SBNS Undergraduate Bursary Award
Neurosurgical Elective at the Queen Elizabeth Hospital Birmingham (QEHB)
13th July to 30th July 2026

I chose QEHB for the breadth and volume of its practice, and above all for its status as a regional major trauma centre. I wanted to see neurosurgery at the pace a large unit works. What follows is an account of three weeks that gave me exactly that.

The shape of the day

Each morning began with handover, and it did not take long to realise this was where the day was really decided. Overnight admissions and referrals were presented, imaging was reviewed collectively, and the emergency operating list was confirmed against clinical priority and theatre capacity. I found the ranking of urgency the most instructive part. Several patients might all reasonably be described as needing surgery that day, and watching the team weigh them against one another, sometimes revising a plan agreed the previous evening based off of the merits of new scans showed me the clinical reasoning used by neurosurgeons. Over time, I began to follow along as the consultants' explained their decisions rather than simply observe it, which was a satisfying shift.

From handover the day opened out into theatre or clinic. Much of my theatre experience was trauma dominated, as I had hoped. Over the three weeks I attended lists covering decompressive craniectomy, craniotomy for subdural haematoma, insertion of external ventricular drains, and several ventriculoperitoneal shunt insertions. On the spinal side I saw lumbar decompression, and thoracic decompression for metastatic cord compression.

Set against all of this, observing craniotomies for brain tumours was quiet revelatory. The contrast with the trauma lists was sharper than I had expected. In trauma the decision to operate was often made quickly, and the objective was decompression and physiological stabilisation rather than definitive treatment. In neuro-oncology cases, the planning had happened long before the patient reached theatre, and the operation itself was a sustained negotiation between extent of resection and preservation of function.

Alongside the cranial cases was elective spinal surgery. With humans living longer and wear-and-tear being the new norm of our bodies, seeing degenerative spinal pathologies is becoming more and more ubiquitous. One exciting case that I observed was an anterior lumbar interbody fusion (ALIF). Such was the novelty of seeing the neurosurgeon go both anteriorly and posteriorly over the course of just a single case. Similar to neuro-oncology, complex spinal cases also involved a great deal of planning. From no significant peripheral vascular disease, a healthy BMI, to pathologies limited to either L4/L5 or L5/S1, many factors played into determining a viable candidate for the ALIF surgery.

Beyond theatre

Clinics gave me the other half of the picture. In the Glioma Clinic I saw longitudinal oncological care and, more instructively, the way uncertain prognoses are communicated to patients who have usually already worked out more than they let on. The Hot Clinic was different in tempo and in kind, dealing with acute and semi-urgent presentations, and showed me how patients are triaged and how readily a management plan is revised. Multidisciplinary meetings then drew the threads together: watching

radiological, pathological, and oncological input converge on a single decision made the collaborative nature of the specialty concrete in a way that a lecture on multidisciplinary working never has.

The weekend on-call shifts were, unexpectedly, among the most valuable sessions of the elective. They stripped away the structure of the weekday timetable and showed me the referral workload as it actually arrives, from across the region, at whatever hour it happens to arrive. One case, rarely seen by even neurosurgeons themselves nowadays, was an extradural haematoma. A boy in his late-teens had been rushed from a local district general hospital to the QEHB, in order to have the haematoma evacuated. This contrasted sharply with the more commonly seen subdural haematomas, which were not as acute as what I saw during this instance.

I watched referrals received, sorted, and prioritised, and I saw the volume and pace of decision-making that sits behind the on-call commitment. If any part of the placement gave me a realistic rather than an aspirational understanding of what neurosurgical training demands, it was this shift. I came away with more respect for the job.

Value of the placement

My three weeks at the QEHB's neurosurgical department was eye-opening. It is not something I could have obtained through my standard undergraduate curriculum, and it has substantially changed how I appreciate the specialty. I kept a structured operative logbook throughout, recording case indications, operative planning, and postoperative priorities, which will support my knowledge as I progress through my medical career.

More than that, the elective confirmed rather than merely sustained my intention to pursue neurosurgery. Seeing the specialty across trauma, oncology, spinal surgery, clinics, MDT, handover, and on-call gave me a rounded and honest picture, demands included. I closed the placement with a mentoring discussion with Mx Crispi about portfolio development. I intend to pass on what I learned to junior students at Leicester through a case-based teaching session with the Leicester SCRUBS Surgical Society this year.

Acknowledgements

I am grateful to Mr Athanasios Zisakis for hosting me and for his supervision throughout, and to Mx Vassili Crispi, whose teaching and mentorship shaped the placement into something considerably more useful than an attachment. My thanks also to the wider neurosurgical team at the Birmingham Neuroscience Centre for making me welcome. Finally, I am sincerely grateful to the SBNS for the Undergraduate Elective Bursary, which made full attendance across all three weeks financially possible.