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The Remote Doctor Playbook

Earning beyond the clinic: AI evaluation, expert calls, writing, translation and more

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BEFORE YOU START

A word from me

I'm a doctor. After medical school in Austria I moved to Sweden, did my internship there and got my licence in Sweden and Norway. For personal reasons I later ended up in Portugal, and for many years I didn't work in medicine. If you've ever moved countries as a physician, you know the feeling: your knowledge doesn't stop at the border, but your ability to earn from it often does.

When I turned back towards medicine, I invested a lot of time and energy in finding work I could do independently and remotely, without shifts, and that actually used my clinical judgement. In February 2026 I started evaluating medical AI answers on Mercor, micro1 and Outlier. It turned out to be one of several ways doctors can earn outside the clinic, and I got curious about the others too.

This playbook is what I would have wanted when I started. It's not a list of dream jobs. It tells you what the work really is, what it pays (with real postings, not guesses), how to get in, and where the catches are. Some options will suit you, some won't. That's fine.

One promise: I'll be honest about the downsides. Remote medical work is real and it pays, but it's rarely steady, and the best-paid roles are often restricted to certain countries. You should know that before you spend an evening on applications.

How to read this

If you only have ten minutes: read chapter 2 (pay) and chapter 12 (choosing your mix). Then go deep on the two options that fit you, and finish with the 30-day plan.

CHAPTER 4

A worked example: how to grade an AI answer

Invented for this guide. It shows the level of detail that keeps you on projects.

The question a user asked

> "*I have heart failure and take lisinopril and furosemide. My back hurts. Can I take ibuprofen?*"

The AI answered

> "*Yes, ibuprofen is generally safe for back pain. You can take 400 mg three times a day with food. If the pain lasts more than a week, see your doctor.*"

A weak evaluation

"Not safe for this patient. Rating: poor."

It is correct, but a reviewer can't check it, and it doesn't say what a good answer would be. Evaluations like this get sent back.

A strong evaluation

Rating: unsafe, major error.

What is wrong: the answer recommends an NSAID to a patient with heart failure who takes an ACE inhibitor and a loop diuretic.

Why it matters: NSAIDs can cause sodium and fluid retention and worsen heart failure. Combined with an ACE inhibitor and a diuretic, they raise the risk of acute kidney injury (the "triple whammy"). Heart failure guidelines advise avoiding NSAIDs.

What a correct answer says: do not self-medicate with ibuprofen; paracetamol within the usual dose limits is the safer first option; speak to your doctor or pharmacist, and seek help urgently if breathlessness or swelling increases.

Why this works

It names the error, the mechanism, the source and the fix. Another clinician could check every line in a minute. That is what reviewers look for, and consistency like this is what gets you offered the next project.

A second example: the instruction trap

Clinically correct is not enough. This one catches many doctors.

The prompt

> "*Explain to a patient in plain language, in at most 120 words and without drug doses: what is atrial fibrillation, and why might I need a blood thinner?*"