

Surgery, Sculpture, and
Déformation Professionnelle:
A Surgeon's Encounter with Trauma in
Richard Selzer's Two Koreas

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Shortly after completing his surgical residency, physician and author Richard Selzer was drafted to serve in the Korean War, leaving him with haunting experiences that would have a lasting influence on his writing. Selzer is known to be prolific, having written many volumes of essays and short stories that confront the cathartic and often painful realities of being a surgeon. However, his time in the military serves as bookends to his writing career, appearing first in his 1973 debut collection of short stories, *Rituals of Surgery*,¹ as the short story, “Korea,” which would be the bones of his 2009 novel, *Knife Song Korea*.² The stories were based on the journals Selzer kept while working as a military doctor in Korea, and so Selzer's subjectivity as an author is implicated in these works. What we encounter through the disguise of fiction are versions of Selzer's professional autobiography, which resonate strongly with the daily experiences of being a doctor. In the Korea stories, we follow a military surgeon named Sloane who provides care to American soldiers and Korean villagers alike in a makeshift clinic in what is now South Korea. Events of the story may be recognizable for anyone who has had encounters working in a medical environment with limited clinical resources and a plethora of patients who are physically devastated by the severity of untreated illness. These events include: performing surgeries and medical procedures without the correct tools and medications; working without an anesthesiologist or nurse; and most of all, having to depend upon the intuition of the physical exam rather than medical technological advances that increase visibility of the interior body.

The two texts present the tensions of provider trauma as it affects surgical practice. In

¹Selzer, Richard. *Rituals of Surgery*. East Lansing, Michigan: Michigan State University Press, 1974. Print.

² Selzer, Richard. *Knife Song Korea: A Novel*. Albany: State University of New York Press, 2009. Print.

“Korea,” the short story, Selzer focuses more on the daily exhaustion of caring for an onslaught of chronically ill patients. The attention of “Korea” is split between Sloane's draining clinical responsibilities, and the sexual relationship he begins with a villager named Shin. Although there is much of interest in this story, my analysis will focus on Sloane's relationship with his profession.³ “Korea” is subtle in its treatment of the “battles” waged in medicine, by concentrating on Sloane's mountain of clinical responsibilities, which, for many providers, also comes with its own set of wounds.⁴ As an expansion of “Korea,” *Knife Song Korea* is able to work at a slower, more detailed pace, making explicit the parallels between the trauma of war and the trauma of performing surgery—a theme that has also garnered attention in medical literature. Whereas “Korea” drops the reader into the chaos of clinical care, *Knife Song Korea* reflects the operating room experience of the trauma surgeon. Both poles of experience in the Korea stories—clinic and acute care—are significant to the ways we may read their portrayal of the emotional impact of providing surgical care. We may look to them insight into how the identity and medical practice of the archetypal “surgeon” begins to form during exposure to urgent and traumatic events.

In this essay, I consider Selzer's work to pose questions about how a surgeon's professional technique, or surgical *style*, may be shaped by traumatic experiences in the operating room. My analysis is informed by my observations in academic medicine at Vanderbilt University Medical Center (VUMC) and my previous experience working at Bellevue Hospital, a teaching hospital that specializes in high-risk care across medical fields. Selzer's work is a familiar, if also amplified, narrative of the balance between chaos and care, where the acute needs of patients in physical

³The affair between Sloane and Shin is crucial to the story of “Korea.” A longer analysis could consider at length the relationship between the blurred lines of the intimacy of medicine as a profession and the intimacy of understanding the body of a lover.

⁴See Bellal Joseph, et al “Unveiling Posttraumatic Stress Disorder in Trauma Surgeons: A National Survey.” *Journal of Trauma and Acute Care Surgery* 77.1 (2014): 148–154. Print. This paper will be discussed further below.

distress can feel both overwhelming and unanswerable. Teaching hospitals often serve an enormous patient population with a wide range of medical needs, similar to what we see in Selzer's writing. His work reflects the shocking “newness” of the constant exposure to surgery and trauma that becomes a part of the medical resident experience. The Korea stories also confront the extent to which providers find difficulty setting boundaries for their own needs within their professional demands. Selzer's writing draws attention to how the process of identity formation and re-formation within physicians occur in tandem with their frequent encounters with traumatic events, which, as a result, affect their future surgical style.

Surgical Style

Surgical style is often molded by the interaction of a number of elements, which may include (1) the body of the patient, (2) the physical capabilities and talent of the provider, (3) the impact of the emotional and intellectual responsibilities of surgery, and (4) the provider's previous experiences, especially experiences that resulted in “poor patient outcomes.” Surgical “style” becomes a process of interpretation between procedural instructions, and the physician's practice, where provider preferences and talent merge with a standardized procedure to complete a given operation. It can come in the form of basic practice, as in which tools or techniques a surgeon will prefer to use—one example of such preference comes from my own from interactions with obstetricians: one I worked with characterized the way she preferred to do c-sections as “cell layer by cell layer” while another said she liked “going down sharp.” Likewise, style can come in the form of handiwork—how the surgeon will stitch, the kind of incision he will make and where. But often style comes from the lessons learned through surgical errors or traumatic events, which may have life-altering or lethal consequences. Mistakes mean that the surgeon's style undergoes a

major, cautionary shift, the memory of having caused suffering informing each subsequent procedure.

Here, we encounter two folds of style: first, I interpret style in surgery to be a mixture of the selfhood of the provider— his or her intuition and cognitive decision-making preferences inextricably tied to physical ability. The second fold of style is how it becomes heavily shaped by provider trauma, or what a surgeon has seen or done as part of his or her practice that has caused grief to the patient—the person to whom the surgeon is supremely obligated as a caregiver, and the figure to whom the surgeon owes his or her career, and identity. Because changes in the provider's surgical style are tied to experience and practice, I consider the surgical encounter as working through an intersubjective embodiment, where the individuality of the surgeon's body impacts the operation as much as the individuality of the patient's body. The needs and desires of the patient, the specificity of his or her body and the nature of the diseased organ, and the provider's ability to perform and comfort with the procedure all combine to make surgery an intersubjective exchange. As a paradigm of relationship between “self and other,” intersubjectivity in the surgical encounter allows theoretical space for the permeability of the provider as human and not all-knowing, very much bringing a “self” to all clinical encounters, which is manifested in the provider's stylistic practice. The style of how the surgeon chooses, or is able, to use his hands is an intuitive and unintentionally creative process as much as it is one that speaks to a professional standard. We tend to think of any stylistic differences in surgery as being contingent upon the differences in patients' bodies. This connects to an assumption that any given surgery is done the same way, and that any changes to the surgical plan—or algorithm—primarily occur because of the patient's anatomy, rather than the stylistic preferences of the provider. Surgery is not a stable practice, but, literally, changes in the hands of the provider so that the style of a specific provider's surgery is unique, just

as the bodies of each of the patients is unique. Intersubjective embodiment speaks to an exchange between the bodies of the surgeon and the patient to create a given procedure. The bodily habitus of each affects the subjectivity of the surgeon.

Because of the influence of experience on surgical style, we may see it as a manifestation of *Déformation professionnelle*—literally, “professional deformation” in French—colloquially known as the tendency to see the world only in the light of one's profession.⁵ It is a “deformation” that is common among people in caregiving fields, though in the surgical encounter it is present as intersubjective embodiment—the physician's body leaving a distinct mark on the patient's body. It also speaks to the identity formation—or deformation—of the surgeon, where, after exhaustive training, his successes, failures, and career, depend on the well-being of the patient. The surgeon's victories and failures become wrapped up in whether or not the patients thrive after their surgeries. The physician's identity tends to be defined by the health and well-being of other people. Decisions for one patient are in part based on what worked or did not work for a previous patient, often guided by memories and anxieties of harm. We find that in surgery, style is ultimately an aesthetic technique guided by moral principles, personal technique and skill, and even provider comfort.

In most contexts the word “style” implies originality; a distinct sense of artistry that works, slightly, against the paradigm of the norm. However, unlike artistic style, medical care works *toward* an algorithm, but is imperfect in its ability to achieve standardization. Koschmann, et al, has outlined the purpose of the algorithm as, “[Making] relevant certain kinds of objects, objects that serve as its materials, tools, end-products, agents, etc. [The algorithm] offer[s] ready-made plans for carrying out a course of action.[...] [P]rocedures must be construed and made concrete

⁵The phrase is thought to have been developed by Belgian sociologist Daniel Warnotte and was used extensively by Robert K. Merton in his discussions of bureaucracy. See “Bureaucratic Structure and Personality.” *Social Forces* 18.4 (1940): 560–568. Web.

within the particulars of the current situation.”⁶ The algorithm is something of a standardized “to-do” list for medical providers, meant to account for a wide variety of possibilities or crises. It is ultimately an overarching set of guidelines, though the reality of providing acute care in surgical or high-risk medical settings means that the knowledge of the algorithm falls a distant second to the knowledge gleaned from provider's own encounters with patients, both successful and traumatic, when outcomes have caused harm, despite the intent to care.

As has been pointed out by Dr. Jeffrey A. Matthews in his 2015 lecture series, “Truth and Truthiness in Surgery,” most surgeons work by an apparatus of experience and intuition—not by the algorithm.⁷ That surgery is such an individualized, interpretive practice may be an uncomfortable realization from a patient’s perspective. We accept, even look forward to, style as an artifact of *artistic* creation. But, it may be disconcerting when we find style present in medical care—particularly when we encounter the idea of a style in surgery, where there is much work done to encourage standardization. To be a patient in general, especially to be a patient in need of surgery, is to be extremely vulnerable. The tendency is to want to believe in a standard practice, a “this is how this surgery is always done and so we are very practiced in doing it this way.” Instead, as many people who have found a professional home in surgery will attest, we find that both diagnosis and surgery is interpretative, aspiring to an algorithmic standard, but heavily informed by the provider's experiences and preferences.

The parallels between surgery and art perhaps became most noticeable with the initial creation of anatomy textbooks, which consist among other things of a strange set of portraits of the

⁶Koschmann, Timothy et al. “‘Can You See the Cystic Artery Yet?’ A Simple Matter of Trust.” *Journal of Pragmatics* 43.2 (2011): 521–541. Web.

⁷ Matthews, Jeffery A. “Truth and Truthiness in Surgery.” Vanderbilt University, Nashville, TN. 2015. General Surgery Grand Rounds/Biennial Barney Brooks Lecture.

interior of the body. Early studies in anatomy each have a specific style—and it is this artistic style that has undermined their significance and use as medical technology.⁸ In “The Culture Industry,” Horkheimer and Adorno write of artistic (not surgical) style as defined by its flaws and quirks, writing that, “The great artists were never those whose works embodied style in its least fractured, most perfect form but who adopted style as a rigor to set against the chaotic expression of suffering, as a negative truth.”⁹ In other words, when we think of art we find that the result of perfection or flawlessness is not style, but is conformity. Style, to the contrary, is an artifact of individual expression that actively goes against the grain of expectation. It would seem on the surface that style is an unwanted interloper in the operating room, where the ideal is standardized practice. The struggle to transcend the human reality of imperfection in the physician is the driving theme of medical practice, though this imperfection would be considered style in the artist. As patients, we do not want surgery to look like art—we want it to be specific and well-practiced. While the great artists who resisted conformity to the dominant aesthetics of their time are remembered for their genius and success in embodying their own style, it is unnerving to think that medicine or surgery can be placed anywhere near the category of art. Instead, the mark of stylistic genius in surgery is anonymity: a surgery that would look like the physician was never even there is the ideal. And yet, even in the attempt to make the marks of surgery invisible, the gestures of surgery are hinged on the style and experience of the provider.

In some respects, surgical style becomes a defense against the struggle of trauma and the physician's professional, somewhat futile struggle to be as flawless, perhaps even as style-less, as

⁸For extensive detail on this topic, see Lorraine Daston and Peter Gallison's *Objectivity*. New York: Zone Books, 2010. Print.

⁹Horkheimer, Max and Theodor W. Adorno, Theodor W. Ed. Gunzelin Schmid Noerr. Trans. Edmund Jephcott. “The Culture Industry,” pgs. 94-136. *Dialectic of Enlightenment : Philosophical Fragments*. Stanford, Calif.: Stanford UP, 2002. Print. Pg. 103.

possible. Photographs, MRIs, CAT scans, have all been the preferable form of images to see within the body so as to work toward standardization. There is a desire to transcend the sloppy visibilities of human biology during surgery; much of the surgical technology available and much of the surgical technique taught is meant to decipher and navigate the overwhelming pink and red fleshiness that obscures so much of the body's indistinct structures. For the most part, it is an important gesture to assert control over a professional practice that is unstable. This instability poses problems not only in the operating arena but in medical education, where surgical training is contingent upon an exercise that is only somewhat exaggerated by the expression “see one, do one, teach one.” From there, we begin to encounter surgical preferences, techniques, inherent talent, all as they begin to weave into a style. Style remains an individualized, and therefore de-stabilizing, force in surgery, where the field of medicine strives to make procedural approaches as uniform as possible.

Plastic surgery, in particular, has been theorized in the context of “sculpture” or creativity.¹⁰ Pop-culture and media will also point us to outlandish events in surgery, like the rare times a surgeon carves his initials into his patient's scar. But, it is important here to stress that I am viewing *all* surgery as engaging with the surgeon's stylistic process—it is not only the rare, the outlandish, or the sought-after beautifying surgeries that resemble sculpture in reflecting the provider's style. Instead, I focus on the subtler notion of the surgeon's “style” as part of the fabric of his identity. The likeness of surgery to sculpture extends well past the often-conjured dynamic of plastic surgery to also include the internal differences: scars on livers, kidneys, stomachs, that bear the mark of the

¹⁰See Alice E. Adams's “Molding Women’s Bodies: The Surgeon as Sculptor.” *Bodily Discursions: Genders, Representations, Technologies*. Ed. Deborah S. Wilson and Christine Moneera Laennec. State U of New York Purchase, 1997. 59–80. Web. SUNY Series in Postmodern Culture; and John W. Jordan's “The Rhetorical Limits of the ‘Plastic Body’.” *Quarterly Journal of Speech* 90.3 (2004): 327–358. Print.

surgeon's physical presence, both in the sense of having been there, and also in the stylistic details of his or her handiwork. The question becomes unavoidable: to what degree does the subjectivity of the surgeon become implicated in his work, such that the objective science of medicine begins to look more and more like the practice of sculpture as the nuance of the surgeon's approach increases? The presence of surgical style, and thus a presence of the individuality of the surgeon, is a daily reality. Surgical style is as common as surgery itself.

Handiwork, the Physical Exam, and Provider Trauma

Despite surgery's preference for imaging technology, Selzer's Korea stories address the importance of the physical exam in medical diagnosis. The practice of medicine has had, at times, the image of being more technologically advanced than it is. Current surgical practice is often associated with the need for visibility, where the use of innovative imaging and procedural technology in the expansion of the physician's toolbox is a key component of the contemporary surgical encounter. While diagnosis is often made with whatever imaging technology is available, many doctors will attest that over-reliance on technology will often lead to mistakes.¹¹ There is a misconception—more widespread among laypeople than medical providers—that technology guarantees a standardized surgical practice, and that we are rapidly moving past the time when the physician's handiwork played a major role in medicine. Selzer's work challenges the broad-sweeping view that the emphasis of surgery is primarily on technological prowess, placing it as another example of medicine's ancient *social* contract, which still presides over the more recent scientific/technological contract between doctors and patients.

¹¹One key source that addresses this issue is Atul Gawande's *Complications.: A Surgeon's Notes on an Imperfect Science*. 1st ed. New York: Metropolitan, 2002. Print.

Surgery is often considered a less philosophical and much more “mechanical” field of medicine than most others. Skills are built around the use of hands, tools, and manipulation of bodies. Whether he or she has “good” or “bad” hands, as the phrase goes in surgeons' shop-talk, is still a factor in the work they do. In a recent book on the use of handiwork as an intellectual exercise, *Shop Class as Soulcraft*, philosopher-turned-mechanic Matthew B. Crawford makes a case for what he calls “manual engagement,” or the emphasis of an engagement of body as well as intellect.¹² Crawford writes, “You come up with an imagined train of causes for manifest symptoms and judge their likelihood before tearing anything down.” Surgery, and the physical exams done in preparation of surgery, remain a physical and intellectual “shop craft.”¹³ In order to understand the dynamics of the surgeon with what could ultimately be called his or her “craft,” it is crucial to understand the style as a cognitive and physical marker of the physician, its presence beginning with the physical exam.

In “Korea” the reader is thrown into the clinic with Sloane immediately and without explanation. Sloane has regular encounters with patients who have diseases like malaria, tuberculosis, and dysentery, cases that would be labeled in contemporary medicine as “urgent, but not emergent.” He offers relief to a patient with agonizing ascites—fluid filled pockets in her abdomen that cause immense internal pressure—by draining them with a needle, without such basic luxuries as anesthetic. These are the patients who have had long-standing, chronic issues that are slow-burning in their destruction. The narrative offers insight into a basic physical exam that is determined by touch rather than by a preoccupation with contemporary imaging technology. At every turn, Sloane finds that he is overwhelmed by the responsibilities of his work, such that there

¹²Crawford, Matthew. *Shop Class as Soulcraft: An Inquiry into the Value of Work*. New York: Penguin, 2009. Print.

¹³Pg. 5

is no distinction between his profession and the rest of his life. During one of his trysts with Shin, he sees in the darkness of her bedroom imagines her lungs, glowing with bacteria.¹⁴

Though the physical exam is Sloane's primary medical tool in "Korea," *Knife Song Korea* works to settle the reader into the environment in a way that "Korea" does not, providing a background narrative for the physical exam. The novel opens at the point at which Sloane touches down in Korea, leading the reader to his introduction to his clinic where he learns he will be the only doctor on staff. He meets his cynical predecessor, Larry Olsen, who calls the work, "bad, boring, degrading," except for when the war comes to "break the monotony."¹⁵ He warns Sloane that this new environment will be challenging and impossible, saying that, "There's no equipment to speak of. There's no sterilizer. And the dirt, the vermin. I just plain don't touch *anybody* unless I have to[.]"¹⁶

Olsen's comments intertwine an understandable desperation to leave his post with a disturbing lack of empathy for everyone from the soldiers (who break up the boredom of his clinical responsibilities) to the sick, vulnerable, Korean villagers. Such ire toward patients is, unfortunately, not uncommon among providers who are burnt-out. However, Olsen is also positioned to be the antithesis to Sloane. Sloane later remembers Olsen's callous vehemence as he commits to the physical exam as integral to his care in Korea. He takes pride in his care—care that the villagers need and are grateful to receive—through the use of an often-ungloved physical exam:

For Sloane, the laying-on of hands worked both ways in dynamic equilibrium. He needed to touch his patients as they needed to be touched. Contrary to what Olsen had said to him, and despite what he himself had felt on his arrival, it comforted Sloane to feel the bodies of

¹⁴Pgs. 79-80

¹⁵Pg. 7

¹⁶Pg. 7

his patients, the heat in them, the whole gorgeous architecture of them. It was as though the body he was feeling passed into his fingers the strength and courage he needed to make it well.¹⁷

That “the laying-on of hands” in the physical exam works in “dynamic equilibrium” for patient and surgeon alike underscores the extent to which surgery is a process of intersubjective embodiment, where the act of the physical exam is healing for both parties. Sloane seeks comfort from his patients through the physical exam, and, likewise, is able to provide them with the care they need through the exam. Overall, *Knife Song Korea* is by no means a sentimental text about the doctor as a hero; Sloane is cynical, certainly bearing a racist and often disgusted attitude toward the Koreans. But, it is at the times when Selzer's narrative focuses on medicine, exam, and surgery that Sloane is able to connect with his patients through his profession. The physical exam, and for that matter, his style and handiwork in implementing the physical exam, is crucial to his identity, a marker in and of itself that causes the villagers to come to him in droves once they learn that a doctor will examine them properly. His ability to provide medical care—specifically to determine whether or not to perform surgery—is contingent on the human-to-human contact of the physical exam.

Both the story and the novel contend with a harrowing in-clinic surgery that occurs because of a diagnosis made by way of a physical exam, where Sloane meets the “tallest Korean woman he had ever seen,” her height emphasized because of an enormous “grapefruit-sized” mass on her neck.¹⁸ Here I will focus on the version found in “Korea,” which opens with Sloane's encounter with this patient, thus framing the physical exam as integral to our understanding of the story as a

¹⁷Pg. 67

¹⁸From “Korea,” pg. 62. *Knife Song Korea* expands this small scene to an entire chapter, pgs. 29-34 (Chapter 8).

whole. He begins the process of diagnosis using one of medicine's most basic tools: his hands.

Sloane led her to a chair and began to outline the tumor with his fingertips. Hopefully he tapped the surface, waiting for the returning vibratory wave which would indicate fluid. Fluid could be withdrawn through a needle to diminish the size of the mass, and make surgery feasible. There was none. Sloane had never seen such a goiter. There was no place to send her. What if there was bleeding from high and behind it, where he could not see to control it? What if she could not tolerate the local anesthetic? He had no means to put her to sleep. It would have to be Novocaine, with her wide awake. In the end he simply dared himself to do it.¹⁹

Selzer stresses the provider's style through the intuitive work of physical exam prior to the patient's operation. Touch and sight work in tandem to create a diagnosis. Crawford's *Shop Craft as Soulcraft* compares "shop craft" to surgery by way of a "diagnostic" process, describing "a stock mental library of sounds, smells and feels."²⁰ Selzer notes that diagnosis is made with touch: the vibratory sensation of fluid in the body is distinct regardless of whether or not imaging technology is available to see it.

In addition to confronting the doubly-embodied physical exam, this scene also confronts the first of many moments of doubt. Sloane stays awake the night before the woman's surgery: "fixed in his mind the exact location of the superior and inferior thyroid arteries, the middle thyroid vein, the recurrent laryngeal nerve. Toward morning he could see an artery torn and spurting, hear the swish of blood from it, knew that it was out of sight, out of reach."²¹ The possibility of a mistake in

¹⁹Pg. 63

²⁰Pg. 25

²¹Pg. 64

the operating room would mean that Sloane could kill his patient. Selzer writes the surgery in tense detail, punctuated by Sloane's anxious inner monologue, “God help me, let me get it out” and “No blood transfusions, no oxygen, no nothing,” all working to underscore *his* vulnerability during the surgery.²²

Here we have a comparatively rare opportunity to glimpse the provider's anxiety during a complicated surgery. We have access to Sloane's fears during the removal of the patient's goiter, but we do not have any access to the patient, who stoically tolerates the procedure with nothing but Novocaine. Sloane cuts from ear to ear, “needing all the room he could get.” Curiously, Selzer writes around the idea of technique, but not directly about it; Sloane gives directives to his assistant (“Clamp!” and “Retractor”) but the nuance of the surgery is eclipsed by the anxiety for, and then relief by, its success. The emotional tension of the operating room, we learn, is balanced by his steady hands as he peels away tissue, sutures a bleeding blood vessel that offered “a lake of blood,” and finally removing “the slippery purple ball” that was resting, boulder-like, on the patient's trachea.²³

As Sloane performs the thyroid surgery, the reader is called to focus on the emotional impact on the provider, rather than the patient. This calls to mind the writing of physician David Grimes, who asserts that the physician should spare the patient by adopting the “the emotional burden of the procedure.” He continues, “That is entirely appropriate. One of our most important roles as physicians is to ease suffering, both physical and emotional.”²⁴ During the surgery, Sloane

²²Pg. 64-65

²³Pg. 64-66

²⁴Grimes, David A. “The Choice of Second Trimester Abortion Method: Evolution, Evidence and Ethics.” *Reproductive Health Matters Supplement* 16.31 (2008). Web. Grimes' article is related to a specific abortion procedure that is under the heat of political debate. It is therefore particular in its empathetic urgency toward patients and can be read as an advocacy piece to providers who are unable or unwilling to learn the procedure because of the potential legal ramifications.

has taken on an immense emotional burden—so great that his burden seems to outweigh the patient's.

In fact, in both “Korea” and *Knife Song Korea* there is a persistent reminder that Sloane's patients are brave, patient, able to tolerate all levels of fear and pain during the many surgeries he must perform with only local anesthetic. This is an interesting tactic in Selzer's writing, one that allows the reader the luxury of rationalizing the event: “the patient is not in pain, and therefore it is acceptable.” Instead of placing our attention on the patient, we are directed to focus on Sloane's anxiety and concern. This, too, is a common rationalization in medicine: care-providers hope that their patients will have high tolerances for medical procedures; no one wants to cause pain, and the act of causing immense pain to provide care presents a difficult emotional and ethical burden for the provider. Thus, in Selzer's work we may find that anxiety is a driving factor in surgical approach.

The Intersubjective Exchanges of Trauma and Surgery

Knife Song Korea is direct in its confrontation with the emotional likeness between war and medicine. The scenes of Sloane's work after battle present an important comparison to the emotional impact of trauma surgery in general. On the day that war comes Sloane must attend to his own small battles in his operating room over the torn bodies of his patients.²⁵ In the course of one day, Sloane performs three major, horrific, operations, with a dysfunctional array of limited resources. First, he repairs an “abdominal wound,” the young soldier brought to him with “a floral

²⁵Pg.50-56 (Chapter 12)

pattern of intestine wound sinuously between the fingers.”²⁶ Another patient is brought to him with an “eyepatch of clotted black blood,” attached to which is “the torn and empty globule that was the eye.”²⁷ The third patient is a comparatively more straightforward repair of a compound leg fracture. Throughout all of this, Sloane is severely ill himself, having recently recovered from malaria and suffering from dysentery. The hours of surgery, performed with only the minimal amount of anesthesia, and all done “barehanded as usual” as he had “long since[...] run out of rubber gloves”²⁸ are punctuated by the phrase, “get the next one” as Sloane moves immediately from one case to the next. He works nearly without respite, besides the urgency with which he must attend to his own illness. The scene ends with a lingering moment of defeat in Sloane's small, medical warzone: he must tell a bewildered patient, sitting in a growing pool of his own blood, that the man has lost his testicles.²⁹ He recalls a quote he heard during residency: “Surgeons are not for sleeping.”³⁰

The conditions of Sloane's work and his makeshift hospital are of course extreme examples of how the operating room and the battlefield resemble one another, yet Selzer offers an important portrayal of the overwhelming nature of surgery, where emergencies are commonplace. The battle scene even offers a sense of how triage works, beginning with the most urgent surgery, gradually tapering to cases that are awful in their singularity, but deemed to be less awful than the rest in the the group. Sloane must carefully mediate his clinical resources and his energy according to what he can feasibly do—and this is a part of medical care. By juxtaposing the war outside with the battle that is providing emergency surgical care, Selzer establishes another comparison between the traumatic

²⁶Pg. 51

²⁷Pg. 51

²⁸Pg. 52

²⁹Pg. 56

³⁰Pg. 55

suffering of doctors and soldiers.

The fact that Sloane must tackle one trauma immediately after the other helps to create a striking atmosphere of despair in this scene, and finds relevance in the conversations in academic medicine that deal with provider burnout, trauma, and the constant, and I would posit, impotent attempt to reduce stylistic differences in surgical procedures. Sloane's time in the operating room is familiar to many emergency-based medical sub-fields—which would include any emergency medical care, most surgical specialties (especially in hospital-based rather than private practices), and OB/GYN among others—where the provider must move from one patient to the next, even when they have experienced an accident or an emergency. There is little room in the profession of surgery for the provider to process intellectually or emotionally the experience—the only option is to keep moving forward. In a *JAMA* article that addresses the issues of provider burnout and trauma in patient care, Marjorie Podraza Stiegler, an anesthesiologist, writes of the nagging double-standard in the medical profession, where doctors are expected to move seamlessly between patients, even in dire circumstances.³¹ She writes, “Physicians are generally expected to continue caring for patients, sometimes without even a brief period of time to reflect or regroup. Patients suffer cardiac or respiratory arrests and other emergencies—they even sometimes die in our operating rooms. And yet many of us feel pressure to get the next case going without delay.”³²

³¹Podraza Stiegler, Marjorie. “What I Learned about Adverse Events from Captain Sully: It’s Not What You Think.” *JAMA* 313.4 (2015): 361–362. Print. The article discusses Podraza Stiegler's recent interview with Captain Chesley B. Sullenberger III, otherwise known as “Sully,” famous as the pilot who was able to land an airplane filled with passengers in the Hudson River after both engines failed. Though he circumvented disaster with skill and elegance—not a single person on that flight was critically injured—Sully and his crew were unable to return to work for at least six months because of the trauma of the event. To most people, this is beyond understandable, both in the scope of the traumatic event and in the number of lives that would be at risk were the pilot and crew to feel unstable at a moment of crisis.

³²Pg. 362

The extent to which trauma informs surgical practice is also highlighted in the 2014 study, “Unveiling Posttraumatic Stress Disorder in Trauma Surgeons: A national survey” by Joseph, et al. The study underlines the significance of “the impact trauma surgeons endure in managing critical trauma cases.” The researchers write that they are aiming to address the problem of provider trauma, which they write, is “unknown” or absent from research literature (of course, one might argue that anecdotally it is a very well-known issue, but one that hasn't been prioritized until recently in research). This study finds statistically significant data to support findings that trauma surgeons do indeed suffer from PTSD alongside their patients—thus suggesting that these concerns go beyond conjecture. The study considered extensive variables which might “pre-dispose” a physicians to PTSD, including salary, work hours, career status (residents, attending, etc.), and even went so far as to include whether or not the provider had previous military experience. However, the primary reasons that physicians would suffer PTSD was linked to exposure to traumatic events: if providers oversaw five or more critical care cases within a month, they were more likely to suffer from PTSD.

Trauma, then, may be an under-acknowledged contributor to the forging of an individual surgeon's style. When surgeons experience trauma, it is certainly a factor in the development of their professional identity, and in many cases, of their personhood. Although much of a surgeon's style stems from personal characteristics and physical abilities, provider trauma, especially the trauma that is mixed with guilt or with feelings of insecurity about decision making, is one of the ways in which style becomes manifested in the hands of the physician.

Two issues become very clear in surgery: one, that human error in medicine, where “humans take care of other humans,”³³ is an inevitable and often terrifying reality. But what often goes unattended in the wider conversation of medical mistakes and surgery is the inherent tension of

³³As heard by an attending surgeon at a Vanderbilt University Medical Center grand rounds lecture.

dedicating one's life to the service and care of people, only to encounter the immense potential for causing accidental harm. The greatest individual tragedy may come with the word “accident,” which implies a problem that is independent from intent. Put plainly, because it is assumed via the Hippocratic Oath that no provider would intentionally cause harm, the good intentions behind surgical decisions—such as performing a surgery on fragile patient at her behest to improve her quality of life—are irrelevant if the outcome is poor.

In the moment of the surgeries, Sloane works entirely by physical action, moving quickly and intuitively, without stopping to doubt or question himself. His anxieties and doubts erupt in the aftermath of the procedures, often in the form of dreams, and often in anticipation of new surgeries. Sloane mourns for his patients constantly, dreads major surgeries and wonders how many more he could bear doing without anesthesia, even when the reader finds him calm and collected in the moment. He craves normalcy; independently of Korea, Sloane has grown tired of pronounced medical anomalies:

By the time Sloane had finished his surgical residency, the early thirst for pathology had already been slaked. It was normalcy he craved, normalcy with its clean lines and rounded glistening eminences, the unclouded lens, the white whiplike of a tendon, the airy comb of the lung, elastic, continually refreshed. Still it was in the ricochet of disease that he was able, privileged, he thought, to see the sad beauty of man, tangentially, on the rebound.³⁴

Especially when working in an environment with so few resources, what constitutes “normal” for the provider changes. Normal is no longer “clean lines and glistening eminences”: instead normal becomes the pathological extreme, such as goiters the size of grapefruits. We also see from this

³⁴From “Korea,” Pg. 63

passage that the normal-abnormal binary is not exclusively located in Korea or a war zone; Sloane has desired normalcy since his residency. It is this long-standing desire for “normal” that may prevent a reading that is “othering” —a story about the hero-doctor who attempts to save the third-world locals at the expense of himself. The disorientation that is Korea, in both of its textual versions, may also be interpreted as a larger metaphor for the isolation that comes with being a surgeon, so that Sloane's desire for normalcy is not contingent on Korea, but rather on his profession. It has been with him since his medical training.

The Suture, Academic Medicine, and *Déformation professionnelle*

In the Korea stories, we encounter a realistic portrayal of the ways that constant exposure to trauma becomes a familiar disorientation, familiar because Sloane's encounters with trauma never stops being traumatic; they remain painful, surprising and thus disorienting. By the end of *Knife Song Korea*, Sloane has suffered the loss of several friends and his lover. The novel closes with Sloane's joyless evacuation. He feels his “deformation” from Korea, and anticipates the changes that will form the roots of his surgical practice:

How much loss was he bringing back with him? A few of his patients had had leprosy, their sores oozing into his ungloved hands. He had long since gotten over the shock, but it was hard not to wonder whether one day he would approach the mirror, expecting to lather his face, and there would be Korea in the form of leprosy. But then, wouldn't he see it, Korea, in his face anyway? Wouldn't he hold it in his hands every time he moved the scalpel? At the Yale-New Haven Hospital his colleagues had moved up the ladder, familiarizing themselves with the latest technology—but what did they know of a

surgical forcep?³⁵

Unable to recognize himself and the life he thought he wanted, Sloane finds that his experiences in Korea have permanently marked him as if they were a sickness. The traumatic events that have been at the core of his time in Korea are inextricably tied to his self, and thus his practice. Here, too, we see that the style of the provider is a manifested reaction of experience, and in the case of Sloane, haunting memory.

In Selzer's fiction we are able to see the extent to which the professional formation of the surgeon turns into the deformation of his own subjectivity outside of his medical life. Such permeability argues against the tendency of medicine to place the provider in a totalizing position toward the patient. In using the word "totalizing," I refer to the assumptions that arise in medical practice when the provider is attempting to unlock the patient's diagnosis before understanding the patient's narrative. It refers to a common tendency in patient care, where the provider is reaching past the surface of what the patient is saying; a form of detective work that leads the provider to listen for clues so that the emphasis is on what is beneath the patient's narrative, not unlike a "symptomatic reading" that leads to assumptions about the patient. To that end, if the provider is placed in a position of "all-knowing" reverence, there becomes an erasure of the patient's actual identity and needs in the name of what the provider thinks the patient needs. At the same time, the attempted objectivity of evidence-based medical practice means that providers cannot implicate their own identity in their care, though of course provider preference and style is informed by provider bias. Even the term, "surgical provider" conveys an important allusion to hierarchy and subordination tipped in the favor of the patient, and yet it

³⁵Pg. 142

is impossible to separate this from the inherent knowledge and cultural power that comes with being a doctor. The tensions between the self and other in the physician's professional identity formation where providing care often leads to the position of the other as holding primacy over the self.

In Selzer's work we find a parallel between the intersubjective blurring of narrative selves between the doctor and the patient, and the "suturing" of the reader to the text by way of Selzer's narrative. Sayanti DasGupta describes this gesture in clinical care as what writers and readers do: all are "entering into [an experience] which necessarily resides outside [one's] own physical and emotional being [and] depends upon...finding an entry point into that suffering from within her own imaginative self."³⁶ Selzer's writing—and for that matter, much of the writing that comes from physician narrative—locates the perspective of the reader within clearly defined boundaries of the protagonist. It is a textual likening parallel to *déformation professionnelle*, where the reader also experiences a world that can only be seen through the narrative of the surgeon. Likewise, it may offer us an opportunity to practice "narrative humility" as it has been described by DasGupta where the reader resists a totalizing position toward the narrative.

In his essay "The Art of the Suture: Richard Selzer and Medical Narrative," Robert Leigh Davis relates how the reader becomes enmeshed in the perspective of the text by way of a narrative technique called "the suture." As a critical term "suture" originates in cinema studies and in psychoanalysis, referring to how a viewer falls within the parameters of the visual narrative and is only able to understand the world of the film through the literal perspective of the protagonist. Through the sutured narration the reader is essentially being given "tunnel vision": we come into

³⁶DasGupta, Sayantani. "Narrative Humility." *The Lancet* 371.9617 (2008): 980-981. Print. Pg. 980

contact with only what the author wants us to see or know. In surgery, “suture” refers to the means by which a wound gets closed, and it remains as a souvenir or reminder of the surgeon's presence on the patient's body. Selzer's Korea stories suture readers to the perspective of the surgeon through a narrative completely focused on Sloane, emphasizing his professional relationships with people above all else. Of the suture in Selzer's work, Davis writes,

[S]uturing [...] refers to a fundamental premise: the claim that works of art expose and then cover over the inadequacies of their subject. They promote an awareness of wounding in order to relieve it, to suture it, in a way that stabilizes the viewer or reader within a preexisting social order[...] And it is this desire that relates the concept of the suture across several fields.³⁷

Flaws or negative character traits—or, “the inadequacies of [the] subject”—become more forgivable as the reader or viewer becomes attached or “sutured” to his narrative. We do not expect literature or film to provide us with one-note heroes; but when we become sutured to the narrative of a protagonist—in this case, to Sloane—flaws or wounds in character become relatable traits to the audience because we become stitched inside of the narrative. The suture helps the reader identify with the surgeon's *déformation professionnelle*; the reader becomes not only attached to the protagonist of a story, but to the experience of a profession—moreover, to a profession in which there is something alien, or surprising, in the daily reality of the work. Medicine, especially when working with a vulnerable population, is filled with the unexpected.

³⁷Davis, Robert Leigh. "The Art of the Suture: Richard Selzer and Medical Narrative." *Literature and Medicine* 12.2 (1993): 178-193. *Project MUSE*. Web. 19 April 2015. Pg. 182

Though the Korea stories rarely conjure Sloane's memories of his medical training—he is more concerned with his present situation and whether or not he will be able to leave at some future point, rather than dwelling on memories of his past—the newness and intensity of his experience in Korea resonates with the resident experience. A physician's professional training is fraught with change and shifts in identity that are often facilitated by a constant and unyielding exposure to death, dying, injury, illness, and trauma. This occurs especially during residency, where young doctors are repeatedly confronted with their new primary allegiance to their *profession* rather than to the rest of their life. The roots of the familiar disorientation the reader sees in the Korea stories actually occur early in training. This is where young doctors jokingly call themselves “the footsoldiers” as they work in hospitals that are often huge, chaotic, and under-resourced. The purpose of a physician's residency, after all, is to expose new doctors to as many patients or surgical cases as possible under the guidance of an attending physician, whose job it is to make most of the decisions about the patient's care. The resident, on the other hand, is to manage the patient's care by providing basic directions, doing exams, and preparing the patient for all of the possibilities of surgery, including complications. Residents do not have any major decision-making power, but this is the time in which the identity of “doctor,” and especially, “surgeon,” begin to solidify. When working in the service of others, new physicians (or, for that matter, anyone who works in a caregiving field) learn very quickly that the needs of a multitude of patients in various states of duress will always take precedence over their own needs. The subjectivity of the doctor becomes formed—or deformed—in light of the profession.

Though people who choose medicine as a career possess a reputation for processing grief or trauma intellectually rather than emotionally—a perception that has been studied empirically as

well as anecdotally³⁸— the grief of trauma significantly impacts all future decisions. The memory of the “poor outcome” informs the provider's future stylistic tendencies in surgery, manifesting in both the surgical decisions, and how the procedure actually, physically, gets done. We may consider surgical practice to be a process of critical aesthetics. Witnessing any part of an operating room setting means one will invariably see that in times of crisis, surgical decisions are based on what the provider feels he or she is capable of doing given the resources available.³⁹ The physical contact of the provider's hands on the patient's body means that the patient will bear the marks of the surgeon's style in the form of the scars on the patient's body, which implicate the physician's body through his handiwork as much as it does the patient's ability to heal.

In the Korea stories, the reader's attention is directed to Sloane's surgical technique. Examples include his “ear to ear” incision during the thyroid surgery for the woman with the grapefruit goiter, or after the battle, his incision vertically down the belly of the patient with the abdominal wound. The sutured scars that run long across the bodies of his patients, are the mark of his experience and thus his subjectivity. Because the reader is sutured to Sloane's narrative, however, we are more concerned with his experience and well-being in performing the surgery than we are about the patient. Through the narrative suturing we glimpse Selzer's own subject position in the text. The tone of anxious dread speaks to the emotional impact of providing surgery, over, and over again, with little ability to anticipate or plan for the well-being of his patients. Surgery's *déformation professionnelle* is that it confronts what will be a permanent reality for medicine: the unplanned events. Selzer's Korea stories bestow on the non-medical layperson a narrative context for “trauma care.” It is a kind of Sisyphean daily task where the provider is aware that each day

³⁸See Richard M. Goldberg, et al. “Coping with Medical Mistakes and Errors in Judgment.” *Annals of Emergency Medicine*. 39.3 (2002): 287–292. Web.

³⁹As discussed in Dr. Matthews' lecture, and in Koschmann, et. al.

will bring a new array of suffering patients who need help badly. But the ways in which they will need help will change constantly, rendering them impossible to anticipate. In the practice of surgery, the epitome of intimate physical encounters, traumatic experience begins to inform practice, the patient's body newly sculpted through the surgeon's professional deformation.