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Cut

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By Eric Plemons

I barely slept the night before my first day of fieldwork in the OR. As a kid I had accompanied my brother to the emergency room and watched a surgeon remove shards of glass from his lower legs. The removal wasn't bad. But when the suturing began, I got dry mouthed and over-warm and nearly fell out of my plastic chair. I was shuttled out to the waiting room and installed in a different plastic chair, where the blood and bodily matter that I could not handle was replaced by the inane drama of televised small claims court that I could. What if it happened again? I worried throughout that sleepless night. Being forced by my weak constitution to trade surgical scrubs for midday television would be too much humiliation to bear.

Much to my relief, I discovered that I really like the operating room. I like seeing the body's usually hidden insides, and I have grown used to the sounds and smells of operation. I have observed about 150 hours of sex reassignment surgery by now, mostly facial reconstruction and a little bit of chest and genital work. None of these is performed through the small incisions of laparoscopy: bodies are cut wide open.

When you or I are rolled, drowsy, into the operating room, there is a lot of work that must be done to prepare us for the operation: our bodies are positioned, draped, scrubbed, shaved, and scrubbed again. Anesthetic chemical compounds are slowly pressed into our veins and then into our lungs. Compression sleeves may be wrapped around our lower legs, and catheters dripping with iodine slid into our urethras. All of this prepares our bodies for the surgeon's first cut, the moment when "the operation" actually begins (its exact time dutifully noted by an ungloved nurse). The first cuts into our skin are made by scalpels, smooth and razor sharp. But once our bodies have been opened, a variety of other instruments might be used to do the cutting: scissors, saws, chisels, electrosurgical devices, and more. These internal dissections are ones that we won't see when we wake up from surgery and look at its mark. What we'll see is the cut that opened us, the place where the solid border between inside and outside was sliced in two, transformed from a smooth plane into a port of entry and exit. The wound of incision is a surfaced and well-ordered replacement for the deeper and hidden malady whose existence the incision marked in both time and place: a good injury exchanged for a bad one.

A plastic surgeon recently told me that sex reassignment surgery is the only procedure he performs whose medical indication he himself is not qualified to determine. Instead, he cuts on referral. Because of its somewhat unique therapeutic configuration—as a medically necessary surgery that operates on otherwise healthy body parts in order to alleviate the psychological distress that often comes from gendered misembodiment—surgical sex reassignment also has a somewhat unique process of diagnosis and treatment; surgeons treat a disorder that they are not trained to identify or to understand. With their hands and other instruments, surgeons open bodies in order to alter skin, bone, nerves, arteries, cartilage, muscle, and so on.[i] They do not operate on *gender* or *recognition*—the kinds of social and personal things that trans- folks often name as their reasons for undergoing surgery. A psychologist or other "mental health professional" must evaluate these things, and then assure the surgeon that operating is an appropriate course of action, that cutting and reshaping the body will enact a therapeutics located elsewhere.

After all of this and so much more, we are all there in the operating room: the surgeons, the nurses, the patient (absented away by anesthesia), and me. It is a cliché of fieldwork but also a true story that once I stopped trying to *figure out* the OR, I began to understand how to be there. New procedures, new patients, new surgeons press me uncomfortably into relations with bodies and the techniques by which they are inhabited and intentionally (re)crafted.

The last surgery I observed was a trans- man's chest reconstruction. His nipples were removed and set aside for grafting, and then the breast tissue was dissected and removed. His ex-breasts, weighing in at just over three pounds apiece, sat in blue plastic tubs on the scrub nurse's draped table. Once it was verified that the operating team had removed an equivalent volume from each side, the tubs' contents—gleaming red and bright yellow under the lights—were ignored. But I sat and stared at them, tried to be with them somehow. And I tried to be with the patient, raised to a sitting position, arms spread wide as the surgical team stuck small circles of tissue paper to his chest with petroleum jelly in order to decide where to place his nipples. And I tried to be with the surgical team, teaching and learning a very uncertain and contested form of medicine while enacting the climax of what had been, for the patient, a very long road to the OR. I was there with them all.

As I watched them suture—rows and rows of small insertions, loops, and firm little knots—I knew the patient's scars would someday look like mine do now: pale pink and six inches across, like a pair of gently shut eyes. They are records of a cut, a line between "before" and "after" that my body keeps for me.

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[i] See Stefan Hirschauer. 1991. The manufacture of bodies in surgery. *Social Studies of Science* 21(2): 279-319; and Rachel Prentice. 2012. *Bodies in Formation: An Ethnography of Anatomy and Surgery Education*. Durham: Duke University Press.

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