizacije (na primjer: Plavi križ/Plavi štit).

- Poseban slučaj predstavljaju „samoosiguravajuće“ tvrtke koje direktno plaćaju sve troškove zdravstvenog osiguranja svojih zaposlenika. U tom slučaju, tvrtka ugovara plan zdravstvenog osiguranja s trećom stranom. „Samoosiguravajuće“ tvrtke najčešće su velika poduzeća, kao na primjer General Motors.

o Financiranje: Osiguranje pod pokroviteljstvom poslodavca financira se od strane poslodavca (koji obično plaća većinu premije) te radnika (koji plaća ostatak premije). 2005. godine godišnja privatna premija osiguranja pod pokroviteljstvom poslodavca iznosila je u prosjeku 4,024 dolara za jednu osobu te 10,880 dolara za četveročlanu obitelj.

o Prednosti: Prednosti se uvelike razlikuju unutar određenih vrsta planova zdravstvenog osiguranja. Neki planovi pokrivaju lijekove na recept, a neki ne. Stupanj podjele troškova (određen iznos kojeg zajednički pokrivaju poslodavac i zaposlenik te iznos osiguranja koje plaća osiguranik) znatno se razlikuje ovisno o vrsti plana.

- Privatno negrupirano osiguranje (pojedinačno tržište)

o Osnove: Pojedinačno tržište obuhvaća umirovljen dio stanovništva te samozaposlene pojedince. Osim toga, ono obuhvaća pojedince koji nisu u mogućnosti dobiti osiguranje od strane poslodavca. Za razliku od grupnog tržišta (osiguranje pod pokroviteljstvom poslodavca), pojedinačno tržište omogućuje osiguravajućim društvima uskraćivanje prava na osiguranje na temelju postojećih uvjeta.

- o **Administracija:** Planovi osiguranja upravljani su od strane privatnih osiguravajućih društva.

- o **Financiranje:** U svrhu pokrivanja troškova osiguranja, pojedinci samostalno plaćaju premije. Rizik ovakve vrste osiguranja ovisi isključivo o zdravstvenom stanju pojedinca, za razliku od grupnog tržišta u kojem se rizik proteže između više pojedinaca. Kao takvo, ovo nisko rizično osiguranje omogućuje zdravim pojedincima plaćanje niske premije, dok za bolesne pojedince visokog rizika vrijedi suprotno.

- o **Prednosti:** Prednosti se uvelike razlikuju unutar određenih vrsta planova osiguranja.

FINANCIRANJE ZDRAVSTVENOG SUSTAVA SAD-a

Financiranje zdravstvenog sustava centrirano je oko priljeva novca iz dva smjera, prikupljanje novčanih sredstava za zdravstvenu skrb (priljev novčanih sredstava) te naknada za zdravstvenu skrb od strane davatelja zdravstvenih usluga (odljev novčanih sredstava). U Sjedinjenim Američkim Državama odgovornost za te dvije funkcije podijeljena je između privatnih osiguravajućih društva i Vlade, te su sukladno tome obje strane u političkom kontekstu poznate kao „obveznici“. Kao takve, Sjedinjene Američke Države smatraju se sustavom „višestrukog plaćanja“.

- **Pojedinci te tvrtke**

- o **Porezi:** Fizičke osobe i tvrtke Vladi plaćaju porez na dohodak. Osim toga, postoji i takozvani porez na isplatne liste za poslodavce i zaposlenike pomoću kojeg se financira program Medicare.

- o **Premije:** Tvrtke plaćaju sve ili većinu premija za osiguranje zaposlenika pod pokroviteljstvom poslodavca dok zaposlenici plaćaju ostatak. Na pojedinačnom tržištu, pojedinci sve premije plaćaju samostalno. Premije za osiguranje pod

pokroviteljstvom poslodavca te premije za pojedinačna osiguranja prikupljaju privatni osiguravatelji.

o Izravno plaćanje ili plaćanje „iz vlastitog džepa“: Ovaj način plaćanja je zapravo izravno plaćanje davatelju usluge za pružanje zdravstvene skrbi (na primjer: participacije).

- Vlada

o Medicare, Medicaid, S-CHIP te VA programi: Novcem prikupljenim kroz poreze Vlada nadoknađuje troškove davatelja usluga koji brinu o pacijentima upisanim u navedene programe.

o Premije javnih službenika: Vlada također koristi novce prikupljene kroz poreze kako bi podmirili troškove zdravstvenog osiguranja za savezne zaposlenike te ostale djelatnike javnih službi.

o Porezna subvencija: Postoji porezna subvencija za osiguranje pod pokroviteljstvom poslodavca (nije prikazano na grafikonu) koja predstavlja veliki izdatak za Vladu (približno 100 milijardi dolara). Zaposlenici primaju porezne olakšice kao naknadu za zdravstveno osiguranje te zbog toga poslodavci mogu troškove zdravstvenog osiguranja pripisati troškovima poslovanja. [Budući da se poslodavce oporezuje samo na profit, to jest primanja koja iznose više od troškova poslovanja, u mogućnosti su uvrstiti zdravstveno osiguranje kao trošak poslovanja te tako ostvariti poreznu subvenciju.]

- Privatni osiguravatelji

o Privatni osiguravatelji prihvaćaju premije od strane pojedinaca, trvтки te Vlade, dok zauzvrat davateljima zdravstvenih usluga nadoknađuju troškove zdravstvene skrbi pacijenata.

- Davatelji zdravstvenih usluga

o Davatelji zdravstvenih usluga (liječnici, srodni zdravstveni djelatnici, bolnice i druge zdravstvene ustanove) brinu o pojedincima. Naknadu za svoje usluge primaju od strane privatnih osiguravatelja te Vlade.

Državnim rashodima 2002. godine pokriveno je 44.9% troškova zdravstva u Sjedinjenim Američkim Državama, dok je preostalih 55.1% pokriveno od strane privatnih korisnika. Sjedinjene Američke Države 2003. godine potrošile su 1.7 bilijuna dolara na zdravstvene izdatke. Od te svote novaca, većina je uložena u bolničku skrb te kliničke i liječničke usluge.

ZDRAVSTVENI SUSTAV SAD-a U INTERNACIONALNOM KONTEKSTU

[Napomena: Ovaj dio preuzet je direktno iz članka „OECD Health Data 2005: How Does the United States Compare” (op.prev. naziv članka)].

Zdravstveni troškovi i financiranje

Sjedinjene Američke Države 2003. godine utrošile su 15% BDP-a na zdravstvenu skrb, što čini najveći postotak u zemljama OECD-a (organizacija razvijenih zemalja). U zemljama OECD-a prosječni postotak BDP-a utrošenog na zdravstvenu skrb iznosi 8.6%. Sjedinjene Američke Države također troše više na zdravstvenu skrb po stanovniku negoli bilo koja druga

zemlja OECD-a. Ukupna zdravstvena potrošnja po stanovniku 2003. godine iznosila je 5,635 američkih dolara (prilagođeno paritetu kupovne moći), čak dvostruko više od OECD prosjeka koji iznosi 2,307 američkih dolara.

Između 1998. i 2003. godine izdaci za zdravstvenu skrb po stanovniku u Sjedinjenim Američkim Državama u realnim uvjetima porasli su u prosjeku za 4.6% godišnje te je ta stopa rasta usporediva s OECD prosjekom koji iznosi 4.5% godišnje.

Javni sektor glavni je izvor financiranja zdravstva u svim OECD zemljama, izuzevši Sjedinjene Američke Države, Meksiko te Koreju. U Sjedinjenim Američkim Državama 44% zdravstvenih troškova financira se putem vladinih prihoda, što je znatno ispod prosjeka zemalja OECD-a koji iznosi 72%. U Sjedinjenim Američkim Državama privatno osiguranje iznosi 37% ukupne zdravstvene potrošnje, što je daleko najveći udio među zemljama OECD-a. Kanada, Francuska i Nizozemska također imaju razmjerno velik udio financiranja od strane privatnih osiguravatelja (više od 10%).

Ljudski te fizički resursi u sektoru zdravstva

- Sjedinjene Američke Države 2002. godine imale su 2.3 uvježbana liječnika na 1000 stanovnika, što je ispod OECD prosjeka koji iznosi 2.9 na 1000 stanovnika.
- U Sjedinjenim Američkim Državama 2002. godine bilo je 7.9 medicinskih sestara na 1000 stanovnika, što je ispod OECD prosjeka koji iznosi 8.2 medicinskih sestara na 1000 stanovnika.
- Broj kreveta za bolesnike s akutnim sindromima u bolnicama Sjedinjenih Američkih Država 2003. godine iznosio je 2.8 na 1000 stanovnika, što je ispod prosjeka OECD-a koji iznosi 4.1 kreveta na 1000 stanovnika.

Zdravstveni status te faktori rizika

Većina zemalja OECD-a doživjela je veliki napredak u produljenju očekivanog trajanja života u proteklih 40 godina. U Sjedinjenim Američkim Državama očekivano trajanje života pri rođenju uvećalo se za 7.3 od 1960. do 2002. godine, što je manje od uvećanja očekivanog trajanja života u Japanu (14 godina) ili povećanja od 8.4 godina u Kanadi. Očekivano trajanje života u SAD-u 2002./2003. godine iznosilo je 77.2 godine, što je ispod OECD prosjeka koji iznosi 77.8 godina. Japan, Island, Španjolska, Švicarska i Australija svrstavaju se u prvih 5 zemalja koje su evidentirale najduži životni vijek među zemljama OECD-a.

U nekoliko posljednjih desetljeća smrtnost dojenčadi u SAD-u pala je u velikoj mjeri, ali opet ne toliko koliko u većini drugih zemalja OECD-a. U 2002. godini stopa smrtnosti dojenčadi u SAD-u bila je 7 umrlih na 1000 živorođene djece, što je iznad OECD prosjeka koji iznosi 6.1. Među zemljama OECD-a stopa smrtnosti dojenčadi najniža je u Japanu i nordijskim zemljama (Islandu, Švedskoj, Finskoj i Norveškoj). U navedenim zemljama stopa smrtnosti dojenčadi iznosi 3.5 umrlih na 1000 živorođene djece.

U Sjedinjenim Američkim Državama udio pušača među odraslima od 1980. do 2003. godine pao je s 33.5% na 17.5%, te uz Kanadu i Švedsku spada u zemlje OECD-a s najnižom stopom pušača. Stopa pretilosti kod odraslih osoba (30.6%, 2002. godine) jedna je od najviših u zemljama OECD-a, nakon čega slijedi Meksiko (24.2%, 2000. godine) te Velika Britanija (23%, 2003. godine).

3.2. COMMENTARY AND ANALYSIS

SOURCE TEXT II: Overview of the U.S. Health Care System

Genre: Health care overview; medical article; life/health article

Source: American Medical Student Association

Reference: Chua, K.P. (2006). *Overview of the U.S. Health Care System*. American Medical Student Association

Audience: The text is written to an unknown audience and it is intended to be read by general population. The author assumes that the reader's knowledge about this topic is not so extensive and that is why he is trying to explain how the system works in the simplest possible way.

Purpose of writing: The aim of this text is to summarise all the basic facts about the U.S. health care system. The author wants to deliver the most important information about the topic to the reader. There is an ongoing debate about the U.S. health care system and the author thinks that the reader needs to understand the structure of the system in order to understand the debate.

Authenticity: Due to the fact that the source of the text is American Medical Student Association and that the article is written by the attending physician in the Division of Emergency Medicine at Boston Children's, who graduated from Vanderbilt University with a B.S. in Neuroscience and received an M.D. from Washington University School of Medicine in St. Louis (Harvard University, 2016), we can consider this article authentic.

Style: Writing style of this text can be considered as expository. The author uses a lot of supportive details, facts and examples. Voice of the text is objective because the author did not include his view on the subject. The author tries to familiarise the reader with the topic by describing the system and that is why we can say that this is a descriptive article as well.

Level of formality: Formal (academic writing; writing follows all the accepted language principles; no colloquial expressions; appropriate for academic setting)

Layout: The text is divided into four main parts. Four main titles are written in bold letters and capitalised, while the subtitles are also written in bold letters but without capitalisation. In the first part the author introduces the reader with the subject. The second part is divided into two sections, public and private health insurance. Those two subtitles are written in Italics. The text in every section is written as a bulleted list. Due to this way of writing, it is easier for the reader to notice the most important facts and figures because the sentences are quite short and not too complex. The third part is also written as a bulleted list. The fourth part is divided into three sections. In this part the author did not use the bulleted list. At the end of the article there is no conclusion, just a reference list. Throughout the text, the author used bold letters for some terms, trying to draw the reader's attention to them.

Content: In the introduction part the author explains what the purpose of this overview is. Since there is an ongoing debate about the U.S. health care system, the author's aim is to provide basic information about it. The author believes that the first step towards understanding this polarising debate is to learn the basic facts about the system in general. The body of the overview is divided into three parts. The first part of the body is focused on the organisation of the U.S. health care system. The author explains the two branches of the system, public and private health insurances. Public health insurance is divided into three main parts, Medicare, Medicaid and other public systems. On the other hand, private health

insurance is divided into two parts, employer-sponsored insurance and private non-group insurance. The second part of the body deals with financing of the system. In this part the author analyses U.S. health care system as a "multi-payer" system. According to the author, the financing of the system is divided among individuals, businesses, the government, private insurers and health service providers. The last part of the body focuses on comparing the U.S. health care system with health services of the other countries. This comparison is based on three different aspects: financing, human and physical resources and health status and risk factors. This last part of the body is also the last part of the overall overview.

Cohesion: Throughout the whole overview the author is dealing with the same topic and accordingly he uses the same terminology from the start to the end. Due to this repetition of the same terms, the author achieves a good integration of the text. This entire overview is focused on just one topic, U.S. health care system, and in every section the author deals with different aspects of that topic.

Sentence patterns: The author uses rather short and simple sentences due to the fact that this overview is written for a general population. His usage of appropriate vocabulary, correctly used punctuation, no jargon or cliches, etc., is suitable for this kind of a formal text. When he is reporting facts and figures taken from the research conducted in the last few years, the author uses past tense. On the other hand, when the author is reporting about the basic principles of the system, he uses present simple since these principles are considered as general actions/situations that do not change over time.

Terminology of the subject: In this overview the author is combining the terminology connected with health services, financing, taxes, insurances, demography, etc. Since this text is not based on just one aspect of the health care system, it is necessary to use terminology of different fields. All the terms used in this text are closely related to the different aspects of the

main topic. For example, the author uses terms such as “infant mortality rate“ (demography), “government revenues“ (financing), “payroll tax“ (taxes), “acute care hospital beds” (health care system), etc.

The most considerable difficulties while translating this overview were the names of the programmes. Since the topic of the text is U.S. health care system, some of the names do not have the corresponding translation in the target language (due to the fact they do not exist in the target language community). For example, “The State Children’s Health Insurance Program” does not exist in the Croatia. The most similar thing is “Program zdravstvene zaštite djece, higijene i pravilne prehrane djece u dječjim vrtićima”, but since this program is designed only for children enrolled in early childhood education, we cannot use this term because it does not fit into the context of the original text. The same situation is with “The Veteran’s Administration” program. I solved this problem using the original names in the translation, explaining the reason for that by writing the translator’s remark in brackets.

Another issue was the translation of the term “AMSA Jack Rutledge Fellow 2005-2006“. Since this term is referring to the scholarship program for U.S. students, there is no equivalent term in the target language.

While translating some of the terms, it was necessary to use descriptive translation due to the fact there is no equivalent term in the target language. For example, the term „acute care hospital beds“ could be translated as “akutni kreveti”, but this translation is not in the tone of the target language. I found some articles in which the authors use this translation of the term, but they put it under the quotation marks. Since this is a formal text I have decided to use a

descriptive phrase instead (“broj kreveta za bolesnike s akutnim sindromima“). I consider that this translation is more appropriate since the word “acute“ refers to the patients, not beds.

Another issue I came across while translating was when the term of the source language has several synonyms in the target language. For example, the term “life expectancy“ can be translated as “očekivani životni vijek”, “očekivano trajanje života”, “prosječan životni vijek”, etc. In order to use the most appropriate term, I checked various demographic reports. The official term which is used in this kind of reports is “očekivano trajanje života” so I used the same term in my translation. The term “infant mortality rate” also has several synonyms when it comes to the target language. In the first version of the translation I used the term “stopa smrtnosti novorođenčadi” but after checking various demographic reports, I found out that the official term which is used is “stopa smrtnosti dojenčadi”.

Sometimes when we are translating from the source language into the target language, it is necessary to improvise in order to keep the meaning of the original phrase. In English language there is a wide range of compound nouns which do not have the equivalent terms in the Croatian language. For example, if we want to translate the term “employer-sponsored insurance”, we need to use a descriptive phrase. One possible translation is “osiguranje od strane poslodavca” but more appropriate translation (the one which is used in the official documents) is “osiguranje pod pokroviteljstvom poslodavca”.

Another example of a compound noun which was quite tricky to translate is “self-insured companies”. Even the author used quotation marks for this term in the original text. Apparently the usage of this term is not so often in the source language as well. One possible translation of the term is “tvrtke koje samostalno pokrivaju zdravstveno osiguranje”, but since

the translation should be clear and concise, I decided to use the term “samosiguravajuće tvrtke” (putting it under the quotation marks). The reader can conclude what is meant under this term from the surrounding text because the real meaning of the term is explained in the next sentence.

While translating, the translator needs to avoid ambiguity. For example, while translating the sentence “states must cover very poor pregnant women, children, elderly...”, translator needs to be very careful. If the translator uses the adjective “poor” at the wrong part of the sentence, the meaning of the original sentence is lost. Literal translation of the sentence would be “države moraju pokrivati osiguranje za siromašne trudnice, djecu, starije...”. This translation is not valid because the adjective “poor” refers only to pregnant women, but in the original sentence it refers to the children and elderly as well. In order to avoid this issue, I did not use the literal translation of the adjective “poor”. Instead of the term “siromašan” I used a phrase “osobe slabijeg imovinskog statusa” and in the next part of the sentence I listed all the individuals who belong to this group. The final translation was “države moraju pokrivati osiguranje za osobe slabijeg imovinskog statusa, što uključuje trudnice, djecu, starije...”.

When translating from English into Croatian language, we need to be careful when it comes to capitalisation. For example, when the names of non-profit organisations such as Blue Cross and Blue Shield are used in the source language every word is capitalised. But when it comes to the target language, only the first word is capitalised (Plavi križ; Plavi štit).

Another difficulty connected with capitalisation was the translation of the word government. In the source language there is no capitalisation of the word, but in the target language there is a different set of rules. Names of institutions, organizations and associations should be written

with a capital letter. The term “federal government” is easy to translate because there is no capitalisation (the same is in Croatian language, for example “hrvatska vlada”). But when the author uses only the term “government”, it is questionable whether to use the initial capitalisation or not. According to the rules of the target language, the term government can be spelled with or without the initial capital letter. Since this is a formal text, I decided to use an initial capital letter because in the official documents of the target language, in the most cases, there is an initial capitalisation of the term.

Since the sentence pattern of this text are rather short and not too complex, there was no need to separate them when translating. In order to adapt the translation to the target language, I used inversion when it was necessary. For example, when translating the sentence “Infant mortality rates in the United States have fallen greatly over the past few decades...”, in the translation I put the time phrase at the beginning of the sentence in order to adjust the translation to the tone of the target language (“U nekoliko posljednjih desetljeća stopa smrtnosti dojenčadi u SAD-u pala je u velikoj mjeri...”).

4. SOURCE TEXT III:

BEING THE FIRST MAN ON THE MOON

This story originally aired on Nov. 6, 2005.

On July 20, 1969, Neil Armstrong stepped out of an odd-looking spaceship and into the pages of history as the first man on the moon.

Today, he remains one of the most famous people on the planet, but he is also famously private. For years, Armstrong has shunned the media and the limelight, but last fall he took a giant leap back into the public view. He has finally authorized a biography, entitled *First Man* and written by James Hansen.

In November, he agreed for the first time to a television profile, speaking to **60 Minutes** correspondent **Ed Bradley** about his extraordinary life.

Neil Armstrong still remembers the powerful liftoff of Apollo 11. "It felt like a train on a bad railroad track, shaking in every direction. And it was loud, really loud."

Armstrong is 75 now, an aging hero, but his winning smile is still there. We remember him as the cool, confident commander of Apollo 11, joined by his crewmates, Buzz Aldrin and Michael Collins. On a windswept day, Bradley went with Armstrong to an old Apollo launch pad at Kennedy Space Center to hear the story of one of man's greatest adventures.

"That July morning in 1969, when you came out and you gave that thumbs-up, I mean, that was a very confident view you put on," says Bradley.

"Yeah, but a little bit of a sham, I admit," says Armstrong. "You know, the reality is, a lot of times you get up and get in the cockpit, and something goes wrong somewhere and you go back down. So, actually, when you actually lift off, it's really a big surprise."

Perched atop a Saturn 5 rocket, the astronauts were on their way to meet the challenge President Kennedy had made eight years earlier: to land a man on the moon and return him safely to earth before the end of the decade.

It took 400,000 workers and \$24 billion, intended in large part to prove American superiority over the Soviets. Armstrong acknowledges that the hopes of the nation were riding on the mission. "We wanted to do well. And, even more than that, you hope that you don't, you as a person, don't make any mistakes." And he didn't. Armstrong's entire life had prepared him well, starting with a childhood fascination with flight. He earned his pilots license at 16 before he learned to drive. By age 21, he was flying combat missions over Korea. After the war, he became a hotshot test pilot, flying the famous X-15 at 4,000 miles an hour to the edge of the atmosphere. It was during that time, in 1962, when he faced his most difficult test, losing his 2-year old daughter, Karen, to brain cancer. Armstrong poured himself into his work. "I thought the best thing for me to do in that situation was to continue with my work, keep things as normal as I could. And try as hard as I could not to have it affect my ability to do useful things."

"But that's not an easy thing to do. How do you think you did?" Bradley says.

"At the time I thought the family was handling it well. And I was doing the best I could," Armstrong says.

During that same difficult year, Armstrong was chosen to be an astronaut. He flew his first space mission in 1966 on Gemini 8, and nearly lost his life when his tiny capsule briefly spun out of control.

He cheated death again two years later, while flying an experimental device designed to simulate a lunar landing. When it malfunctioned, Armstrong was sitting at the controls. He ejected barely 100 feet from the ground.

After the almost-fatal ordeal, Armstrong went back to his office to do some paperwork. "I did. There was work to be done," says Armstrong, matter-of-factly.

"Wait a minute. You were just almost killed," Bradley says.

"Well, but I wasn't," says Armstrong.

Armstrong stood out, even among a class of astronauts that had the right stuff. His depth of experience and nerves of steel earned him, at age 38, the command of Apollo 11. The trip to the moon took four days; after achieving lunar orbit, Michael Collins would remain in the command module, while Neil Armstrong and Buzz Aldrin climbed into the lunar module, undocked, and began their descent.

But the landing took an unexpected turn: the onboard guidance system was sending Armstrong and Aldrin right towards disaster.

"Our autopilot was taking us into a very large crater, about the size of a big football stadium with steep slopes on the crater, covered with very large rocks about the size of automobiles. That was not the kind of place I wanted to try to make the first landing," Armstrong says.

Armstrong overrode the autopilot and looked for a safe place to land, but the detour cost them precious fuel, and they were about to run out.

A worldwide television audience of a nearly a billion people was on the edge of their seats and so was CBS' own Walter Cronkite. **60 Minutes** couldn't resist reuniting the former anchorman with the former spaceman. There are things they can laugh about now but, at the time, those final seconds were almost unbearable.

"We were following the flight plan and we suddenly realized that he had made a detour and we didn't know how long that detour was going to be," remembers Cronkite. "Yes, I was very much concerned. I think all of us who were following the flight that closely were scared to death. If he wasn't, we were."

Then came Armstrong's famous words: "Houston, Tranquility Base here. The eagle has landed."

"Roger, Tranquility, we copy you on the ground, you got a bunch of guys about to turn blue. We're breathing again. Thanks a lot," mission control replied.

The landing left Cronkite almost speechless.

"You are a man who I've known for years never to be at a loss for words but you were at a loss for words then. I think all you could come up with was, 'Oh, boy,' " says Bradley.

"It turned out I didn't have anything to say at all except, 'Wow, oh, boy. Oh, boy,' " Cronkite says, laughing. "Perfectly speechless."

The ghostly image of man on the moon was beyond words. Armstrong paused on the bottom rung of the ladder and planted his left boot on the lunar dust.

"That's one small step for man, one giant leap for mankind," Armstrong said as he set foot on the moon.

"Do you recall how you came up with that 'A small step for man?' What was the inspiration for it?" Bradley asks.

"I thought, 'Well, when I step off, I just gonna be a little step.' ... But then I thought about all those 400,000 people that had given me the opportunity to make that step and thought 'It's going to be a big something for all those folks and, indeed, a lot of others that even weren't even involved in the project.' So it was a kind of simple correlation of thoughts," Armstrong says.

Armstrong clearly remembers the lunar surface. "It's a brilliant surface in that sunlight. The horizon seems quite close to you because the curvature is so much more pronounced than here on earth. It's an interesting place to be. I recommend it."

Armstrong and Aldrin spent just a short time on the lunar surface, testing the gravity, completing a long list of experiments, and marking their journey. They had come in peace for all mankind, but stayed less than a day.

The hard part was re-entry. But when they returned to earth, they were superstars. In New York, four million people showered them with ticker tape. On a 45-day victory lap around the world, they were met by crowds in the Congo and by the queen at Buckingham Palace.

But as Armstrong reveals in his new biography, published by CBS sister company Simon & Schuster, he was unprepared for his sudden celebrity, and found it to be both a blessing and a burden.

"Friends and colleagues all of a sudden looked at us, treated us slightly differently than they had months or years before when we were working together. I never quite understood that," Armstrong says.

"You said once to a reporter, 'How long must it take before I cease to be known as the space man?' Why did you make that comment?" Bradley says.

"I guess we all like to be recognized not for one piece of fireworks, but for the ledger of our daily work," Armstrong says.

Strolling around the Ohio farm where he was born, Armstrong is easy to talk to, but hard to know. He can seem guarded, but above all we were struck by his humility.

"You sometimes seem uncomfortable with your celebrity. That you would rather not have all of this attention," Bradley says.

"No, I just don't deserve it," Armstrong says, laughing.

"But look. How many people have walked on the moon? Twelve? You were the first. You were chosen to do that. That's special," says Bradley.

"Yeah, I wasn't chosen to be first. I was just chosen to command that flight. Circumstance put me in that particular role. That wasn't planned by anyone," Armstrong says.

After Apollo 11, Armstrong hung up his spacesuit, and never felt the need for an encore. For eight years, he taught engineering at the University of Cincinnati, surely the students' only professor who had walked on the moon.

"In the midst all your professional achievements, you've managed to get married, to have a family. Was it a difficult balance for you to maintain both sides of your life?" Bradley asks.

"The one thing I regret was that my work required an enormous amount of my time, and a lot of travel," Armstrong says. "And I didn't get to spend the time I would have liked with my family as they were growing up."

Armstrong has two sons with his wife of 38 years, Janet, who divorced him in 1994.

He remarried several years ago. In the autumn of his life, he lives very much in the present, refusing to let his famous deed define him. He has made a comfortable living serving on corporate boards, but even in retirement he keeps a watchful eye on the space program. He would like to see it restored to its glory days.

Armstrong knew the Apollo program had a limited life but expected it to last longer. "I fully expected that, by the end of the century, we would have achieved substantially more than we actually did."

"And why do you think we didn't continue?" Bradley says.

"When we lost the competition, we lost the public will to continue," Armstrong replies. The man who once rode a 160-million horsepower rocket now flies a glider, a plane with no engine.

"Glider, sail planes, they're wonderful flying machines. It's the closest you can come to being a bird," says Armstrong.

What does Armstrong get out of gliding? "Oh, it is self satisfaction. A sense of accomplishment. At trying to do a little better than you think you possibly can," he says.

NASA recently announced plans to send men back to the moon by 2018 and later to Mars. Don't think Neil Armstrong hasn't noticed.

"You said you would like to see us go back to the moon, and then go on to Mars. Something you want to do at this point in your life?" Bradley asks.

"I don't think I'm going to get the chance. But I don't want to say I'm not available," Armstrong says, laughing.

4.1. TRANSLATION OF THE SOURCE TEXT III:

PRVI ČOVJEK NA MJESECU

Ova priča izvorno je emitirana 6. studenog 2005. godine.

20. srpnja 1969. godine Neil Armstrong izašao je iz neobične svemirske letjelice te ušao u povijest kao prvi čovjek na Mjesecu.

Neil Armstrong ostao je sve do danas jedan od najslavnijih ljudi na svijetu, posebno poznat po tome da se nikada nije previše izlagao očima javnosti. Armstrong je godinama izbjegavao medijsku pažnju no prošle jeseni napravio je veliki korak te se otvorio javnosti. Konačno je odobrio vlastitu biografiju pod nazivom *Prvi čovjek* autora Jamesa Hansena.

U studenom je po prvi puta pristao na televizijski intervju, pričajući o svojem izvanrednom životu s **dopisnikom emisije 60 Minutes, Edom Bradleyem.**

Neil Armstrong i dalje pamti spektakularno polijetanje Apolla 11. „Osjećao sam se kao da sam u vlaku koji se kreće po lošoj pruzi, sve je podrhtavalo. Bilo je glasno, izrazito glasno.“

Danas ovaj ostarjeli junak ima 75 godina no njegov privlačan osmijeh još uvijek je na njegovom licu. Uz ostale članove posade, Buzza Aldrina te Michaela Collinsa, Armstronga pamtimo kao staloženog, uvjerenog zapovjednika Apolla 11. Tog vjetrovitog dana, Bradley je otišao s Armstrongom do svemirskog centra „Kennedy“, gdje se nalazi stara lansirna rampa Apolla, kako bi čuo priču o jednoj od čovjekovih najvećih avantura.

„Smatram kako je tvoj nastup bio veoma samouvjeren kada si tog srpanjskog jutra 1969. godine izašao i podignuo palac,“ rekao je Bradley.

„Da, ali moram priznati kako je ta gesta zapravo bila varka“, rekao je Armstrong. „Znaš, stvarnost je kada se pojaviš, uđeš u pilotsku kabinu i nešto pođe po zlu pa se moraš vratiti. Tako da kada zaista uzletiš, sve predstavlja jedno veliko iznenađenje.“

Smješteni na vrhu rakete Saturn 5, astronauti su bili na putu da ispune izazov kojeg je predsjednik Kennedy najavio osam godina ranije, spustiti čovjeka na Mjesec te ga sigurno vratiti na Zemlju prije kraja desetljeća. Bilo je potrebno 400 000 radnika te 24 milijarde dolara, velikim dijelom namijenjenih kako bi se dokazala američka nadmoć na Sovjetskim Savezom. Armstrong priznaje kako je nacija polagala sve nade u ovu misiju. „Željeli smo uspjeti. No još više od toga, nadaš se da ti kao pojedinac nećeš napraviti neku pogrešku.“ I Armstrong nije pogriješio. Njegov cijeli život bio mu je dobra priprema, počevši od očaranosti letom još od djetinjstva. Pilotsku dozvolu stekao je sa 16 godina, prije negoli je naučio voziti. Do svoje 21 godine, letio je u borbenim misijama u Koreji. Nakon rata, postao je uspješan testni pilot, leteći poznatim raketnim zrakoplovom X-15 sve do ruba atmosfere, brzinom od 4000 milja na sat. U to vrijeme, 1962. godine, našao se pred najtežim ispitom, izgubivši 2-godišnju kćer, Karen, nakon borbe s tumorom na mozgu. Nakon toga Armstrong se posvetio poslu. „Smatrao sam da je najbolje za mene u toj situaciji samo nastaviti s radom, držeći stvari u normali. Trudio sam se najviše koliko sam mogao da to ne utječe na moju sposobnost obavljanja korisnih stvari.“

„Ali to nije tako lako učiniti. Što misliš kako si uspio?“, pitao je Bradley.

„U to vrijeme mislio sam da se moja obitelj dobro nosi s tim i ja sam činio sve što je u mojoj moći,“ rekao je Armstrong.

Tijekom te iste teške godine, Armstrong je odabran za astronauta. Njegova prva misija u svemiru bila je 1966. godine letjelicom Gemini 8, kada je skoro izgubio život uslijed kratke nekontrolirane vrtnje male kapsule u kojoj se nalazio.

Dvije godine kasnije, dok je letio na eksperimentalnoj napravi konstruiranoj za simulaciju slijetanja na Mjesec, Armstrong je opet prevario smrt. Upravljač je letjelicom kada je uslijedio kvar te se jedva uspio izbaciti 30 metara iznad tla.

Nakon bliskog susreta sa smrću, Armstrong se vratio rješavanju papirologije. „Posao se morao obaviti“, hladnokrvno je rekao Armstrong.

„Samo trenutak. Skoro si poginuo,“ rekao je Bradley.

„Da, ali nisam,“ reče Armstrong.

Armstrong se isticao čak i među najboljim kolegama astronautima. U 38. godini svojim iznimnim iskustvom i čeličnim živcima zaslužio je upravljanje Apollom 11. Put do Mjeseca trajao je četiri dana. Nakon ulaska u mjesečevu orbitu, Michael Collins je ostao u upravljačkom modulu, dok su se Neil Armstrong i Buzz Aldrin popeli u usidreni lunarni modul te započeli spuštanje na Mjesec.

No uslijed slijetanja dogodio se neočekivani obrat, ugrađen sustav za navođenje slao je Armstronga i Aldrina ravno u propast.

„Autopilot nas je vodio u veliki krater strmih padina veličine prostranog nogometnog stadiona koji je bio prekriven golemim kamenjem veličine automobila. To nije bilo mjesto za pokušaj prvog slijetanja,” rekao je Armstrong.

Armstrong je isključio autopilot te se bacio u potragu sigurnog mjesta za slijetanje, no to skretanje s puta ih je stajalo dragocjenog goriva koje je ionako bilo pri kraju.

Ljudi ispred malih ekrana diljem cijelog svijeta, kao i CBS-ov voditelj Walter Cronkite, nervozno su pratili što se događa. Voditelji Emisije **60 Minutes** nisu mogli odoljeti želji da ponovno spoje tadašnjeg urednika vijesti s nekadašnjim astronautom. Postoje stvari kojima se sada mogu smijati, ali onda su te posljednje sekunde bile gotovo nepodnošljive.

„Slijedili smo plan puta no odjedanput smo shvatili kako smo skrenuli s rute i nismo znali koliko će taj obilazak trajati“, prisjeća se Cronkite. „Da, bio sam jako zabrinut. Mislim da smo svi mi koji smo izbliza pratili let bili preplašeni na smrt. Ako on nije bio, mi jesmo.“

Onda su uslijedile Armstrongove slavne riječi: „Houston, ovdje Baza tišine. Orao je sletio.“

„Sve je u redu, Baza, primili smo na znanje da ste na tlu. Ovdje se nalazi puno ljudi koji su ostali bez daha. Ponovno možemo normalno disati. Hvala puno,“ odgovorila je misija kontrole.

Slijetanje je Cronkitea ostavilo bez riječi.

„Ti si čovjek kojeg poznajem godinama i koji nikada ne ostane bez teksta no tog trenutka si zanijemio. Mislim da su jedine riječi koje si uspio izgovoriti bile „O čovječe“,“ rekao je Bradley.

„Ispalo je da nisam imao ništa drugo za reći osim „O čovječe. O čovječe,“ rekao je Cronkite smijući se. „Zanijemio sam.“

Ta sablasna slika čovjeka na Mjesecu bila je neopisiva riječima. Armstrong je zastao na posljednjoj prečki ljestvi te je lijevom čizmom stao na mjesečevu prašinu.

„Ovo je mali korak za čovjeka, ali veliki za čovječanstvo,“ rekao je Armstrong nakon što je spustio nogu na mjesečevu površinu.

„Sjećaš li se kako si se dosjetio izreke „Ovo je mali korak za čovjeka“? Odakle ti inspiracija za to?“ pitao ga je Bradley.

„Razmišljao sam o tome kada siđem kako će to biti samo mali korak... No onda sam se sjetio onih 400 000 ljudi koji su mi dali priliku da napravim taj korak i pomislio sam kako će to biti nešto veliko za sve te ljude i mnoge druge koji čak nisu ni bili uključeni u projekt. Tako da je to ustvari bilo jednostavno povezivanje misli,“ rekao je Armstrong.

Armstrong se jasno sjeća površine Mjeseca. „Na toj sunčevoj svjetlosti Mjesec je jedna blistava površina. Čini se kao da je obzor sasvim blizu jer je zakrivljenost mnogo više naglašena nego na Zemlji. Zanimljivo mjesto za vidjeti, preporučujem.“

Testirajući gravitaciju, dovršavajući dug popis eksperimenata te obilježavajući svoje putovanje, Armstrong i Aldrin nisu proveli puno vremena na mjesečevoj površini. Došli su u miru u ime cijelog čovječanstva, a ostali su manje od jednog dana.

Slijedio je teži dio, povratak. No kada su se vratili na Zemlju, bili su zvijezde. U New Yorku ih je dočekalo četiri milijuna ljudi obasipajući ih ukrasnim trakama. Na 45. dan pobjedničkog kruga oko svijeta, susreli su se s mnoštvom ljudi iz Konga te s kraljicom u Buckinghamskoj palači.

U novoj biografiji koju je objavila sestrinska tvrtka CBS-a, Simon&Schuster, Armstrong otkriva kako nije bio spreman na svu tu iznenadnu slavu te kako smatra da je to s jedne strane blagoslov, a s druge strane teret.

„Priatelji i kolege odjednom više nisu jednako gledali na nas, odnosili su se prema nama drugačije negoli prije par mjeseci ili godina kada smo radili zajedno. Nikada nisam to razumio,“ rekao je Armstrong.

„Jedanput ste rekli novinaru: „Koliko vremena treba proći prije nego prestanem biti poznat kao čovjek iz svemira?“ Čemu takav komentar?“, upitao ga je Bradley.

„Mislim da mi svi nismo htjeli biti priznati za samo jedan mali dio obavljenog posla, već za sve ono što radimo svaki dan,“ rekao je Armstrong.

Šetajući po farmi u Ohiou gdje je Armstrong rođen, bilo je lako voditi razgovor s njim, ali ga je bilo teško upoznati. Čini se kao rezervirana osoba, ali prije svega bili smo očarani njegovom poniznošću.

„Ponekad se čini kao ti je neugodno zbog tvoje slave. Čini se kao da radije ne bi htio tu svu pažnju,“, rekao je Bradley.

„Ne, samo je ne zaslužujem,“ rekao je Armstrong smijući se.

„Ali gledaj to s ove strane, koliko ljudi je hodalo po Mjesecu? Dvanaest? Ti si bio prvi. Bio si odabran za tu ulogu. To je nešto posebno,“ rekao je Bradley.

„Da, ali nisam bio odabran da budem prvi. Izabrali su me samo za upravljanje letom. Spletom okolnosti sam se našao u toj ulozi. Nitko to nije planirao,“ rekao je Armstrong.

Nakon Apolla 11, Armstrong više nije koristio svoje svemirsko odijelo te nikada nije osjetio potrebu za tim. Osam godina je poučavao strojarstvo na Sveučilištu u Cincinnatiju, gdje je sigurno bio jedini profesor koji je hodao po Mjesecu.

„Uz sva profesionalna dostignuća, uspio si stupiti u brak te osnovati obitelj. Da li je bilo teško držati ravnotežu između ta dva aspekta života?“, upitao ga je Bradley.

„Jedino zbog čega žalim je to da moj rad zahtijeva ogromnu količinu vremena te puno putovanja,“ rekao je Armstrong. „I zbog toga nisam mogao provesti onoliko vremena koliko sam htio sa svojom obitelji i djecom kada su odrastali.“

Armstrong ima dva sina s bivšom 38-godišnjom ženom Janet, od koje se razveo 1994. godine.

Prije nekoliko godina ponovno se oženio. U tom periodu svog života, Armstrong se trudio živjeti u sadašnjosti ne dopuštajući da ga određuju njegova poznata djela. Osigurao si je lagodan život radeći u korporativnim odborima, no čak je i u mirovini pažljivo pratio svemirske programe. Htio je doživjeti povratak slavnih dana prošlosti.

Armstrong je znao da Apollo program ima rok trajanja, ali je očekivao da će trajati duže.

„Iskreno sam mislio da ćemo do kraja stoljeća postići znatno više nego što zapravo jesmo.“

„Što misliš, koji je razlog zašto nismo nastavili s napretkom?“, pitao je Bradley.

„Gubitkom konkurencije izgubili smo i volju javnosti za napretkom,“ odgovorio je Armstrong.

Čovjek koji je nekada vozio raketu sa 160 milijuna konjskih snaga sada leti jedrilicom, avionom bez motora.

„Jedrilice su izvanredni leteći strojevi. Pomoću njih čovjek može najbliže osjetiti kako je to biti ptica,“ rekao je Armstrong.

Što Armstrongu predstavljaju jedrilice? „Ah, to je vrsta osobnog zadovoljstva. Osjećaj postignuća. Kad pokušavaš učiniti nešto bolje nego što misliš da možeš,“ rekao je Armstrong.

NASA je nedavno objavila kako planira poslati ljude na Mjesec do 2018. godine, a nešto kasnije i na Mars. Nemojte misliti da Neil Armstrong to nije primijetio.

„Rekao si da želiš vidjeti kako se vraćamo na Mjesec, a nakon toga kako idemo na Mars. Da li je to nešto što bi želio učiniti u ovom trenutku svog života?“, pitao je Bradley.

„Nisam siguran hoću li dobiti priliku. Ali ne želim reći da nisam na raspolaganju,“ rekao je Armstrong kroz smijeh.

4.2. COMMENTARY AND ANALYSIS

Genre: An interview; (auto) biographical article

Source: CBS News

Reference: Schorn, D. (2005). *Being the first man on the Moon*. Retrieved from:
<http://www.cbsnews.com/news/being-the-first-man-on-the-moon/3/>; on 4 May 2016

Audience: Unknown audience; general population; the readers of the CBS News

Purpose of writing: The aim of this interview is to share the specifics of Neil Armstrong's life and his space adventure. Since Armstrong did not like to mix his private life and the public sphere, many people were interested into the details of his lifestyle. Through this interview, the public got a chance to meet real Armstrong and find out how is it like to travel in the space. Since Armstrong was the first man on the Moon, the audience got an insight into his first impressions while stepping on the Moon. Also, through this interview the public got all the information about his space adventure and the whole space experience.

Authenticity: Since the interview is based on Armstrong's confessions which the author gathered while talking with him, we can conclude that this interview is authentic.

Style: The writing style of this text is descriptive, but narrative as well. Responding to the questions asked by his interlocutor, Armstrong is actually describing his life. What is more, various comments made by Armstrong's interlocutor give us an insight into his lifestyle as well. This kind of subject-oriented writing style is suitable for the text like this. While reading this interview, the reader has a feeling like he or she is reading a story. This text is filled with details, jargon language, dialogues, comments and the tone is appropriate for such kind of writing. Writing style of this interview combines autobiographical and biographical details of

Armstrong's life (combination of Armstrong's responds on the given questions and commentary made by the author of the text).

Level of formality: This is an informal text. Since the text is basically a conversation between two people, we can conclude that the level of formality is appropriate for this kind of personal and self-expressive extract. The text contains colloquial and slang expressions. Another element which shows us that the level of formality is not that high is the structure of the text (dialogues and comments). The author addresses Armstrong by using second person pronouns (you, your), which is another element of the informal text.

Layout: Since this is an informal interview, the layout is quite unique. There is no standard question/answer interview structure. Instead, the whole text is a combination of short dialogues between Armstrong and his interlocutor and various remarks made by the author of the text. There is no introduction part, body or the conclusion. The whole text is a single unit.

Content: This interview deals with details of Armstrong's personal life and his space adventure. At the beginning of the interview, the author made a short introduction with only few sentences, where he described the importance of this great man. The dialogue between Armstrong and his interlocutor started immediately afterwards. The interlocutor did not ask typical interview questions. Instead, he shared his personal opinion and remarks regarding Armstrong's life and space travel. Armstrong's task in this interview was to comment the interlocutor's words and ideas. At the beginning the conversation was focused on Armstrong's space travel and Moon landing, and soon the subject changed swiftly towards Armstrong's personal life. They tackled one particularly sad event from Armstrong's life, the death of his 2-year old daughter. After that, the subject was again changed and they started talking about Armstrong's outbreak as an astronaut. After a short analysis of his career, the subject changed again, this time towards Armstrong's space adventure known as the Apollo

Program. In this part of the text the main focus was put on the difficulties that occurred while landing and what actually happened after it. The next part of the text is focused on Armstrong's life after his space adventure and how this event affected him and his personal life. The last part of the interview deals with Armstrong's present life and his views on the development process of future space programs.

Cohesion: Throughout the whole text the author is changing the course of the conversation very swiftly. Even though the main subject is the same throughout the whole text (Armstrong's personal life and his space adventure), there are a lot of variations on the topic. As I already mentioned, the whole text is one single unit because there is no introduction part, body or the conclusion. But the reader could easily get lost while reading the text, because the author shifts from one aspect of his life towards another and then comes back to something mentioned before, which is quite confusing. The cohesion of the text would be a lot better if the course of the conversation did not change so often.

Sentence patterns: This text is comprised of short and rather simple sentences. Since the audience is general population, there is no need to use complex structures. As it is already mentioned, this is an informal text which can be verified while examining sentence patterns. For example, the text is comprised of few verbless sentences (such as "Wow, oh, boy.", "Perfectly speechless."). Since the conversation is shifting between past and present time, the author uses past and present tenses depending on the time reference of the current topic.

Terminology of the subject: Besides Armstrong's life, the topic of this interview is space travel and accordingly the terminology is based on space flight and space technology basics (for example, "the lunar module", "command module", "cockpit", "capsule", etc.). The text is filled with colloquial expressions such as "folks", "superstars", "thumbs-up", etc. The rest of the used vocabulary is a mix of a jargon and standard English language.

While translating this text, I came across few difficulties. The first was how to translate the name of the newsmagazine “60 Minutes”. The problem is that this show is not aired in the country of the target language, so there is no official translation. It is possible to improvise and translate the name literally, but then another issue occurs. There is a newsmagazine with the same name in this area and if we translate the name, the reader could easily mistake those two shows. In order to avoid possible ambiguity, I decided to leave the original name in the translation.

Another issue I stumbled upon was translation of the phrase “famously private“. Since there is no equivalent phrase in the target language, I decided to use the descriptive phrase instead (“poznat po tome da se nikada nije previše izlagao očima javnosti”). Even though this translation is not concise, I think that it is the best way to transfer the meaning of the original phrase.

Since this is an informal text, it is filled with colloquial expressions which can be tricky to translate. For example, the term “thumbs-up” does not exist in the standard Croatian language. After a thorough research, I decided to use the literal translation (“podignuti palac”) because this is an informal text and even though this term does not exist in the standard Croatian language, its usage is not so unusual among young people who use jargon.

Another phrase which was problematic to translate is “to turn blue”. My first association about this term was Croatian phrase “pozeleniti od muke”. But this phrase is not appropriate because it does not fit into the original context. The translator’s role is to examine the surrounding context of the word because it can be helpful while translating. And this was the case with this term. After examining the surrounding context, I concluded that the best choice for translation would be “ostati bez daha” because in the next sentence the author wrote

“We're breathing again.”. Moreover, the phrase “to turn blue” could literally mean to turn blue due to the lack of air.

The phrase “watchful eye” used in the last part of the interview is an interesting example of how some phrases are used in the same context in the source and the target language. Translation of this phrase is “pratiti budnim okom”. Even though this is an informal text and the usage of this phrase would be appropriate, I decided to use another phrase instead (“pozorno pratiti”) because the literal translation is not in accord with the rest of the sentence.

On several occasions the author used the term “Oh boy” in the text. Since this phrase does not exist in the target language, I decided to improvise and use the Croatian equivalent of that term (“O čovječe”).

The translation of this interview was not that difficult since the vocabulary of the text is quite simple, suitable for everyday conversation. The terminology of the text is rather understandable. The dialogues are filled with phrases which are used mostly in everyday speech, both in the source and target language.

5. CONCLUSION

Even though the definition of translation is quite simple, there is an entire hidden background story behind that term. Translation is a demanding task that requires a lot of effort from the translator. Translator needs to be an expert in the source language, but in the target language as well. Translating is a complex process and it has a lot of steps. Prior to the translation, translator needs to analyse the original text in order to familiarise with terminology, the structure of the text, style, tone, level of formality, etc. If it is necessary, translator can study similar articles written in the target language. After that, he or she can start the translation. While translating, the translator needs to bear in mind the culture of the source language, the context in which the text is written and the audience to whom the text is written. If he or she misses to include one of these elements into their translation, the final result will not be representative. It is a time-consuming process which requires patience, great knowledge of various topics and wide range of vocabulary and proficiency when it comes to the source and target language. These are just some of the skills which every competent translator need to possess. Even though translating can be really demanding, the final result makes it all worth it. Translator becomes an author because the translated text is actually his or hers work of art.

In this thesis I have translated three texts of different genres. While translating I came across a lot of various issues, doubts and uncertainties. I dealt with medicine terms, terminology connected with finances, insurances, space travel and technology and so forth. Since I was not familiar with a lot of these terms, it was necessary to make a thorough research in order to make my translation the best possible. Even though it was a time-consuming process, I benefited from it. I have gained advanced knowledge about various topics and expanded the vocabulary of the source language, but the target language as well.

To conclude, translation is an elaborative process which contributes to translators in so many ways. It empowers them to learn about various cultures, fields of science and numerous interesting topics. What is more, while translating translators inevitably expand the vocabulary of the source and the target language. It enables them to master grammar, spelling, semantics and so many more as well. Translation is a process which involves a lot of hard work, but it enriches the translator in a lot of different aspects.

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