CATALYSTMR
transforming market research data into marketing solutions

METHODOLOGY PAPER

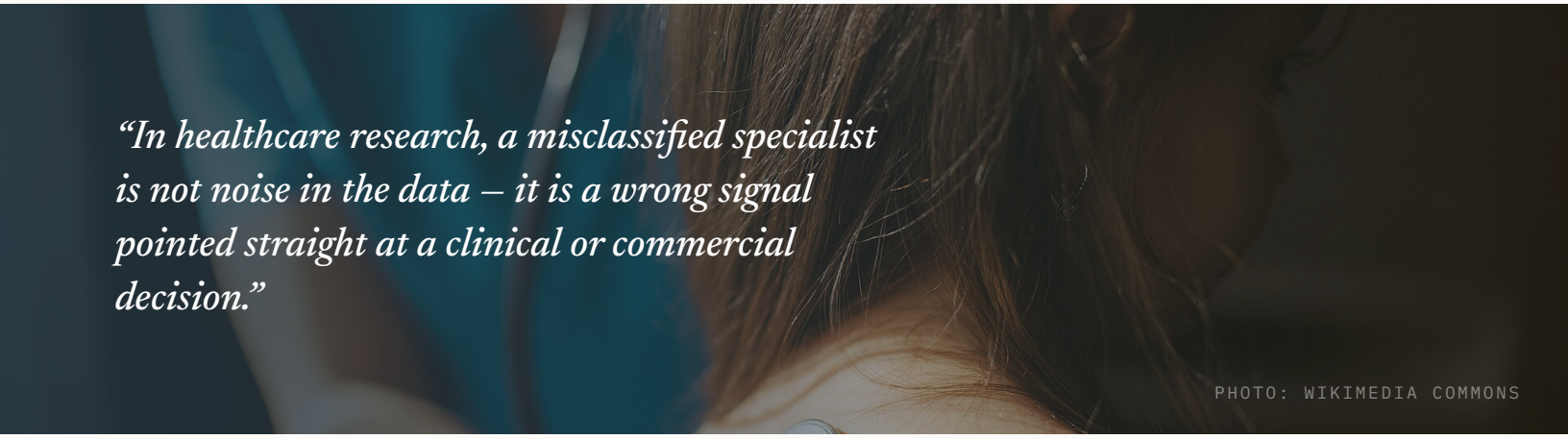
HEALTHCARE RESEARCH · CREDENTIAL VERIFICATION

Credible *Physician* Sample

A Methodology for Verifying Healthcare-Professional Credentials

A self-reported specialty is a claim, not a credential. This paper is a vendor-neutral guide to the discipline that separates a defensible physician sample from a list — an evidence ladder from self-report to primary-source registry match, where verification happens across the respondent lifecycle, and how credentialing differs across EU, UK, and US markets.

PUBLISHED BY	SERIES	READING TIME	EDITION
CatalystMR Research Team	Methodology Papers	~18 minutes	2026



ABSTRACT

Healthcare research informs decisions — drug launches, device positioning, formulary strategy — that carry consequences far beyond the cost of the study. The variable that most often decides whether an HCP data file can be trusted is not how the audience was specified or how feasibility was modelled, but whether each respondent's professional credentials were genuinely **verified** — or merely self-reported and accepted.

This paper concentrates on that one discipline. It sets out a four-tier **evidence ladder** from unverified self-report to primary-source registry match; shows **where** verification has to happen across the respondent lifecycle for credentials to stay current; and maps how credentialing infrastructure differs across **EU, UK, and US** markets — so a buyer fielding internationally knows what "verified" should mean in each. Audience specification, feasibility, mode choice, and post-field QC are covered in companion papers; here they appear only where credential verification touches them.

CONTENTS

WHO THIS IS FOR

Client-side healthcare insights and research buyers commissioning HCP studies; **agency, pharma, and med-device researchers** designing and fielding them; and **procurement and medical-affairs leaders** evaluating sample partners across markets. No prior sampling expertise is assumed; practitioners can skip to Section 02.

01 THE PROBLEM

A self-reported specialty is a claim — verification is what makes it evidence.

A respondent who selects "cardiologist" from a dropdown has made a claim. Whether that claim is true is the single question on which an HCP study's credibility rests, and it is answered not by the screener but by **verification** — testing the claim against independent professional evidence. Three features of healthcare sample make that discipline non-negotiable.

Incentive pressure meets low incidence

Qualified clinicians are a small, high-value slice of any panel, and the incentive to complete a specialist study is exactly the pressure that tempts a near-miss respondent to round their role up to the target specialty. Where eligibility rests on unverified self-report, that pressure quietly inflates the qualifying population with people who do not belong in it.[1]

Clinical terminology can be pattern-matched

A motivated respondent can recognise the clinical language a screener seems to reward and select it without holding the credential behind it. Trap questions help, but the durable answer is to anchor eligibility to evidence that exists independently of the survey — a licence, a registry entry, a board certification — rather than to the respondent's account of themselves.

The cost of one bad completion is asymmetric

In a large consumer tracker, a few bad completes barely move the result. In a study of a narrow specialist cell, a single fabricated or misclassified respondent can visibly distort a finding that informs a clinical or commercial decision. The rarer the audience, the more each completion has to be earned through verification — not assumed.

> THE THROUGHLINE
>
> **Verify the credential, don't accept the claim.** This paper is about how that is actually done — the strength of different kinds of evidence (Section 02), the points in the lifecycle where verification has to happen (Section 03), and how the available evidence differs by market (Section 04). Specification, feasibility, and QC are the work of companion papers.

02 EVIDENCE

Not all "verification" is equal — know which rung you are standing on.

"Verified" is used loosely in sample procurement. The useful question is not whether a provider verifies, but against what evidence. The four rungs below run from the weakest basis for eligibility to the strongest; each rung up is harder to fake and more defensible to a stakeholder.

TIER 3

Primary-source verification

The credential is matched against an authoritative external register — a national medical-council listing, a provider registry, or a board-certification record — independent of anything the respondent typed. The strongest basis, and the one a defensible HCP file is built on.

TIER 2

Documentary evidence

The respondent supplies a verifiable artefact — a licence or registration number, a provider identifier — that can be checked against a primary source. Stronger than assertion, but only as good as the check that follows it.

TIER 1

Profiled & cross-checked self-report

Self-reported specialty reconciled against data the panel already holds — prior profiling, response history, consistency traps. Catches drift and contradiction, but still rests on earlier self-report.

TIER 0

Unverified self-report

A specialty chosen from a dropdown, accepted as fielded. Adequate for broad consumer work; insufficient on its own wherever clinical accuracy drives the decision.

WEAKER BASIS → STRONGER, HARDER-TO-FAKE EVIDENCE

HOW TO USE THE LADDER

Decide the **minimum tier** your study requires before fielding, and write it into the spec. A broad attitudinal survey of clinicians may live safely at Tier 1; a study naming a subspecialty, or one informing a regulatory or commercial decision, belongs at Tier 3. The mistake is discovering only at analysis that "verified" meant Tier 0.

03 LIFECYCLE

A credential is verified at three moments — not one.

Reaching Tier 3 once is not enough, because a credential's accuracy decays as clinicians change roles, settings, and focus. The most defensible HCP programs verify at three points in the respondent lifecycle, each catching what the others cannot.

STAGE 1 · RECRUITMENT

Establish at the source

Match the credential to a primary source when the clinician joins — before any study creates an incentive to misrepresent.

- Registry / licensure primary-source match
- Specialty, setting & patient volume captured
- Invite-only, verified professional recruitment

STAGE 2 · SURVEY ENTRY

Re-confirm in the moment

Cross-check screener answers against the stored credential record, and catch clinical inconsistency as it happens.

- Screener-to-credential cross-validation
- Clinical terminology & consistency traps
- Device fingerprint, geo-IP & VPN checks

STAGE 3 · POST-FIELD

Audit the completes

Inspect finished data for clinically implausible, inattentive, or duplicated responses before delivery.

- Clinical-plausibility review
- Open-end auditing (incl. AI-text)
- Flagged completes removed & replaced

Why one verification moment is never enough

Recruitment-time verification is the strongest single check, because the respondent has no study-specific reason to misrepresent — but it ages the moment a clinician changes specialty emphasis or practice setting. Entry-time cross-validation catches that drift against the current screener; post-field auditing inspects behaviour rather than claims, catching the inattentive or fabricated completion that a valid credential cannot rule out. No single layer is sufficient; the combination is what makes the file defensible. [2] Post-field quality control is itself a deep topic — Paper No. 137 sets out the full eleven-point framework.

04 MARKETS

"Primary source" means something different in each market.

Tier-3 verification depends on what authoritative register exists in a given country — and they differ. A buyer fielding internationally should expect a provider to name the specific source it verifies against in each market, and to conduct healthcare research under a recognised healthcare-MR code. In Europe, the **EphMRA Code of Conduct** is the sector's self-regulation framework for primary and secondary healthcare market research, complementing the ICC/ESOMAR Code.[3]

MARKET	AUTHORITATIVE PRIMARY SOURCES	CONDUCT FRAMEWORK
UK	National medical-register listing (e.g. the General Medical Council register) and Royal College / specialist-register entries.	EphMRA · ICC/ESOMAR
EU & EEA	Each country's competent-authority register — national medical chambers and councils that license and list physicians by specialty.	EphMRA · ICC/ESOMAR
US	NPI registry (CMS / NPPES), state medical-board licensure, ABMS board certification, and primary-source-verified AMA physician data.	ESOMAR · Insights Assoc.
Other markets	The national licensing or registration authority for that country; where none is accessible, verification falls back down the ladder and should be disclosed as such.	ICC/ESOMAR · local

BUYER'S QUESTION FOR MULTI-MARKET WORK

Ask: **"In each market in my study, what register do you verify against, and what tier of evidence does that give me?"** A credible international provider answers market by market — and is candid where a country offers no accessible primary source, rather than implying uniform Tier-3 everywhere.

05 INTEGRITY OVER TIME

A credential verified once is not verified forever.

Verification is not a one-time stamp; it is a state that decays. Clinicians move between settings, shift subspecialty emphasis, retire, or change prescribing authority — and a panel that verified them at join may be carrying records that no longer match reality. Maintaining credential integrity is its own discipline.

What keeps a credential current

- **Periodic re-verification** — re-matching stored credentials against the primary source on a schedule, not just at recruitment.
- **Change-of-status capture** — prompting for setting, subspecialty, and authority changes over time.
- **Recency requirements** — treating a long-stale verification as expired, not current.
- **Audit trail** — recording when and against what each credential was last verified.

The AI-text threat to open-ends

A valid credential does not guarantee an attentive, genuine response. AI-generated open-ends can now mimic clinical phrasing and pass naïve exact-match checks, which is why clinically-aware human review of verbatims — not just trap questions — belongs in any serious HCP programme. The ESOMAR Guideline for Online Research and the ICC/ESOMAR Code emphasise human oversight of automated processes for exactly this reason.[4]

> VERIFICATION ≠ A FINISHED DATA FILE
>
> A credential confirms who the respondent is; it says nothing about whether this completion is attentive, unique, and clinically plausible. Credential verification and post-field quality control are complementary disciplines — neither substitutes for the other. The full QC framework is the subject of Paper No. 137.

06 IN PRACTICE

A credential-verification do and don't.

The discipline reduces to a short set of habits — and a matching set of traps to avoid. These are specific to credential verification; the companion papers below carry the specification, feasibility, mode, and QC questions, so nothing here repeats them.

✓ DO	– DON'T
+ Set the **minimum evidence tier** before fielding, and write it into the spec.	– Accept the word **"verified"** without asking against what evidence.
+ Require **primary-source matching** for named specialties and decision-grade studies.	– Assume a **general panel's** self-reported specialty is a credential.
+ Ask which **register** is used in **each market**, and what tier it yields.	– Treat one market's **registry depth** as if it existed everywhere.
+ Insist on **periodic re-verification**, not a one-time check at join.	– Read **headline panel size** as proof of verified specialty depth.
+ Pair verification with **post-field QC** and clinically-aware open-end review.	– Let a **stale** recruitment-time check stand in for current status.

WHERE THIS SERIES GOES DEEPER

No. 131	**Specification & sourcing.** Turning a clinical audience into auditable variables and sourcing it transparently.
No. 134	**Feasibility & incidence.** Modelling how rare a specialty target is, and how long it takes to field.
No. 135	**Mode choice.** When to reach subspecialists by telephone (CATI) or mixed-mode rather than online alone.
No. 137	**Quality control.** The eleven-point pre-field, in-field, and post-field framework applied to every complete.

CATALYSTMR
transforming market research data into marketing solutions

▲ CONCLUSION

A defensible physician sample is verified, not asserted.

Physician sample earns its credibility one credential at a time. Decide the evidence tier each study needs and write it into the spec; verify against a primary source wherever clinical accuracy drives the decision; check at recruitment, entry, and post-field rather than once; name the register used in every market; and keep verification current rather than treating it as a permanent stamp. Do that, and the data file rests on evidence instead of assertion. The EphMRA, ESOMAR, and ISO 20252 frameworks exist precisely so buyers can ask for this rigour in consistent terms — and recognise it when they see it.[1,3]

§ REFERENCES

[1] ESOMAR. **37 Questions to Help Buyers of Online Samples.** Amsterdam: ESOMAR, 2023. esomar.org

[2] ICC/ESOMAR. **International Code on Market, Opinion and Social Research and Data Analytics.** ICC & ESOMAR.

[3] EphMRA. **Code of Conduct.** European Pharmaceutical Market Research Association. (The healthcare-MR sector's self-regulation framework for primary and secondary research, intended for international use.) ephmra.org

[4] International Organization for Standardization. **ISO 20252:2019 — Market, opinion and social research, including insights and data analytics — Vocabulary and service requirements.** Geneva: ISO, 2019.

Standards and sector codes are cited for the conduct and quality frameworks referenced. Provider registries and licensure databases (e.g. the UK GMC register; the US NPI/NPPES registry, state medical boards, ABMS, and primary-source-verified AMA physician data) are named as verification methods and examples, not as quantified or endorsed sources. Methodological principles stated without a citation are definitional to survey sampling. This paper publishes no incidence, fraud, or quality-rate figures; any figure specific to a study should be measured from that study's own data.

§ ABOUT

CatalystMR

CatalystMR is a global market-research panel and fieldwork partner specialising in **hard-to-reach healthcare, B2B, and niche audiences**. We verify clinical credentials against primary sources, re-verify over time, and pair verified online sample with live telephone (CATI) capability for the specialties online alone cannot reach — under one screener, one QC standard, and one point of contact.

We publish our own responses to ESOMAR's 37 Questions and design credential verification into every HCP engagement rather than treating quality as a post-field cleanup.

Compliance posture: our methodology is aligned to the ESOMAR Code and Guidelines, the EphMRA Code, and the ISO 20252 framework, and we are certified under the EU-U.S., UK, and Swiss Data Privacy Frameworks, with personal data siloed from response data.

HCP SAMPLE · CREDENTIAL VERIFICATION · PRIMARY SOURCE · EPHMRA · ESOMAR 37 · ISO 20252

Tell us your specialty target and markets, and we'll tell you the evidence tier we can verify to in each — with a modelled feasibility range, typically within 24 hours — not a hopeful number.

sales@catalystmr.com
1-800-819-3130
catalystmr.com