ZOOMRX

The Last Mile in Lung Cancer

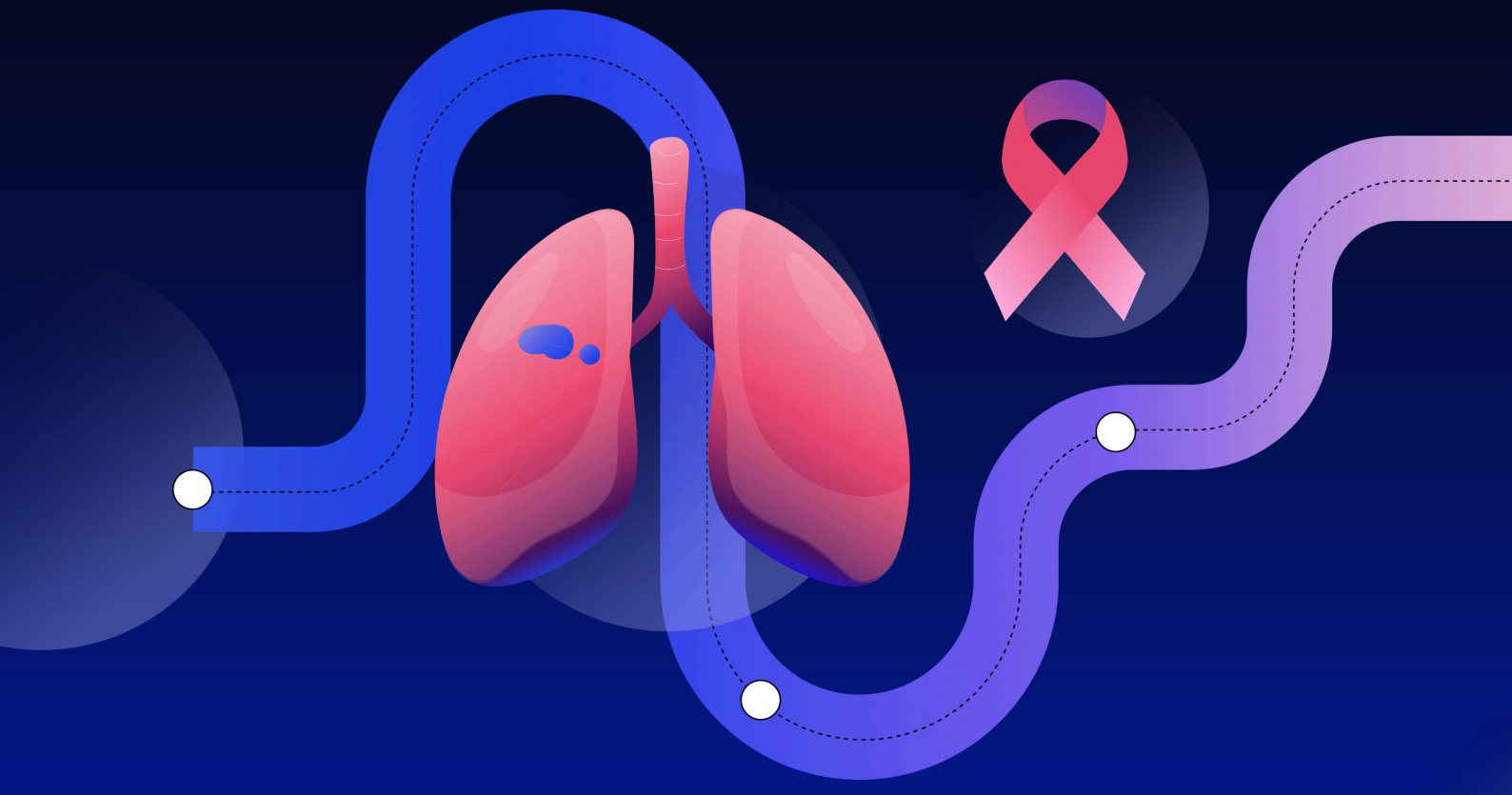
What real exam room data reveals about how NSCLC treatment decisions are actually made — and where confidence forms, breaks down, or never leaves the room.

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READING TIME

15-20 minutes



ABOUT THE AUTHORS



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PRODUCT MANAGER, HCP-PATIENT CONVERSATIONS

Vincent Valant is the product manager for HCP-Patient Conversations at ZoomRx, where he leads the best-of-class observational point-of-care research methodology based on real-world audio recordings of clinical doctor-patient interactions. With over a decade of experience in pharmaceutical market research, he specializes in capturing what actually happens in the exam room and translating it into patient-centric intelligence that life sciences companies can act on.

Vincent has helped shape ZoomRx's HCP-Patient Conversations methodology to organically capture unbiased real-world clinical conversations, surfacing key moments of truth through an interactive portal with AI-powered navigation for direct access to the patient experience. HCP-Patient Conversations is built on the belief that healthcare decision-making is a fundamentally human experience, and that making patient voices heard is the fastest path to improving it.

135+
Projects delivered

20
MD specialties

800+
Unique HCPs

ABOUT THE AUTHORS



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Rokesh Palanisamy is a Product Consultant for HCP-Patient Conversations at ZoomRx, focused on building the operational and analytical infrastructure that support the consulting teams running HCP-Patient projects. He bridges product strategy with technical execution, designing AI-driven workflows that accelerate everything from survey design to insight delivery.

Rokesh is the architect behind HCP-P's agentic AI layer — building intelligent systems that help navigate the dataset and enable our team of expert consultants to operate at scale without sacrificing depth. His work is grounded in the conviction that the best research platforms don't just collect data — they think alongside the people using them.

143,000+
Conversation snippets analyzed via Galen

4,800+
Themes powering the AI layer

100+
Indications covered

Executive Summary

An oncologist sits across from a patient whose biopsy results just came back with an EGFR mutation. What happens next should feel uncertain — but it doesn't. The test result has already organized the recommendation. The physician connects finding to treatment in a way that feels complete, even inevitable. Across the hall, a different oncologist faces a patient with no actionable biomarker. The treatment may be equally appropriate, but the conversation has to do different work. There is no molecular bridge. Confidence must be built from reassurance, familiarity, and careful expectation-setting.

These two conversations happen in the same clinic, on the same day, under the same guidelines. But they unfold differently — in structure, in tone, and in where uncertainty sits when the patient leaves the room.

Clinical evidence tells us what should work. Claims and prescribing data tell us what was used. What those sources do not show is how the decision itself was made, or where confidence formed and weakened in the process. The exam room is the last mile between treatment logic and treatment uptake. ZoomRx's HCP-P conversation data makes that last mile visible.

Two Tracks, One Decision

The clearest finding in these conversations is that NSCLC treatment discussions follow one of two recognizable tracks depending on whether the physician has an actionable biomarker to anchor the story. These are not rigid categories — real visits can contain elements of both. But the distinction shapes where uncertainty sits, what patients ask next, and where physician language sounds most fluent or most strained.

When the Biomarker Is Present

When an actionable biomarker is found, the physician connects diagnosis and treatment in a way that feels internally complete. The recommendation is not simply offered — it is explained as the natural consequence of what has been discovered. The test result does part of the persuasive work. The physician does not need to spend as much energy justifying why this treatment should be considered, because the finding itself has organized the recommendation.

HCP

"I have some excellent news actually. It seems as though your tumor expresses one of the specific mutations we were looking for. And in simple terms what that means is, you would actually be an excellent candidate for a targeted therapy as opposed to chemotherapy."

What matters here is not simply optimism. It is closure. The physician is not presenting a menu of options. The physician is explaining that the finding itself has organized the recommendation. The treatment feels less arbitrary and less open-ended — there is a complete explanatory chain from what was found to what comes next.

When the Biomarker Is Absent

When no actionable biomarker is found, that explanatory bridge is not available. The physician can still recommend treatment effectively, but the explanation must do

different work. It must create confidence through standard practice, reassurance, and concrete discussion of what treatment will involve.

HCP

There does not seem to be any targetable genetic mutations. So unfortunately, we can't do any of those pills that specifically target your cancer. But what we can do, which is the standard of care, would be a chemotherapy plus an immunotherapy."

The treatment remains clinically grounded, but the structure of the explanation is different. The recommendation is no longer the natural resolution to a specific finding. It is the best next step in the absence of that match. The difference is not that one conversation is medically sound and the other is not — it is that one is easier to explain, and explanation is what builds patient confidence.

This difference matters because it changes more than tone. It changes what kind of uncertainty remains unresolved when the recommendation is made. In one track, the physician is resolving uncertainty into a plan. In the other, the physician is helping the patient tolerate uncertainty well enough to move forward.

What Patients Still Need to Decide

Patients are not trying to independently evaluate every dimension of treatment. They divide the decision unevenly. The physician's role is to determine what makes medical sense. The patient's role is to determine what treatment will mean for life outside the clinic.

That division explains why patient questions so consistently cluster around side effects, daily routine, fatigue, reversibility, and practical disruption. Those concerns are not secondary to the decision. They are the part of the decision patients experience as their own.

Testing for Agency

> PATIENT
>
> *"The side effects sound okay. But if I do not feel well, I can stop, right?"*

This is not a challenge to the physician's clinical recommendation. It is a question about whether the patient will still have agency once treatment begins. The patient is not adjudicating efficacy. The patient is testing whether the treatment remains livable and reversible enough to accept.

Deferring to Process

> PATIENT
>
> *"I don't know about the side effects... I think I'll need to talk to family and we'll have to get back to you."*

High acceptance should not be confused with passive compliance. Patients may accept quickly because the clinical judgment has already been delegated to the physician, while still remaining highly active around the consequences they feel entitled to judge for themselves. The physician is explaining two things at once: why the plan makes medical sense, and why life on that plan will remain manageable enough to proceed.

Cost Before Commitment

Cost enters these conversations in a notable pattern: often early, and often through the physician rather than the patient. Physicians are proactively introducing cost to prevent it from arriving later as an unmanaged shock. By naming the issue early and pairing it immediately with a path forward, they acknowledge the burden without leaving the patient alone with it.

HCP

"If you cannot afford the co-payment, then you need to call me and I will call our financial advisor and she'll try to get you a grant from the company."

The importance of this language is not that it removes the problem. It prevents cost from remaining an undefined threat. The patient hears not just that treatment may be expensive, but that a process exists if affordability becomes a barrier.

Cost is not always experienced as literal out-of-pocket expense. In some settings, the more salient burden is time, disruption, and the practical cost of fitting treatment into daily life. In both cases, the common thread is that cost destabilizes commitment when it appears after confidence has begun to form but before the patient knows how the burden will be managed.

The Rehearsal Gap

One of the most revealing shifts in tone appears when the conversation moves from starting treatment to what happens later if the treatment stops working. The language changes. First-line recommendations sound compact, familiar, and settled. Progression discussions sound looser, less specific, and more tentative.

First-Line: Fluent and Settled

HCP

"Over the past few years we have a drug that targets that bad mutation directly.And this drug is a pill. You're going to take it once a day."

The language is direct and settled. It gives the patient a plan in terms that sound familiar to the physician saying them. Physicians have likely delivered first-line

explanations many times, refined them through repetition, and heard similar language from peers. The result is communication that sounds fluent without sounding scripted.

Progression: Tentative and Conditional

HCP

"If it does come back at some point down the road, you already have this mutation, we can always consider you for a pill form... unless something new comes along."

The issue here is not lack of knowledge — it is lack of fluency. The physician knows there are additional paths, but the language becomes more conditional and less stable. The plan may exist, but the narrative carrying it is less rehearsed.

Some of the most consequential weaknesses in treatment communication are not information gaps. They are rehearsal gaps: places where the medicine is real, the options are real, but the language for carrying the story forward has not yet been practiced into confidence.

The Decision Extends Beyond the Room

Treatment decisions are not always fully made in the exam room, even when the recommendation is delivered there. In some cases, the decision remains open until it has been discussed with family or caregivers. In others, the patient arrives with expectations shaped elsewhere.

PATIENT

"I think I'll need to talk to family and we'll have to get back to you."

That statement matters because it shows that acceptance is not always determined by physician confidence alone. The recommendation leaves the room before the decision is complete. It still has to survive another interpretive setting: home, family conversation, logistical reality.

The exam room remains the most visible part of the treatment decision, but it is often only one part of a broader decision ecosystem. Confidence has to survive beyond the recommendation itself.

The Numbers Behind the Conversation

~2 in 3	**Biomarker-positive conversations where the treatment recommendation is "internally complete" — requiring minimal additional persuasion**
~1 in 3	**Conversations where physicians proactively introduced cost before the patient raised it —pairing it with a support pathway**
~4 in 5	**Conversations where patient questions clustered around side effects, daily routine, and practical disruption — not efficacy or mechanism**
Notable Gap	**Narrative fluency dropped markedly when moving from first-line to progression language— less settled, more conditional, more hedged**

In biomarker-positive conversations, the treatment story often arrived with its own explanatory momentum. Physicians spent less time building the case and more time confirming the plan. Patient questions came later and focused on logistics, not rationale. The biomarker did not eliminate uncertainty, but it narrowed the range of what still needed to be explained.

In biomarker-absent conversations, physicians worked harder to create the same level of confidence. The recommendations were equally appropriate, but the conversational path to acceptance was longer, more reliant on reassurance, and more vulnerable to unresolved cost or side-effect concerns.

The rehearsal gap showed up most clearly in progression discussions. First-line language across both tracks was practiced, concise, and confident. The moment the conversation moved beyond the initial plan — what happens if this doesn't work, what comes next — the language loosened. This was not a knowledge gap. It was a fluency gap, and it was visible across physician experience levels.

Decisions that left the room without resolution — deferred to family, to a follow-up visit, or to further reflection — were more common in biomarker-absent conversations and in discussions where cost or side effects were introduced late rather than early.

What This Means for Brand Teams

Build messaging that travels beyond the room.

Confidence formed in the exam room is not always finalized there. Family discussion, logistics, and the patient's ability to carry the recommendation into life outside the room all shape whether it holds. Messaging that only works when a physician is delivering it in person will not survive the decision ecosystem. Materials should equip physicians with language that patients can repeat — to a spouse, to a caregiver, to themselves.

Script the progression story, not just the first-line story.

The clearest drop in physician fluency appears when the conversation moves from the initial plan to what comes next. This is not an information gap — physicians know the options. It is a rehearsal gap. Training programs and medical affairs materials should give physicians practiced, settled language for the progression conversation, not just the first-line recommendation.

Lead with cost — don't wait for it.

Physicians who introduced cost early and paired it with a support pathway kept commitment intact. Physicians who waited for the patient to raise cost — or who left it unaddressed — risked destabilizing confidence that had already begun to form. Brand teams should design cost messaging as part of the treatment conversation, not as a separate financial counseling step.

Design for both tracks, not just the biomarker-positive story.

Biomarker-present conversations have built-in explanatory power. The treatment "makes sense" because the finding explains it. Biomarker-absent conversations require a different kind of support —language that builds confidence through standard-of-care framing, outcome expectations, and practical reassurance. Most brand messaging is optimized for the biomarker-positive story. The biomarker-absent conversation is where the unmet need is greatest.

> *Treatment uptake in NSCLC is shaped not only by evidence and access, but by how clearly the plan can be explained, how well the lived-experience burden is addressed, how fluently the next step can be narrated, and how far the recommendation can travel beyond the room. The conversation is the last mile — and the last mile is where decisions are won or lost.*

Pharma teams that understand this structure can design better HCP support tools, better field messaging, and better training programs — grounded not in what physicians report saying, but in what they actually say.

If your brand is navigating the gap between what physicians know and what they say in the room, ZoomRx would welcome the conversation.

ZOOMRX

ABOUT ZOOMRX

ZoomRx is a life sciences strategy consultancy that captures and analyzes real physician-patient conversations across therapeutic areas. To learn more about HCP-P conversation research, contact your ZoomRx representative or visit zoomrx.com.

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