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Welcome to the 2025 Post Conference News

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EPHMRA Conference 2025: Conference Opening

Speaker: Karsten Trautmann, EPHMRA President

Karsten opened the conference with a introduction to the event and the programme, designed to help delegates learn what is new, connect with each other, and to be inspired.

The conference aims to help delegates to shape not only the future of our organisations but the future of our industry. He shared his belief that the mandate for insights professionals is to guide the creation of evidence-based alternative scenarios which will enable our stakeholders to be confident in their business decisions.

He used the analogy of the nervous system to describe the insights role within our industry: connecting different parts of the body or organisation, perceiving the outside world, quickly bringing information together from different stimuli or inputs, and ultimately interpreting the range of information and triggering actions as a result.

He noted that this role helps our organisation to respond to events and trends, both internally and externally. Over the past years, the conference has facilitated discussion of a range of trends from new therapy areas to AI, as well as new government policy that may hinder our organisations in delivering effective products to patients. Karsten noted that we often respond to such trends initially with some anxiety, but also curiosity, and that ultimately we shift our mindset and find ways to turn a potential threat into an opportunity.

Karsten thanked all the volunteers behind the range of EPHMRA committees, producing invaluable work to help shape our insights industry. He summarised and commended the contributions of each of the committees, from Classification, Data & Systems, Devices & Diagnostics, Ethics, Fieldwork Forum, AI Community, Young Professionals, Forecasting Forum through to Learning & Development, highlighting their contribution to ensuring our future readiness as an organisation and helping to shape our industry. He also thanked the Events and Programme Committees who ensure the content and quality of the conference and Chapter Meetings to maximise our opportunities to learn and be inspired. Finally, he summarised the role of the EPHMRA Executive Board, working across committees and shaping the strategic direction of the organisation.

He highlighted upcoming Chapter meetings in the UK, Germany and Switzerland, and shared some new initiatives including publishing guidelines, the AI Community group and the Young Professionals group, as well as collaborations outside Europe including Asia, LatAm and the gulf region. The organisation is also addressing ways in which EPHMRA can help to make members' working lives easier, including ways to engage with senior stakeholders to strengthen their understanding of the overall value of insights.

Karsten took a moment to reflect on what sets EPHMRA apart from other similar organisations. He noted that we are wholly focused on healthcare market research and insights. EPHMRA provides ethics and compliance support at a global level, as well as providing opportunities for professional development and business networking.

He concluded by emphasising our role as navigators and innovators in insights, and reassured us that this role is not under threat from new developments such as AI. He invited us to make the most of the rest of the conference, using the opportunity to be inspired, to learn and think differently, and to connect with colleagues across all areas of our industry.

The Future of Insights in MR - Panel Discussion

Panellists:

Vijay Chand
Head of Transformation
Alexion

Dr Nick Coates
Global Director,
Strategy & Innovation
C Space

Samantha Schofield,
Global Strategic Insights Lead
Grünenthal Group

Convenor:

Amr Khalil
Ripple international

The panel discussion looked at the road ahead in terms of our industry and asked the delegates to vote for their top three topics for the panellists to focus on. These were commercial storytelling, data rich or insight poor and synthetic data friend or foe. As a fourth topic - human vs. machine - scored highly, it was also added to the agenda.

Nick began on the topic of storytelling by stating that we are in the business of changing what people do, not what they know. We need to think equally about insights and their delivery method - in other words, we need to talk about storytelling together with strategy and not think about it as 'qualitative fluff'. Samantha concurred with this and said that being crystal-clear on our business objectives will give us a strategic narrative. Vijay added that for successful storytelling, it is essential to know your audience and who you are presenting to.

Moving on to data rich or insight poor, Samantha said that the increasing amount of data captured in silos is leading to us missing opportunities to connect the dots. We need clarity over the questions we are trying to answer and we need strong hypotheses about behaviour changes. Nick reiterated this and said that we need to focus on AI's ability to look at datasets and find connections, while Vijay said that we need a framework in place for which dots are connected so that we can move the needle with our strategy. Vijay also stated that for anyone involved in data management, it is a feat to align stakeholders and tell your story in an easy and coherent manner.

Looking at the topic more broadly, Nick asked if we are polluting the world with all of the data we are collecting, or in fact, recycling. Amr stated that we are competing with other industries that are also generating large amounts of data while Vijay said that having somebody to pull all the data together is essential.

On synthetic data friend or foe, Amr asked if it is being amalgamated in pharma without being labelled as such, although he admitted that there is a temptation to use it in areas such as the rare disease space. Nick offered a note of caution and said that if you can't see what is going on, we have to be careful of the 'snake oil' that synthetic data can offered, particularly in areas such as ethnography. Samantha expressed excitement at what synthetic data might offer and said that it could have a space but that it needs to be used transparently. It will allow insights to be more in the room. Amr continued by saying that it is being used much more frequently in pharma and we need to identify what role it fulfils.

Vijay gave an example of how synthetic data can be used to test messages for the sales force to give to HCPs and their willingness or reluctance to hear the information. Samantha continued by saying that one of the problems with synthetic data is that it is inherently retrospective and we need to continually update it for it to be meaningful. We should always use it cautiously and transparently and be clear about its limitations.

On the final topic of human vs. machine, Samantha stated that we don't need to be technical but we do need to know enough to apply AI and to maintain data integrity. Vijay put the discussion into context by stating that we are in a similar place to where we were 10+ years ago with bitcoin. The challenge currently is the value of using synthetic data compared to human experience which may be missing at the moment but will be there in 5+ years' time.

Nick said that we should always check about the human in the loop and warned that ChatGPT cannot scroll down web pages. Vijay rounded off the discussion by saying that the biggest concern was that AI becomes the gatekeeper before we access humans - this is common practice in many helpdesks.

Selected Q&As:

Q Why haven't we nailed commercial storytelling?

A Nick said that we are often not clear about our story before building a slide deck. Vijay queried whether the story itself is worth telling, while Amr added that we get bogged down with analysis and then try and create a story.

Q Is AI sustainable?

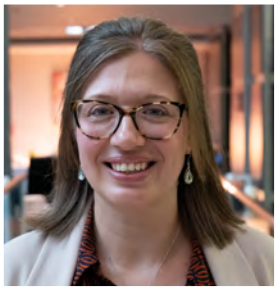
A Vijay answered by saying that as time goes on, there will be efficiencies but it is challenging in the short-term. Nick felt that with AI, Pandora's Box has been opened. We will see more high-quality datasets that are controlled in a different way.

Using AI to unearth the 'past stories' to guide our future decisions

Speaker:

Lucy Ireland
Branding Science

Convenor:



Lauren Halliwell
UCB

Lucy's paper focused on how we can make artificial intelligence (AI) work hard for us, and make our insights more valuable.

Lucy opened by framing the impact that AI might have on insights, using the analogy of the invention of tractors for agriculture and farming. Tractors, she reminded us, were a big step forward in increasing farming efficacy, transforming a highly "human-intensive" sector by alleviating manual graft. Tractors have evolved into sophisticated machines, for example, measuring moisture levels, calculating the required cropping height for harvesters and helping farmers to optimise the harvesting process. She observed that this revolution in farming practices had not meant that all the humans lost their jobs.

For the insights industry, Lucy sees AI as a similarly transformational tool, allowing us to dive into data, identify patterns and increase our understanding, while increasing efficiency. Although excited about all that AI can do for us, Lucy strongly believes that we need to ensure that we combine artificial intelligence with human intelligence (HI), as AI and HI together are better than AI alone or HI alone.

Lucy challenged us to make a decision: are we going to learn to drive a tractor, or are we going to try to fight the advance of the tractors? She encourages us to start thinking about how we can innovate using AI.

When thinking about innovation in our industry, Lucy defines three key areas for innovation which bring insights to life and increase their value:

- **Tools:** eg simulated eye-tracking, synthetic moderators
- **Thinking:** eg Behavioural Science, Futures and Foresight Thinking
- **Activation:** eg storytelling with avatars, embedding segmentation into tailored customer engagement strategy

Lucy observed that in many companies, generative AI (GenAI) is already being trained on previous transcripts and reports, and utilised to answer new questions using old studies, therefore increasing the value of the original insights. However, her focus for this paper is on the use of AI to ensure we deliver actionable recommendations, and help us to better predict the future.

When thinking about using AI to deliver more actionable recommendations, Lucy described a familiar scenario where our research recommendations include the provision of education for healthcare professionals or patients to support a change in behaviour. She explained that AI could be used to analyse previous research outputs and company initiatives (history), across different therapy areas (analogues), and leverage previous intervention feedback and outcomes (prediction) to ensure our recommendations can be actioned to optimise education materials and focus on the interventions most likely to be successful. (She noted that this would be contingent on the company having recorded the intervention and outcome so that it could be used to train the AI model).

She then presented two case studies to demonstrate the use of AI in generating actionable recommendations:

- The first, for the positioning of a 3rd-to-market product in a stable therapy area, where CIMZIA was used as an analogue to inspire a positioning based on a large unmet need for a significant niche group of patients
- The second, for predicting responses to a Core Visual Aid (CVA) based on AI trained on previous communication testing, alongside a behavioural science framework. This approach delivered a significantly faster process compared with HI an PMR, and detected nuances that might have been missed previously

Moving then to thinking about the use of AI to make our insights more powerful and better predictors of the future, Lucy observed that humans tend to either overpredict or underplay future development, particularly when we ask them to predict more than 5 years ahead. This clearly represents a challenge when we are basing recommendations on HCPs' reported predictions of the future evolution of a therapy area, for example. Lucy advocates the use of an appropriate analysis framework to help us work out what might happen in the future. Three tools that help us to build the analysis framework include existing knowledge within the organisation which can be mined, along with past stories that recur within our world, and finally societal trends and horizon scanning which help us predict which way the future is heading.

Lucy advocates using these tools at two different stages within studies, to create better stimuli to explore futures. She used the example of showing a doctor a target product profile in an interview, explaining that they are unlikely to be able to process its future impact without further information or a more holistic picture of how the future might look. These tools can also be used in the analysis of how the therapy area might evolve, such as "past stories" such as the association of biologics entering a new therapy area, where initially they are typically reserved for later use to prevent negative events, before further data show a slowing of underlying progression leads to earlier use.

Lucy shared a case study utilising Past Stories and Trends as tools to create a vision of future product needs in 2030 to help the client build their target product profiles for a new portfolio of products. The project started with KOL, PAG and Tech expert interviews to understand the current and near-future needs and the general direction of travel, but then added Trends, Competitive Intelligence, Horizon Scanning and Past Stories to explore how the therapy area could evolve over the longer term to 2030.

AI was used to collate the trends and past stories to speed up the process, resulting in a strong idea of how the 2030 therapy area and needs might look. This enabled the client to develop the target product profiles to underpin their R&D and BD approach for the next three years.

Lucy notes that these tools have been available for years, but that AI makes them accessible in terms of both time and budget. She advocates developing a process to systematically find and report these trends and past stories and avoid unfocussed questioning, and shared a process structure, including four key stages:

- **Brainstorm:** Starting with internal/team knowledge provides direction and captures the type of stories that regularly appear, without the potential challenge or paralysis from starting with a blank sheet of paper
- **Template:** Agree a template for collecting/recording the trends and stories so that they are easy to find within the AI model (for example, recording which prompts/queries were used and which ones work best within the AI model)
- **Search:** Using a mix of internal AI trained on the company's previous research, alongside deep search with public AI (such as Google Gemini) to identify the stories and trends, and checked for AI hallucinations
- **Report:** All the stories and trends are housed in a single, easy-to-search document accessible to your internal AI and easily referenced

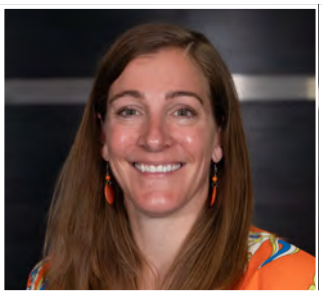
Lucy concluded with a call to action for us all to think about how we can use AI to make our insights and recommendations more valuable, and encouraged us all to learn how to drive this new "tractor".

Examples of how you have used AI:

- I have used AI to make a documentary about the cost of living. It created a short list for the film crew and in doing so, became part of the creative team.
- I am using AI to look at patient insights and co-create solutions based on secondary data across different therapy areas.
- We have used AI with internal and publicly available data to answer specific business questions. It has helped us, but you need a clear framework and a clear business question.
- We are starting the insight gathering process.
- The human brain has not changed. The wobble factor with AI is heuristics. We can use the AI lens to get a good idea of what irrationality looks like.

From Glitches to Insights: The journey of AI avatars in healthcare research

Speakers:



Katy Irving
HRW

Rory Mitchell
HRW

Convenor:

Mike Pepp
Beyond Blue

Katy and Rory shared with us the story of Frankenstein, reimagined for our digital age.

Katy outlined the challenge: trying to truly understand the breadth, depth and nuances of the doctor-patient consultation. Current market approaches, such as role play, using actors, or listening to recorded consultations each provide some of the answers, but each have different limitations, from artificiality, ethical considerations or cost-inefficacy.

The advent of AI avatars presented a potential new approach for simulating the doctor-patient consultation to enhance our understanding of how those interactions work in real life.

Rory highlighted some of the different types of avatars that they considered:

- **Scripted avatars** use pre-scripted content that is then turned into a talking avatar video using AI. Rory showed an example video and explained that these are very helpful, but are not interactive. Multiple branching clips could be recorded so that respondents could select their own narrative, but the number of scenarios required would make this approach impractical
- **Interactive AI** tools (chatbots or AI voice calls) could be used to mimic a doctor and respond in real time. Again Rory played an example audio clip, and observed that it can work well, but there is no visual component for the respondent to see "who" they are talking to

Rory observed that the ideal solution would be an **interactive avatar** – something with both the visual element and real-time response.

He explained that these tools are rare and still early in development, but the team found one that looked interesting, and decided to experiment with it by building a proof-of-concept test of a simple doctor avatar. They chose some more intimate therapy areas (such as heavy menstrual bleeding, HIV and urinary symptoms) to test whether patients would feel comfortable speaking to an avatar about these topics. Rory shared a video clip of this early prototype. He noted that the technology was not smooth, with uneven timing, basic visuals, and required recorded voice notes as inputs, but the test avatar did function and follow-up appropriately, and the team felt that it showed real potential.

Rory took a moment to explain the technology behind the tool. The avatar's "brain" is powered by a large language model (LLM) like ChatGPT, which had been trained extensively on language, but also a custom knowledge base to tell is who it's meant to be (ie a doctor or patient) and what it knows. The voice is generated by AI text-to-speech, and the speech is then lip synced with the video of a realistic avatar. This gives us a real-time conversation, powered entirely by AI, which opens us fascinating possibilities for research. Then real people can interact with these avatars, like a video call but with an AI avatar.

They created an avatar prototype of a bladder cancer patient. Katy described how the knowledge elements (such as bladder cancer symptoms, family history etc) worked well, with the avatar able to answer questions about the disease. However, the avatar behaved in ways that were not "human". To address this, the team performed extensive testing to identify the strange behaviours, and then adjusted the avatar not to do those specific things.

Katy recalled several areas where the patient avatar needed refining:

- **How to speak:** initially, the avatar delivered all its knowledge without pauses, and had to be taught to speak a few sentences at a time and add pauses to make the speech more realistically human
- **How to behave:** the avatar exhibited some non-human behaviours, such as volunteering information in their medical history without being asked, and had to be taught only to reveal certain information if asked

- **Who to be:** many use cases for interactive AI avatars are in customer service, so the model had learned to say things like "how can I help you today?", "is there something you'd like to discuss regarding your health?" or "I'm here to help". The knowledge base had to be adjusted to help with the role confusion and teach the model not to say this type of thing in their role as a patient, and also that, despite the knowledge base, the patient avatar should not know what condition they had
- **How to feel:** avatars tend to lack emotion, are robotic and very confident. It proved difficult to achieve a medium level of emotion

When the team moved on to working on a doctor avatar, this proved easier to achieve, as, for ethical reasons, they did not want the doctor avatar to be giving medical advice to a real patient. To achieve this, the doctor avatar was created that simply used very open questions to seek information, rather than giving medical advice.

Specific, strict, instructions were still required in the knowledge base to elicit the desired behaviours, such as teaching the avatar that it did not know anything about the patient's medical history and was to ask open questions, without forming judgements or giving a diagnosis.

Regarding empathy, the team experimented a little with the doctor avatar to try to make it more and less empathetic. Again, the avatar struggled with mid-level emotions, instead leaning towards the extremes of being too empathetic or inappropriately non-empathetic.

Extensive testing was conducted internally, and then three avatars were ready to take part in a self-funded pilot study with real patients – a neutral doctor, an empathetic doctor and an avatar mimicking a supportive friend. In parallel, real GPs were recruited to speak to three patient avatars, each with a different health concern (symptoms of bladder cancer, HIV, and a parent with infant vaccination concerns).

Before the pilots took place, steps were taken to ensure ethical integrity. This involved different steps at the screening stage, and at the start and end of the interview. These steps

covered data processing consents, information in line with the EU AI Act, explaining that the avatars were experimental and may behave oddly, and emphasising that the avatars should not give medical advice and that respondents should speak to their own HCP regarding any health concerns.

Now it was time to see what would happen when the avatars were put in front of real doctors and patients. Rory and Katy shared a video clip of the first interview with a real doctor speaking to one of the patient avatars. They had goosebumps and were delighted to see that it worked!

However, the first interview with a doctor avatar speaking to a real patient was fraught with issues, including the doctor avatar misunderstanding the patient, and frequent interruptions. Having made some changes to the avatar based on the first interview, the next patient interview worked well, with a health consultation that unfolded naturally. Rory described some of the ups and downs of the subsequent fieldwork, with some successes and some technical issues, but with each step helping to develop and refine this cutting-edge technology to help get closer to the reality of the doctor-patient consultation.

Katy reflected on the many learnings from this experience:

- **Lack of natural timing to the conversations:** participants needed to avoid interrupting or speaking over the avatars, and had to get used to the rhythm of speaking to the avatar, including a lack of natural conversational pauses or verbal acknowledgements
- **AI hallucinations:** the avatars were prone to making up information on topics that had not been included in their knowledge base. Sometimes this was helpful, such as responding credibly on topics that they had not been trained on, but it was difficult to predict when they might hallucinate or not. However, sometimes the hallucinations or strange behaviours were problematic, such as saying "child's name" instead of using an actual name, asking irrelevant questions, or speaking with an unnatural tone or emphasis
- **Very variable technology:** as this was the leading edge of new technology, the tech itself was highly variable, with new companies entering the market, or new updates causing changes to the platform, including new bugs appearing each day without warning, or latency issues where the avatar took a while to respond

Respondent feedback varied, with some respondents describing the experience as "creepy" or "weird", whereas others found it "super realistic".

Katy concluded with some thoughts on where this technology could be applied. She believes that there is great potential in using this approach to get to the heart of the doctor-patient consultation. However, she also advocates caution, recalling the crucial lesson from Dr Frankenstein, which was not regarding the creation of his monster, but in neglecting his responsibility afterwards. AI avatars are improving every day, but continue to be unpredictable, even when thoroughly developed. We therefore need to set appropriate expectations for respondents, moderators and clients in terms of their potential to be valuable, and their potential to misbehave. They remain experimental, and are therefore best suited to projects that can tolerate a degree of potential chaos! She left us with the reassurance that, unlike Dr Frankenstein, they will guide their digital beings with vigilance and wisdom.

The Power of Passive – how it addresses the omnichannel challenge / Would your customers lie to you? Telling the Truth with Passive Tracking

Speakers:

Xierong Liu
Ipsos

Hiren Odedra
Roche

Convenor:

Georgina Cooper
Basis Health

This paper began with a "reality check".

Hiren asked us to imagine that we are looking at data about a customer's digital channel behaviour.

They describe their day: get up in the morning, quickly check emails, get ready, take children to school, go to work. In clinic in the morning, then some meetings, catch up on some professional reading in the late afternoon. Then go home, cook dinner and do a little more work in the evening after the children have gone to bed. Their day sounds very rational and structured, with a clear schedule.

Then he showed us a snippet of reality.

The real digital journey was unstructured, highly varied, and alternated with surprising frequency between personal and professional digital tasks, mostly of very short duration before switching to another task. This example demonstrated how varied and how fleeting online digital behaviour can be, from Mozart for baby's brain development through Trump and Rolex to imaging techniques and PubMed articles.

Xierong summarised that this snapshot of a digital journey tells us that Healthcare Professionals (HCPs) are very "normal", with chaotic and distracted digital behaviours, and that personal and professional interests are interspersed and alternative with quick succession. It reminds us that HCPs are not only professionals, but have a "normal" side to their life too, and, like many of us, are trying to juggle professional and personal life.

This example prompted a question to the audience: to what extent are customers "telling the truth" when they respond to questions about their digital lives? To what extend do we really think they are able to tell the truth and record this level of behaviour and capture it in the timeline.

Xierong outlined a dilemma that this reality creates for us as an industry. She noted that 50% of the HCP workforce now come from the Millennial generation, rising to 75% in a few years' time. This generation, she reminds us, have experienced several technological revolutions and are adaptable and tech savvy. This experience, she explains, creates certain expectations about information being readily available, which has implications for an industry wanting to offer excellent customer engagement. However, the dilemma for our industry is the lack of availability of data reflecting true behaviours in the real world, and little connectivity between Customer Relationship Management (CRM) datasets to help us interpret behaviours.

Xierong asks if passive tracking could provide a solution to this dilemma by filling in some of the gaps in our data?

The snapshot of a digital journey our speakers shared earlier was an example of output from passive tracking - an application downloaded onto digital devices that monitors a customer's online activities over a period of time. She reminds us that passive tracking is real and unbiased data, garnered from digital observation rather than being

based on recall or perception as with self-reported data. Passive tracking data is granular, and allows us to capture the sequence, duration, frequency and content of digital interactions.

Our speakers highlighted some of the common objections and challenges when using passive tracking, and offered some hints and tips to overcome them.

Myth 1: passive tracking is "spying" and nobody will agree

Xierong shared data showing a sample across five European markets, with a representative mix of genders and a range of generations from Millennials to Boomers. She noted that, not only were they able to recruit doctors who wanted to take part, but that 50% of the sample had been recruited from a target list, with all the challenges that entails. Including target list physicians enables the passive tracking data to be linked with other internal data sources.

Xierong made some suggestions on how to overcome this particular myth. She recommended thinking about the type of information a respondent might need in order to agree to take part. This could be in the form of participant information packs, which can be particularly effective if kept to a manageable length, with an engaging format with professional and localised information. Providing objection handlers to fieldwork partners is also welcome and highly effective.

Myth 2: customers won't behave "normally" with the app monitoring their devices

Xierong shared data showing the proportion of online visits by topic or content type. These data showed that respondents were not restricting themselves to professional websites only, but were happy to reveal their visits to a range of sites from social media to adult content.

Practical tips for success included prioritising participants with multiple devices, ideally involving one personal phone and one work device to capture the full extent of online activities, professional and personal. Devices used by more than one person should be excluded to avoid obfuscation.

Myth 3: this is a compliance and privacy nightmare

Xierong revealed that, once the process has been properly explained, particularly regarding what is NOT being captured (nothing that is not already in the public domain, such as personal photographs, email content or passwords), people are much more willing to take part.

Key to success were the clear briefings and Q&A sessions with stakeholders, defining the data that would be tracked and not tracked, and communicating the methodology clearly.

Xierong shared some key insights to illustrate the type of data generated and the insights that emerge.

- The data reveal the true challenge of meeting customers at "moments that matter", with only 1% of site or apps visited relating to journals or publications. Only a small minority of respondents' time is spent on professional content that companies can influence, even when looking at senior HCPs.
- Not only are the "moments that matter" very limited, but they are also very fleeting in nature. 61% of sessions lasted for less than 2 minutes, and only 10% of sessions lasted more than 10 minutes.
- Basic demographics matter and may be as relevant as professional metrics. The data show that digital content topics vary by gender, often reflecting gender stereotypes. Age was also a differentiator when looking at online behaviour, with younger doctors spending a higher proportion of time on healthcare and professional content compared with older doctors. Xierong put forward a hypothesis that this might be because younger doctors are at an earlier stage of their careers and are more motivated to seek out professional development than established doctors.
- The "say-do" gap (a disconnect between self-reported and independently observed or captured data) is apparent when comparing data from these different sources. Xierong gave the examples of 66% of HCPs reporting that they use PubMed at least weekly, whereas passive tracking indicates that only 31% of HCPs accessed PubMed within a fortnight, indicating that HCPs are likely to overestimate how much they consume professional content. Similarly, most respondents report using their smartphones before 9am, whereas the reality is that phones are used more during the day, particularly the afternoons.

Hiren shared some insights on the impact that this work has had within Roche, and how he has used these data to change how customers are viewed within the organisation, demonstrating to the Marketing department that many of the assumptions and plans based on self-reported data may require some adjustment. The insights have highlighted how varied and irregular HCPs' day-to-day activities can be, increasing the challenge of capturing attention with our communications.

With these insights our speakers hope to inspire some new ideas on how to engage with customers, particularly the Millennials who are increasing in number within our target groups. They reported that, despite early scepticism from internal colleagues, the passive tracking data was considered impressive, not only in terms of insight but in terms of the practical challenge of achieving it!

Hiren and Xierong left us with three key takeaways:

- Where possible, use multiple data sources to ensure you capture the bigger picture, mitigate inaccuracies and aid interpretation in a wider context
- Work closely with your agency partner to engage internal stakeholders, so that agency, fieldwork partner, global and affiliate teams work effectively together
- Be bold – there is a first time for everything, and the effort spent overcoming any initial challenges will be worthwhile

Reality Based Forecasting

Speaker:

Richard Murgatroyd
Roche

Convenor:

Erik Holzinger
groupH

Richard began by explaining that his paper is based on his article that was published in Foresight, a non-pharma journal, in Q1 2025, which looked at why the curve of optimism around a product launch drops and what we can do to prevent this from happening.

Pharma is a very large global market that is worth $1 trillion. It is however risky, with only 1 in 20 molecules reaching market and the industry therefore having to pay for the molecules that do not achieve this. It is all about the pipeline.

Richard outlined that forecasts are easy to manipulate for a number of reasons and a unique combination of factors in the pharma industry. These include low manufacturing costs and once a patent expires, anybody can make the product. The pipeline needs a constant flow of new drugs, the total market is immeasurable and most pharma products don't cure the disease.

There are many different types of forecasts and most are based on a series of numbers. It is about sorting the wheat from the chaff to find the 'gold nuggets'. Richard explained that Roche has a committee that looks at forecasts and there are typically 11 facets you can use to change the numbers. He presented an example that showed that an initial forecast was close to what happened in reality.

In conclusion, Richard proposed a way forward for forecasting involving:

- Acknowledging the high level of subjectivity that can be involved
- Enforcing rules e.g. using correct financial returns
- Generating probabilistic outputs and educating on charts and numbers
- Carrying out a peer review of the forecast, not a management review

Selected Q&As

Q What is your experience around the communication of forecasts?

A We have had to go through an education process at Roche which has been done in partnership with Franchising and Marketing. It is easier for management when all sides ae working together.

Q What is the role of market research in linking long-term strategy with tactical forecasting?

A Market research gives an understanding of what doctors' priorities are within their sphere of understanding. The most useful research in terms of forecasting is qualitative TPP i.e. what type of patient would you use this for? We use an 11-point scale which can be adjusted for different countries.

Q Do you carry out a comparison between Roche's forecast and that of HCPs? Have you measured the difference?

A We have been to patients with a product profile but this did not prove useful. It was a little better with doctors, but patient and doctor estimates are generally wildly optimistic.

Q How do you forecast when combined with a conjoint?

A We combine variables of the patient profile with the product profile. You need to include 'would not prescribe'

Q How do you deal with management expectations on forecasting?

A Forecasts report through commercial people. We have got better at dealing with management expectations and we have developed a relationship with our business development team. In Roche, this doesn't happen unless you go out of your way to develop a trusting relationship.

Q Have you been in a situation where bias was good?

A We had a group of people who strongly believed in a product and found the low bias forecast unhelpful. The case for the molecule required belief in a new mechanism and we ended up with two forecasts that were far apart. The forecast was rescheduled and we finished with a new forecast that was the same as the old lower forecast. I would always believe in the lower number in a case like this.

Q To what extent do you think that companies want accurate forecasting?

A There is a strong case for wanting accurate forecasting from the supply chain team but I have spent a lot of time explaining that this was unrealistic. The expectation was there because they need to know for a number of practical and logistical reasons.

Driving Acceptance and Actionability of Engage 360 – a multicountry corporate reputation

Speakers:

Virginie Kraif, BMS
Co-Speaker: Allen Titto
ZS Associates (not present)

Convenor:

Amr Khalil
Ripple International

Virginie opened by paper with a question to us all: had we ever experienced sharing brilliant insights, only to be met with resistance or finger-pointing? She postulated that this may not be the fault of the message, but in how that message lands with the audience.

Virginie shared her own experience of this unexpected and unwelcome reaction, and explained the context and events, as well as how she ultimately achieved success with a satisfied audience and valuable insights.

The study in question, Virginie explained, was a thorough and elaborate company reputation study, conducted annually. The objective was to evaluate and compare BMS against its competitors in immuno-oncology, and identify ways to improve the quality and impact of their interactions with HCPs.

Allen explained the importance of the study in understanding what truly drives HCP perceptions in order to inform commercial strategy to build and maintain brand equity and lasting relevance. The study covered eight European markets, and delved into metrics such as company reputation, services, interactions and perceptions of treatment. Virginie explained that this approach was unique within the BMS markets and teams, and she had high hopes and expectations for the study to make a big impact.

Allen provided further details about the methodology, describing the sample of 282 immuno-oncologists across 8 countries, and explaining the strong methodology with multi-dimensional benchmarks comparing BMS with key competitors. The approach included indirect questioning and derived analysis to limit bias, and MaxDiff, TURF and driver analysis to inform prioritisation of future communication initiatives.

Allen shared some insights that emerged from the research, helping BMS to identify the real drivers behind perception shifts. There was a number of different "ah-ha" moments that would be game-changing for BMS and transform that way it interacts with prescribers. Allen highlighted a few examples:

- In a time period where COVID-19 had catalysed a shift to online touchpoints, the research indicated that face-to-face presence was very important, particularly involving experts and thought leaders
- Impact is determined by the quality of touchpoints, not the quantity, highlighting that not all touchpoints are equal
- Peer-driven learning opportunities elevate perceptions of the sponsoring company
- Multi-channel touchpoints gain greater impact when they are carefully orchestrated, ensuring reach without compromising depth

Virginie described her excitement about the results, with her confidence based on the strong metrics-based methodology which delivered impactful insights with clear and actionable takeaways. She was sure they would be very well received

in all countries involved, and would be impactful for the BMS leadership team.

Virginie recounted how she had delivered the "good news story" to each country and to the leadership team, highlighting metrics where BMS was performing well. She had also highlighted to her audience other areas where BMS had an opportunity to improve, and provided clear and actionable guidance on how to tackle those specific elements.

However, she explained, as she proceeded with the presentation, she became aware that her audience was not sharing her excitement. Instead, they seemed to be focused on one underperforming metric, or comparing themselves unfavourably to another country. A few outlying datapoints were overshadowing the broader, solid story. She started to hear murmurs questioning the methodology, and scepticism spread. Virginie had been taken aback: she was delivering a "good news story", but the insights were being met with scepticism. She was baffled by the response. And very disappointed.

Virginie described how she shook off her disappointment and was determined to turn things around and find a way to communicate the valuable and positive insights that this important study had revealed.

She met the scepticism with transparency, rebuilding trust in the data through validation, data checks and confirmation of the relevance and credibility of the sample. She addressed every one of the concerns and questions. She expanded her reporting to include additional data cuts to identify drivers for weaker results, such as one subgroup of HCPs responding differently to a particular interaction, and highlighting how this could be overcome, explaining the variation in country performance on different metrics and using best practice success stories to show how different countries could learn from each other. She increased communication with stakeholders, for example involving medical staff who had not been involved at first, clarifying findings, addressing concerns and reinforcing confidence in the process. She delivered tailored presentations to different teams to ensure consistency of takeaways and to facilitate shared understanding of the insights.

Her hard work paid off – she was able to help her audience view the results through a different lens. Now, she recounted, she observed some "light bulb" moments from her audience as they understood the insights and what could be done to improve customer interactions. She had won their attention and trust.

Now, two years after the study, Virginie reported that the study remains relevant today. She feels that because of the additional work undertaken to dissect every aspect and communicate it extensively, it is still considered a reference point for many teams, with new and old team members. She noted that she still receives requests from many countries asking for more analysis or a new iteration of the study, demonstrating that it remains strategically important.

Reflecting on her experience, Virginie believes that the market research journey is not only about a robust methodology delivering great results, but about how to communicate the insights to stakeholders and respond to their questions.

Allen and Virginie summarised the lessons learned from this experience, and the formula for a successful study:

- Choose the right partners who challenge assumptions and sharpen insight in order to generate the right output, and who are willing to come on the journey with you to co-create different creative outputs to meet the needs of the team
- Employ a robust methodology aligned to the objectives to elicit not just data but direction
- Go beyond obvious top-line metrics to reveal deeper insights, even if this requires additional effort to dig into the details
- Keep a flexible mindset and adapt communication of results to different teams and markets, as one approach rarely fits all when interpreting multi-country data

Keeping communication channels open, Virginie believes, helps to build trust by being transparent, flexible and accepting feedback, and being prepared to put in the extra effort required to engage all stakeholders.

For both Virginie and the ZS team, there was no doubt that the determination and commitment to extra thinking and extra effort really made this study count, and turned a difficult situation into a clear success.

Cracking The Engagement Code: Modelling to maximise social media success for disease awareness

Speaker:

Jamie Doggett, Lumanity
Co-Speaker:
Stephane Lebrat
Takeda (not present)

Convenor:

Georgina Cooper
Basis Health

Jamie set out a dilemma facing many teams trying to raise disease awareness using social media. He noted that Marketing teams often rely on lagging indicators (retrospective metrics); a prevalence of A/B testing which can be accurate but often time and resource intensive; content based on past experience and intuition but potentially lacking examples of what might work in a specific therapy area or market. Taken together, he observed, these factors can limit our ability to engage effectively with audiences and achieve our desired outcomes.

Together, Lumanity and Stephane have been tracking social media and online sources for many years, looking at conversation volumes, levels of engagement, themes and campaigns in a specific vaccination area, and had collected an impressive dataset. However, Stephane believed that there was potential to move beyond the insights that a typical social media tracker could deliver: there was a lot of insights locked up in the data that were not being accessed, that might help the team move from using guesswork to guidance when shaping disease awareness programmes.

Stephane joined the meeting via video, to explain the challenge he was facing. Following on from a previous paper presented at EPHMRA, Stephane recognised the limitations of A/B testing and wanted an alternative approach that would increase engagement by understanding what actually works.

Stephane and Jamie realised that there was an opportunity to use predictive analytics to indicate whether a post was likely to work or could be improved to work more effectively. More recent advanced analytics such as neural network models are already being used in other industries, such in e-commerce which uses browsing history to make product suggestions. The team wondered if they could do the same with social media campaigns, using previous material that had resonated with audiences to build a model which could predict which future material would perform well. They wanted to answer some very practical questions, such as when might a campaign perform better? What makes it go viral? Who shapes the online narrative? How can we improve content and maximise engagement?

They then focused on the content of the post, looking at the words and themes that audiences need and want, and considering how Natural Language Processing might provide insight on this. Analysing the metadata that is usually hidden would provide insight on features associated with a successful post. At every point in the process, the objectives and intent of the project needed to be at the forefront of all the decisions made during the project.

Jamie then outlined the build of the project, starting with engagement metrics from different channels (such as views, likes, comments and reposts) as well as inputs such as hashtags, word counts and time of posting metrics. The team evaluated and selected the most appropriate models that could be blended to create a predictive model with a blended outcome. Jamie revealed that the model did successfully predict engagement – although with variable accuracy depending on channel (for example the model gave better results for YouTube than for Twitter).

Jamie cautioned that the process had not been as straightforward as it might sound, and shared with us some of the challenges they experienced, as well as the learnings that helped to overcome them.

The first challenge came with the data limitations: Jamie explained that there were gaps in the data that needed to be filled, and, where that was not possible, a decision had to be taken on whether to include the incomplete data. The channels themselves also presented limitations in completeness of data, as the same metrics are not always available from all channels or all authors. For example, Instagram does not always provide the number of likes on posts.

Similarly, Jamie explained that the sentiment classification of health-related social media posts is notoriously inaccurate, and decisions had to be made on which datapoints to include in the model.

There were also challenges from the changing landscape of social media platforms. The project ran over several months, during which time social media platforms changed their algorithms and Application Programming Interface (API) which allows access to the metrics.

Another challenge the team faced was due to the global nature of the project, where language, cultural nuances and even seasonality needed to be considered. This led to a decision to run one model per market, rather than a single global model.

Jamie described a test phase to ensure that the model could predict with accuracy. Two posts were compared. The posts looked similar in many ways: both from Instagram, both videos, both users had a similar number of followers, and the posts used similar word counts, but were posted at different times and with a different number of hashtags. These two posts elicited very different outcomes, with one garnering significantly more likes and comments than the other.

The team wanted to understand before they post which features are going to affect the outcome more strongly than others. They also wanted to be able to feed a post into the model and ask it to optimise the post for likes or for comments. Jamie explained that optimising for likes focuses on increasing awareness – more likes will help to communicate your message by appearing on the home feeds of new individuals who aren't yet following you. The model will give recommendations for optimisation, such as changing the time of posting or changing the word count. Similarly, to optimise for comments, the team would select that option in the model, and it may make very different recommendations.

Jamie reflected that this functionality enables the Marketeer to create their social media posts with confidence, allowing the model to optimise the more functional elements and focusing themselves on the more creative, softer or more "human" elements.

The team used correspondence analysis to map some of the variables, which revealed some valuable synergies.

For example, if posting about vaccines, the model recommended posting about "mosquito borne disease" and "location" together to create better engagement. The correspondence map could also identify which themes do not work together so well to create engagement, such as "authorities" (ministry of health, drug regulatory body etc) and "risk and protection".

Via video, Stephane then shared some of the impacts that the model has had on the business in terms of how the model could be used and the outlook. There is a pilot in the one country seeing how the team can anticipate the impact of certain messages through the model. They select message, put them online, measure the performance and then we can fine tune the model. This allows the team to generate more and to be more creative. The hope is to develop the approach for all countries in the future.

Jamie summarised three key takeaways from the project:

- Build smarter from messy data: we need to overcome the "noise" of incomplete or inconsistent data to build a robust modelling approach
- From insight to foresight: being able to predict the social media response before posting helps us to optimise the post in advance more effectively than traditional A/B testing
- Data-driven doesn't mean creativity-free: social media posting is a creative endeavour and requires an understanding of what humans are going to appreciate online. Predictive insights can sharpen creativity to help marketeers craft bold, tailored campaigns that drive impact across every channel

He concluded that in the age of AI, we are challenged to work smarter, and to unlock and leverage the enormous amounts of data that surround us to boost efficiency and accuracy, and enhance our performances. Approaches such as this are a step forward, but the real opportunity lies in how we as researchers push these tools further and lead the next wave of data-driven innovation and insight.

Who's Really Steering The Ship? Translating global brand strategy into insight-driven local plans

Speakers:

Clare Carroll
UCB

Rhodri Williams,
Accenture Song

Convenor:

Sarah Phillips
IQVIA

Clare and Rhodri's paper showcased how close collaboration between global and local teams can ensure that market research insights drive brand success, helping us to deliver the full potential of pharmaceutical assets.

Rhodri outlined the challenge pharmaceutical companies face when bringing a new drug to market. He noted the level of investment and preparation required, and the long development timeframe, compared with a very small window for a product launch and maturity phase to deliver product success. With the increasingly competitive regulatory environment, and complex and diverse local markets, he emphasised the importance of clear connection between global strategy and local insight.

Rhodri observed that insights professionals experience a number of pain points, reminding us that global brand teams are responsible for driving the strategy but that local team input is critical to ensuring that the strategy works for those "on the ground".

An audience poll showed that the balance between global and local teams tends to sit at "mostly owned by global teams", with "a good balance between global and local ownership" coming second.

Clare reiterated that UCB faces the same challenges as other pharma companies with teams in very different, diverse places from market research and real world evidence to finance and pharmacovigilance, 1 all holding different information on how our brand is living and how the brand execution is happening across the world. All these inputs needs to be integrated and understood to reveal meaningful insights.

She then talked us through what a strong global-local collaboration looks like in practice, using the example of a brand 2 years post-launch, where the brand strategy was well-understood but there were some challenges in execution. The

company brought the local teams together for a face-to-face workshop to understand the challenges they were facing and uncover insights that would help to inform the global team in partnership with them.

Clare described the framework that was used to try to pull the multitude of insights together. The process started with articulation of the problem to be solved – the identification of some specific pain points in the patient journey. The country champions and local teams then conducted some pre-work, pulling together insights from the patient journey and identifying potential leverage points to bring to the workshop for discussion. At the workshop, a creative exercise to help articulate the problem used collage with posters,

magazines and scissors to select images to represent the problem. Then the pre-collected insights were mapped onto each problem or pain point to create an aggregated global view. Finally, the discussion focused on the actions to be taken to address the problems. To finish, participants summed up the discussion with a fun exercise to select an image that represented each insight and opportunity, giving it a title using a song, metaphor or quote to bring it alive for them.

Clare shared an example of this, showing an insight opportunity around "success breeds success". Soon after launch, the sales force was being asked for real world evidence (RWE) which obviously was not yet available. In lieu of RWE, physicians wanted to hear the experience of others before actually taking the leap to prescribe for themselves. There was an opportunity to start documenting successes with the product, qualitatively and quantitatively, to provide the body of evidence that physicians desired, and creating the building blocks to success. This approach was incorporated into local tactical plans, translating the insight opportunity into high impact activities. Clare reported that at the end of that planning cycle, the country teams were feeding back plans with each insight opportunity front and centre within their plans, with positive feedback from senior management about the clarity and cohesion of the plan, and recognition that the insights had really driven the activity planning.

Rhodri then talked to us about how to apply this approach to other situations. He noted that the approach doesn't need to be "high tech", but more about the close collaboration of teams to develop a shared understanding of the problem and potential solutions. He highlighted some other considerations to help accelerate and smooth the process. In order to drive a stronger connection and shared understanding, Rhodri recommends a centralised platform for insight sharing so that everyone can access and update them. Empowering our partners within the local markets to take a more strategic view, and working closely with them, helps to bring insights up through the organisation. He also advocates measures to ensure the strategy remains consistent and clear. Building capabilities within the organisation to create structured feedback loops and measure the impact of local adaptations ensure that the insight stays sharp. Investing in people to build those capabilities and skill sets and providing learning opportunities will also sharpen everyone's understanding.

Rhodri summarised some key takeaways to help us embed insights-driven brand planning:

- Local insights are a strategic advantage, not a "nice-to-have" tick box exercise but a fundamental part of successful product launches
- Use structured, repeatable methodologies to gather the insights, ensuring that they are streamlined with minimal friction to reveal great insights more often and more effectively
- Embed the insights deeply in the strategic planning and execution
- Empower local teams to help shape the global strategy, but also to adapt it effectively to the needs of their local market

Selected Q&As:

Q How do you bring local insights into a centralised way of dissemination and how do you upskill the differences between insights and observations?

A It is difficult to divide insights and observations but it is good to have a sense of this as an insights professional. Communicating in bite-sized chunks as to what data is and what insights are is a good starting point, but it is becoming harder with the volume of data we have.

Q We are considering using AI to generate field insights and look for patterns. What are your thoughts on this?

A We send a 1-page situational analysis to markets for them to complete. We then have a 3-hour session sharing key insights from the markets. It is all about how you build capability and cross-functional representation.

Q What is a feasible number of countries to include in global insights?

A It is impossible to give a number but the responsibility really lies with regional teams. We ladder everything up to the global team. It is also about prioritisation. You cannot get to everyone. We start with five or six key markets and use technology to hear from everyone.

Q Getting teams together is challenging. How do you go about justifying it and what value does it bring?

A I am drawing my example from European countries, but I think it is very valuable. We have done it every year since 2021 with an insights face-to-face workshop. Everybody has felt very empowered and listened to. It is harder to get people together on a global level, but there is real value if you can do this. That said, the biggest pushback can be from global people. It is important to demonstrate value and that you have key people in the room. You don't need 40 people - you just need 15 or so who are empowered to make decisions. It is an opportunity for regional colleagues to show what they are doing and ground this in commercial reality.

Q I want to re-imagine our insights strategy and better leverage what we have to do. What platforms are you using?

A We have a knowledge management system for people to upload into and it has an AI interface. Different teams have their own AI and it is going to be a challenge to link them together. You need to make all platforms as operational as possible and avoid them being a dumping ground for information. This needs coordination and a clear strategy.

Reaching For The Top: How a client/agency partnership conquered new heights in brand tracking

Speakers:

Richard Head
Research Partnership

Mattias Blomgren
J&J

Convenor:

Letizia Leprini
Roche

Perhaps unexpectedly for an EPHMRA conference, this paper was opened by the Chairman of the Swedish Mountaineering Club...!

Richard explained the relevance of the mountaineering analogy. Mountaineering, he said, is hard work. Reaching the highest summits requires years of planning, skilled teams, the right equipment and the ambition to conquer the heights of the mountain. This paper shared Richard and Mattias' journey to reach new heights in brand tracking, focusing on the key success factors that helped them to achieve their goal.

J&J wanted to transform and harmonise their brand perception tracking, tailoring it to the complexities of over 25 countries and 10 therapy areas, with the ambition to deliver the right insights at the right time to the right people, to drive brand performance at scale.

Mattias set the context for the project, explaining that a few years ago, J&J was juggling 150 different brand trackers across the region, with 60% duplication between regional and local trackers, and 40 different Key Performance Indicators (KPIs) with varying definitions making it difficult to leverage the data for advanced analytics at scale.

J&J recognised this inefficiency and wanted to completely re-think the approach to brand tracking, to ensure that the market research function could provide the timely insights to guide the organisation in making impactful business decisions. The first step, he recalled, was to recognise the problem, and that there was a mountain to climb.

The vision for the new brand tracking programme was to design a state-of-the-art, future-facing brand and company perception tracker that could benchmark competitiveness for any brand in any country, pinpointing both the brand drivers and the required actions to optimise brand performance.

The programme needed to be easy for all stakeholders to understand and use. It would eliminate the duplication across the region, delivering a single integrated tracker, and distil down the KPIs into 10-15 common metrics, representing a single source of truth for all teams. A modular design optimised wave frequency and improved sample robustness, while the enhanced analytics capability (including future-proofing automated analytics and GenAI compatibility) delivered a faster time-to-insight, reducing some trend analysis from 9-12 months to 2-3 months. The engaging delivery platform increased accessibility and collaboration between stakeholders. This new tracker programme helped J&J to drive brand performance, at scale, in a more consistent and efficient way.

Richard shared further details to illustrate the size and scale of this new tracker, describing it as the "Himalayas of trackers". In 2024 alone, over 16,000 interviews were conducted, generating almost 100 million datapoints in the dashboard. Over 250 reports were delivered, accompanied by over 470 workshops and alignment calls, and involving 560 different dashboard users within the J&J team.

Mattias wryly observed that the vision and ambition for the project was an important first step, but that, equivalent to gaining your partner's approval to climb Mount Everest, there was an important job to do in gaining leadership approval to allow the project to go ahead. The team needed to sell the vision to all the internal stakeholders, to bring them along on the journey. This engagement and change management stage required careful communication to build not only belief in the project's aims and benefits, but momentum to achieve it together. He explained that J&J is a decentralised organisation with 150 different teams impacted by the project, each with different priorities and motivations, from Finance keen to de-duplicate, Data Science keen to have one source of truth with harmonised KPI language, and Commercial keen to have faster insights, through to the market research team who wanted to help the business with better insights. As well as the required internal collaboration, Mattias realised early on that they would also need a highly collaborative relationship with their partner agency, as it would require a bespoke approach to achieve the vision.

Mattias emphasised the importance of a strong internal project team. J&J put in place a Program Steering committee to engage with senior leadership, facilitating the Core Team to co-ordinate the project, and with smaller Squads to collaborate and engage with individual stakeholder teams across the organisation. Similarly, Richard described putting in place a strong central team, led by senior quant directors, and assigned a Director to each Therapy Area (TA) team, supported by a senior TA lead, who worked together with each respective brand team.

Richard noted that mountaineers who reach the summit might get all the glory, but that a broad team supports them at base camp. It was the same, he explained, with this project. The IT team developed and managed the dashboard, implements the monthly updates and capability enhancements, alongside Data Processing partners who run the data and produce tables, and the Advance Analytics team who developed the model and run regular analytics and continue to develop the predictive capabilities, working closely with the J&J Data Science team. The Operations team, lead by a senior leader, has been instrumental in delivering the fundamentals of the sample, working with their Fieldwork partner at M3 to develop a sample that is almost all J&J's target customers.

The RP internal Steering Committee includes the CEO and senior leadership, reflecting the importance of the project to both RP and J&J. Monthly review meetings between the RP and J&J teams ensure good, two-way, communication and tight control, and assessment against a series of KPIs for the delivery of the project. Weekly meetings focus on the functional operations of the project, and biannual whole-team meetings focus on strategic developments and next phases of the programme.

Richard noted the size and complexity of the programme, and explained that delivering the volume and complexity of data required some innovative approaches. Just as successful mountaineers need all the right equipment, this project used technology in the form of AI. The modular approach offered standardisation, but also the flexibility to add brand-specific questions. A range of deliverables was created, to meet the needs of different J&J stakeholders. A dashboard was used as the main platform to access the more frequent data collection, with the ability to add the data to the J&J internal data lake. To maintain data quality, despite the more frequent data collection, respondents were asked to provide open-ended responses to capture spontaneous perceptions, which were then analysed using AI text analytics to quickly identify red flags of threats to the brand. Autocharting was used to achieve the volume of reports (twice-yearly in every therapy area per country).

Richard encouraged us not to be afraid to experiment, citing the example of the team's initial text analytics partner which closed down, they switched to another with a more robust platform and powerful visualisations. He also reminded us that AI needs the human touch. Although AI is clearly instrumental in the management of project analysis and deliverables on this scale, human intelligence is required to steer the AI, and to analyse what emerges from the AI outputs.

Mattias explained that although the combination of technological innovation and clever market research design had helped them to reach new heights in brand tracking,

the journey had not been a straight path, with almost two years of preparation and challenges before they were able to achieve their ambition. Just as mountaineers encounter rock falls, landslides and barriers on their route to the summit, the team encountered some unexpected challenges too, which required them to work as a team to resolve.

One of these challenges, Richard explained, was developing powerful and differentiating KPI measures. Having developed a forward-looking measure of brand share with good predictive power and high statistical relevance, the team realised that it was difficult for the Commercial team to understand, and was making it difficult to differentiate between brands and to identify opportunities to address any barriers to brand success. For these reasons, it did not align with the original vision and ambition of the project.

The team went back to basics, and developed a new, easy-to-understand, composite KPI, which was extensively tested and validated to ensure it also had the necessary predictive power. It was a solution that struck the right balance between what was best analytically, statistically, and what was best for the business.

Richard described another challenge: that of the balance of the need for standardisation, but also needing to be flexible. He shared an example from Multiple Myeloma – a core area for J&J with four brands launched or launching in Europe. The challenges of monitoring this therapy area reflected the pressures of the different brand teams, all wanting answers for their brands in different indications and regimen combinations, each with different competitor sets. Changing the KPIs enabled the team to remove some restrictions on the competitive sets and make it easier for respondents to complete the reporting tasks. The redesign had to avoid any impact on other therapy areas or deliverables to maintain data integrity, and involved adding parallel surveys with targeted respondents, focused on earlier vs later lines of Multiple Myeloma therapy, whilst maintaining the same structure, and allowing respondents to complete a survey in an acceptable timeframe. This change delivered results that were much more relevant for the brand teams, and underlined the importance of being able to flexibly adapt to nuances of different therapy areas, whilst maintaining a standardised overall design.

Richard concluded with a summary of key takeaways to consider when planning to revitalise your brand tracking:

- Have a clear and simple vision of where you want to go, and why you are setting out on the journey
- Be ambitious – aim for the top, but also be realistic with your leadership team about a journey that may not deliver results overnight
- Be clear about the expected benefits, and sell that vision to get all stakeholders on board
- Form a strong partnership with you market research agency and be ready to solve challenges together as a team
- Recognise that the journey is longer than you think, and will take twists and turns, sometimes taking a few steps back before we can move forward

Mattias shared some takeaways from the pharma company perspective:

- Brand tracking underpins the whole business as the evidence base for critical decisions, so it is essential to get it right
- It is important to keep developing and enhancing the programme, leveraging the advantages that technology brings
- The new tracking programme delivered significantly faster speed to insights, as well as a more consistent approach, and the leadership team could have confidence in collecting the right insights from the right people at the right time
- There is always another mountain to climb, and more ways to push the boundaries, such as using new technology to grow our capabilities
- Although the journey might be hard work, the view from the top is spectacular.

Forecasting Roundtable:
Conjoint and Qualitative Primary Market Research in times of AI

Speaker:

Okke Engelsma
Cerner Enviza

Erik Holzinger
groupH

In their roundtable discussion, Okke and Erik looked at the use of AI with a particular emphasis on Large Language Models (LLMs), before moving on to look at the benefits of AI more generally and the caveats that are currently needed.

Erik began by stating that AI can work very well with LLMs. It can give quick and cheap outputs that look fantastic and you can upload, customise and modify data easily. However, it needs to be used with clear caveats. We have to remember that what we are getting back is a simulation that tries to mimic human output. The AI output is based on probabilities and a machine-learning model. It wants to optimise what makes you happy.

Okke went on to say that it is easy to check if your LLM is a good one and if you make it more restrictive, you can get good insights based on selective sources you can trust. While it is easy to get a synopsis, it is important to dig deeper into what is being used. What we get with AI depends on the prompts you put in and you have to be selective. With machine learning, there are lots of parameters to work with and you have to understand how the parameters influence the result you get.

Okke continued by saying that you have to understand your data and you cannot automatically use algorithms across different therapy areas. He explained that we must not forget that much of the data we get comes from humans, not machines. There is something special that humans bring which is emotion and we work on the basis of feelings. Okke stressed the time-saving advantages of AI but emphasised that it is important that we figure out which attributes are driving conjoints i.e. you do a conjoint when you are not at the TPP stage, but would you let AI do this?

Erik reiterated that the human stays in charge and this will be the situation for some time to come although in the future, it will be possible to get an explanation of how AI came up with the model. At the moment, there is always the need to interpret what the AI gives us.

Okke said that the premise of AI is based on how the human brain works. If you have a big dataset, it will do a great job as it does some things that we don't do very well e.g. remember.

Erik mentioned that as well as using AI for processing and coding, it can be helpful when used to brief yourself for a qualitative interview. It can help you get up to speed quickly and create a hypothesis. However, as market researchers, we have to be able to explain and offer judgement and Erik said that in the foreseeable future, he does not want to leave this to AI. He gave the example of doctors who frequently don't like to admit that they don't know something. Erik therefore does not always take what they say at face value and this kind of judgement cannot be left to an AI model. In concluding, Erik said that AI can certainly help us in making real-life conversations better.

Driving Change In Prescribing Behaviour: What actually works

Speakers:

Aurora Albert
Branding Science

Saumya Soni
UCL University

Convenor:

Mike Pepp
Beyond Blue

Aurora set the context for this paper, beginning with the premise that our industry is focused on changing behaviours, whether that is helping HCPs to move from habitual prescribing to evidence-based prescribing, prescribing the right drugs to the right patient at the right time, reducing suboptimal prescribing or reducing polypharmacy.

She recognised that there are multifactorial challenges that prevent behaviour change, including emotional states, social norms and environmental cues, and that the critical field of Behavioural Science has emerged over the past 20 years to help us understand decision-making and how to change behaviour. She postulates that although our industry is adept at understanding the complexity of decision making, we need to understand what will actually drive change in prescribing behaviours. To identify the strategies that really do work to change prescribing behaviour, Branding Science teamed up with University College London (UCL) to perform a systematic and rigorous review of all published evidence.

Saumya outlined the study process to review publicly-available, academically rigorous, research. She noted that much of the research is from public health settings, which tend to have different prescribing goals than the pharmaceutical industry. She described how an initial 1,074 articles reporting changes in prescribing behaviour were whittled down to 21 studies that met the agreed criteria and quality standards for this review.

Detailed Behaviour Change Technique (BCT) analysis was conducted to identify and code the 93 separate behaviour change strategies used. BCTs are the smallest active components of an intervention designed to change behaviour, and by identifying these precise techniques, Saumya explained, the team was able to understand how and why these interventions worked. However, the interventions were measured at an overall level, and so isolating the effect of individual BCTs was tricky.

Aurora revealed the first insight that emerged from the review: 90% of effective interventions included 4 or more BCTs – **ie a multifaceted approach is more effective than a single strategy** in changing behaviours. She noted that some BCTs are found in both successful and unsuccessful approaches, suggesting that effectiveness may depend on other factors such as context or synergy.

The strategy most frequently used across the 21 studies was education (used in 1 in 5 studies) in various forms from e-learning to classroom sessions or distribution of educational materials. However, only just over half of the studies using education as a primary intervention actually managed to demonstrate a significant impact on behaviour.

Saumya shared a case study from the review, involving an intervention of two educational sessions, supported by practice-specific prescribing data to flag up potentially inappropriate medicines (PIMs) in patients aged over 65, along with a task for care teams to co-create their own medication review procedures. Despite this comprehensive educational approach, there was no significant reduction in emergency visits, hospitalisations or PIM prescribing.

Saumya concluded that knowledge alone isn't enough to change behaviour, and explained that the learning needs to go beyond knowledge and translate into real-world prescribing decisions in order to deliver meaningful behaviour change. Using Miller's pyramid, which charts stages of clinical competence, we need to aim for the type of interventions that allow clinicians to apply and embed their learning into their real-world workflows, helping them to understand not only the "what" but the "how" of best practice.

Aurora then focused on the second insight to emerge from the study: **leveraging social norms is one of the most powerful tools** to influence prescribing practices. One in five of the reviewed studies used feedback on behaviours as a strategy. Aurora explained that this played to several human truths, such as the need for awareness of our own behaviours in order to change; our tendency to conform when we are observed; and our desire for control over our own behaviours. 71% of the studies that used feedback as an intervention (such as comparison with other physicians or advice from experts) demonstrated a significant impact on prescribing behaviour, and Aurora reported that feedback on behaviour is the single BCT that delivers the most effectiveness in behaviour change.

Saumya shared another case study showing how feedback was successfully used to change prescribing behaviour in managing chronic heart failure. She explained that, despite strong evidence, beta-blockers and ACEIs/ARBs are often underutilised. An intervention using quarterly feedback on patient audit data, delivered by a senior clinician, helped to increase ACEI/ARB prescribing, which in turn translated into better patient outcomes. Saumya concluded that education can kickstart change, but structured, repeated, feedback can help sustain it and help to turn knowledge into impact.

Aurora reflected on the implications of these insights for the pharmaceutical industry. She noted that it may be difficult to replicate these interventions in a commercial setting, but recommended that interventions based on social normal are more likely to be successful, as are those which instil a sense of shared

responsibility amongst prescribers. Comparative feedback is particularly effective for physicians to understand how their prescribing compared with their peers, and can contribute to behaviour change.

Aurora shared another interesting insight: **pharmacists can act as influencers** in bringing about behaviour change. She noted that 1 in 5 of the studies involved pharmacists to deliver their intervention, focusing on how the interventions are delivered, rather than just which type of intervention is used. 77% of the studies involving pharmacists demonstrated a significant impact on prescribing behaviour.

Again, she reflected on the implications for the pharmaceutical industry, emphasising the potential to strengthen the role of pharmacists as educators and facilitators in influencing behaviour change. She encouraged us to think about opportunities to foster trust and improve communication and collaboration between pharmacists and prescribers, and to consider their role in shaping prescribing behaviour.

Another example of focusing on how the interventions are delivered was that of **digital interventions.** She noted that 2 in 5 of the studies reviewed involved digital interventions, and of those, 81% delivered significant impacts – the highest result seen so far.

Saumya shared a case study using a mobile app to deliver an intervention to help General Practitioners identify PIMs in older adults. The app offered real-time information on risky medications, safer alternatives and prescribing guidance, resulting in strong and consistent reductions in inappropriate prescribing, with nearly 9 out of 10 physicians reducing their PIM prescribing. Saumya concluded that digital tools embedded into clinical workflows can amplify the impact of stand education and training, supporting better prescribing decisions at the moment they matter most. Aurora highlighted some other digital and AI-driven interventions that delivered significant results, such as a web-based treatment algorithm that recommended alternative treatment options, a real-time epidemiological dashboard providing local disease rates, and a gamified approach to education where physicians were sent 20 multiple choice questions for 20 days, which showed results were sustained 24 months after the intervention.

In her conclusion, Aurora noted that there is an opportunity to deliver more interventions than were found in the 21 papers reviewed as part of this study, as only a third of all available BCTs were included in the 21 papers. She advocates further experimentation and testing to explore which interventions are likely to be successful and in which context.

Our speakers left us with a recipe for success in driving behaviour change in prescribing:

- Layer education with behaviour change techniques to help them translate knowledge into decision-making
- Design for continuous feedback and social comparison, using audit data and feedback loops with peer benchmarking to tap into social norms and motivate change
- Mobilise pharmacists as behaviour change allies, using them as educators, facilitators and influencers
- Leverage digital and AI-enhanced tools to help deliver adaptive education, real-time feedback and personalised insights to enhance engagement at scale
- Continue testing to learn about which interventions have greatest potential to deliver behaviour change in physicians.

Tackling The Obesity Crisis Using Behavioural Science 2.0

Speaker:

Chris Harvey
Activate Research

Convenor:

Sarah Phillips
IQVIA

Chris's paper explored how Behavioural Science 2.0 can help us overcome two key challenges we face in tackling the obesity crisis. First, understanding why many of us find behaviours like dieting and exercise so difficult; and second, exploring how to help people get better at these types of behaviour.

Chris began by outlining the scale of the problem with some statistics. There are nearly one billion people globally who are living with obesity, and rates are rising, particularly among adolescents. In the UK alone, over one in four people are obese, and the National Health Service (NHS) is spending around £11 billion per year treating the effects of obesity.

Chris noted the rapid rise in the use of obesity medication in recent years, with often very positive outcomes. However, the medical community cautions that although obesity medications are a valuable addition, they are most effective when used in conjunction with other weight management behaviours, including dieting and exercise. It therefore remains critical to fully understand the human challenges associated with behaviours like dieting and exercise – and this is where Behavioural Science comes in.

Chris first reviewed how Behavioural Science has typically been used to date, reminding us that Behavioural Science 1.0 focused principally on two systems in the brain: System 1, which drives fast, intuitive, automatic behaviours, and System 2 which dictates slow, deliberate, more effortful behaviours. He noted how governments and businesses were quick to attempt to tap into these two systems to try to nudge people towards desired behaviours.

However, Chris then shared evidence suggesting the need for a new Behavioural Science, version 2.0. A study by DellaVigna & Linos from 2022 reviewed 126 different randomised controlled trials (RCTs) covering 23 million people worldwide and concluded that behavioural nudges have not in fact been very effective at changing behaviour. One of the key reasons put forward was that nudges are often narrow in scope and try to solve often complex problems through simplistic solutions. This paper, along with others, has shaped a growing consensus among behavioural scientists that if we want to get better at behaviour change, we need to get much better at thinking holistically.

Chris explained that we can do this through the new idea of a 'system of behaviours'. Essentially this involves exploring the way in which multiple different behaviours come together to affect an overall goal. Chris demonstrated this idea with an audience participation exercise, showing that even for a goal as simple as each audience member getting to the EPHMRA conference, multiple different behaviours were typically involved.

Turning back to the obesity crisis, Chris then proceeded to visually illustrate a four-step process to exploring the system of behaviours involved in healthy eating.

The four steps described were as follows:

Step 1: Consider individual behaviours

First, Chris explained the need to break down the goal of healthy eating into key **individual behaviours** likely to determine success. He cited the examples of **buying healthy food** and **preparing healthy food** as two likely important individual behaviours. While these are unlikely to be the only two such key individual behaviours, Chris noted that to keep the example simple he would limit it to them.

Step 2: Consider others' behaviours

Chris next described how our goals are also often influenced by the **behaviours of others.** As regards **other people,** he shared the surprising statistic that when compared with eating alone, we typically consume 40% more food when we eat with just one other person – while also noting we are especially influenced by the behaviours of **family and friends.** In addition, he described how our goals are often also influenced by the **behaviours of organisations,** such as advertisers' promotion of fast food.

Step 3: Consider influences

The next step, Chris explained, is to explore the different **influences** on each of the key behaviours and players identified in Steps 1 and 2. To illustrate influences on individual behaviours (see Step 1 above) he cited a paper looking at barriers to healthy eating in young people. This first found a significant barrier to the behaviour of **buying healthy food** was cost, while lack of knowledge was a key barrier to **preparing healthy food.** Chris also noted that influences can affect multiple behaviours, describing how **time barriers** were found to affect both the buying and preparing of healthy food.

Step 4: Consider root causes

The final step, Chris explained, is to explore whether there might be **root causes** also affecting the goal of healthy eating. Root causes are other behaviours which have an indirect but often significant effect on goals. He shared a paper which described how **time barriers** to healthy eating in young people (identified in Step 3 above) were greatly influenced by the root cause behaviour of **working.**

Through recapping and visually summarising Steps 1-4 Chris noted how this approach helps us to understand difficult behavioural challenges much more clearly. He then shared a recent academic review of studies which summarised how interventions based on the idea of a system of behaviours – from family level nutrition programmes to activities undertaken by employers in their on-site cafeteria – have reduced BMI, sugar intake, and other key metrics.

Chris then reflected on the relevance of the system of behaviours to our industry, and its importance when thinking about the behaviours of HCPs, patients, caregivers and other stakeholders. He noted that many of the challenges we face in healthcare are complex, often involving lots of different individual behaviours, other people's behaviours and often organisations' behaviours. The 4-step approach described, he suggested, should be considered the next time we have a proposal or brief focused on behaviour change, as well as when revisiting existing research.

Chris then presented an example of three specific ways in which the principles behind the system of behaviours could be applied to enhance patient support programmes (PSPs):

- First, he noted that better recognising **multiple key individual behaviours** associated with a goal (Step 1) could help to boost patient success through an increased focus on, for example, achieving high initial engagement with peer support programmes
- Second, Chris described how the significant **impact of others** on our behaviours (Step 2) suggests PSPs could be enhanced by more consistent engagement with support networks of family, caregivers, and close friends
- Finally, Chris noted that negative impacts of wider **root cause behaviours** such as working (Step 4) could be countered by helping patients to better understand how to communicate with others about their disease or illness

Chris concluded with a recap of the key areas covered: our examination of the obesity crisis; our need for behavioural science to think more holistically; the four steps to exploring a system of behaviours; and a consideration of how this approach relates to our work in healthcare insights.

Piecing Together the Caregiver Experience: A mosaic of challenges and insights

Speakers:

Kilian Teutsch
Boehringer Ingelheim

Abigail Graham
HRW

Convenor:

Herminder Bains
The Planning Shop

Abigail prepared our mindset for this paper by asking us all to imagine the last time that a loved one was sick. She asked us to recall the practical and emotional impact that this had, from additional caring responsibilities, increased housework and cancelled social plans through to increased tiredness and anxiety. This, she explained, is the 24/7 reality for those caring for people with schizophrenia.

Kilian shared some context to help us understand the impact of living with schizophrenia, from the chaotic, unpredictable and deeply distressing impact of "positive symptoms" such as hearing voices and persecution delusions, to the struggle of dealing with "negative symptoms" such as withdrawal and difficulties with engagement and motivation. For the carers supporting their loved ones, both positive and negative symptoms can be equally difficult to manage.

Kilian explained that current treatment focuses on stabilising patients with antipsychotics, but that this only stabilizes positive symptoms and can still leave patients with little joy, connection or drive. To address this unmet need, Boehringer are developing a novel personalised app-based Prescription Digital Therapeutic (PDT).

This PDT will be prescribed by a physician, using clinically proven (FDA approved), efficacious and safe psychosocial techniques to specifically address negative symptoms.

The company recognises the importance of caregivers and commissioned some research to better understand the real-life impact of schizophrenia on caregivers, including physical, social, emotional and financial burdens. The insight would be used to develop a relevant and effective communications programme to support caregivers, and also to shape the team's market access approach as part of an impactful and inclusive communication and commercialisation strategy.

Abigail outlined the multi-phase methodological approach the team used to explore the day-to-day lived experiences of caregivers. An initial 2-week online bulletin board used different activities to tap into daily life, including a daily log of activities carried out for the patient, a letter to the condition, and some blue-sky thinking exercises to understand what their ideal support might look like. This was followed by qualitative interviews in a subgroup of respondents to dig deeper into some of the insights emerging on the physical, financial and emotional caregiver burden.

Abigail shared some impactful video footage from the qualitative interviews with caregivers, demonstrating the physical, financial, emotional and social impact they experience. She described the downward spiral of stress, leading to "burnout" in caregivers, resulting from a state of constant hypervigilance, and described the long-term implications for both physical and mental health. She also highlighted the stigma surrounding the diagnosis, which increases the isolation of the caregiver as family and friends withdraw. Kilian noted the financial burden as caregivers reduce their working hours, take career breaks of leave their jobs entirely, at the same time as facing additional costs incurred in the care of their loved one. As their own health declines, he explained, it becomes harder to care for the loved one, which again increases the stress. This is known in behavioural science as "compassion fatigue", and results in reduced empathy and increased feelings of hopelessness, as well as reduced ability to absorb new information. Boehringer wanted to rethink how they support caregivers to make sure they reached them at the right point on the disease journey, sharing information when they are receptive to communication, to see if they could ease the caregiver burden, reduce the pressure and help them to feel less alone in the process.

Abigail returned to the research project, describing how caregivers were asked to write a letter to schizophrenia about how it impacted their lives. The powerful letters were full of emotion, and linguistic analysis identified the use of passive voice and present static tense, indicating that caregivers believe that schizophrenia means that they have no control over their or their loved ones' lives. Kilian explained that Boehringer wanted to help caregivers regain this control.

They were able to refine their communications to position the caregiver and patient as the agents, using the active voice and concrete action verbs to activate behaviour change.

Kilian summarised the strategic impact that the research has had for Boehringer, and how their communication has evolved as a result:

- **Disease state education** activities educate key stakeholders (HCPs, payers, patients and caregivers) about the significant burden of illness, unmet needs and limitations with current standard of care
- Communication with market access / payers (in the form **of pre-approval information exchange (PIE) and burden of illness (BoI)** decks) emphasises the societal impact on caregivers, and highlights the impact of negative symptoms on healthcare costs, quality of life and independence of both patients AND caregivers
- A Prescription Digital Therapeutics **(PDT) pathway campaign** raised awareness of this evidence-based treatment modality for serious mental illness, explicitly educating caregivers on the benefits of PDTs by communicating their FDA clearance confirming efficacious, accessible and safe treatment.

Abigail then reflected on the implications of the study findings beyond schizophrenia and the wider pharmaceutical industry. Using oncology as an analogue to dig into other therapy areas where caregivers play a crucial role, she quoted the statistic that in the UK alone, one in two people will develop some form of cancer in their lifetime – a condition that has huge impact for the caregiver as well as the patient. In a similar picture to that seen in schizophrenia, caring for someone with cancer requires caregivers to provide support with daily tasks, daily emotional support and financial support. Caregivers also have a higher risk of clinical depression which is partly due to increased loneliness and isolation.

Kilian concluded that, as with schizophrenia, caregiving in cancer is associated with physical, emotional, financial and social implications for the caregiver. In many similar conditions, the wider societal impact of being a caregiver is clear – the diagnosis has implications far beyond the patient themselves. This paper cemented the importance of caregivers in their own right, and recognised them as stakeholders that the pharmaceutical industry should support throughout the treatment journey.

Selected Q&As

Q Given what you have said about compassion fatigue, how can you be sure that your product will reach caregivers?

A Caregivers are looking for support and to be signposted in the right direction. They told us they feel like they are at the end of the line.

Q How is the product going to keep patients engaged and coming back to the app?

A We are collaborating with New York-based Click Therapeutics on the product in that they are developing it and we are commercialising it. There is behavioural science in the mechanism which we believe will keep patients coming back.

It is also important that prescribers adopt the product. We need to co-create a feedback loop and integrate the app into their workflows. They will be able to pull reports on a patient over a 16-week period. The app has so many paths that a patient will not do the same exercises a second time.

Integrating Real World Evidence (RWE) into Human Factors Testing Criteria and Reporting

Speaker:

Victoria Barnosky
Suazio

Convenor:

Elizabeth Kehler
Adelphi

In her paper, Victoria gave an overview of retrospective usability testing before moving on to present a study that involved Real World Evidence (RWE) in the use of a wireless fetal Doppler device.

Victoria began by clarifying that retrospective usability testing is used when traditional usability testing is not feasible, such as for legacy devices. It relies on existing real-world data and it must demonstrate that critical tasks and non-related risks are identified and appropriately controlled, aligning with FDA and MDR guidance.

The study using the Doppler device involved a large sample of RWE data (over 16,000 device measurements) obtained from October 2021 to September 2023 in the US, Europe and Australia. A master usability test plan and protocol were used, based on:

- Why the steps were chosen.
- What were determined to be critical steps based on the device's risk assessment.
- Why these steps were important.

Victoria outlined the inclusion and exclusion criteria, based on the use of the device itself. Field entries had to be complete and pregnant women greater than 12 weeks were included because it is difficult to find a heart rate below this. One of the exclusion criteria was any measurements that were taken which lasted less than 5 seconds, as this would not give an accurate heart rate and the device would not work. Users under 21 were also excluded and the data had to be completely clean, excluding formatting errors and typos.

The tasks involving the Doppler device fell into three categories:

- Critical tasks - the ones that were the most important to look at, based on the manufacturer's risk analysis.
- Essential tasks - things that have to be done in order to move to the next task e.g. if you pick up the device, you can't do anything until it is powered on.
- Non-essential tasks - things that aren't critical and don't necessarily have to be done but are an important feature.

Victoria explained that four major tasks were measured:

Frequency of use.

This was important from a regulatory perspective, as the authorities wanted to know that there were no outliers or people using the device excessively. Users were differentiated into US and non-US (Europe and Australia), with the overall average being less than two times per week during the duration of the pregnancy. This was assumed to be appropriate from a best practice perspective and came to about 12 sessions in the US and 9 internationally.

Search duration.

This was how long it took for the patient to start the device, put it on their stomach and find the fetal heart rate. Early in the pregnancy i.e. weeks 12 to 20, it took around 380 seconds in the US and around 300 seconds in general to find the heart rate. After week 30, it took a little over a minute to do this.

At this point, the fetus is stronger and the heart is beating with more force so it is easier to find.

Measurements per second

Just over 1 measurement per second was successful i.e. the participants were not putting the probe on themselves and measuring themselves for a long period of time. They were getting their measurements successfully on the first attempt and then stopping the use of the machine.

Session quality

There was no major correlation with age and session quality. There was a slight impact relating to BMI in the US but there wasn't enough volume internationally to see a high number of BMI patients. There was a strong correlation with gestational age.

Victoria moved on to explain that the device had two surveys embedded which the user had the opportunity to complete (this was not compulsory). The first was on the training and self-help app that is connected to the device i.e. how well did the app help them to operate the machine. The second was about overall satisfaction in having the ability to use the machine.

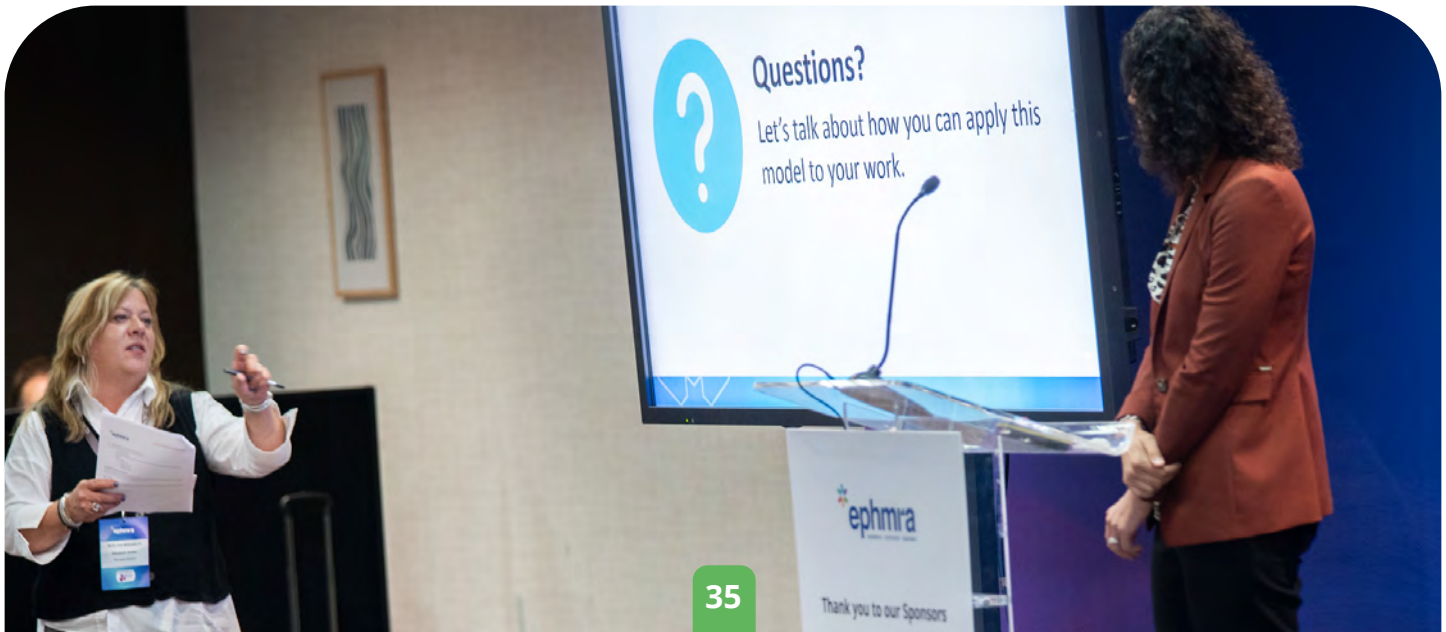
The majority of the users were happy that they did not have to see their doctor to get this task done. They were doing it because their doctor had told them that there might be a problem with the baby and they needed to monitor the heart rate. A small number of users would have felt more comfortable going to see their doctor, especially during a time when appointments were increasingly being done remotely. A small proportion were happy to use the device but would have preferred to see their doctor, rather than trusting their own ability.

The end goal was ultimately to submit for regulatory approval i.e. aligning with guidelines across the FDA and MDR. The retrospective approach was most appropriate for this study because there was a large database of users and it involved no risk to them as they were already collecting the data. The high volume of users also meant that statistical analysis was possible.

Victoria concluded with lessons that were learned from the study and a look ahead to the future.

Surveys that are embedded early in the product lifecycle provide an opportunity to gain information, although this is slightly counterintuitive to what we promote in market research. Having surveys available helps with the timeline and workflow. This approach also provides opportunities to partner with regulatory teams. who are the experts in the field to be able to give guidance. In addition. RWE usability can support stronger product claims, rather than relying on situations created in a simulated environment.

In the future, more devices will qualify for retrospective usability, although not every device will be suitable. With the push towards OTC and self-administered diagnostics, retrospective usability is an easy way to see how a patient is going to use a device in the RWE, not a simulated lab. Ultimately, this approach is a much broader path that marketers can branch off into.



Human-Out-the-Loop?
When is Human in the Loop actually hindering our insights?

Speakers:

Viv Farr
Narrative Health

Sian Guthrie
Narrative Health

Convenor:

Jocelyn Archbold
Jazz Pharma

This paper explores how removing human moderators from the qualitative research process can lead to deeper, more authentic insights in specific contexts. It focuses on three key areas: research on stigmatised topics, research with teenagers, and studies involving traumatic experiences.

The discussion acknowledges the traditional emphasis on rapport-building in qualitative research. Establishing trust is often seen as essential to eliciting rich, personal narratives. However, the paper challenges this assumption by asking: Do human moderators always facilitate better insights? In some cases, the presence of a human interviewer may actually inhibit openness due to social biases, perceived judgment, or emotional discomfort.

Example 1:
Stigmatised/taboo areas - weight and weight loss

Research about weight is particularly susceptible to bias and stigma. Despite efforts to build rapport, participants often feel judged or vulnerable when discussing their weight with another person. These dynamics can significantly limit the depth and honesty of their responses.

The paper firstly questions the need to speak to people directly – social media/forums have a wealth of data already available which can be utilized. It then presents a case study demonstrating how AI moderation in an anonymised setting enabled participants to speak more freely and in greater detail. The absence of a human interviewer reduced social pressure and encouraged more candid storytelling. Notably, this approach also accelerated recruitment without sacrificing the richness in data.

Example 2:
Teens/young adults - stress and exam pressure

Teenagers and young adults are a notoriously difficult demographic to engage in research. Building rapport with this group can be challenging due to generational gaps and social discomfort.

A self-funded study compared AI-moderated interviews with traditional human-led sessions. While participants appreciated the human interaction, many found the AI format less intimidating and more convenient, allowing them to participate in their own time. The approach also helps aid recruitment and reach a more diverse audience.

Example 3:
Traumatic experiences - sharing treatment experiences

The final case study examined research involving individuals who had experienced a traumatic event / experience (for example, when researching treatment experiences). The paper highlighted how societal discomfort with trauma often leads to an overemphasis on positivity, which can impact the narrative a participant provides.

Examples were shared of participants recounting harrowing experiences while laughing—an emotional defence mechanism. The presence of a human moderator can unintentionally reinforce this behaviour, limiting the depth of disclosure.

By removing the moderator and using journalling techniques, participants were given the time, space and control to process and articulate their experiences more fully. This method not only empowered participants but also resulted in emotionally powerful and insightful data.

The paper concluded with three key takeaways:

1. Removing human moderators can create a safer, more open environment for participants, leading to richer qualitative insights.
2. AI moderation can improve recruitment by reaching more diverse and hard-to-access populations.
3. Researchers must be mindful of the subtle pressures they may place on participants. Sometimes, stepping back yields the most authentic data.

Selected Q&As

Q Does the AI moderator make people think too much?

We are finding our way with this. Some tools elicit more responses than others. We don't want people to work too hard with their responses.

The Treatment Persistence Puzzle: Cracking the code of treatment adherence

Speaker:

Mandira Kar
Research Partnership
Co-Speaker:
Ana Claudia Alvarez
Sanofi (not present)

Convenor:

Elizabeth Kehler
Adelphi

Treatment persistence as a major challenge in chronic disease management—one that persists despite numerous support initiatives. This was the case for the Dupixent team, prompting Sanofi to explore deeper, real-world drivers of non-adherence and develop a global action plan that extended beyond traditional Patient Support Programmes (PSPs).

The approach began with a review of existing knowledge, followed by ethnographic and qualitative research to capture the lived patient experience—shaped by culture, context, and personal history. A multidisciplinary team of sociologists, anthropologists, and behavioral scientists then analyzed the findings to uncover hidden drivers and cultural nuances often missed by conventional methods.

To ensure authenticity, the research design minimized judgment and encouraged open, honest responses. This multi-layered analysis revealed subconscious motivations and root causes critical to shaping effective, culturally sensitive intervention.

The paper will demonstrate some key outputs from the study; insights and patient and HCP voice:

The Treatment Continuum

The paper demonstrates a treatment continuum that mapped the patient experience from initial prescribing to long-term stability. Unlike traditional journey maps, this model identified distinct stages—each with unique challenges requiring tailored interventions. Patients move from **hope and anticipation** at the start, through **uncertainty during early treatment**, to a **sense of control during transformation**, and finally to **stability**. At this final stage, patients diverge: some remain committed, while others become uncertain and may disengage from treatment.

The Impact of Cultural Beliefs

The study revealed that cultural beliefs strongly shape adherence, with notable contrasts between countries.

In **China,** the lowest adherence rates were linked to traditional health views. Patients feared long-term use of Dupixent could harm vital organs, influenced by beliefs in **yin-yang balance** and **Traditional Chinese Medicine (TCM),** which favors strong treatment during flare-ups and gentler approaches during remission. Dupixent was seen as too potent for long-term use.

In contrast, **Japan** showed the highest adherence, driven by cultural valueslike **ikigai** (purpose), **giri** (duty), and **issokenmei** (wholehearted effort), which promote treatment commitment. However, concerns about steroid side effects and the cultural drive for **kaizen** (continuous improvement) led some patients to seek alternatives, even when satisfied with treatment.

The mimetic power of social media

Social media is reshaping healthcare, especially during treatment stability when patients have less contact with physicians. Patient influencers, seen as credible due to shared experiences, often promote narratives like dose stretching or treatment breaks. These messages gain traction through social media echo chambers, where opposing views are drowned out—creating a perception of truth, regardless of clinical accuracy.

Physicians as Unintentional Drivers of Non-Adherence

The study revealed that physicians may contribute to non-adherence by recommending dose stretching after stability is reached. This stems from the principle of using the lowest effective dose—originally ethical, now also cost-driven. Some physicians also draw from experiences in other conditions, like psoriasis, where tapering is common. However, evolving beliefs and new data are prompting a shift toward deeper understanding of long-term disease control.

Understanding the Dupixent Cycle

The study demonstrated how adherence is shaped by a complex interplay of physiological recovery, cultural beliefs, and psychological shifts. The cycle begins with patients seeking help, followed by symptom relief and disease control. Ironically, as stability sets in, adherence often declines—a paradox known as the "mythical quadrant," where freedom from symptoms undermines the perceived need for continued treatment.

Strategic Impact

Four strategic pivots that shaped the study:

1. **From patients to partnerships:**
   Early insights revealed that adherence is co-shaped by both patients and HCPs, prompting a deeper look into their interactions.
2. **Re-engaging physicians:**
   To explore differing interpretations of key terms like "remission."
3. **Cultural deep dive:**
   A cultural expert was brought in to decode market-specific drivers.
4. **Two-stage reporting:**
   Country-level analysis was followed by a global synthesis.

The study had a wide-reaching impact for Sanofi:

- **A behavioral blueprint** mapped stage-specific interventions.
- **Tailored PSPs** were developed for each market.
- A **rapid response in China** addressed low adherence.
- **PSP investments** were reassessed in high-DoT markets.
- Findings were integrated into **2025–2026 brand planning.**
- An **HCP engagement strategy** was built around adherence-oriented behaviors.

Long Live Ethnography: Learning from a menopause case study, getting us closer to the lived experience

Speakers:

Lizzie Eckardt
STRAT7 Incite

Maria Colarusso
STRAT7 Jigsaw

Convenor:

Tracy Machado
Elma Research

Lizzie and Maria's paper shared a self-funded study to compare the relative benefits and limitations of traditional vs digital immersive ethnographic research approaches.

Lizzie and Maria opened with a video example of immersive ethnographic research. Lizzie explained that the "This Girl Can" campaign was a public health initiative from Sport England who identified that there was a significant gender gap in physical activities. The campaign was associated with 2.8 million women becoming more active – a great example of how immersive ethnography research can be used to create amazing communication strategies. Lizzie explained that the Sport England team identified that it wasn't just time or access that was preventing women taking part in exercise, but deep-seated emotional barriers and fear of judgement.

As the pharmaceutical industry continues to become much more customer-centric, Lizzie believes that ethnography, in all its forms, remains the gold standard customer-centric methodology that will get us much closer to the "lived experience" that really helps us to understand our customers.

However, Maria observed that traditional ethnography comes with its challenges of time and cost, and also the clear observer effect which can influence the very behaviours that we are trying to understand. Advances in digital ethnographic methodologies bring new benefits in long or 24-hour hour observations, and overcome limitations of geography and access to "hard to reach" respondents, including physicians. But, she noted, there are concerns that digital approaches may miss some of the richness of traditional ethnography, not least because it can reveal the "unknown unknowns" – the unexpected insights that reveal uniquely human and authentic behaviours.

A quick poll of the audience asked whether traditional ethnographies can ever be fully replaced by digital approaches. Of the three possible responses - Absolutely, No Way and Possibly - the vast majority of the audience thought Possibly was the best answer.

Lizzie and Maria had wrestled with exactly this question, and decided to run a self-funded study to explore the pros and cons of traditional vs digital ethnography. The traditional ethnography arm consisted of a one-day observation with a respondent, with a follow-up interview the next day. The digital ethnography involved a seven-day digital diary via a WhatsApp tool, and a wrap-up question set for the final day.

Lizzie explained that they selected menopause for the case study for a range of reasons. It affects half of the population at some point in their lives, and has been more visible as a topic in recent years with conversations in the media and workplaces, and even as part of public policy; however, she observes that although there is a lot of talk, there is still not much action about this emotionally, culturally and behaviourally complex topic.

Lizzie and Maria then shared with us some of the findings from each approach, with Lizzie arguing the case for the benefits of traditional ethnography, and Maria for the digital approach.

Via a videoclip, they introduced us to Anne, a freelancer writer and journalist who lives in London with her family. Over the past 6 years she has managed her symptoms with HRT and holistic solutions, as well as targeting her mental and physical well-being. Lizzie observed that the traditional ethnography approach enabled us to step into Anne's private life and see a glimpse of her experience of menopause and how she manages her symptoms, as well as seeing her in the context of her home and décor which gives insights about her values and attitudes and her general approach to life. Critically, the observer was able to build up rapport and trust which helped her to share her vulnerability and candour about her experiences.

Lizzie also noted the challenges with the approach, explaining that recruitment had been challenging, and that the limitations of Anne's schedule meant that they could only observe her during school hours. It also required time investment in the onboarding process, the observation stage, as well as editing the footage at the end of the observation period. She noted that, during the snapshot of the observation period, they did not actually see any symptoms, which did limit the insight.

Maria then introduced Jo, who took part in the digital ethnography arm of the study. Jo is a civil servant in her 50s who has experienced menopausal symptoms for several years and been on HRT for three years. The video showed that many of Jo's symptoms related to her mental health, including anxiety, mood swings and feelings of overwhelm. She also experienced physical symptoms such as hot flashes and fatigue, night sweats, itching and occasions heart palpitations. The symptoms varied a lot over the week, but the digital data collection timeframe allowed them to be captured. She spoke about using HRT to manage her symptoms, but that she also needed other coping strategies such as changing her diet, and using exercise and medication. Jo also shared the impact of menopause on her work and personal life. The digital approach allowed the team to see Jo's experience over a number of days, encompassing some highs and lows, and to capture those repeating occasions. She was very frank in her WhatsApp interactions.

As with the traditional approach, Maria noted some challenges with the digital approach. Self-reporting of symptoms, Maria explained, can lead to inconsistencies as it relies on memory and loses the "live" element of in-the-moment observations. The quality of the footage can vary

widely with the respondents' device and surroundings. Maria also noted that there can be some emotional distance, where for a topic as emotive as menopause, this approach may not capture the full emotional impact of her experience, and there may be non-verbal cues that would be missed. Jo herself commented that she might have been a little more open in an in-depth interview with a human.

Maria reflected on the findings from this comparative study, and noted that the findings from both Anne and Jo were very valuable. She observed that the traditional ethnography approach provided very rich, personal context, and we were able to see the emotional responses for ourselves. However, the digital approach captured the breadth of her experience over time. Maria accepts that the limitations of the traditional approach mean that digital ethnography is becoming much more prevalent, and as the technology improves, it is likely to become more commonplace in delivering live insights in an efficient yet powerful way.

Maria summarised for us some hints and tips on how to maximise the digital approaches to make them more powerful, including bringing in traditional ethnography where you can, even with a limited number of respondents, to enrich your digital findings. Maximising methodological rigour with a pre-task, depth interviews or simply asking the right questions will make the outputs more powerful and ensure you capture the right kind of responses. Briefing respondents carefully will help to ensure you obtain the right media and capture the specific areas of interest. Think carefully about the timeframe to maximise the capture of the symptoms or events of interest. Consider the balance of the need for focus to capture details with the benefits of a broad brush to capture the unspoken truths; for example, talking the respondent outside the topic and asking more generally about their daily lives can help to understand their broader mindset.

Lizzie concluded that valuable insights were obtained from both methodologies. Strat7 has been monitoring some of the emerging trends in female health generally, as well as for menopause specifically, and she noted that some of these topics were coming across from the respondents they spoke to, such as the powerful shift in how we talk about female health and menopause, and that women over 50 are demanding to be seen and supported, leading to a surge in menopause-friendly work policies and championing an approach to see menopause as a transition to thrive through rather than suffering in silence. Another trend, she explained, is the collapse of the idea of "having it all", the pursuit of which has led to significant mental and physical health issues for women. She reports that women are now much more focused on having a better work-life balance and their well-being being more important than those traditional measures of achievement. The final observation she shared was the emergence of the concept of the "sacred self", where women are beginning to romanticise and find enchantment in their health practices, moving away from clinical practises and looking beyond science for new ways and rituals to support them with their health.

Selected Q&As:

Q Do you get more negative responses with a digital approach?

A This is probably the case. When you ask somebody to record their feelings about their symptoms, you are going to get a more negative view because of this type of approach and this is the risk. Focusing on the negative prompts the negative.

Q Both approaches have pros and cons. Will we do the two together in future?

A This is definitely the sweet spot and the human element is very important. Some groups, such as Gen Z, could feel more comfortable with a digital approach. Our hope is that we don't lose track of the human element because of technological innovations.

A Case Study in Giant Brain Aneurysms - How a patient-centric approach leads to better outcomes

Speakers:

Stephen Potts
Purdie Pascoe

Dr Sergios Gargalas
St George's Hospital

Convenor:

Amr Khalil
Ripple International

The paper presented by Stephen and Sergios focused on Stephen's personal journey, in recovering from a giant brain aneurysm, and how this has real learnings, not only for pharmaceutical market research but also for the wider healthcare industry.

Sergios continued by describing a brain aneurysm, which is a small area in a weak blood vessel in the brain that balloons out and fills with blood. It can put pressure on the brain or nerves and in some cases can rupture, which is the biggest risk and which leads to a haemorrhage. About 2% of the population has a brain aneurysm and many go undetected. Risk factors include high blood pressure, smoking and a family history, while treatment options are clips, coils and/or flow diverters. The bigger the aneurysm, the higher the risk of rupture. There is a subset of aneurysms called giant brain aneurysms which are rare and are defined by a diameter of 25mm or more.

Stephen went on to describe the seven steps of his giant brain aneurysm. He met Sergios after his diagnosis and after his first angiogram. This meeting focused on his treatment plan and Stephen gave his experience of those discussions. Although Stephen's surgery was successful, greatly reducing the risk of his aneurysm rupturing, it also caused inflammation which affected his mobility, eyesight and hearing. Over time, the inflammation has subsided, and his mobility, eyesight and hearing have improved.

One of Stephen's takeaways from his experience was that if you motivate patients, the outcome can be so much better. He attended a neurorehabilitation unit in Woking where a therapist focused on his own personal interests to help with his recovery. Stephen is very keen on fencing and couldn't straighten his right arm until a sabre was put into his hand and a mask was placed in front of him. His muscle memory kicked in and he was able to do a lot more than before. The unit also allowed him to go home at weekends which took things to another level for him, before he moved home permanently to continue his recovery.

Stephen's key takeaways were:

- Motivation drives better outcomes.
- Healthcare succeeds when it prioritises patients' physical and emotional needs.
- Doctors, nurses, therapists and patients must work in sync to achieve the best results.
- Pharma companies talk about patient-centricity but very few are changing their businesses to be more patient-centric.
- As an industry, our role needs to extend beyond innovations. We must create 'beyond the pill' solutions that facilitate this alignment and lead to better outcomes.

Bringing Patient Centricity To A Broader Audience Via Academic Publication: insights from a global patient experience study on genetic testing in mCRPC

Speakers:

Rob Seebold
buzzback

Katie Pascoe
J&J

Convenor:

Xierong Liu
Ipsos

In this paper, Rob and Katie presented a case study based on a multi-national patient and caregiver experience survey in metastatic castration-resistant prostate cancer (mCRPC) fielded in 2022. The 7-country study involved 30-minute, blended qual-quant interviews with patients with mCRPC or caregivers of mCRPC patients. The n=380 interviews focused on the patient experience, including the future potential for treatments based on genetic testing. Katie explained how this type of work can be used to establish the value of a medicine to support market access.

Rob talked through some of the key findings from the survey that were included in the final publication and the clinical and patient focused aspects included in the research. He highlighted the life-changing nature of a diagnosis with mCRPC, and the impact of negative emotions throughout the cancer journey. As might be expected, negative emotions dominate during the initial diagnosis stage, but the team was interested to note that positive emotions increased later in the cancer journey, particularly in the later stage after hormone resistance was confirmed.

Emotional impact encompassed not only mood and mental health, but interconnected impacts on quality of sleep, energy levels and romantic relationships. Loneliness was a common theme. Patients reported that they tried to keep life as "normal" as possible, despite the emotional turmoil. Practical impacts affected work, finances and day-to-day challenges such as the significant pill-burden.

The interviews with caregivers (typically the patient's partner/spouse) revealed many of the same impacts and burdens as were reported by the patients themselves in terms of emotional and practical impacts. Caregivers spent on average 11 hours a week on care. For some, the situation brought the couples closer together; but for others there was a negative impact on relationships. Caregivers also reported increased feelings of disconnection and loneliness.

Rob and Katie revealed that a key avenue of hope for patients is genetic / biomarker testing and the possibilities for subsequent treatments that they might unlock. At this point in their cancer journey, some patients express more positive emotions, than earlier in their diagnosis, as a result. They report high awareness and openness to genetic testing, with around two-thirds of patients aware of genetic tests including germline, tumour, BRCA and HRR gene mutation testing, and over half of patients being open to undergoing genetic tests. Patient understanding of germline testing in particular is good, with patients recognising the benefit of mitigating hereditary risks and identifying possible new treatments; however, the paper highlighted that there remains a significant information need to support patients at this decision point.

Katie explained the importance of payers, patients and healthcare providers as key stakeholders for access to new therapies, all of whom need to understand and communicate the value of specific medicines. She then shared how the J&J team is applying the learnings from the primary market research (PMR) in both market access materials and health technology appraisal (HTA) submissions. Insights in key areas such as unmet needs, patient burden and quality of life impact are used to shape the Global Value Dossier.

Katie also highlighted the publications strategy, explaining that the study had already been presented as a poster at the JADPRO Live 2024 conference for oncology advanced practitioners, where HCP feedback had been positive, particularly from nurses. The paper has recently been accepted for publication in the Future Oncology journal.

The presenters then guided us through the process of designing PMR with the end-goal of peer-reviewed publication, giving us a step-by-step guide and highlighting points to consider.

The process, they explained, involves three stakeholders:

- The client, who provides guidance and reviews all study materials (including the study protocol and report) and medical writing deliverables
- the agency, who leads the PMR design and implementation, and connects with the external marketing writing partner for peer-review activities
- the medical writer who provides peer-review medical writing and strategy recommendations for where to publish

A flowchart outlined the 10 key steps in the process, and identified stakeholders involved at each step. The presenters walked us through the process, starting with a literature review to identify gaps, developing the study materials and protocol for submission to the independent review board (IRB), through fieldwork and reporting, to workshopping and developing the publication materials and finally submission to journals or conferences. The presenters noted the need to establish from the outset, whether the project falls under primary market research vs real world evidence and establishing which compliance processes might need to be employed (and which may vary by company).

As well as the step-by-step process, our presenters highlighted some areas where particular thought might be needed when undertaking a project like this. For example, consideration may be required regarding how the market research methodology is conveyed to a scientific audience where this is not a usual patient research methodology, or the need to build in sufficient time to allow for the review processes, particularly for scientific publications where the process may add more than a year to the overall timeframe.

Our presenters concluded with some key take-aways from the project:

- PMR can be used to capture valuable and robust patient and caregiver experience insights in a cost-efficient manner, which can be used to inform Market Access materials and commercialisation strategies, alongside other sources such as clinical trials, real world evidence and patient reported outcomes
- Internal alignment of different stakeholders is key to project success. Internal stakeholder involvement and shared understanding of the project objectives and rationale can help to shape the PMR and leverage published materials into internal materials and strategies
- The "how to" guide encourages us to take primary market research through to peer-reviewed publications, which will add value to the wider literature and bring the patient voice to wider audiences.

Evolving Market Research: Designing dynamic deliverables for a sustainable future

Speakers:

Georgia Culley
boxee group

Katy Bunn
Chiesi UK

Convenor:

Samir Paul
Instar Research

Katy and Georgia provided the background context for the project shared in this paper, noting that every country uses formularies, and that there will be many different pressures that Healthcare Professionals (HCPs) and the pharmaceutical industry will need to consider when selecting products from formularies. This paper took the example of one particular pressure experienced by the UK's National Health Service (NHS) at the moment that is reflected in formulary guidelines: sustainability. The NHS has set goals for sustainability for 2045 and are working towards initiatives such as carbon reductions. HCPs are having to balance optimal patient care with environmental sustainability, not only looking at the needs of the patient in front of them, but also considering environmental factors when selecting products.

Katy explained the perspective of the pharmaceutical industry, highlighting that inhalers are responsible for 3% of the NHS greenhouse gas emissions, and noting the complexity of the formulary categorisations for inhaler emissions and how they vary by UK region, giving examples of comparisons with car CO2 emissions per mile and simple colour coded carbon footprints, for example.

Katy explained that Chiesi UK wanted to create an easy-to-use tool that would take different formulary guidelines across the UK regions and provide an easier way to translate the different categorisations between regions. This tool would be used by Chiesi UK to help them tailor their discussions with HCPs.

Georgia then walked us through the project and all its stages. They started with desk research, which immediately highlighted the sustainability rules applied by the UK's Integrated Care Boards (responsible for planning and funding health services for their local population) in their formulary guidelines. This provided a solid understanding of the guidelines in each region, and how they might impact HCP priorities and prescribing decisions. Georgia explained that this step provided a 2-fold benefit: it provided the market researchers with a solid understanding of the guidelines in preparation for the qualitative interview stage of the research, but also facilitated the later stage of reflection and refinement when developing the tool.

Qualitative interviews were then conducted with an inclusive and broad spectrum of stakeholders including commissioners, respiratory specialists, specialist nurses, GPs, practice nurses and pharmacists, followed by a validation phase of follow-up interviews and a short online quantitative survey. These insights then enabled the team to create the categorisation tool.

The team then took time to reflect on what they had learned from the process, and realised that they needed to change their perspectives. Reflecting on the tool and the definitions obtained from the desk research and sustainability map revealed that the strict guidelines would be discouraging use of inhalers with a negative environmental impact in favour of, for example, dry powder inhalers, which might have an impact on Chiesi UK's inhaler portfolio. The team realised that they needed to revisit insights from the project, and adapt the learnings to focus on Chiesi UK's needs.

Katy highlighted another driver that would impact the value of the tool: the British Thoracic Society published a significant guideline update of their own. Katy explained that nationally and internationally, guidelines for respiratory change are updated on an ongoing basis, and the team realised that the tool could not be a one-off stand-alone deliverable, but needed to evolve with time to adapt to changing guidelines.

Their approach was to issue the tool, but then to take time to gather feedback and digest, and update the tool over time to ensure all information was up to date. The team created a web page that showed an interactive map which provided a guideline overview for different regions. They used a traffic light system of red, amber or green to indicate the strictness of the region's sustainability guidance. Chiesi UK also wanted to add more detail regarding sustainability, and Georgia explained how key stakeholders were added to the tool to indicate their potential impact on Chiesi UK.

The tool, known as the Sustainable Respiratory Care (SRC) Map, was shared with internal Chiesi UK stakeholders from Sales, Marketing and Insights, and further feedback incorporated into future iterations of the tool. User metrics indicate that page views are increasing, and that the average duration of time spent on the website exceeds 2 minutes (where sometimes averages can be around 10 seconds), indicating user engagement with the content was high.

Katy summarised the broader learnings from the project. She emphasised the importance of meaningful partnership between agency and pharma teams, facilitating long-term support rather than a transactional interaction and helping to ensure that the market research insight produced is not only relevant, but flexible in adapting to changes in the environment. She noted that ultimately this can lead to more valuable conversations with HCPs, making the most of their limited time and delivering the targeted information that they need from pharma touchpoints. The efficient use of insights enabled the Chiesi UK team to pivot their conversations with stakeholders to ensure they were talking to them about the right things according to their needs.

Plans for next steps include incorporating feedback from the wider Chiesi UK team on how to extract the most value from the tool, along with regular updates - approximately twice yearly - to incorporate ongoing changes to guidelines, and to ensure the tool adapts to changes in the wider environment in the UK.

Katy closed the paper with key takeaways or learning objectives, focused on making the most out of market research:

1. **The importance of understanding what your stakeholders think, and the pressures they experience**
2. **How we can act upon environmental pressures**
3. **How to create adaptable tools, so that your "final" version doesn't always have to be your final version – there is time to reflect and adjust**
4. **Recognising that market research is most valuable when it lives on**

Beyond Recall: Uncovering True HCP Decision Journeys
Using simulated patients' cases to assess the clinical decision-making process of HCPs

Speaker:

William Neill
Adelphi Research

Convenor:

Tracy Machado
Elma Research

William began by highlighting the persistent challenges of diagnostic delays and variations, underscoring their real consequences for patient care. He engaged the audience with a poll about research methods for delayed diagnosis in rare diseases, prompting reflection on whether traditional approaches truly capture the full complexity of clinical decision-making.

He then addressed the "diagnostic dilemma," discussing factors such as diagnostic inertia (the tendency to stick with an initial diagnosis), symptom overlap, and system-level pressures like limited resources and time. These factors often push clinicians towards shortcuts and can reinforce delays or errors.

William made the case that standard market research typically captures what HCPs say after the fact, but often misses the nuances of the actual decision journey. In contrast, simulated patient cases let researchers "step inside the consultation room," observing clinical reasoning as it unfolds. HCPs engage with evolving patient scenarios, requesting information, ordering tests, making diagnoses, and planning next steps - just as they would in practice. This reveals not just the what, but the why behind each decision.

He described the simulation process in detail:

- HCPs start with a basic patient profile, then gather further history, request examinations, and order tests as needed.
- Scenarios are interactive, challenging, and realistic - crafted with input from clinical experts and refined through piloting.
- HCPs faces the same set of cases, allowing for direct comparison and identification of where and why diagnostic challenges arise.

William detailed his "art and science" approach to simulation design:

- Begin with clear objectives and review current guidelines and studies to ensure clinical relevance.
- Collaborate with practicing specialists to embed real-world complexity and avoid "textbook" simplicity.
- Structure cases to reveal information in stages, reflecting real clinical encounters.
- Iterate and refine with feedback to ensure cases are both credible and practical.

He emphasised that this approach generates insights that are not only robust and actionable for pharmaceutical clients, informing education, interventions, brand strategies, and benchmarking, but also elevate the quality of outputs for publication and wider industry impact. For market research agencies, this method differentiates services by moving beyond reported to observed behaviours and enabling richer storytelling.

William shared key considerations:

- Upfront investment in time and resources is required, including strong client and expert engagement.
- Best suited for exploring complex or ambiguous diagnostic pathways.
- Early planning for publication is critical to meet rigorous standards and maximize the reach of findings.

He closed with three core learnings:

1. **Collaborate with clinical experts:** Authentic, robust cases start with early and ongoing expert involvement.
2. **Track the full decision journey:** Focus on the 'how' and 'why' of decisions, not just the endpoint.
3. **Share insights strategically:** Plan for dissemination beyond internal teams to influence broader practice and guidelines.

William concluded by underscoring the power of simulated patient cases to move beyond recall, offering a clearer, deeper understanding of real clinical behaviour. His four key takeaways were:

- Simulated cases reveal true HCP decision-making
- Pinpoint actionable barriers and gaps
- Expert collaboration ensures credibility
- Design with publication and impact in mind

Patient Voice – the red thread through the drug development lifecycle

Speakers:

Susann Walda
IQVIA

Victoria Siegrist
Roche

Convenor:

Letizia Leprini
Roche

Victoria and Susann took us with them on a journey to learn more about the importance of incorporating the patient voice in early product development. Victoria opened by asking the audience to share their current challenges when gathering insights from patients. These included the tendency to focus more on HCPs as a priority, capturing the voice of the less engaged patient and recruitment. She emphasised the importance of the early inclusion of the voice of patients living with a specific disease, to ensure that we truly understand what they are going through.

Victoria introduced the area of obesity, noting that by 2035 it is expected that more than half of the global population will be living with obesity and overweight, and pointing out that over the past decade, no country had yet been able to reduce or stabilise those numbers. The implication, she explained, is that we need to acknowledge obesity as a chronic health disease, requiring action from both a pharmaceutical and community perspective.

Victoria explained that Roche's therapy area strategy in diabetes and obesity included developing a broad portfolio of potentially best-in-class or first-in-class assets, including oral and injectable therapies. It will be important for Roche to understand all stakeholders in order to differentiate their assets in line with customer benefits and their impact for people living with obesity. Victoria noted that factors such as tolerability, route of administration, quality, quantity and maintenance of weight loss as well as the impact on other comorbidities such as cardiovascular or kidney disease would need to be understood. To ensure a full understanding of the holistic picture, Roche wanted to listen to the people's voice very early on in the process.

Susann emphasised the complexity of the topic of obesity, and the many aspects and layers that need to be considered when talking about patient engagement, and observed that every new interaction with a person living with obesity brought new learnings and identified potential new actions points to be considered.

She shared some examples of points of consideration when taking about patient engagement in obesity. She noted the noise and activity within the pharmaceutical industry but also amongst new players such as wholesalers and online retailers, as well as patient communities. She noted that internal stakeholders are very passionate about achieving meaningful change in this area to make a difference to people living with obesity, but that their experience is based on traditional approaches to patient engagement and product launches. She highlighted the volume of information available in the public domain, and observed that everyone has an opinion on obesity, making it important to understand and adjust for our own biases. Stigma still exists, she explained, where obesity is associated with lack of self-control or laziness, and a tendency to oversimplify the situation, believing that people living with obesity just need a little help to regain control over their lives again. She emphasised that there is no such thing as a typical person living with obesity, and further emphasised that we need to think in terms of "people" rather than "patients", and be aware of the considerable vulnerability and sensitivity when considering the language that we use in this area. So what does this complexity mean, she asked, for our clinical trials and development, to ensure that all these elements are reflected in our framework?

Victoria responded that we need to make sure that we are talking to the right people at the right time, enabling us to develop the right solutions. Patient communities, she explained, span a wide range of roles from individuals, through informal support groups and influencers to online communities and expert patients. Our target audience will vary depending on the topic under exploration, from clinical trial recruitment and retention to understanding the patient's lived experience. Likewise, the timing of those conversations will vary, but Victoria explained that Roche tries to partner early and systematically with these different patient communities for greatest impact and shared some examples supporting the benefits of early engagement, from a three-month reduction in clinical trial recruitment to Health Technology Assessment agencies including opportunities for patient involvement.

Susann confirmed that the patient voice is important throughout the entire product lifecycle, informing different strategic or business questions based on a holistic understanding of the lived experience and insights into the medical, emotional and psychological journeys as well.

For the different assets in Roche's portfolio, the team wanted to understand the lived experience from a community perspective to understand what is truly meaningful for people living with obesity. This insight would be used to inform clinical trials to understand motivation based on attitude and behaviour, drivers and barriers.

To do this, Susann explained, the team ran an Advisory Board (AdBoard) with representatives from national and international Patient Advocacy Groups (PAGs) who were living with obesity or overweight, talking about their own experiences.

The community was asked about their lived experience, as well as feedback on clinical trial design, their assessment on meaningful Patient-Reported Outcomes (PROs) for patients living with obesity, and recruitment and retention strategies, as well as involvement in the co-creation of support materials.

Susann explained that there was regular two-way engagement through virtual meetings and individual 1:1 interactions, creating a safe space to discuss any sensitive topics. They also facilitated peer-to-peer interaction to share experiences and best practice with each other. Victoria explained that an independent, external market research agency was used to undertake this research to ensure a neutral facilitator to get the best out of every interaction, as well as challenging the internal perceptions, to balance what is right for Roche vs what is right for the community.

Early on in the engagement process, people living with obesity explained that involvement in patient engagement programmes can feel like a "tick box" exercise. To address this, the team ensured there was two-way communication, including sharing findings with the community and being transparent about which actions are feasible and where the limitations might lie.

Internally, the insights are shared across various teams within the Therapy Area, developing a clinical trial playbook to embed all the knowledge and learnings to ensure clinical trial activities reflect the patient experience.

Susann summarised the many key learnings from the experience and shared with us a detailed "cheat sheet" of considerations for successful patient engagement. This included tips such as remembering that we never "know" patients, and that there will always be more to learn about how they are feeling and what they want. We need to be aware of our own biases and beliefs, and challenge our own thinking, stepping out of our comfort zone. She emphasised the importance of "people-first" language, such as a "person living with obesity" rather than an "obese patient". We need to think carefully about who to speak to, to elicit the right information at the right time. We should be persistent in challenging our internal teams or clients, bringing in new ideas and helping them to prioritise themes emerging from the research, and ensure learning is shared across teams with an action plan prepared to raise awareness of the project and help embed the resulting actionable insights. Finally she emphasised the importance of making the engagements mutually beneficial, not only co-creating but feeding back insights emerging from the research and inviting their review and input. She reminded us to think ahead and make sure the insight is relevant for the future as well as today, as obesity is expected to become more prevalent than any other disease area.

Victoria concluded by selecting her top three takeaways for us to consider:

- Understanding your target group as people
- Prioritising the theses and areas for engagement to ensure they are actionable, early and continuous and ensure you do not stop learning
- Make the engagements mutually beneficial and co-create.

Selected Q&As:

Q Can you cover the diversity of demographics in the obesity space?

A It comes down to using a mix of approaches and being creative, as well as understanding the patient. We worked with a group of advisors from local organisations to identify people for specific tasks. We also carried out market research to reach difficult-to-reach patients. In other words, we used a mixed approach to avoid silos.

Q How do you remove bias when talking to patients?

A Everyone has an opinion. Remind yourself to go in with an open mindset. Having said that, we should not ignore our ideas and biases. It is about what we want to hear and get out of the conversation.

Q Are you planning to work with public health on obesity?

A We are in the early stages of creating an obesity portfolio. There is a view about holistically understanding what is going on so that we can make mindful decisions about approaching people.

The Virtual Moderator Revolution: How AI chatbots are driving innovation in healthcare Market Research

Speakers:

Samy Issaoui
Instar Research

Joe Perluzzo
Instar Research

Convenor:

Georgina Cooper
Basis Health

Samy set out the premise for this paper on the evolving role of AI in market research, specifically looking at how AI-driven virtual moderation is reshaping the way that we collect qualitative insights within quantitative studies. He noted that as AI tools mature, they open up opportunities for improvement in scale, speed and adaptability, but stresses that AI is here to enhance traditional qualitative market research, not to replace it.

He recognises the challenge of trying to balance the depth of human nuance obtained from qualitative research against the reach and statistical confidence of quantitative surveys, particularly when qualitative research can be expensive, time-consuming and difficult to scale. Open-ended questions are a common work-around for obtaining the "why" behind quantitative data, but Samy notes the limitations of this approach, particularly in the fast-paced, low-attention setting of online surveys where responses are often brief and shallow.

Samy puts forward AI-driven Moderation as a potential solution for obtaining qualitative insights at scale. Rather than relying on static open-ended questions, he explains, the AI Moderator tool can analyse responses in real time and generate adaptive follow-up questions to probe more deeply. He again emphasises that this approach will not replace human moderators, but represents a hybrid model to layer the richness of qualitative dialogue on top of the scale and structure of quantitative research, leveraging the AI strengths of consistency, speed and adaptability.

Samy gave us an overview of how adaptive AI moderation works, explaining that the AI interprets the responses, not only by looking for keywords, but looking for context and sentiment within the responses in order to generate relevant follow-up questions which are personalised and conversational. This approach allows us to access qualitative depth at the scale of large, diverse, samples.

He shared several comparison of the typically brief responses obtained from traditional open-ended questions which use static probing (eg Q: "What do you think of Product X?" A: "It's effective") with the adaptive probing, where the AI tool can follow up to explore specific benefits (eg Q: "Can you explain what makes you say it's effective? Any specific benefits or concerns?") which can provide a more detailed response, and therefore a much clearer view of the respondent's mindset, definitions, motivations or context that might otherwise remain hidden. Additional probing and follow-up can enhance the response further and facilitate more strategic application of the findings.

AI Moderation also has the capability to address disconnects, inconsistencies or mixed signals within the interview; for example, if a respondent responds that a product is "innovative" but later gives a low score for innovation, the

AI can detect and challenge the inconsistency and probe to understand this further to understand the context, or to ask what data would be needed to overcome the inconsistency. This process, Samy observed, leads to sharper, more actionable insights to guide positioning, messaging and strategy.

Joe then shared a case study of a real-world example of how to apply the virtual moderator approach. He ran through the objectives of the study, focused on understanding perceptions of a new therapy in Type 2 Diabetes which was positioned

as distinct from current competitors. The client wanted to explore interpretations of the term "new class" within the diabetes treatment landscape and relative strengths and limitations of the association with a new product.

Joe described the benefits of using a virtual moderator, citing its ability to use real-time adaptive probing based on sentiment to simulate a natural, reflective conversation which could pivot and adapt based on the physician responses. He shared some of the outputs, explaining that this approach enabled the team to uncover not only physician beliefs but the reasoning and nuance behind those beliefs, and that this was achieved across the scale of a statistically significant quantitative sample including multiple specialties and geographies.

Sharing an example of a simulation demonstrated the way that the conversation develops, building on previous responses and reacting to sentiment such as use of words like "promising" and deepening the conversation at each step. Joe also shared a real (blinded) output, demonstrating the depth of nuance and understanding that could be achieved to help us understand not only that Product X had a new mechanism of action, but the follow-on implications and beliefs that it would then mean that there might be other benefits for Type 2 Diabetes such as weight loss, which in turn would increase adherence rates and achieve the ultimate goal of lowering blood sugar and HbA1c. The insights generated can then be used to refine positioning and develop strong messaging for the new product.

Joe distilled the value of a virtual moderator into key benefits, such as reducing ambiguity, responding to sentiment, checking for logic and allowing scalability, and also summarised the key learnings of the need for conversational language and the need for smart probing to reveal true meanings, as well as real-time reflections and adaptability. Key learnings for the analysis of conversational data focused on interpretation, which requires human judgement, the need for structure within the analysis framework to enable meaningful understanding, and the recognition that sentiment and logic can often diverge, requiring careful examination to reveal the full picture.

Bringing the audience from theory to practice, Joe described some practical considerations and limitations of the virtual moderator approach, from careful study design through the blend of machine analysis and human judgement to a reminder that HCP engagement can vary within an online survey, impacting depth and nuance.

He concluded with a summary of the benefits of AI Moderation, as well as the places where human-led qualitative research remains a more effective approach, such as in deep exploratory qualitative research or more emotionally complex topics.

Finally, he looked at the future for AI in market research, both from a qualitative perspective in terms of AI-driven personalisation, deeper, more sustained interactions, peer benchmarking and longitudinal engagement; but also from a general market research perspective, touching on AI-augmented analysis, generative insight summaries, adaptive survey design and predictive modelling and signal detection. Joe ended by saying that AI and humans work best as a team and the future is AI with humans to elevate the value of research.

Selected Q&A:

Q We have experienced challenges with Compliance when we started using AI. What can you do to prevent this?

A There is no way to prevent it entirely but you can input strong constraints on the AI. As long as you have a strong framework, you can rein it in so that it is a predictive path. You can repeat different questions in different scenarios.

Unlocking Prescription Drivers: Integrating a driver analysis suite with behavioural science

Speakers:

Daniel Kok
SKIM

Bipul Ayan
BMS

Convenor:

Xierong Liu
Ipsos

This paper outlined how BMS and SKIM collaborated on an ambitious programme to optimise prescription drivers, using a blend of behavioural science and driver analysis.

Daniel opened the presentation with a compelling analogy: navigating the London Underground to reach the EPHMRA conference venue. He illustrated how travellers weigh factors like speed, distance, efficiency, crowding, and stress - drawing a parallel to the complex decisions faced in pharmaceutical marketing. Just as commuters optimise their routes, pharma marketers must navigate multiple pathways, making strategic choices to maximise impact - whether that means arriving at a destination or influencing prescribing behaviour.

Bipul then set the context, explaining that BMS had launched its brand tracking programme a year before product launch. Six months post-launch, however, the brand was falling short of expectations. The team faced a clear challenge: to cut through the noise and identify key pathways that could shift the brand from stagnation to success. In a highly competitive market, strong data alone was not enough. The brand team needed a deeper understanding of which behavioural levers to activate - and which strategic routes would most effectively optimise prescribing - navigating the market much like travellers navigating a tube map.

Daniel observed that individual research techniques can sometimes offer only limited insights on their own, but when combined, they can deliver far more powerful and actionable outcomes. In this project, the team integrated behavioural science (via the COM-B model), driver modelling (using Shapley values and Bayesian maps), and Expectancy Analysis to create a comprehensive framework for understanding and influencing behaviour change.

He explained that the COM-B model served as the starting point, helping the team think beyond traditional tracking metrics and identify new, more meaningful drivers of behaviour. By structuring behavioural influences around the COM-B framework (Capability, Opportunity, and Motivation) the team was able to map out a broader set of factors influencing prescription behaviour.

Next, Shapley values were used to quantify the relative importance of each driver in shaping prescribing decisions,

while Bayesian maps provided a deeper understanding of how these drivers interrelate, highlighting both direct and indirect pathways of influence. This allowed the team to uncover how different factors work together to amplify impact.

Finally, Expectancy Analysis was applied to evaluate brand performance against the key behavioural metrics identified earlier, helping to pinpoint where messaging needed refinement in order to maximise effectiveness. Daniel emphasised that each of the four techniques brought a distinct value to the research, and together they were instrumental in driving the programme's success.

Daniel returned to the analogy of the London Underground tube map, explaining that the COM-B model played a similar role to naming stations on a blank map. It helped structure the key behavioural drivers and ensured that all relevant influences on HCP prescribing behaviour were captured and tracked. He also outlined the core principle behind COM-B: that behaviour change occurs only when Capability, Opportunity, and Motivation are all present. By mapping each identified driver to one (or more) of these dimensions, the team was able to build a comprehensive view of behaviour change enablers.

This approach added value not only at the start of the project but also in its final stages. When defining strategy with brand teams across different countries, the COM-B framework helped prioritise the most influential drivers of behaviour. It also highlighted how these priorities, and the corresponding strategies, differed by market, allowing for more targeted and effective planning.

Bipul highlighted that a key success factor for this approach was the early alignment of the commercial team on the COM-B attributes. This alignment ensured that business teams had confidence in the process, knowing that the approach was grounded in an exhaustive and robust framework from the outset.

Daniel built on this by returning to the tube map analogy. Just as some stations are more central or "busier" than others, some behavioural drivers carry more weight in influencing outcomes. To identify these, the team used **Shapley Values,** a technique that quantifies the contribution of each individual driver to the end result, in this case, prescribing behaviour. The analysis generates a score for each driver, allowing them to be ranked and prioritised based on their relative importance.

To explore different routes to our final destination, the team used the Bayesian network model, also known as belief network, which examines the connections between different stations (or drivers) and how they influence each other. This helps to guide decision-making and focus within brand communications. This model reveals how different drivers influence one another, mapping out the complex relationships between them, much like how certain stations connect and influence routes on the tube map. The Bayesian network provides strategic guidance, highlighting not only the most impactful individual drivers but also the most efficient pathways to influence behaviour, thereby informing brand communications.

Bipul illustrated this with an example involving three key metrics: Trust, Quality of Life, and Efficacy, the "stations" leading to the "final destination" of prescribing behaviour. He explained that Trust had a direct impact on prescribing, while Quality of Life influenced Trust. Therefore, messaging that highlights Quality of Life indirectly builds Trust, reinforcing the likelihood of prescribing. The model also revealed an alternate route: if the company chose not to emphasise Quality of Life, it could instead focus on Efficacy, which also has a pathway to impact prescribing behaviour.

Once the team had mapped the broader category landscape, the focus shifted to brand-level analysis. Daniel introduced Expectation Analysis, which assesses how a brand and its competitors perform against the key drivers identified earlier. This method helps pinpoint areas of meaningful differentiation, either where the brand already excels, or where there is "white space" the brand can claim, avoiding overcrowded messaging territory dominated by competitors. Acknowledging that HCPs perceive brands differently, Expectation Analysis also highlights whether a brand is successfully leveraging the most influential drivers and whether it's using the most effective routes to behavioural change.

Bipul shared a real-life application of this insight, explaining how it helped spark productive brainstorming around product positioning and key messaging. The analysis enabled the team to categorise drivers as strengths, opportunities, areas for improvement, or untapped "white space." This comparative framework helped to prioritise marketing efforts, focusing on areas where the brand performs strongly, and where it could stand out from the competition.

He emphasised the importance of aligning the optimal route with the company's overarching business priorities. Often, this involves a deliberate shift, moving away from messaging that may be performing adequately, to focus instead on drivers that analysis suggests could deliver greater impact. This strategic pivot is supported by the development of new promotional materials, perhaps centred on a secondary metric where the brand outperforms competitors.

To ensure the strategy translates effectively in the field, Bipul noted the importance of rep training. Sales teams need to adapt based on the context, whether it's the treatment line, country, or time constraints with the HCP. The training ensures reps can confidently prioritise the most effective drivers in different situations, tailoring their messaging to maximise relevance and impact.

Bipul shared some practical tips on how to introduce this complex set of analytics to a wider commercial audience, particularly those less familiar with advanced analytical techniques. One key recommendation was to break down the insights into manageable steps. When presenting driver networks, for instance, he advised starting by explaining the individual drivers, then introducing the connections between them, and only afterwards highlighting the optimal routes that lead to prescription behaviour. This step-by-step approach helps build understanding and engagement, making the insights more accessible and actionable for commercial teams.

The presenters wrapped up the session with a quick recap of the four core techniques used in the project (COM-B, Shapley Values, Bayesian networks, and Expectation Analysis) and left the audience with two key takeaways:

1. **Optimising product success is about choosing the right pathway**
   Blending behavioural science with advanced driver analysis allows teams to build a clear, data-driven roadmap. The COM-B framework helps structure and guide performance tracking by aligning behavioural attributes with business objectives and establishing actionable KPIs from the start.

2. **The power lies in combining techniques**
   Using multiple modelling approaches together produces a richer, more robust set of insights than any one method alone. This triangulated analysis not only identifies the most impactful behavioural drivers but also takes into account HCPs' perceptions of brand strengths and weaknesses. It reveals alternative routes to success, offering new strategies to influence prescribing behaviour more effectively.

The Power of Words: in Sickness and in Health

Speakers:

Mike Pepp
Beyond Blue

Sam Hope
Beyond Blue

Convenor:

Herminder Bains
The Planning Shop

Sam opened by observing the rise of the Wellness world, characterised by themes such as self optimisation, self-enhancement and supplements. She noted that this market is set to become an economic giant, already reaching $6.3 trillion in 2023 and expected to grow to nearly $9 trillion by 2028. This would be larger than the global pharmaceutical sector.

The Wellness industry had caught her eye, and Sam wondered what the insights from an industry that was doing something very right, could teach us as researchers and healthcare strategists in the pharmaceutical industry. Sam outlined the scope of their paper:

- To understand how people think and perceive Wellness products compared with prescription medicines, and how they are communicating their value
- To understand how Wellness products communicate directly with patients, and what we can learn from them about branding and positioning strategies
- To identify learnings from Wellness products to help us better engage with patients and drive adherence

Outlining how the team undertook this exploration, Sam explained that the project studied the Wellness market in multiple stages, starting with hypothesis formation based on previous research in obesity, menopause and long-term chronic conditions and exploring the impact of framing treatments as wellness tools impacted patient acceptance and adherence. This was followed by desk research to identify relevant sources for social media listening, AI analysis and hypotheses to test in later stages. They explored online communities to understand natural language, associations and compliance, before undertaking a period of social media listening including telehealth. Analysis was conducted using AI analytics of open-ended community responses, and emotion analysis of voice notes using Phebi. Key insights were then condensed into strategic recommendations for pharmaceutical industry interventions, which were reviewed by trusted industry partners, before arriving at the EPHMRA paper shared with us today.

Sam emphasised the caveat that the pharmaceutical industry is heavily regulated, and that there are some initiatives from the Wellness world that would not be possible in pharma; however, by sharing these insights they hope to share learning, and then apply these learnings back in the real-world pharmaceutical context in which we work.

The first insight Sam shared addressed the question of what the Wellness world is actually selling. The analysis revealed that they are not really selling products at all, but are creating communities, shaping beliefs and culture, and allowing individuality to flourish while creating a sense of belonging. She noted that Wellness is influencer and advocate led, rather than product led, but the product pitch is supported with concrete examples that resonate powerfully with patients.

Mike reflected on what this means from a pharma marketing perspective, and what we can learn from this. He observed

that we need to understand the extent to which patients are aligned with the belief system around our product. He noted that many prescription drugs are transactional in that a physician prescribes it and it is the patient's duty to take it. There isn't a sense of community of belief in the product.

He also suggested that we need to look at the proof that is provided for our products, and explore "social proof" rather than a specific efficacy measure. Patients are using a different language and knowledge base, and we can explore the opportunities to tap into this.

The next insight examined the relationships being forged between the customer and Wellness. Sam explained that Wellness product strategies are grounded in the notion of trust. Strong, trusted relationships were found to be associated with the most adherent patients, whether in the Wellness populations or the prescription medication population. She also noted that in the prescription world,

the trust was with the doctor, rather than the product. So, she asked, how do Wellness products build these trusted relationships, and what can pharma learn from them?

Wellness products use advocates and influencers as trust transfer models, embodying the needs of the customer with the vision of the brand. Mike reflected that this accentuates the importance of understanding the interaction between HCPs and patients. We need to understand how HCPs can better facilitate the trust transfer and build emotional connections, which is particularly challenging when interactions with patients tend to be limited for practical reasons.

Next, Sam explored the story that Wellness products are telling, noting that our industry recognises the importance of narratives and storytelling in embedding our insights. She explained that with Wellness products, the story is focused around incremental gains and micro-benefits in a real-world value story. This focus on very achievable claims rather than big promises means that customers have moderate expectations from the products, which we don't tend to see with product expectations in the pharmaceutical world. Sam wonders if, because the Wellness customer has chosen and interacted with the product, they are willing their product to succeed, to prove themselves right, which fuels enthusiasm and motivation.

Sam described the scenarios that were tested in a self-funded study, where half of the sample were shown hypothetical product scenarios framed in the same way that they are presented for a typical pharmaceutical product (focusing on a clinical, practical and medical benefit), but the other half of the sample were shown product scenarios framed using the Wellness-centric approach (focusing on the value that it was aiming to achieve, but with no guarantees). They found that the Wellness-centric scenarios performed consistently better in all respondent groups in terms of interest to learn more, interest to speak to their doctor, and showed lower levels of safety concerns.

The study also showed that Wellness products are positioning a story around hope and a very emotive partnership. Sam explained that the language and sentiment focuses on an optimistic future, rather than fixing a problem or unmet need which is familiar to us in the pharma world. The communication is often very symbolic and visual, rather than focused on clinical data like many pharmaceutical communications. Despite focusing on hope, Wellness products are using deep relationships to ask for understanding and realistic expectations, while delivering little that is measurable or tangible in the way that pharma products do. Sam explains that one of the interesting forces in the Wellness world is the power of feeling in control. By contrast, pharmaceutical products offer facts and evidence, but the emotional connection is missing.

Mike reflected that we need to think about how we're framing treatments to address patient value and ensure that the physicians talk about patient value in their conversations with patients, rather than just clinical outcomes. He suggests that we need to consider whether we are equipping the physicians with tangible benefits that they can put across to patients to garner engagement, such as giving them a little more energy, which might be more compelling for the patient than

telling them about long-term clinical outcomes that feel more abstract.

He suggests that there is a potential role for us to explore the semiotic, deep exploration of what illness means, to help us identify opportunities to create communication strategies that engage patients in our brands. He also advocates exploring how we can help patients to have that sense of control, choice and ownership which is so important in building adherence.

Sam then moved on to the exploration of the world of telemedicine and the digital landscape, and how it might be fuelling the rise of Wellness culture. Their analysis showed that telemedicine makes decisions feel easier and safer, and give a sense of control and empowerment because the patient feels part of the decision. Decisions are made in a "click", rather than needing to get a prescription which may feel like a barrier.

Mike reflected that reducing friction makes access to the products feel easy – there are fewer hurdles and delays, and if the pharmaceutical industry can remove some of those hurdles it could give greater immediacy between their decision to address a problem and being able to access the treatment. Telemedicine platforms are designed to be user-friendly, with simplified decision architecture and patient friendly language. If we can remove some of the obstacles in terms of language and what needs to be done to address insurance etc, we may be able to engage more effectively with our patients.

Sam explained that one of the central objectives of the study was around adherence. She revealed that Wellness products have unlocked the secret to short-term commitment, linked with the focus on the patient value story and emotional connections discussed earlier, which impact adherence. Sam observed that adherence is stronger in the Wellness market than in pharma, specifically in the first six months, fuelled by the perceived value of the products and the emotional connections which mean that patients achieve full commitment from day one. By contrast, with prescription treatments, adherence is a struggle for the first six months, but if the doctor invests in patient engagement and helps the patient to embed the treatments into their routine, then after six months the adherence is much stronger. Sam hypothesises that this will be because the prescription treatments are likely to work, and some patients describe them as transformational, but there are also barriers to discontinuation if you need sign-off from the doctor or need to titrate down over a period of time.

Mike reflected that the learning from this insight is that the value story matters – it is powerful and builds initial engagement and adherence. Helping the patient to engage with the treatment from the beginning, through understanding the likely benefit and giving a modest aspiration for a short term benefit can boost adherence in the first six months. After six months, high quality pharmaceutical products with a strong evidence base can win the engagement and endorsement of customers by proving that they work. The action for our industry is to learn from Wellness how to engage and retain the patient for the initial six month period, leveraging the short-term commitment to help the patient reach the six month mark.

Sam returned to the theme of empowerment, noting how telemedicine platforms and building closer connections between the customer and the end product, helping them to feel autonomous in their decisions, which increases empowerment. Empowerment in turn leads to interest, uptake and adherence, but Sam revealed that there is a bell curve for adherence versus empowerment, with an initial positive increase, but a point at which increasing empowerment leads to isolation and reduced adherence, with risks from patients relying exclusively on Google for knowledge or choosing to discontinue their treatment.

In the final part of the paper, Sam and Mike returned to the reality of a highly-regulated pharmaceutical industry, and reminded us that the approaches that work well in the Wellness industry may not all be appropriate for pharmaceuticals. Despite this, there are elements of the Wellness industry success factors that could be applied to the pharma industry very effectively when building impactful positioning and communications strategies: - Emotional connections and real aspirations: making sure that our messaging aligns with the patient's priorities

- Symbolism around your brand: consider whether the visual, emotional and linguistic symbols of our brand are signifying a partner, a friend, or hope
- Relationships and trust transfer: we need to equip the physician to be able to work on our behalf to build relationships with patients that are aligned with the cultural values and ideals in the disease area that we're working in, using the HCP as a conduit for our brand messaging and belief system to drive the trust transfer
- Adherence in the first six months: we need to spend enough energy, asking the right questions in the right way, to ensure that patients understand what to expect in that initial period
- The empowered patient: we want to empower the patient so that we can be more successful, but we need to understand more about how to manage and shape how they support the brand strategy.

Amplifying Patient Voices: an ERG and Community-Based Approach to LGBTQIA + POC Patient Research

Panellists:

Convenor:

Chloë Davies
UK Black Pride

Kyle Haynes
Elma Research

Crystal Todd
Black Beetle Health

Christine Taylor
Gilead Sciences

Sylvia Alfred
Gilead Sciences Europe

Samir Paul
Instar Research

The paper from Kyle and Christine outlined a true partnership that is taking place between a client, an agency and two community groups. They were joined in the discussion by Chloe Davies of Black Pride and Crystal Todd of Black Beetle Health and together, they explained that although the LGBTQIA+ community is very vibrant, their voices are rarely heard in market research. Access to healthcare services has been a longstanding issue and there have historically been a number of barriers to treatment, leading to widespread mistrust and a lack of engagement.

The four panellists and their organisations have brought considerable lived experience to the research and Chloe and Crystal acknowledged that collaborating with the LGBTQIA+ community will bring trust. Kyle admitted that there is frequently a gap in market research between who designs and delivers it and who reaps the benefits. He said that trust Is essential and this is why Black Pride and Black Beetle Health are at the centre of the project.

The lack of representation of people of colour in market research has real consequences concerning access to medication and health outcomes. Chloe described how this project is part of an ongoing relationship with Gilead based around mutual areas of interest including HIV. Kyle emphasised that diversity is critical for market research and Elma Research wanted to focus on a community that is frequently overlooked. Data is only ever as good as the people we talk to.

Kyle explained that the project has started with desk research which confirmed that there is a general lack of information and what is already known is at best fragmented. The qualitative phase will involve interviews with 1500 people and this will be followed by a design focus group and a quantitative questionnaire which will be informed by the qualitative phase.

Moving into the panel discussion, Christine went on to say that co-creation lies at the heart of the project, working with the other partners who have a shared vision that is honest and transparent. Kyle said that although Elma knows its pharma clients, this project was different and is ultimately about giving back to the community through exploring information gaps.

Chloe emphasised that building meaningful relationships is at the heart of what Black Pride does and that it is important that the project takes time to understand all the issues that will be raised. The use of respectful language is a key part of establishing trust and Crystal said that this has to be appropriate so that respondents can feel comfortable and

be willing to participate. It can be a factor in a reluctance for some in the LGBTQIA+ community to access and engage with medical services.

In bringing the discussion to an end, Crystal reiterated that everyone involved in the project will need to listen and be open to learning for the study to be successful. Christine said the for the research and recommendations to live on, it will be critical to make all relationships intentional and that the findings are not just simply presented without further continuing work. This will require deeper involvement, the ability to have honest conversations and mutual respect. In a broader sense, Christine urged delegates to consider that experience goes beyond a disease area. We should empower people to co-create and support them to reach out to work with diverse communities as much as possible.

Selected Q&A:

Q Have any of you collaborated before and is there a big difference in your perspectives?

A Black Beetle Health has collaborated with Black Pride before but they have not been partners on a specific project. There is not a big difference in any of the perspectives as we are all focused on the same goal of hearing from those who have experienced considerable barriers to accessing healthcare services and who have been historically under-represented in market research.

Which Of Your Stresses Are Working For You? Some stress is good for you

Speaker:

James Pickles
Certified
Performance Coach

Convenor:

Sarah Phillips
IQVIA

James shared a very personal account of his journey to understanding and controlling stress. He opened this session with the candid admission that, in the past, he had not cared about stress, or managing stress. But he does now.

He explained that he had spent 20 years in market research for a panel and software company, in a client facing role selling projects to large brands including well-known financial services companies. He shared a graph of his team's sales targets, showing year on year increase in targets, as is common in many companies. Sales achieved also showed a year on year increase, as the team found ways to deliver what was asked of them.

He explained that he had learned (from both success and failure) that higher sales figures came from working harder and longer, and saying "yes" to everyone and everything, at all times. The graph showed that this approach had been successful. Then in 2019, the graph showed a sales crash.

James revealed that he hadn't realised at the time that he was developing an anxiety disorder, until somebody had asked James how he was, and he had forgotten to lie. This acknowledgement of how he was actually feeling, triggered a profound physical and emotional reaction, causing his cognitive function to crash and leading to a medical sign-off from work for 9 months. As a result of this experience and his 1 recovery process, he became very interested in stress, and this paper shared the stress triggers that he identified, and some potential solutions for our consideration.

James talked for a moment about mental health. He noted that we need to understand what it is, and what it looks like for us, and that it is a dynamic state that will oscillate over time - the pressures and strains of the world ebb and flow, as does our ability to react to it. He summarised mental health as our ability to cope and manage with the stresses and pressures that surround us.

After COVID, he recalled, as people returned to work, lots of companies were very interested in health and wellness, and had funding available for initiatives focusing on reducing stress, pressure and anxiety. He observed that this also had the effect of demonising stress to some extent, and he wanted to remind us that stress is not always a negative force.

He unequivocally stated that too much "bad" stress, for too long, is bad for us physically and mentally, impacting the quality of our work, and our behaviours. He highlighted the serious consequences of deprioritising our rest and recouperation when we are too stressed.

He then explained that the "right" stress (termed "eustress"), utilised in the right way, in small doses, can be good for our brains. It can give us the energy to achieve our goals, whether large or small. James wryly explained that he had searched the internet for scientific evidenced to support his theory!

A study from the University of Penn State (based on a robust sample of over 2,700 people) utilised a diary study over 7 days to report their levels of daily stress, and mapped stress levels to both their emotional reaction and cognitive function tests.

James shared the understanding that the absence of stress is associated with better physical health and longer lifespan (due to reduced inflammation). However, he was surprised to find that people living with the lowest levels of stress were associated with the lowest cognitive function results, equating to a brain age 8 years older than their chronological age. The paper concluded that this was due to the absence of brain stimulation and challenge. Unexpectedly, the study also showed that the people under the least stress were also the least happy.

James concluded that some stress is good for us. He shared a recent example of a world-class tennis player, two sets down in an important tennis match, who had been able to harness the eustress to drive him forward to ultimately win the match. He suggested that nobody has been able to achieve anything truly great without some degree of stress to motivate and stimulate them – when we can harness it, he declares, we can do great things.

James cited two more studies supporting the notion of stress having a positive outcome in certain situations.

One study, published by University College London

(UCL), tested the performance under stress of nearly 800 people to explore whether feeling more stressed about a task decreased their ability to complete the task. This study showed that no matter what level of stress, the higher the level of control over the test and the situation that the participants believed that they had, the greater their ability to perform the task.

He highlighted the nuance that this was not actual control, but the sense of control – as the subjective stress increased, performance decreased (and vice versa).

The second study, published by the American Psychological Association (APA), examined self-reported stress over a 30-day period. This study demonstrated that on days where participants felt they had a high level of control, the levels of their symptoms of stress were significantly lower (and vice versa).

James was interested to note that there was a latent legacy of performance benefit: a participant who approached a new task the day after having experienced a high level of control in a stressful situation, was able to perform at a higher level as a consequence of improved resilience in dealing with future stresses.

James shared a visual of the Stress Curve, highlighting that insufficient stress can lead to understimulation, with a negative impact on performance, just as too much stress can also lead to poor performance.

He reassured us that, with practice, we can learn to exist in the optimal section of the stress graph, carefully and slowly shifting our comfort zone and resilience to enable us to achieve more of what we want to achieve. But he noted that this is difficult to achieve on our own, and highlighted the benefit of having another person truly listen to us and help us to formulate our own plan of action, rather than jumping in with a ready-made solution to our stresses. He translated this scenario from the therapists' chair to the work environment, where we may need to recognise the role that is required of us in a given situation: to support, or to solve. If we are unsure, he encourages us simply to ask! In the home situation, he suggests that this can be achieved with the question "do you need help or a hug?". James describes the support role as a soundboard, whether we have one for ourselves, or act as one for others.

James noted that another important tool we need to manage stress and pressure is building breaks into our lives. He cited research showing that unrelenting stressful stimulus (whether meetings, tasks or other stressful stimuli) over time increases the beta waves in the brain, which in turn reduces our ability to perform efficiently and makes us less and less equipped to deal with those stresses. Breaks, he explains, need to be genuine breaks, not just switching one screen for another, but the brain only needs 5 minutes to recuperate. He suggests that taking the time for a comfort break and a drink will help to hydrate and re energise the brain, making us more productive and more able to handle stress.

In an ideal situation, we would time block and batch process our tasks to maximise our productivity, to avoid excessive "code switching" when we have to switch from one task or topic to another.

James highlighted the need to understand the difference between importance and urgency, with an audience participation exercise using a combination the Eisenhower Matrix and the Warren Buffet two list framework. He noted that when we are feeling stressed, everything feels urgent and important, and we tend to tackle a "to do" list from top to bottom, rather than evaluating and prioritising them by importance or urgency. The audience exercise asked us to sort a "to do" list by what to do now, and what to do next, and James noted that by having a plan to tackle our tasks, we are already gaining control over the situation and helping to reduce negative stress. He talked us through the need to identify, set and defend boundaries in our daily diaries, and acknowledged how difficult it can be.

James used the final section of the session to invite some live examples from the audience, highlighting real-life challenges in defending boundaries. The examples ranged from people sharing the difficulties in protecting your own working time rather than allowing that time to be used for the benefit of others who request your time, to situations where encroaching on a person's protected time might be the only way to obtain the go-ahead for a business-critical strategic decision. Potential solutions were also highlighted, including a company culture that imposes a company-wide embargo on meetings during a certain timeslot to ensure each employee can maintain focused working time, or ensuring that meetings begin at 5 minutes past the hour and end at 5 minutes to the hour, creating a 10 minute transition slot for a comfort break.

James concluded by emphasising that the session aimed to begin the conversation about managing stress, and encouraging us to think through the challenges we face, and work towards the strategies, hints and tips that will help us to take control of our own time and help us to control our stress.

Building Synthetic Participants: Leveraging Generative AI to bring the customer to life and deliver ongoing value

Speakers:

Damian Eade
Lumanity

Mattias Blomgren
J&J

Co-Speaker: Kristina Ogneva, J&J (not present)

Convenor:

Letizia Leprini
Roche

Damien and Kristina's paper opened with a quick poll of the audience to understand the level of familiarity with the concept of synthetic research, and which organisations are considering adopting synthetic research in the near future.

Damien noted that the conference agenda had covered a number of AI topics, but that this paper was not talking about AI in general, but would focus on the implications and application of synthetic research, looking beyond the tech to share their story of using synthetic research to address real-world questions, and sharing all the challenges and learnings that it revealed.

Setting out the context for the case study, our speakers outlined the "evergreen problem" that they were facing – that of market research that sits on a metaphorical shelf, underutilised, rather than being actioned. In this case, within an extensive disease area, meaningful segmentation was critical to brand success, and although a segmentation was in place, the teams were not engaged with the outcomes, rendering it ineffective.

Damien articulated the new goal for the team: to find a simple, elegant way to inspire action.

The new challenge was therefore how to develop an intuitive, elegant, simple solution to bring the segments to life. Damien noted that in a perfect world, we would have a customer next to us whenever we hold a workshop, write a report, or create new ideas or thinking to drive business impact; however, this is seldom a practical solution. Instead, the team turned to synthetic personas.

Damien briefly explained what was meant by "synthetic personas", describing them as a virtual representation of key customer segments, with which we can interact dynamically in real time, just like having a customer sitting next to us in the room, and going beyond delivery of insights to provide a conversational tool to engage teams with the customer.

Damien highlighted three key challenges that the team faced when developing the synthetic personas, along with the learnings that helped to overcome them:

Calculated risks:
It is challenging to take a calculated risk when using new technology that is untried and untested, and Damien

advocated ensuring a phased build approach to demonstrate value and impact along the way, rather than developing the personas in a single step. For this project, there were two proof-of-concept (PoC) stages: the first built on existing aggregated knowledge and insights from previous market research reporting, and the second built upon and fine-tuned, adding colour, texture and nuance, using a language model based on raw customer data. This enabled the team to get the basics right before moving to more technically challenging development. The phased build enabled the team to test and verify, not only throughout the build, but beyond to the user stage, fostering trust in the AI functionality and the process, giving confidence in the outputs, which in turn would encourage the field force to use the tool in their conversations with HCPs

Accepting imperfection:

Damien noted that goal definition with open-ended technology can be very difficult, and it is easy to be caught up in the pursuit of endless perfection. The team was clear that the fundamental goals for the tool were that it needed to be accurate, but also authentic and intuitive so that people would engage with it. Damien noted the balance between accuracy and authenticity, and acknowledged the tendency for the agency to focus more on the accuracy side of the balance, despite this being almost unachievable due to the endless possible permutations. Working closely with Kristina, the team was able to understand where to draw the line to manage expectations between accuracy and authenticity, applying human judgement, expertise and discretion, rather than putting the AI in control, and, once a high level of accuracy had been achieved, allowing authenticity to take greater precedence to make the tool as engaging as possible

Human-first:

The team acknowledged that they were building a tech solution, but that the tech solution needed to work for a human user audience, otherwise it may meet the same fate as the market research left on the "shelf". When planning for deployment, there were so many possible use cases, but the team realised that they needed to demonstrate value in specific cases, and confirm that they were meeting a need. This would build trust in the tool before scaling up.

Damien outlined four main use cases that were used to deploy the tool with end users, measuring them against specific needs and ensuring that the team listened to the end-users to adapt the plan as needed. To demonstrate this, our presenters shared a video of what the tools looks like in action.

Damien and Kristina then shared some outputs from the pilot phase, demonstrating the satisfaction, quality and specific examples of use of the tool in the real world, along with feedback and challenges from the team that allowed further refinement of the tool.

They left us with examples of key learnings and implications, based on practical stories of impact of the tool within J&J.

Unlock the Hidden Goldmine: Making Strategic Decisions Without New Research

Speakers:

Su Sandhu
SkyBlue Healthcare

Joanna McDonald
GSK

Convenor:

Lucy Ireland
Branding Science

In this paper, Su and Joanna shared case studies using structured secondary research, supported by AI and a smart analysis framework, to answer complex business questions, and therefore maximising the value of our existing research.

Su opened by challenging the stereotype of secondary research being boring. She set out her belief that, on the contrary, when used in the right context and with the right analysis structure, secondary research can not only save time and money in really helping us to get the most out of existing research, but that in fact secondary research is the goldmine of data within our industry.

She shared a statistic from an ESOMAR study that showed 65% of market research insights are never acted upon, and explained that this was due to poor integration where the insights are disconnected from the decisions that matter.

Su was quick to clarify that they are not advocating removing primary market research (PMR), but increasing the value of existing research. By looking at multiple studies, rather than one in isolation, she explained that we can then focus our needs for additional research onto the gaps in knowledge.

She hypothesised that one of the reasons that we often overlook what we already know, is that we are drowning in data and overwhelmed by the task of wading through reams of disparate data sources, and it therefore feels easier to go and buy another report or commission some more primary market research. She suggested that the overwhelm is often because we try to "eat the elephant" in one go, and advocated breaking the process down and taking it "one bite at a time".

Su introduced us to the DIVE framework which breaks down the process into four parts:

- Discover: identify what existing data is available and identify knowledge gaps
- Interpret: analyse and synthesise insights from diverse sources to find meaning and trends
- Value: assess the relevance and business impact of the insights uncovered
- Enhance: use findings to optimise future research, strategy and decision-making

She explained that DIVE makes sense of disparate sources, identifies surface patterns and gaps, prioritises business-relevant insights and drives confidence decisions without reinventing the wheel.

Joanna then walked us through the first case study, in which GSK was exploring the social stigma associated with various conditions such as non-small cell lung cancer (NSCLC), and how it might impact and influence Health Technology Assessments (HTAs). She explained that they initially considered PMR to address this question but the team recognised early on that recruiting participants with relevant experience and insight into social stigma would be difficult given the limited pool available. Moreover, they suspected that the nuanced nature of this topic would be hard to uncover through interviews alone. An initial exploratory scan suggested that relevant insights might already exist in the public domain.

The team decided to go ahead with secondary research, understanding that it might not provide all the answers, but would be a good first step to understand what was available and what they could do with it. As an organisation, GSK did not have the time to do this themselves as they were focused on other key strategic priority areas. (This business question was considered important and part of the pipeline understanding, but was not an immediate business need.)

They decided to work with SkyBlue, who were able to find a wealth of information freely available. However, Joanna, cautioned, it was only freely available if you knew where to look for it. She explained that the search required skilled and trained professionals who understand how to find hidden gems of information, rather than just typing a question into a standard search or even AI.

The skilled search identified key stigma points across the NSCLC journey, and where they had the most impact on patients. They identified nine past HTAs that referenced social value judgements, including one from GSK's counterpart ViiV. They also revealed emerging patterns in terms of how the decisions made by the National Institute for Health and Care Excellence (NICE) were influenced by those factors.

Joanna outlined the impacts that the study had for GSK. The team was able to confidently revise their strategy on using HTAs within NSCLC and develop a blueprint for the use of social value justice in HTAs beyond NSCLC to multiple therapy areas. She noted that this approach not only saved budget and timelines incurred in commissioning new PMR, but also freed up resources to focus on priority strategic projects.

Su shared another example of an opportunity assessment conducted comparatively across European markets for a rare disease area where PMR would have been more difficult to recruit. The team wanted to reserve the limited respondent pool for later PMR addressing key questions.

Su described how a combination of AI-assisted literature review and desk research of internal and external sources looked at epidemiology across the different markets, identifying differences in clinical practice and existing treatment protocols, as well as access barriers. This research was conducted in parallel with an internal medical literature review, adding value from the commercial lens scrutinising market opportunities in different potential indications and helping to price and prioritise the different indications and shape early forecasts, refine the scope of PMR and advisory boards. The strategic recommendations helped accelerate decision-making based on the evidence provided, saving time, cost and effort.

Su reflected that secondary data is not always the whole answer, with some information not readily available, and some insights requiring direct voices from doctors or patients. She advocates combining methodologies, ramping up our efforts to interrogate the secondary data first, enabling us to refine our PMR objectives to focus on closing the gaps rather than reinventing the wheel. Additionally, by integrating secondary sources like sales data into the final analysis, we can strengthen conclusions and ultimately generate richer, more relevant insights.

Su recognised that the idea of conducting secondary research is not new, but observes that the advent of AI has enabled us to accelerate, broaden and deepen our secondary research analysis, allowing us to add greater strategic insight to our strategic recommendations.

Su concluded with some key takeaways:

- Secondary data can answer more than we think, if used strategically
- Using an analysis framework helps us to assess if we already have enough data to make a decision, or identify key, focused, questions for PMR
- Combining AI with human insight delivers faster, deeper value

She gave us an action plan for Monday morning back in the office:

- revisit recent research briefs for secondary insight opportunities
- audit existing secondary data to understand what is already available
- encourage the layering of secondary and primary research for future projects

The 360 Degree Approach: unlocking the power of patient voice and co-creation

Speakers:

Emma Keetels
SKIM

Nassima Trad
BMS

Convenor:

Tracy Machado
Elma Research

Emma introduced the paper, describing the research described in the paper as a "fusion moment" – the process of joining two or more things together to form a single entity.

Nassima set out the context from the BMS perspective, explaining the challenge they faced in terms of low awareness and diagnosis rate within a cardiac indication and its potential impact on product launch, and highlighting the need for innovative support and the importance of prioritising challenges.

Emma similarly outlined the challenges for SKIM, highlighting the changes that we are seeing with AI developing faster than ever, and behaviour changes impacting the way we make decisions and view landscapes and products. She noted that researchers collect these data, but also want to work with businesses to solve complexity and address challenges for our clients, from answering business questions through to taking action and monitoring performance.

For this particular project, BMS wanted to focus on the patient from the outset, to build understanding of patient unmet needs in a therapy area that was new to the company. Emma noted that, traditionally, a research programme would start with landscape exploration with cardiologists, but the team saw that this would not fully address BMS's objectives, so they devised an approach which started with the patient.

Emma introduced a schematic of the journey of the project, highlighting its five stages alternating between project stakeholder team actions and research inputs:

- Stakeholder alignment – BMS and the Patient Organisation aligned from the beginning to create the materials, ensuring that the correct questions were addressed from the start
- Patient deep dive – patient duo interviews
- Stakeholder immersion – sharing initial learnings
- Cardiologist perspective – bringing together the insights from the patient research and the stakeholder immersion
- Activation and prioritisation – a final workshop to complete the 360-degree approach

Each phase started with an ideation phase which built upon the learnings from previous phase(s) and tested new ideas, ensuring that inputs from patients, cardiologists and stakeholders were integrated and collaborative.

Emma highlighted the **first key takeaway from the project: the importance of involving key stakeholders influencing patient support from the very beginning, from the patients themselves to those who are involved in creating and providing the support.** She highlighted the different roles that each stakeholder played in the process. At the beginning of the process, stakeholder input guided the questions that were asked. For example, the patient organisation might focus on questions related to patients' everyday use, whereas BMS might ask questions related to the regulatory process. Multi-stakeholder involvement was crucial throughout the project, and the BMS team kept in mind their end-goals to ensure not only that internal stakeholders were onboarded, but also external stakeholders within local healthcare ecosystems who would need to be involved after the project to ensure the patient support was effectively implemented.

The **second key takeaway recognised the importance of stakeholders who would ultimately optimise patient support, by immersing them in the patient experience to limit their own personal biases.** Emma recognised that each stakeholder has a different perspective of the problem, and the first immersion workshop helped them to see from the patient's perspective and think beyond their own personal perspectives. Interactive exercises involved stakeholders role-playing different patient profiles to explore their likely thoughts, feelings and actions, adding depth and intensity to the creation and selection of ideas to take forward to the next phase of research.

The **third key takeaway highlighted the need to build on different stakeholders' perspectives, noting that this was more powerful than collecting perspectives in isolation,** and enabled the team to create a concrete action plan and optimise the patient experience. Emma explained that each stakeholder group (BMS, patient organisations, patients and cardiologists) was asked different questions, with the responses tested amongst the other stakeholder groups, building "stackability" of beliefs throughout the system, as well as focusing on the gaps highlighted by discrepancies between stakeholder groups.

The next step in the 360-degree approach, Nassima explained, is to bring together all the beliefs from different stakeholder groups, and the solutions that have emerged, and to prioritise them into concrete actions. To do this, a final workshop was held with BMS and the patient organisation, leading to highly effective discussion and collaboration, where different stakeholders adopted different actions based on their individual reach or remit, and could implement their actions immediately.

Nassima reported that the long-term impact of this approach was significant, with a strengthened BMS patient support strategy involving a patient portal and a dialogue tool for patients and HCPs to facilitate communication between them. It also strengthened external collaboration efforts with other patient organisations to communicate the key insights revealed by the 360-degree process.

Emma concluded by reviewing the three key takeaways from the process: involving key stakeholders from the beginning; immersing different stakeholders to overcome their personal biases; and building on each other's perspectives to create more powerful insight than collecting beliefs in isolation. This approach, she explained, allows each stakeholder to leave the room with actions that can be implemented immediately.

Nassima reflected on learnings from the process, and whether there was anything that could be done differently, recognising that the answer to this question was still being discussed, such as how to use the outcomes of the research to alert stakeholders about patient needs. The challenges of trying to publish a research paper based on the process were highlighted, with Nassima explaining that there were limitations on publishing the research due to internal SOPs, despite involving Legal and Compliance departments early in the process, and discovering that they would need to go through a scientific committee in order to publish.

Suggestions and discussion from the audience were invited.

Meeting Patients Where They Hang Out

Speaker:

Rachel Lawes
Lawes Consulting Ltd

Convenor:

Viv Farr
Narrative Health

Rachel's paper shared examples of semiotics and discourse analysis from the public domain, describing how people communicate with each other about antidepressants.

Rachel opened with an overview of these methods, contrasting research methods from psychology (traditional "inside out" methods such as surveys, focus groups and depth interviews which reveal attitudes, beliefs and perceptions) with culture methods (such as ethnography, semiotics and discourse analysis) which explore the impact of "outside in" inputs such as mass media, pop culture and advertising in shaping those attitudes, beliefs and perceptions. Semiotics

and discourse analysis are closely related, she explains, with semiotics focusing on visual signs and symbols, whereas discourse analysis focuses on language.

In the depression study, Rachel wanted to explore the spontaneous conversations such as on social media, to understand what they said to each other. She shared some results from semiotics, which identified imagery such as Barbie linked with different antidepressant brands. She noted that use of this imagery was normalising and feminising taking antidepressants and indicating that if you take antidepressants, you can be a "happy Barbie" and there is nothing to be ashamed of.

Throughout the presentation, Rachel contrasted an older antidepressant (Effexor /Venlafaxine) with a new ketamine-based nasal spray (Spravato /Esketamine).

The conversations around Effexor focused on concerns about dose (taking too much or too little), or negative effects during treatment or after discontinuation, as well as some narrative around people not having heard of the product. By contrast, the Spravato imagery was associated with high expectations of psychedelic effects, feelings of euphoria or attaining spiritual enlightenment in a temporary state.

Rachel then focused on discourse analysis, used to explore what happens when people talk to each other about antidepressants, and described three common discursive strategies that we need to be aware of when communicating with our customers.

Firstly, she spoke about myths.

She quickly clarified some terminology, noting that a "myth" is commonly understood to mean a wrong belief, but that in the professional area of semiotics and discourse analysis, a myth is a story that is conferred elevated status because of its explanatory power – it becomes iconic because of its powers to explain problems and resolve them. She noted that brands can become mythical (such as Prozac).

Focusing on how people on social media were talking about Venlafaxine, she shared an example focused on Effexor's reputation for harsh withdrawal effects and how it was described as "the big guns", hitting your depression with a sledgehammer. Rachel highlighted the importance of this myth: the expected withdrawal symptoms might be severe, but the efficacy in tackling depression was the myth that justifies its continued use in certain cases. Here, she explained, the myth was not a falsehood but a powerful explanatory story.

Similarly, Rachel looked at how people were talking about Esketamine. She highlighted a puzzle about Esketamine that consumers try to solve: how is it legal to receive a ketamine nasal spray from the clinic, but ketamine is not legal? Rachel explained that people try to solve this puzzle by creating myths to explain the conundrum. One myth suggests that there are some types of particularly resistant depression that require a treatment like Esketamine. Another myth suggests that some people are genetically predisposed to respond poorly to other antidepressants and need Esketamine. These myths help the patient by solving the "problem" and making the confusion go away.

We need to take these narratives and their myth creation into account when we are marketing drugs, because, Rachel explains, if we don't take the lead in solving people's problems, then our customers will answer those questions themselves, perhaps in a way that we would not like.

Rachel then spoke about particularisation.
Particularisation is a defensive strategy that demolishes unpopular opinions, through moving from general concepts to specific details and examples to strengthen the argument. She explained that this can happen when people are emotionally attached to certain versions of the truth, and want to defend them. She observes that a lot of arguing on social media can occur when a favoured opinion is challenged or where somebody has an unpopular stance, and these views can be demolished by particularisation.

Rachel showed an example from a forum about antidepressants, where one person initiated a thread called "Stop praising antidepressants", with a strongly expressed belief that antidepressants do more harm than good. The opinion was understandably unpopular in a forum where almost everyone was taking antidepressants and did not want to hear that they may be doing the wrong thing. Rachel showed a response to the thread, where another person on behalf of the group took offence to the original post, and immediately tried to discredit the original poster, and put forward an extreme example to make their point. The original poster then countered with specific examples from their personal experience, and the objector flagged up that specific examples can't be generalised to the whole group, before moving the topic on to failure of their doctor to warn them about potential side effects. This example, Rachel explained, shows a common strategy for shutting down disagreements when people are emotionally attached to a particular version of the truth, such as that antidepressants are worth taking, even if they have regrettable consequences for some people.

The third discursive strategy was category membership.
Rachel explained that this is a strategy that people use to award themselves authority in a conversation. She showed an example from a good-natured exchange on MumsNet where the original poster had asked for ideas on what members do to help them stay well. A person responded, and invoked category membership to let the original poster know that they are a reliable source of information – in this case by indicating that they had elder status or life experience (by sharing that they had experienced major depressive episodes for decades until they reached the menopause, using technical language, and sharing other information to indicate solid life experience which would confer credibility).

She shared other examples of category membership, with varying degrees of argument strength, such as being more credible than the FDA due to being married to a pharmacist.

Rachel then examined why the pharmaceutical industry should undertake discourse analysis and how it can be applied in practical marketing strategies to engage patients and invigorate communications.

The most important reason, she explained, is to inform our communications, from understanding doctor-patient interactions or writing better patient leaflets to creating websites. She shared examples of using discourse analysis to recognise that physicians and patients using different language, with doctors focused on biology and technical language, where patients focus on their real lives.

Rachel concluded with some suggestions on new applications for discourse analysis. She advocates using more discourse analysis in the area of improving peer-to-peer education. She notes that people are already educating each other every day via social media platforms about medicine and healthcare, and that we could improve the quality of that peer-to-peer education by sharing information that is correct, but that also answers the questions that they actually want to ask. If we join those conversations, she believes, we can take the opportunity to make them richer and better.

Selected Q&As:

Q When would you recommend using discourse analysis as a complement to a qualitative patient session?

A It is ideal to use discourse analysis when patients are able to talk to each other because it will tease out the dynamics of the conversation.

Q Is there a gap between what is communicated and what is perceived?

A We are focused on technical details but patient questions are not technical. They want to know the basics e.g. will I experience pain? Maybe we find that it is somebody else's job to fill in this gap.

EPHMRA Conference 2025: Conference Opening

Speaker: Karsten Trautmann, EPHMRA President

Karsten closed the conference, revisiting the objectives he shared at the opening session and expressing his hope that delegates had found the conference valuable, enjoyable and engaging. He hoped that they now feel inspired by the papers and the passionate discussions that contribute so much to the EPHMRA community.

He hoped that delegates, like himself, had enjoyed connecting with new colleagues and reconnecting with old colleagues, exchanging ideas and feeling energised to implement some of those inspiring actions on their return to the office.

He reminded everyone that the QR code in the delegate bags gave access to the list of attendees as an aide-mémoire, well as summaries of many of the papers presented at the conference. He urged all delegates to complete the post-conference survey, including suggestions for improvements for future events. The delegate bags also contained the latest edition of EPHMRA News, including details of all the EPHMRA committees, and Karsen invited everyone to get involved or to get in touch with any questions.

Looking ahead, Karsten shared details of the upcoming Chapter Meeting hosted by Roche in Switzerland. He also looked further ahead to the 2026 conference (details of which will be communicated in the next few weeks), and invited us to think about submitting our own inspiration paper to contribute to the EPHMRA community discussions.

Karsten ended with sincere thanks to all who make the conference possible, including the Programme Committee, EPHMRA committees, speakers, the Executive Board, the Conference Team, the hotel and technical teams, and last, but not least, to Bernadette Rogers for all that she does to make the conference a success.

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