Health Communication in a Dutch Hospital Serial:
Collaboration and Appreciation

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Preface

Approximately one year ago, after I finished my bachelor thesis, I swore to never write another thesis again. But here you are, holding my master thesis in your hand and about to start reading it. This thesis is the result of my participation in the master program Media and Journalism and it means that my university career has officially come to an end. I am very grateful that I was given the chance to participate in this master program and that I was allowed to write my thesis about the serial *Centraal Medisch Centrum*. The past year has been very educational and inspirational, as well as a lot of fun. However, without the help of a number of people, all of this would not have been possible.

First of all I would like to express my sincere gratitude to my supervisor Martine Bouman. Without your advice and support, this thesis would never have been possible. Not only did you make this into a successful thesis, you also encouraged me to make the most of it and to enjoy the entire process. Also, thank you for allowing me to write my thesis in English. I know it might not have been the most logical choice, but I prefer writing in English and I hope that this thesis can now be helpful to a larger audience than it would have been if it was written in Dutch.

Furthermore, I would like to thank all the respondents whom I was allowed to interview, for their time and for sharing their experiences. Accordingly, I want to thank all the respondents who participated in the focus groups. Thank you for sacrificing your free Tuesday nights to watch an episode of the serial with me and thank you for sharing your thoughts and opinions. Without the willingness of all of my respondents, this thesis would not have been possible.

Also, I want to say how eternally grateful I am for the huge amount of support I received from my family and friends. I know that I can be very emotional when I am stressed and therefore I feel amazed that you kept supporting me throughout the entire process. There are two people in particular whom I'd like to thank. Firstly, Dennis, my sweet and loving boyfriend. Not only did you have to put up with my moody behavior, you also had to endure all of the episodes of *CMC* (multiple times) and allowed me to host the focus groups in our home. Thank you! Lastly, I would like to address my mother. Mom, I can't possibly put into words how grateful I am for all of your love, support and motivation. Despite everything, you were always there for me and kept me going with your many loving messages, phone calls and warm hugs. I couldn't have wished for more.

HEALTH COMMUNICATION IN A DUTCH HOSPITAL SERIAL: COLLABORATION AND APPRECIATION

ABSTRACT

One way for health communication professionals to reach a large audience with their health message is the Entertainment-Education (E-E) strategy, which means that their message is incorporated in an entertainment program. The most recent E-E production in the Netherlands is the hospital drama serial *Centraal Medisch Centrum*, which was broadcasted in the last months of 2016 on the commercial channel RTL4. The aim of this thesis is to shed light on how the different involved professionals collaborated in the designing, production and implementation of *CMC* and it examines how the health messages in the serial are appreciated by the professionals and by viewers. Furthermore, a narrative analysis of three storylines explores how the health issues are incorporated in the serial.

Results of six in-depth interviews with respondents from different health organizations, the Friends Lottery and RTL, suggest that the health organizations played the smallest role during the collaboration process. Their role was mainly to provide facts and information, whereas the production company Talpa had the biggest influence on the scripts. The health organizations were not involved in the decision-making process, rather they were dependent on the choices of the Friends Lottery, RTL and Talpa. Therefore, this collaboration process bears most resemblance to an E-E service partnership arrangement. The results also suggest that the interviewed stakeholders are content with both the process and the results.

By conducting three focus groups with members of the audience, this thesis shows that even though it is argued that the serial is not very sensational and the health messages are not very strong, the viewers are still able to reproduce health information from the episodes. Therefore, this thesis shows that this particular type of E-E collaboration can lead to increased awareness and knowledge among viewers about health issues. As such, it hopes to provide useful information for professionals who want to produce a similar E-E hospital serial in the future. Further research is suggested to explore the long-term effects of this E-E production and to keep improving this type E-E collaboration.

KEYWORDS: *Entertainment-Education, E-E service, collaboration, appreciation, health communication, health professionals, television professionals, Centraal Medisch Centrum, hospital serial*

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1. Introduction

Every day 35 people die of a heart attack outside a hospital in the Netherlands (Netherlands Heart Foundation, 2016). According to the Netherlands Heart Foundation (NHF) (2016) this is caused mostly due to a lack of knowledge among the general public about heart diseases and first aid and a lack of funding for medical research. Additionally, 1000 Dutch people die on a yearly basis caused by kidney diseases and 1.7 million people suffer from chronical kidney damage, which again is largely due to a lack of general knowledge about kidney diseases and ways to prevent them (Dutch Kidney Foundation (DKF), 2016). What a lot of people do not know is the fact that kidney damage can also increase the chances of dementia or Alzheimer's disease (Dutch Alzheimer's Association (DAA), 2016). There are several more risk factors for developing dementia, such as smoking and an unhealthy diet, however, again, according to the DAA, knowledge among the general public about behavioral determinants leading to dementia is limited. Health organizations often tend to have difficulties with providing health information in such a way that the public gets involved with the issues. Especially when it comes to preventive health issues, meaning there is no urgent health problem that needs to be solved, the audience is hard to reach with only factual information or rationality (Bouman, 1999). Instead, health communicators need to make more use of popular communication methods and affective principles that appeal to the emotion in order to gain and maintain the public's attention and to make the public reflect on their own health behavior (Bouman, 1999; Bouman, Maas & Kok, 1998).

There are several ways to reach a large audience with health information, one of which is incorporating health messages in popular television programs, known as the Entertainment-Education (E-E) strategy (Singhal, 1990; Bouman, 1999). The three abovementioned Dutch health organizations (Netherlands Heart Foundation, Dutch Kidney Foundation and Dutch Alzheimer's Association) and four other health organizations have, with funding of the Friends Lottery, collaborated in the production of the Dutch hospital serial *Centraal Medisch Centrum*, as produced by the production company Talpa Nederland and broadcasted by RTL4.

On the second of October in 2016, a Sunday evening, 1.5 million people watched the first episode of the new Dutch hospital drama serial *Centraal Medisch Centrum* (Tomas, 2016), a weekly serial consisting of ten episodes and broadcasted every Sunday evening during prime-time (9:30 p.m. tot 10:30 p.m.) on the commercial broadcasting network RTL 4. The serial revolves around Cleo de Waard, the new managing director of the almost-bankrupt hospital CMC, who was hired to make the hospital profitable again. The combination of patients with several medical issues and romance and intrigue between the medical staff makes *Centraal Medisch Centrum* an entertaining hospital drama. However, all the medical

issues discussed in the series are reality-based and the episodes include numerous health messages, which were designed in collaboration with seven different Dutch health organizations, such as Netherlands Heart Foundation, Dutch Kidney Foundation and Dutch Alzheimer's Association. In order to further increase the reliability and accuracy of the medical issues discussed in the serial, the actors who played the roles of medical staff had to work at a medical facility for several days to learn more about working in a hospital. Adding to that, the serial was recorded in an actual hospital in Emmeloord (De Stentor, 2016).

The television serial was accompanied by several supporting activities, which included television commercials dealing with the medical issue that was discussed in the most recent *CMC* episode. These commercials, or so-called promo's, both referred to the television serial as well as to the involved health organization, they included a health message and they referred to a website or app to learn more about the health issue. The commercials were aired in the commercial break during the episode itself, but also in the days following the specific episode. For example, after a *CMC*-episode about a kidney-patient, viewers got to see a commercial about "the salt-meter", which is a website launched by the DKF to check whether people's salt intake is healthy or not.

Centraal Medisch Centrum is the most recent E-E production in the Netherlands and was preceded by series such as *Medisch Centrum West* (Bouman, Maas & kok, 1998), *Costa!* and *Villa Borghese* (Bouman, 2004). However, in order for the use of the entertainment-education strategy to be successful, all the involved parties must work collaboratively (Bouman, 1999; 2002). The combination of entertainment and health information should be carefully balanced, so input from both health and television professionals is vital for a successful implementation of the E-E strategy.

The aim of this thesis is on the one hand to analyze the collaboration process between health and television professionals and on the other hand to find out how the health messages in *Centraal Medisch Centrum* were appreciated both by the professionals and by viewers of the serial. This thesis will specifically focus on the three earlier mentioned health organizations (Netherlands Heart Foundation, Dutch Kidney Foundation and Dutch Alzheimer's Association), that were involved in the designing and implementation of *Centraal Medisch Centrum*. Therefore, this thesis will answer the following research question:

How are the health issues in the Dutch hospital drama serial Centraal Medisch Centrum *produced and appreciated?*

In order to answer the research question in the best way possible, it will be divided into three sub-research questions. The first sub question is: *How are the health issues portrayed in the episodes of*

Centraal Medisch Centrum? The second sub question is: *How did the health professionals and television professionals collaborate during the production of* Centraal Medisch Centrum*?* And the third sub question is: *How are the health issues in* Centraal Medisch Centrum *appreciated by the health professionals themselves as well as by viewers?* The first research question will be answered by a small narrative analysis of the relevant storylines that feature the three health issues (cardiovascular disease, kidney disease and Alzheimer's disease. The second sub question will be answered by conducting in-depth interviews with the health professionals who were involved in the production of *CMC*. The third question will be answered by focus group discussions with viewers.

By finding the answer to the research question, this thesis will add to the understanding of the Entertainment-Education strategy in three different ways. First of all, since this thesis aims to shed light on the collaboration process between health and television professionals and it's downfalls and successes, this thesis can provide insights for health and television professionals who want to collaborate in the production of an E-E hospital serial in the future. Adding to that, the level of appreciation by the health experts and members of the audience will show whether this E-E hospital serial was actually successful in reaching the goals it aimed to reach, which in turn can reveal whether this specific type of E-E collaboration might need certain alterations for the designing and implementation of similar E-E hospital serials in the future. Thirdly, this thesis will apply the existing theory about collaboration processes in the E-E strategy to practice, which might ultimately lead to the formation of new theoretical insights.

2. Theoretical Framework

2.1 Television as medium

This chapter will provide theoretical insights about the television as a medium. It will start with a discussion about narratives, their importance and the role of television in providing the audience with narratives. This will be followed by the effects that television watching can have on the public, their knowledge, attitudes and behavior. Furthermore, theory and academic research will provide a discussion about television genres and more specifically, the genre hospital drama. The chapter will conclude with a discussion about the shift in the television landscape that was driven by the commercialization and the challenge it poses for health communication professionals.

2.1.1 Television and narratives

Stories have existed since the beginning of humanity, a world without them is unimaginable since they are everywhere. According to Roth (2015) stories are made up of a series of events that are arranged according to time and have the goal to make the audience want to know what happens next. Stories can have multiple functions, such as entertainment, information and teaching the rules of a society (Barthes, 1982, in: Krijnen, 2007). By listening to different stories, people can learn certain things which they can later use in their own lives. Almost every media format contains a story, including drama series, comedy series, but also news messages and advertisements (McQuail, 1994).

Stories and narratives are often confused with each other, however it is important to distinguish between the two, especially when transmedia storytelling is being researched (Scolari, 2009). Halverson (2011) argues that narratives are made up of several interrelated stories that work together as a system. To put it in other words, a system of stories about a certain event or person make up the narrative about that event or person. An alternate definition of narratives is provided by Kreuter et al. (2007, p.222), who state the following: "*A narrative is a representation of connected events and characters that has an identifiable structure, is bounded in space and time and contains implicit or explicit messages about the topic being addressed.*" The narrative system is used to structure the content of a story in such a way that the images and words make up a coherent entity in which ideas, themes and characters can develop during the duration of the story (Casey, 2002). Television programs, such as drama serials, tell stories about events and characters that are linked to each other. These stories are systematically structured and take place in a certain time frame and place, which means that these are not 'just stories', rather they make up a narrative.

According to Holland (2004) storytelling is one of the most important functions of the television. She argues that the television is such an appropriate medium for storytelling, because it can combine images with sounds, meaning that the story can be told and shown at the same time. This makes the television a medium that can represent reality as closely as possible and can tell a story in the most accurate way. Often viewers feel like they are being transported into the narrative. In this context, transportation refers to "*the process by which an individual becomes immersed into a story, losing track of the real world as he or she experiences the unfolding events in the story"* (Moyer-Gusé & Nabi, 2010, p.29). Westers and Weijers (2006) argue that because of this, the television can be used to teach the public moral values and can help the public understand who they are, how values can change and how attitudes can shift. Adding to that, they say that television drama is an appropriate way to teach the public life lessons and inspire them to deal with the problems in their lives.

Iguarta and Casanova (2016) argue that narratives often are more useful than non-narrative formats when it comes to providing health information and changing attitudes. This is because narratives do not contain explicit arguments, but instead they illustrate these arguments through the presentation of events, while the action is focused on the main characters in the story. Narratives function as entertainment and they are designed for enjoyment (Iguarta & Casanova, 2016). Green and Brock (2000) argue that narratives have the ability to mentally transport the audience into a fictional world, which allows them to experience the story as if it was real. This can result in the audience taking over knowledge, attitudes and behavior from the stories.

2.1.2 Effects of Television

Television has been, and still is, one of the most important media in the Western world. In 2016, 96,5% of the Dutch households owns at least one television (Stichting Kijkonderzoek, 2016) and in 2015 the Dutch people watched an average of 184 minutes of television per day (Wennekers, De Haan & Huysmans, 2016). According to Brusse, Fransen and Smit (2015), the most important motivation of television viewers is the need for relaxation and entertainment, which could explain why entertainment programs account for a large market share (Glik et al., 1998). But besides providing a means of entertainment, research has shown that television often functions as a prime source of medical information for the public (Davin, 2003; Brusse, Fransen & Smit, 2015).For example, 70% of the adult population admitted in a survey that they obtain knowledge about emergency medicine from watching hospital drama serials (Hetsroni, 2009). Another research about health information in entertainment programs found that 26% of the audience saw entertainment television as one of their top sources of health information and 52% said they consider the health information in such programs to be accurate

(Murphy, Frank, Moran & Patnoe-Woodley, 2011).

Since television is such an important medium on which so many people rely, a lot of research has been conducted on the effects of television viewing on behavior and attitudes. Dixon et al. (2007) for example, state that recurrent messages on television can reinforce and normalize certain behavior, meaning that the audience assumes that the behavior they see on television is normal, which makes them more likely to adopt that behavior. This phenomenon can be explained by Bandura's (1986) social cognitive theory, which states that an individual can learn through observing and imitating overt behavior of other individuals in real life as well as displayed on television, which is called vicarious learning. Vicarious learning is the most successful when viewers can identify and relate with the role models on television and when the viewers are able to recognize the issues as relevant for their daily life (Bandura, 1986). Individuals are more likely to copy a behavior that they have seen being performed than a behavior that was recommended but not demonstrated. Furthermore, Bandura (1986) found that viewers are more likely to imitate role models that were rewarded for positive behavior, than those who were punished for negative behavior. The audience does not adopt all the observed behavior, rather they only copy the behavior when they are motivated and able to do so (Moyer-Gusé & Nabi, 2010).

Media are proven to play a crucial role in the formation of perceptions and images about certain topics, meaning that television can attribute to shifting attitudes (McCombs, 2003). For instance, the cultivation hypotheses states that heavy television viewers are more inclined than non-heavy viewers to hold beliefs that reflect the television's dominant and recurrent messages (Dixon et al., 2007). Additionally, television programs have the ability to direct the viewers' attention to certain issues and problems. In other words, television (and other media) can tell their audience what to think about (Cohen, 1963). This is referred to as agenda setting and entails that the media can raise attention to certain issues, suggesting what the public should think about, know about and have feelings about (McCombs & Shaw, 1972). According to McCombs (2003) the amount of emphasis put on a certain topic by the media can determine how important the audience perceives this topic to be.

2.1.3 Television genres and hospital serials

Every television genre has its own codes and conventions (Casey, 2002) and includes informal rules that television programs should follow in order to belong to a certain genre (Ang, 1982). These rules or conventions are not only recognized by television professionals or academics, because the audience is also able to recognize and interpret television genres (Creeber, 2004). For example, when characters in a movie start singing and dancing, the audience knows that the movie is a musical. The audience is often aware of the genre before the start of a movie or television program, which means that they have

certain expectations about the program (Creeber, 2004). Most of the television genres are based on already existing genres in literature, music and other art forms (Creeber, 2004), however it can be argued that the diversity in television program has grown so large, that television genres are not applicable anymore (Allen, 1982, in: Creeber, 2004). According to Turner (2002) genres tell us a lot about important aspects of television programs, such as characters, audience enjoyment and conventions. Since the differences between television genres can be so large, it makes it nearly impossible to study television as a whole without taking genres into consideration. Therefore, understanding genres is of great importance when researching television (Turner, 2002).

The hospital serial as television genre started in 1959, when Norman Felton came in charge of development at the CBS Network. One of his aims was to create a hospital drama, but senior executives thought this was not such a good idea, because they thought that people would not want to watch sick people (Davin, 2003). However, fifty years later the hospital serial is one of the most popular television genres (Davin, 2003). The development of the hospital serial genre happened in three different stages: *the paternal blind trust phase* (1950s-1960s), *the rebellious spirit phase* (1970s-1980s) and *the nihilistic phase* (1990s-now) (Jacobs, 2001). In the beginning of the genre, during the first phase, hospital serials often featured a single doctor and increased public trust in the medical profession. Later, during the second phase, the set of hospital serials changed from private clinics to hospitals, where a team of medics had to deal with both internal and external conflicts. However, the medical teams in the serials never made any errors and patients played only small roles. During the third phase, patients were finally given a voice and played bigger roles, while medical staff began to make mistakes (Hestroni, 2009).

Even though hospital serials often claim to be accurate and factual (Goodman, 2007), according to Hetsroni (2009) they are far from reality. By analyzing the content of several popular U.S. hospital drama's such as *ER* and *Grey's Anatomy* and comparing the results with a survey of actual hospitals, he found that the mortality rate among television patients is nearly nine times higher than that of actual hospital patients. Furthermore, the diagnoses in television series are biased towards dramatic diseases and problems that are easily visible or graphic. Lastly, the format of the genre limits the accuracy, since medical cases are usually introduced and resolved within one episode, so 45 or 60 minutes.

2.1.4 Television and commercialization

Approximately thirty years ago an important shift took place in the television landscape due to the commercialization, which caused that already existing public broadcasters suddenly came to exist side-to-side with commercial broadcasters (Arbaoui, De Swert, & Van Der Brug, 2016). The emergence of

commercial broadcasters meant a dramatic increase in competition, meaning that already existing broadcasters had to make their programs more and more attractive for their audience in order to keep and maintain the attention of the public. Consequently, broadcasters did no longer see their audience as 'ordinary citizens' who need to be informed and educated, rather they came to see their audience as potential customers to whom they must sell their product (Arbaoui et al., 2016). This phenomenon posed a new challenge for health communication professionals who want to reach and educate the public and it lead to the increased importance of using 'social marketing principles' (Bouman, Maas & Kok, 1998). One of the most important aspects of social marketing is a consumer orientation rather than an expert-driven orientation, which means that heath organizations now need to be more aware of and respond to the needs of consumers (Bouman et al., 1998). This is also known as the shift from the *Trustee Model* to the *Market Model*, meaning that television programs are now more often based on what the consumers want to see, rather than based on what the producers think is important for the consumers to see and know (Schudson, 2003).

The past few years the process of commercialization received a huge boost due to the digitalization and the rise of new and social media, increasing the challenge for health communication professionals even further. New media technologies caused a shift in the way that content is created and used; whereas the focus used to lie in the broadcasting and consumption of content, the focus has now shifted towards active production and sharing of content. Because the new media allow consumers to actively engage with content and information, it is a very important medium to consider when trying to reach and teach the digital native generation (Isacsson & Gretzel, 2010).

2.2 Entertainment-Education

2.2.1 Definitions of Entertainment-Education

Singhal (1990) defined the Entertainment-Education strategy as follows:

> "*the process of putting educational content in entertainment messages in order to increase knowledge about an issue, create favorable attitudes, and change overt behavior concerning the educational issue or topic*." (Singhal, 1990 in Bouman, 1999, p. 24).

According to Bouman (1999) this definition is not complete in numerous ways. First of all, it assumes that the initiative is always taken by the health professionals, which is not always the case since television professionals can also choose to include health information in their entertainment programs for which they will contact health professionals. Furthermore, this definition neglects some of the most important stages of behavior change, such as awareness and maintenance of behavior change. The stages of behavior change are further elaborated on in paragraph 2.2.6. Lastly, and more importantly, the definition of Singhal (1990) describes the Entertainment-Education strategy as something static by using the words *"…putting educational content in…".* Bouman (1999) argues that the E-E strategy entails much more than simply putting information into something, rather it is a process of carefully designing and implementing a program that is meant to both entertain and educate. Based on this, Bouman (1999) created the following definition of the E-E strategy:

> "*the process of purposively designing and implementing a mediating communication form with the potential of entertaining and educating people, in order to enhance and facilitate different stages of pro-social (behavior) change."* (Bouman, 1999, p.25).

One of the most important aspects of the E-E strategy is that it favors a storytelling approach in health awareness campaigns rather than spreading specific messages or points of views through advertising, news programs or documentaries (Glik et al., 1998). In this thesis the definition of the Entertainment-Education strategy by Bouman (1999) will be used as guidance for the research.

2.2.2 History of Entertainment-Education

One of the first television program that was designed with the deliberate intention to educate, is the U.S. children program Sesame Street which aired in 1969 (Giles, 2003). The intention of the show was to teach young children with different social backgrounds about the alphabet and numbers, but also to foster social change by promoting ideas such as 'racial harmony'. The implementation of educational aspects in Sesame Street proved to be highly successful and influential (Giles, 2003). According to Brown

and Singhal (1999), the designing of E-E productions had a slow start, which was surprising considering the fact that many nations know a rich oral tradition, where folktales with moral messages were an important part in the informal education of its citizens. It was estimated that in 1997 approximately 75 Entertainment-Education projects were running, in over 40 different countries (Brown & Singhal, 1999).

The Netherlands has a history since the late 1980's when it comes to E-E programs. In order to prevent cardiovascular diseases, the Netherlands Heart Foundation took the initiative in the late 1980's and 1990's to closely collaborate with television producers and scriptwriters of the hospital serial *Medisch Centrum West* (Bouman, 1998) and the drama serial *Villa Borghese* (Bouman, 2004). *Medisch Centrum West* was an inscript-participation type of collaboration and *Villa Borghese* a co-production type of collaboration (see paragraph of 2.2.3.). Another example of a Dutch E-E project is the serial *Costa!* The Dutch STD foundation collaborated with the producers of the serial in order for them to incorporate educative messages about safe sex and to occasionally show condoms on screen (Bouman, 2004). This was an inscript-participation type of collaboration.

2.2.3 Types of Entertainment-Education collaborations

An E-E production is always the product of a collaboration between two (or more) different organizations. Usually this is a health organization working together with a broadcasting company, as was the case with the Netherlands Heart Foundation and the STD Foundation who worked together with the makers of *Villa Borghese, Medisch Centrum West* and *Costa!* The production of *Centraal Medisch Centrum* is also a collaboration between health organizations and television professionals. According to Bouman (2002) it is important to know who was involved in the production process and what role they played. There are five different types of E-E collaboration arrangements (Bouman, 1999; Bouman & Brown, 2011; see also Lubjuhn, 2012 and Reinermann et al, 2014).

The first type of partnership arrangement is E-E production, which means that a health organization takes the initiative to individually and independently design and produce an entertainment program for social change purposes and then sell it to a broadcasting organization. In this collaboration type, the health organization assigns television professionals to make a certain E-E program and it has full authority over the entire production process. The second type is called E-E coproduction (such as in *Villa Borghese*), in which a health organization and a broadcasting company work together to design, produce, and broadcast a new entertainment program with the purpose of social change. It includes a formal contract and financial transaction. The third type is E-E in script participation (such as in *Medisch Centrum West* and *Costa!*), in which the health organization and the broadcasting company agree to incorporate a health message or prosocial issue in an entertainment program that already exists to

promote social change (Bouman, 1999). This arrangement also includes a formal contract and a financial transaction. The fourth type of collaboration is called E-E service, which has a lower level of collaboration. In this partnership, the health professionals are not actively involved in the decision-making process, rather they only give advice to the television professionals and provide them with factual and timely information (Bouman & Brown, 2011). The partnership arrangement with the lowest level of collaboration is E-E license, in which health professionals pay a fee to the television professionals so they are allowed to use an existing entertainment program for educational purposes after it has been broadcasted (Lubjuhn, 2012).

2.2.4 Stages of Entertainment-Education collaboration

The first three E-E collaboration arrangements all take place according to a number of stages. This is not the case for E-E service and E-E license, since no real collaboration takes place in these partnership arrangements. Bouman (1999) researched this process and came up with four different stages: Orientation, Crystallization, Production and Implementation. More recently, the Center for Media and Health (2016) updated the model produced by Bouman (1999) by adding a fifth stage: dissemination. An overview of the renewed model can be found in figure 1: 'Media Mapping': Stages of E-E Collaboration.

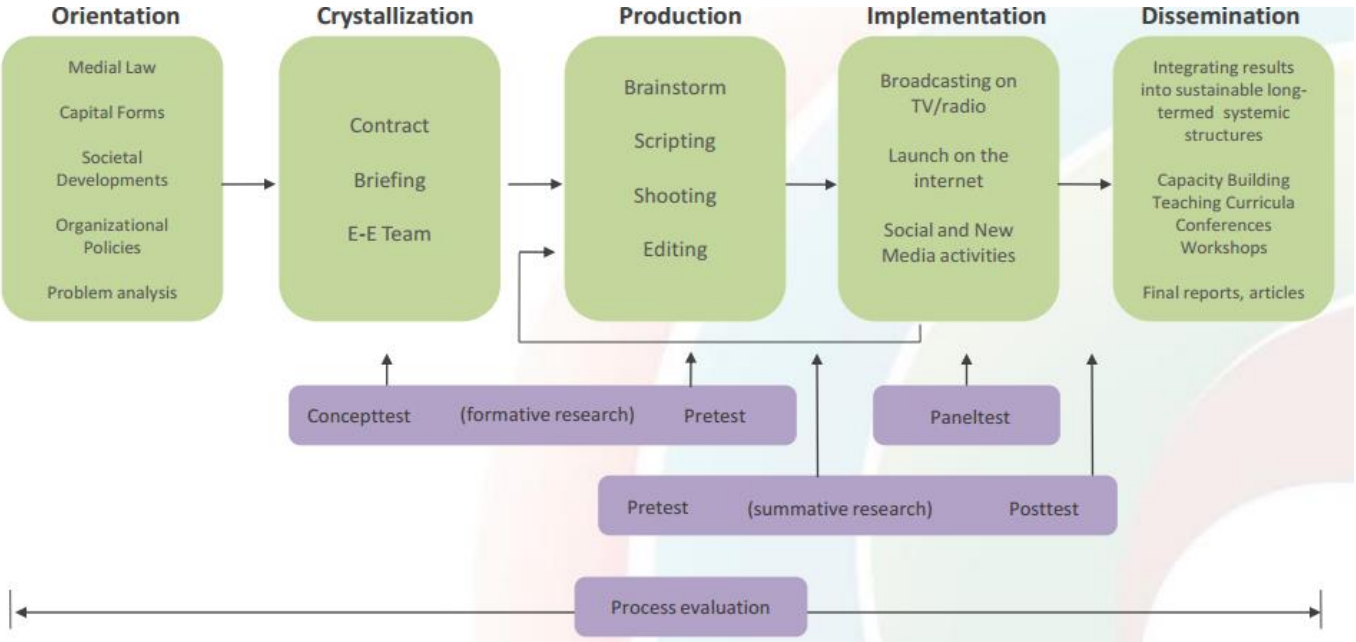

Figure 1. 'Media Mapping' Stages of E-E collaboration, Center for Media & Health, 2016.

The first stage is the orientation, during which the health organizations learn about the external and internal conditions and decide on the appropriate collaboration type. They take factors such as finances, corporate identity and media regulations into account while making their decision. The second stage is the crystallization. Now, the E-E team is formed, which includes both health and television professionals and a contract is set up. The third stage is the production, where the script is written and the scenes are recorded and edited. During this stage the input from all members of the E-E team is vital. Following the production is the implementation, the fourth stage. This not only entails the broadcasting of the episode or serial, but also follow-up activities to give the audience further information and handling publicity. Furthermore, formative and summative research is conducted to find out the reactions, knowledge, attitudes and behaviors of the viewers (Bouman, 1999). The fifth and last stage, the dissemination, includes forming long-term strategies based on the results of the audience research. Also the results and lessons learned are shared and taught through conferences and workshops (Center Media & Health, 2016). During the entire process, continuous research is conducted in order to make sure that both parties are still on track (Bouman, 1999).

2.2.5 Challenges of Entertainment-Education collaboration

Besides the fact that E-E programs are often more complex to produce, require more planning and analysis than regular programs and can raise difficult ethical questions (Brown & Singhal, 1999), there are more possible challenges that might arise during an E-E collaboration. The first challenge is caused by the competitive entertainment market in which television producers are under high pressure to constantly produce hit shows and to maintain high ratings (Glik et al., 1998). This makes it hard for scriptwriters and television producers to handover control over their story development to others and including health messages usually does not have priority, since gaining high ratings is their most important goal. However, because the television world is constantly in need of new material, outsider information can sometimes be welcomed with open arms. It is thus important for health communication professionals to tailor their message in such a way, that it can be seen as new and valuable television material (Glik et al., 1998).

Furthermore, the fact that health professionals and television professionals come from different worlds and work environments might lead to tension during a collaboration, especially in the E-E co-production and E-E inscript-participation types of partnership arrangements (Bouman, 1999). Firstly, the health professionals often start the collaboration process feeling as if they are in charge, since they provide the most capital (not only in financial terms, but also in terms of social contacts, knowledge and factual information). However, as the process evolves, the television professionals tend to gain more

power, because the health professionals often are insecure or overshadowed (Bouman, 1999). Also, the television professionals are of the opinion that the health professionals only have to provide the knowledge and health information, while their own job lies in the creative process. The television professionals believe that the health professionals are not supposed to intrude in the creative process, but the health professionals do not always agree with this (Bouman, 1999). These differences in expectations could lead to confrontations or disappointments for both parties.

The difference in workstyle and -culture can also lead to tension between health and television professionals. For example, the health professionals usually perceive the television world to be fast and quick and it usually takes them some time to adjust to this. Accordingly, the television professionals can struggle with getting used to the slower working pace of the health professionals, which sometimes causes irritations. Furthermore, the health professionals think the television professionals have big egos, which can lead to tensions on a personal level. In short, as Bouman (1999) argues: The television professionals are 'peacocks' and the health professionals are 'turtles'. On a more positive note, the health professionals can be positively surprised by the creative side of the television world and have a favorable attitude towards this (Bouman, 1999)

2.2.6 Positive effects of the Entertainment-Education strategy

Now that the Entertainment-Education strategy and it's possible challenges are explained, it is important to understand the effects that this strategy can actually have on the public. Firstly, embedding health messages in entertainment programs often are more effective than using traditional public service campaigns, because they are less obvious, which makes the audience less resistant to its content (Murphy, Frank, Moran & Woodley, 2011). Moyer-Gusé (2008) argues that the key to overcoming resistance by the audience is to diminish the perception that the message has the intention to persuade them. Accordingly, the narratives persuasion model argues that E-E formats can cause changes in attitudes through identification with the characters, as Iguarta and Casanova (2016) found in their research. Adding to that, the extended elaboration likelihood model and the entertainment overcoming resistance model argue that identification with main characters and engagement in the narrative decrease the motivation of the audience to counterargue, which means that the message is accepted by the audience without much resistance (Iguarta & Casanova, 2016). In other words, when the audience can identify with the main character(s) in the episode who transmits a health prevention message it leads to a more desirable attitude towards the topic that is addressed (see also Bouman, 1999). In this context, identification refers to "*an emotional and cognitive process whereby a viewer imagines himself or herself as a particular character*" (Moyer-Gusé & Nabi, 2010, p.29). The viewer takes over the feelings,

goals and viewpoints of the character and loses self-awareness (Cohen, 2001). Nabi and Thomas (2013) also saw that through identification with role models in the episodes and through seeing their success, the audience might be motivated to take on similar healthy behavior. However, Murphy et al. (2011) on the other hand, found that character identification is not the main predictor for knowledge and behavior change, rather emotional involvement with the narrative was the best predictor in their research. They argue that character involvement may be more important for its ability to heighten transportation and emotion, which in turn produce changes in viewers' knowledge, attitudes and behavior. In all the models and theories explaining persuasive effects of E-E, the key seems to be involvement in the characters and/or the narrative.

A lot of research has been done on the effects that specific E-E projects have had on the audience. Probably one of the most researched entertainment programs is the U.S. medical drama *Grey's Anatomy*. Research has for example shown that watching *Grey's Anatomy* increased knowledge on the heart transplant waiting list (Movius, Cody, Huang & Berkowitz, 2007), the BRCA1 breast cancer gene and its implications (Hether et al., 2008), organ donation and it could even lead to viewers signing up as organ donor (Morgan, Movius & Cody, 2009). Similarly, a study by Brodie et al. (2001) about the U.S. medical drama *ER* reported that one in seven regular viewers of *ER* spoke with a healthcare provider about a health issue they had seen in an episode of *ER*. Adding to that, half of the *ER* viewers spoke with family and friends about health issues that were shown in the program and a fifth of the viewers searched for additional health information after an *ER* episode. Furthermore, Ritterfeld and Jin (2006) found that watching an accurate and empathetic movie about schizophrenia increased knowledge about mental illnesses and reduced stigma. And a storyline about breast cancer in the serial *All in the Family,* where a prominent character found a lump in her breast, led to an increase in the number of women taking breast exams and mammograms (Glik et al., 1995).

Another example is the U.S. Harvard Alcohol Project, which was launched in the U.S. in the 1980s and worked together with film and television industries to promote the concept of the designated driver (Brown & Singhal, 1999; Glik et al., 1998). The designated driver message was aired in over 140 prime-time television programs, under which was an episode of the popular television serial *My Two Dads*. According to Glik et al. (1998) evaluations on the effects showed a 10% increase in the number of people that use designated drivers almost all the time. However, Brown and Singhal (1999) found that the messages did increase awareness and understanding of the concept, but they found no evidence of the episodes changing attitudes or behavior. This is typical for E-E-productions in the U.S., argue Moyer-Gusé and Nabi (2010), because the U.S. knows a highly competitive media environment with little government

regulation. This leads to a lower amount of E-E productions and often these E-E productions have just one educational scene, episode or storyline incorporated in an otherwise purely entertainment program. To illustrate, Farrar (2006. In; Moyer-Gusé & Nabi, 2010) found that in the U.S., exposure to characters using condoms in entertainment programs did lead to more favorable attitudes towards condoms, but it did not affect the intention to use condoms.

As briefly mentioned before, the behavior change triggered by Entertainment-Education does not happen at once, rather it happens according to various stages (Damoiseaux et al, 1987; see also Bouman 1999). Awareness is the first step. The serial *CMC* has to create awareness among the audience about prevention and recognition of heart diseases, kidney diseases and Alzheimer's disease and the role of a healthy lifestyle in this. The audience needs to be aware of the problem and discuss it with each other. The second phase is understanding. The audience needs to understand what a healthy lifestyle is, what the symptoms of such diseases are and how they can prevent them. Attitude change is the third phase. The serial should lead to favorable attitudes of the audience towards a healthy lifestyle and enable the audience to consider the positive and negative consequences of their behavior in a more critical and conscious manner. The fourth phase is intention to change, meaning that the audience is actually willing to make changes in their behavior leading to a healthier lifestyle. Phases five and six are behavior change and behavior maintenance and are dependent on supervision and counselling and need a long term approach (Kok in Damoiseaux et al, 1987). The research in this thesis focusses on the first two stages of behavior change, so awareness and understanding.

3. Method

This chapter will discuss the research method that was used to answer the research questions of this thesis. A qualitative research method was deemed the most appropriate, which is not about statistics or numbers, rather it is about exploring and understanding certain themes or phenomena. Qualitative research methods are used to find and name relevant characteristics, through which the researcher finds new results and adds to existing literature (Wester, 2004). Furthermore, it can be used to describe and understand certain situations, people or events (Reulink & Lindeman, 2005). The data used in this thesis is gathered through a number of qualitative, semi-structured, in-depth interviews as well as through semi-structured focus group interviews. All the interviews and focus groups were conducted in Dutch, since the episodes as well as the respondents are Dutch. The transcripts (available on sin-online) are also in Dutch, however the codes and analyses are in English. Furthermore, a small narrative analysis is conducted on the relevant storylines of *CMC* in order to find out how the health issues are incorporated in the episodes of the serial. The following paragraphs will further elaborate on the different methods that were used.

3.1 Narrative analysis

The first research question of this thesis asks how the health issues are portrayed in the episodes of *CMC*. To answer this question, a small narrative analysis has been conducted on three episodes of the serial *CMC*. The episodes used for this analysis are the same episodes that were shown to the respondents of the focus groups, meaning episodes 3, 5 and 9. Furthermore, the narrative analysis only focused on the storylines about the researched health issues, meaning heart disease, Alzheimer's disease and kidney disease. The narrative analysis in this research is based on the WOW-analysis scheme that Wester and Verbrugge (2000) used in their research where they aimed to explore cultural messages in eight American sitcoms. Their analysis is based on four principles. The first principle is that stories, or narratives, are carried out by characters. Without characters, there would be no story and no plot. The second principle is that narratives are made up according to the narrative cycle, which consists of three steps. It starts with a character in a certain situation where he or she encounters a problem, which requires him or her to make a decision and which then leads to him or her undertaking action. The third principle is that usually television programs consists of multiple storylines, which each has their own main characters who act according to different narrative cycles. The fourth and final principle is that storylines can be brought back to themes that relate to cultural categories, such as norms, values, life lessons or goals (Wester & Verbrugge, 2000).

The WOW-analysis scheme resembles a topic list with a number of points that can be used to describe the content of stories in television serials. The narrative analysis with the WOW-analysis scheme as Wester and Verbrugge (2000) conducted it, consists of four steps. It starts with making a transcript of the episode(s) and naming the characters and storylines. The second step refers to making an inventory of explicit or implicit norms, values, characteristics or goals of the characters. This is followed by a manifest story analysis in which the development of the storylines is described. This results in a description of whether or not the characters in the storyline are successful or not and the reasons for this. The final step is a so-called latent story analysis, in which attention is paid to contradictions in the storylines (Wester & Verbrugge, 2000).

For the analysis of the storylines concerning the health issues in *CMC*, not every aspect of the WOW-analysis scheme is relevant. For example, a large part of the scheme is dedicated to finding and naming relevant storylines or discovering the underlying message of a storyline. However, in this research, the relevant storylines and their "hidden" messages are already determined and known beforehand. After eliminating irrelevant aspects of the WOW-analysis scheme, the following points were used to guide this narrative analysis:

1. Make a transcript of the storylines with consecutive scenes. Shortly describe the situation, including important characters and the location. For every scene, write down the dialogues and subtitles and add important features such as facial expressions.
2. Write down the lesson of every storyline in one sentence
3. Describe every storyline according to the narrative cycle: problem – decision – result
4. Determine who are main characters and who are side characters in every storyline
5. Describe every main character of the storylines and the goals they pursue
6. Describe which main characters were successful in reaching their goals and who were not and the reasons that the storyline give for this outcome
7. Describe the contradictions that complicate the decision and choices of the main characters

3.2 In-depth interviews

The second research question, concerning the E-E collaboration process, is answered through conducting several in-depth interviews. According to Gilbert (2008) the aim of interviews is to obtain detailed descriptions of what is happening and they are useful for obtaining different opinions on a certain topic and relevant dimensions of attitudes. Stake (1995) argues that interviews are especially useful when the researched topic is a certain process which cannot be observed, meaning that the information has to be

gained from people that are part of the process. More specifically, the interviews used for this research were semi-structured, meaning that the interviews are based on a topic-list, but the questions and the order of the topics are not static. Rather the conversation leads itself, but it can be steered in the right direction when needed (DiCicco-Bloom & Crabtree, 2006). When deemed appropriate, questions can be added or left out in order to obtain the wanted results (Baarda, Goede & Teunissen, 2001). The interviews are usually scheduled in advance at a designated time and place outside of everyday events (DiCocco-Bloom & Crabtree, 2006).

The interviews were conducted with different people (N=6) who were involved in the production process of *CMC*. Besides the health and television professionals, more stakeholders are involved in the process, such as advertisers and production companies (Bouman, 2002). The personal interviews were conducted with four health professionals, one from the Netherlands Heart Foundation, one from the Dutch Alzheimer's Association and two from the Dutch Kidney Foundation. All four health professionals were involved in the process and functioned as a contact person between their health organization and the other involved parties. Another interview was conducted with a spokesperson from the Friends Lottery, who functioned as a contact person between the health organizations and the television professionals. Lastly, a researcher from RTL, the broadcaster of the serial, who was involved in the effects-study of the serial *CMC*, was interviewed. All the respondents were notified in advance that the interviews would be recorded for research purposes and they were promised confidentiality.

As briefly mentioned before, the interviews were conducted with the help of a topic list. The sensitizing concepts used by Bouman (2002) in her research functioned as a basis for this topic list. These include capital forms, cultural differences, professional standards, personal traits, selection criteria and genre features. After modification and adaption, the topic list for the interviews consists of five different themes, or topics, including the following: their storyline, the process, agreements and influence, personal collaboration and evaluation (see appendix 2). The questions in the interviews aim to uncover which type of E-E collaboration partnership arrangement is applicable, the closeness of the collaboration, what the collaboration process looked like, the successes and downfalls of the collaboration, as well as the opinion of the respondents about the entire process and the final result.

3.3 Focus group interviews

The third and final research question concerns the public's appreciation of the E-E product and was answered through focus group interviews with viewers of the serial *CMC* (N=14). Focus groups are a useful method for finding and understanding the experiences and attitudes of a group of people. During a focus group the participants can discuss about their attitudes leading to an answer to the research

question (Wester, Renckstorf & Scheepers, 2006). The aim is to find different viewpoints on an issue, rather than reaching consensus on a certain issue (Kvale, 2007). One of the biggest strengths of the focus group method is that respondents might say things whilst talking among each other, that they would not have said or thought of in an individual interview (Peek & Fothergill, 2009). The researcher functions as observer and monitor who can provide the participants with information or subjects to discuss. It should be kept in mind that it is possible that opinions held by dominant participants can come to overshadow the opinions of less-dominant participants (Wester, Renckstorf & Scheepers, 2006). In order to make sure that every individuals' opinion and attitude is included in this research, the respondents each were asked to fill in an individual questionnaire before the start of the group discussion (see appendix 3).

3.3.1 Set up of the focus groups

In total, three focus groups were conducted and each focus group was assigned to a different episode of the serial. The first focus group was assigned to an episode from the Dutch Kidney Foundation, meaning they watched episode 9. The storyline which was co-produced with the DKF was scattered across three episodes, however in episode 9 the most information was given and it was not harmful for the understanding of the storyline when episode 8 or 10 was missed. The second focus group watched episode 3, which was made in cooperation with the Netherlands Heart Foundation. The third focus group was assigned to episode 5, made together with the Dutch Alzheimer's Association. The episodes were watched either on DVD or through RTL's video on demand service RTLXL, meaning that the episodes were free of commercial breaks and the so-called promo's, or activation messages of the health organizations. The focus groups were held in the home of the researcher, this was done to assure a comfortable and home-like ambiance, which would most likely resemble the natural situations in which viewers would normally watch the serial.

Before the start of each focus group discussion, the assigned episode was shown to the respondents. Screening the episode before the discussion was deemed appropriate and necessary, since the episodes were broadcasted on television several months earlier. This means that it is very likely that the viewers do not remember details or information from the episodes, thus making a group discussion about the episode useless. When the screened episode was over, the respondents were told about the aim of the study and what was expected of them. It was deliberately chosen to explain the goals of the study after the respondents had seen the episode, because it was believed that knowing the aim of study could influence the way the respondents would watch the episode. After this, all the respondents were asked to fill in an individual questionnaire (see appendix 3) about their attitude regarding the serial and their understanding and appreciation of the health information that was incorporated in the episode.

The group discussion followed and was meant to delve deeper into the attitudes and experiences of the respondents, in order to fully understand how they appreciate *CMC* and the health messages. Both the questionnaire and the group discussion were meant to research the first two stages of behavior change, thus awareness and understanding (Damouiseaux et al., 1987). In other words, the aim of the focus groups was to find out whether the episodes raised awareness among the respondents about the specific health topics and to what extent the viewers understood the health topics and the provided information.

3.3.2 Respondents

One focus group consisted of four respondents and two focus groups consisted of five respondents, adding up to a total number of fourteen respondents (see appendix 4 for overview of respondents). The type of respondent depended on the assigned episode. The respondents in the first focus group were males and females aged between twenty and thirty, because the protagonists of the storyline were in their twenties. Therefore, it was expected that the respondents would be able to identify with and relate to the characters in the episode. The respondents in the second focus group were women aged forty to sixty. This was because the health issue featured in the episode concerned a middle-aged woman in her menopause who suffered a heart attack. Again, it was expected that the respondents would be able to identify with and relate to the main character in the storyline. The respondents who participated in the third focus group were men and women aged twenty to forty, because the main characters in this storyline were young adults who took care of their sick mother.

The respondents all had different levels of education and varying occupations in order to make sure that no point of view was left out of the discussion. The respondents were found by using the snowball sampling method, where the researcher used her personal network and asked acquaintances if they knew any potential respondents for the focus groups. Later, initial respondents were also asked to find more potential respondents (Browne, 2002). In advance, the respondents were notified about the fact that the discussion would be recorded and they were asked to sign a consent form.

3.3.3 Topic list

The topic list that guided the focus groups is based on the research by Bouman, Maas and Kok (1998) in which they researched the appreciation of the E-E hospital serial *Medisch Centrum West* by the public. In their research the following topics were the most important: involvement, credibility, impact in terms of reflection, appreciation and noticing health information. Except for impact in terms of reflections, all these topics were also included in the topic list for the focus groups. After modification, the topic list

consists of the following main themes: appreciation, credibility, role models and identification and knowledge. These main topics were featured in both the individual questionnaires and the topic list of the group discussion (see appendices 2 and 3)

3.4 Coding procedure

The data gathered through the interviews and focus groups was coded with the help of the computer program Atlas.ti, which is qualitative data analysis software (Hwang, 2007). The analysis of the interview and focus group transcripts was done according to the thematic analysis as explained by Boeije (2010), which entails segmenting the data and reassembling them again with the aim of transforming data into findings (Boeije, 2010). The coding process is done according to three sequential steps, starting with open coding. During open coding, all the relevant data is segmented into smaller parts to which codes are assigned. The data is not yet interpreted but are coded according to the literal texts. During the second phase, called axial coding, the data is reassembled again by putting codes into categories and looking for connections between the different categories. Selective coding is the last phase and entails the identification of core categories or themes and relating these to each other as well as to the other categories. Furthermore, the findings are related to the theory to find out whether or not the results are in line with previous findings.

3.5 Reliability and Credibility

One of the biggest challenges in qualitative research is the reliability of coding. Especially when only one person does all the coding, the reproducibility across coders (intercoder reliability) is at stake (Campbell, Quincy, Osserman, & Pedersen, 2013). Therefore, *intercoder reliability* will be established in this research, which is reached when "*two or more equally capable coders operating in isolation from each other select the same code for the same unit of text*" (Campbell et al, 2013, p. 297). When the second coder finishes coding a sample of the transcripts, the codes of both coders are compared and the coders discuss which codes should be changed or altered. In total, the second coder will code roughly 10% of the transcripts, but it depends on when the researcher is satisfied with the level of intercoder reliability. In this case, an independent coder was asked to code one interview transcript and to compare her codes with the codes of the researcher to find out whether there were any large differences or queries. Since this was not the case, it was deemed enough to let her only code one transcript.

The credibility of the results can also be increased by providing quotes from respondents, as long as respondent confidentiality is preserved (Boyce & Neale, 2006). Lastly, as mentioned before, credibility of focus group interviews is at stake because dominant respondents can take over the conversation,

meaning that other viewpoints can be overshadowed and left out of the discussion. In order to make sure that every single viewpoint and opinion came to light and was incorporated in this research, all the focus group participants were invited to fill in an individual questionnaire beforehand.

4. Results

This chapter will discuss the results of the different analyses and as such it will provide answers to the three sub-questions of this thesis. The chapter is structured accordingly to the sub-questions of this thesis

4.1 Narrative analysis

This paragraph discusses the narrative analyses of the three specific storylines. The first step of the narrative analysis was to make a transcript of the storyline with a short description of the situation, location and characters and including all dialogues, subtitles and important facial expressions. These transcripts can be found in appendix 1. The subsequent steps will be executed and discussed in this paragraph.

4.1.1 Episode 3, heart attack among women

The first storyline that was analyzed is the one that was made in collaboration with the Netherlands Heart Foundation about the symptoms of heart attacks among women. The lesson of this storyline is that the symptoms of a heart attack are different for women than for men and that there is still a lot unknown about heart attacks among women. This health message is both implicitly and explicitly incorporated in the storyline. An example of the latter, is when cardiologist Lis van der Laan has a conversation with her patient Sonja Bos:

> Sonja Bos: *I was tired, nauseous and I had trouble breathing. Short of breath. And he said it was stress*
>
> Lis van der Laan: *Usually it is indeed. Unfortunately, there is still not much known about cardiovascular diseases among women. The small blood vessels calcify very gradually, whereby the blood supply to the heart becomes very difficult*

The message is also implicitly incorporated in for example a dialogue between two doctors, where one of the doctors gave a wrong diagnose because she thought the symptoms were signs of menopause, instead of a heart attack.

When looking at the storyline in terms of the narrative cycle, it became clear that the problem in the storyline is that the patient, Sonja Bos, is brought in the emergency room of the hospital after she suffered a heart attack. She went to see a doctor earlier, because she was feeling tired, nauseous and had trouble with breathing, which are symptoms of a heart attack. However, her gynecologist Mia Verhulst, said these was just symptoms of the menopause. If Mia Verhust had diagnosed her correctly in

the first place, Sonja Bos would have been treated immediately and would not have ended up in the emergency room. Two decisions were made to solve the problem. On the one hand, cardiologist Lis van der Laan treated the patient accordingly with catheterization and a dotter treatment. As a result, the patient was cured and allowed to leave the hospital after two days. On the other hand, Lis van der Laan decided to confront Mia Verhulst about her wrong diagnosis. At first, the confrontation does not go very smoothly, as Mia Verhulst said she acted in the way she thought was right and then walks away because she felt attacked by the way Lis van der Laan spoke to her. But in the end, Mia Verhulst and Lis van der Laan are able to solve their disagreements and have dinner together.

The storyline has three main characters. Firstly, Sonja Bos, the 52 year old ballroom dancer who ends up in the hospital after she had a heart attack during a dancing competition. She lives a healthy life, does not smoke and dances four times a week. She had been feeling a little unwell for a period of time and went to see a doctor about this, but she was told that it was either just stress or the menopause. Sonja was shocked by her heart attack and felt scared and insecure during her treatment in the hospital. But when her dance partner Onno comes to visit her, it looks as if she has forgotten all about it and starts laughing again. The second main character is Mia Verhulst, who loves her job as a gynecologist at the CMC hospital. She was married to another doctor at CMC, but they divorced a couple of years ago. Mia is the doctor who misdiagnosed Sonja's complaints in the beginning, but she argues that she acted in the way she thought was right, because Sonja's hormone levels showed that she was in her menopause and the symptoms Sonja had are symptoms that every woman has during her menopause. However in the end, she can admit her mistake and discuss it with her colleague Lis van der Laan. The third main character is the pregnant cardiologist Lis van der Laan. She can be very direct, sometimes even rude, to her colleagues at CMC but she does everything to cure her patients and make them feel better. Lis can be seen as a workaholic, who does everything for her patients but neglects her own health by working too hard while she is pregnant. She is married to a journalist who wrote a very negative article about the hospital and they have two children.

In this storyline, all the main characters accomplish their goals. Sonja's goal is to get better and probably to be able to dance again, while Lis' and Mia's goal is to treat and cure their patients. In the end, Sonja is cured and the disagreement between the two doctors is also solved. The main contradiction that played a big role in this storyline is that of the symptoms of heart attacks among women versus the symptoms among men. Along the same lines, the contradiction of symptoms of a heart attack versus symptoms of menopause played a crucial role. This reflects back to the disagreement between the cardiologist and the gynecologist. However, it is logical that the main contradiction is

between symptoms among men and women, since that was also the main theme, or message, of this storyline as the NHF wanted it to be.

4.1.2 Episode 5, Alzheimer's disease and caregiving

The second analyzed storyline is made in collaboration with the Dutch Alzheimer's Association and focuses on people who take care of family members who suffer from Alzheimer's disease. The main message of the storyline is that caregiving to someone with Alzheimer's is extremely hard and very demanding on the life of the caregiver. Furthermore they wanted to draw attention to the fact that caregiving is often underestimated and that there are a number of possibilities to lessen the burden on the caregivers, such as case managers. The message is especially explicitly incorporated, because the characters literally mention it.

Tara: *The deal is that you can live in her house for free and that you watch her when I am at work.*

Rodney: *I know what the deal is, but it is fucking hard.*

Emily: *Maybe a nursing home isn't necessary yet. You can get a casemanager, that is covered by the basic health insurance. That is someone who can help you with looking for a solution. There are for example different kinds of daycare that you could consider.*

The storyline revolves around Tara and Rodney who take care of their sick mother Wonnie, however the situation is starting to grow over their heads. The problem is that they can't handle the care of their mother anymore with just the two of them, which becomes clear when they lose sight of Wonnie two days in a row and when Wonnie ends up in the hospital after she was ran over by a cyclist. When this happened, Tara and Rodney decide to sit down with the psychiatrist Emily to discuss their options. During the conversation, several options are mentioned, such as a nursing home, a case manager and day care. After this conversation, where they were relieved to hear that a nursing home is not necessarily their only option, Tara and Rodney make up and promise to also take care of each other while they are holding each other's hands.

This storyline has two main characters; Tara and Rodney. Tara works in the canteen of the CMC hospital where she is popular among her colleagues and known for her delicious coffee. She hid from her colleagues that her mother has Alzheimer's, because she felt like her colleagues have to deal with enough illness and drama already. Rodney lives with their mother, so he can take care of her when Tara is at work. The first time Wonnie walks away from home, Tara and Rodney get in a fight because Tara blames Rodney, while he argues that she has no idea how hard it is. A day later, when Wonnie ends up

in the hospital after being ran over, Tara wants to blame Rodney again but realizes that that would not be fair because it is just too hard for them to take care of their mother alone. Other characters in the storyline are of course Wonnie, their mother who has Alzheimer's, Emily the psychiatrist and Dilem, Tara's colleague.

Tara's and Rodney's mutual goal is to take care of their mother and to make sure nothing bad happens to her. This goal seems to have failed when Wonnie ends up in the hospital after she is ran over by a cyclist. Tara and Rodney are aware they need help, but for a long time they were reluctant to accept this. On the one hand, they argue this is because Wonnie does not want help from outsiders and on the other hand they think that a nursing home is their only option. They really don't want her to go there, because they are afraid they will lose her when she does. However, when Wonnie is in the hospital, they finally agree to sit down with psychiatrist Emily to discuss their options. During this conversation it turns out that besides a nursing home, there are several options, such as a case manager and different forms of day care. Tara and Rodney seem to be relieved when they find out there are more options than a nursing home and it seems like they will finally accept some help so they can still take care of their mother without her having to move away. So Wonnie's accident can be seen as a turning point, which finally made Tara and Rodney open their eyes and accept that they need help to keep pursuing their goal: taking care of their mother without her being in a nursing home.

4.1.3. Episode 8,9 and 10, chronic kidney disease

The third and final storyline that was analyzed, is the storyline about chronic kidney disease that was made in collaboration with the Dutch Kidney Foundation. In contrast to the other two storylines, this storyline covers three episodes instead of just one, which means there is more time for the characters to develop. The storyline contains two messages about kidney disease. On the one hand they wanted to make clear that living with a chronic disease is very hard and on the other hand they wanted to make it known that living donation is possible. The first message is more explicitly incorporated, while the second message is more implicit. The patient, Sam, mentions a few times how hard it is.

> Sam: *Dialysis is not living. It's just surviving. I've been through it already, I know what it is like and I don't want it anymore*.

> Sam: *You know how hard the last transplantations were and again and again that fight against rejection symptoms. Which I lose every time*.

The message about living donation is a bit more implicit. In a dialogue between the doctor and the patient's sister it is mentioned that the waitlist for a dead donor is too long, but that Sam could survive with a living donor. But the living donor message is shown throughout the storyline, where Sam's best friend turns out to be a match and wants to donate her kidney to Sam.

The storyline is thus about a kidney patient named Sam. The problem is that his body is rejecting his latest donor kidney, but Sam does not want to undergo dialysis and he also does not want a new kidney from a living donor, even if that means he will die. Even though he already accepted his own death, his sister Lucy does not and tries to convince him otherwise. In the end Sam does decide to accept a donor kidney from a living donor, meaning that he will survive after another kidney transplant.

The storyline has three main characters; Sam, his sister Lucy and doctor de Moor. Sam's latest donor kidney is being rejected by his body, which means that he has to undergo dialysis and receive a new donor kidney. However, Sam does not want this anymore. He argues that dialysis is not living, it is just surviving and he does not want to do it anymore. Also, Sam does not want a kidney from a living donor, because he does not want to burden his family and friends with this again. Furthermore, the transplantation is very tough and demanding on his body, as it has to fight against rejection symptoms. He only wants a dead donor kidney and nothing else and he has accepted that he will probably die, because the waiting list for a dead kidney is too long. His goal is to make the most of the rest of his life and to convince his sister Lucy to accept the fact that he does not want a living kidney and thus will probably die. His sister Lucy on the other hand, is determined to keep Sam alive, no matter what. She does not accept his wishes and goes behind his back to find a match who is willing to donate a kidney. Sam's best friend Wendy is a match and wants to donate her kidney, but Wendy and Lucy have to do their best to convince Sam to accept it. Only when Lucy starts to cry and calls him selfish, Sam changes his mind and accepts Wendy's living kidney. This thus means that Lucy accomplished her goal by convincing Sam to accept the kidney and stay alive. Sam on the other hand, did not accomplish his goal because he swore he did not want another living kidney. The third main character of the storyline is doctor de Moor who is treating Sam and also tries to convince him to keep undergoing dialysis and to accept a kidney. However, no matter how bad he wants Sam to get better and survive, he also makes very clear that he can never go against the wishes of his patient. His goal is also accomplished, since Sam decided to accept the living kidney, doctor de Moor can start his treatment again to make sure that Sam will survive.

4.2 The collaboration process

One of the first things that became clear during the interviews with the different parties that were involved, is that this collaboration process was somewhat unconventional and does not completely fit in one of the E-E partnership arrangements as described in paragraph 2.2.3 (Bouman, 1999; Bouman & Brown, 2011). To start with, the initial initiative to produce this E-E serial originated from the Friends Lottery, which is a Dutch commercial lottery that structurally donates money to their associated charities and health organizations and occasionally grants extra funds or projects to these charities. According to a respondent from the Friends Lottery, the idea to make a drama serial that features a number of their charities or health organizations arose after a presentation in which they were told about the example of *Grey's Anatomy* where an incorporated health message about HIV caused increased knowledge about this among the public. After the idea of an E-E drama serial arose, the Friends Lottery turned to the commercial broadcasting agency RTL to discuss the possibilities and to turn the idea into something more concrete.

> Respondent Friends Lottery: *RTL said they had been wanting to make a hospital serial for a long time. Together we looked at how we could get this done.*

She added to this that after their meeting, RTL turned to the production company Talpa to further elaborate on the idea of the hospital serial. So the concept of the hospital serial *CMC* did "*not come from one father*" as the respondent said it, rather it came from collaboration and several meetings between the Friends Lottery, RTL and Talpa.

Now that the concept of the hospital serial was more concrete, the Friends Lottery decided which seven of their health organizations would be featured in the serial. Once that decision was made, these seven health organizations were brought into contact with Talpa by the Friends Lottery. The health organizations then each had a meeting with Talpa, during which they discussed relevant themes that the health organizations would like to be incorporated in their storylines. During the meeting Talpa and the health organizations brainstormed together. A respondent from the Dutch Alzheimer's Association explained this.

> Respondent DAA: *During the meeting with Talpa we explored a number of storylines, we named a lot of things that happen in practice. What do you come across? What can happen?*

There were several different people present at these brainstorm meetings, including the scriptwriters and a medical advisor from Talpa. For each health organization, it was different whom they brought along. From the NHF there were three people present at the meeting, namely a marketing and communication manager, an account manager and a medical expert. The DAA-team existed of two people; a communication advisor and also a medical expert. From the DKF two communication advisors were present, they did not bring their own medical expert.

After the meeting, the scriptwriters from Talpa wrote the scripts based on the discussed themes and examples. When the scripts were finished, they sent them to the Friends Lottery and the health organizations to be checked. When the scripts were approved, Talpa started the production and shot and edited the scenes. Besides contact with Talpa about the scripts, the health organizations also had contact with RTL about the so-called "promo-package", which includes short activating clips, billboards and logos. The health organizations and RTL together discussed the content of the clips and the activation message that would be shown. After all the episodes of *CMC* were broadcasted, RTL, the Friends Lottery and the health organizations came together for an evaluation during which an effect-study by RTL and research organization Motivaction was presented (more details about the research can be found in paragraph 4.2.3). All the respondents mentioned that most of the contact with the collaboration partners went either via email or via telephone, so there was barely any real-life contact. Furthermore, it was mentioned that, especially in the beginning, most of the contact had to go through the Friends Lottery, meaning that originally the health organizations did not have any direct contact with RTL of Talpa (except for the brainstorm session), not even through email.

> Respondent NHF: *Actually the Friends Lottery functioned sort of as a pivot between the health organizations and Talpa as producer and RTL as broadcaster.*

So for example, when the health organizations had a question for Talpa about the scripts, they had to contact the Friends Lottery and then the Friends Lottery would pass on the question to Talpa and then the answer from Talpa back to the health organization. However, many of the respondents mentioned that in the end they decided to directly contact RTL and Talpa anyway, because that was a lot easier and faster than through the Friends Lottery. The respondent from the Friends Lottery also mentioned that somewhere along the process the organization decided that their 'pivoting function' was not as useful as they anticipated in advance and therefore they disregarded it.

The collaboration did include a financial transaction. The health organizations did not have to spend their own money for the incorporation of their message, because this was done with money from

the Friends Lottery. All the respondents from the health organizations strongly emphasized this, as it was important for them that people knew that it was not donated or gifted money that was spent on this.

> Respondent NHF: *What we, as charity, have to think about is that we earn our money through people who donate, bequeath or collect for us. So we spend our euro's very carefully. And productions like this cost serious money. So we didn't spend a dime on this, it was all done with money from the Friends Lottery.*

The respondent from the Friends Lottery explained that they were able to reserve an amount of money and then they divided this amount among the seven health organizations. This amount is approximately two hundred thousand euros per health organization, according to the respondents from the DKF. As explained by the respondent from the Friends Lottery, the health organizations received money from the Friends Lottery so that the health organizations could order a storyline in a drama serial at RTL. So in other words, the Friends Lottery donated an amount of money to each health organization and then the health organizations paid this amount to RTL in order to be incorporated in the serial.

There was also a contract, or a "sponsor-agreement" as some of the respondents called it, however it did not become very clear from the interviews what this contract specifically stated, since the respondents gave vague or even contradicting answers. For example, one of the respondents from the DKF said the following.

> Respondent 1 DKF: *I don't literally know what was in the contract. I have not seen it.*

The other respondents from the health organizations were also rather vague about the content of the contract and mentioned that besides the arrangements concerning payments, there were no real agreements in the contract, as these occurred more naturally during the process. Sometimes the respondents even contradicted each other. For example, according to the respondent from the Friends Lottery, the contract also included concrete agreements about visibility, so the number of billboards, promo's etc. However, one respondent from the DKF said those agreements about visibility were not literally in the contract because they were made later in the process. To conclude, there was a contract, but what it exactly agreed upon, is not clear.

When looking back at the different types of E-E partnership arrangements that were discussed in paragraph 2.2.3, it could be argued that this particular collaboration process is an E-E coproduction partnership arrangement. In this type of collaboration, a health organization and a broadcaster work together to design, produce and broadcast a new entertainment program with the purpose of social changes. Furthermore, it includes a formal contract and a financial transaction (Bouman, 1999). Firstly,

CMC is a new entertainment program which did not yet exist and which was especially designed with the purpose of implementing health messages from health organizations. Apart from E-E coproduction and an E-E production, all the other partnership arrangements make use of an entertainment program that already exists, so therefore they do not apply to *CMC*. Furthermore, the E-E production partnership arrangement does also not apply to *CMC*, since that arrangement only applies when a health organization takes the initiative to individually and independently produce an E-E program and then sell it to a broadcasting organization. But *CMC* was mostly designed and produced by the production agency Talpa, as will become more clear in the following paragraphs. Furthermore, the program was not sold to a broadcasting agency, rather the broadcasting agency RTL paid partly for it themselves and they received money from the Friends Lottery, through the health organizations, to incorporate the health messages.

So in that regard, the E-E coproduction looks as the best applicable partnership arrangement to the collaboration process of *CMC*, however, it is not a perfect fit. First and foremost because of the role of the Friends Lottery. The Friends Lottery donated the money that was necessary for the health messages to be incorporated, meaning that the health organizations did have to spend their own money. Also, the initial idea to design and produce an entertainment program with educative health messages came from them, not from a health nor from a broadcasting organization. Furthermore, the Friends Lottery decided which health organizations would be able to incorporate their health messages in the serial and they kept a mediating role throughout the entire process.

Secondly, health organizations typically play a bigger role in the entire process of an E-E coproduction than was the case with *CMC*. As will become more clear in the following paragraph, the role of the health organizations was mainly to provide ideas, information, facts and feedback to the television professionals. They were not part of the decision-making process, because this was mainly taken over by RTL, Talpa and the Friends Lottery. In this regard, the collaboration process of *CMC* can better be seen as an E-E service partnership arrangement (Bouman & Brown, 2011), which is characterized by a lower level of collaboration in which the health organizations are not incorporated in the decision-making process and can only provide advice and information (Bouman & Brown, 2011).

4.2.1. Influence on the scripts

The role division when it comes to the scripts became very clear from the interviews. Basically, production company Talpa was in charge of the scripts and had by far the biggest influence. The role of the health organizations was mainly fact-checking and making sure that the storylines were factually correct, credible and realistic. The Friends Lottery had a mediating role, intervening when problems

arose and making sure that all the involved parties were pleased during the process. As mentioned before, the health organizations had one meeting with Talpa where they discussed relevant themes and explored possible storylines, which Talpa then took into account while writing the scripts. Talpa decided which themes they would use and created the storylines around those themes.

> Respondent1 DKF: *The script is up to the producer.In the end, you don't have any influence on it… They choose the characters, they make the serial. And of course, it needs to be based on dramatic principles… And what you do have is really checking whether it is credible. Or whether it is factually correct. More that role. So we were able to make sure that the storyline was realistic. And that the message was right.*

The respondents from the DKF added to this that during the writing process, the health organizations were kept in the dark about the chosen themes and the storyline and that there was a long period of time between the brainstorm meeting and when they received the first script.

However, the respondents did not really seem to mind their limited influence on the script. Only the respondents from the DKF mentioned once that they would have liked to have more influence or power when it comes to the scripts. The other respondents did not talk about wanting to have more influence and seemed to be fine with their role. Firstly, all of the respondents made clear that they were aware that the writing process was not their expertise, but that of the scriptwriters.

> Respondent NHF: *In the end you have to leave it to the creativity of the scriptwriters to make sure that the message comes across in a good way… Yes, we checked it on factual correctness. Look, it is not our expertise. If you look at the producers, they really have a track-record. So it really is not up to us… Everybody has their expertise and they are also the producers of* Gooische Vrouwen *for example. They truly know what attracts a large audience.*

All of the respondents mentioned something about that writing the scripts for a dramatic hospital serial is not their expertise, thus making it clear that they thought it was right that the scriptwriters took on the creativity and had the biggest influence.

Secondly, all the respondents from the health organizations really seemed to value their fact-checking role, as they all put emphasis on the importance of their storylines being factually correct and credible. The respondents mentioned that when the scriptwriters were done with the scripts, the scripts were sent to them so they could check whether the information was correct, their message was correct,

the storyline was credible and not insulting to anyone. Furthermore, the respondents from both the DAA and the NHF emphasized that Talpa, RTL and the Friends Lottery worked very precisely and also wanted the information in the serial to be factual and correct. Both respondents stated to be very content with this.

> Respondent NHF: *But again, I really want to emphasize this, there really was a lot of thoroughness from the Friends Lottery, Talpa and RTL. So that makes it a nice way of working*.

The two respondents from the DKF did not share this opinion, as they mentioned that after the first brainstorm meeting they never again saw or heard from Talpa's medical advisor. Adding to that, they said that the first time they received a draft version of the script from Talpa, the facts were incorrect and the storyline was not credible, but with their fact-checking role they were able to change this.

4.2.2. Appreciation of the collaboration process

As mentioned earlier, all the respondents stated that most of the communication with their collaboration partners went either via email or via telephone. Since the partners only met up once or twice, it can not be stated that they could really get to know each other. In general all the respondents were happy with how the collaboration went, however there were some minor hiccups or points that could be improved. A theme that came back in all the interviews was that the process and the communication sometimes was last-minute or fast.

> Respondent DAA: *Sometimes it was a bit last-minute, like we are going to shoot tomorrow. For example doctor Jacob, at a certain moment he went in a scan. How do you find out he has Alzheimer's? And I had to check that too… But frankly I could often answer it pretty quickly. So sometimes it was last-minute, but except for that it was fine.*

The respondents from the DKF also mentioned they had to provide feedback very quickly once they received the proposal scripts, because Talpa wanted to shoot the scenes as soon as possible. Adding to this, they said that this sometimes made it a bit hard, but that in the end in turned out fine. The respondent from the Friends Lottery also mentioned that the serial was produced in a hurry and she called the production process "*a race against the clock*". According to her, this hastiness was on the one hand caused by the fact that the Friends Lottery wanted to do it as soon as possible and on the other hand it was due to the program planning of broadcaster RTL. Only the respondent from the NHF did not

mention anything about fastness, hastiness or last-minute feedback.

Another reoccurring theme in the interviews was the difference in objectives or aims between the health organizations and the scriptwriters from Talpa. The respondents seemed to be aware of the fact that their main objective was to produce a factual and credible health message, while the main aim of the scriptwriters was to produce sensational and dramatic storylines. Furthermore, they argued that it is important to find a good balance between an educational message and drama. Adding to this, all the respondents from the health organizations mentioned that implementing a health message in a drama serial requires a different way of thinking about and tailoring the message. The respondents saw this as a positive challenge and as a new, promising way to convey their message to the public. Only the respondents from the DKF stated that the difference between drama and education sometimes made them worry, the rest of the respondents from the health organizations did not mention something about the differences causing problems or concerns. The respondent from the Friends Lottery however, did mention that one time a disagreement between a health organization and the scriptwriters arose.

Respondent Friends Lottery: *For example about the scripts, the scriptwriters wanted a storyline to develop in a certain way, because this was sensational for the serial. But the health organization said that that was not what they wanted to communicate. So it needed to be changed. So yes, it does happen. And there you have the difference between wanting to create a responsible message, while for the scriptwriters it often has to do with sensation or fitting in the bigger picture.*

So all the respondents showed awareness about the difference between wanting to create a responsible health message and wanting to write dramatic and sensational storylines. The respondents were aware that their goals differed from that of the scriptwriters and that implementing a health message in a drama serial requires a new way of thinking about it. However, this difference resulted in disagreements only a few times. Only the respondents from the Friends Lottery and from the DKF mentioned disagreements or worries, the others did not. Maybe this difference between the DKF and the other two health organizations can be explained by the notion that both the respondents from the DAA and the NHF stated that they had a lot of confidence in the capability of the scriptwriters and that they believed the scriptwriters to be able to convey their health message in a credible and convincing way. Adding to this, both of them mentioned they were enthusiastic about the idea of *CMC* as soon as they heard about

it, while the respondents from the DKF said that they had doubts about whether or not they wanted to participate in the serial.

> Respondent DAA: *Yes so they (the Friends Lottery) brought us into this and immediately we thought it was a very good idea… Frankly, we had all the confidence in that our message would be told in a good way.*

> Respondent 1 DKF: *It was uncertain because it didn't exist yet, so are we going to do it or not? … Unclear yes, but that was from two sides I guess. In the sense of are we going to do it? And can we justify it?*

Thus it can be argued that the respondents from the DKF had concerns about the scripts and the balance between drama and education, because they already had less confidence in the process in the beginning. Especially because the two other respondents expressed their immediate enthusiasm and confidence in the entire project and later did not encounter any problems when it came to the scripts.

The third recurring theme in the interviews is that some aspects were unclear or a little vague, especially in the beginning of the process. First of all, it was not clear from the beginning what the promo package from RTL would entail and what it would look like. For example, the health organizations did not know from the start that there would be an activation message that should lead to a test or quiz. This could be frustrating, since it could result in the health message in the episodes of the serial not corresponding to the activation message or the quiz in the promo video, as was the case with the DKF. The respondents from DKF explained that because they did not know about the activation message and the quiz during their meeting with Talpa, their health message in the serial focuses on living donation, while their activation message was about salt intake and referred to the Saltmeter-test. Secondly, the respondents mentioned that they were not aware that RTL would conduct an effect study. This was mentioned by the DKF as well as by the DAA. Even the respondent from RTL who conducted the effect study said that the research department of RTL was contacted relatively late. Thirdly, the respondents from the DKF mentioned that the communication process was unclear, because they sometimes felt they were kept in the dark about for example their storyline or the broadcasting dates.

> Respondent 2 DKF: *And at a certain moment they said they would start broadcasting in September. But then that changed to October and then it changed back again to September. And in the mean time we sat waiting and we didn't hear anything about it being moved. It's fine that they move it, but just let us know.*

According to nearly all the respondents there were a number of uncertainties during the production process. Only the respondent from the NHF did not mention anything about things that were unclear or unknown, rather he was extremely positive about the entire collaboration process.

To sum up, the collaboration process brought some difficulties. First of all, it was sometimes last-minute, forcing the health organizations to respond fast. Secondly, the different goals of the health organizations and the scriptwriters could lead to worries or disagreements about the scripts. In general this proved not to be a big problem, because the respondents were aware of the conflicting goals and knew that implementing a health message in a drama serial requires a different way of thinking about it. Thirdly, some aspects of the process were unclear, especially in the beginning. However, when everything became more concrete, the respondents stated that everything went in a nice manner. All in all, aside from a few small difficulties, the respondents were relatively positive about the entire collaboration process.

Respondent 1 DKF: *In the end, if we got something and it was clear what we were going to do, then it went fine.*

Respondent NHF: *Over all, about the collaboration, the preciseness and in the end the results, we can only be very pleased.*

4.2.3. The results

First of all, all the respondents were happy with how their storylines ended up. The storylines turned out to be what the respondents from the health organizations expected and they were content with how their themes were incorporated. The respondent from the NHF was extremely positive about their storylines and mentioned that he was glad that the characters ran through all the steps in one episode. Furthermore he emphasized that according to him, the balance between drama and education turned out very good. The respondent from the DAA was also content with their storylines and called it "*a present*" that the DAA got two different storylines about dementia in the serial. The respondents from the DKF were very happy with the fact that their storyline runs across several episodes, because it gives viewers more time to get to know the characters and to take in the story. However, one of them mentioned that some of the viewers had negative comments on the storyline because they thought it was unrealistic that Sam (the protagonist of their storyline) made such an important decision in such a short amount of time. But on the other hand, there were also viewers who said that it was good that attention was paid to the subject, so according to the respondent there were mixed reactions. The respondent from the Friends Lottery thought the serial turned out fine, but it could have been better.

Respondent Friends Lottery: *About the serial itself; I thought it was fine, but not exceptionally good. But it was made in a lot of hurry. This time there is more time, so I hope that it will all be a bit more beautiful. A bit more carefully shot and edited. And that's how it always goes, the first version is never a 100% perfect.*

Besides the fact that the storylines turned out good, the respondents were also very happy with the results they saw on their own channels. It was mentioned that the results were unexpectedly great and that certain health organizations had never had such high amounts of visitors on their websites. All the respondents stated that the serial and the surrounding promo messages led to more traffic to their websites and tests. The DAA's website even got so many visitors at once that the servers were overloaded and the website shut down. The respondent from the Friends Lottery also mentioned that the serial and promo's resulted in more traffic to the websites of the health organizations and that everybody was extremely happy with the results. On social media the health organizations did not see much results, but that was mainly because the organizations themselves did not pay very much attention themselves to the serial. This was mainly caused by the fact that the health organizations were restricted by RTL in terms of sharing content due to copyrights. The respondents from the NHF as well as from the DAA thought this was a loss and would have wanted to be able to share more content about the serial on their channels.

All the respondents were also very pleased with the results in terms of knowledge transfer, because the effect study by RTL and Motivaction showed a lot of positive results. The respondents mentioned that they were happy to see that the serial had the effects that it claimed to have in advance and that the goals of the health organizations were accomplished.

Respondent NHF: *A research organization did a study about the effects. Also in terms of knowledge, with a pre- and posttest. And then you can really see that it did something, when it comes to the knowledge goals we formulated in advance. So that is great. And I believe in it for sure*.

The respondent from the DAA also mentioned the effects that were measured by RTL and Motivaction and said that their storyline contributed to improved knowledge about Alzheimer's disease and caregiving. However, she did mention that the effect was less strong than for the NHF, but she explained that this is caused by the fact that the knowledge level about Alzheimer's and caregiving was already very high at the pretest. This thus means that there is less space for improvement. But still, the storyline

did contribute something and therefore the DAA was pleased with the results. The storyline about kidney diseases from the DKF was not researched by RTL and Motivaction, so the respondents could not comment on knowledge transfer. They said to believe that it is possible that implementing a message in a drama serial can have effect and can attribute to something, since they also saw the positive results for the other storylines.

As mentioned earlier, RTL collaborated with research agency Motivaction to study the effects of the serial *CMC*. A Team manager of Research and Intelligence at RTL explained how the research was conducted and talked about the positive results that *CMC* had on knowledge transfer. Together with Motivaction, RTL started with selecting storylines that would be researched in the study. According to the respondent, there were two selection criteria for choosing the storylines. Firstly, the storyline had to start and finish within one episode, because it would have been too hard to find respondents that watched all the episodes. Secondly, the health message of the storyline should be explicitly mentioned in the episode, because it would have been too challenging to measure knowledge transfer if the message was very soft and implicit. However, they also chose to research one storyline in which the health message was more implicit, because they wanted to "*spread the risks*".

This resulted in three different storylines, the storyline about heart attacks among women, about Alzheimer's disease and caregiving and about FAP, a genetic intestines disease. In order to measure the effects, a pretest was conducted among viewers after the first episode of *CMC* was broadcasted. This test included a questionnaire in which the level of knowledge about the three diseases was measured with open and closed questions. Then after the broadcasting of each selected episode, a different group of people received a questionnaire about that specific disease with the same questions that were used in the pretest. The questionnaires were sent within 24 hours after the episode, so the effects were short-term. In order to measure the long-term effects, the respondents who received the questionnaire about FAP, received the same questionnaire seven weeks later. For the other two storylines, the long-term effects were not measured. Furthermore, there was made a distinction between live viewers and online viewers. The live viewers were the people who watched the episode when it was broadcasted on RTL4 at Sunday evening and they received the questionnaire the following day. The online viewers were people who watched the episode via the online on-demand service and they were sent a link to the episode on the Wednesday before it was broadcasted on television and they received the questionnaire on Thursday.

The results showed that all the effects were positive, meaning that the researched storylines contributed to more knowledge about the specific diseases. The highest effect was measured for the

storyline about FAP, but according to the respondent this is mainly caused by the fact that the knowledge level about this disease was very low in the pretest. The second highest effects were found for the storyline about heart attacks and the lowest, but still positive, effects were for the storyline about Alzheimer. The respondent explained that on the one hand this is because the level of knowledge was already very high and on the other hand because the message about Alzheimer's was very soft and subtle incorporated in the episode, whereas the other two message were more explicit and clear. A very surprising result was that the knowledge transfer for online viewers was a lot higher than for the live viewers. It was expected that live viewers would have a higher knowledge transfer, because they also saw the promo clips, which were not shown to the online viewers. However, it thus turned out to be the other way around. The respondent assumes that this is because online viewers watch more concentrated and are less distracted than live viewers.

4.3 Appreciation of the viewers

4.3.1 General appreciation

In terms of general appreciation of the shown episodes, it became clear from the focus groups that the viewers were not very enthusiastic about the serial. Most of the respondents did not necessarily dislike their episode, but they also did not find it very catchy, exciting or sensational. This was especially the case for the viewers who participated in the third focus group:

> Anoek: *So how did you like the episode?*
>
> Koen: *I didn't really think the story was compelling or catchy or anything. It's not like I lost myself in the story, that I wanted to know how it ended.*

The other respondents in this focus group agreed to this, except for one viewer, Charlotte, who could relate to the storyline about Alzheimer's disease because her grandmother also suffers from this disease. The adult women in the second focus group were a little less negative, but they also lacked enthusiasm. They did not dislike the episode and did not find it annoying or boring to watch, but they did mention they would not stay at home for it. The respondents from the first focus group were the least negative and said they enjoyed the serial, however they did mention that the bad acting of some of the cast members did irritate and distract them. It was mentioned by a few respondents that they would have enjoyed the episode more if it was more dramatic and sensational, so they would be more transported into the story and compelled to know how it ends.

The respondents were also asked about their opinion of E-E productions in general, so whether they thought it is good or bad that entertainment programs are sometimes used for educational

purposes. Only one respondent, Marion from the second focus group, said she did not like this idea because she feels like she is influenced by so many different people and programs already.

Anoek: *And what do you think of it in general, that television programs sometimes contain messages?*

Marion: *Well I actually wanted to mention that, I think it is starting to get a bit much. Programs influence us on politics, really in so many different way. Sometimes I actually don't really like it. Recently I read an article about how television programs can influence your political views and social media can also be very important to steer people in a certain direction. […] Sometimes I think it's a bit scary. It's not like you're being brainwashed because you can think for yourself. But unconsciously…*

The rest of the respondents thought that it was a good idea that serials like this exist and that people can be educated or informed through entertainment programs. However, it was mentioned a couple of times that the messages in *CMC* could have been more powerful and that it should have been made more clear that the episodes were made in collaboration with health organizations. All the respondents said they did not know that the episodes were made in collaboration with health organizations or that the episodes included health information and because they did not know about this, they missed relevant information. According to them, they would have learned more if they knew in advance that the episode contained health information. Some of the respondents even called it a missed opportunity, because they felt that the message would have come across a lot stronger if the role of the health organizations was made more clear. Furthermore, the majority of the respondents thought that viewers would not be discouraged to watch the serial if they knew that the episodes contain health information or messages, only two respondents thought that making it more clear could possibly put viewers off.

4.3.2. Credibility and realism

Overall, the respondents thought that the shown episodes of *CMC* were credible and realistic. It was mentioned that the storylines were realistic and the health information was trustworthy and provided in a credible way. It should be mentioned however, that two of the respondents explicitly mentioned that they believed the health information to be true because they had no knowledge of the subject.

Diann: *If we only talk about the information, then I think it's credible. And I also have no knowledge about it, so then I believe it even more.*

In general, the entire episodes as well as the specific storylines were perceived as realistic and credible, however when the focus groups deepened their discussions, it turned out that there were several unrealistic features in every episode. For instance, the respondents of the first focus group thought that the bad acting of one of the main characters in the kidney-storyline, made it unrealistic and less credible. According to them, her acting was so terrible that it caused them to be distracted and irritated.

Denise: *I think that because of that sister it became less realistic.*

Wendy*: I agree with that.*

Denise: *Yes maybe they should have used a different actress for that role.*

Diann: *Yes it's a pity. Just like with that one scene. That was pretty emotional, but then she started laughing at once. Her sadness didn't get across to me.*

The respondents even argued that the message of the episode was lost because they were so annoyed with the actress. Besides the irritation caused by the bad actress, the respondents from the first focus group also argued that it was not realistic that Sam (the kidney patient) changed his mind about his donor-kidney so quickly. In the episode, Sam is at first determined that he only wants a kidney from a dead donor even if that means he would probably not survive. But in a matter of minutes, after one discussion with his crying sister, he gives in and accepts a kidney from his best friend.

Dennis: *He changed his mind pretty quickly. When his sister started to cry he suddenly said that he would do it.*

Denise: *Yes indeed, suddenly he did want it.*

This sudden change of mind was also something that the respondents of the third focus group mentioned to be unrealistic about the Alzheimer's storyline in episode 5. At first, Tara and her brother declined the offer of a psychiatrist to help with their sick mother, but a day later they change their mind and agree to sit down with her to discuss the options. According to the respondents, their decision was too sudden, without a good explanation and it came too much out of nothing. The viewers argued that more attention should have been paid to the event that made them change their mind. This would not just have made it more clear, it also would have made it more sensational and more recognizable for viewers who are going through a similar situation at home. Furthermore, the viewers of episode 5 thought the scene where a doctor left behind a giant piece of iron in someone's leg after a surgery was also not realistic and according to them it did not add something to the story.

The respondents from the second focus group also had a few discussion points in terms of realism and credibility. For example the scene where a clumsy male nurse knocks over a table and sends

dozens of pills flying through the air, was not perceived as realistic, since medicine are always kept in small, sealed, plastic bags. But more importantly, the respondents argued that some information was missing, causing the heart attack storyline to be less realistic. Firstly, the patient's dress is cut open by the paramedics without any explanation or warning, while in reality, doctors always have to tell what they are doing and why. This relates to the second point, where doctors apply medical equipment to the patient without telling her what it is and why they are doing it. Thirdly, some of the doctors come to help her but they do not introduce themselves or tell her why they are there. And that even though the patient is awake and conscious the entire time.

Gerda*: I can understand why Sonja was scared. Because it wasn't really explained to her what was happening to her. Normally when you are in a hospital and they apply something to you, a sticker or something, they explain what they are doing. But they didn't do that all the time. […]*

Marion: *Yes and when she was brought in they cut open her dress. And they didn't explain or react to that or anything.*

Dunja: *No it wasn't stated or explained.*

According to the viewers, who have either personal experience with hospitals or a medical background, doctors always have to tell who they are, what they are doing and why they are doing it, especially when the patient is awake and conscious. So according to the viewers, in the beginning of the storyline some information is missing, making the storyline less realistic. But after the patient is brought in and doctor Lis van der Laan starts the patient's treatment, the viewers thought a lot of correct and useful information was provided.

4.3.3. Knowledge

One of the most recurring themes in terms of knowledge or information reproduction, is that the information was either unclear or not complete. Especially in the first focus group it became clear that the respondents missed a lot of information, which, according to them, led them to miss the core message of the episode. The message that the DKF wanted to convey in Sam's storyline is about living donation, however the respondents stated that the episode lacked information that contributed to this message. For instance, the respondents raised questions about when you are a match to a patient and which factors determine whether or not you are a match. Also they would have wanted to know more about the steps that should be taken when you want to donate a kidney.

Diann: *It was mentioned a couple of times, that you can donate when you are alive, but they didn't give a lot of information about how that works and what you have to do.*

Diann: *They should have made it clearer when you are a match and what exactly you should do when you want to give someone a kidney. Or at the end of the episode they could have said something like do you want to become a donor, then you should do this or that. Then it would have been more clear that that was their message.*

But even though the respondents might have missed the core message of the episode, they did pick up some medical information about kidney diseases. They did for example remember that waiting lists for dead donor kidneys are very long, kidney transplants are terribly hard and demanding, the patient decides whether he wants a new kidney or not and that the body can reject multiple kidneys.

Also the respondents from the third focus group argued that the message could have been made stronger and that more information about Alzheimer's disease and caregiving should have been provided. The core message that the DAA wanted to convey in the serial is that taking care of a family member whom suffers from Alzheimer's disease is very demanding on the lives of the caregivers. Furthermore they wanted to provide information about different options for help, such as a case manager. First of all, one of the respondents argued that more basic information about Alzheimer's disease should have been provided, even if it was just very briefly and quickly. They did stress that it should not be too long or too much, because that would make it boring. Secondly, the respondents stated that the message that caregiving is hard and demanding, was very weak. It was said in the episode, but the viewers couldn't actually see it. The respondents believed that the message would be a lot stronger if for example they were shown a scene at home with Wonnie and her kids, where Tara and Rodney are taking care of her.

Guido: *It would probably make it more realistic if they were at home, so you can really see that they are taking care of their mother. Because now they discuss caregiving, but you don't actually see it. Now you're more like how hard can it be? While if they showed you a couple of things, you could see how tough it really is.*

It was also suggested to show a fight between Wonnie and her kids about her disease or that she didn't want any help. Because the respondents argue that Tara said her mother did not accept help, but yet again this is not shown. This would not only make the message stronger, it would also add drama and sensation, which is something the viewers missed in the episode. Furthermore, the respondents thought that viewers who also have family members with Alzheimer's would probably be able to relate to this.

Koen: *I think they could have made it a lot more dramatic, because there are a lot of dramatic cases. I think they left it pretty soft.*

Menno: *Yes, a little bit more focus on her, that she makes mistakes or doesn't remember things. You don't see any drama or frustration at all.*

Guido: *Right now she doesn't notice it anymore so she is really calm about it. But I can image that it is really frustrating when you notice about yourself that you keep forgetting things. In the beginning you'll probably be aware of it and that frustration could really add something to the serial.*

Even though the respondents were of the opinion that the message could have been a lot stronger, all of them agreed that caregiving to a family member with Alzheimer's is incredibly tough and often underestimated. They had doubts about whether the storyline could change the image of caregiving because it was not really shown how hard it is, but yet it is striking that they all agreed that it is extremely hard while most of them have no personal experience with it. Furthermore, they did notice the information about the case manager and the fact that it is covered by the basic health insurance.

It was mentioned earlier that respondents from the second focus group also had the feeling that information was missing, however according to them, that missing information only made it less realistic, it did not weaken the message or affect the understanding of the message or the disease. One respondent however, Sylvia, noticed that it was not explained what stents are, even though the doctor mentioned they had placed two of those. Also, the respondents heard that the doctor said something about aftercare, but they noticed that information about what it is and how it works, missed. But in general, the respondents agreed that a lot of medical information was provided and that this information was necessary and credible.

Gerda: *She (doctor van der Laan) was clear in her information. Maybe it was bit much sometimes, but not superfluous. She also wasn't preachy. But that would not be possible since the patient has a healthy lifestyle.*

When the respondents were asked whether they thought they learned anything about heart attacks among women, it became clear that most of the information was already known by them. For example they were already aware that the symptoms are different for women than for men and they also knew what the symptoms were. Furthermore they were familiar with terms like stents, dotter treatments and catheterization. However, the respondents were aware that almost all of them either had a medical background or personal experience with heart attacks or hospitals.

Anoek: *The doctor also talked about stents, dotter treatments and catheterization. So a lot of information, but it was not too much?*

Dunja: *No. But those terms are well known*

Marion: *Yes and they just go with it*

Dunja: *Yes you just know that terms like dotter treatments and catheterization go with it*

Marion: *But I also think that it plays a part that apparently a lot of us have a medical background. Or personal experience*

Gerda: *Yes and also what you encounter in your personal surroundings of course*

Sylvia: *Yes I don't know if for example younger people would know all of this.*

So among the respondents of this focus group, the majority of the medical information was already known before the episode, however the respondents concluded that the information that was provided was necessary and correct. Furthermore, they mentioned that even though the information might be familiar to them, it is plausible that especially younger people don't have any knowledge about the subject. One respondent, Dunja, did learn something from the episode, since she did not know beforehand that symptoms of heart attacks are often confused with symptoms of the menopause.

5. Conclusion and discussion

One of the aims of this thesis was to gain insight in how the health organizations and television professionals collaborated in the designing, production and implementation of the Dutch hospital drama serial *Centraal Medisch Centrum*. By conducting several in-depth interviews with health professionals and a contact person from the Friends Lottery, it was revealed what the collaboration process looked like, what the different involved parties thought of the process and how it could have been improved. A small narrative analysis shed light on how the three different themes were incorporated in the serial as a result of the collaboration process. Furthermore, this thesis aimed to find out how both the collaboration partners themselves and members of the audience appreciated the serial and the incorporation of health messages. The appreciation of *CMC* by the public was studied by conducting three focus groups, during which the respondents discussed their opinions of the serial. An in-depth interview with one of RTL's researchers also provided insights in how the serial is appreciated and what the effects were in terms of knowledge transfer. By combining all of the abovementioned findings, the research aimed to reveal whether this specific way of collaborating was successful and whether it resulted in an appreciated Entertainment Education program. All in all, this thesis answered the following research question: *How are the health issues in the Dutch hospital drama serial* Centraal Medisch Centrum *produced and appreciated?*

After analyzing the interviews with health professionals and the Friends Lottery, it became clear that E-E collaborations do not always perfectly fit within one of the E-E partnership arrangements as described in paragraph 2.2.3. (Bouman, 1999; Bouman & Brown, 2011; Lubjuhn, 2012). At first sight, *Centraal Medisch Centrum* seemed to be an E-E coproduction, because it is a new serial that was specifically designed to contain health messages. However, in the end, the E-E service turned out to be the most applicable partnership arrangement to this particular collaboration process. The power in terms of scriptwriting was almost completely in the hands of the scriptwriters from Talpa, whereas the role of the health organizations was mainly to provide information and feedback to make sure that the health information was factually correct and credible. Furthermore, the health organizations were not included in the decision making process, as they were almost completely dependent on the choices of RTL, Talpa and the Friends Lottery.

When looking at the model describing the six stages of a collaboration process (Center for Media & Health, 2016), it becomes clear that the collaboration between health and television professionals only took place during a small part of the third stage. The third stage includes brainstorming, scripting,

shooting and editing and according to Center for Media & Health (2016) it requires the input of both the health and television professionals. However, the input of the health professionals in the case of *CMC* was only needed during the brainstorm session to propose possible themes and after the scriptwriting to provide feedback about facts and credibility. But despite their limited role, the health professionals seemed to be generally pleased with how the overall process went, as they saw their fact-checking role as very important and they were aware that scriptwriting is not their expertise. It was mentioned that there were some difficulties, but overall the health professionals were happy with both the process and especially with the results. According to the respondents, the broadcasting of *CMC w*ith the incorporated health messages and the surrounding promo's led to great positive results. Besides just leading to more traffic to the websites of the health organizations, it also resulted in increased knowledge about the specific diseases according to the effects-study by RTL and Motivaction.

The focus group respondents in this thesis generally lacked enthusiasm about the shown episodes of *CMC*. It was mentioned that the serial could have been more dramatic and sensational, because it was not captivating or exciting enough as it was. Furthermore, the episodes and specific storylines were in general perceived as credible and realistic, but when the conversations deepened, each focus group came up with specific aspects that were unrealistic or not credible. This is in line with the discussion by Hetsroni (2009), who argued that hospital drama serials often do not reflect reality, since the medical cases often focus on dramatic or graphic diseases and the format of the genre limits the accuracy due to time constraints. All respondents, except for one, thought it was good that serials like *CMC* are produced, where entertainment is combined with education. However, they felt like the health messages in *CMC* could have been made stronger and more clear. But still, all of the respondents were able to reproduce at least some of the medical information that was provided in the episodes. Therefore it can be argued that the storylines can indeed contribute to increased awareness and knowledge of certain health issues, but that this process happens unconsciously. Even though the viewers might not be aware of the fact that an episode contains health messages, they still take in some of the information. This thus means that the first two stages of behavior change as described by Damoiseaux et al. (1987), which are awareness and understanding, are accomplished by *CMC*. For example, after watching the episode from the NHF, the respondents were aware that there is still a lot unknown about cardiovascular disease among women and that men and women show different symptoms of a heart attack. They understood the provided health information and knew what the symptoms are and what the treatment looks like. However, whether or not the serial actually lead to behavior change can not be concluded from this research, since that would require a more long-term

approach.

So to sum up and answer the main research question of this thesis, the health issues in the serial *CMC* were produced in a somewhat unconventional collaboration that can not be simply placed in one of the E-E partnership arrangements. The collaboration bears most resemblance to an E-E service due to the limited role of the health organizations. Aside from a few difficulties, the health organizations are positive about the process, happy with their storylines and enthusiastic about the positive effects. The viewers thought the serial was fine and relatively credible, but not very exciting and sometimes a bit unrealistic. They do however appreciate the fact that serials like this are produced and they have a positive attitude towards the Entertainment-Education concept. Even though they argued that the messages could have been stronger and clearer, they still were able to reproduce health information that was provided in the episodes.

With these results this thesis has shown that utilizing the Entertainment-Education strategy can indeed contribute to increased awareness of and knowledge about health issues that are incorporated in entertainment programs. The results show that the E-E strategy is a useful way for health organizations to reach a large audience with their message, which is very important since it is becoming harder and harder for health organizations to keep and maintain the attention of individuals. Furthermore, health organizations typically earn their money through donations, so they have to think twice about spending their money on advertising or campaigns. Knowing that the E-E strategy is a useful and promising way of sharing their message can therefore mean they do not spend donated money on campaigns that do not have the desired effects. Lastly, this thesis has proven that theoretical concepts or models do not always apply in reality. The collaboration process that led to the serial *Centraal Medisch Centrum* was somewhat unconventional and can not be fully described by one of the partnership arrangements and the collaboration process did not completely follow the six stages. This finding can be of great importance for organizations that plan to design and produce an E-E program in the future, so they will not be surprised or disappointed when their collaboration process deviates from theoretical models.

5.1 Limitations and future research

There are a number of factors and limitations that might have influenced the results of this research. Firstly, the incorporation of their health messages did not cost the health organizations any money, as it was a gift from the Friends Lottery. The overall positivity and enthusiasm of the respondents from the health organizations might be largely caused by this fact, as it can be expected that it is harder to be critical about something you received for free. It is both interesting and important to question whether the respondents would have been just as positive about the process and their storylines if they would

have had to pay large amounts of money for it. Another factor that possibly affected the interviews with the respondents, is the fact that the interviews were conducted after the health organizations learned about the positive effects of the serial that were found by RTL and Motivaction. It might be the case that the respondents felt more positive about the collaboration process because they knew that the process led to positive effects for their organizations. If the interviews would have been conducted before these results were shared, there is a chance that the health organizations would have been more critical about the process. This can be illustrated by the fact that the storylines of the NHF and the DAA were both included in the research, whereas the storyline of the DKF was not included. During the interviews, the respondents from the DKF were clearly less positive about the process and their storyline than were the respondents from the NHF and the DAA. Therefore, it could be said that the health organizations whose storylines were researched, were less critical about the process during the interviews.

One of the limitations of this research is that no in-depth interviews were conducted with the scriptwriters of *CMC*. Unfortunately this was not possible due to time constraints, but it would have added another point of view on the collaboration process. Even though the interviewed respondents already revealed a lot about the entire process, it would have been very interesting to speak with the scriptwriters about the scriptwriting process and their views on the health organizations and their roles. The second limitation is that only three out of seven health organizations were interviewed and that only their storylines were analyzed in this research. It is not expected, but it could be possible that professionals from the other health organizations experienced the process completely different from the interviewed health professionals, which would have led to different results and conclusions. Furthermore, it would be interesting to see whether or not viewers appreciate the other health storylines in *CMC* in the same way. Another limitation is that there were no pre- and posttests conducted during the focus groups, which makes it hard to fully prove that the respondents learned something about the health issues from the episode. Even though the respondents were able to reproduce some of the information from the episode, it might be possible that they already knew all the information beforehand. Lastly, it should be kept in mind that a production like *CMC* has never been done before in the Netherlands. It is the first time that a commercial lottery decides to produce an E-E program and donates money to seven different chosen health organizations so their storyline could be incorporated. The entire collaboration process was already different from the very beginning, so it is not shocking that it does not fit into one of the theoretical models from previous research.

There are a number of possibilities for future research on this topic. First of all, it could still be interesting to talk to the scriptwriters of *CMC* or to the remaining four health organizations. Another

possibility might be to research the long-term effects of *CMC* in terms of awareness and understanding. This could for example be done by inviting the focus group respondents to come together again several weeks or months after the initial focus group discussion or they could be sent a questionnaire in which their knowledge about the specific health issues is measured. Furthermore, at the moment of writing this thesis, the preparations for season 2 of *CMC* are ongoing. It could be valuable to interview some of the professionals that are involved in both seasons to see whether or not changes have been made to the entire process in order to increase the effects or the happiness of the involved parties. Lastly, it is important to keep researching new E-E collaborations, because the media environment keeps evolving (Arbaoui, De Swert & Van Der Brug, 2016). It was mentioned before that television professionals already have to deal with a lot of pressure concerning ratings and success, whereby they struggle with handing over influence on scripts to others (Glik et al., 1998). So if television professionals have to deal with an ever-growing amount of competition both from each other and from new media producers, this might ultimately mean that health professionals in the future might find themselves struggling even more to be able to incorporate their health message in entertainment programs.

Besides its limitations, hopefully this thesis added something to the understanding of the E-E strategy, it's effects and the collaboration between health and television professionals. It is strongly suggested to keep researching these subjects in the future with the hope of further improvement, because I believe that the E-E strategy is a very useful way to educate the public.

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Appendix A – Transcripts of storylines

1. Netherlands Heart Foundation: Heart attack women

Episode: 3; Egokweller
Health message: Women show different symptoms for a heart attack than men do. The symptoms are often confused with the menopause, so it is very important to know the difference and look for medical attention on time.
Summary and context of storyline: Sonja Bos (52 years old) is brought to the emergency department of CMC because she suffered a heart attack. A few weeks earlier she went to see doctor Mia Verhulst because she was not feeling well, but dr. Verhulst said the symptoms were part of the menopause. As it turns out, Mia Verhulst was wrong and cardiologist Lis van der Laan explains to the patient that this is a common mistake, since the symptoms of a heart attack with women are not well known and therefore are often confused with menopause.
Scenes:

[Episode 3, 7;25-7;54*. Er wordt een vrouw binnengebracht op een brancard bij de eerste hulp. Een arts van de spoedeisende hulp noemt de feiten op]*

[Arts]: Mevrouw Bos, 52 jaar en is onwel geworden tijdens een stijldanswedstrijd. Ze heeft tweemaal gebraakt. Voorgeschiedenis is voor zover we weten blanco. Bloeddruk 110 over 70. Pols van 90. Temperatuur 37,2. ECG tonen geen eenduidige tekenen van een infarct.

[Cardioloog Lis van der Laan komt aangelopen en zegt tegen iemand die bij de patiënte hoort]; Wilt u wachten in de wachtkamer?

[Daarna komt zij binnen in de kamer waar de patiënte op de behandeltafel ligt en omringd wordt door drie andere artsen]

[De spoedeisende hulp arts tegen dokter van der Laan]: Mevrouw Bos, 52 jaar, onwel geworden. Bloeddruk 130 over 85. Kortademig, misselijk, heeft twee keer gebraakt.

End of scene.

*[**Episode 3, 12;40-13;59**. Patiënte ligt inmiddels op haar kamer en dokter van der Laan staat ernaast]*

[Dr. van der Laan tegen patiënte]: U heeft een hartinfarct gehad. En volgens de ECG was dit niet uw eerste. Ik ga u hartkatheterisatie geven, daarbij brengen we een katheter aan in uw lies. Met contrastvloeistof kunnen we precies zien of er vernauwingen zijn rondom het hart."

[Patiënte]: Jeej, ik dacht stress.

[Dr. Van der Laan]: Rookt u?

[Patiënte]: Nee. Nee en ik ben gezond. Ik dans vier keer per week. Nooit problemen gehad.

[Dr. Van der Laan]: Afgelopen jaar nooit naar de huisarts geweest?

[Patiënte]: Euh jawel, ik was moe, misselijk en ik ademde lastig. Kortademigheid. En hij zei dat het stress was.

[Dr. van der Laan kijkt in de computer en zegt]: Is het ook meestal. Over hart- en vaatziekten bij vrouwen is helaas nog niet zoveel bekend. De kleine bloedvaten verkalken heel geleidelijk, waardoor de bloedtoevoer naar het hart heel moeizaam wordt.

[Patiënte]: Maar de dokter zei dat het de overgang was

[Dr. van der Laan]: U bent 52.

[Patiënte knikt en zegt]: Ik moest naar de gynaecoloog. Zij zei me dat die klachten inderdaad door de overgang kwamen. Dat hartkloppingen enzo daar nou eenmaal bij horen

[Dr. van der Laan]: Dat is een veelgemaakte fout.
[Dr van der Laan kijkt verbaasd naar het computerscherm en zegt]: Dat… Dat was hier?

[Patiënte]: Dat klopt. Ehm dokter Verhulst.

End of scene.

[Episode 3, 15;20-17;00*. Patiënte ligt op de operatietafel. Dr van der Laan en andere dokter zijn bezig met onderzoek. Patiënte is bij.]*

[Dr. van der Laan tegen andere dokter]: Spuit de contrastvloeistof er maar in

[Andere dokter doet dit, kijken beiden naar een scherm waar het hart op te zien is]

[Dr. van der Laan tegen andere dokter]: Pompfunctie oké. Hartklep is in orde. Maar wel wat vernauwingen wat ik al dacht. Maak maar dicht

[Dr. van der Laan tegen patiënte]: Ik ga u morgen dotteren.

[Patiënte]: Ik vind dit doodeng

[Dr. van der Laan]: Veel mensen die een infarct hebben gehad, zijn bang dat het weer gebeurt. We hebben daar een speciaal nazorgtraject voor en onze verpleegkundige zal u daar straks op wijzen. En voor de rest gezond eten, lekker bewegen en goed naar uw lichaam luisteren.

[Patiënte]: En niet naar een arts die zegt dat het de overgang is?

[Dr. van der Laan]: Tot morgen.

[Shot verwisselt. Dokter Mia Verhulst is klaar met haar dienst en loopt richting uitgang. Dokter Lis van der Laan houdt haar tegen]

[Dr. van der Laan]; Hé

[Mia Verhulst]: Hé

[Dr. van der Laan]: Heb je even? Ik kreeg vandaag een patiënt van je op de eerste hulp. Sonja Bos

[Mia Verhulst]: Help me even, je weet hoe slecht ik ben in namen

[Dr. van der Laan]: 52. Doet aan ballroomdansen

[Mia Verhulst]: Oooh die ja, daar heeft ze over verteld

[Dr. van der Laan]: Hartinfarct. En volgens het hartfilmpje was dat niet haar eerste. Ik dotter haar morgen. Je had haar moeten doorverwijzen.

[Mia Verhulst verontwaardigd]: Ze is één keer bij me geweest

[Dr. van der Laan]: Ja met klachten waarvan al je alarmbellen hadden moeten afgaan

[Mia Verhulst]: Met klachten die elke vrouw in de overgang heeft. Moet ik nu ineens bij jou op het matje komen? Daar heb ik helemaal geen zin in.

[Dr. van der Laan]: Ze had dood kunnen zijn

[Mia Verhulst]: Ik heb haar onderzocht en haar hormoonspiegel wees uit dat ze vol in de overgang zit. Stom van me, dat ik die diagnose heb gesteld. *[Zucht en loopt weg.]*

End of scene.

*[**Episode 3, 31;09-31;53**. Patiënt ligt weer in haar bed, dr. van der Laan staat ernaast]*

[Dr. van der Laan]: Het is helemaal goed gegaan. We hebben de vernauwingen opengemaakt en twee stents geplaatst. Ik hou u nog twee nachtjes hier, en daarna kunt u er weer tegenaan.

[Patiënte]: Onno belde, mijn danspartner. We zijn kampioen geworden

[Dr. van der Laan]: gefeliciteerd

[Patiënte zuchtend]: De afgelopen 24 uur waren zo heftig voor me.

[Dokter loopt weg, man wil de kamer van patiënt in]

[Man]: Ik weet dat het bezoekuur is afgelopen, maar Son is zo bang.

[Dr. van der Laan]: Gaat u maar. Weet u? Ik denk dat Sonja nu wel behoefte heeft aan een beetje afleiding.

[Man gaat naar binnen, Dokter loopt weg.]

End of scene.

*[**Episode 3, 34;15- 35;05**. Dokter van der Laan is op haar kantoor. Mia Verhulst komt binnen gelopen]*

[Mia]: Hoe is het met Sonja?

[Dokter van der Laan]: Goed. Maar geschrokken.

[Mia]: Sorry dat ik gisteren zo weg liep. Maar ik heb echt naar ieder geweten gehandeld.

[Dokter van der Laan]: Dat weet ik. Maar het was een foute inschatting. We maken allemaal weleens een fout, maar dan moeten we er wel over kunnen praten.

[Mia]: Dat moeten we zeker. Maar het is een beetje de toon waarop hè Lis.

[Dokter van der Laan]: Ik snap het. Kom je morgenavond eten?

End of scene.

2. Dutch Alzheimer's Association: Caregivers

Episode: 5
Health message: It is extremely demanding and difficult to take full care of family members who suffer from Alzheimer's disease. There are a number of possibilities to lessen the burden, one of which is a case manager. The case manager can help the caregivers and is part of the basic health insurance.
Summary and context of storyline: When Tara Kuipers, the much-loved canteen employee at CMC, does not arrive at work, her colleagues go searching for her. In turns out that Tara was looking for her mother, who suffers from Alzheimer's disease and ran away from home when Tara's brother was showering and left the door unattended. The next day Tara's mum is taken into the hospital after she was hit by a cyclist when she wanted to get groceries for Tara's brother. Tara is angry with her brother and blames him, until she realizes that their burden is too big and they need help with taking care of their sick mother. The CMC psychiatrist advises Tara and her brother to take on the help of a case manager.
Scenes:

[Episode 5, 9;00-9;40*. Verpleegkundige Dilem ziet een oudere vrouw alleen in de kantine van het CMC zitten. Ze vermoedt dat het de moeder van Tara is en gaat erheen]*

[Dilem]: Hallo, kan ik u helpen

[Moeder van Tara]: Ben ik er al?

[Dilem]: Waar?

[Moeder van Tara]: Hij heeft me geholpen. Hij heeft me gebracht.

[Dilem]: Wie?

[Moeder van Tara]: Ehm Hij was heel aardig

[Dilem]: Hoe heet u?

[Moeder van Tara]: Wonnie

[Dilem]: Hi Wonnie, ik ben Dilem.

[Moeder van Tara]: Dat is toch geen naam?

[Dilem]: Wonnie, heeft u een telefoon?

[Moeder van Tara]: Tuurlijk

[Dilem]: Zou ik die mogen zien? Dan kunnen we er misschien achter komen op wie u zit te wachten.

[Moeder van Tara]: Ja hoor.

[Dilem]: Wacht u op Tara?

[Moeder van Tara]: Mijn mooie kind

[Dilem]: Ik bel haar even, mag ik uw telefoon gebruiken?

End of scene.

*[**Episode 5, 11;41-12;30**. Tara komt binnengelopen in de kantine van het CMC en loopt op haar moeder af die nog bij Dilem zit]*

[Tara]: Mam.

[Moeder van Tara]: Meisje

[Tara]: Mam, je had beloofd dat je niet weg zou rennen

[Moeder van Tara]: Als ik niet bij jou ben, mis ik je

[Tara]: Ja dat snap ik mam, maar ik moet ook werken

[Tara tegen Dilem]: Dankje

[Dilem]: Graag gedaan. Ik wist niet dat je…

[Tara]: Ja, ze heeft Alzheimer.

[Dilem]: Wat verschrikkelijk. Zorg jij voor haar?

[Tara]: Al jaren ja. Ga lekker werken joh, mijn broertje komt ook zo.

[Dilem]: Oké.

[Dilem tegen moeder van Tara]: Dag Wonnie

[Moeder van Tara]: Wie is dat?

[Tara]: Dat is Dilem

[Moeder van Tara]: Dat is toch geen naam? Dilem?

End of scene.

*[**Episode 5, 15;50-16;33**. Tara is inmiddels aan het werk in de kantine van het CMC. Maar haar moeder loopt haar in de weg. Uiteindelijk komt haar broertje, Rodney, er ook aan]*

[Rodney]: Jo Taar

[Tara]: Waar bleef jij nou?

[Moeder van Tara]: Hee

[Rodney]: Hoi Mam

[Moeder van Tara]: Heb je al gegeten?

[Rodney]: Nee nog niet

[Tara]: Waar was je?

[Rodney]: Ik was even thuis aan het douchen

[Tara]: Je hoeft alleen maar ervoor te zorgen dat ze niet wegloopt. Hoe moeilijk kan het zijn? Dit had goed mis kunnen gaan.

[Rodney]: Ja dat snap ik, maar het is niet misgegaan.

[Tara]: Nee nu niet nee. Jezus. De deal is dat jij gratis in haar huis kan wonen en dat jij op haar let als ik moet werken

[Rodney]: Ik weet wat de deal is, maar het is fucking zwaar

[Tara]: Dat snap ik.

[Rodney]: Nee, je snapt er geen ene reet van

[Rodney en Tara lopen weg. Moeder komt uit de keuken van de kantine met een bord eten]

[Moeder van Tara]: Rodney? Waar is die jongen? Hij moet eten.

[Tara zuchtend]: Hij komt zo wel weer mam.

End of scene.

*[**Episode 5, 28;39-28;47.** Tara's moeder ligt op een ziekenhuiskamer met bliepende machines te herstellen nadat ze is aangereden door een racefiets. Tara zit aan haar bed en haar broertje, Rodney, komt binnen]*

[Rodney]: Sorry

[Tara]: Gister zei ik het nog hè. Dat het ook mis kon gaan. Jij zou opletten

[Rodney]: Sorry, echt sorry

[Tara]: Ze ging broodjes voor je halen en nu ligt ze hier

[Rodney]: Ik heb de sleutel in de deur laten zitten

[Tara]: Ik ben zo boos op jou

[Rodney]: En terecht

[Tara]: Niet. Niet terecht

[Rodney]: Tuurlijk wel

[Tara]: Nee dat is het niet. Het is gewoon te zwaar. Het spijt me Rodney, ik had eerder iets moeten regelen. Het is niet jouw schuld dat ze hier ligt. Maar als ze in een tehuis zit dan..

[Rodney]: Ja dan is ze echt weg.

End of scene.

***[Episode 5, 32;05-32;49**. Rodney en Tara zitten aan tafel met psychiater Emily Zomer om te praten over hun zieke moeder]*

[Emily]: Misschien is een tehuis nog niet eens nodig. Jullie kunnen een casemanager krijgen, dat zit in de basisverzekering. Dat is iemand die jullie thuis kan begeleiden met het zoeken naar een oplossing. Zo zijn er bijvoorbeeld allemaal vormen van dagbesteding waar jullie naar kunnen kijken.

[Rodney]: Zodat ze nog wel thuis kan eten en slapen

[Emily]: Ja precies. Maar ja, het is natuurlijk wel verstandig om alvast wat tehuizen te gaan bekijken, voor het geval dat dat niet meer gaat.

[Tara]: Voor als ze ons niet meer herkent bedoel je?

[Emily]: Bijvoorbeeld. Of als jullie het om de een of andere reden niet meer aankunnen. Jullie moeten niet alleen goed voor jullie moeder zorgen, maar ook voor jullie zelf.

[Rodney]: En voor elkaar

[Emily]: Ja. Ook voor elkaar.

[Rodney en Tara houden elkaars hand vast.]

End of scene.

3. Dutch Kidney Foundation: Life with a chronic kidney disease

Episodes: 8,9 & 10
Health message: Living with a chronic kidney disease is extremely difficult and demanding. It is also possible to donate organs when you are alive (as long as you are a match with the patient), so patients do not have to wait for organs from dead donors, as the waiting list for new organs is very long.
Summary and context of storyline: Sam has a kidney disease and is struggling. His new kidney is again failing, because his body is rejecting it. Sam refuses to undergo dialysis, because this is demanding and tough, even though this decision might lead to his death. To complicate things further, Sam only accepts a new kidney from a dead donor, which enrages his younger sister Lucy. Lucy does not understand Sam's decisions and tries to convince him to accept Wendy's kidney, whom is a confirmed match and wants to help Sam. In the meantime, Sam's body is weakening further and further and the waiting list for a dead kidney is way too long. In the end, Wendy and Lucy convince Sam to accept Wendy's kidney.
Scenes:

*[**Episode 8, 17;06-18;00.** Sam, nierpatiënt zit bij de internist Sebastiaan de Moor]*

[Sam]: Laat me raden, ik ben een medisch wonder. Er is een nieuwe perfect werkende nier zomaar vanzelf aangegroeid.

[Dokter de Moor]: Voel je je alsof je een perfect werkende nier hebt?

[Sam]: Nou ja. Je weet hoe ik me voel

[Dokter de Moor]: Ja, ik heb de uitslagen van de onderzoeken gezien. Volgens mij hoef ik je niet te vertellen hoe je ervoor staat.

[Sam]: Weer aan de dialyse?

[Dokter de Moor]: Ben bang van wel

[Sam]: Hoeveel doet ie nog?

[Dokter de Moor]: Nog 10%. Dus ik wil beginnen met drie keer per week. Maar ik denk eigenlijk dat we vrij snel naar de vier moeten.

[Sam]: En weer een nieuwe nier?

[Dokter de Moor]: Ja.

[Sam]: Dat is dan de vierde nier die mijn lichaam heeft weten te slopen. Dat is op zich wel weer knap

[Dokter de Moor]: Dat doen inderdaad niet veel mensen je na.

[Sam]: Mooi Twitter-moment. Fotootje van m'n kapotte nier, met daaronder #supertrots.

[Dokter de Moor]: Dus? Wij gaan een afspraak maken voor de dialyse morgen?

[Sam]: Heb ik een keus?

[Dokter de Moor belt naar de receptie.]

End of scene.

*[**Episode 8, 37;00- 38;27**. Sam staat beneden bij de koffiebar te kletsen met Tara. Dokter de Moor was al ruime tijd naar hem opzoek en komt snel aangelopen]*

[Dokter de Moor, boos]: Waar was jij?

[Sam]: Eh hier.

[Dokter de Moor]: Ja, ja. Dat zie ik ja. Je had twee uur geleden al aan de dialyse moeten zitten.

[Sam]: Ja, even over de dialyse. Ik denk dat ik dat toch niet meer doe.

[Dokter de Moor]: Sorry? Wat zeg je?

[Sam]: Dialyse dat is geen leven. Dat is alleen maar overleven. Dat heb ik al gedaan, ik weet hoe dat is en dat wil ik niet meer.

[Dokter de Moor]: Sam, als je geen dialyse doet, ga je dood.

[Sam]: Ja.

[Dokter de Moor]: Maar dat hoeft helemaal niet. Er kan weer een nieuwe nier komen

[Sam]: Die ik dan weer binnen een paar jaar kapot maak. Ik wil dat niet meer.

[Dokter de Moor]: Je hebt niks kapot gemaakt. Je bent zo'n beetje de braafste nierpatiënt die ik ken. Je hebt gewoon heel veel pech gehad.

[Sam]: Ja. En als ik zo veel pech blijf hebben, dan heb ik zeker zes nieren nodig voor de rest van mijn leven. Zes! Dat slaat toch nergens op? Geef die nieren lekker aan iemand die er langer mee doet dan ik.

[Tara]: Sam?

[Sam]: Ik begrijp best wat jullie denken, maar dit is heus geen opwelling hoor. Ik weet hoe het leven kan zijn. Maar ik wil niet meer terug naar dat andere leven met een zieke nier en eindeloze dialyses. Dat ken ik al veel te goed. Uit eindelijk is het mijn keuze toch?

[Dokter de Moor]: Ja. Het is jouw keuze. Maar alsjeblieft, ga vandaag naar de dialyse. Dan gaan we het daarna erover hebben. Kom op.

End of scene.

*[**Episode 9, 1;30-2,36**. Sam ligt in ziekenhuisbed en praat met dokter de Moor]*

[Sam]: het is een dode donor of niks

[Dokter de Moor]: Sam de wachtlijst is te lang, dat je redt je niet.

[Sam]: Nou, dan ga ik dood. Dat weet ik. En dat accepteer ik. Nu alleen de rest nog.

[Dokter de Moor]: Heb je dat al met je familie besproken?

[Sam]: Nee

[Zus van Sam, Lucy, komt binnen]

[Lucy]: Heeft hij wat al met zijn familie besproken?

[Sam]: Dag Lucy. Ah je bent bij Tara geweest *[pakt zoutvrije muffin aan van Lucy]*

[Lucy]: wat heb je nog niet met ons besproken Sam?

[Sam]: Laten we het over jou hebben zusje en je woeste studentenleven. Kom, ik wil alles horen. Hoe is het met die pannenkoek? Hoe heet ie ook al weer?

[Lucy]: Ben je echt maar tijdelijk opgenomen, zoals je aan de telefoon zei?

[Sam]: Mijn lichaam kan de dialyse niet meer aan.

[Lucy]: Dus je lichaam heeft deze nier ook afgestoten?

[Sam]: Ja de zoveelste. En als we geen nieuwe nier van een dode donor kunnen vinden dan is het voorlopige ook de laatste.

[Lucy]: Wat? Hoe bedoel je de laatste?

[Sam]: Dat ik jullie er niet meer mee lastig ga vallen. Het is mooi geweest.

[Lucy]: Wat een onzin

[Sam]: Luister naar me. Ik ga geen nieren meer van mijn familie aftroggelen die mijn lichaam vervolgens toch weer uitkotst

[Lucy]: Dat weet je niet

[Sam]: Ik ga dat hele proces niet nog een keer meemaken

[Lucy]: Dus je geeft gewoon op

[Sam zuchtend]: Ik ben gewoon realistisch en dat moet jij ook zijn.

End of scene.

*[**Episode 9, 11,28-12;22**. Lucy zit op de gang van het ziekenhuis en Sams arts ziet haar en gaat ernaar toe]*

[Dokter de Moor]: Hee. Je hebt hem nog niet om kunnen praten?

[Lucy hoofdschuddend]: Hoe lang heeft hij nog?

[Dokter de Moor, gaat naast Lucy zitten]: Een maand. Twee maanden hooguit. Zijn lichaam is nu in hoog tempo aan het vergiftigen

[Lucy]: Hoe lang is de wachtlijst voor een nier van een dode donor?

[Dokter de Moor]: Te lang

[Lucy]: Maar met een levende donor zou hij het kunnen redden?

[Dokter de Moor]: Lucy, hij is zwak. Hij is heel zwak. Dus een niertransplantatie met alle nabehandelingen die daarbij komt kijken. Het zou een enorme slijtageslag op zijn lichaam zijn

[Lucy]: Maar het zou kunnen werken?

[Dokter de Moor]: Theoretisch, zou het kunnen

[Lucy]: Dat is goed genoeg voor mij. Ik ga een nier voor hem regelen. Als hij er geen van zijn familie wil, dan vind ik iemand anders die bereid is er eentje af te staan.

[Lucy loopt weg]

End of scene.

***[Episode 9, 25;02-26;10.** Lucy zit bij Sam op zijn ziekenhuisbed.]*

[Lucy]: En als het bijvoorbeeld iemand is die het heel graag wil? Ik bedoel, als ik een match was geweest, zou ik het ook heel graag willen.

[Sam]: Dat is heel tof van je Lucy, maar ik moet het zelf ook willen. Je weet hoe zwaar die vorige transplantaties waren en steeds dat gevecht tegen die afstotingsverschijnselen. Dat ik elke keer weer verlies.

[Lucy]: Voor hetzelfde geld is dat nu niet. Dat kan toch ook, dat het deze keer gewoon goed gaat?

[Sam]: Ik wil jullie ook niet weer zo'n lijdensweg aan doen. Jou en pa en ma.

[Lucy]: Denk je dat dat ons iets uitmaakt? Die zogenaamde lijdensweg, zoals jij dat noemt. Natuurlijk niet, want we houden van je.

[Sam]: Mij maakt het wel iets uit. Ik heb mijn hele leven al van alles moeten missen en laten door die klote nieren. Ik vind het wel genoeg zo. Ik wil jullie leven er ook niet meer mee verzieken. Jij moet ook door Lucy

[Lucy]: Je wil gewoon dood. Dat is toch wat je zegt? Je vraagt nu mijn toestemming om dood te gaan?

[Sam]: Nee natuurlijk niet

[Lucy]: Dat heb je echt net gedaan hoor. Je kan het mooi vergeten. Ik ga jou niet helpen met je idiote plannetje. Mooi niet.

[Lucy loopt boos weg]

[Sam]: Lucy

[Lucy]: Niks Lucy.

End of scene.

*[**Episode 9, 30;27-32;23**. De beste vriendin van Sam, Wendy, komt op bezoek]*

[Sam]: Lucy heeft jou zeker gestuurd?

[Wendy]: Betrapt. Ze heeft me gebeld. Ik heb liever dat jij dat de volgende keer gewoon zelf doet.

[Sam]: Nou ik wist dat jij vroeg of laat wel zou opduiken en voilá.

[Wendy]: En niet met lege handen. Ik heb een verassing voor je. Van harte, je nieuwe nier *[wijst naar zichzelf].* Ja we zijn een match. Dat is natuurlijk de vorige keer al onderzocht, maar toen kreeg je die nier van je tante. Al die moeite voor niks

[Sam]: Zo is het niet helemaal gegaan. Maar goed.

[Wendy]: Whatever. Maar dan kan je het nu goed met me maken

[Lucy komt aangelopen]

[Lucy]: Volgens mij wil hij het niet goed maken Wendy. Al ben je tien keer zijn beste vriendin

[Sam]: Nee nee nee. Dit gaan we echt niet doen. Ik ben toch duidelijk geweest, Lucy. Het is een overleden donor of geen. En aangezien dat waarschijnlijk niet op tijd zal gaan lukken, zul je moeten wennen aan het feit…

[Lucy]: Dat je de rest van je leven aan de dialyse moet. Of dat je dood gaat. Als je Wendy's aanbod niet accepteert.

[Sam]: Ik wil niet de rest van mijn leven aan de dialyse en ik wil ook geen levende nier.

[Lucy]: Heb je serieus nog steeds dat belachelijke idee? Besef je dan echt niet hoe egoïstisch dat is?! Denk je dat mijn leven doorgaat? Ooooh ik heb net mijn broer begraven, niks aan de hand jongens, kom we halen een biertje. En wat dacht je van Wendy? Zij moet door met de wetenschap dat ze je had kunnen redden. Dat ze jou had kunnen laten leven. Hoe kun je zo makkelijk voor de dood kiezen als je gewoon een kans hebt om…? Ik snap het gewoon niet Sam. *[huilt]*

[Sam]: Oké dan. Oké.

End of scene.

*[**Episode 10, 11;28-12;11**. Sam's arts staat bij Sam aan het bed]*

[Dokter de Moor]: Het is misschien een beetje droge kost, maar ik moet het operatieve traject met je doornemen.

[Sam]: Pff totaal geen zin in. Verdoof me nou maar gewoon en doe het. Als ik wakker word dan hoor ik wel of het gelukt is.

[Dokter de Moor]: Ik vind het ook niet super spannend Sam. Maar het hoort er nou eenmaal bij. Het is verplicht.

[Sam]: Het komt nu wel heel dichtbij hè.

[Dokter de Moor]: Ja, daarom

[Sam]: Nou, kom maar op.

[Dokter de Moor]: Nou, het is misschien een open deur, maar de operatie zal plaatsvinden onder gehele narcose. De operatie duurt ongeveer twee à twee en een half uur. Maar dat zijn richttijden, het zou kunnen dat het bij jou…

[Sam doet alsof hij in slaap valt]

[Dokter de Moor]: Sam. Ogen open. Dan kan ik zien dat je wakker bent. Ja, goed zo.

End of scene.

*[**Episode 10, 14;45-15;03**. Dokter de Moor staat nog steeds bij Sam aan zijn bed om dingen over de operatie te vertellen.]*

[Dokter de Moor]: Hou vol, we zijn er bijna. Als je bij komt van de operatie, dan is er een maagzonde geplaatst. Dat is een slang die door je neus naar je maag gaat om maagsappen tijdens en vlak na de operatie af te voeren. Er is ook een zuurstofslang…

[Pieper van dokter de Moor gaat, het is een noodgeval en hij moet weg]

End of scene.

Appendix B – Topic Lists

Topic List – Interviews with health professionals

1) Introduction: Introducing myself, my research and the aim of this conversation. Also asking permission to record the conversation.

2) The storyline: Discussing their storylines in the serial, whether it is what they had in mind or not, how they like it and their opinion of the final result.

3) The process: Talking about what the collaboration process looked like. How it all started and who contacted who, with what question. What happens in a health organization when such a request comes in? Who is involved in such a collaboration and how did they contact each other? How often did they actually meet and what was discussed during these meetings? What was everybody's role during the process?

4) Agreements and influence: Which agreements were set up in advance, who came up with these and were they included in an official contract? Who paid for the serial and how did this work? Did the organizations have an idea about potential themes or storylines in advance? How much influence did the health organizations have on the script and their storylines? What was the role of the health organizations in the scriptwriting-process? Were the health organizations allowed to provide feedback on the scripts? Are they satisfied with their amount of influence and the result?

5) Personal collaboration: What was it like to work together with television professionals? Was is easy or hard and why? Are there big differences between health and television professionals?

6) Evaluation: Were there any evaluation moments together with the producers and/or broadcaster? How does the health organization look back at the collaboration process and what could be improved? Are they satisfied? Did they reach the goals they wanted to reach? Did they see more traffic to their website or discussion on social media? Would they do this again in the future?

7) Finishing up: Checking whether I forgot anything. Asking the respond whether he or she would like to add or ask something. Thanking for their time and help.

Topic list – Focus groups

1) Short introduction: Explaining what we are going to do. Telling them that I'll explain the purpose of the focus group and the aim of my research AFTER they saw the episode, because knowing this might influence the way in which they watch the episode

2) Show the episode

3) Hand out questionnaires and consent forms

4) Appreciation of the episode: How did they like it? Was it entertaining, sensational? Did they feel transported or compelled to know how it ended?

5) Credibility and realism: Was the episode credible? Realistic? Was the specific health storyline credible and realistic? Could this happen to you or someone you know? What did you think of the doctors who gave the health information, were they good doctors, credible doctors? Do you believe the medical information that was given?

6) Role models and identification: What did you think of Sonja Bos/Tara/Sam? Can you identify with him/her and their situation? Could this happen to you or someone else? How did they handle the situation?

7) Knowledge: Did you notice any of the health information about heart attacks/Alzheimer's or kidney disease? Did you learn something about this disease from the episode? Discuss following statements:
    a. Heart attacks: Men and women have different symptoms/symptoms are often confused with menopause or stress/ symptoms include tiredness, nausea, shortness of breath/ a heart attack can happen to anyone, even if you live healthy/ the blood vessels calcify very gradually/ there is a form of aftercare because people who suffered a heart attack are often scared that it will happen again
    b. Alzheimer's and caregiving: Alzheimer's has a big impact on the lives of the people surrounding the patient/people who suffer from Alzheimer's can not live independently at home without the help of others/caregivers to people with Alzheimer's have it hard/Caregivers have the right to a casemanager/ a casemanager is covered by the basic health insurance/ a nursing home is not the only option
    c. Kidney disease: The waiting list for dead donors it very long/ a kidney transplant is very hard and the body needs to fight against rejection symptoms/ without a new kidney, a kidney patient needs to undergo dialysis or he will die/ if your kidney fails, your body starts to poison itself/ you can donate a kidney when you are alive/ not only family members, but also friends or strangers can be a match for a kidney transplant

8) General appreciation: What do you think of how the information was incorporated? How do you like it when producers incorporate health messages in a medical drama serial? Do you think it is a good combination? Do you take the medical information serious? What do you think of it in general that entertainment programs contain messages and are used for educational purposes?

Appendix C – Focus group questionnaires

Questionnaire Alzheimer's

1. Op een schaal van 1 tot 10, hoe leuk vond je deze aflevering?
2. Ik vond deze aflevering realistisch. Eens/Oneens
3. De ziektebeelden die in deze aflevering worden geschetst zouden ook in het echt kunnen gebeuren. Eens/Oneens
4. De artsen in deze aflevering vond ik geloofwaardig. Eens/Oneens
5. Ik geloof de informatie over Alzheimer en mantelzorg die de artsen in deze aflevering verstrekken. Eens/Oneens
6. De medische informatie in deze aflevering is juist. Eens/Oneens
7. Ik kan me inleven in de situatie Tara. Eens/Oneens
8. Wat Tara is overkomen in deze aflevering zou mij misschien ook ooit kunnen overkomen. Eens/Oneens
9. Na het zien van deze aflevering heb ik iets geleerd over Alzheimer en mantelzorgers. Eens/Oneens
10. Ik weet nu meer over Alzheimer en mantelzorgers dan voor het zien van de aflevering. Eens/Oneens
11. Ik vond de medische informatie die in deze aflevering is verwerkt te opvallend. Eens/Oneens
12. Het verwerken van medische informatie in een ziekenhuisserie maakt het voor mij: leuker/minder leuk/maakt mij niks uit.
13. Wat kun jij na het zien van deze aflevering, vertellen over Alzheimer en mantelzorgers?

Questionnaire heart attack

1. Op een schaal van 1 tot 10, hoe leuk vond je deze aflevering?
2. Ik vond deze aflevering realistisch. Eens/Oneens
3. De ziektebeelden die in deze aflevering worden geschetst zouden ook in het echt kunnen gebeuren. Eens/Oneens
4. De artsen in deze aflevering vond ik geloofwaardig. Eens/Oneens
5. Ik geloof de informatie over hartinfarct bij vrouwen die de artsen geven in deze aflevering. Eens/Oneens
6. De informatie over hartinfarct bij vrouwen in deze aflevering is juist. Eens/Oneens
7. Ik kan me inleven in de situatie van mevrouw Sonja Bos. Eens/Oneens
8. Wat Sonja Bos is overkomen in deze aflevering zou mij misschien ook ooit kunnen overkomen. Eens/Oneens
9. Na het zien van deze aflevering heb ik iets geleerd over hartinfarct bij vrouwen. Eens/Oneens
10. Ik weet nu meer over deze ziekte dan voor het zien van de aflevering. Eens/Oneens
11. Ik vond de medische informatie die in deze aflevering is verwerkt te opvallend. Eens/Oneens
12. Het verwerken van medische informatie in een ziekenhuisserie maakt het voor mij: leuker/minder leuk/maakt mij niks uit.
13. Wat kun jij na het zien van deze aflevering, vertellen over een hartinfarct bij vrouwen?

Questionnaire kidney disease

1. Op een schaal van 1 tot 10, hoe leuk vond je deze aflevering?
2. Ik vond deze aflevering realistisch. Eens/Oneens
3. De ziektebeelden die in deze aflevering worden geschetst zouden ook in het echt kunnen gebeuren. Eens/Oneens
4. De artsen in deze aflevering vond ik geloofwaardig. Eens/Oneens
5. Ik geloof de informatie over nierziekte die de artsen geven in deze aflevering. Eens/Oneens
6. De informatie over nierziekte in deze aflevering is juist. Eens/Oneens
7. Ik kan me inleven in de situatie van Sam. Eens/Oneens
8. Wat Sam is overkomen in deze aflevering zou mij misschien ook ooit kunnen overkomen. Eens/Oneens
9. Na het zien van deze aflevering heb ik iets geleerd over nierziekte. Eens/Oneens
10. Ik weet nu meer over deze ziekte dan voor het zien van de aflevering. Eens/Oneens
11. Ik vond de medische informatie die in deze aflevering is verwerkt te opvallend. Eens/Oneens
12. Het verwerken van medische informatie in een ziekenhuisserie maakt het voor mij: leuker/minder leuk/maakt mij niks uit.
13. Wat kun jij na het zien van deze aflevering, vertellen over een nierziekte?

Appendix D – Overview focus group respondents

Focus group 1:

Number of respondents: Four participants, one male and three female. One participant called in sick at the last moment

Age of respondents: Between 20 and 29 years old

Level of education: Ranging from HAVO to Master's degree

Place of residence: 2 from Ermelo, 1 from Putten and 1 from Zwolle

Focus group 2:

Number of respondents: Five respondents, all female

Age of respondents: Between 43 and 58 years old

Level of education: Ranging from MAVO to Bachelor's degree

Place of residence: Ermelo

Focus group 3:

Number of respondents: Five respondents, four male and one female.

Age of respondents: Between 21 and 34 years old

Level of education: Ranging from MBO to Master's degree

Place of residence: 4 from Ermelo and 1 from Amersfoort