EphMRA

keeping members informed and involved

Post Conference news

September 2015

Reports from the Amsterdam Conference

Sessions

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Diary

15 October 2015
2nd Japan Local Chapter Meeting.
Venue: Tokyo

17 November 2015
1st France Local Chapter Meeting
Venue: Paris

21-23 June 2016
2016 Healthcare Market Research Conference
Venue: Frankfurt

Copy Deadline

15 October 2015 is the deadline for submitting your copy for the December 2015 issue.
Send to: generalsecretary@ephmra.org

Get in touch

If you have any enquiries, suggestions or feedback, just phone or email us:
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Welcome to EphMRA

What a great conference we had in Amsterdam - feedback so far has been overwhelmingly positive and thanks to all who attended and contributed.

Didn't attend? You missed one of the best agency:pharma ratios ever - practically 2 to 1 and many full service agencies for those looking for customers in this area. We had fantastic papers delivered by our great speakers.

Put 2016 in your diary already: 21 - 23 June, Kap Europa, Frankfurt

Here's some quotes from delegates:

'Thoroughly enjoyed this year's conference, the content and organisation were of a really high standard and I particularly thought the choice of venue was exceptional'

'It was really an excellent event (from my agency attendee perspective) – for us it brought many great client interactions, quality discussions – and even new business – we are really pleased'

'This was the best conference I have attended for a long time'

'I did very much enjoy the conference, I've been to 4 now and thought it was the most interesting and informative for me so far. I went to loads of the papers/discussions and really enjoyed them all'

Bernadette Rogers
General Manager
generalsecretary@ephmra.org

AGM for Full Members

Thomas Hein, EphMRA President gave an update to Full Members on the Association's activities over the past 12 months.

Membership:

There are currently 41 Full Members and since last year the Association has gained Celgene, Ipsen and Tillotts as members. In addition GE Healthcare has decided to rejoin the Association this year.

However Novo Nordisk is no longer a member but it is hoped they will become a member again

There are 160 Associate Members and over the past 12 months around 10 Associate Member companies have left the Association.

Thomas then went on to outline how the June Conference has had a revamp:

- The Board has acted on feedback and the event is now back to 2-3 days
- F2F workshops moved back to Tuesday
- During the conference there are more sessions and more networking time
- A Conference Hub is the centre for networking
- The EphMRA App has been developed to support delegates get the most out of the time
- Attractive Sponsor and Exhibitor Packages were on offer

In summary Thomas said that:

- Economically it is still a tough environment. Members are experiencing budget and head count pressures and margins continue to be squeezed.
- FM attendance numbers have exceeded expectations - over 35 companies represented
- The Board has been looking at what member engagement means and have been talking to members about how they value membership

Following this overview, the Treasurer, Michel Bruguiere Fontenille then updated the Full Members on the Association's financial status and presented the budget for 2015 – 2016. The budget was approved by the Full Members.

AGM for Full Members

Board Members

Those standing for election as Board members are shown below and all were successful in the voting. The voting in of the new officers for 2015 – 2016 was conducted by Bernadette Rogers, General Manager.

Standing for President:

Dr. Thomas Hein
Global Director Customer Insight and Strategy, Thermo Fisher Scientific Immuno Diagnostics

Standing as Board Members:

Georgina Butcher
Associate Director Marketing Intelligence, Astellas Pharma Europe

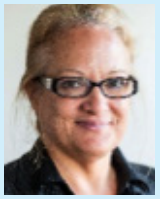
John Shortell
Director of Global Market Research, Bayer HealthCare Inc

Xander Raijmakers
Consultant Market Research, Eli Lilly

Karsten Trautmann
Associate Director Global Business Intelligence, Merck Serono

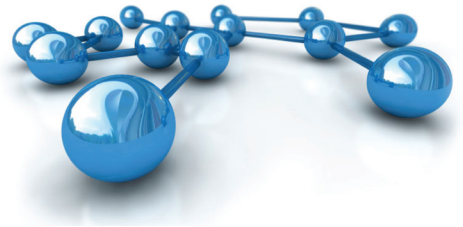
EphMRA Thanks To:

Bernd Heinrichs
Grünenthal: Head of Global Market Insight Team who leaves the Board on 30 September 2015



Karen Giorgi-Vigo
Shire Pharmaceuticals: Associate Director Business Insights who left the Board in April due to leaving Shire.

Update from Associate Members



It was great to see so many Associate Members in Amsterdam at the conference this year, thank you to everyone who came along to the AM meeting. This year voting took place by email for the AM Board members. Thanks to all who participated.

Your Board Associate Members as of 1 October 2015:

Lee Gazey
Managing Partner, Hall & Partners,
l.gazey@hallandpartners.com

Sarah Phillips
Partner, Prescient Healthcare Group
sphillips@prescienthg.com

Richard Head
Director, Research Partnership
richardh@researchpartnership.com

Anton Richter
Managing Director,
M3 Global Research
arichter@eu.m3.com

Gareth Phillips
Managing Director UK and Head of
Western Europe, Ipsos Healthcare
gareth.phillips@ipsos.com

Many thanks to Kim Hughes and David Hanlon who leave the Board on 30 September 2015

Kim Hughes,
CEO, The Planning Shop international,
Kim.hughes@planningshopintl.com

David Hanlon,
Senior Group Director, Kantar Health,
David.hanlon@kantarhealth.com

2015 President's Award

Awards:

Announcement of the winners of the EphMRA President's Award for Contribution to Pharmaceutical Market Research.

In 2001 EphMRA initiated an award which was first presented at the Athens 2001 conference. This award is a recognition of a person's outstanding contribution to pharmaceutical market research.

Both Full and Associate members can make nominations and the Board pharma members then vote.

The award recipient can be from a pharmaceutical company or supplier/agency and will receive the award based upon:

- having made an outstanding/recognisable contribution to EphMRA
- having made an outstanding/recognisable contribution to pharmaceutical market research

Joint Winners:

Sarah Phillips
Prescient Healthcare Group

Alexander Rummel
Aurum Research

Runner Up:

Georgina Butcher
Astellas Pharma Europe

The 2015 Nominations were:

David Hanlon, Kantar Health
Throughout David's long and dedicated career he has exemplified the goals of EphMRA in his role as healthcare market researcher in both agency and client side. He is always looking for new and better ways to conduct market research. He is not just an expert quantitative market researcher but also an ambassador for market research and a mentor who prioritises the development of other researchers.

Georgina Butcher, Astellas Pharma Europe
She has been very active in EphMRA for a number of years now and has always been very reliable, thorough and her contributions have always added value. Her most recent involvements have been on the EphMRA board and now as joint Chair of the Ethics committee.

Barbara Lang, Point Blank International
Barbara gives outstanding support of EphMRA's LCM in Germany. Barbara has again spent a large amount of time in designing and organising the latest meeting with many ideas. She has helped making these LCMs a unique institution in Germany and created/ renewed positive awareness for EphMRA.

Sarah Phillips, Prescient Healthcare Group
Sarah has been extremely active behind the scenes for EphMRA both in the Board and Conference organisation and presenting. In term of Healthcare environment she has brought some interesting approaches to research and is always ready to challenge the status quo.

Alexander Rummel, Aurum Research
Alexander has been a long standing LDC member and has contributed to numerous webinars and workshops over many years. He is generous with his time and always ready with a constructive viewpoint. In addition he is one of the drivers and convenors of the Germany Chapter meeting.

James Rienow, Pfizer
James has contributed actively across the Association and has been a Board member and conference and NYF meeting speaker and contributor. He also lead the Working Party to overhaul our statutes and shape them to be fit for the future.

Year	Winner	Runner-Up
2014	Bob Douglas, PSL Group	Georgina Butcher, Astellas Pharma Europe
2013	Stephen Godwin, The Planning Shop international	Bob Douglas, PSL
2012	Jacky Gossage, GSK	Angela Duffy, The Research Partnership
2011	Kurt Ebert, Roche	Bob Douglas, Synovate Healthcare
2010	Rob Haynes, Merck Inc	Roger Brice, Adelphi
2009	Bob Douglas, Synovate Healthcare	Janet Henson
2008	Steve Grundy, Marketing Sciences	Anne Loiselle, Abbott Laboratories
2007	Barbara Ifflaender, Altana Pharma	François Feig, Merck Serono
2006	Hans-Christer Kahre, AstraZeneca	Barbara Ifflaender, Altana Pharma.
2005	Colin Maitland	Hans-Christer Kahre, AstraZeneca
2004	Isidoro Rossi, Novartis	Dick Beasley
2003	Janet Henson and Bernadette Rogers	Dick Beasley
2002	Allan Bowditch, Martin Hamblin GfK	Rainer Breitfeld
2001	Panos Kontzalis, Novartis	Allan Bowditch, Martin Hamblin GfK

Best Conference Paper

Jack Hayhurst Award:

We have 13 papers this year which are eligible for consideration for the JH Award – a prestigious award given to the 'best paper' at the conference.

These papers are judged by our dedicated panel of judges over the summer, using rigorous scoring criteria. The winner(s) of the JH Award will be announced in September – watch out for the announcement on the EphMRA website!

The EphMRA Jack Hayhurst Award Judging Panel

Thank-you to all our judges:

Hilary Worton Aequus Research
Thomas Hein EphMRA President and Thermo Fisher Scientific
Bernd Heinrichs Grünenthal
Alex West Instar Research
Gareth Phillips Ipsos Healthcare
Martin Schlaeppi Praxis Research
Sarah Phillips Prescient Healthcare Group

Thank you to the Programme Committee for all their hard work in the lead up to and during the conference

Sam Scott Fieldwork International
Lee Gazey Hall & Partners
Stephanie Ludwig GfK
Karin Busse Grünenthal
Caroline Jameson HRW
Alex West Instar Research
David Hanlon Kantar Health
Martin Schlaeppi Praxis Research
Sarah Phillips Prescient Healthcare Group
Amr Khalil Ripple International

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In 2015 we're celebrating our 25th anniversary of dedication and excellence in global healthcare market research.

Be part of our exciting plans for the next 25 years.

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Wednesday 23 June

Workshop 1: Strengthening the Role of Market Researchers in Product Forecasting

Speakers:	Alec Finney, Pharma Forecast Insight and Nich Guthrie, Boehringer Ingelheim
Convenor:	Alexander Rummel, Aurum Research and EphMRA Learning and Development Committee member


Alec Finney


Nich Guthrie


Alexander Rummel

"Forecasting is not new, but vital to our industry".

With these words Alexander Rummel started the workshop on strengthening the role of market researchers in product forecasting. Market research can contribute to forecasting, but the questions that remain are: where and how can market research contribute and support it?

During this workshop Alec and Nich tried to go into the details of product forecasting to answers those questions.

Describing a roadmap for creating and delivering quality forecasts

The two main objectives Alec focused on during his presentation were: how forecasting and planning activities should be designed to support investment decisions and how market researchers can maximise the benefits of their contribution.

Throughout Alec's talk there were three main themes to take into consideration, which he pointed out several times during this workshop:

1. **Get a seat at the table;** engage with the people who have all the information that is needed to develop a good forecasting model and who know the market
2. Forecasting and planning activities are the most **disruptive** and **inefficient** parts of most business processes
3. The core purpose of the forecasting function? 'To get the **right information** to the **right people** at the **right time**'.

Forecast process in a nutshell

Although the process of setting up a forecast can be an extensive process, Alec showed us an easy to use forecast process which can be used for any type of forecast. The first step is to define a purpose and scope of the forecast you are building. Alec mentioned that you should think about the horizon of your forecast, i.e. is it a forecast for 5, 10 or 20 years?

The next step is to agree on the assumptions of your forecast. What will drive your forecast? What do you expect from competitors? What percentage of market share do you expect to reach?

To decide on the forecast model, a good understanding of the different models is needed. Do you need input on incidence or prevalence numbers, etc?

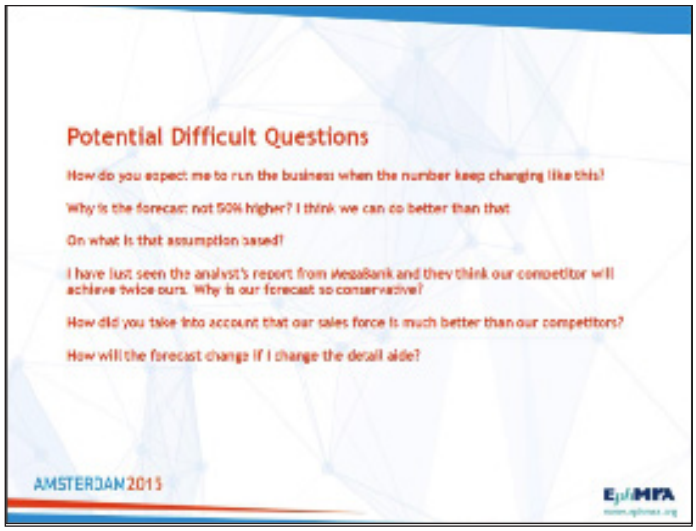
The final step in the process is to deliver the output and how this is communicated. You can deliver a set of numbers, but what do they really mean if you miss the context. Therefore, Alec mentioned we should deliver the insights, based on the assumptions we know how the assumptions change, how the output changes, etc.

Where can a market researcher contribute or support in this process?

Alec emphasised again that getting a seat at the table in an early stage of the forecast development really helps to better understand how the forecast is specified, created and communicated. Challenge clients constructively.

As a market researcher you have the knowledge of how the market looks, how patients behave, all the vital information for creating the forecast model. But make sure you use simple models, so you don't have to populate every part of a disease area with every forecast, it will only distract you from your most important job and finally as a market researcher you should embrace uncertainty.

Alec concluded his talk with the words: "The numerical outputs from a forecast are the start rather than the end providing context and insight to decision makers."



How do you expect me to do business with these numbers?

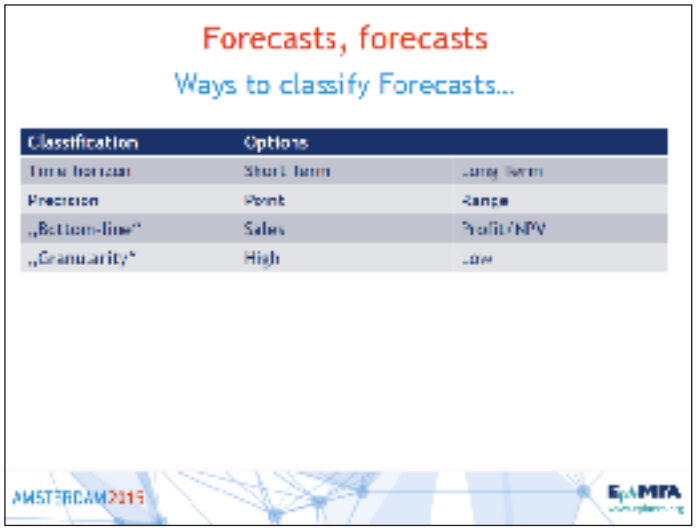
After a forecast research is delivered and insights are presented to clients, often many difficult questions come up: Why do we see this uptake? On what assumptions is this forecast based? How did you take into account that our sales force is better that competitors?

In this interactive part of the workshop, Alexander, Alec and Nich, talked us through a number of these potential difficult questions. Delegates were split into groups and each group received one of the difficult questions and had 15 minutes to discuss the question and reach agreement on the response of the question.

Dealing with changing numbers was addressed in the first difficult question. The group that answered this question, mentioned that giving a range of forecast numbers would overcome the problem. This could be done by giving a low, medium and high scenario. Secondly they addressed getting a seat at the table helps because if, for example, the question was raised by the CEO, he or she would be aware of the forecast, the assumptions of the forecast and the granularity, when you change a small assumption what impact it has on the model.

Nich, who actually received the question from one of his CEO's, mentioned that it is all about managing uncertainty and therefore providing a range of forecast numbers is indeed the best way to address this question. One of the other difficult questions addressed during this part of the workshop was: how will the forecast change if we change the detail aid? The workshop group that worked on this question, mentioned that they didn't know. They felt that it was difficult to measure the impact of changing the detail aid.

And they wondered how much change is really needed. Alexander interrupted here since he felt that indeed it is difficult to quantify here, but with market research you could test different versions and quantify the impact. Another group member indicated that they had many discussions going on and that intermediate steps need to be taken in order to even begin to answer such a question. Are there any gaps in the market? Could we modify the detail aid to address those gaps? What impact would that have on the market share? Or is there new data out, so there is a real reason for changing the detail aid? Nich honestly mentioned that sometimes this question is addressed to him, but declines to answer it.



Forecasting & market research: a marriage made in heaven or hell?

Nich started his presentation with explaining that there were different types of forecast and the choice for a forecast depends on what output is needed. Whether you need a short term (1 or 2 years) or a long term (5 to 10 years) forecast, a sales or profit forecast, each forecast requires different things, different thinking and different levels of information. Nich referred back to Alec's advice on why it is so important to get to the definition of what the forecast is for, before starting to work on it.

To achieve a long term forecast, Nich mentioned he uses a patient based forecast. This long term forecast is for 10 to 15 years or even more and focuses on investment decisions. The purpose is to understand the size of an opportunity for development purposes. A short term forecast is often done based on the sales that are going on in the market, for the company's own and competitor's product. The objective is often to get a short term sense of where things are heading and what the current projection is. However according to Nich most companies do both forecasts.

Why a patient based forecast?

Patient data on different illnesses can be easily found online, in WHO databases or by conducting primary market research. This is therefore a good starting point of your forecast.

Nich took us through the process of a patient based forecast. It is usual to start with the number of patients out there, but this doesn't give a robust forecast and therefore you could next look at the number of diagnosed patients. If you work in oncology, for example, you would know the number of diagnosed cancer patients, and the number of drug treated patients. You may also know the number of patients treated by the medication in your therapy class.

Next you can look at the different characteristics of the company's product and competitor products: how much better efficacy can we offer, how much better safety, what about convenience, can something be done on price, can we make it more attractive by promoting it, better messaging, etc.

Based on all of these aspects a number is derived which is the basis for our forecast. Nich suggested that this process may seem simple, however a forecast evolves over time and we need to project these numbers into the future: how will the patients change over time? How will the diagnosis rate change over time? How will the therapy class or drug treatment change over time?

So how accurate is the data we use in our forecast?

Sales data from our own brands is something we know, we can check with our finance department what has been sold. Also through IMS data we can easily find out what the market size is and what competitors are doing. The number of drug treated patients is more difficult to get insight in. So next we start looking online, in secondary data or even undertaking primary research. Questions you can ask in primary market research can be: how many patients do you treat with...? However physicians are not always good in remembering those numbers and therefore you could take a look at case records. The number of diagnosed patients is becoming even harder to get an accurate handle on. So it is helpful to look at scientific literature or there may be other resources that could give accurate data where you can work with in your forecast.

So if epidemiology data is less accurate, why do we use it?

This mainly has to do with the speed of change. Epidemiology data changes slowly. For most diseases the number of patients does not change quickly and is therefore relatively stable. Stability makes forecasting easier!

So what is our ability to influence on this?

We can change the market share through all our marketing and sales efforts: how is our brand perceived? What message do we use around brand perception? Which trials can we participate in to increase products' perception? In the end we have most control over our own brands and not on the number of patients that are sick out there.

Before wrapping up, Nich addressed the need of the forecaster which is mainly numbers. Numbers on diagnosis rate, treatment rate, launch dates, etc.

If the forecast doesn't receive any actual numbers the forecaster will make them up. The market researcher on the other hand will bring in information; for example the current diagnosis rate and how it can be influenced. Market researchers also question why physicians expect certain change in the future. Market researchers really help to get insight into stakeholders' attitudes and opinions and how they think the future will develop.

When moving from market research to forecast there are a few challenges that need to be taken into consideration according to Nich:

- Preference share versus market share; physicians often overestimate when a new product comes to the market and they are asked about their future prescribing behaviour. So how do market researchers take this into account and how is this preference share converted to market share?
- Perfect knowledge versus real world noise
- Analogues
- Old information; by the time data is available, it is often too late and is already considered as old information

"Market research is very helpful in trying to explain why we think and what we think is going to happen. A forecast does not mean we will sell more products, but the question back is: What are you going to do to let the forecast actually come true. The forecast will only help us to make decisions on what actions we will carry out. Market research is needed to justify the forecast!"

Written by:
Adriënne Hoevers-Den Hollander
SKIM

Wednesday 23 June

Workshop 2: Getting the most from your Secondary Data Sources

Speakers:	Rich Kaminsky, Boehringer Ingelheim and Donny Wong, IMS Health
Convenors:	Rich Kaminsky, Boehringer Ingelheim and Jayne Shufflebotham, Themis Analytics


Rich Kaminsky


Jayne Shufflebotham


Donny Wong

Enhancing decision making in mass-market and specialty therapy areas

The workshop showed how you can get the most from secondary data, whether in a mass market or a highly specialised therapy area. As time and resources continue to be squeezed, having the time to analyse and fully utilise our secondary data can seem rather daunting and we often wonder whether the outputs from this desk research can actually enhance decision making within our organisation.

Rich Kaminsky, Boehringer Ingelheim

The current perception of secondary data is that it is a historical record, "hard" data and that it offers no insight. Is secondary data therefore more a limitation than an insight? Not exactly, as secondary data has certainly more to offer and can enhance decision making. Although secondary data can provide insights, it is not used to its full potential as many customers often don't know what information is available to them and/or don't understand it or how to make best use of it.

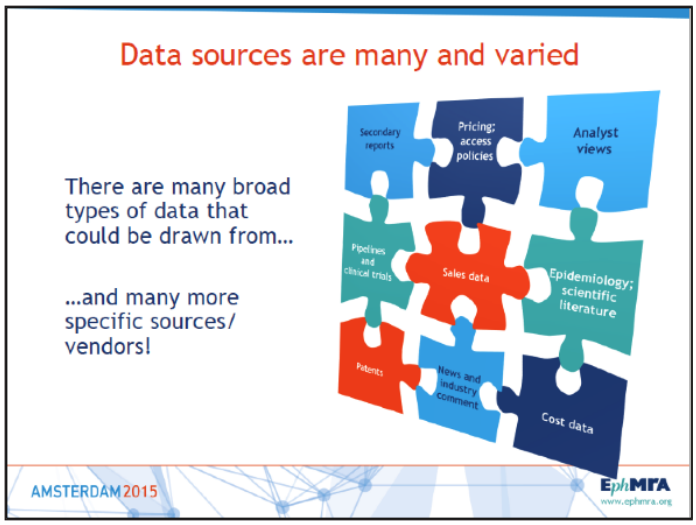
The role of secondary data, when used effectively, is threefold:

1. **Speed** as secondary data produces findings more quickly and can potentially be expedited by vendor support
2. **Confidence** by moving away from relying on single source (triangulation), and it's an independent external source
3. **Efficiency** as benefits of what already has been purchased can be maximised and the primary research time and budget can be maximised.

It is important to apply secondary data appropriately to make the most of the data, as it is not created to answer a specific question. It is, therefore, essential at the outset to know that you are addressing the right questions to meet the real business needs. However, these questions aren't always forthcoming from the customer, as they can be:

- Too specific and prescriptive: based on assumptions about the "right" approach
- Too vague: research questions don't have enough context or direction as to key outcomes.

Rich stressed the importance to address the right questions from the outset, as the customer won't always ask them. By using an example of a research brief, he showed that when receiving such a brief it is key to further probe what kind of questions should be asked to formulate a clear business question.



This is needed to investigate what can be answered with secondary data and what secondary data sources are available to answer your questions. The clearer the research questions and business needs are, the better you can put secondary data to use. Your customer may value the process of refining the brief and they will certainly value the more relevant and impactful outcome.

A "big" or complex brief and many different potential data sources can be perceived as overwhelming. There are many different data sources, that all can answer different type of research questions.

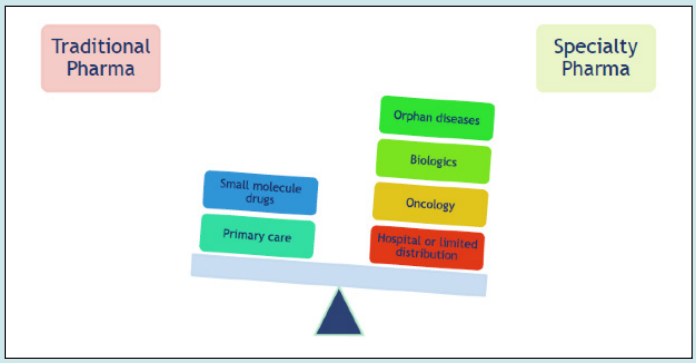
Therefore, a structured approach is important. For example, big strategic questions can often be broken down into pieces of evidence needed to support a given conclusion. Potential data sources can then be aligned to these. The following questions can be asked:

- What are the sub-questions or pieces of evidence needed?
- What types of data could help to address each?
- How do we build the answer to the questions?

Asking these questions will help to tackle a "big" question and help to make the many possible sources more manageable.

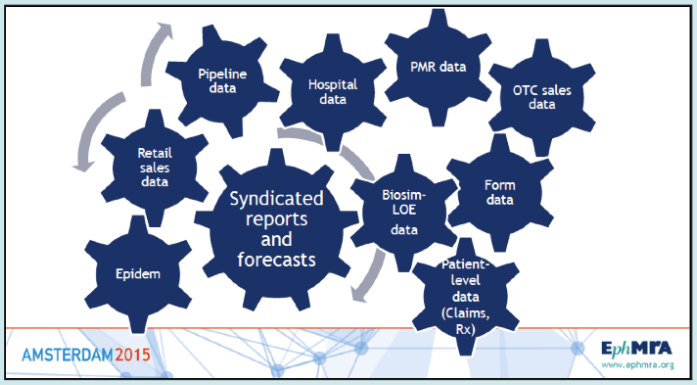
Donny Wong, IMS Health

The industry is shifting towards specialty pharma drugs, requiring unique approaches to understand and to analyse their markets.



When using secondary data for specialty drugs, more challenges arise. Biologics are penetrating markets traditionally covered by small molecule drugs and they have made profound impact on many disorders with more to come.

Multi-indication approvals are becoming the norm for specialty pharma drugs. Donny used the example of Humira® to show the challenges this can bring, such as the more complex regulatory pathway than small molecule drugs (BLA); approval for 7 indications in the US but approvals coming at different times (2002 for RA, 2005 psoriatic arthritis...), etc.



When analysing primary care indications, the tools required for analysis are relatively straightforward. However, when analysing specialty indications, a wider set of tools is required as off-the-shelf solutions will not answer all the questions. The challenge, therefore, is that additional data sets don't always fit well with one another.

Donny provided an extensive overview of different existing sources and methodologies including its caveats. For example, he showed the difference between analyst consensus forecasts, syndicated forecasts and internal forecasts.

Analyst consensus forecasts were described by Donny as routinely bullish and not at all transparent. He mentioned that they rarely provide country splits and provide inconsistent indication splits. Syndicated forecasts can vary in quality, breadth, depth and transparency.

They are dependent on events and assumptions that may not align to yours. There is also a time lag from market event to publication. Finally, internal forecasts may carry bias due to different agendas and internal politics.

To decide on which source to use there are several points that need to be taken into consideration:

- You must make trade-offs between time, cost, and accuracy
- The choice of solution is dependent on final use of analysis: tactical decision making vs. strategic view vs. level survey of market landscape
- You may require different solution for each geography based on data availability
- You may need to make assumptions to fill gaps (e.g., apply same splits between Italy and Spain, or between UK and Germany?)

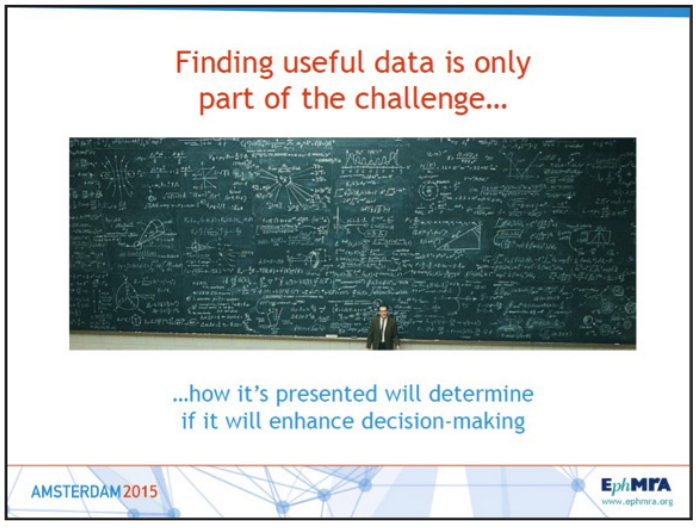
By using an example within dermatology, Donny showed that branded drugs, large numbers of generics, and OTCs which vary by geography make this market difficult to study. The data sources aren't straightforward, as you need OTC, brand, generic sales and volume sales data. Also dosages are a major challenge and the impact of a novel pipeline agent is difficult to assess due to maturity of the market. This example shows that a lot of assumptions are required to adequately understand dermatology markets.

Donny also provided examples in the oncology market where transparency is particularly important because of small patient numbers, large variety of sources, and complexity of therapy area. His take-aways for the oncology market were:

- Be as transparent as possible about assumptions
- Epidemiology estimates more important to get right because of small numbers of patients
- Indication splits can be difficult to assess
- Levers that determine market potential more pronounced

Rich Kaminsky, Boehringer Ingelheim

Rich emphasised that finding useful data is only part of the challenge, as how it is presented will determine if it will enhance decision-making. He provided a thorough summary on how to better manage secondary data.



First, when thinking about the overall approach it is important to:

- Focus on the business questions by ensuring the purpose is clear and all findings are linked to the business questions and not to give a "data presentation"
- Tell a story by providing some narration to show how the data fits together, and/or with existing understanding

Second, when setting out the content it is important to synthesise by drawing data from different sources, quantitative and qualitative, to support a given point. But also to ensure clarity by giving points room to breathe; keeping charts clean and putting detail to backup to keep the focus on the key message and making sources clear but not intrusive.

Third, the challenge of dealing with too much, and not enough data can be overcome by 'comparing and contrasting'. Where there is variability, triangulate between sources; make use of quantitative and qualitative, and indicate where there is more or less confidence. Also, highlight gaps and flag where understanding is incomplete and propose a hypothesis and what work could address it.

Fourth, to understand and manage data quality it is important to stress-test the data. When dealing with inconsistency or ranges, think about "what would you have to believe" to test how credible the data is, and how well it fits with everything else you know.

Also, understand your sources; look into the basis of the information, its strengths and weaknesses and how these relate to the question at hand; have a view on data quality and where it is more or less robust.

Rich concluded that if the following challenges can be overcome, secondary data can have a significant role to play in enhancing decision-making:

- Secondary data may be underappreciated
- The customer may need help articulating what they need from it
- It can be useful to break down the task and align potential data sources
- A clear, simple story around the business questions is often effective
- Different therapy areas may have different levels of complexity, both of business challenges and data sources

"Build a clear, simple story around the business questions, drawing on different sources and highlighting levels of confidence plus how gaps could be filled."

Written by:
Laura Dekker
SKIM

Wednesday 23 June

Workshop 3: How eHealth can change your life – how eHealth is impacting market research both now and in the future

Speakers:	Richard Jackson, Message Dynamics, Jack Bowman, Handle My Health and Serena Slavenburg, MD PhD.
Convenors:	Julie Buis, Aequus Research and Marcel Slavenburg, SKIM: both EphMRA Learning & Development Committee members

Julie Buis

The workshop gave a multi-faceted perspective of the impact of eHealth on healthcare systems and society, and the difference it makes on patients' lives. Where Richard and Jack from a business driver perspective addressed the potential of eHealth, Serena addressed reality in everyday clinical practice. Even though reality seems far from ready in dealing with and integrating these large streams of information, all acknowledged the impact of eHealth applications on compliance and adherence and, thus, contributing to healthier healthcare.

Key Trends

by Marcel Slavenburg (SKIM)

eHealth is more than using apps, mobile phones, webcam's or gadgets. Connectivity and digitalisation are transforming the world around us, and greatly impact the way healthcare is perceived and healthcare systems are organised. Today's topic is a recent healthcare practice that leverages electronic processes and communication to manage healthcare information. It involves simplifying processes related to information, communication and transactions within and between healthcare institutions and professionals by utilising information and telecommunications technologies.

eHealth can effectively manage the entire healthcare continuum, including health monitoring, wellness programmes, preventive health measures such as smoking cessation, chronic disease management, post-acute care management and patient safety management. Some of the benefits include improving coordination and integration of healthcare delivery, empowering individuals and families to better manage their own health and participation in their healthcare plans. eHealth is an umbrella term that covers Health Informatics, Telehealth and other ICT solutions in healthcare.

It also incorporates virtual reality, robotics, multi-media, digital imaging, computer assisted surgery, wearable monitoring systems and health portals.

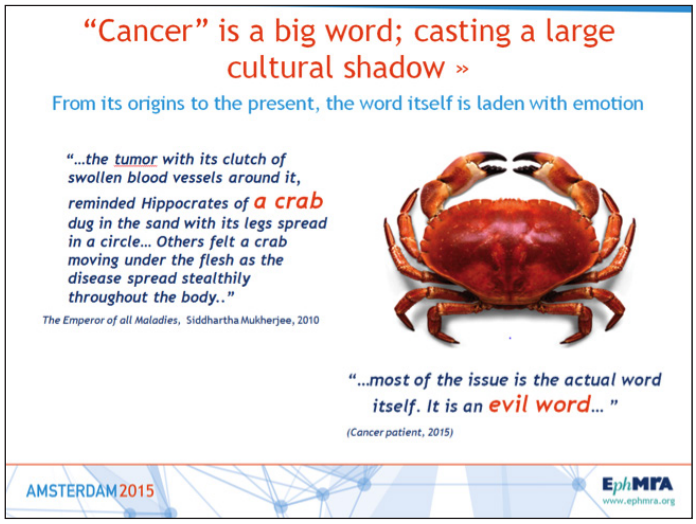
In a broader sense, eHealth characterises also a state-of-mind, a way of thinking, regionally and worldwide, by using information and communication technology. All of this is not happening at once. Marcel took us to the drivers of this paradigm shift and explained which barriers need to be overcome to facilitate these changes.

It became clear that eHealth offers many benefits:

- **Improved information availability:** eHealth initiatives provide clinicians with vital, secure information about their patients at the point of care.
- **Interoperability:** eHealth provides a solid level of interoperability between physician-maintained electronic health records (EHRs) and patient-maintained personal health records (PHRs).
- **Efficient healthcare delivery:** eHealth offers a mechanism that eliminates duplication of efforts and provides operational and administrative efficiencies, reducing costs.
- **Overall health promotion:** This provides a means to improve individual and community health.
- **Technology adoption:** Adoption of the technology facilitates efficient deployment of emerging technology and healthcare services such as e-prescribing.
- **Promoting consumer-driven healthcare:** eHealth stimulates consumer-driven healthcare, encouraging patients' involvement with their own care and promoting health education.

Telehealth and Telemonitoring

by Richard Jackson (Message Dynamics)



Richard started with a definition of telehealth by using the definition of the Telecare Services Association: "Telehealth is the remote exchange of data between a patient at home and their clinician(s) to assist in diagnosis is and monitoring typically used to support patients with Long Term Conditions."

After knowing how telehealth works, Richards asked the question if telehealth works. There is a lack of clear evidence, resulting in the fact that some avoid the adoption of telehealth. To see if telehealth works, Richard has taken a look at 430 studies from 1988 to 2011. He reviewed studies that measure one or more of the following impact criteria:

- Service utilisation
- Clinical effectiveness
- Costs and costs effectiveness
- Social care outcomes
- Patient report outcomes (PRO)
- User / carer experiences

In the end, evidence is mixed but "paints a positive picture overall".

Although there are big savings and telehealth works, it is (too) expensive compared to regular healthcare, so less cost effective. "Telehealth does not seem to be a cost effective addition to standard support and treatment" according C. Henderson et al 2012.

How could we make it more cost effective? The solution of Richard is to use the patient's own equipment.
An example of low(er) cost telehealth is "Monitor" (Message Dynamics). This 'Monitor' calls COPD patients twice a week and asks five simple questions (e.g. How short of breath are you today? Do you have a new cough today?). If a patient indicates they are at risk, an SMS alert is immediately sent to the nursing team to take appropriate action.

Why are SMS messaging services successful?

According Richard the key take away is that patients can use their own devices, making it cost effective. Next to that, these services are successful because they create a two-way dialogue with patients. Simple daily reminders to take medications are not effective, but when you create a two-way dialogue with the patient, medication adherence improves.

This dialogue with patients is important. That is where IVR (Interactive Voice Response) shows up. IVR is ideal for creating a dialogue with patients. An example of IVR is asking 4 questions over the phone to patients over a period of three months (e.g. do you understand why you have been prescribed the medicine? Do you intent to take the medicine as prescribed?). Richard showed the audience two studies that show IVR has a positive impact on both medication adherence and intermediate outcomes.

In the real world, and linked to market research, measuring effect of eHealth solutions such as SMS / IVR programs involves two elements: compliance (taking the correct dose at the right frequency) and persistence (taking the drug for the correct duration).

Mobile health and social media

by Jack Bowman (Handle my Health)

Health information comes from multiple sources. Some datasets have greater clinical value than others. Jack introduced the "Data Gap". This is the siloed and incomplete "gap" between the first administration and an actual event.

The result of this data gap is that treatment plans are a best guess, based on what the patient has told his or her healthcare professional. This process can be optimised by providing data that is self-reported, real-time, longitudinal, deep and valuable.

What we need, according to Jack, is a single ecosystem that is:

- **Patient centered:** The ecosystem should take the privacy and information governance into account.
- **Real-time and holistic:** The ecosystem should be up to date and dynamic.
- **Crosses all health and wellbeing:** From wellness through to mental and nutritional health and nutrition.
- **Supports innovation:** The ecosystem must ensure others benefit and can contribute to the ecosystem.
- **Open:** The ecosystem should not restrict access to any individual.

Jack shared some examples, such as "MIAMI", a platform created by Handle My Health. It is a web and smartphone based patient intelligence platform. MIAMI offers the care network a real-time view on how you are responding to and how you (as a patient) receive personalised care. It makes it visible how your treatment and lifestyle impacts your overall health and wellbeing. This platform also makes it easy to synchronise apps and medical devices, so you can view and update all of your health information in one place.

This platform can also be used in market access, for example in R&D, collecting real word data, phase 1 modelling or real-time or remote monitoring in trails. It can also be linked to EHRs and other telehealth or eHealth systems, resulting in an improvement in adherence and patient outcomes. Although it sounds promising, we have to take into account some important factors such as the security of the platform, the quality of the data, the interoperability, coverage and general due diligence.

During the interactive session, the audience was asked to think about how eHealth can be used in market research. The following applications were mentioned:

- For patient recruitment.
- Accessing patient data, events, symptoms or problems. This data can be used as stimulus to talk to patients or HCPs in a market research setting.
- To turn (big) data into evidence and improvements in (predicting) patient outcomes.
- For testing hypotheses: what will be the future trends.
- Give more insight and understanding of the life of a HCP and a patient.
- Evaluation of the current eHealth apps to identify best practices and/or to optimize new apps.

From electronic health records to translational informatics; how computers, mobile phones and tables can serve as support aids for HCPs in managing patients

by Serena Slavenburg (MD, PhD)

Serena Slavenburg, currently resident internal medicine at the St. Lucas Andreas Hospital in Amsterdam, shared how eHealth has impacted her professional life and the lives of her patients. Serena invited the audience to come along with her on a typical day of her working life. "A typical day starts with an interdisciplinary handover meeting. In this meeting, all patients that were admitted the day/night/weekend before and their current status are discussed. For some, all diagnostics are already collected and presented (photos are displayed and other details are presented).

In addition, further 'treatment steps' are discussed and handed over to the physician responsible. For others, some diagnostics are still pending." After that, she does rounds supported by a 'cow' to combine the data from the handover meeting with that of the clinical presentation of the patients. All this is then updated in the EMR (Electronic Medical Record). Unfortunately, though, not every hospital has fully transferred to EMRs yet, which implies a lot of paperwork.

Dr. Google

Serena shared a patient story to explain where patients start looking for information and how she deals with this. More and more patients and caregivers search for information on the internet before or in between visits to their healthcare professional. It enables them to find out more about symptoms, diagnostics and treatments. Factual information and emotional experiences are shared and learnt from to inform or reassure themselves and others. Serena points out that a lot of time is spent on putting this information in the context of the individual patient, herself, the hospital and society as a whole.

The information available online also has a downside though. Nowadays, new treatment options and combinations of treatments are available on the market - patients learn this when searching the Internet. However, although Serena would like to offer those new options to her patients, she is limited by the constraints of the hospital and health insurance guidelines. Some patients are even referring to new clinical trials and pipeline products in the US. Serena states that "You can imagine that a lot of time is spent on explaining the situation and comforting the patients when a particular treatment option is not relevant to them even though they think it might save their life."

Patient self-reporting has gone mobile: the impact of using of health monitoring apps

One of the key drivers for successful disease management and medical intervention is 'patient insight'. It implies that the patient is aware of the illness, recognises the illness and can explain this to his or her healthcare professional. In terms of eHealth, self-reporting tools, such as logs or diaries have always been used and if completed correctly, have proven to be a powerful tool to generate insight. The power of those self-reporting tools lies in combining descriptive data with numerical data – which is used by HCPs to help support their patients. In the early days written diaries were used. With smartphones penetration rates ever increasing, self-reporting has gone mobile.

So, what is the impact of eHealth for the healthcare practitioner?

With the rise of technology, connectivity, apps and self-diagnosis, more information becomes available and patients become more self-aware and knowledgeable. However, does a physician really need all this information to reach a decision with the limited time they have? With the costs of healthcare increasing rapidly, new healthcare professions, such as physician assistants and nurse practitioners have been introduced to interpret and manage patients' questions and patients' data so that Serena can focus on more complex care. Ultimately, in this way, costs are managed more effectively.

Serena recognises, that connectivity and going digital (or mobile) has the additional advantage of quicker (joint) decision-making, most, if not all information being accessible by a range of specialists required for the optimal treatment of the patient in case of complex medical care and, therefore, the reduction of medical errors.

This workshop left the audience with more questions than ever about eHealth and the future. Some examples are:

- Evidence gap: who is ultimately responsible for any gaps in the electronic data records of the patients?
- If data collection is no longer done at the 'point of care' and is used for treatment decisions; what happens if a patient entered wrong data or metrics or used diagnostic tools incorrectly? What happens when patients is not physically / mentally able to enter data?
- What will be the role of insurance companies? How or will they use the data available?
- What will be the best way to use eHealth for pharmaceutical companies? How to measure the success and ROI of eHealth?
- From a market research perspective: How should we deal with adverse events, as eHealth implies more extensive contact between patients, HCP's and (perhaps) pharmaceutical companies?
- From a patient perspective: eHealth can become overwhelming. Who is going to monitor (and even review or assess) your life?
- How should a HCP deal with eHealth? It might be frightening for a HCP to deal with too much or too fast information. Is there a need to filter information upfront?

Written by:
Jeroen van den Hoven
SKIM

Wednesday 24 June

Opening Plenary

Keynote speaker:	Jack Lewis, Neuroscientist and Presenter
Chair:	Thomas Hein, Thermo Fisher Scientific and EphMRA President


Jack Lewis


Thomas Hein

"I'm here to sort your brain out", Jack told delegates.

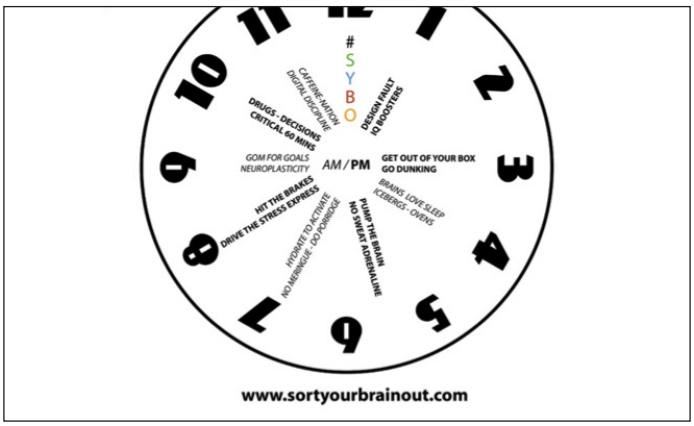
He explained that he was going to take the audience 'around the clock', with a series of brain-optimisation principles (BOPs for short) placed at the hour of the day that he considered them most useful.

Jack began 'at four a.m.' Jack recommended cleaning the oven if we wake up then. Reading or watching TV rewards the subconscious for waking you up, making it more likely to recur.

Jack then put sleep's importance to the brain into context. He spoke of 'neurons, the brain wires along which electrical messages are sent, from top to bottom, from front to back of your brain every millisecond of every day'. There are 86 billion of these, all requiring maintenance. This takes place primarily overnight. If you are a chronic bad sleeper, you will 'lose your marbles quicker', Jack said. Sleep is also important in terms of memories. Overnight, protein is laid down and new synapses created, turning temporary memories into permanent memories.

Jack told the audience that sleep – literally – is 'a washing machine for the brain', flushing out neurotoxins overnight. It also boosts insight.

It's now 7 a.m. We should reach for a glass of water. Everyone wakes up dehydrated, every morning. Every single time we exhale, we lose water, which we are unable to replace while asleep.



"Your brain is 73% water. If it's slightly dehydrated, every single one of those 86 billion brain wires is functioning less efficiently", Jack said.

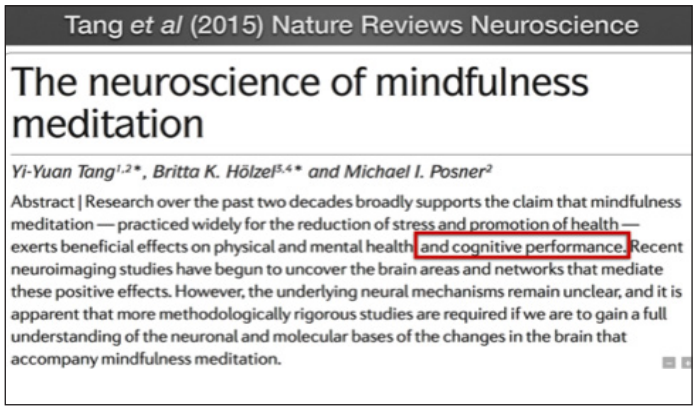
Breakfast time is also when we tend to start thinking about food. Jack introduced the concept of the 'sugar rollercoaster': By eating a sweet breakfast, 'we're dumping a huge amount of immediately available glucose into our blood stream', Jack explained. Rocketing glucose levels cause a spike of insulin. Glucose levels then plummet, possibly prompting a mid-morning visit to the sweet vending machine. And so it continues.

"When you eat like this, the day is punctuated by periods of lethargy, irritability, low glucose levels, meaning that you're making hasty decisions", Jack said.

To get an even release of glucose into the blood stream, he recommended eating slow-release carbs, such as vegetables, whole grains, and fruits.

"It's 9 a.m. Now we're going to talk about 'Gom for Goals'", said Jack. Gom is the Tibetan word for meditation, he explained, explaining meditation's importance to the brain by quoting a recent Nature Reviews Neuroscience article: Jack asked delegates to invest five minutes in mindfulness. He recommended 'Seven/11 breathing' (breathing in for seven seconds, and out for 11). Three or four minutes of this results in a calm brain and the ability to set goals for the day.

He then moved on to neuroplasticity, explaining that we can physically change the structure of our brains, according to what we do regularly, intensively, and over long periods of time. Doing something once a week, won't work.


Tang *et al* (2015) Nature Reviews Neuroscience

The neuroscience of mindfulness meditation

Yi-Yuan Tang[1,2], Britta K. Hölzel[3,4]* and Michael I. Posner[2]*

Abstract | Research over the past two decades broadly supports the claim that mindfulness meditation — practiced widely for the reduction of stress and promotion of health — exerts beneficial effects on physical and mental health and cognitive performance. Recent neuroimaging studies have begun to uncover the brain areas and networks that mediate these positive effects. However, the underlying neural mechanisms remain unclear, and it is apparent that more methodologically rigorous studies are required if we are to gain a full understanding of the neuronal and molecular bases of the changes in the brain that accompany mindfulness meditation.

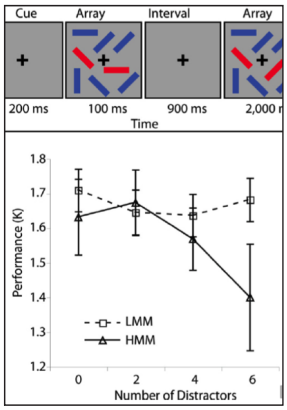
London taxi drivers, for example, spend on average three years studying for 'the knowledge' (an understanding of London's roads). This results in a physical change in their brain – the hippocampus has become larger. This is because it is involved in both navigation and memory – episodic memory (remembering what you had for breakfast) and semantic memory (knowing that Paris is the capital of France). Practice makes perfect because it physically changes your brain. That expansion in the hippocampus is because there are more synapses connecting neurons there. Practice increases synapses, leading to faster, more efficient communication between brain areas, so the next time you come to execute that behaviour, you do it better. The point is, you can teach an old dog new tricks.

"How often do you get to 11 o'clock, and you've achieved absolutely nothing of any significance, because you're too busy reacting to your smart phone?"

Neuroplasticity happens for better or for worse, Jack explains, and there is an argument that we are over-using our devices. He spoke of heavy media multi-taskers, watching TV while surfing the net on a laptop, stopping periodically to check their phone, and low media multi-taskers, doing one thing a time. Adding distractors to the latter will not much affect their performance, but adding them to the former will make their performance decline markedly.

"This suggests that we are multi-tasking ourselves into oblivion", Jack said. "Neuroplasticity is taking place, it's adapting our brains". The only way to stop this process is to exert some kind of control.

1 p.m. It's lunch time and we are facing a design fault – our eyes are bigger than our bellies, and it takes 15-20 minutes from a belly becoming full to the brain feeling full. Jack recommended the Okinawan practice of 'hara hachi bu', or 'eat until you're eight tenths full', adding that more people in Okinawa live to and beyond 100 years of age than anywhere else. He also suggested spending part of lunchtime on brain training. This began in 2004 with Dr Kawashima's Brain Age game, followed by Lumosity.



More recently, Susanne Jaeggi and Martin Buschkuehl developed Dual N-Back Training, which has been shown to improve the working memory.

"It's 3 p.m., time to go fishing", announced Jack, fishing for ideas, that is.

He spoke about American inventor Thomas Edison, who 'caught' ideas by quietening his conscious brain sufficiently for them to bubble up from his subconscious. Edison would bring to mind a problem, hold a ball bearing in each hand, sit down and shut his eyes. He would then enter the hypnogogic state, between waking and sleeping, when the frame of mind is typically crisp and creative. As he nodded off, he'd drop the ball bearings, waking up in time to capture the ideas. Jack recommended 10-15 minute-long naps.

6 p.m. The working day is almost over. It's time for exercise. From the brain's perspective, just 20 minutes a day are needed.

"Quite often you won't feel like going to the gym. But if you do, even for a short period of time, you'll release beta endorphins, the euphoria-inducing drug. You can make yourself feel happy", Jack said.

"I'm talking about investing 20 minutes, just so that you can be cognitively more effective."

8 p.m. The evening is for building cognitive reserves by taking up pastimes that can help develop parts of the frontal and parietal cortex. This means, Jack said, that when the brain areas get coshed by the metabolic processes of Alzheimer's, it can compensate.

He cited the Einstein Ageing Study, conducted in New York, which found that people who regularly danced as part of a couple – or played a musical instrument – experienced a later onset of dementia.

10 p.m. There's a critical 60 minutes before sleeping where we should not eat a huge meal, exercise, or have a bath or a shower. All of these heat the body at a time when the brain needs to cool.

"Many of you will say 'I exercise just before bedtime, I eat a huge meal all the time'. Humans are incredibly adaptable. You may well be able to do it. But if you didn't, you'd get to sleep sooner, and we all know sleep is really important for your brain", Jack concluded.

Keynote: Dare to be Trivial: Tackling medication non-adherence using Behavioural Science

Speaker:	Jez Groom, #Ogilvychange
Chair:	Sarah Phillips, Prescient Healthcare Group

Jez Groom

Sarah Phillips

Jez Groom entertained and enlightened us with his presentation which dared the audience to consider trivial or small changes for a significant impact. He opened with some entertaining comments about relative framing, how he personally, as a creative, was trying to look more scientific by wearing a tie and cardigan, unlike the previous speaker who was a scientist trying to look creative, and hence was in jeans and t-shirt.

Jez (also known as Yoda!) firstly began by showing us what it is to be human. He gave the audience a series quick-fire questions, on the surface which looked very relatively easy to answer. Many in the audience declared they had scored three out of three, until Jez pointed out that he had given the wrong 'correct' answers, and only those who had scored zero had everything correct.

The demonstration was one to show intuitive, instinctive thinking (system 1) versus more considered or difficult thinking (system 2). This is the fundamentals of behavioural economics. The 'correct' answers were predictable and systematic, only those who had applied more thought knew the real answers, which was tough so early in the morning.

Jez described how the human brain makes decisions by taking mental short-cuts to speed up the decision-making process, based on our previous personal experience and thousands of years of evolution. This mental model was first developed in 1984 but recently came to the fore with Daniel Kahneman's book "Thinking, fast and slow". It applies to all human behaviours, whether choosing what to have for breakfast or choosing a house - we are not always as objective and rational as we would like to think.

This type of thinking is hard wired into humans, and is not unique to us as a species, Jez showed one of the funniest videos to demonstrate from 'monkeynomics' that the routes of human irrationality run deep, as monkeys make the same silly choices and have similar emotional reactions to humans. In short, monkeys experience similar unfairness and react accordingly as humans do.

Jez described two ways of thinking, characterised by "Spock" and "Homer Simpson". Many people consider themselves rational and objective, controlled, ethical and self-aware (like Spock), but in fact many decisions are made by the part of our brain that is Homer Simpson.

The automatic (Homer-like) decision is made effortlessly, quickly and easily, whereas the reflective decision-making process requires thought, reasoning and effort. Jez explained that we use both systems, but tend to rely more on one than the other depending on the type of decision being made. For example, the question "5x2=?" is quickly answered by system 1 - the answer "10" pops into our heads. By contrast, the question "17x24=?" is a much greater cognitive load, which means we have to take time and mental effort to calculate the answer, hence utilising system 2.

But how do we use behavioural science to change behaviour?

Jez shared more examples of decision-making which can be subtly influenced by appealing to different parts of our brains. In an experiment to persuade people to eat more healthily, Ogilvy set out a Monday breakfast buffet including croissants and fruit, and found that many people reached for the pastry treats.

The following Monday, they made a subtle change to the table layout, putting the fruit in the middle on a raised platform and placing a mirror behind the table. They found that people were more likely to reach for the fruit. Jez explained that the position of the healthy option made it easier to select, and that the mirror behind the table showed people their reflection reaching for the less healthy options, which triggered their rational consideration of the decision and overrode their system 1 instinct to choose croissants.

There are a number of other influences and irrationalities of the human mind that can be exploited to influence behaviour. For example, if a task is chunked up into pieces, it is easier to achieve than if it is one large task, so it is easier to remember a phone number which has breaks in it, such as 020 8XX XXX, rather than remember 9 or 10 numbers all at once. In addition, people are influences by different colours and shapes, we expect certain things to be a particular colour, or react differently, for example, if something is red, it signifies danger or warning (like a red traffic light).

"Chunking" - a theory from Rosenbloom & Newell, is the way in which a task is presented influences our motivation to start and complete it. Something that is presented as one long task to be conducted in a single act will be less likely to be completed than something that is "chunked" into smaller stages.

A full course of medication can feel too big a task, but if broken up into smaller steps, each step seems more achievable and we gain motivation from completing each step.

Jez wanted to show how these theories can be used practically to influence behaviour, such as patient adherence. He highlighted the extent of the problem of non-adherence, costing an estimated $564 billion per year. However, he had translated the theoretical into a practical, yet trivial intervention which was proven to significantly increased adherence by 21%.

In an experimental design, volunteers were told that they were taking part in a study to look at the impact of cod liver oil and vitamins on wellbeing. Participants were allocated to one of two study groups. The "treatment" group received three colour coded bottles and were given instructions to take the red tablets first, then the yellow, and finally the green over the course of a month (the task was chunked up for them into three stages, and colour coded). The "control" group were given a bottle of white tablets and asked to take one each day.

The study showed that the group given the three colour coded bottles were 21% more likely to complete the course than the "control" group, this was a significant impact on the rate of adherence.

Jez concluded by reviewing the 2 thinking systems ("Homer" and "Spock"). When applying rational thought to designing an experiment or crafting a solution to patient adherence, he encouraged us to think about appealing to the system 1 operating system.

The experiment conducted was only part of the solution, it was not a magic bullet to end all mal-adherence. However, he showed clearly how making small changes can have a dramatic impact.

Written by:
Sarah Phillips
Prescient Healthcare Group

Wednesday 24 June

Session 1: Oncology and Shakespeare: Is it time we added some culture to our research mix?

Chris McPartland

Greg Rowland

Speakers:	Chris McPartland, Hall & Partners and Greg Rowland, The Semiotic Alliance
Chair:	Sarah Phillips, Prescient Healthcare Group

An intriguingly-titled paper from Chris McPartland and Greg Rowland suggested that we add some culture to our research mix – but did they manage to successfully link two topics as seemingly disparate as oncology and Shakespeare?

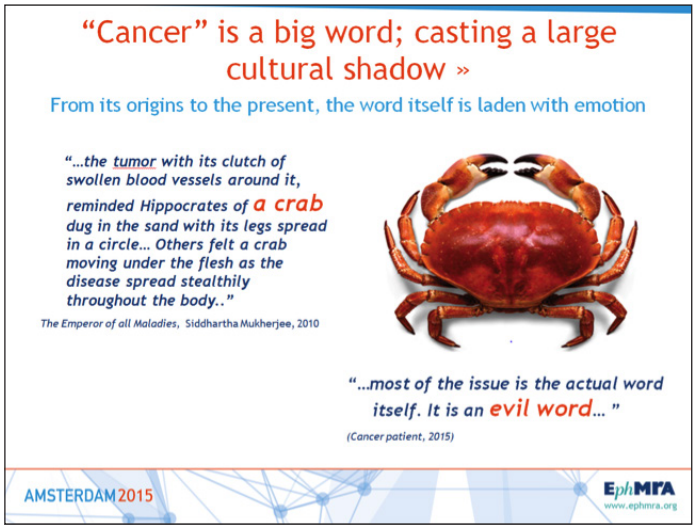
Chris opened the presentation by reinforcing the need to go beyond the standard market research methodologies and consider more carefully the impact of language and culture on the way we conduct research but also the way that we interpret and act upon our findings, and in how we communicate with patients.

Chris and Greg chose cancer as the subject of their paper, conducting research from multiple angles to explore its image and associations amongst cancer sufferers and the media. Chris led us through a brief history of the language of cancer – a condition that is not only the most widely researched area in pharma at present, but also an area that holds a particular place in our minds and imaginations.

From Hippocrates through Shakespeare and to the present day, he highlighted examples which demonstrated the large cultural shadow cast by cancer and characterised the metaphors commonly used to describe this condition, including the emphasis on military metaphor which pervades our language today. He quoted Susan Sondheim's book which made the point that cancer patients are "shamed and silenced by metaphor" – the pressure to "fight cancer" puts responsibility on the patient to overcome an enemy that cannot always be beaten, resulting in feelings of personal failure. He noted also that although cancer treatment has become more personalised over the years, the language used to describe in our society it has remained largely unchanged.

Chris and Greg's paper was based upon research comprising four main elements:

- Netnography following patients with breast, prostate and lung cancers (blogging and online tasks over a 2 week period)

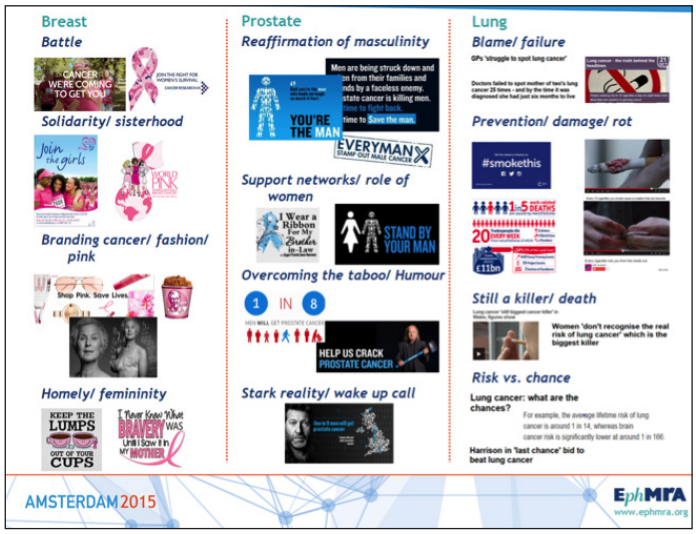


- Semiotics and cultural analysis (based on the broader cultural dynamics of cancer)
- A semantic sweep of the mainstream UK media (desk research)
- Language of cancer workshop (with an oncology nurse, oncology communication specialist, a semiotician and market researchers)

Greg provided a brief overview of semiotics – understanding how culture and meaning are generated based upon symbolism and language, but affected by our culture, education and past experience.

He provided examples from other cultures to show how the western view can be interpreted very differently in other cultures – for example, the differing attitudes to life and death in western vs Asian cultures. He explained that in the western world we understand by binary opposition – for example, we understand "dead" as meaning "not alive", and that we struggle with concepts that don't conform to this way of processing our understanding.

The semantic sweep of the media in relation to cancer demonstrated clear communication cues for each of the types of cancer looked at. Breast cancer focused on pink colouring, very popularist, almost a third way of feminism.



For prostate cancer, male blue colours are in force, combining battles with humour. Lastly for lung cancer, there is very little residual energy, imagery looks as if it is from the 1970s, almost in a culture of blame.

Greg and Chris then outlined three hypotheses about the metaphors describing cancer, derived from semiotics and the semantic sweep of today's media, and the extent to which they matched the feedback from patients with cancer.

1. Cancer is anarchy: Greg described cancer as a "cellular mob", lacking a purpose that would enable westerners to make sense of it using normal western binary thinking. Chris confirmed that the metaphor of anarchy was felt amongst the cancer patients who highlighted the unpredictability and lack of rules that surrounded cancer. He linked this with the common way in which cancer patients undertake diversion tasks or break down the enormity of cancer into smaller chunks which can be controlled, to try to overcome the sense of helplessness in the face of anarchy.

The semantic sweep also showed strong themes focused on making order out of anarchy – "fighting" cancer, "beating" cancer – describing cancer as the enemy. This was consistent with the approach taken on many pharmaceutical company websites.

2. Cancer is a living death: Greg described how this binary opposition presents westerners with a problem that they cannot resolve, leaving us anxious about the devastatingly unknown. Chris reported that the idea of "living death" emerged strongly from the research amongst cancer patients, with the feeling that the media focuses too much on those who die of cancer rather than cancer survivors. He reported coping strategies such as a positive mindset, or keeping busy on a day to day basis as a distraction from the clear sense of looking death.

Some patients admitted that a state of denial about the future also helped them deal with daily life.
This theme was strikingly strong in the semantic sweep in relation to lung cancer in particular, where the media focus was on the self-inflicted causes of lung cancer, the poor survival rates and lack of cure.

3. Cancer is de-gendering: Greg explained how cancer deconstructs a classic example of western binary thought – the male-female axis. He described how cancer created a de-gendered person, with certain cancers figuring largely in this context. The hypothesis suggested that cancer robs us of a fundamental way that we look at humanity.

Chris reported that de-gendering was less apparent in the cancer patient population, although some did talk about loss of sexuality. However, the semantic sweep showed that in the media, the very opposite of de-gendering was evident in the use of strong masculine and feminine themes and colours apparent in reporting on breast and prostate cancers. There was also evidence of reaffirmation of de-gendering from the pharmaceutical company websites.

So, what does all this mean for us?

The speakers identified two clear themes about how patients wanted to deal with their cancer:

- Finding normality within the anarchy
- Living life as opposed to a living death

Having a full understanding of the language and culture of cancer can help us to communicate effectively with cancer patients, whether we are speaking as a physician, pharma company or friend. It can help us understand the need to think about the language we use to describe cancer, to reflect the metaphor used by the individual patient and to help patients break down the enormity of cancer into their own specific, personalised condition.

They concluded by acknowledging that we cannot change the current language of cancer overnight, but by going beyond traditional market research approaches we can deepen our understanding of the semiotics of cancer, examining it through a cultural lens to uncover insight to help us communicate effectively.

They closed by encouraging us to add some culture to our research mix to ensure that "all's well that ends well" rather than "much ado about nothing".

Written by:
Sarah Phillips
Prescient Healthcare Group

Session 2: The Traveller's Journey – insights into the traveller and their attitude towards travel advice and vaccination, based on online narrative research methods

Speakers:	Lucas Hulsebos, DVJ Insights and Chris de Jong, Sanofi Pasteur MSD
Chair:	Caroline Jameson, HRW


Lucas Hulsebos


Chris de Jong


Caroline Jameson

Chris de Jong and Lucas Hulsebos's paper showcased a new and innovative approach to exploring the customer journey, using customer storytelling on a large 'quantitative' scale to deliver market understanding in an area where very little real insight and information existed. The approach was embedded in a process to build partnership between pharmaceutical company and different travel clinics.

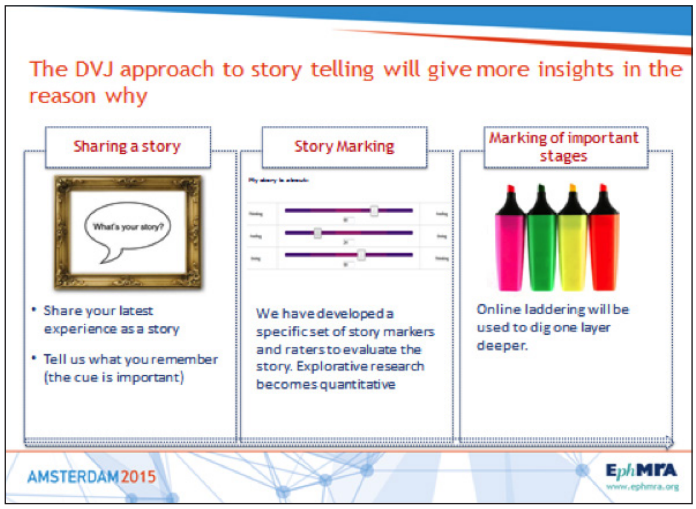
For the benefit of members of the audience from outside Europe Chris opened the session by letting us all know that Sanofi Pasteur MSD was a joint venture, undertaken by the vaccines division of MSD and Sanofi Pasteur. He also mapped out (literally) what the travellers' world without travel vaccines looked like.

Chris introduced the challenge being faced by Sanofi Pasteur MSD in relation to their travel vaccines market which was characterised as Extra Mural (GPs and City Pharmacies) and Intra Mural (GGDs public health bodies, travel clinics, hospitals, army and other) with Sanofi Pasteur MSD's focus being largely on the Intra Mural market. Despite the fact that people are travelling more and more and countries with a need for vaccination are increasing, the market is decreasing, with fewer travellers presenting to travel clinics for vaccinations. Sanofi Pasteur MSD wanted to understand the market better in order to help their clients (the travel clinics) to reach out to end users (travellers), but the challenge they faced was a lack of information!

The project was designed in three stages, beginning with an extensive kick-off stage during which all existing materials were reviewed, project objectives and key issues to be resolved were discussed with project stakeholders. From this stage, it was apparent that there was little information available on the "5 Ws" (who, what, where, when, why) and the "How?" – that is to say there were a large number of unanswered questions and very little true insight in this area. These answers were necessary to determine the marketing activities better.

In the second stage, travel clinics were interviewed to understand their problems and challenges. Again it became clear that the travel clinics themselves did not know how travellers made their choices in terms seeking health advice and where best to source travel vaccinations, although there were suggestions from the travel clinics that location and cost were likely to be key drivers of choice. Only a minority of clinics were proactive in communication with their target customer group.

The final (main) stage of the project involved discussions with 800 travellers to capture the journey that travellers make before and after they go on holiday in respect of travel vaccinations. Lucas highlighted the "traditional" approach to customer journey research, in which researchers validate what was believed to be known, often using radio grid style questionnaires, first asking "do you do [something]?" and then following up with "why/why not?". This approach is boring for respondents to complete, and does really address or reveal any attitudes or motives. Even worse, a traditional questionnaire that is used in 90% of all studies will decrease the motivation to participate within 10 minutes with more than 25% (source: international validation study). It is remarkable how much trust we have in traditional techniques in research knowing that the outcomes could be misleading and wrong.



For this project, Lucas recounted, that they used a new approach based on storytelling and free associations. They first asked people to share their associations on the category and different aspects. Using free associations will reveal the real mental network much better traditional techniques and the correlation with real behaviour is much higher. The stories were ignited by using different cues related to travelling. These stories covered the whole duration of the traveller journey. The unique part is that we ask people to classify their own stories and giving meaning and interpretation to it.

Examples using prompts such as "the person in this study is a person who...." or "the moment in this story is a moment of..." or "the role the clinic played is...". Lucas explained that this approach generated lots of qualitative insights, but combined this with quantitative statements helped them to understand different segments in the market. This also allowed them to interview a quantitative sample but to benefit from qualitative insights via what was revealed in the stories they had captured.

Lucas described how they also used free associations, again starting with an open question ("what do you think of when you think of....?") and then asking the respondents to classify the association themselves in terms of whether it was positive or negative, relevant or not relevant etc. The self-classification not only made analysis quicker, but also more accurate as it removed the risk of analyst misinterpretation and bias.

The findings revealed a number of insights about travel clinics and the travel vaccines market which could be used by Sanofi Pasteur MSD to support their clients, the travel clinics. They were able to identify opportunities for travel clinics, such as:

- creation of familiarity (to rival the convenience and availability of the doctor as the preferred alternative to the travel clinic)
- generating awareness of the risks involved in travel and the benefits of vaccinations
- expansion of supply to offer packages suited to different customer types, before and after the trip, including practical information
- communication to both increase awareness and establish travel clinics as the experts in travel/health advice via multiple channels including via online travel providers.

Chris explained how these insights were being used in practice to help travel clinics understand their customers. He highlighted an unexpected benefit of the storytelling approach which delivered not only a deep understanding of the traveller journey, but the stories were also collected into a bound storybook. This was distributed amongst all the travel clinics where the stories that had been collated were used to broaden and deepen the understanding they had of their target customers – the traveller – and were soon incorporated into their customer communications.

As a result of the online narrative research method employed, SPMSD was able to build on the relationships they already have with the travel clinics and develop partnerships for future initiatives. Of course time will tell whether or not the impact of the research and SPMSD's response to it will have the desired effect on the travel vaccines market.

There was some time for questions after the main presentation with some interest in how specifically the storytelling element of the project was undertaken. What were the key cues used and in what way were the respondents prompted. Overall this aspect of the project and the interpretation of the outputs from the high volume storytelling part of the research was felt to be a really interesting and potentially useful approach!

Written by:
Andrew Foreman
Branding Science

Wednesday 24 June

Session 3: Hot Topics Round Table Discussion: Fieldwork – Are we meeting the challenges?

Facilitators:

Martin Schlaeppi
Praxis Research

Sam Scott,
Fieldwork International

Karin Busse
Grünenthal


Martin Schlaeppi


Sam Scott


Karin Busse

Introducing the round table session, Martin Schlaeppi of Praxis Research explained that prior to the conference EphMRA had sent out a short survey to members to identify what topics were challenging the fieldwork agencies day to day.

The main focus of the round table was to provide a forum where the fieldwork agencies could openly discuss; three selected hot topic challenges, share the solutions being applied within their own businesses, and how EphMRA could further assist fieldwork agencies.

The three discussion Hot Topics were:

1. The diminishing respondent pool of Healthcare professionals and how do we increase the pool
2. How to reach hard to reach patients, e.g Orphan diseases
3. Recruitment from address lists provided by pharma companies (quality, limited no. of addresses and how to reach the targeted samples)

Delegates were asked to select the topic most relevant to their business and answer the following questions:

- What are the issues relating to this topic and what impact does this have on your day to day working?
- What do you think the solutions are to these issues?
- What could EphMRA do to help resolve some of these issues?

With over 40 delegates attending the session, it was interesting to see that the groups were evenly distributed, with both agencies and healthcare companies present. Teams were allowed 30 minutes to discuss and then each group was asked to feed back on the questions raised. The teams got straight down to work discussing the challenges in their groups; it was great to see the energy and passion around the room.

1. The diminishing pool of HCPs

Delegates raised the issue that there are different challenges facing those who work in Qualitative versus Quantitative methodologies but the key areas that are seen as an influence on the diminishing pool of HCP's are:

a) Respondent fatigue: HCP's identified as high prescribers, or who work in areas of interest are heavily researched.

b) Screeners are increasing in length due to the extra information needed for legal and ethical requirements. Specific targeting of HCP's has also seen extra questions added to screeners.

c) Incentive caps and fair market value is very topical with field agencies. The need to obtain a balance is paramount; to prevent further loses.

d) Length of questionnaires/surveys continues to affect the pool of doctors.

e) Limited locations for Qualitative fieldwork. Various causes raised from limited studios, interviewer availability, and client and moderator travel requirements.

f) Currently the industry incentivises HCP's through financial reward. The delegates recognise the need for other external rewards

This group voiced that solutions were harder to reach in the time allowed, as the topic covered so many elements. They discussed the need for an ongoing field forum to be created to implement change with involvement from all areas of the market research industry.

The team suggested EphMRA could help alleviate the issues raised on the diminishing pool of respondents, with the following ideas:

- Best Practice Guidelines for Incentives (Fair Market Value), Length of screeners and questionnaires and compliance
- Education and lobbying of regulatory authorities to standardise compliance
- Involve Pharma/Full members to help bring change across the industry
- Advice on external rewards

2. How to reach hard to reach patients

This group were aligned on the challenges this area of fieldwork brings:

a) Considerable effort and time is required to recruit these types of patients and currently the compensation does not reflect this

b) Allowing adequate time to recruit for this type of work contributes to its success but it was discussed there is a lot of inconsistency. There is a perception that some fieldwork agencies will state shorter timelines to win work, other agencies are over cautious

c) Universes of patients can be very small making feasibility difficult to predict.

d) The channels of recruitment used were similar across the delegates, with similar challenges raised:
- Associations are not always willing to support
- Physicians are less and less willing to make referrals

e) Ethical considerations were raised. Where do we draw the line?

The group then discussed solutions and ideas they felt were worth investigating further within the industry, considering the need for more flexibility on quotas to make this work more commercially viable. However there is a need for more formality and best practice around recruitment through Physicians and Patient associations, whilst ensuring the patient needs are protected.

To help us recruit hard to reach groups of patients, the group stated we need to obtain better engagement via educating Doctors and Patient Groups about why research is conducted. Delegates acknowledged a need to try new channels of recruitment, mentioning Mobile Apps, Facebook and patient groups.

To work well in this particular area of research, one key subject kept surfacing around the industry need to build a higher level of trust with every touch point.

Delegates discussing this topic also agreed there were areas where EphMRA involvement would be of assistance:

- EphMRA to take a prominent lead in promoting and educating those outside of the industry on what we do. Building trust with the participants and groups we need to reach these hard to reach patients.
- Best Practice Guides for working with hard to reach patients

3. Recruitment from address lists provided by pharma companies

The last group were focussed on a topic that has become rather hot over the last few years, emphasising an increase of 20% in work where clients are providing lists of HCP's they would like targeting.

a) The delegates talked openly about the quality issues of the lists provided by end client's, outlining how often they are out of date.

b) There was real concern that fieldwork teams could be upsetting the Pharma companies' clients, as these lists are overused by one agency to another for each research study.

c) The group discussed how often they are not informed the project will have a client list and the impact this can have on logistics and costs. The delegates also raised they are asked to provide a cost prior to seeing the list and volume of contacts.

d) The delegates highlighted that more education is required around how lists can be used to ensure data protection is not in breach.

The group reiterated education and best practice is essential to help the industry solve these problems. It was also questioned; could these participants be reached through targeting via screeners, rather than client lists?

Similar themes evolved on where EphMRA can support agencies, mainly with a focus on guidelines and best practice for Pharma and Fieldwork Agencies when working with client lists.

It was agreed that the issues highlighted at this session will be raised with the relevant EphMRA committees and board. A final recommendation was that a field forum is required to continue the work from this engaged group of fieldwork agencies.

Session Chair Sam Scott, Fieldwork International. I was thrilled to see such a great group of professionals come together to discuss such relevant topics for the fieldwork industry. If we are to meet today's challenges we need to work collaboratively across the industry in conjunction with EphMRA and other bodies.

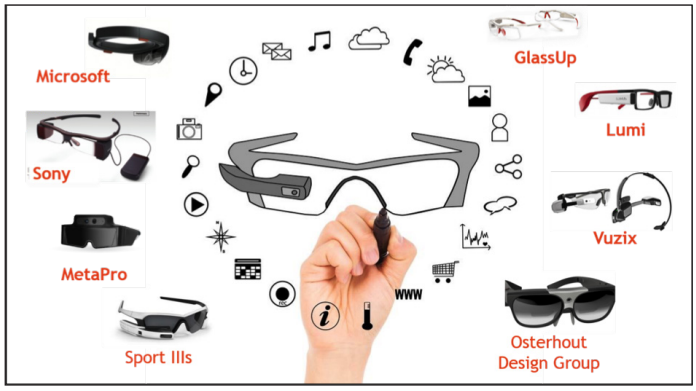
Written by:
Sam Scott
Fieldwork International

Wednesday 24 June

Session 4: Through the looking glass: a case study of Heads up Technology in oncology patient research

Speaker:	Katy Irving, HRW
Chair:	Amr Khalil, Ripple International

Katy Irving



Katy Irving's paper provided a fascinating introduction to one of the newest emerging heads up technologies – Google Glass – and its application to market research.

Katy opened by highlighting a common challenge we face in market research: ensuring that we are genuinely "accessing reality" with our market research approaches; and the challenges of overcoming memory fallibility, catching participants in the right context, and bringing to life a tangible portrait of customers for clients and their internal teams.

The advent of "heads up display" technologies, Katy suggests, may now offer us a chance to get closer to our patients' reality by offering all the functionality of a mobile phone, but in a wearable, hands-free format. But how effective are they in practice?

Katy gave us an overview of the array of "heads up display" technologies now available and, using Google Glass as an example, walked us through the functionality, including an optical display showing the wearer a screen with apps installed, voice and touch commands, sound audible only to the wearer, Wi-Fi connectivity, built-in cameras for photographs or videos and the capacity for voice notes based on voice-recognition technology. Such technologies offer us the functionality of a Smartphone but in a wearable hands-free format.

During a series of self-funded studies, Katy and her team explored the Google Glass functionality and conducted a "test drive" to evaluate its value in market research. The studies represented a series of adapted ethnography projects with cancer patients, which made use of the photograph, video and voice note capture capabilities whilst exploring both the technical and ethical realities of using Google Glass for patient research.

Based on her experiences, Katy was able to highlight a number of benefits and limitations of Google Glass. She highlighted various limitations, including current hardware limitations such as battery life and tendency to overheat, and software limitations due to the relatively recent emergence of the technology. The current novelty-value of the technology may influence how people react to the wearer, which needs to be taken into consideration when interpreting results.

Katy pointed out an important issue regarding the privacy and ethical guidelines pertinent to market research that do not yet accommodate these emerging technologies, and the requirement to obtain the relevant permissions for all individuals being recorded by Google Glass may cause an administrative bottleneck in the research process.

Perhaps a more long-term limitation of the approach is the subjectivity of data capture, whereby the respondent actively decided what and when to record / photograph / share a given moment, thought or activity. Katy noted that this means we only see what respondents want us to see – not the deeper moments that perhaps they were uncomfortable sharing.

However, Katy was also able to highlight some compelling benefits of the technology. Again, due to novelty value, she reported infectious excitement from everyone who came into contact with the technology during her project. She commented on the novelty of having respondents clamour to take part in market research, but acknowledged that this benefit may well diminish over time!

A more enduring benefit, she feels, is the capacity to interact and provide additional information during the research process. The technology allows researchers to "push" questions to the respondent at the moment they are needed or relevant – a function which may well become more sophisticated in future iterations.

The hands-free, wearable characteristic offers a practical benefit in that respondents do not need to stop what they are doing in order to use it – voice activation of video capture, voice notes, photographs etc allows the researcher to see how respondents approach specific situations without halting the flow of that situation. However, the perhaps unique benefit of the wearable, eye-mounted format is that it allows the researcher to "see through the eyes of the customer" as outputs are captured from the customer's vantage point. This provides an unusual and impactful observation experience that facilitates empathy.

Katy showed a case study based on research conducted with "Mario" – a patient with colorectal cancer, which poignantly highlighted the impact the cancer had on his life, and showcased a video that demonstrated the benefit of the approach in providing a portrait of the patient experience, brought to life for the observer.

Katy added further insight to the technology review by sharing some additional analysis which looked at the depth of response obtained in different respondent settings. The team discovered that the greatest depth of insight resulted from observations where the respondent was "lost in thought" and engaged in other actives (e.g. making coffee, cleaning up) significantly more than when simply sitting still and responding to a question.

She postulated that the difference may be due to the capture of raw emotion in the unguarded moment, rather than focused post-rationalisation when the respondent is over-conscious that they are taking part in research and considering the question carefully.

Katy summarised her evaluation of the Google Glass technology by concluding that this approach delivered valuable results for:

- "in the moment" research, such as decision making and real-time accounts of specific situations. It offered an excellent observational approach to identifying unmet needs and usability for treatment or device testing
- device testing or topical treatment application where the hands-free nature of the technology allows use of both hands
- understanding use of media and information resources, particularly online where the technology captures browsing history for later review
- product profile testing, where the ability to feed additional information (for example a product profile or additional questions) at the appropriate point helps to replicate the "real life" situation more accurately.

Katy then shared her hopes and expectations for the future development of the technology to encompass greater use of "augmented reality" – the capability of these technologies to sense and interact with the real world. She pointed out that other tech companies are developing better even more capable technology for augmented reality that will allow us to create virtual prototypes to test in context as well as a more nuanced and engaging perception of the world around us.

These approaches can help provide additional information based on the respondent's location or setting, and the likely development of a greater number of purpose-built market research applications to capture a greater variety of data through this methodology. She also hoped that as the technology continues to develop there will be more companies developing purpose-built market research apps which would allow us to push questions to participants and collect answers to multiple choice questions as well as track a greater variety of different metrics.

Katy highlighted that Google have a track record of launching early prototypes of technology to test them in market before withdrawing and updating them from the knowledge and experience. She was therefore hopeful that although Google glass has currently been withdrawn for further development it (or something like it) will soon be re-launched in a revised, new and more effective format.

Her "road test" complete, Katy concluded that Google Glass and its competitors offer the potential for a very exciting opportunity for market research; by offering timely entries that overcome memory fallibility, context-driven data capture that delivers portrait of the real situation, and an opportunity to put the audience 'behind the eyes' of the participant that brings the research to life. And, she said, ultimately the future of this technology as a research tool depends on the acceptance by the public; as we know that the more commonplace the technology becomes, the more that it becomes an already integrated tool for research and the more developers evolve it for multi-purpose uses like research.

Written by:
Amr Khalil
Ripple International

Wednesday 24 June

Session 5: Future Leaders Presentations: Dating Strategies for Market Researchers

Speaker:	Sam Hope, Prescient Healthcare Group
Chair:	Lee Gazey, Hall & Partners

Sam Hope

Sam Hope's paper took an entertaining look at what Sam calls "the people behind the PowerPoint" – and how to demonstrate to our clients that our proposal showcases that we have the best people for the project.

Sam opened by drawing an analogy between proposal writing and dating – proposals are an opportunity to make a first impression... a little bit like a first date. If the proposal shows that your team is strong, it can be the start of a fantastic relationship.

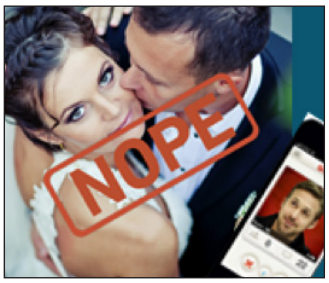
However, often proposals contain faceless teams or generic biographies which do not give the client enough tangible and relevant information about the agency researchers involved.

Sam observed that dating, like proposal writing, has evolved. Where dating used to consist of sitting in a bar, placing a personal ad in a paper or making connections via friends, now prospective daters use web-based tools. Those can strongly vary in their approach, so Match.com and Tinder represent the full spectrum and vary also in the statistics of successful long-term partnerships. For those of us who are out of practice with the "dating game", Sam explained that Match.com uses extensive profiling to increase the chances of a good match, whereas Tinder uses a more visceral approach with users making a quickfire decision to "swipe left" or "swipe right". Sam provocatively states that our proposals might be sometimes a little too "Tinder" and challenges us to make them more "Match.com"!

But how can we demonstrate in our proposals that our people are a good match for the project in question? Sam went on to highlight the big "dating challenges" of today and how to ideally respond to these:

- **Time:** time is shorter than ever – our clients are busier than ever and we need to do something a bit different to capture their attention in our proposals. Sam suggested creative options such as including mock interviews of videoclips to demonstrate the skills of the core team members
- **Connections:** despite the networking opportunities available at EphMRA, it is more difficult to make industry connections these days, placing greater emphasis on clients asking the right questions to assess whether we are the best fit for them and their project
- **Risk:** For up and coming researchers who are not known to our clients, we represent a risk. How can we make our clients more comfortable committing a precious project to us? We need to show them the future of the relationship and reassure them that they are in good hands.

Match.com: is said to result in 12 engagments or weddings per day



Tinder: Out of 450 million profiles, it has successfully led to 150 marriages

Sam showed some examples of approaches used to communicate personal "profiles" to prospective clients, or in her case study, employers. She here introduced us to Nina, whose application for a job at Airbnb went viral and captured the attention not only of Airbnb but even the Queen of Jordan herself. She also gave the example of video clips taken at the internal brainstorming where the RFP was discussed. This included in the proposal gives the client real insight in the way the team thinks and works.

In her conclusion, Sam encouraged agencies to spend more thought on communicating to clients who their project team will to be and why they are the best people for the job. She encouraged agencies to try to think creatively about how to show clients how in particular the future relationship might look if it came to the collaboration and partnership. Working together, agencies and pharma companies can ensure that each project is a match made in heaven!

Written by:
Stephanie Ludwig
GfK

Session 5: Get it right! Use the correct medical terminology to engage your audience

Speaker:	Laura Dekker, SKIM
Chair:	Lee Gazey, Hall & Partners

Laura Dekker

What happens when we speak of Barlow`s disease and translate that name into different languages? To which extent can this bias the content?

Laura Dekker highlighted the potential pitfalls of translation of our highly specialised medical language from and into different languages and showed how this can cause implications for physician engagement.

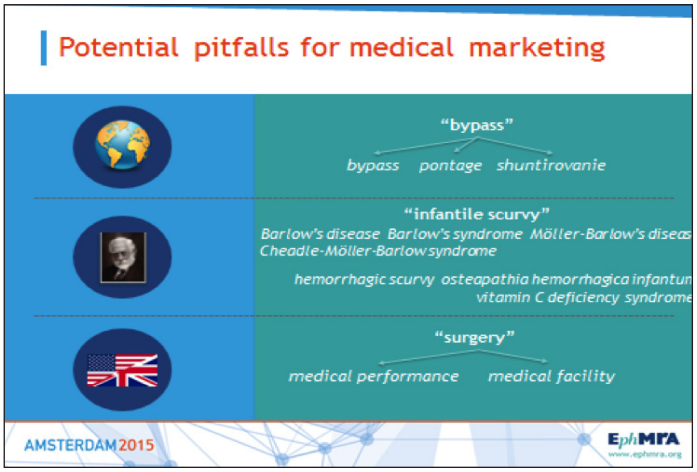
Laura opened by reminding us of the time pressures that physicians are under in today's digital century characterised by an enormous availability of information and multiple channels vying for their attention. They have limited time available to keep up to date on clinical data and have an increasing administrative workload. Laura asked how, as marketers of pharmaceuticals or medical devices, we can ensure that our marketing messages are being heard amongst the digital "noise"?

Laura exhorted us to engage with physicians via medical language, explaining that the brain filters all the incoming information that we are presented with to focus on elements that interest us the most. To engage with physicians, she said, we need to both attract their attention and to ensure that they become involved. One way to achieve this is by using the actual medical language used by the physician - rather than the pharma company`s or consumer`s language. This allows the physicians to filter, relate to the content and actually engage.

Starting by using entertaining, but also impressive examples from the FMCG field, she showed how difficult this can be and what amount of confusion can be caused in some countries. This can then happen even with experienced brands such as Pepsi and Schweppes Tonic Water falling foul of the marketing message being lost in translation.

She then explained how the medical language is also subject to these potential pitfalls by giving some examples:

Laura identified three typical examples of situations where particular care needs to be taken with translation of medical language:



- **English terms vs native language:** although there are some English terms that are accepted and understood in other language (such as "bypass"), other countries require a native language translation
- **Eponyms:** when translating eponymous conditions such as Barlow's disease, we need to check very carefully to ensure that we use the correct local language term for the same condition
- **Homonyms:** where a word has two potential meanings, such as "surgery", which in US English means a place where a patient receives surgery, but in UK English is also a physician's office or the time period or opening hours during which patients are seen.

Laura suggested a solution for capturing the correct terminology: Online chat groups amongst professional peers allow the individuals to type in their real language as used in daily conversations. Moderators should interfere as little as possible so that afterwards a glossary can be compiled per country (and/or language).

In her conclusion, Laura encouraged the medical industry to target physicians by using the physicians' own terminology in marketing communications, using medical terminology to increase engagement and make the most of any marketing effort.

Written by:
Stephanie Ludwig
GfK

Session 5: Tips & Tricks for Qualitative projects with hard to reach populations and sensitive topics

Speaker:	Mathew Francis and Stuart O'Connell, KJT Group
Chair:	Lee Gazey, Hall & Partners

Mathew Francis

Mathew drew on his extensive qualitative patient experience to present some key considerations when researching hard to reach respondents and sensitive topics.

Firstly, to frame the discussion, Mathew defined the terms "hard to reach" and "sensitive topic." "Hard to reach" populations were defined in the literal sense, as those people who are not easy to find, such as minority groups or less prevalent segments of the populations. He also referred to those who do not wish to be found, or the "hidden populations," such as addicts. "Sensitive topics" were defined as anything that people want to keep private, or find difficult to share, such as anything to do with income, sexuality, medical conditions – especially embarrassing ones or those with stigma attached – and compliance to medications. He also made it clear that what is sensitive to one person may not be for another.

Mathew then shared the first of the considerations, "Removing the Artificial," and discussed how the interviewer must strive to turn the interview into a discussion by showing a true interest in the person and their experience. He suggested how one should "melt the ice" with a patient as opposed to "break the ice," and went on to share some real life experiences of doing this during research engagements. One such example was when he invited patients out for dinner the night prior to a focus group about sensitive topics for the purpose of meeting them in a neutral and relaxed environment; this way, it would be that bit easier for the patients to discuss their experiences with someone they had previously "broken bread" with.

The next consideration called for the implementation of a positive transaction model by interviewers, and how building rapport through this model is vital to uncovering the emotions patients are dealing with. This moved nicely into the third consideration, to study the rationale decision making, but understand and focus on the emotional drivers of the patient's decisions.

The fourth consideration dealt with the duty of care being to the patient at all times. Mathew noted how this is a "cornerstone of research," and how it is the responsibility of the researcher to stop an interview when they feel the patient is too emotional to continue, but have sufficient preparations in place to fulfil the research for the client.

The second to last consideration talked of implementing creative and empathetic recruitment methods, and how important building trust is when recruiting hard to reach populations. He also suggested using "true incentives," as opposed to purely monetary ones, and that sharing input given by patients with them at the end of the research can increase response rates significantly.

The final considerations dealt with how the interview should have flexibility, both in terms of how it is designed and implemented. This encompasses type of interview and how multiple approaches should be leveraged; being mindful of question order, as with all good qualitative research, the use of open, unstructured questions is essential; and we were encouraged to consider carefully the necessity of audio or video recording.

He concluded that by using flexibility and creativity, the challenges of hard to reach respondents and sensitive topics can be overcome.

Written by:
Stephanie Ludwig
GfK

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Wednesday 24 June

Session 6: The latest research innovation: Welcome to the world of consumer neuroscience

Speaker:	Dr Cristina de Balanzó, Walnut Unlimited
Chair:	Amr Khalil, Ripple International

Cristina de Balanzó

How much of our brain activity is conscious?

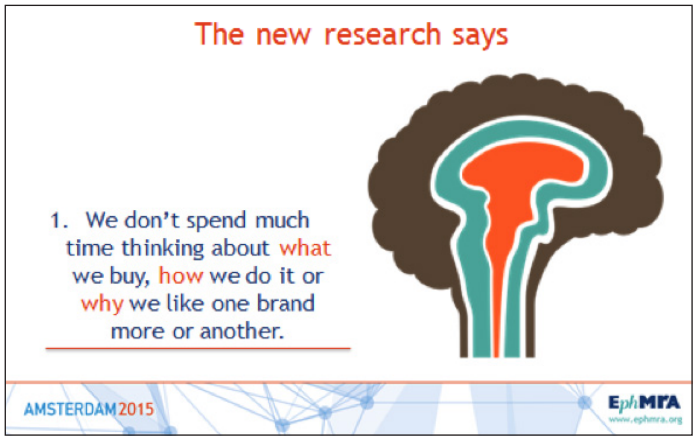
Eminent neuroscientists declare this "a tricky question", but all agree that the "conscious bit" is actually a tiny portion of total brain activity.

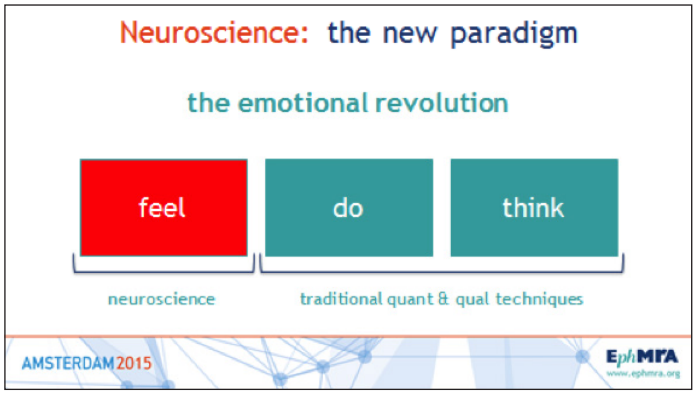
Cristina de Balanzó showcased the topic of consumer neuroscience and how it is being used to explore unconscious emotional reactions to provide a deeper understanding of the effectiveness of brands.

Cristina opened by discussing the way in which we make decisions such as product purchases, combining both conscious and unconscious evaluation processes into our decision-making. It is thought that we spend less time than we might think considering what to buy, how we are going buy it or why we like one brand over another: instead, many decisions are actually made on a unconscious, emotional level – an influence which is much more difficult to measure via traditional market research techniques.

Traditionally, the neuroscientific description of the process followed the paradigm of "think – do – feel". Our traditional market research approaches are effective at asking what consumers "think", and we have very well-developed ways of measuring what consumers "do".

Brand engagement is focused on how to make the consumer "feel" the way we want them to feel about the brand.

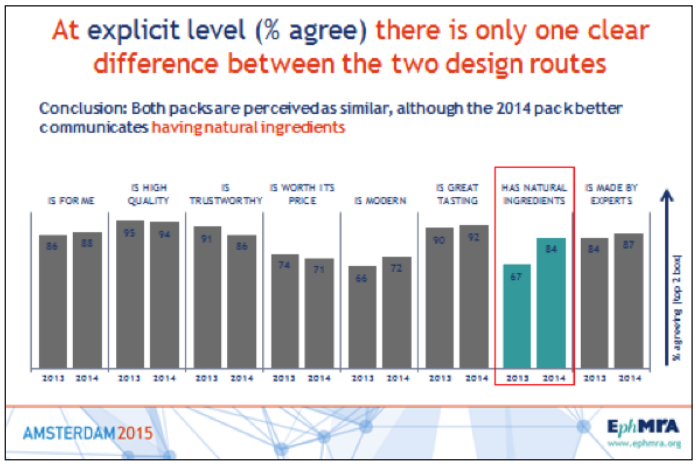




However, Cristina highlighted new research which has changed the way that we look at the decision-making process, reversing the stages in a new paradigm that Cristina terms "the emotional revolution": "feel – do – think". In order to fully understand brand engagement, traditional qual and quant market research techniques can address the "do" and "think", but, suggests Christina, to fully understand the "feel" we need neuroscience.

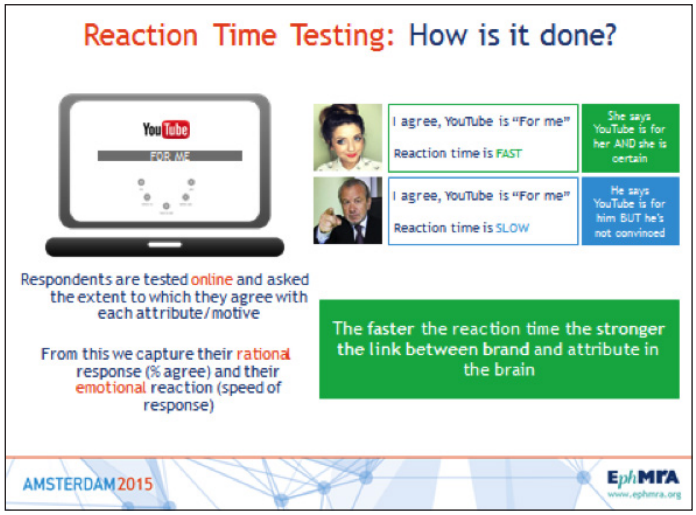
Neuroscience adds a second layer of insight to current research tools, complementing what we do already, but also giving us access to unconscious, emotional processes that have previously remained hidden from research. These neuroscience techniques help us to understand why some creative concepts are more or less successful than others by exploring emotional insights. Using neuroscientific metrics will give us greater accuracy and reliability when integrated with current research tools.

Cristina outlined several neuroscientific metrics which can be used to add value to our current tool kit. These included reaction time testing, which works on the basis that "what fires together, wires together" (Hebb 1949). This means that, in real life, reaction times are based on experiences stored in the brain throughout our lifetimes. These emotional reactions are not within our conscious control. Because respondents are not aware about their response latency, they do not control it, Our approach assesses the strength and accessibility of the declared attitude – the certainty of the answer.



Decisions can be made more quickly and efficiently based on these memories and emotional associations, rather than by rational assessment of every new situation from scratch. Brands become shortcuts in decision-making, based on the emotional associations and expectations of the brand and reflecting our previous experiences. The faster the reaction time – the stronger the associations and the emotional link, Cristina presented several case studies that showed the additional insights offered of this approach which was taking into consideration two aspects of people's responses: (a) what is expressed verbally – declarative opinion provided on a scale – which is Explicit measure and (b) the response latency – the time that body needs to produce the reaction (pressing the button on the scale) – which is Implicit. The case studies combined explicit questioning (eliciting verbal responses via traditional market research) with implicit non-verbal metrics (such as reaction times).

For example, Cristina presented highlights from a study amongst medical representatives which looked at the reps' own views of the products they were selling. Looking at both rational ratings of the product on specific parameters (e.g. efficacy), and the speed of response in answering the ratings questions, areas where the reps remained unconvinced were revealed.



Cristina was able to highlight specific areas where extra training was needed. The client could then focus on specific areas to reinforce messages on product effectiveness. These "weaker" areas had not come to light from the results of traditional rating questions alone.

A second case study examining doctors' views of a pharmaceutical company used a similar approach and revealed that the client's sales team should focus on specific messaging themes in order to strengthen the customer engagement with their brand. While in traditional rating scales, doctors were very polite and over 90% positive, the implicit techniques revealed unconscious doubts, which had possibly been suggested by competitors.

Cristina also showed other neuro techniques to the measurement of attention and emotion combined include:

- attention (eye tracking to identify which parts of the stimulus is being noticed);
- relevance (using EEG to determine the emotional valence via brain activity how positive (approach), negative (withdrawal) or neutral the stimulus is for the respondents, and;
- activation (using Galvanic Skin Response or GSR to explore the levels of short-term excitement which predicts whether consumers are energised and driven to action by a given stimulus).

Cristina concluded her paper with a clip from the James Bond film 'Çasino Royale', demonstrating the significant differences in male and female reactions to a high engagement scene.

Cristina summarised by concluding that the addition of neuroscience to traditional market research approaches can help us to tap in to unconscious emotional processes in order to strengthen brand engagement, understand better human complexity and better predict behaviour.

Wednesday 24 June

Session 7: Taking the blinkers off tracking studies

Speakers:	John Janes, Astellas and Gary Johnson, Inpharmation
Chair:	Martin Schlaeppi, Praxis Research


John Janes

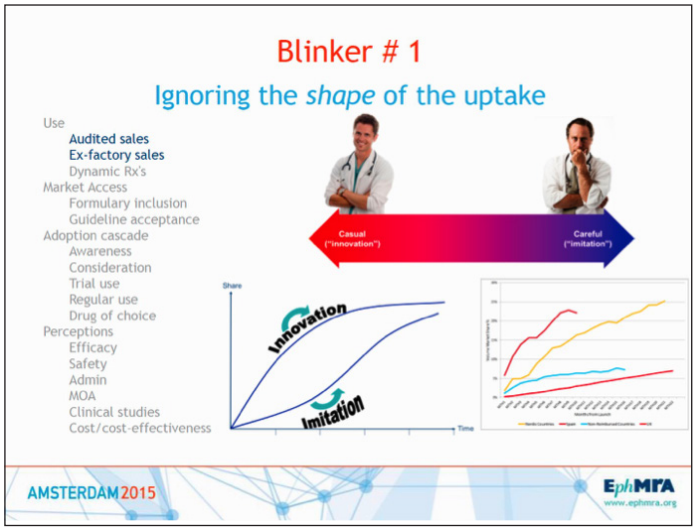

Gary Johnson


Martin Schlaeppi

John Janes and Gary Johnson provided an insightful and practical guide to improving the value obtained from tracking studies by applying some additional thought and understanding to the metrics selected. Whilst almost everyone uses a fairly standard approach to tracking awareness and usage, market access, perceptions and so on, the speakers highlighted the key components that deliver the greatest insight and provide the best predictors of eventual market share. Importantly Gary and John identified a range of issues that can blinker users of tracking data such that the data are less than optimally informative and therefore of less use to brand and senior management.

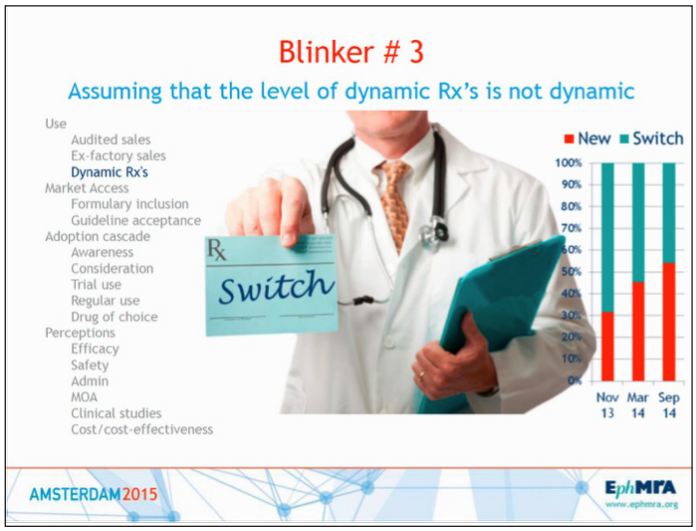
Using, as a case study, the 2013 launch of a novel, first-in-class therapy for the treatment of over active bladder into a market where Astellas already had the leading brand, John highlighted the importance of closely tracking the market dynamics looking for early evidence of impact for the positioning or communication for either brand. Where speed is of the essence, the speakers identified key tips and pitfalls which can differentiate an ordinary tracking study from a fast, effective and illuminating tool.

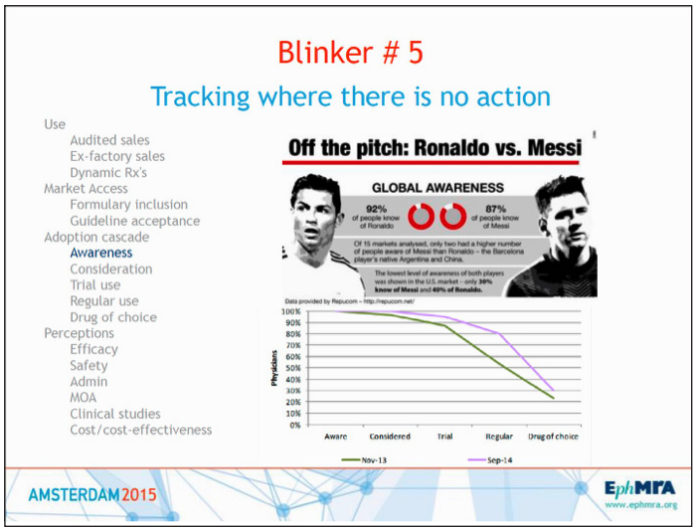
John outlined the "textbook" expectations for the new product's uptake and growth: they expected most physicians to adopt a cautious prescribing approach to the new therapy class whilst waiting for the more adventurous prescribers to use a novel, first-in-class therapy for the treatment of over active bladder first. Gary described how the shape of the curve is an important guide to the prescribing approach being adopted by users and gives more information than simple absolute levels of prescriptions. He showed us an "r" shaped rapid uptake innovation curve which was at odds with the "wait and see" approach that John was expecting.



This result whetted the appetites of senior executives who became increasingly hungry for further insights and metrics. Audits gave good share data, but feedback was required more quickly than the audits could deliver, so the team looked to ex-factory sales. Gary emphasised the importance of adjusting for stocking and parallel trade effects which could smooth out some of the imperfections of this measure whilst providing fast feedback.

Gary implored us to consider the aspects of product use that are good predictors of longer term performance and focused on the value of dynamic prescriptions (switch andd new) as an example. The dynamic segments of the market act as leading indicators and Gary explained that new prescriptions tend to rise and peak more rapidly than repeat prescriptions and provide a good predictor of eventual share, therefore providing greater value than measuring overall prescription rates. However, care must be taken when using these dynamic metrics since they are themselves dynamic.





Switch prescription rates have a tendency to spike rapidly before dropping back to a more stable level; an incautious researcher might use the spike figure in a forecast and significantly overestimate the sales potential.

John looked at Market Access issues - considered by some, not least the Market Access teams, to be the most important factor is a brand's lifecycle. He shared the finding that many doctors claim not to work to formularies in this condition and that forecasts can be derailed by the assumption that just because a product is on the formulary, it will be prescribed. (Gary characterised this with the analogy of agencies on a preferred supplier list - being on the list is no guarantee of business, and similarly, NOT being on the list doesn't necessarily preclude you from working with a particular agency.) In the case of the therapy for the treatment of over active bladder, although it had a weak position on the formulary, overall performance was strong enough to overcome this and result in stronger than predicted sales.

Moving on to discuss the traditional adoption cascade in more detail, we were reminded that the purpose of tracking studies is to look at metrics that are changing. As different metrics have dynamic phases at different times, it is important to review our focus as launch progresses and ensure that we pay attention to the right metric at the right time. Gary and John explained how, for example, awareness is usually easy to 'buy' via marketing and promotion campaigns and so tends to rise very quickly before the hitting a ceiling (you cannot go higher than 100%) and is therefore only of interest in the very early launch stages. Measures such as trial and regular usage are more useful when tracked over longer periods of time.

An example of the meaningless results that can be garnered from tracking metrics was shown using awareness of the footballers Cristiano Ronaldo and Lionel Messi.

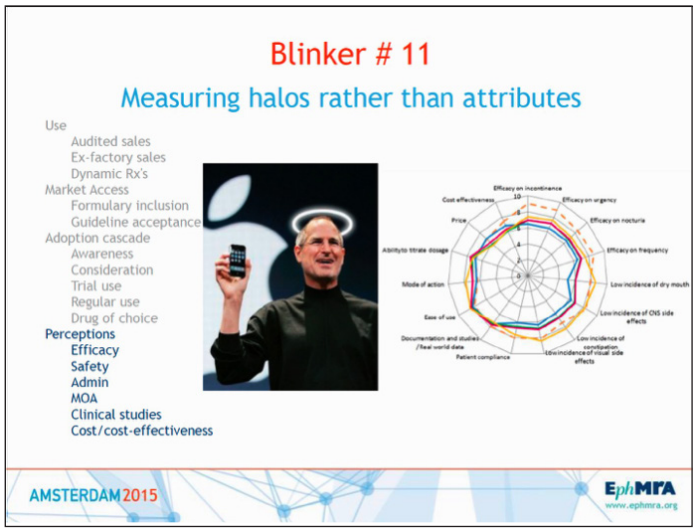
We were encouraged to think carefully about how we ask the questions in tracking studies, as additional richness can be obtained from simply amending our question phrasing. For example, tracking whether a physician has considered prescribing Product X can be much more illuminating if we also track the vector, the direction of the resulting attitude - not only have they considered it but what have they thought about it, have they considered it positively or negatively? This variation on a standard question provides a good early steer as to how consideration might translate into slower to develop measures such as trial usage, which increases more slowly.

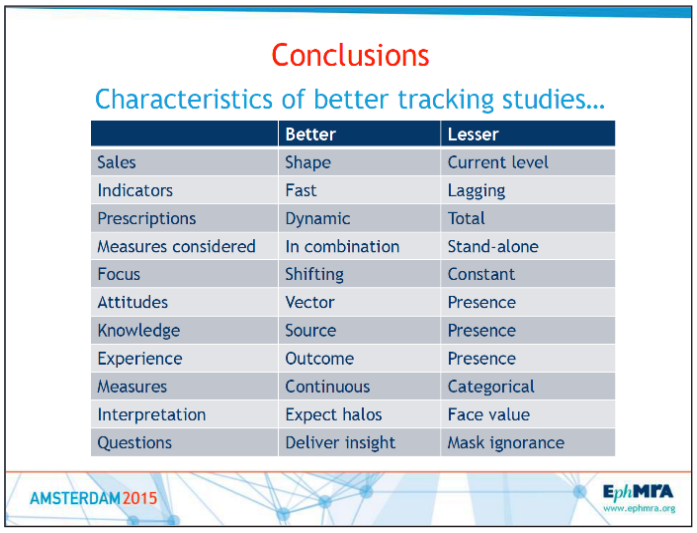
In a multi-channel world, our speakers reminded us that it is valuable to track the source of information that is causing a shift in behaviours - and that this can tell us more than simply which channel is proving effective. For example, behaviour change driven by peer contact rather than rep contact may suggest that physicians consider the product to have a measure of risk attached to its use. The study showed a high degree of overlap (or contagion as John put it) between those using this novel, first-in-class therapy for the treatment of over active bladder as a result of peer contact and those who had seen a rep. Despite this, there was a significant rep effect seen on prescribing behaviour.

We were encouraged to expand the scope of our tracking metrics for example by looking at one of the pivotal measures of brand uptake - trial usage. At this point in the cascade, results become more about the product than about the marketing and, by adding a question on the outcome of product trial, one gains insight into one of the most important elements of a tracking study.

The speakers encouraged us to use continuous measures rather than binary or crude categorical responses in order to obtain greater richness from our tracking studies. For example, asking how much they use Product X is much more informative than asking if they are a regular user ("Yes" or "No") and avoids an area of subjectivity - does the doctor's interpretation of "regular" mean the same as the researcher's? Similarly, we were also warned against making assumptions - such as that doctors have a single drug of choice when, in fact, just like eaters of chocolate bars do, they usually have a repertoire of products that are used.

John went on to explain the halo effects that must be considered using example of iPhone users who claim that their brand is better than Android competitors on every single attribute despite the fact that independent reviewers would typically highlight only one or two clear advantages. The novel, first-in-class therapy for the treatment of over active bladder scored well on efficacy and HCPs went on to rate it as more efficacious despite the fact that clinical trial data showed it to be equivalent on that measure.





	Better	Lesser
Sales	Shape	Current level
Indicators	Fast	Lagging
Prescriptions	Dynamic	Total
Measures considered	In combination	Stand-alone
Focus	Shifting	Constant
Attitudes	Vector	Presence
Knowledge	Source	Presence
Experience	Outcome	Presence
Measures	Continuous	Categorical
Interpretation	Expect halos	Face value
Questions	Deliver insight	Mask ignorance

Gary went on to highlight a common misconception whereby predictable relationships between metrics such as loyalty and product use are sometimes misinterpreted as new insights rather than an inevitable function of the laws of brand performance.

Our speakers concluded by summarising a number of simple but effective ways to improve the value of tracking studies, increasing effectiveness by asking more intelligent questions and focusing on the right metrics at the right time.

By employing these tips and tricks of the trade, we can take the blinkers off textbook tracking studies, deliver real insight and run studies that are as dynamic and flexible as the products and markets they are measuring.

Written by:
Martin Schlaeppi
Praxis Research

Japan Chapter Meeting – 15 October 2015

The 2nd Japan chapter meeting will take place in Tokyo on 15 October 2015 and is being steered by EphMRA in conjunction with a highly esteemed Programme Committee:

Ken Shearer
MSD K.K.

Kazumi Fujikawa
Takeda

Akira Miyamoto
Nippon Boehringer Ingelheim

Kimi Shigekuni
Janssen Pharmaceuticals K.K.

Yoshiya Nishi
Anterio

Hitoshi Dennoh
SSRI

Registration now open.

France Chapter Meeting – 17 November 2015

To add to the EphMRA portfolio of local chapter meetings, we will be holding the first meeting in Paris, France, in the latter part of 2015. The programme is being worked on by EphMRA and local convening committee and the details will be announced very soon.

The convenors for the meeting are:

Natasha Brachet
AplusA Research

Nicki Germain
GIM France

Perrine Bes
Ipsen Pharma

Wednesday 24 June

Session 8: "Talk-To-Me" How to collaborate with patients and improve communication strategies within a company

Speakers:	Carl Vandeloo, UCB and Magali Geens, InSites Consulting
Chair:	David Hanlon, Kantar Health


Carl Vandeloo


Magali Geens


David Hanlon

Carl and Magali delivered an extremely interesting paper on how to better engage internal stakeholders in research. In an environment where market research increasingly has to justify its value, they showed ways of helping to raise the profile of research internally, so that it does not sit gathering dust on the shelf.

Patient research has become paramount in the last 5 years and Pharma companies are increasingly listening to the voice of the patient. However, getting internal stakeholders, who have very busy schedules, to stop and listen to what patients have to say can be challenging.

At UCB they have listened to many patient stories and have learned much, particularly that it is not easy for patients to express what they have to endure.

UCB puts patients right at the centre of their thinking and acting

UCB have recognised how isolated patients can become if others fail to understand them. Through fully understanding, appreciating and communicating patient stories it has helped to change the hearts, minds and actions within UCB.

The company have developed an approach that puts patients right at the centre of their thinking and acting. This strategy is based on the Berry-AMA award winning book **STRATEGY from the OUTSIDE-IN**; which is very much in favour at UCB and in summary covers the following:

- **An Inside-Out approach** is guided by the belief that the inner strengths and capabilities of the organisation will make the organisation prevail
- **An Outside-In approach** instead is guided by the belief that customer value creation, customer orientation & customer experiences are the keys to success.

An **Outside-In strategy** is not only about analysis, positioning, clever planning and effective implementation, but also about the experiences, **convictions and beliefs of all the people involved**.

From an outside-in perspective, there's basically 2 simple yet important factors:

1. Do you know who your **targeted customer segments** are, what **needs and behaviours** they have, how to best solve their relevant problems and what kind of value to provide them?
2. Is there a **strong fit** between your target segments' needs, your value proposition, internal processes and a **customer-oriented organisational culture**, with **focus on creating value**?

At present the "OUTSIDE-IN" approach is very much in favour at UCB

UCB are very serious about their commitment to putting the patient at the heart of their organisation. The company truly believes this involves close engagement with patients whose lives can be changed for the better if companies better understand their context, their day-to-day struggles and their unmet needs. It's about giving patients a face, a voice and having them step-up and engage with all company employees. Listening to patients and the insights this provides can be incorporated into strategy, helping UCB bring added value to their lives.

Also it is important to establish a way of working that allows each and every company co-worker to be touched by patient's stories. However, this needs to be made practical as of course there are potential obstacles for such strategic ambition and there needs to be processes in place to help obtain the necessary buy-in to make it work.

One of the key elements that contributed to the success on OUTSIDE IN was the implementation of an educational framework.

As researchers we all recognise the following scenario; the meetings in which we present research findings to internal stakeholders who say **'thanks, this indeed confirms what we know.'** This may often be the reality, but sometimes great insights are often **"so true and simple"** that at first sight that people have the feeling they've already known this **even if that was not the case.**

To ensure a maximal return on research investments, it is necessary to involve internal stakeholders as early in the process as possible. They also need to be challenged to voice the knowns and make their knowledge gaps more explicit. Ideally, this can be done in discovery workshops, but quality time is scarce, travel budgets are tight, and so we have to compromise with conference calls. Insight teams, therefore, have to more creative in finding ways of better involving internal stakeholders. We need to create forums to share the present beliefs and formulate hypotheses, make explicit what is known and what is not. This enables us to be more successful in bringing added value from an OUTSIDE IN approach.

Briefly in the examples shown by Carl and Magali, their R&D project covered a range of areas and explored potential opportunities. The research design involved a Patient Consulting Board comprising a Patient Online Research Community. From the subsequent SWOT analysis the opportunities were situated around the level of communication.

For example it was found that a relatively straightforward symptom - "fatigue" - is hard to explain in relation to its true impact on quality of life. Often such an important insight is only touched on briefly in the findings, but in fact needs much greater discussion.

When there is such a clear conclusion, the objective is to be able to touch ALL employees with the research findings, and thus needs a strategy to help engagement.

Being research professionals, Carl and Magali quite rightly point out that we are not always aware of how much 'jargon' we actually use or how routine practices (like recruitment methods) may not be so evident for our colleagues.

For example, in a brand tracker meeting it became clear that the internal customers assumed that sales representatives would ask the questions to doctors. This shows we can't take colleagues' level of understanding for granted and need to educate them in research methods so everyone is aligned. Moreover, we have to guide them in kick-off meetings to think about who the research participants should be and why, and what type of deliverables they envisage (beyond the death by PowerPoint deck).

One communication aid (or educational framework) InSites Consulting crafted, in collaboration with UCB, was the card decks and stimulus material shown below. They serve different purposes along the research journey, but help engage the audience. When facing internal clients - especially non-research savvy co-workers - it enabled UCB researchers to discuss evident things (like recruitment) in a very pragmatic way.

The second most important thing to **"Share the findings"**. Carl and Magali recognised this and implemented a programme of internal PR to raise the profile of the study and make sure the key findings were on show and available to all. This is where cleverly designed attractive communication materials in the form of newsletters / magazines posters, insight cards and info-graphics to raise awareness and make the research stick.

In todays changing environment it is essential that we as researchers should be proactive in raising the profile of research and take responsibilty for communicating the insights to all, rather than let them gather dust on a shelf or slip to the bottom of a folder on a hard drive.

The moral of the story is to use techniques such as OUTSIDE-IN to increase attractiveness of, and engagement in, market research, ultimately helping buy-in to the insights. We also need to take a leaf from the advertising agencies book and actively promote the research so the key messages stick and get implemented into strategy.

Written by:
David Hanlon
Kantar Health

Wednesday 24 June

Plenary: Soap Box Session:

When physicians get emotional: using mobile devices to capture the truth behind prescribing decisions

Speaker:	Nicole Drake, SKIM Europe
Chair:	Sarah Phillips, Prescient Healthcare Group

Sarah Phillips

Nicole Drake

Nicole spoke first about Daniel Kahneman's book Thinking, Fast and Slow, with its explanations of **System 1** (emotional and intuitive), and **System 2** thinking (more complex).

She used chess player Gary Kasparov to illustrate the concept:

"Picture him at his chess board, making his move. He makes it instinctively", she said. "Whereas as a chess player I would sit there and try to analyse. I would then not very confidently make my move, after putting a lot of thought into that. "

This concept could, Nicole said, apply to the prescribing decision.

System 1 applies to the confident, experienced physicians in market research surveys. They see a patient, they hear a few symptoms, and they intuitively know what product they need to prescribe.

System 2 is the resident, the medical student trying to figure out what product he's going to write, based on guidelines, the symptoms and the indications of the product.

In a market research context, Nicole explained, there can be significant delays between the physician seeing the patient and him talking a market researcher through his prescribing decisions.

Today, however, we have new tools. We have mobile devices. This means that as soon as the physician has seen a patient, he can open a mobile app, type in the patient's details, and record a note explaining why he prescribed that particular medication.

This new system can be used to address a number of business problems, Nicole said. It is particularly effective where two brands are perceived as very similar.

Market research tells the client that that their product has the same efficacy as the competitor's, but for some reason, it isn't doing as well. The client wants to understand the underlying drivers so that there can create messages around what physicians feel are their product's strength.

Nicole said: "This is indeed a great project for mobile market research because you are capturing it directly after the prescribing decision. That's why this method can get us to a deeper understanding."

She admits that the mobile app technique does have its limitations, for example, where brands are perceived as similar, but market researchers want to determine what role cost plays, and to identify certain patient types where cost plays a role. In cases like this, mobile market research would not work.

"Here we want to understand the deeper why. Why is cost an option for these patients? In mobile market research we have one open end that we ask them, a big open end, but we can't dig deeper, so this is not a good option", she concluded.

Ten ways to build a powerful brand

Carolyn Chamberlain

Speaker: Carolyn Chamberlain, Millward Brown Healthcare Qualitative

"Investment in your brand, what makes a meaningful difference, is critical, not just for success but for survival", Carolyn began. She then talked delegates through ten powerful ways to build a healthcare brand:

Innovate and delight: Innovation is highly prized and in some cases a condition of market entry. To delight our customers, we need to pick the right innovations, focusing on parameters that are important, Carolyn said. This may mean not only specific clinical outcomes, but also other tangible benefits, such as improved compliance.

Be meaningfully different: In healthcare there is no room for 'me too' products. Yes, they may meet the regulatory hurdles of efficacy and safety, but in order to become successful brands, they need to be able to be prescribed.

Believe your own positioning and reinforce it: Carolyn explained that healthcare brands must stand for a purpose, something that has a positive impact on customers' lives. This may mean not only delivering a clinical benefit, but also a measureable effect on quality of life, for example.

Walk the talk: Ensure consistency in getting behind the brand purpose. This is essential for credibility and encompasses all employees.

Build and maintain trust: Consistency in communication and execution is key, whether over the lifetime of a therapy area franchise or that of a single brand. Being honest is paramount, as is dealing promptly and appropriately with problems. Demonstrating care and concern for customers will help trust to accrue over time.

Focus on the brand experience:
It's important to renew and improve the brand experience. At every customer touch point there is an opportunity to reinforce brand values, from initial product information through to patient support. The brand experience builds loyalty over time, differentiates a company from its competitors, and delights customers.

Customer insights: Those healthcare brands who connect with customers on multiple levels, from basic needs to emotional actualisation, can truly understand them, and ensure that their product offering is aligned with their rational and emotional requirements and desires, Carolyn said.

Think holistically: Integration, organically and in terms of communication, can reinforce the brand. This is especially important today, with customers exposed to so many multi-channel product communications. In healthcare terms, holistic thinking can – and should – go beyond the product itself, to deliver a holistic product package of services and product support and contributions to online physician and patient communities.

Get noticed: Customers no longer rely on the sales rep – Google is the go-to reference in many doctors' offices. In this joined-up world, we need to communicate our brand values by multiple channels of communications, to reinforce our message.

Keep changing: Keep changing but not for change's sake. Customer brand loyalty can be enhanced by new product iterations to keep things fresh, but only if the changes offer something new. Branding is a process with no end. It moves as fast as customers change, in the best cases, even faster.

"My last comment on this, is that the healthcare industry should always be chasing the future", Carolyn said.

Incentive caps: fair market value?

Speakers: James Cain and Paul Morgan, M3 Global Research

James Cain

Paul Morgan

Paul described this session as a short presentation on incentive caps and fair market value when it comes to physician participation in market research studies.

He said that M3 Global Research had noticed, from surveys and speaking with clients and competitors, that physician incentive levels can have an impact on market research participation. In some cases, he added, they can actually affect data quality.

The company surveyed 504 European physicians, to ask their opinion on how honorarium levels affect their engagement with market research.

The physicians were split across five countries: France, Germany, Italy, the United Kingdom, and Spain. The sample was evenly distributed across three tiers.

Tier 1 was made up of GPs and experts in internal medicine, Tier 2 consisted of specialists, and Tier 3 was composed of oncologists and sub-specialists. This was a quick five-minute survey, and no incentive was offered for participation, James explained.

He asked 'What is a fair market value for a physician's time?'

M3's experience has been that there are different levels, depending on the client sponsor.

James said: "The question we wanted to ask was 'What do physicians think they should get paid per minute to participate in our studies?' "

There was significant fluctuation between the different markets, they found, but overall, across the board, EU physicians do expect to earn more for market research engagements than they would for consultations in their practice.

Over three quarters of the physicians interviewed confirmed that they had declined participation in market research surveys because the incentive offered was too low.

James said: "I think when we're dealing with limited universe sizes here in Europe, it can be detrimental to a study to have lower participation rates, especially when the qualification criteria is strict or there's a very ambitious sample size."

He added that survey abandon rates are also a concern, with many market researchers having experienced a physician dropping out of a survey on finding the interview much longer than originally advertised. The market researchers, however, had to persevere with the survey at the incentive rate initially agreed.

"Of the 500 physicians we interviewed here, seven out of 10 confirmed that they have in the past abandoned a survey because the interview length advertised was not accurate", he confirmed.

Data quality can also be an issue. M3 found that 'just under half the physicians' interviewed admitted that the compensation levels of surveys had affected the quality of their engagement and the answers they provided for service.

The remote working revolution: why it's a good thing

Tracy Machado

Speakers: Tracy Machado, Phoenix Healthcare

Tracy began by pointing out remote working is on the rise. Around half of UK and US office workers, she said, are able to work remotely. Advances in technology have made it much easier to work remotely, whether from home or on the road.

"There's the ability to save money on overheads, there's the ability to recruit talent from a wider pool, and of course it's kinder to the environment as well", she stressed.

Yet there are concerns and myths surrounding remote working that still exist.

"Let's dispel some of these myths", Tracy said.

A common one is that remote working is isolating and that remote workers are less engaged. Remote working is seen as an opportunity to work less. There's also the myth that remote workers are more easily distracted by chores around the home, and workers who are more widely spread out don't feel part of a team, much less part of an organisation.

With the technology available to us today, work is much more accessible than it ever has been. Tracy mentioned webcams, email, intranets, instant messaging even the humble telephone.

"With these avenues, it is still possible to communicate with your colleagues, connect with them, get to know them, and feel a part of an organisation and part of a team, but everyone has to put the effort in to communicate", she explained.

"Do remote workers really spend their day working less, skiving? No. We don't", she said.

Work-life balance tends to be better when working remotely, she said.

"If we think about Jack Lewis's session this morning, about having that freedom, using time more efficiently, it protects the brain. Take that 10 minute nap. It's easier to pop out for that walk and come back with creative ideas. So it enhances creativity as well", she pointed out.

"When you love what you do, when you feel appreciated and trusted (your company allowing you to work remotely gives that message of trust - they are trusting you to be able to do your job), that instils satisfaction, leaving you more motivated to get your work done. And at the end of the day, we still have deadlines to meet for our clients".

Tracy the addressed potential distractions for remote working, stressing that one of the key advantages of remote working is the lack of commute. There's less noise when working from home, and there are fewer unnecessary meetings.

And the proof is in whether people do it successfully.

"At Phoenix, colleagues have been doing it successfully for 10 or more years. We communicate really well as a team. We have regular TCs, we have regular newsletters, and an intranet. We instant message on a regular basis, and we get together in person as well when the need arises, just to keep that communication", she said.

Tracy concluded with a quote: 'Work is what you do, not a place you go'.

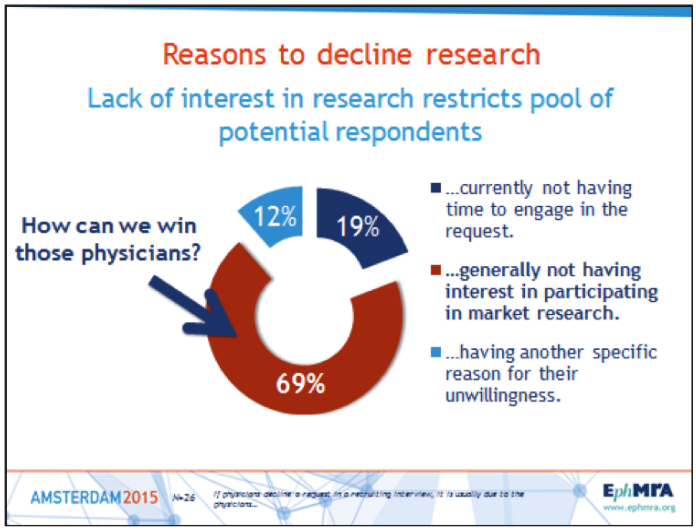
Session 9: Hey, I've seen this guy before" – are we diverse enough in pharmaceutical market research?


Christoph Petersen


Cathrine Schoss


Stephanie Ludwig

Speakers:	Christoph Petersen and Cathrine Schoss, Roche Pharma AG
Chair:	Stephanie Ludwig, GfK



Christoph and Cathrine addressed an issue that many of us are likely to have wrestled with at some point – are we seeing a diverse range of respondents in qualitative research?

Christoph opened by setting out the premise of qualitative research: to gain a deeper understanding of barriers and motivations of our customers, hearing them explain why they do what they do and, if possible, obtain a view of the reality behind their rational façade and textbook responses. Samples are small – not big enough to make generalisations, but from a few people we obtain a snapshot representation of the wider market.

But, he asks, if it is really true that qualitative research always or almost always speaks to the same people, is this methodological approach then still valid?

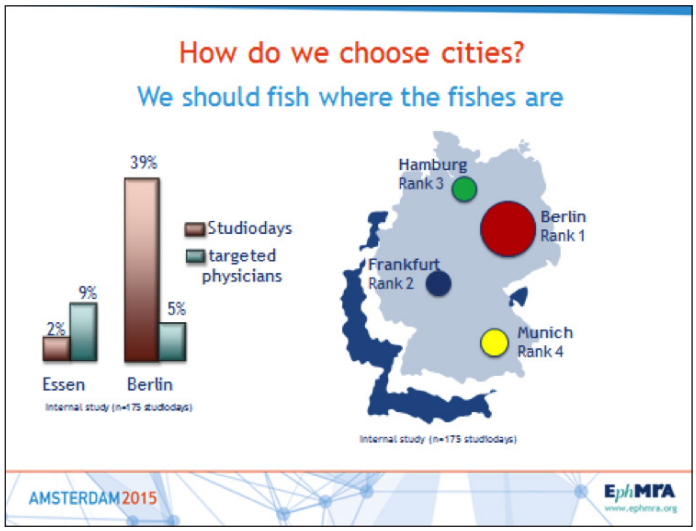
Christoph observed that, in his daily work environment, qualitative research in Germany, he has in fact often seen the same faces. Christoph ran a quick audience poll to make sure that his and Cathrine`s experiences were represented also in the EphMRA audience and some of the delegates had experienced the same thing. Prior to the conference Roche had taken this question to various market research agencies and found that also most of them agreed. This was indicator enough that a closer look at the facts and figures around this could provide some further insight.

Based on the rule of thumb often taught in market research, the 1:10 rule, Christoph worked on the basis that for every 10 physicians contacted, only one would agree to take part in a qualitative market research session - interview or group setting. Applying this rule to the universe size of German oncologists and rheumatologists and then applying common recruitment filters, the potential sample of respondents soon dropped from a promising 4,500 to a handful of individuals who were based in a specific city and who worked for different institutions. This quickly confirmed his observations that we always end up seeing the same physicians. Roche decided to again look into this issue further.

Why do physicians decline market research invitations Roche asked some of the agencies they work with? The agencies reported that although some respondents were too busy or unavailable at the time of the research, the largest group of "refusers" were those who were not interested in market research.

So, Christoph wondered, how can we encourage a more diverse group of physicians into research? What could we do differently to not accept that as a given fact?

The agencies were able to identify the main hurdles of incentives and bureaucratic hurdles - over which we as an industry have little control. However, another identified issue, the often inconvenient timing, could be addressed



quite easily: Christoph noted that we tend to schedule research for the convenience of the research or client, rather than the convenience of the physician. In Germany, Wednesday or Friday afternoons are likely to be most convenient (when clinics are closed or physicians are running their own practices) rather than Mondays or Tuesdays between 10 am and 6 pm.

Christoph went on by exploring options for making research in general more interesting for respondents. He suggested that, rather than recruit respondents according to prescribing patterns, we could add recruitment criteria that would help us to achieve the best results. This could include selecting respondent according to their preferences - for example, recruiting creative respondents to review new creative materials, or recruiting respondents with an interest in digital media to research our digital communications. If reviewing scientific data, why not recruit respondents with an academic interest who would find the task stimulating?

Cathrine continued to think aloud about the topic of market research interest per se. She then asked the sobering, but highly relevant question of whether we would always attend our own research as a participant. She observed that we are still a quite conservative industry that for the majority of time still does what always had been done - in companies that are primarily used to traditional approaches and not necessarily open to change easily.

Cathrine discussed the issue of location, and suggested that we should "fish where the fishes are". The agencies report that large cities are chosen because of claimed physician coverage (which was proved not to be true), customer request (including requests to attractive shopping and lifestyle environments) and obviously infrastructure (easy to get to from the airport and station etc.), but other options could and should be explored.

Those could be smaller cities, but also quite engaging environments different from the usual, such as theatres or cinemas.

The market research agencies generated a wide range of ways to make research participation more attractive to respondents. There was no single solution, but a number of "quick wins" including better timeslots (convenient for physicians not clients), better moderation and questionnaire design (stimulating topics and also questions, the application of newer approaches and methodologies such as gamification instead of asking for pure prescription intentions). Another way of reaching and engaging more physicians and respondents in general, could be the idea of providing more information about the research so that respondents can decide whether to attend and define their interest realistically upfront. Respondents might also be attracted by the offer to receive some of the study results in the end.

Christoph concluded that seeing the "same old faces" does not have to be the case if we are prepared to be more flexible about where we go and how we do research.

He provided the following recommendations for all of us being involved in qualitative research from any side:

- **Pharma companies:**
  - focus on your customer and their convenience rather than our own interests
  - be more courageous about where you do research and the timelines that are requested
- **Market research agencies:**
  - be more creative and courageous in terms of methodologies and research settings
  - make sure that the participation in your research projects as respondent is a positive experience – by using creative techniques and ideas.
- **Fieldwork agencies:**
  - resist the urge to try to make any clients' crazy wishes and timelines possible
  - help us achieve our research objectives rather than just qualify respondents according to the screening criteria
  - think creatively about how to provide a decent range of physicians in market research

If we are all flexible and embrace change, we can achieve the real and primary goals of qualitative research – and then we will also start seeing "fresh faces" taking part in market research.

Written by:
Stephanie Ludwig
GfK

Thursday 25 June

Session 10: Beyond the social media hype: new, now and next for physicians and pharma

Speaker:	Emma D'Arcy, SERMO
Chair:	Amr Khalil, Ripple International

Emma D'Arcy

Amr Khalil

Emma D'Arcy's presentation focused on social media, examining what is (or isn't!) new, what is happening now and what needs to happen next for physicians and the pharmaceutical industry. She cut through the hype and busted some common myths to show the dynamic nature of social media and what our industry needs to do to keep up in this fast-evolving sphere.

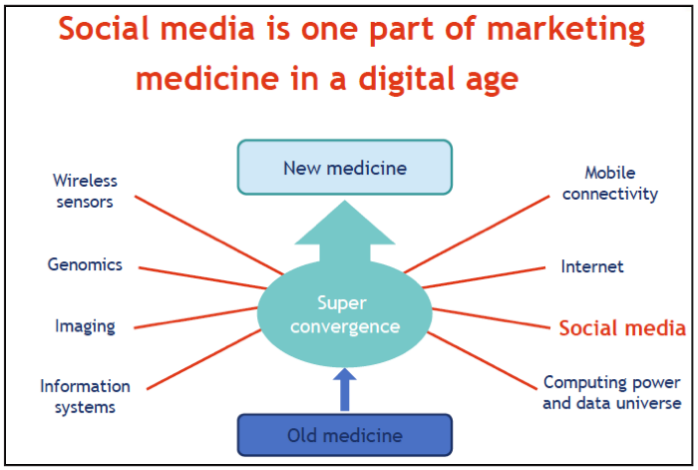
Emma opened by outlining some of the criticisms levelled at social media, such as the lack of scientific validity and the perception that it is "soft support" that cannot effectively demonstrate ROI. It is claimed that social media is not a relevant component to the practice of medicine. However, Emma reminded us that that there has always been a shared or social element to health, whether discussing ailments and seeking peer support from a neighbour over the garden fence, or physicians gathering together for key events such as observing the first dissections, but that the social arena is now increasingly moving online.

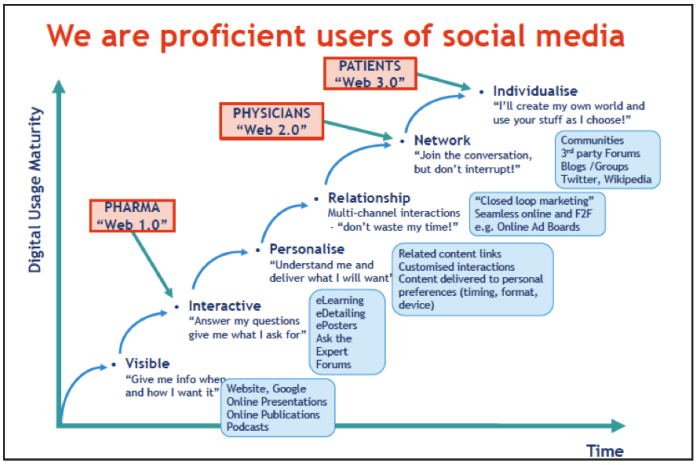
Emma highlighted the power of social media in raising awareness and bringing about behavioural change, sharing examples from the past and present, such as Van Gough who openly talked about his mood disorder in a similar way to Kim Kardashian tweeting about her psoriasis. In Kim's case, this led to a measurable increase in people seeking help, support and diagnosis for psoriasis. Peer HCP networks, such as SERMO, 23andMe and Health Unlocked are now the preferred go-to places for doctors to enhance their learning, get insights on difficult cases and share the challenges of practicing medicine in a social age.

So, she suggests, the "social" element in medicine is not new, but the "media" has changed as a result of a super-convergence of digital technologies.

Emma then talked us through the maturation of digital usage from initial visibility of websites, through interaction, personalisation, relationship-building and networking to individualisation of digital media.

She emphasises that each stage of maturity is equally important – it is as vital that a pharma company website provides accurate and balanced information as it is for pharma to individualise (for example by joining a blog or twitter feed around a condition).



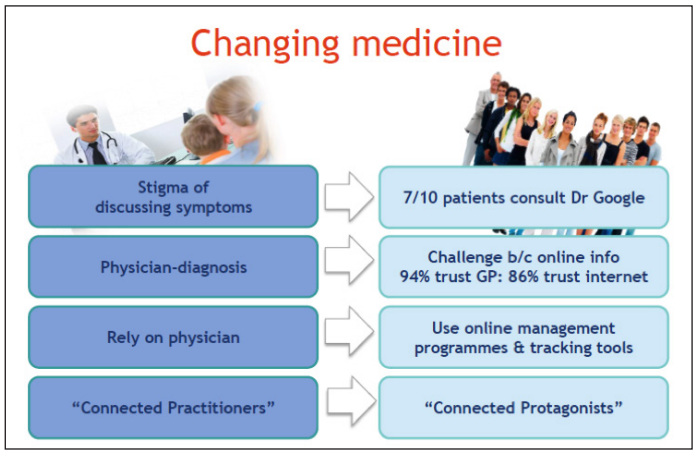


She observes that patients, physicians and the pharmaceutical industry all occupy a position along the spectrum of digital usage, with the patients at the forefront, embracing new innovations and driving the cascade: physicians follow their lead, prompted by the increasingly well-informed patient presenting with information they have gained from social media.

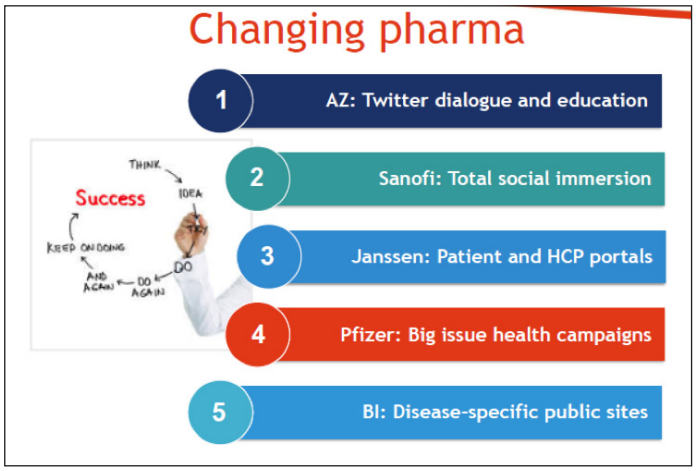
In turn, the physicians turn to the pharma industry for support and the industry moves through digital maturity as quickly as regulations will allow.

Emma then addressed the criticism that social media is a "soft science", referring to Forrester's POEM model which examines the relative characteristics and benefits of Paid, Owned and Earned media and the "know me, like me, follow me" principle of social media success.

When it comes to demonstrating ROI, Emma challenges us to change the currency used to calculate ROI from the traditional marketing parameters to the currency of social media – likes, followers, shares, comments and actions. Some companies (such as Philips Healthcare on their LinkedIn profile) are already using social media metrics to demonstrate ROI as they recognise that the people we formerly knew as patients are now "consumers of healthcare", using social media to research their condition with "Dr Google" before presenting to their physical doctor, reading reviews of drugs and hospitals, and sharing their own health experiences to contribute to "real world" data which is becoming a condition of reimbursement.



The world is changing, said Emma. Social media is not only helping us to talk about health, but we are changing health. The "Angelina effect" led to a quadrupling of genomic testing in breast and ovarian cancers. The ALS ice bucket challenge led the social media communities to donate $200 million in 2 weeks. Brittany Maynard blogged about the right to make life or death decisions which triggered a review of the laws on voluntary euthanasia. Physicians are also changing, although at a slower pace, and, Emma suggests, pharma can support HCPs make the transition to using social media in a professional context.



Pharma itself is changing. Emma highlighted a number of good examples leveraging the benefits of social media, from individual pharma company activities to the ASCO conference.

Emma summarised:

- New – Emma reiterated that the "social" element of healthcare is certainly not new, but that technological advances in the "media" used to engage socially are evolving at a phenomenal pace
- Now – "real world" efficacy, data from online communities and dedicated social networks in specific therapy areas are well established and well used
- Next – technology will continue to advance, healthcare consumers will embrace the changes and physicians and pharma will keep working to catch up in the era of "health entrepreneurs"

Emma urged us all to adopt social media as a vital tool to help us understand our customers. As pharma companies, we can engage with healthcare consumer communities, focusing on "earned media" and play a key role in providing accurate information and supporting physicians to make the transition to using social media in its professional context. As agencies, we can find new and creative ways to enrich our understanding of the patient experience, using the plethora of social media interactions now available to us.

We can all put the myths and hype behind us and embrace the value that the phenomenon of social media brings to our industry.

Written by:
Amr Khalil
Ripple International

Thursday 25 June

Session 11: Streamlining Workflow: Integrating compliance into market research technology solutions

Speakers:	Markus Kotterer, Roche and Leslie Crist, Focus Vision - Research Reporter
Chair:	Sarah Phillips, Prescient Healthcare Group

Markus Kotterer

Leslie Crist

Markus Kotterer and Leslie Crist demonstrated how Roche implemented an electronic system to streamline workflow. The paper presented how the system not only improved the lives of the market researchers using the system, but painlessly integrated the many compliance processes required in pharma companies today.

Leslie explained the key challenges faced by pharma company researchers, including: how they are required to understand their customers (who / what / when / where / why are our customers doing what they are doing), meet business needs (who / what / when / where / why), as well as meeting financial and compliance requirements. Leslie stressed how much of the pharma researchers time is spent on dealing with administration; an aspect which we could all relate to.

Markus set the context of what was being experienced within Roche; he explained multiple systems were needed to run projects. It had become a "battle of the systems" as they were not built for Market Research. Restructuring and staff reductions added more pressure leading to attrition issues, dissatisfied staff, strained relationships and a general lack of trust. All of these pressures were happening whilst the business still had to continue with day to day business and also they were being audited financially and needed to meet industry compliance requirements.

It was clear from Leslie's observations these challenges were neither new nor unique to Roche, often finding the systems do not talk to each other and/or there is a duplication of work required by users. Leslie mentioned it normally takes a major event to trigger such an audit which makes a business stand back and decide to review whether change is required at our end before they will go through a major overhaul of their workflow and systems.

Markus outlined that key stakeholders involvement is required to ensure successful adoption within a business and cited that having a senior sponsor was critical to success. Markus talked about the process being a balancing act and that you need to take into account needs and other political pressures for a positive outcome.

Leslie and Markus talked through the need to do a full evaluation to identify the workflow tools needed to meet the business requirements. Highlighting the need of being aware that the needs will vary across the business, whilst ensuring you focus on the main reason that pushed the business to start the process. Markus explained that Roche designed a score card so they could compare the internal offerings with external suppliers in an objective way. This made it easier for stakeholders to review and to ensure that the offered solution was not challenged at a later date.

Leslie adamantly stated the importance of continued self-questioning throughout the process, to ensure the outcome meets the defined business needs. Focussing on the questions: What do you want? What do you need? What must you have to be successful?

When using an external supplier, Markus mentioned certain stakeholders within the business may raise concerns around the supplier being too small, or questioning if they meet security requirements. To mitigate this situation he raised that you should ensure you involve IT and compliance as part of the stakeholder team. Markus disclosed a persuasive argument they raised was the resource saving benefit of suppliers being able to share some of the administrative burden, this generated buy in of those involved.

One of the recurring messages of advice that Markus and Leslie shared was the need for testing, testing and more testing. Their knowing smiles showed this insight had been gained through some tough times during the process.

All the effort was worthwhile however; as Markus reported that they now had a system that allowed multiple systems to play nicely with each other, with user engagement increased due to a one system log in to the tools needed to complete market research.

Markus explained that since the system went live in 2011 in Basel and San Francisco, further countries and regions were implementing the system, having seen the benefits of the original global system in practice.

Roche regularly assesses end user feedback on IT solutions implemented within the company. It is testament to the rigour of their design and implementation process that end users of the system reported the 2nd highest feedback for this tool – 2nd only to Microsoft Office!

Markus concluded by summarising the importance of involving the right stakeholders early in the process, with extensive testing to ensure that their requirements are embedded in the system. Usability was a key priority, and the implementation and usage of the system was the focus from the outset of the system design.

Leslie encouraged us all not to be afraid of complexity. Despite the complexity of requirements within pharma, she believes that a focus on the end user perspective from the outset will enable the end result to flow seamlessly. She reiterated that successful system implementation is typically a result of a focus on adoption from the beginning, identifying pain points that can be addressed, ensuring long term flexibility and ultimate end-user satisfaction.

Our presenters ended by reiterating their conclusion that market research compliance doesn't have to hurt – we really can go from pain to happiness!

Written by:
Sam Scott
Fieldwork International

Thursday 25 June

Session 12: It's (the) thought that counts

Speakers:	Bob Douglas and Okke Engelsma, Instar Research
Chair:	Caroline Jameson, HRW


Bob Douglas


Okke Engelsma

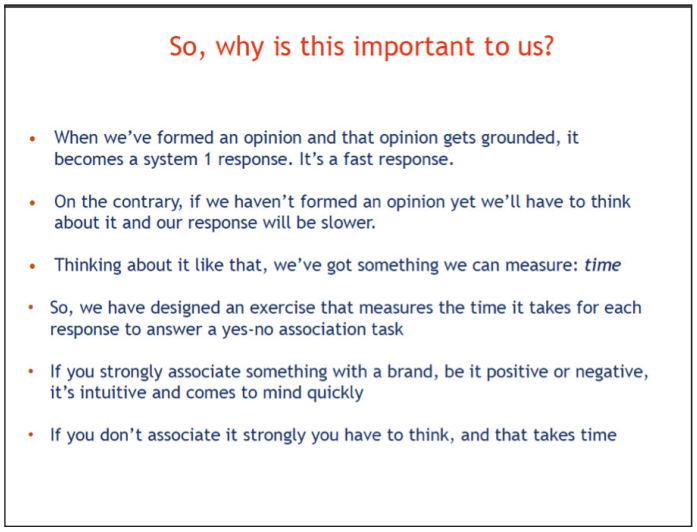

Caroline Jameson

Bob Douglas and Okke Engelsma presented an informative and entertaining paper taking us on their journey of firstly getting to learn about and understand the principles of Behavioural Economics and then how together they looked at whether these principles could be applied in the market research setting and how they could help optimise brand message strategy.

Bob first outlined the premise of Behavioural Economics, specifically with respect to decision-making theory and drawing the connection between Behavioural Economics and Market Research - both of which are concerned with how we make decisions and how to influence those decisions.

Bob reflected that conference papers on Behavioural Economics have tended to focus on "nudges" - stimuli which nudge people and encourage them to make the choices and decisions that you want them to make – such as governmental anti-smoking campaigns or patient compliance campaigns in healthcare.

This paper, however, focuses on a different element of Behavioural Economics - that of directly measuring System 1 and System 2 thinking. Using Daniel Kahneman's international bestselling book "Thinking, Fast and Slow" as inspiration, Bob outlined the principles of fast, intuitive thinking based on learned associations (system 1) vs slower decisions based on rational thoughts (system 2). Okke presented some examples to highlight the type of system 1 associations that people commonly hold, and then showed us how to apply the same principles to associations held by physicians about pharmaceutical brands.



But what does all this mean for us?

Bob and Okke explained that the key characteristic of system 1 and system 2 thinking – namely time taken to come to a decision or association – is a direct consequence of the extent to which those associations are grounded in our minds: if we are secure in our convictions, it becomes a system 1 response, whereas if there is uncertainty, we will have to think about the associations more carefully and our response will be slower.

Crucially, if our minds are not yet made up (we are still using system 2 thinking as we learn about the situation), there is an opportunity to influence our associations and decisions. The speakers emphasised the importance of this from a pharma brand perspective: when doctors are learning about a brand there is an opportunity to influence their learning, but once the learning has occurred and the doctor has made associations, it is much more difficult to change their mind.

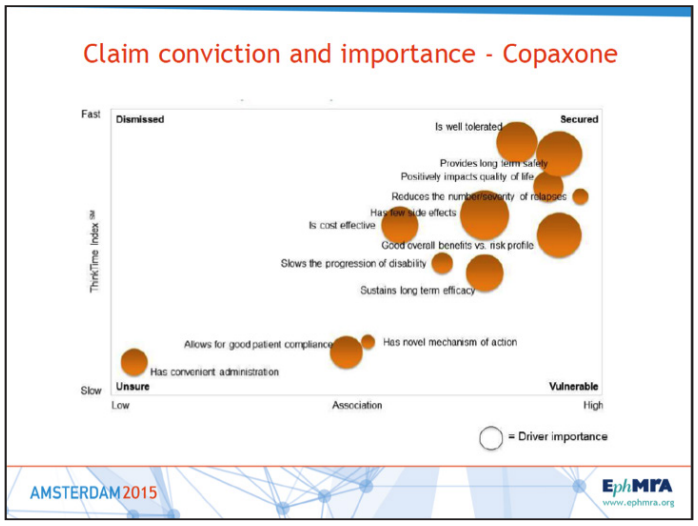
So, how can we measure associations?

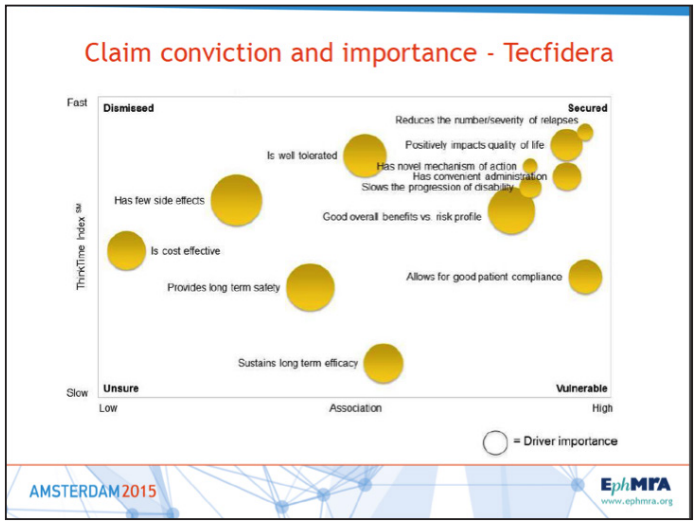
There are established methods of measuring associations - such as with IAT (Implicit Association Test), but Okke explained that the application of IAT in market research was limited as the nature of the test is to measure whether someone is (socially) biased. This requires a complex design and for market research would be a time consuming exercise. Okke argued that doctors' responses to typical market research questions regarding associations of attributes with drugs, have little to do with socially desirable answers. For market research purposes therefore IAT is over elaborate and cumbersome. An alternative method is preferred.

Bob challenged Okke to find a way to measure system 1 thinking in a way that is relevant to market research. Okke highlighted the practical challenges of such a tool, including the compounding factors specific to an individual situation, such as broadband speed or native language, which can seemingly affect a tool that measures reaction times.

The speakers used a live audience participation exercise to explore brand associations using fictitious examples, and shared the results in a matrix chart of strength of association vs decision-making speed.

We then saw a case study from the Multiple Sclerosis market, which showed a typical matrix pattern for an established market leader, Copaxone, where attribute associations were clustered at the top right of the matrix, indicating that strong positive associations were quickly made about the brand.





By contrast, the matrix pattern for new market entrant Tecfidera indicated that although some associations had been already secured, they were not necessarily the strongest drivers of product choice, and that a number of key drivers of choice were not yet so well associated with the brand. The positive news for the brand team was that the associations were still being made with system 2 thinking (taking longer as doctors had to think about them), which offered an opportunity for the brand team to change doctors' perceptions of the brand before they became established associations (system 1).

Bob and Okke concluded that this new market research metric successfully provided a method of measuring system 1 and 2 thinking, therefore answering Bob's challenge to Okke. They affirmed that the approach not only provides a way of measuring respondents' conviction in their answers, but also offers practical value in enabling us to identify clear routes to affecting behavioural change by indicating which brand messages to prioritise in order to strengthen the desired brand associations.

Finishing with a quotation from Einstein, they suggested that much of market research is spent understanding the rational mind and that we, as an industry, need to spend more time understanding the "sacred gift" of the intuitive mind.

Written by:
Caroline Jameson
HRW

Session 13: The way of insight beyond technique – creating an insight culture to inspire transformation

Speakers:	Vivek Banerji, Insight Dojo and Takashi Takenoshita, Shionogi
Chair:	Amr Khalil, Ripple International


Vivek Banerji


Takashi Takenoshita


Amr Khalil

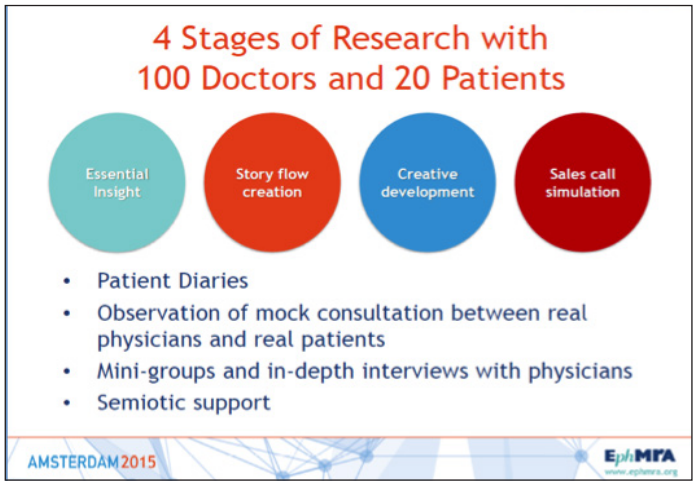
Vivek Banerji and Takashi Takenoshita presented an inspiring paper on creating an embedded insights culture to inspire transformation.

They opened by talking about the inspiring effect of great insights, which not only inspire better business decisions but also inspire people, motivating and energising them and reinforcing their desire to seek out further insights.

In this paper, Vivek and Takashi set out the five practices required in order to generate insights on a sustainable, large scale, and the four ways in which such an insights culture can be embedded into an organisation's culture.

The case study on which this paper was based involved a new product in women's health that required both physicians and patients to undergo significant behaviour change in order to adopt the product over the existing established competitors. Shionogi required a physician sales aid to introduce the product and convince prescribers that it should be their treatment of choice. In order to do this, it was essential to fully understand the needs and pain points of both physicians and patients.

The research involved 4 phases of research, starting with essential insight and encompassing story flow creation, creative development and finally sales call simulation.



A variety of research approaches were employed, from patient diaries and mock consultation observations to in-depth interviews and group discussions, alongside semiotic support to fully explore the cultural and language complexities of the product context.

The research programme delivered impact on three levels: not only a sales aid that delivered impressive impact on qualitative and quantitative measures, but impact beyond the scope of the original project in terms of use of the outputs for staff training and identification of "soft signs" to identify likely product ambassadors but also the impact on engagement, energy and creativity within the wider organisation. It is on this third area, the creation of an insight culture, that the paper focused.

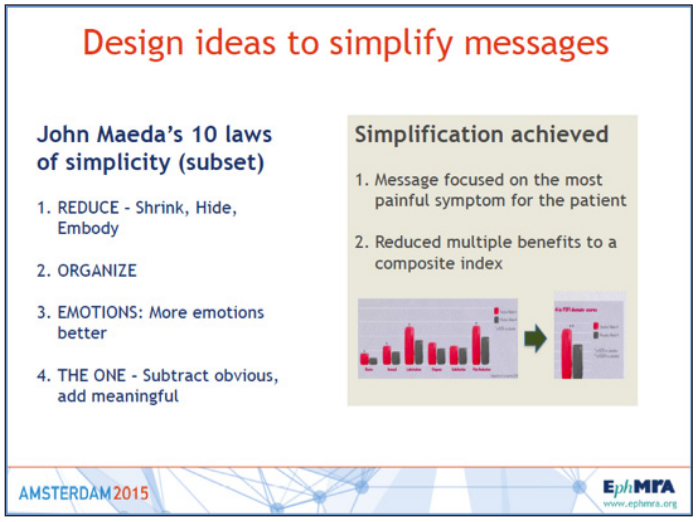
The speakers identified five practices that helped to create the right environment to nurture insight generation.

1. Receptive mastery: Drawing inspiration from Japanese themes such as masters of Karate, "wasa" (meaning technique as art) and creating a "flow" experience on the journey, receptive mastery was described as the ongoing journey towards perfection in which we not only perfect our skills and techniques in the mechanical sense, but also set them into a fluid, synergistic and somewhat reflective context to ensure that we go beyond the logical outputs or preconceptions and are receptive to new ideas and ways of thinking.

2. Co-creation: Using the example of a jazz trio starting to play sheet music but quickly moving to improvisation, based on an understanding and connectedness not only to the music but to each other, the speakers described how co-creation involving client and agency teams can work together to create insights. The benefit of this approach, they note, is not only in terms of stakeholder buy-in across multi-functional teams and the synergies that result from integration of the different perspectives of each member of the co-creation team, but in the deeper understanding and longer lifespan of insights that results when we experience them in their original context.

3. Mindfulness: To illustrate mindfulness, the speakers described the quiet, reflective state achieved via meditation. In the market research context, they championed the benefits of structuring time for true reflection in order to generate insights – whether we are listening intently and receptively whilst observing fieldwork, clearing our schedules to focus without distraction on the project in hand, or ensuring that we have a clear head and calm mindset when absorbing and understanding our customers' practical and emotional needs. They described how to focus on empathy and sensitivity during the deep immersion process, using meditation and breathing exercises to create the calmness required to look at the problems with fresh eyes.

4. Polymathy: Citing examples from books such as "Art and Physics" and "Proust was a Neuroscientist," the speakers described the rich connections and hybrid solutions that can result when we use diverse skills, knowledge and expertise to solve seemingly unrelated problems. This involves using all of our own experiences from different areas of life and also drawing on the expertise of our colleagues and external experts. We were introduced to John Maeda's 10 Laws of Simplicity, used in design, and how they could be translated into a process to simplify a communication message without losing any of the impact.



5. Strategy and Action:

The speakers described the role of Steve Jobs as the integral link between strategy, insight and action and how we might employ a similar approach, using strategy to frame the context for our explorations and focusing our search for insight. They purported that the ultimate test for insight is action, and that actionable insight engages stakeholders and inspires teams.

An injection of realism reminded us of the potential barriers to implementing these approaches, both on an individual and corporate level, but the speakers outlined four ways in which an "insights culture" could be embedded:

1. Defining the vision and values: Starting with the creation of a clear, customer-focused vision, corporate and individual shared values can be built around it.

2. Living the values: It isn't enough to have our vision and values written down for all to see – we need to put it is to practice – by repetition, leading by example and intervening when old behaviour patterns are seen. The speakers described the Shionogi "WOW Book" which describes Ways of Working to guide all employees.

3. Making learning a priority: The importance of continual learning was emphasised. To embed the insights culture, organisations need to prioritise and invest in formal training, experiential reflection and also the cross-fertilisation of ideas and experiences that can result when we draw upon other sources of inspiration including non-work-related hobbies and interests.

4. Creating a partnership of equals: The speakers described the holy grail of client-agency relationships, where both entities work as partners toward a common goal, based on a balance of similar values, autonomy and collaboration rather than hierarchy.

In conclusion, the speakers championed the insights culture which puts humanity at its core – not only to facilitate better business decisions, but for the benefits to customers and employees that result from the energy, inspiration and happiness!

Written by:
Jessica Makovsky
GfK

Thursday 25 June

Session 14: Harnessing Omnichannel Metrics to Shape Meaningful Customer Experiences and Drive Commercial Success

Speaker:	Julie O'Donnell, Global Head of Digital Interaction Management, Lundbeck
Chair:	Alex West, Instar

Julie O'Donnell

Alex West

Julie presented an in depth and engaging case study from the digital team at Lundbeck – a rich, real life example of how multi-channel digital interactions are used in practice to increase brand engagement.

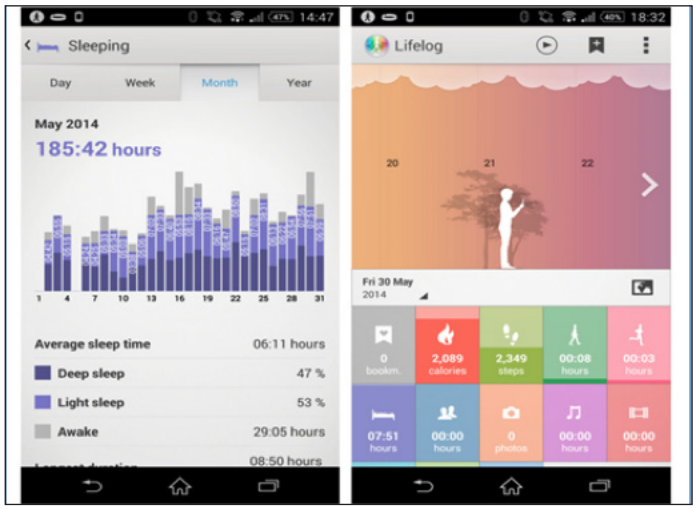
Julie opened by highlighting the holistic, team-centred approach to omni-channel marketing which is required in order to deliver each individual aspect of multi-channel campaign elements from brand strategy to content, visuals, promotion and web & app tools. Julie described how, at Lundbeck, a Global Customer Integration Management team has been set up, responsible for digital engagement across channels to ensure a consistent customer experiences wherever the customer sits in the world or the ether. She emphasised that, in today's world, the customer experience IS the brand, and that in order to monitor and shape the customer experience effectively, you need metrics. And there are plenty of them....

Julie outlined the scope of digital channels and metrics available in the modern world, from the use of apps or emails to engage with customers, to our own personal use of digital metrics such as personal biometric logs providing highly granular, personalised metrics on aspects as diverse as sleep quality, activity levels, coffee consumption, social interaction and leisure activities.

Google is testing how they can 'quality control' health content through a partnership with Mayo Clinic, rumours saying Facebook is testing similar approaches for healthcare. In pharma HCPs are aware that their patients are expecting this, but they have little experience in going down this path.

This relates closely to the idea of the 'internet of things'. However, this is focusing on the demand and wish to know what's going on around and inside you. How long did you sleep, when did you come home, how long did it take you to bike to work, how many calories did you eat, and in return how much did you get rid of at your latest workout. The amount of devices and apps that can help you with this is growing day by day. With this is the volume of data and the expectation on healthcare providers to 'do something' with it. This is a topic within healthcare communities and also within pharma – data integration.

The digital experience doesn't stop at metrics – you can receive your own, personalised alert which tells you when you've consumed too much coffee! These tools are becoming ingrained into daily life, with ordinary people tracking their own behaviour in a highly personalised way. The opportunities are available to create a similarly personalised, but brand-consistent, customer experience.



For the digitally-literate pharma company, there is a plethora of channels that need to be integrated to ensure that the customer receives a consistent brand message, including non-personal interactions such as websites, emails, direct mails and apps and also personal interactions, such as conference attendance, the traditional face-to-face detail or a medical enquiry. Julie highlighted research that has shown that a customer exposed to messaging consistently across different channels is 30% more likely to prescribe. The key lies in using each cross-channel communication to move them along from awareness to brand belief.

But how do we do this? Julie gave us some detailed insight into how Lundbeck is telling a brand story in the modern world, deconstructing the traditional detail aid's linear story and using the individual building blocks to tell the same story in a way that engages the customer. Using the principles of "reaching the right customer, at the right time, with the right content, which is tailored to their needs", she highlighted that to do this effectively you need to fully understand your customer. And so the starting point in all cases is customer insight.

Tools are available to help us to understand not only what the customer thinks, but how they respond to our interactions. We can track how customers respond to our digital touch-points and identify that to maximise impact, a message should be sent out by SMS at time X on day Y, or that our webinars should be held at time A on day B in order to attract the right audiences.

Lundbeck has developed in internal benchmark system which has redefined what "good" looks like. A small number of KPIs – no more than 6 – have been identified and used to create a global "digital intelligence hub" which uses detailed local information and universal tools (such as Google search metrics) to enable the company to look at internal benchmarks to track performance against other brands or other geographical markets so that colleagues involved in a product launch across 47 countries can all learn which elements are working and which would benefit from further refinement.

The digital teams can measure which channels are the most effective and which activities result in greatest customer engagement, enabling the brand teams to be more agile in their brand communication approaches.

Julie explained that the focus is on true customer engagement, rather than simply "clicks", and showed an example of an engagement funnel which enabled the team to assign target numbers to customers at each stage of brand engagement, with 5 interactions identified to move a customer from initial exposure to prescribing, and which helped them to identify the most efficient way to move the customers through the channels to strengthen engagement.

The approach was therefore clear in terms of what could reasonably be achieved. Tracking engagement was key to the success of the system, with different engagement scores allocated for different types of content from visiting the web page through to signing up and contributing to a discussion. The metrics enabled the team to show senior management the tangible benefit of multi-channel activities by calculating the cost for a single customer to move through the process to full engagement and comparing it with the typical cost of medical representative interaction.

Julie summarised by highlighting some key take-home messages:

- Use metrics to avoid bias – everyone has their own favourite tools, but select key simple tools to standardise the approach and use them consistently – make the data live!
- Create small working groups of like-minded people with similar agendas who can work together for a common goal
- Ensure a clear vision is set from the beginning of the process
- Education is essential to ensure the tools are fully utilised
- In an increasingly busy world where data is complex and people are time-poor, keep the key metrics simple and effective
- "Show" rather than "tell" to illustrate successes and share learnings to maximise the impact of the integrated multi-channel approach

Written by:
Alex West
Instar Research

Session 15: Creating an Inspirational Environment in B2B: How dentists get inspired from hairdressers and clams

Speakers:	Kathrin Wahl, Ivoclar Vivadent AG and Tanja Woppmann, advise research GmbH
Chair:	Lee Gazey, Hall & Partners


Kathrin Wahl


Tanja Woppmann


Lee Gazey

Kathrin Wahl and Tanja Woppmann provided a fascinating insight into how agencies and manufacturers work together to stimulate new thinking. In re-presenting an ESOMAR paper they showcased a novel approach for generating and brainstorming innovation. They demonstrated how looking beyond your usual horizons and taking inspiration from sources as unlikely as hairdressers and clams can help to identify new disruptive innovations.

Using an engaging role play style of presentation, Kathrin introduced Ivoclar Vivadent - a global company offering a comprehensive range of innovative products and systems for dentists and dental technicians. Their current need was to develop inspiring innovation in the area of dental bonding, against a challenging background. The usual market research routes were limited by the commercially sensitive nature of the product ideas, each of which would need a patent before being discussed with the traditional respondents of dentists and technicians. Additionally, although dentists were the obvious choice for discussion of customer needs, they may not be the first target respondents for inspiration and disruptive thinking.

Tanja agreed that "company blindness" resulting from an ingrained immersion in company history and thinking can make it difficult for employees to think outside the box when it comes to innovation generation. Tanja suggested a novel approach to brainstorming: a multi-level analogy study.

This approach would involve talking to people from totally different businesses, but who are dealing with the same problem - that of bonding. The task was to find people who could talk (?) over bonding! This would allow the project team to be inspired by totally different target groups – such as hairdressers to fix hair extensions, clams which adhere to rocks so tightly that it's almost impossible to move them and last but not least geckos with their sticky feet

Tanja described the 6-step approach:

1. Define the search field:

This was considered a very important step as the project team created a realistic image of what might be obtained from the outputs of the research. All stakeholders were involved from the beginning, from R&D, product strategy, CTO and operational experts. This early involvement allowed established buy-in from the very beginning and helped the team to work together throughout the project.

When defining the search field it was preferable to keep some of the variables the same (in this case the target customer group - dentists) for practical and financial reasons, but to keep the choice of materials and technology open. The project team generated a list of terms associated with bonding which would be used to guide the second stage.

2. Brainstorm via social media:

The list of terms generated was programmed into a web crawler which identified 450,000 text fragments related to the topic of bonding. These were filtered to remove spam, and test correlations used to reduce the list to 5,000 items, each of which were read by a human being to identify 20 industries and fields of application relevant to bonding of different materials.

3. Round table discussion:

An internal workshop was held to discuss the 20 fields of application of bonding, where each area was evaluated to ensure a realistic analogy to dentistry. Each project team member used "power dotting" to allocate points to the most promising application field from his or her point of view.

4. Workshop:

Based on the analogous fields, a group of disparate external experts, from academics to pragmatic thinkers, was recruited from very different fields, but all related to the topic of bonding. The extended workshop took place over 2 days, first involving only the external experts to avoid bias from entrenched company perspectives, but based on an introduction to the problem (how to bond teeth in the mouth) and some of the fixed parameters (such as the maximum temperature and non-toxic materials which could be used). The Ivoclar Vivadent team observed the discussion via videostreaming to avoid introducing any company bias, before joining the enthusiastic discussions the following day.

5. Quantitative screening

After the initial idea generation, the project team critiqued the ideas using a standardised evaluation system including feasibility, financial investment required and degree of uniqueness. This process shortlisted 5 concrete ideas and identified 2 (and a half!) ideas which were very interesting and considered worthy of further development.

6. Ongoing community discussion:

An Online community was set up to include the external experts and the internal project team to bring them together again after the 2 day workshop. Participants had 24/7 access to the forum and could discuss ideas, ask questions and review inputs as well as participating in some "real time" chat sessions.

Kathrin identified some clear benefits of the approach for Ivoclar Vivadent:

- Time saving - generated 5 ideas within 3 months
- Using external experts obviated the need for large market research surveys
- The approach overcame "company blindness" and opened participants' minds to alternative solutions to old problems
- MR was involved from the beginning as a sparring partner and proved so valuable that they are now involved in other initiatives from the very first stages

Tanja and Kathrin also identified some tips and pitfalls, including the benefits of involving all stakeholders from the start and the challenges of scheduling workshops with busy experts. In addition, companies should be aware of the additional time (and possible financial) implications of embarking on such a study.

The speakers encouraged us to adapt this approach to other business areas including the medical sector, to deliver inspiring ideas of disruptive innovation, because even clams can be inspiring when you think outside the box!

Written by:
Lee Gazey
Hall & Partners

Thursday 25 June

Session 16: Cultures of Secrecy and Hiding

Speaker:	Victoria Guyatt and Alessandra Franceschetti, IPSOS
Chair:	Caroline Jameson, HRW

Victoria Guyatt

Alessandra Franceschetti

"Watch this film," one of the session presenters exhorted, "and tell us, how does it make you feel and what do you see?"

The video begins...

Her hands covered in rubber gloves and her arms in a long-sleeved jacket, a woman scrubs her home incessantly as she discusses how psoriasis has affected her life, even distancing her from her young son.

As another woman applies medication to her scalp, a female patient wistfully recalls a fulfilling career in management before psoriasis got in the way and she shrank from the forefront.

A man shows the many tubes of sticky ointments he has used to treat his condition.

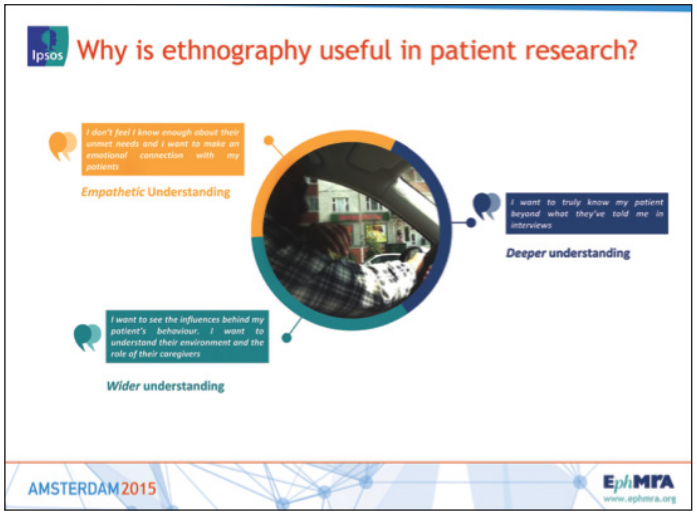
How did viewers feel? What did they see?

"Embarrassment." "Slouching." "Uneasiness."

This video was part of "Cultures of Secrecy and Hiding," a presentation about a global ethnographic study of patients living with psoriasis. Victoria Guyatt and Alessandra Franceschetti presented IPSOS's award-winning paper (MRS Grand Prix for Greatest Impact Paper 2014) showcasing the in-depth global ethnographic study, which delivered a unique insight into the patients' "lived experience" of psoriasis.

Ethnographers recorded days in the lives of 50 psoriasis patients in 8 markets around the globe: Brazil, Canada, France, Germany, Italy, Spain, the United Kingdom, and United States. Ethnographers captured more than 250 hours of footage, working singly with each patient, so that they could spend time unobtrusively with their subjects, hopping on a bus, visiting the home, etc. Patients were recruited through physicians in some cases and through associations in others.

Victoria and Alessandra opened their presentation with the video excerpt from the study, and it was clear from responses that audience members discerned multiple visual clues regarding the debilitating physical and emotional trauma that results from living with psoriasis.



With this opening exercise, the speakers demonstrated the strength of their chosen methodology: an ethnographic study which, they asserted, enabled the patients to tell the stories that are not usually told. The ethnographic approach seeks to go beyond the issues that patients tell us about directly by looking at and revealing the broader environmental influences which can provide detailed and sometimes unexpected insight. As Victoria noted, "A lot can be learnt from observing patients."

Victoria championed the use of ethnography in patient research for its ability to deepen our understanding on multiple levels:

- empathetic understanding – spending 5-6 hours in the life of the patient enables us to gain a deeper insight and understanding of the unmet needs and to make an emotional connection with the patient
- wider understanding – being able to see the influences behind the patients' behaviour, both in terms of how they live their lives and how they interact with those around them
- deeper understanding – fully immersing ourselves in the patients' lives to explore beyond what has been discussed in formal interviews

The ethnographic approach was considered particularly beneficial for this study, whose objectives were to better understand the everyday reality of patients with psoriasis, including the psychological impact of the disease and the effect that this has on behaviour to increase understanding of patient needs. The work was used to understand barriers and drivers of medication choices and to understand therapy administration rituals, particularly regarding the biologic therapies commonly used in severe psoriasis.

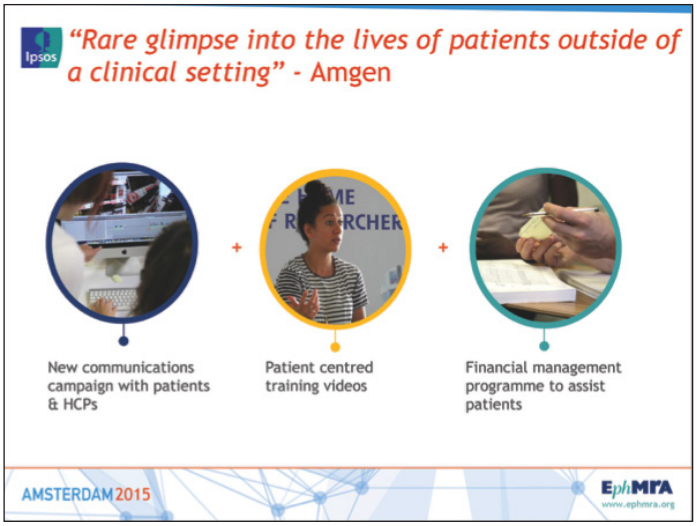
Victoria outlined the strong arguments for the ethnographic approach, stating that although in healthcare there are continued calls to put the patient at the heart of decision making, we still conduct most of our research amongst physicians, instead gathering the physicians' perceptions of the patient experience.

Through this ethnographic film study, the presenters said, they were able to explore what patients are unable to tell HCPs or others regarding the effect of environment, home, emotions, etc. They were able capture the neglected stories, ones clients and researchers might not learn otherwise because of the patients' culture of hiding and secrecy from embarrassment over psoriasis. This aspect, the presenters said, provided the greatest findings for the client.

Victoria candidly shared some of the misgivings that needed to be addressed to secure stakeholder buy-in, with resistance experienced both within Amgen (where stakeholders were unfamiliar with the ethnographic route and needed explanation to convince them of its merits) and from local fieldwork agencies (who suggested that ethnography was unnecessarily intrusive and that 1-2 hour interviews would be more suitable).

To overcome this reluctance to embrace the ethnographic approach, the team had argued that the 1-2 hour interviews would be unable to uncover the "lived experience" that the objectives required, and emphasised the necessity of being able to observe the behaviours that were contrary to the verbal story told during direct questioning in order to uncover the issues that patients are unable to tell us or their doctors. The approach would take rich understanding from the non-verbal information, such as what patients' homes looked like and their relationships with their close friends, family, and carers.

Alessandra then shared some of the "secrets" uncovered during the research. These were often tragic or heart-wrenching insights into the realities of how the condition affects patients day to day – the rituals and routines which patients had adopted as coping mechanisms and which revealed so much more than the answers to direct questions. Secrets such as the young woman and her father who both suffered from psoriasis but who had never spoken about it to each other. The office worker who went to the work early to cover his desk with papers to disguise any sign of flaking skin.



The study highlighted the lack of cultural discourse around psoriasis – it is not a condition that is discussed, understood, and accepted to the extent of other diseases. It revealed the extent of the frustration and psychological scarring experienced by patients living with the condition for the duration of their lives. They study also highlighted patient isolation and self-loathing, the reluctance by some to change their habits or to use biologic injections, and the financial impact of using biologics.

The speakers described how the study had a dramatic impact for Amgen, with new communications developed which focus on empathy for the patient, as well as programmes to support patients with the financial management of treatment. A quotation from the company declared their increased motivation commitment to improve their patient care programme.

At the end of the session, the hosts played more of the video for attendees. In it, the woman who used to be in management says, "I miss myself," and she displays her back, full of sores and patches of flaking skin. A middle-aged man says, "It's not just the skin, it destroys you mentally." A young woman says it is hard to socialise. A mother says her son doesn't like to touch her, even though she now is receiving treatment for psoriasis and the sores are gone. Some express concern about taking biologics, while others use them and say they help to reduce the severity or outbreaks. One woman shows off the hazardous waste bin in which she discards her injectable medication, noting that the shots she has taken for about 3 years don't let psoriasis "spread as much." The young man who used to apply 3-4 tubes of ointment daily demonstrates how he uses an injectable biologic now and says, "It gives me quality of life."

Thursday 25 June

Session 17: Constellation Studies: Triangulating the Truth

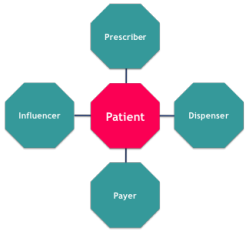
Speakers:	Steve Martino and John Surie, M Health
Chair:	David Hanlon, Kantar Health


Steve Martino


John Surie


David Hanlon

It is difficult to appreciate the depth and complexity of any topic if you look at it from only one perspective. Truth is always multidimensional. To grasp it, you have to approach it from multiple points of view.



This principle has important implications for market research. It suggests that gathering data from just one type of respondent, physicians for example, is fundamentally inadequate. To truly understand a clinical issue, you must interrogate patients and physicians, whoever supplies or administers the product, whoever pays for it, and the other relevant influencers – caregivers, advocacy groups, KOLs, policymakers. The truth of the issue never lies with just one set of stakeholders, but with all of them.

It is difficult to appreciate the depth and complexity of any topic if you look at it from only one perspective

In their session, Steve and John explain this basic premise of Constellation Studies, a study design whereby related respondents are recruited in clusters or "constellations" to allow unprecedented exploration of the attitudes, behaviours, influences, and interrelationships of all the relevant players.

Additionally, since the perceptual, cognitive and communication styles of respondents vary widely, Constellation Studies typically employ multiple data collection methodologies, such as IDIs, video diaries, image projection enabling analysis from multiple research perspectives – including anthropological, behavioural, linguistic and psychological. This richness adds even greater dimensionality to the multiple perspectives of this research approach.

This type of multi-dimensional study enables very specific conversations about actual events rather than abstract generalisations. Constellation Studies are therefore particularly good at revealing:

- Miscommunication and disconnects
- Stakeholder relationships and influence
- Different stakeholder motivations
- Gaps in the continuum of care
- Opportunities for brand intervention

Steve and John presented two case studies, one from the world of haemophilia, the other from a more sensitive topic, severe mental illness and concomitant substance use disorder, also known as "dual diagnosis."

The example from haemophilia below shows a variety of perspectives from different people in the constellation.

In young adult haemophilic men, adherence to treatment often drops off precipitously. This is critical because it can result in internal bleeding, causing significant joint damage, debilitating pain, and permanent disability. Here the client wanted to explore attitudes, behaviours, emotional drivers, relationships and influences that either support or undermine adherence to hemophilia A prophylaxis in patients age 18 to 24.

Each constellation comprised four members: the patient himself his haematologist, the patient's parents, and the patient's best friend or girlfriend. The patients completed a three-week video diary in which they addressed a number of predetermined topics. While the patients were completing their video diaries, the research team conducted tele-depth interviews with the other members of the constellation. After the TDIs and video diaries were completed and analysed, each patient participated in an exit interview that probed the questions, gaps and contradictions emerging in the analysis.

Rich insight often arises out of contradictory research results, and this study produced some fascinating contradictions. Members of the same constellation often answered the same questions in remarkably different ways, as shown in the verbatims below regarding the most non-adherent patient – "Tom":

He was always sheltered as a child. Lots of times mother kept him home from school because she was afraid he'd get bullied. She's still very protective. She's always asking him if he's done his infusion. If he says no, she'll give it to him herself.

Patient's sister

Women pass along the gene for haemophilia, so sometimes the mom blames herself and overcompensates by never giving up control of the factor.

Nurse Practitioner

When I have a teenager in my office, but his mom won't let him get a word in edgewise, that's a problem. I know that guy is going to have issues down the road.

Haematologist

Haemophilia has made me a better mom. It's given me the chance to go places and do things I never would have done otherwise. It's changed my life. In a way, haemophilia is one of the best things that ever happened to me.

Mother

Analysis of the constellations revealed very different parenting styles. In Tom's constellation his mother was a classic ***Hemonster***, a determined mom who devoted herself completely to his son's hemophilia to the point of coddling and stifling him. Tom and other patients exhibited ***Defeated Dependence***, young men who had a defeatist attitude toward their disorder, were socially withdrawn, and remained dependent on caregivers to prompt or even administer their factor.

In contrast, several of the patients were categorised as ***Protected Independence***. Their parents were protective of their sons, but also allowed them to discover what their limitations were. Steve and John also identified a sub-group of HCPs who required families to comply with a policy of ***Forced Empowerment*** designed to engage young hemophilia patients in taking responsibility for their condition. Haematology practices with this this type of policies tended to have more adherent adult patients.

The second study concerned severe mental illness and here the constellations consisted of patients, their psychiatrists or rehab counselors, and the family member most involved in their care, usually a mother. The objective of the study was to understand the patient journey and decision process, including the rational and emotional drivers and barriers to choosing a treatment center, focusing on young men age 18 and over.

In the next graphic, the study showed that ***Initial Symptoms***, either mental health or substance-related, emerge during the middle or high school years and are rarely recognised as the onset of a serious dual-diagnosis. ***Initial Diagnosis*** may be complicated by patient denial or underreporting of substance use, which may blur the lines making it unclear if symptoms are due to intoxication or underlying mental illness. For many, there is a repeat of ***Relapse and Retreatment*** that can last years. Typically, patients are initially diagnosed with ***either*** a mental illness or a substance use disorder. It isn't until they enter this ongoing cycle of relapse and retreatment that a dual-diagnosis is finally made. Some patients eventually go on to a sustained ***Recovery***. However, recovery rates for dual-diagnosis patients are very low.

In this instance, understanding initial symptoms, initial diagnosis and treatment right through relapse/retreatment to eventual recovery provided insights with respect to where the main marketing opportunities lay.

Patient journeys lend themselves to analysis by journey segment. Constellation studies lend themselves to analysis by stakeholder. This study combined both and in the end a major strategic opportunity was identified at the beginning of the relapse-retreatment stage of the journey, when the complexity of the clinical situation has become apparent, and parents are most open to reevaluating earlier treatment decisions.

Challenges can involve recruitment, timing and numbers

As with any complex study with multiple components there are practical challenges associated with recruiting Constellation Studies.

Recruitment of patients through managing physicians and influencers through patients (for example) requires every stakeholder's individual engagement and cooperation. This can sometimes lead to bottle-necks in recovery of deliverables – video diaries for example. Also, the sample recruitment very quickly expands – 12 constellations of 4 respondents per country very quickly adds up.

Timing is key and it is important to draw up realistic timelines and not over promise to meet some unrealistic client deadline.

Confidentiality is also important and changing regulations in compliance and data protection require greater levels of permission and documentation.

Ultimately, market research is concerned with discovering the truth about a given subject, and truth is never one-dimensional. Constellation studies give researchers and their clients both new and richer lines of sight into the complex truths they seek to comprehend.

Written by:
David Hanlon
Kantar Health

Thursday 25 June

Session 18: Hot Topics Round Table Discussion on Ethics and Compliance

Facilitators: Thomas Hein, EphMRA President and Thermo Fisher Scientific; Bob Douglas, Instar Research; Xander Raijmakers, Eli Lilly

Following on from last years' lively discussion on the compliance and ethics issues facing us in Pharma, Bob Douglas introduced this hot topics discussion focussing on key questions at the forefront of the pharma market research industry.

Delegates were given three topics and broke off into groups to discuss. The issues posed to the groups were:

1. The competency test and the problem of varying uptake
2. Managing conflicting requirements between pharma and agencies on personally identifiable information
3. Managing transparency issues regarding payments to doctors

Each group was asked to brainstorm and then report back to the wider group in which the topic was opened up for questioning.

The first group took on the topic of the competency test and the issue of varying uptake within the industry, with some delegates admitting this was a problem within their own organisation. Many delegates suggested the tests were cumbersome and sometimes frustrating to complete, with little or no admin visibility of who has taken the test within the company. It was also suggested that the certificate should be sent in PDF format, as a lot of delegates have experienced issues in downloading certification. Many clients request proof of completion and sometimes have to rely on trust that the test has been successfully completed.

Another potential problem is the availability of the test in English only. It was suggested providing the test in multiple languages may increase uptake within the industry. Delegates also recommended that opportunity should be given to non-members who may not have the budget to join, providing a lower level of membership that gives the ability to complete the competency test without paying a full membership fee. Many EphMRA members are also BHBIA members and the BHBIA competency test has a higher uptake. However, the preference would be for the EphMRA test given it covers more markets and therefore provides a broader understanding of compliance across Europe.

Pharmaceutical companies and EphMRA could partner to take the lead in promoting the importance of completing the test and provide some enforcement, such as forming part of the Master Service Agreements (MSAs), as is currently done with adverse event reporting. Advertising through a potential partnership with ESOMAR and CASRO would open up the arena to more researchers, providing a greater coverage and visibility within the industry and increase traffic.

This topic is clearly a passionate subject for market researchers, fieldwork agencies and pharma companies and highlights the importance of a unified and consistent message across the board. Compliance and ethics are constantly evolving in this industry and the need for regular testing is imperative to ensure companies are adhering to the regulatory standards.

The second group tackled the issue of personally identifiable information and the differing requirements between pharma and agencies. Agencies often receive requests from pharma companies which contradict the code of conduct and the MR data protection obligations of the agency. Common problems regularly faced are:

- Pharma wanting to use recordings for non-research purposes or requesting them after the interviews have taken place (without prior consent from the participant)
- Companies in smaller markets knowing potential respondents therefore limiting the ability to provide recordings
- Companies trying to use consultancy agreements for market research HCP participation

- Companies using their own market research participation agreements that don't allow the HCP to withhold agreement to waiving anonymity
- Pharma companies asking for HCPs hospital/clinic name which would allow identification of the HCP

It was also noted that there is often conflict within the pharma companies themselves, with different departments offering differing opinions on the matter which causes confusion. It can occur when agencies receive inconsistent guidance from the same pharma company for the same study.

In order to manage these conflicts EphMRA could provide more support to agencies, offering template materials and guidance to help resolve conflicts when they occur, as well as educating pharma companies on the country specific variations that exist. EphMRA could also provide clear definitions of what is considered market research and what is not market research, which would reduce the upfront requests received by agencies. This is clearly another very important problem within the industry and setting the expectations of the client from the outset by proper management could reduce much of the conflict currently experienced.

The final group talked about the issue of incentive transparency which is a prevalent problem faced in market research. The implementation of transparency agreements in several markets over the last few years has catapulted this issue to the top of the list and consistently causes confusion among pharma, agency and fieldwork providers. The group felt the main issue was the lack of understanding within the industry of who was responsible for each stage of the reporting process. And given the different rules in place depending on the market, it's understandable why there is such confusion. The Sunshine Act in the US was the first to be put in place as part of the US healthcare reform law design to ensure transparency in pharmaceutical company – physician relationships. It was considered that patients should have the right to know if their physician is getting paid by a certain drug company or has a financial interest in something that they are prescribing. The US act was closely followed by the Loi Betrand in France, which at present is still being lobbied against. Physician incentive is to be reported regardless of whether the identity is known to the client. Then in 2015 the ABPI introduced disclosure of payments in the UK in order to increase transparency between HCPs, HCOs and pharma companies. Disclosure is required only if the respondent identity is known to the commissioning company, the majority of market research falls outside the scope, however issues are faced when it's the exception.

Other issues which were discussed due to transparency were the impact it could have on recruitment, if physician payments are publically disclosed, will physicians still want to take part? There is also the potential for overloading participants.

The publically available data could act as a list of 'research friendly' doctors opening them up to bombardment from agencies and undermining the business model for panel companies. This poses several concerns around the ethical and moral use of the lists, having participant lists still requires an opt-in to contact physicians and just because the list is published does not mean it can be freely used for market research purposes.

It was also mentioned that there are conflicting laws with regard to data protection. In some cases, the same legislation applies across Europe but is interpreted differently in different countries, which suggests the need for greater clarity, more education and training within the industry.

The requirement to declare studies to the relevant healthcare professional bodies (CNOM, CNOI etc) in France one month in advance of fieldwork could have a major impact on timelines. Often we do not have such a long lead in to the research and risk delaying research or contravening law in order to complete studies on time.

Another major problem discussed was the differing guidance from pharma companies. There is no consistency from pharma and the reporting processes range from simple emails and spreadsheets to lengthy training on online platforms. The lack of consistency causes further confusion and could lead to missed deadlines for reporting and missing data.

The group felt the ideal way to manage the issue was, where possible 'double blind' the research and keep the participants anonymous. By ensuring the payment is made by a third party (i.e. not the pharma company) and the respondent identity remains concealed the incentives would then not need to be disclosed. In situations where the respondent is recognised (or in France where all incentives must be reported) EphMRA could assist by providing country specific guidelines and templates to offer greater consistency and clarity to members, aligning the reporting procedures and reducing confusion.

The subject of payment transparency is a key debate within compliance with ever changing goalposts, and the inevitability of the addition of more markets introducing legislation. The better procedures and protocols we have in place, the easier it will be to accept new legislation.

This interesting and productive session touched on a few of the key issues facing the industry, there was a sense of agreement of the importance of the problems currently faced and a suggestion that the role of EphMRA could be key in providing greater clarity, education and support to all members, providing the link between the agencies and pharma companies.

Written by:
Kate Shaul
Blueprint Partnership

Session 19: More hands on! The value of immersion techniques and the integration of multiple stakeholders for need-based innovation

Speakers:	Paul Dennis, SCA Hygiene Products and Johannes Hilf, Point-Blank International
Chair:	Caroline Jameson, HRW

Paul Dennis

Johannes Hilf

Paul Dennis and Johannes Hilf delivered a fascinating case study showcasing what can be achieved from a combination of immersive ethnographical approaches and multi-stakeholder co-creation workshops.

The client, SCA Hygiene Products, wanted to identify pain points and insights around skincare routines in nursing homes in order to guide them in their aim to develop product innovations centred around user needs.

Johannes opened by drawing our attention to the many changes experienced in the healthcare industry which make it increasingly difficult to foster genuine product innovation. As a result, he observed, many key players are focusing on development of services for patients, doctors and carers, including apps, websites, patient support programmes. But to ensure that these products and services truly meet customers' needs, we need a deep and broad understanding of the user, going beyond the time-honoured approaches of IDIs and focus group discussions which, he suggests, are better suited to product-centric understanding.

He pointed out the use of immersive, ethnographic and co-creative approaches employed by our consumer colleagues in order to foster need-driven innovation, where behavioural economics has shown that people are typically bad at explaining their behaviour or struggle to access or articulate their unmet needs, and cannot answer via conscious recall the "Why? What? How?" questions that researchers ask of them.

Nursing care staff use hygiene products as part of daily routines which are learnt and conducted unconsciously. This automatic process would make it difficult for users to express product benefits & limitations in the traditional research setting. Additionally, users are committed to providing high standards of patient care and may be reluctant to identify anything that does NOT work well for fear of indicating substandard care. They needed to be able to see and understand how their products were used in real life.

In healthcare, however, patient immersion approaches are rarely considered. The pharmaceutical industry has become sensitive to the data protection and privacy issues surrounding such patient exposure, and the challenges of working around the many layers of regulation and gaining approval for observational studies often stops us from benefiting from new methods in innovation research.

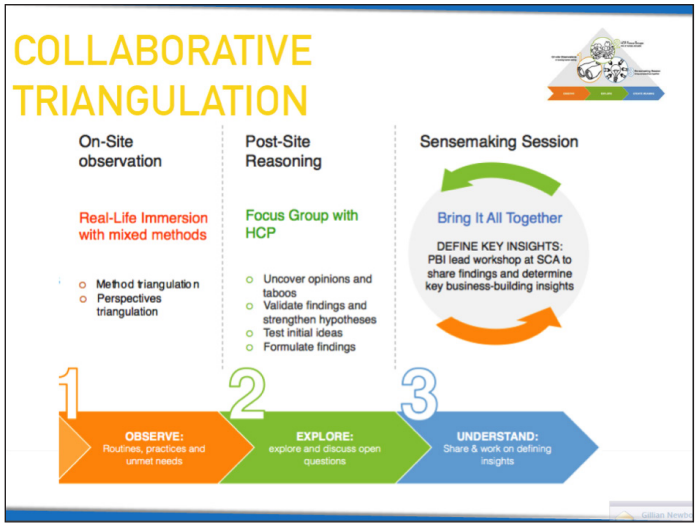
Specifically in the area of incontinence care within nursing homes, the presenters were fully aware from the outset of the challenge of an immersion approach in a field with very high personal sensitivity and strong data and privacy protection regulations.

With this case study, they aimed to show that carefully adapted ethnographic immersions and collaborative ideation setups involving multiple stakeholders are feasible in the healthcare context – if all stakeholders are willing to work together to embrace change and expanded roles.

But how did they go about it?

The team decided to reach out to their users in their own setting – the nursing homes. SCA had well-established contacts inside nursing homes, so their customers were familiar with them and viewed them as partners helping them to improve care. Drawing on this relationship of trust, the team was able to conduct onsite observations in the nursing home. These observations involved not only a local moderator, but a PBI moderator with native language skills and, crucially, an SCA team member (from the brand innovation team or market research department). The observations were followed by a traditional focus group with nurses and aids to follow up on specific issues.

The fieldwork was followed by "sensemaking sessions" – workshops in which the joint SCA and PBI team reviewed the fieldwork findings and worked together to design a framework to structure the outputs in order to identify relevant pain points and insights. In a single day, the co-creation workshop enabled them to move from the findings themselves to the joint creation of the conclusions.



The SCA managers reported that being part of the data gathering and analysis process was immensely insightful, enabling them to learn first-hand from their customers about their needs and the environment in which they operated. This experience not only energised and inspired them but gave them additional confidence in their convictions when pitching new innovation proposals to senior management.

Reflecting on the success of the process, Paul and Johannes highlighted three main conclusions:

- The process requires us as clients to become more active and engaged in the research process – not only a receiver of insight but co-producer of the learnings/ insights which helps us to understand our customers and to guide us on the route to innovation
- This approach calls for an adaptation of the typical researcher role – creative workshops require a specialist facilitator who can spark and guide ideation in an effective and meaningful way
- The case study shows that there are ways to overcome barriers to more challenging approaches to achieving need-driven innovation. Not using these approaches is not a solution – so we must find our own solution which works for our customers and clients. They urged us to "do it our way" with a final call to action: "Be bold, but be sensitive"

Written by:
Caroline Jameson
HRW

Thursday 25 June

Session 20: Brain, heart and intuition – showing new ways to make healthcare solutions more relevant

Speakers:	Dr Christiane Quaas, Boehringer Ingelheim and Patricia Blau, GIM
Chair:	Martin Schlaeppi, Praxis Research

Christiane Quaas

Patricia Blau

Dr Christiane Quaas and Patricia Blau presented a new way to make healthcare communications more relevant to customers, by integrating brain, heart and intuition.

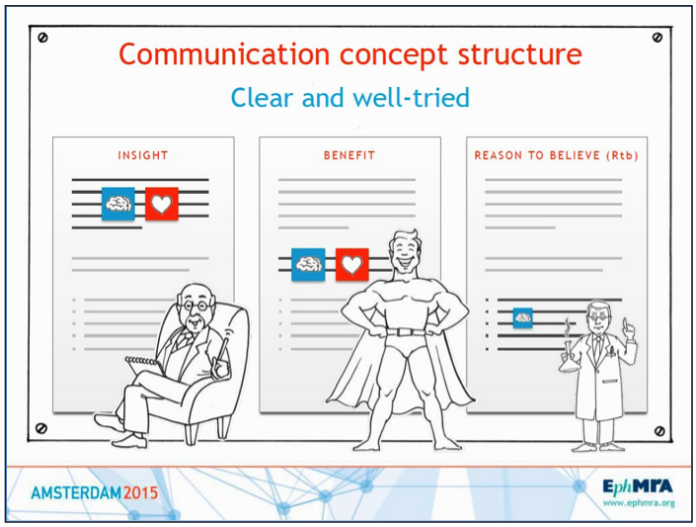
Christiane opened with the premise that marketers face the same challenge of trying to understand customer thinking when choosing between different options to address their needs – whether those customers are healthcare professionals, patients or, as in the examples discussed in this paper, consumers. Although, she states, at first glance this might seem to be a simple question of rational necessity, Christiane acknowledges the universal acceptance that customers use a combination of logic, gut feeling and emotion when making product choices – and that customers think a lot less than we think!

Christiane observes that marketers aim to create communication concepts for key initiatives that try to integrate both rational and emotional facets. This is commonly achieved via a "classic" structure of insight – benefit – reason to believe (RTB), in which the rational and emotional elements are both included. This is often used to ensure that the insights resonate well with their intended audience and that the audience feels reflected in that insight.

They observe that many companies differentiate too much between the rational and emotional elements within this structure, whereas human decision-making is a more holistic one.

In addition, as Christiane states, the effort goes mainly into the insight and benefits elements of communication whereas the RTB more often takes the form of a factual product description appendix. The presenters believe that simply acting as a product attribute appendix is an underuse of a part of the product message that is actually unique.

Translated into classic communication approaches, as taken by Boehringer Ingelheim Consumer Healthcare and by its competitors, this often leads to the following flow: communication starts by representing an insight that explains a health need. This is addressed by a RTB based on scientific facts – nice product attributes – and ends with the benefit that is about shiny, happy people or a cute animal. The speakers shared some examples of OTC advertising and television commercials which follow this classic structure and have proven to be effective, but warn that this can lead to a formulaic structure split in clear-cut rational and/or emotional sections.



consumers are highly motivated to select the most appropriate medication for their condition. They want and need to believe that the product will help, and look for guidance and trust when considering product explanations. Addressing this universal need requires a combination of rational and emotional components, but presented on the holistic level to reflect the way in which decisions are made. Ultimately the Reason To Believe must become the Reason To Be.

Patricia summarised the view that, currently, RTBs do not leverage the potential of RTBs to be the Reasons To Be. In addition, they do not given sufficient credit to the interaction and co-dependency of the various elements of decision making, such as fast and slow thinking, feeling thinking and gut-feeling and the whole system 1 and system 2 thinking covered in other papers.

Patricia introduced a new way of conducting concept research that runs in the opposite, bottom-up, direction and starts with the RTB and delivers a more holistic view of consumer logic thereby benefiting not only the development of RTB but the whole concept development process.

Patricia described the new approach, which involves looking at customers' "inner pictures" of their problem and their views of their treatment options, metaphorically and literally. The approach, using visual moderation techniques, involves consumers taking a tour of their bodies and helps respondents to describe points of interest regarding their health. The consumer is the tour guide and the researcher "takes pictures" of the points of interest via a graphic artist who participates in the interviews or group discussions. Following the "tour", the respondents review the pictures with the researcher, adding commentary and explanation to enrich them and generate additional learnings by reflecting on what they see.

Patricia shared some of the images elicited by this technique which represent the metaphoric nature of different health issues – for example, a sail boat in a dilapidated state representing the respondent's run-down physical condition and an image of an explosion, representing painful bursting.

The respondent narratives added to the visual outputs, and revealed more of the consumer logic such as the heart being represented by a towering castle being eroded by cholesterol which leads to a loss of stability and vibrancy.

Christiane then tackled the topic of how the healthcare product and its RTB interacted with these basic pictures. She took as her example, cold viruses that were described as aggressive monsters – intruders which are everywhere and attack you. This was a case in point which showed how respondents combined medical facts with imagination, and which inspired an intuitive explanation of the mode of action of the cold remedy being explored.

Christiane shared a television commercial that had been developed from using consumers' inner pictures of these alien invaders and how the remedy dealt with them, stating that, although not yet perfect, the RTB was beginning to seem much more intuitive. It also demonstrated that the actual output does not always need to be humorous and child-like. It is up to the brand team and the agency to craft a communication that fits the needs of the consumer and their understanding of how a product works which can use any emotion the team wishes as long as it is not neutral. The technique transforms the RTB from a scientific fact-based appendix into a trustworthy guide who speaks in the consumer's language.

She explained that the inner pictures had proven valuable beyond their role in shaping the RTB, being used to deepen understanding of the situational and emotional context of the health issue and providing a very tangible perspective for marketing teams to help them understand their customers more holistically. The visualisations may also help to uncover previously undiscovered needs or illuminate product benefits that the customers have not yet discovered.

Patricia also highlighted the use of this technique beyond the area of market research, including communication with the medical department (where the consumer-generated images prompted the medical staff to translate their highly specialised knowledge into simpler and more tangible terms); communication with physicians (where the images can be used as a basis for communication materials for the HCP to use when speaking to patients); and in generating more effective patient leaflets (where the visualisation approach can be used to combine the expert knowledge of the doctor with the patient experience).

Our speakers concluded with some key learnings emerging from use of this new approach:

- Customers (whether consumers, patients or HCPs) think less than we think
- Currently RTBs address the brain, but not always the heart and intuition. We are not leveraging their potential as "reasons to BE" or "reasons to TRUST"
- Capturing "inner pictures" acts as a natural bridge between cognition and emotion and helps us to use RTBs holistically
- A good RTB contributes to a "rational" product decision that feels right
- Inner pictures are valuable beyond television communication concepts
- And, ultimately, writing concepts for marketing initiatives remains both an art and an analytical marketing task.

Written by:
Martin Schlaeppi
Praxis Research

Session 21: Precedent and Consequence Research to Undergird Orphan Reimbursement Strategy: a multi-layered, non-traditional approach

Speakers:	Jack Gallagher, Clarity Pharma Research and Kevin McDermott, Insmed Incorporated
Chair:	Alex West, Instar

Jack Gallagher

Alex West

Jack presented an interesting and informative paper highlighting the challenges of orphan drug reimbursement dossiers and how scientific-grade market research can play a central role in reimbursement success.

Jack set out the challenges experienced in the pre-launch development of orphan drugs. Orphan indications are characterised by the unmet needs of a small but typically very vocal group of patients.

Rare diseases account for approximately 7,000 in number, affecting some 5% of the population globally. However, reimbursement authorities need to understand the outright need for medications tackling rare diseases so developing an evidence package to support the orphan drug can be challenging.

Payers claim to be satisfied with symptomatic treatments, and require evidence to support new technologies. As orphan indications, the awareness and evidence available to support new treatment is either minimal or non-existent, requiring manufacturers to organise and amplify the impact of the disease to secure reimbursement status. Jack suggests that the hurdles for reimbursement may be more challenging than those for regulatory approval, which focus on metrics of efficacy and safety which are generating during the drug development process. By contrast, demonstrating the burden of disease is a more complex process.

Jack highlighted Kevin's experience in the reimbursement team of a small company focused on orphan diseases to show how a multi-layered, non-traditional approach to market research was able to generate the scientific-grade evidence required by reimbursement authorities despite limited resources and lack of previously available data.

From the outset, this paper challenged pharma manufacturers to consider their own corporate position and commitment to reimbursement success compared with regulatory approval or market readiness, and challenged market research providers to consider the business service opportunities available in providing value to reimbursement teams – particularly in orphan diseases. He highlighted that CEO questions of sales volume and price points are often accompanied by benchmarks from other orphan indications, but without comprehensive information on the investment in the "evidence" in order to achieve such prices. He emphasised the need to employ competitive reimbursement intelligence services to reset CEOs' expectations by providing tailored benchmarks (such as different populations, stage of data used, comparators used and burden of illness demonstrated) in order to provide an accurate and relevant benchmark.

As part of his own learning curve to comprehend the ever-changing global reimbursement landscape, Jack described a recent project aiming to demonstrate burden of illness (BOI) for a new orphan drug and the dilemmas he encountered.

Dilemma 1 – What is the precedence?

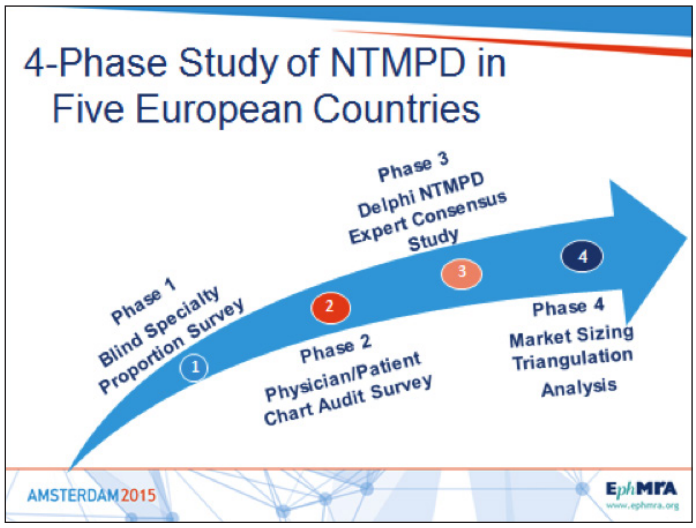
There is a clear difficulty in getting comparables. Jack described his own desk research to identify recent examples of reimbursement success, which revealed considerable variation in the evidence packages submitted for reimbursement approval and revealed the key questions relevant to his own company's situation. They needed to identify the treatment patterns that would prove value, to demonstrate the burden of disease and to specify where their rare patients could be found – and these questions needed to be answered to scientific-grade standards that would be recognised by the reimbursement authorities as they conducted their own research and literature reviews.

Dilemma 2 – Who to pick to get your information?

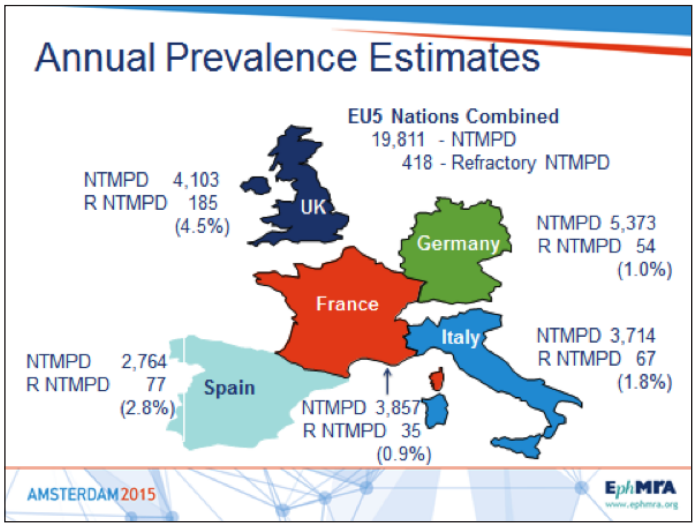
As a small company with limited resources, it was important to work with external experts to achieve reimbursement success – but where were the skills that were required? Many companies promised the "one stop shop" of skills and capabilities, but couldn't provide evidence of the number of orphan reimbursement successes that they had achieved. Jack described how he took a risk with a "crowd sourcing" approach, from which he identified 6 talented firms who could contribute in different ways to the reimbursement strategy, from value proposition, publication plan and economic model to customer engagement and dossier development.

Jack then described how the team achieved a BOI study in a disease area where no such study had been conducted previously. They started by defining the universe in order to identify the relevant sample frame by using a blind specialty proportion survey to identify how many physicians in a given specialty would be likely to treat this condition. They then put together a team of experts to generate reliable prevalence evidence, using a Delphi approach to come to consensus.

Next, they conducted the BOI study, using physician-sourced patient records to capture relevant patients, before triangulating the data to produce a pharmacoeconomic model including, finally, the costing.



The evidence generated was published in reputable peer-reviewed journals and forums relevant to the therapy area, lending further credibility to the results and ensuring that the information was firmly in the scientific domain to be found by the reimbursement authorities when they conducted their own systematic research and literature reviews.



Jack concluded that their unusual collaborative approach, cherry-picking expertise from multiple sources to contribute to the common goal, had started to yield the results that they needed to build up credible information in the market place and to demonstrate that this was a very important disease that payers need to address.

Jack closed the session with questions for both market research organisations and pharmaceutical executives, challenging us on our willingness to step outside traditional market research and embrace a new collaborative approach which would put reimbursement at the centre of its efforts, and emphasising that beyond the regulatory hurdles of efficacy and safety, the hurdle of market access will make or break product success.

Note from the session chair: It was unfortunate that Kevin was not in a position to attend the session on the day so I would like to thank Jack for taking on Kevin's slides and presenting them in an admirable fashion.

Written by:
Alex West
Instar Research

Communication skills of a hostage negotiator – how to listen effectively

Speaker:	Richard Mullender, The Art of Connection
Chair:	Lee Gazey, Hall & Partners

Richard Mullender

Lee Gazey

Anyone who's stayed to the end of any conference would expect to see dwindling crowds and a less than inspiring closing paper. This was not the case for the significant number of people who attended the final plenary session at the EphMRA conference in Amsterdam this year.

The title of the paper, "Communication skills of a hostage negotiator" may have done something to draw the crowds. The fact that the speaker, Richard Mullender, was the Former Lead Trainer at Scotland Yard's National Crisis and Hostage Negotiation Unit undoubtedly attracted conference attendees to stay and listen to his inciteful presentation.

They were not disappointed and Richard provided us with a highly entertaining and useful crash course on how to listen properly.

In Richard's paper he drew on his real life experience in being able to listen and negotiate in high tension situations and translated that into insight that will help us be even more effective in our jobs. He even claimed to know the secret to convincing a child to eat their vegetables, but that seems like a claim too far!

OK, so what is listening? Well, according to the dictionary, it's "the identification, selection and interpretation of key words that turn information into insight".

Well, our industry is built on Insight, so the promise of unlocking the key to success was a powerful lure. We were hooked!

Given that our industry is built upon the idea of asking great questions, Richard started his paper controversially. If you really want to be able to listen to what a person is saying you need to start by stop asking questions! He contended that as soon as you ask a question you change the direction of the discussion from one which is led by the client (or kidnapper, hostage taker etc.) to a direction which is led by you.

This immediately means the conversation about you (the listener) and not about what the client wants to talk about. This was golden rule number one – don't ask questions. But, if we can't ask questions, how can we get the information we need? It turns out a successful negotiator and a tennis player have much in common – it's about a well-timed grunt or groan. Or a judicious, nod, smile or "mm" or "ah" will also do the trick. The key is to get people to open up and talk about what's important to them, their values. And, of course people love talking about themselves. So let them talk and it won't be long before they're giving away secrets that will allow you to understand them better and influence their behaviour.

In the Listening Business, trust is the most important feeling to get someone talking – not rapport, as any sales person will tell you. There are various types of trust, such as organisational trust (do I trust this company will do the job I'm paying them for?) but none is more important than personal trust – Do I trust that the person sat in front of me will do thing they are promising to do?.

If you can make a person believe that, Richard claimed that you will be successful in your negotiations. BUT you can only achieve this if you know what values and beliefs drive them – and you can only do that if you listen precisely what they say and mean.

Richard provided an example – "A drunken husband comes home one evening and accuses his wife of having an affair. He pours petrol over her and is threatening to set her alight. You've got 20 seconds to work out what he wants…." By listening to the clearly distraught husband's words and feelings, Richard explained how simple it is to tap into his motivations and moral compass, to stop him from lighting the petrol on his wife.

Perhaps not a scenario that we would experience in our everyday lives, but it certainly got the message across. Skip back to our world and consider how many times we've been in meetings and have used "clever" questioning to drive the conversation to what we want to talk about, be it our latest product, or service. We might be better served understanding what it is our client actually wants and helping them with that.

So how do we become great listeners? Clearly it takes a lot of practice. Richard is still doing an hour a day, even with a life time's experience. But there are also some practical things we can do in our daily routines. First and foremost, know exactly what it is you're listening for! Secondly, adopt the correct physical position. Sitting slightly forward with an open stance can certainly help. Maintaining eye contact certainly doesn't, and can be a little bit creepy! According to Richard, you can overcome this by adopting a "ten to two position" (as on a clock).

So, some great practical examples of how we can all become more effective in our listening skills. But, in honesty, no written description of Richard's paper could do it justice. It was a brilliant and interactive session full of audience participation (amusingly, to the discomfit of several audience members at some stages!). It was also a fitting way to end one of the best EphMRA conferences I've been to in many years.

But, despite Richard's incredible skills, I doubt even he could get my kids to eat their vegetable!

Written by:
Lee Gazey
Hall & Partners

Associate Member News

Research Partnership promotes Will Tolley to Associate Director. Will is part of a large team of specialist quantitative directors and project managers working across our six global offices. www.researchpartnership.com

KJT Group welcomes Mathew Francis as Research Director. Located in the United Kingdom, Mathew will support KJT Group's growing European practice and global operations which are headquartered in Amsterdam.

Lisa Tam joins the PLAMED ASIA as Director from June. With 19 years of experience leading fieldwork business in APAC, we are excited to have her on board.

Kantar Health has promoted Jade Cusick to head its new global Client Consulting group as Chief Client Officer.

Services

42 market research, a leading provider for online market research in the healthcare sector, announces the launch of its new panel in the Czech Republic. www.42mr.com

QualWorld announces the opening of its US branch, QualWorld USA. The purpose of QualWorld USA is to bring top quality services to our clients throughout the US and Canada.

Your trusted partner in Japan is now available in China. Contact us for your China healthcare MR needs. www.ssri.com/cn

Your reliable research partner in the medical industry; GoodDr (www.gooddr.com) provides you with high-quality data, innovative solutions and efficient fieldworks to fulfil your research needs in Asia.

ANTERIO is proud to announce the addition of INTAGE's OTC service offering to its existing Rx business as of April, allowing a 365°view of the health service consumer.

KeyQuest Health, the global qualitative experts, now offer a stand-alone Analysis service across 5EU and USA. Upload your digital recordings and our expert Analysers will do the rest. Contact info@kqhealth.com

Payers and approval agencies want evidence of value and efficacy. We provide journal-quality research supporting evidence packages needed for optimising market access and reimbursement. Contact information@claritypharma.com or visit www.claritypharma.com.

Company News

At EphMRA 2015, SKIM highlighted the importance of using correct medical terminology in marketing. We also spoke on behavioural economics in the context of mobile research. For more information: www.skimgroup.com/ephmra-2015

Our London team outgrew their building so have moved to shiny new premises near London Bridge. Come see this new office there, or visit us in Oxford, Basel, or Manhattan!

Our Paper, 'Oncology and Shakespeare', highlights the need to bring a cultural lens to cancer, enabling us to challenge the status quo, to improve our communication and engagement amongst stakeholders.

Deadline for contributions:
7 September 2015

EphMRA

2016 Annual Conference
Frankfurt - KAP Europa
21 - 23 June 2016

Call for Contributors

Join us and add your contribution