



Kent Academic Repository

Gomez, Kelvin, McKeown, John, Jackson, Ben, Fairclough, Sara, Rogers, Duncan, Neden, Catherine, Taggar, Jaspal, Harrison, Kathryn J., Harding, Alex and Pope, Lindsey (2026) *Livestreaming clinical education in general practice: practical lessons from implementation across seven UK medical schools*. Education for Primary Care . pp. 1-6. ISSN 1473-9879.

Downloaded from

<https://kar.kent.ac.uk/115950/> The University of Kent's Academic Repository KAR

The version of record is available from

<https://doi.org/10.1080/14739879.2026.2673398>

This document version

Publisher pdf

DOI for this version

Licence for this version

CC BY (Attribution)

Additional information

Versions of research works

Versions of Record

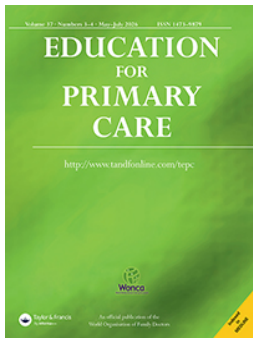
If this version is the version of record, it is the same as the published version available on the publisher's web site. Cite as the published version.

Author Accepted Manuscripts

If this document is identified as the Author Accepted Manuscript it is the version after peer review but before type setting, copy editing or publisher branding. Cite as Surname, Initial. (Year) 'Title of article'. To be published in **Title of Journal** , Volume and issue numbers [peer-reviewed accepted version]. Available at: DOI or URL (Accessed: date).

Enquiries

If you have questions about this document contact ResearchSupport@kent.ac.uk. Please include the URL of the record in KAR. If you believe that your, or a third party's rights have been compromised through this document please see our [Take Down policy](https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies) (available from <https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies>).



Livestreaming clinical education in general practice: practical lessons from implementation across seven UK medical schools

Kelvin Gomez , John McKeown, Ben Jackson , Sara Fairclough , Duncan Rogers , Catherine Neden , Jaspal Taggar , Kathryn J. Harrison , Alex Harding & Lindsey Pope

To cite this article: Kelvin Gomez , John McKeown, Ben Jackson , Sara Fairclough , Duncan Rogers , Catherine Neden , Jaspal Taggar , Kathryn J. Harrison , Alex Harding & Lindsey Pope (14 Jul 2026): Livestreaming clinical education in general practice: practical lessons from implementation across seven UK medical schools, Education for Primary Care, DOI: [10.1080/14739879.2026.2673398](https://doi.org/10.1080/14739879.2026.2673398)

To link to this article: <https://doi.org/10.1080/14739879.2026.2673398>



© 2026 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.



[View supplementary material](#)



Published online: 14 Jul 2026.



[Submit your article to this journal](#)



Article views: 310



[View related articles](#)



[View Crossmark data](#)

Livestreaming clinical education in general practice: practical lessons from implementation across seven UK medical schools

Kelvin Gomez^a, John McKeown^b, Ben Jackson^c, Sara Fairclough^c, Duncan Rogers^d, Catherine Neden^e, Jaspal Taggar^f, Kathryn J. Harrison^d, Alex Harding^g and Lindsey Pope^h

^aLeeds Institute of Medical Education, Leeds School of Medicine, University of Leeds, Leeds, UK; ^bSchool of Medicine, University of Aberdeen, Aberdeen, UK; ^cSchool of Medicine and Population Health, University of Sheffield, Sheffield, UK; ^dSchool of Medicine, University of Liverpool, Liverpool, UK; ^eKent and Medway Medical School, University of Kent, Canterbury, UK; ^fSchool of Medicine, University of Nottingham, Nottingham, UK; ^gDepartment of Primary Care (APEX), Exeter University, Exeter, UK; ^hUniversity of Glasgow Medical School, University of Glasgow, Glasgow, UK

ABSTRACT

General practice placements are facing increasing pressure from global clinician shortages, rising workload and limited physical space. Meanwhile, medical school cohorts continue to expand to support the global clinician shortfall. This mismatch creates a growing bottleneck for authentic patient-based learning and has intensified interest in digital placement models of education. Livestreamed Clinical Experiences (LCEs) – real-time broadcast consultations between clinicians and patients – offer a potential way to extend access to clinical learning, increase exposure to diverse cases and enable participation by rural or underserved communities. However, despite growing interest, educators currently lack practical guidance on how to implement LCEs in general practice in ways that are ethically robust, technically feasible and pedagogically purposeful. Drawing from educator experience, literature and pilot data, we outline key practical considerations across five themes: planning and governance, technical setups, patient-centred consent, pedagogically purposeful delivery, and sustainable evaluation and scale-up. Our aim is to provide a concise, practice-oriented narrative reflecting what worked, what proved challenging and what may support others to implement effective LCEs. We include a practical implementation checklist and an LCE facilitation model to guide educators through the planning, ethical and technical stages of delivery.

ARTICLE HISTORY

Received 6 February 2026
Revised 23 February 2026
Accepted 9 May 2026

KEYWORDS

Livestreaming; clinical education; general practice

Introduction

Learning from patients is essential to undergraduate medical education [1], yet the availability of general practice placements has not kept pace with growing student cohorts [2,3]. General practitioners continue to face increasing clinical workloads and limited physical space to deliver traditional in-person placements. This risks reducing access to consultation-based teaching and increasing the variability of students' exposure to general practice.

Livestreamed clinical experiences (LCEs) have emerged as a promising supplement to placements, allowing students to observe real-time patient consultations from remote locations. LCEs involve the synchronous transmission of clinical interactions between healthcare professionals and patients to remote learners via secure telecommunication platforms. In this paper,

we use the term 'livestreamed' to mean live-only transmission of consultations without recording or storage. The educational value of LCEs is in real-time observation and facilitated participation. The absence of recordings reduces confidentiality risk and differentiates LCEs from asynchronous libraries of recorded consultations.

In general practice, literature suggests LCEs offer particular advantages [4]: access to diverse patient groups and cases (including rural or vulnerable individuals), opportunities for supervised observation without overcrowding clinical settings and enhanced opportunities for peer-to-peer discussion around clinical scenarios. In practice, LCEs have been used to broaden access to geographically distant GP contexts (e.g. livestreamed consultations from rural/remote practices to learners based elsewhere, enabling earlier exposure to remote and rural primary care without the travel, housing and capacity constraints of physical placements).

CONTACT Kelvin Gomez  A.K.gomez@leeds.ac.uk  Leeds Institute of Medical Education, Leeds School of Medicine, University of Leeds, Leeds LS2 9JT, UK
 Supplemental data for this article can be accessed online at <https://doi.org/10.1080/14739879.2026.2673398>.

© 2026 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.

This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

They may also increase access to consultations that patients would otherwise decline for face-to-face group observation (e.g. where a room full of students feels intimidating) [5]. Finally, LCEs can increase exposure to uncommon presentations or specialist clinics at scale compared with opportunistic placement learning.

Despite growing interest and uptake, there remains limited practice-oriented guidance on how to setup and govern LCEs in general practice. This gap is important as LCEs sit at a sensitive intersection of patient care, confidentiality, and education; and weak governance or poor pedagogical design could undermine patient trust and produce variable learning quality.

This manuscript draws on experiences implementing LCEs across seven pioneering UK medical schools to share a series of practical lessons for general practice educators. We present this as a narrative covering five themes: planning and approval; technical setup; ethical and patient-centred practice; pedagogical delivery; and evaluation and scale. Our aim is to provide a realistic guide for colleagues considering LCEs in their own setting. To support implementation, we have synthesised these lessons into a practical 'LCE Implementation Checklist' (Appendix A in the supplementary material), as well as an LCE facilitation model (Table 1).

Planning and approval

The planning and approval process centred on three questions:

- (1) What learning outcomes justify livestreaming?
- (2) Which delivery model fits your setting?

- (3) What governance approvals are required to ensure safety and compliance?

This created a solid foundation for later stages of implementation.

Prior to any technical or logistical decisions, it is important that the intended learning outcomes are clearly defined. This ensures that the use of technology is driven by learning, as opposed to the novelty of a particular tool or technology. We found it useful to refer to a review of LCEs [4] for a list of benefits and limitations to understand whether livestreaming was an appropriate method to deliver the desired learning outcomes over other forms, such as recorded content. Defining the advantages and constraints of LCEs also helped reconcile the differing assumptions of key stakeholders, ensuring the necessary consensus for the successful implementation and administration of these sessions.

We used Experience-based Learning (ExBL) [1] as a design and evaluation lens to ensure that livestreaming decisions remained learning-outcome led rather than technology driven. ExBL emphasises that students develop intellectual, practical and affective capabilities through (a) access to real patient learning (RPL), (b) progressive participation (from observation to contribution), and (c) organisational, pedagogic and affective support. In our implementation, LCEs were positioned primarily to extend access to RPL and to support activated observation and early participation (e.g. structured history-taking tasks, opportunities for clinical

LCE facilitation model.

Phase	Pedagogical purpose	Educator role	Learner activity	Example strategies / prompts
1 Introduction (framing)	Establish psychological safety; clarify expectations, learning outcomes, and 'ways of working' (supports ExBL organisational & affective conditions)	Introduce session aims; reconfirm patient consent; state live-only / no recording; clarify learner role/visibility and professionalism; set turn-taking norms; orient learners to what to attend to (including relational/interactional aspects)	Join securely; confirm confidentiality and suitable private space; review learning objectives; prepare to observe and engage	'We'll pause at agreed points for input'. 'Use chat/hand-raise to avoid talking over'.
2 Consultation (guided participation)	Promote active observation of the unfolding consultation; develop clinical reasoning while recognising communication/rapport (ExBL pedagogic support; progressive participation at an appropriate level)	Signpost key moments; invite learner input without disrupting clinical flow; 'broker' the triad (patient-clinician-learner); narrate reasoning when appropriate	Observe consultation; summarise problems; suggest differentials / questions; shared decisions, continuity-of-care cues	Chunking/checking stops: (a) 1-sentence problem representation, (b) differentials & red flags, (c) plan & safety-net. Use chat/polls to include quieter learners. Screen-share selectively (e.g. results/letters) to teach continuity.
3 Debrief (facilitated reflection)	Consolidate learning; explore reasoning and uncertainty; reflect on communication and continuity of care (ExBL pedagogic & affective support)	Lead reflective discussion; unpack decision-making; address complexity/uncertainty; give specific feedback; agree take-home actions	Reflect on communication, reasoning, uncertainty and continuity; ask questions; identify action points	Debrief structure: 'What happened?' > 'Why?' (reasoning/uncertainty) > 'How was rapport managed on screen?' > 'What will I do next time?' (action plan).

reasoning ‘stops’, and debrief-based reflection). Outcomes requiring hands-on skills, such as physical examination techniques, were not possible to assess. We therefore framed LCEs as a complement to in-person GP placements: LCEs can effectively expand RPL exposure and standardise case access, whereas in-person experiences remain essential for hands-on examination and situated participation [4].

Choosing the mode of delivery also requires clarity of purpose. Through our work across sites, we identified three possible modes of learning (see Figure 1); individual learning; group learning, and remote supervision of students physically present in practice. In general practice, small-group learning was most feasible, allowing a single clinical educator to broadcast consultations to multiple students without room-capacity limitations. Group learning consisted either of individuals and a facilitator from different settings engaging remotely, or learners co-located together in a teaching setting with a facilitator. Appendix B (in the supplementary material) provides a list of key benefits and challenges as they relate to each mode of learning to help you identify the relevant mode of learning and access.

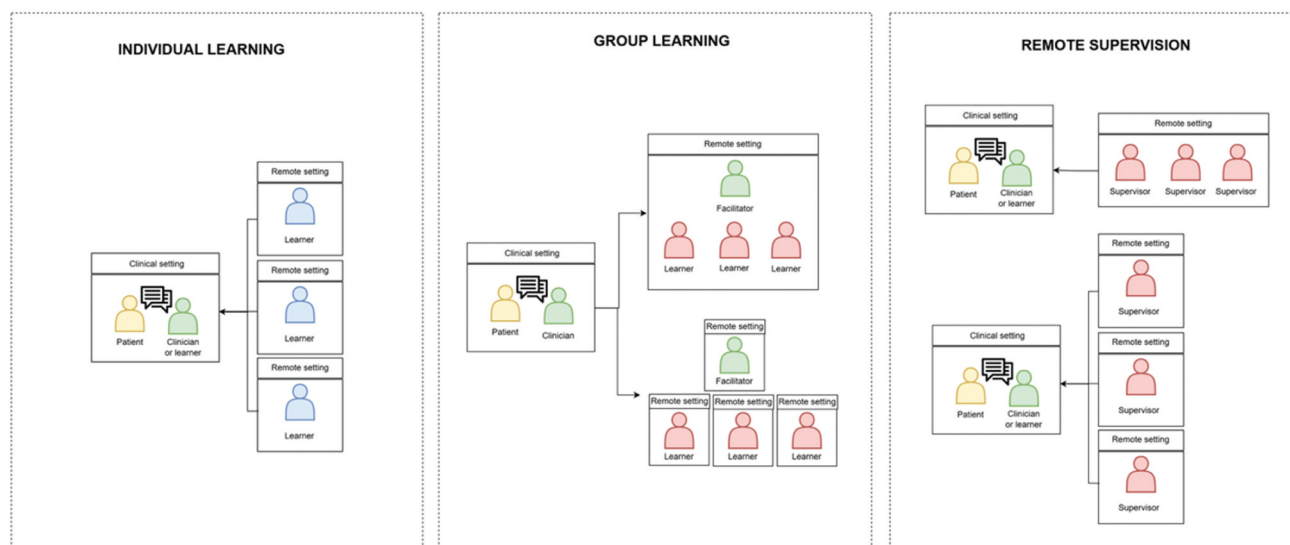
Securing institutional and healthcare-provider approval is a crucial early step. Most general practices, as well as information governance teams, had limited experience

with livestreaming. Both required patient confidentiality assurance, including that patient data would not be recorded or stored. Starting these conversations early with IT colleagues from both the medical school and practice sites helped to avoid delays. They will be aware of specific institutional cyber security requirements and able to guide you through the end-to-end processes required for data protection approval. Clinical educators also needed clear guidance on what aspects of their workflow would or would not be altered.

Building a feasible technical setup

A suitable setup in general practice is one that clinical educators can use reliably, patients can trust, and learners can engage with safely and effectively. Complexity without sufficient testing risks reducing authenticity or increasing cognitive load.

The most important lesson was to keep the setup simple in the first instance. A single high-quality webcam, a reliable microphone and a secure telecommunication platform proved sufficient for most of the clinical experiences. Starting with existing institution-approved telecommunication platforms may reduce costs and minimise approval barriers. Our pilots across multiple general practice sites uncovered issues that were not apparent in controlled demonstrations. For example, careful camera positioning was essential for learners to understand the clinical environment and improve the authenticity of the interaction. We also found that some rooms had poor Wi-Fi coverage, requiring temporary hotspot connections. We optimised the visual



A typology of three key modes of learning and access through LCE's.

learning experience by using high-definition wide-angle cameras to capture the clinical educator and patient from a distance with the greatest visual clarity. This was strongly welcomed by learners. Other enhancements, like wearable cameras or digital otoscopes/stethoscopes, added authenticity in specific scenarios but were not essential. Their introduction required additional training for clinical educators. Depending on the level of technological competence, we observed that additional tools could distract from the natural flow of the consultation (particularly the patient-clinician interaction). We found that enhancements were best introduced gradually and only after the core system was functioning reliably.

Ethical and patient-centred livestreaming

Livestreamed clinical teaching needs its own consent process, distinct from routine face-to-face co-located student encounters. Patients should understand exactly what they are agreeing to – why the session is being livestreamed, who is observing, what they will see or hear, and any involvement they may have with teaching. Importantly, patients should be told explicitly that the consultation is not recorded, will not be retained for future teaching, and that their consent relates to a single live session only. This is a key ethical distinction from asynchronous recorded consultations. If a session is recorded, it ceases to be an LCE in the sense used here and introduces additional confidentiality, governance and consent complexities. Most patients understood the purpose easily when it was explained. Best practice is to give written information in advance, for instance leaflets or posters that are clear and simple and if necessary, in appropriate languages [6]. It should also be clear that saying no, at any point, will not affect their care. Consent should always be confirmed, even if patients have previously agreed, to check the patient is still happy to go ahead [7]. Verbal consent is sufficient but must be explicit and documented in the clinical record contemporaneously.

Accessibility considerations were important for learners. Not all students have stable internet connections or private spaces for viewing LCEs. To ensure an equitable learning experience, it is important to ensure that learners have access to suitable rooms in their institutions to support confidentiality and inclusivity. Our students did not disclose any learning needs, but the use of captioning or transcripts may be a requirement for learners with hearing needs.

Delivering pedagogically sound sessions

Preparation for both educators and learners was essential, and is requirement in some institutions. Learners and clinical educators benefitted from an introductory session to familiarise themselves with the telecommunication platform and complete preparation tasks such as checking internet connectivity. Students were briefed on how to join securely, maintain confidentiality and engage professionally.

Attending to the relational and interactional nature of consultations is particularly important in LCEs because technology-mediated encounters can reduce or distort non-verbal cues (e.g. gaze, posture, micro-pauses) and can change turn-taking, rapport-building and learners' sense of psychological safety [4,8–12]). Evidence from remote/telemedicine learning highlights risks of reduced rapport, uncertainty about when learners should speak and passive observation unless educators redesign roles and interaction structures rather than simply moving teaching online [4,9,12–14]. We therefore recommend that educators make the relational work of the consultation an explicit learning outcome and teach 'telepresence' skills (e.g. camera framing, sound, explicit narration of silences or movements) alongside other capabilities.

We found it useful to structure each session into three phases: introduction, consultation, and debrief (refer to Table 1 for an example LCE facilitation model). A short introduction allowed clinical educators and students to establish rapport, explain the context, and set learning outcomes. At this stage, we reassured learners it was a safe learning space while reminding them that professionalism standards remained the same – they were expected to demonstrate good professional behaviours. This was also an opportunity for patients to meet learners on screen, confirm who is present and how many, and establish turn-taking norms with students (e.g. 'hands up'/ chat-to-speak; one named student speakers at a time; explicit pauses for student questions or micro-debriefs).

During the session or consultation, targeted tasks promoted active engagement. Learners should be expected to interact with the patient as they would in a face-to-face setting, to achieve meaningful interaction between learner, patient and clinical educator [5]. Educators should 'broker' triadic moves between student and patient, by actively bringing the patient into the educational purpose and inviting student questions. For example, students were asked to summarise the presenting complaint partway through the encounter. By asking learners to summarise or via 'chunking and checking' you can assess understanding and identify areas for future development [12]. Screen-sharing to show previous consultations, recent investigations and

hospital letters helped to provide context and support learning about continuity of care; a key feature of general practice. The debrief after the consultation provided a space for learners to reflect on their experience, explore decision-making processes and consider more complex topics such as managing clinical uncertainty. Where a separate facilitator is available, this can help to free time for the clinical educator to complete any administrative tasks before seeing the next patient without limiting valuable debrief time.

Educators should also anticipate unintended educational consequences of LCEs. Without careful facilitation, LCEs can drift towards learner passivity (watchers rather than participants), and reduce attention to the embodied and relational elements of consultations. There is also a risk of hidden-curriculum messages – the unintended lessons learners infer from the way the session is organised – such as the impression that consultations should be optimised for efficiency and observer visibility (‘good performance on camera’), rather than prioritising rapport, empathy, and relationship-centred care; inequalities in participation (only confident students speak); and distorted case-mix if only stream-friendly cases are selected [4,12,13,15,16]. These risks reinforce the importance of structured interactivity, explicit attention to rapport/communication, and using LCEs to complement, rather than replace, in-person placements.

Ultimately, the most effective sessions were those that combined purposeful pedagogy with clinical authenticity. Over-engineering (e.g. implementation of multiple tools beyond the basic setup) risked making encounters feel artificial, while leaving pedagogy entirely implicit reduced learning value. Finding the right balance requires iterative refinement.

Evaluating, iterating and scaling

Most LCE initiatives began as small pilots. While pilots were useful, successful uptake of LCEs was unlikely if a clear path to long-term integration was not defined from the beginning. We found a phased approach to integration to be most effective; expanding from initial test runs with specific student groups/years, to wider cohort student groups. This required building capacity among clinical educators’ confidence in livestreaming, strengthening the support available to practices, and careful selection of teaching rooms with appropriate equipment for co-located group livestreaming with a facilitator.

Timetable flexibility matters. The nature of livestreamed teaching means it happens only at a certain time. Offering multiple session times supported learners with caring responsibilities or disability needs. Incorporating

formative assessments and reflective exercises within LCEs was valuable. Reflective prompts or real-time feedback helped students engage without the pressure of summative evaluation. Insights from IT teams were equally important, helping to identify connectivity problems, access issues, or platform limitations.

Scalability of livestreaming is likely to be greatest when it complements rather than competes with existing placements. For example, in practices where there is limited physical space for learners – LCEs can not only broaden participation without increasing clinical educator workload, but can also help remove geographical barriers and enable students to access remote practices more easily.

As clinical educators move from initial pilots to wider cohort integration, maintaining consistency across sites is vital. The checklist provided in Appendix A offers a structured framework to ensure that governance, technical, and pedagogical standards are maintained during this scaling process.

Conclusion

As student numbers grow, general practice teaching will need to adapt in ways that protect teaching quality and patient care. LCEs offer a valuable supplement to traditional placements when implemented thoughtfully. Drawing on the experience across seven UK medical schools, this paper highlights LCEs not only as a response to capacity pressures, but also to support high quality and inclusive learning. When aligned with clear learning outcomes and robust governance, LCEs can widen access to diverse, authentic consultations and reduce inequalities related to access, including geography and physical space. They allow meaningful participation of students without compromising the setting of the consultation. Purposeful pedagogical design allows LCEs to enhance, rather than dilute, learning in general practice.

LCEs should not be viewed as a replacement for in-person GP placements, but as a complementary approach to improve learning, whilst being considerate of the realities of modern general practice. We hope that the practical considerations outlined in our paper, and the accompanying implementation checklist (see Appendix A), will help support clinical educators to implement LCEs in a way that prioritises the patient perspective, teaching sustainability and educational quality.

Acknowledgments

We would like to thank all members of our Livestreamed Clinical Experience Oversight Group for their valuable

comments and feedback. In particular, we would like to extend our gratitude to our colleague Professor Jane Kirby who has been instrumental in establishing the Livestreamed Clinical Experience Oversight Group which led to the creation of this manuscript. Additionally, we thank Dr. Matt Homer for his insightful review of the manuscript and helpful feedback. Surface-level grammatical refinement was supported by Microsoft Copilot (enterprise edition: bizchat.20260129.44.2).

Author contributions

CRedit: **Kelvin Gomez:** Conceptualization, Methodology, Project administration, Visualization, Writing – original draft, Writing – review & editing; **Ben Jackson:** Conceptualization, Writing – original draft, Writing – review & editing; **Sara Fairclough:** Conceptualization, Writing – original draft, Writing – review & editing; **Duncan Rogers:** Conceptualization, Writing – original draft, Writing – review & editing; **Catherine Neden:** Conceptualization, Writing – original draft, Writing – review & editing; **Jaspal Taggar:** Conceptualization, Writing – original draft, Writing – review & editing; **Kathryn J. Harrison:** Conceptualization, Writing – original draft, Writing – review & editing; **Alex Harding:** Conceptualization, Writing – original draft, Writing – review & editing; **Lindsey Pope:** Conceptualization, Writing – original draft, Writing – review & editing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The author(s) reported there is no funding associated with the work featured in this article.

ORCID

Kelvin Gomez  <http://orcid.org/0009-0004-5858-9230>
John McKeown  <http://orcid.org/0009-0000-1078-8274>
Jaspal Taggar  <http://orcid.org/0000-0002-5031-0977>
Lindsey Pope  <http://orcid.org/0000-0003-0899-9616>

References

- [1] Dornan T, Conn R, Monaghan H, et al. Experience based learning (ExBL): clinical teaching for the twenty-first century. *Med Teach*. 2019;41(10):1098–1105. doi: [10.1080/0142159X.2019.1630730](https://doi.org/10.1080/0142159X.2019.1630730)
- [2] Sassoon EC, Craig RC, O'Brien DG. The challenges of expanding medical student numbers in the UK: a scoping review. *Future Healthc J*. 2025;12(3):100278. doi: [10.1016/j.fhj.2025.100278](https://doi.org/10.1016/j.fhj.2025.100278)
- [3] Scottish Government. Medical education capacity in general practice in Scotland working group: interim report. Edinburgh: Scottish Government; 2025 Dec 18 [cited 2026 Jan 28]. Available from: <https://www.gov.scot/publications/medical-education-capacity-general-practice-scotland-working-group-interim-report/>
- [4] Gomez K, Edwards HL, Kirby J. Livestreaming clinical experience to remotely located learners: a critical narrative review. *Med Educ*. 2024;58(9):1032–1041. doi: [10.1111/medu.15392](https://doi.org/10.1111/medu.15392)
- [5] Gomez K, Edwards HL, Kirby J. “Who’s watching?”: exploring patients’ acceptance of having their consultations livestreamed for educational purposes. *Med Teach*. 2024;46(5):853–857. doi: [10.1080/0142159X.2024.2377813](https://doi.org/10.1080/0142159X.2024.2377813)
- [6] Howe A, Anderson J. Involving patients in medical education. *BMJ*. 2003;327(7410):326–328. doi: [10.1136/BMJ.327.7410.326](https://doi.org/10.1136/BMJ.327.7410.326)
- [7] Mill T, Parikh S, Allen A, et al. Live streaming ward rounds using wearable technology to teach medical students: a pilot study. *BMJ Simul Technol Enhanc Learn*. 2021;7(6):494–500. doi: [10.1136/bmjstel-2020-000739](https://doi.org/10.1136/bmjstel-2020-000739)
- [8] Newcomb AB, Duval M, Bachman SL, et al. Building rapport and earning the surgical patient’s trust in the era of social distancing: teaching patient-centered communication during video conference encounters to medical students. *J Surg Educ*. 2021;78(1):336–341. doi: [10.1016/j.jsurg.2020.06.018](https://doi.org/10.1016/j.jsurg.2020.06.018)
- [9] Rueda AE, Monterrey AC, Wood M, et al. Resident education and virtual medicine: a faculty development session to enhance trainee skills in the realm of telemedicine. *MedEdPORTAL*. 2023;19:11302. doi: [10.15766/mep_2374-8265.11302](https://doi.org/10.15766/mep_2374-8265.11302)
- [10] Koppel PD, De Gagne JC, Webb M, et al. Guidelines for rapport-building in telehealth videoconferencing: inter-professional e-Delphi study. *JMIR Med Educ*. 2025;11:e76260. doi: [10.2196/76260](https://doi.org/10.2196/76260)
- [11] Nowell L, Dhingra S, Carless-Kane S, et al. A systematic review of online education initiatives to develop students remote caring skills and practices. *Med Educ Online*. 2022;27(1):2088049. doi: [10.1080/10872981.2022.2088049](https://doi.org/10.1080/10872981.2022.2088049)
- [12] Armstrong S, Alberti H, Bhattacharya A, et al. Students’ and tutors’ experiences of remote ‘student–patient’ consultations. *Med Teach*. 2023;45(9):1038–1046. doi: [10.1080/0142159X.2023.2170777](https://doi.org/10.1080/0142159X.2023.2170777)
- [13] Walthall H, Schutz S, Snowball J, et al. Patients’ and clinicians’ experiences of remote consultation? A narrative synthesis. *J Adv Nurs*. 2022;78(7):1954–1967. doi: [10.1111/jan.15230](https://doi.org/10.1111/jan.15230)
- [14] Pinedo-Torres I, Garcia-Villasante EJ, Gutierrez-Ortiz CC, et al. The doctor-patient relationship and barriers in non-verbal communication during teleconsultation in the era of COVID-19: a scoping review [version 1; peer review: 2 approved with reservations]. *F1000Res*. 2023;12:676. doi: [10.12688/f1000research.129970.1](https://doi.org/10.12688/f1000research.129970.1)
- [15] Hovaguimian A, Joshi A, Onorato S, et al. Twelve tips for clinical teaching with telemedicine visits. *Med Teach*. 2022;44(1):19–25. doi: [10.1080/0142159X.2021.1880558](https://doi.org/10.1080/0142159X.2021.1880558)
- [16] Nunneley CE, Fishman M, Sundheim KM, et al. Leading synchronous virtual teaching sessions. *Clin Teach*. 2021;18(3):231–235. doi: [10.1111/tct.13282](https://doi.org/10.1111/tct.13282)