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From Admiration to Understanding

My HPB Observership at MD Anderson Cancer Center in Houston, TX



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So here I was – finally stepping into what I had long considered the “dream system” for a European surgeon. Comparing surgical training systems is rarely straightforward. Institutional pride, cultural loyalty, and the natural tendency to view one’s own formation through a favourable lens all complicate the exercise. When I was offered the opportunity to complete a hepato-pancreato-biliary (HPB) observership at MD Anderson Cancer Center in Houston, TX, my intention was simple: to understand, rather than judge, a system I had long admired from a distance.

That image of the U.S. system did not arise in abstraction. It first took shape during a prior research fellowship at the University of California, San Diego (UCSD), in a translational research laboratory led by Dr. Rebekah White – Professor of Surgery, pancreatic surgeon, and my principal investigator. Her research focuses on novel approaches to earlier detection and improved treatment of pancreatic cancer, including strategies to enhance anti-tumour immunity through local ablative therapies such as irreversible electroporation in locally advanced disease. Dr. White would become more than a principal investigator – a mentor and role model whose influence on my career I did not fully anticipate at the time.

Like many opportunities in academic surgery, this one began with a connection. One of my mentors introduced me to Dr. Jean-Nicolas Vauthey, a pioneering HPB surgeon whose clinical and research work has focused on improving outcomes after hepatic resection for hepatobiliary malignancies. His contributions to the field have been recognised with numerous distinctions, including the 2025 Nonie Lowry Distinguished Service Award – the highest honour bestowed by the Americas Hepato-Pancreato-Biliary Association (AHPBA). He subsequently introduced me to Dr. Ching-Wei D. Tzeng, Chief of Hepatobiliary Surgery and HPB Fellowship Program Director at the same institution, an educator whose commitment to surgical training runs through every aspect of his role, who welcomed me into his team and the broader department of HPB surgery.

I arrived in Houston in mid-September 2025, uncertain what the weeks ahead would reveal, but willing to set aside assumptions.

The MD Anderson Environment

What defines MD Anderson Cancer Center is not only its scale, among the largest oncology institutions globally, but its coherence. Everything is

aligned toward a single purpose: the understanding and treatment of cancer.

The clinical day begins early. Fellows are on the wards by 5:30 a.m., reviewing patients and coordinating care with physician assistants and nurse practitioners. By 7:00 a.m., the full operating team consisting of fellow, attending surgeon, anaesthesia, and OR staff convenes for final preparation, including patient verification, positioning, imaging review, and instrument setup. Incision typically follows shortly thereafter.

In complex HPB procedures, fellows frequently operate as primary surgeons while attendings assume an assistant role. This reflects a deliberate training model centered on progressive autonomy, with responsibility transferred incrementally as fellows approach independent practice. This structure places clear expectations on both sides. The institution delivers operative training, and the fellow is expected to arrive fully prepared with detailed anatomical and procedural knowledge as well as familiarity with individual attending preferences.

Beyond the operating room, this integrated structure continues throughout the clinical week. Multidisciplinary tumor boards, grand rounds, case conferences, and research meetings are not peripheral activities but embedded components of training. Academic exchange and operative work function as complementary expressions of the same role.

Within this framework, fellows are trained simultaneously in surgery and oncology and see themselves as “quarterbacks” of multidisciplinary cancer care, integrating complex oncologic decision-making from a surgical perspective. This reflects an explicit aim to train surgeons who are not only technically proficient but also grounded in cancer biology, systemic therapy principles, and multidisciplinary care.

What struck me most, however, was how explicitly teaching formed part of the identity and expectation of the attending surgeon. This was not optional but embedded in departmental culture and reinforced by leadership. Performance was assessed not only by clinical and research outcomes but equally by the ability to train the next generation. There is a strong sense of continuity: trainees are shaped by their mentors and in turn become responsible for those who follow. Progression is therefore inseparable from teaching.

This culture was not abstract but immediately visible in daily practice. On my first day, the first case I joined was in the operating room of Dr. Matthew Katz, Department Chair and pancreatic surgeon, known for his work on neoadjuvant therapy strategies for pancreatic cancer and surgical decision-making in borderline resectable and locally advanced disease. He was assisting a newly rotated fellow performing a Whipple procedure, while music played in the background (I later identified it via Shazam as the Jerry Garcia Band). The combination of informality and technical precision was striking, and difficult to reconcile with my prior expectations of such an environment.

The United States Training Pathway

Surgical training in the United States is intensive and highly structured. Following a competitive national matching process, residents enter a defined programme with explicit milestones, continuous evaluation, and clear progression criteria.

From the outside, this structure can appear rigid. Observing it more closely, it felt more like clarity.

General surgery residency typically spans five years, with the option of additional protected research time for those pursuing an academic track. Fellowship training follows, lasting one to two years depending on the subspecialty. In HPB surgery, most programmes run for one year. The trajectory, once entered, is largely defined.

And yet, there is something clarifying about that transparency. The demands are real, and personal life often becomes secondary. But research consistently identifies uncertainty and lack of progression clarity as significant drivers of trainee distress, often more so than workload alone. A system that is demanding but predictable, where expectations are explicit and the endpoint is defined, may make the associated sacrifices easier to accept. The logic is not that the sacrifices are small. It is that they are knowable, and perhaps that makes all the difference.

The Swiss Training Pathway

The Swiss model combines a defined structural framework with a high degree of individual variability. Surgical training begins with general surgery and requires experience across institutions of differing case volume ("A" and "B" centres). There is no centralised matching process, and career trajectories are not predetermined. Movement between institutions is common, and progression is shaped as much by opportunity as by planning.

The initial training environment is influential. Academic centers provide early access to mentorship, research activity, and academic orientation, whereas smaller, non-academic hospitals often offer broader operative exposure and earlier technical development. Both settings are complementary, and transitions between them are typical.

Access to certain subspecialty procedures is not uniformly distributed. In highly specialised medicine, fields designated as HSM in Switzerland, case volumes are concentrated in a limited number of centers, and not every trainee will accumulate equivalent operative experience within a given timeframe. This is not arbitrary: it reflects the institutional pressure to manage complex cases with the greatest possible safety, which necessarily limits exposure for those not yet at the center of that workflow.

As a younger resident, I caught myself thinking that things would be easier if I were the favourite – the chief's preferred assistant, the one who seemed chosen. A mentor stopped me in that thinking: at the end of the day, he said, you simply have to be good. Not someone's favorite. Because what happens when that person leaves, or when you do? You have to be good consistently, relentlessly, regardless of who is watching. That is what you must work on. That reframing has stayed with me ever since.

That shift in perspective changes how the system looks. What initially appears as exclusion can be understood differently: as the freedom to seek training elsewhere, to engage with other health care systems, to return with something earned rather than simply assigned. Within academic centers, advancement follows a recognised if not formally defined trajectory. Those pursuing an academic surgical career are expected to pursue habilitation, a postdoctoral qualification conferring eligibility for independent teaching and professorial roles, typically alongside research time, often combined with a clinical or research fellowship abroad, and continued clinical responsibilities. Positions are limited, and progression depends on a combination of performance, profile – and timing. Not all who qualify will advance, and opportunity is never free from circumstance.

These dynamics are not unique to Switzerland, but they are less formalised than in systems where progression is standardised once entry into a defined

cohort is secured.

The Swiss model places greater responsibility on the individual. In fields as specialised as HPB surgery, that means flexibility is not optional – it is the condition under which a career is built.

And there is something honest in that. The system does not promise an outcome. It creates conditions. What one does within, and beyond those conditions is, in the end, a personal responsibility.

Reflections

This observership did not confirm what I expected, it complicated and sharpened it. The clarity, accountability, and deliberate training culture at MD Anderson were striking. But that culture comes with a premise: you have earned your place through a highly competitive matching process, and in return the system delivers on its promise. The training is real, the progression is defined, and the sacrifices are accepted because they are bounded. You know what you are giving, and you know when it ends. There is an endpoint, and that changes everything about how the weight of it is carried.

What this experience taught me is that building a career without a predetermined map is not a disadvantage. It is a privilege. One that comes with the freedom to decide where you go, who you learn from, and how far you are willing to push yourself.

But that freedom has a condition. The challenge in such a system is not necessarily the absence of structure. It is finding the people who believe in you – those who see your potential before you fully see it yourself, and who are willing to invest in it. Those relationships, more than any program or pathway, are what make the difference.

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