2026; In Press: https://doi.org/10.36834/cmej.82757

COMMENTARY AND OPINIONS

The rural emergency department: an overlooked learning opportunity for pre-clerkship medical students

Benjamin Hewins,[1] *Joe Gillis*[2]

*Author information is provided in the back matter of this manuscript

Le service des urgences en milieu rural : une occasion d'apprentissage négligée pour les étudiants en médecine en préexternat

As I sat down in an office off the main hallway of a busy emergency department (ED) and began reviewing the first case of the day, a 10-year-old girl, I found myself wondering: "How will I adapt my approach to communicate with this child? How will I direct my questions to the patient, not her parents?" This case represented my first pediatric patient as a first-year medical student studying at a rural satellite campus in Nova Scotia, Canada. As I reflect on my day spent shadowing a rural emergency medicine (EM) physician, I feel that this opportunity would benefit all pre-clerkship medical trainees. I highlight three takeaways from my rural EM observership and how similar opportunities could positively influence medical students' education and decisions to practice rural medicine.

Learning experiences in EM for first-year students in Canada is largely limited to observerships and electives. The ED is a high-stakes environment limited by physical space, resources, and time. For many EM physicians, the time required to discuss each case and provide a "teachable moment" risks subtracting from efficient, quality care. As a result, most pre-clerkship opportunities in EM are learner-initiated and require approval from the institution and a preceptor. Orchestrating these opportunities can be challenging or impractical for students, as they must align demanding academic schedules with those of a preceptor.[1] Despite these challenges, early EM elective opportunities positively change students' attitudes and interests in the specialty.[2]

I spent the day observing an emergency physician at a rural level III trauma centre. For each case, I first saw the patient in my private room to complete a preliminary history and physical exam while my preceptor was in his adjacent office, wrapping up his previous case. I then presented the case to him; we re-entered the patient room together to finish the encounter and discussed afterward. This learning structure enabled me to practice my communication, history-taking, focused physical exams, case presentation, and documentation skills that I had learned in clinical labs. The added benefit of a rural setting is that I

did not have to compete for my preceptor's time or physical space with residents, fellows, or other medical students.

As a student at a medical campus that is geographically distant from the province's specialty hospitals, opportunities for interaction with certain patient populations are limited. Equally, in rural areas of Canada, families rely heavily on local EDs due to the time and resources required to travel to level I centres.[3] Consequently, rural EDs provide learners with a wide range of clinical learning encounters, spanning neonatal, pediatric, obstetric, and geriatric care, often within a single shift. This requires rural ED physicians to have a broader spectrum of clinical suspicion, deeper consideration of barriers to care, and better management of uncertainty. I observed this during my shift in the ED, where I interacted with multiple pediatric patients. This experience was valuable and underscored areas where my communication skills required refinement.

I observed the cooperative and multidisciplinary nature of a generalist in a rural setting. We saw a patient who had experienced hand trauma, and rather than waiting for the report, we walked to the radiology department, reviewed the imaging with the radiologist, and then established a care plan. This high-functioning, yet friendly and collaborative, interprofessional environment embodied team-based care, outlined in the fundamental CanMEDs roles of collaborator and communicator, critical concepts in Canadian medical education.[4]

First-year medical students are impressionable, and our early elective choices shape the trajectory of our careers. My preceptor's approach demonstrated an effective teaching strategy that did not disrupt patient care. I encourage those shaping pre-clerkship curricula in Canada to consider facilitating early rural EM learning experiences. This experience inspired me and may inspire medical learners across Canada to consider a career in rural medicine.

Author information:

1- Faculty of Medicine, Dalhousie University, Nova Scotia, Canada

2 - Yarmouth Regional Hospital, Nova Scotia Health, Nova Scotia, Canada

Correspondence to:

Benjamin Hewins

benhewins5@gmail.com

Published ahead of issue:

Jan 20, 2026; CMEJ 2026

Conflict of Interest:

The authors of this manuscript have no conflicts of interest to declare.

Edited by:

Marcel D'Eon (section editor); Christina St-Onge (editor-in-chief)

References

1. Huo B, MacNevin W. The importance of specialty experiences for Canadian medical student career exploration. *CMEJ.* 2021 Nov;12(5):71–2. https://doi.org/10.36834/cmej.70749
2. Penciner R. Emergency medicine preclerkship observerships: evaluation of a structured experience. *CJEM.* 2009 May;11(3):235–9. https://doi.org/10.1017/S1481803500011258
3. Rezapour A, Turner H, Newbery S, Grzybowski S, Mackey P. Supporting future and current rural physicians. *CMAJ.* 2024 Nov 18;196(39):E1311–4. https://doi.org/10.1503/cmaj.231292
4. Pullon S, Wilson C, Gallagher P, et al. Transition to practice: can rural interprofessional education make a difference? A cohort study. *BMC Med Educ.* 2016 May 28;16:154. https://doi.org/10.1186/s12909-016-0674-5