Turning a doctor into a surgeon has traditionally been a practical, hands-on business. It was considered in Britain to require 21,000 hours of specialist training, mostly spent examining patients in the emergency room and treating them in the operating theatre. The aim of this training is to instil the skills – part learned, part intuitive – of how to handle instruments and human tissue, and to comprehend the intimate three-dimensional relationships of organs and body structures, so that you know in the depths of a wound what nerve or vessel your operating scissors will cut through if you close them a millimetre more. It teaches the process of constantly comparing what you are doing with your intended surgical outcome: anticipating complications; planning for contingencies; responding to problems.

The first systematic practice of surgery involved treating the stabs, bullet holes and bludgeonings caused by human conflict, and the first great reference book on the subject used as its frontispiece the iconic image of the Wound Man, his head and body sprouting arrows, perforated by gunfire, split with sabre and battleaxe, pierced through from every side by spear and pike and javelin. A new speciality of trauma illustration arose, from intricate anatomical renderings to graphic depictions of the effects of “gunpowder poisoning” and delicate watercolours showing the skin-tints of gangrene. But like many textbooks their uses were limited; some things cannot be taught by theory alone, and as the 16th century physician Paracelsus advised: “To learn the art of surgery go to war.”

Perhaps there are similarities in the assimilation of the practice of photojournalism. A certain amount can be learned by studying images, to see how the maestros work, but in the end you need to go there; not necessarily to war, but somewhere to be immersed in the intense apprenticeship of shooting pictures. If your pictures aren't good enough, it may be because you aren't close enough. But there are also problems with being too close.

I work periodically as a surgeon in war zones, trying to treat the victims of conflict without becoming one myself. The characteristics of war injuries are their suddenness and violence. In the minds of each of us exists an idealised image of the body – its proportions, lines and limbs. Wounds cause monstrous disruptions of that image, a horror great enough to disrupt thought. That paralysis must be overcome, for there is work to do. You have to be able to deal with the bullet in the neck that comes out through the eye, or the arrival of a truck-full of soldiers hit by the same shell, where some of their injuries have been caused by flying pieces of other men. Cases need to be prioritised according to available resources, the number of casualties expected, the length of time an operation might last and the possibility of imminent evacuation.

These medical assignments are voluntary and unpaid, with a tendency to last longer than expected. Over the years I've discovered that my closeness to events, immersions in war, has meant that I might interest a foreign editor in a story and a couple of photographs filed from some obscure conflict, which on my return I could sometimes parlay into a magazine feature with a better rate of pay. Then I'd be asked to come in and show my pictures to the photo editor. “But,” he'd object, “where are the images of you operating?”

Graphic depictions of surgical gore do exist, but I feel queasy about their use as medical pornography. Such faintheartedness is not going to trouble the commercial media, eager to commodify whatever sells. Reality surgery is huge entertainment, while the globalisation of war makes it likely that images of forensic prurience will continue to be in demand.

Global instability is bringing other changes, in the teaching of doctors. This is the emerging field of Conflict Medicine, with a need for expertise and instruction. Militarism and extremism are back in favour, bombs could detonate at any time on city streets spreading mutilation and blood and doctors must be trained to deal with this.

But there is an increasing shortage of people with the sort of general experience useful for dealing with such disasters. Over the past decade surgical training in the UK has been cut back – it has now been decided that a surgeon requires 9,500 hours to be competent – and has become super-specialised, with the time spent in the area in which the surgeon will practise. Even medical school has become streamlined, and students with pre-existing degrees in diverse fields can now become doctors after three-and-a-half year's study.

Many of these changes in training have been made possible by the introduction of imaging technology. Anatomy can be taught on virtual bodies – replacing a year’s painstaking dissection classes – which also allows
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surgery to be rehearsed and simulated. Representation of the body has become the latest medical advance, concentrating on ways of making it more realistic through the use of 3-D visualisation, remote-control instruments and force-feedback manipulation. Computer-generated digital casualties can give the military surgeon a range of injuries and complications to treat, while the same technology is being applied in reverse: the US army is looking at the development of “remote telepresence surgery modules”, in which emergency operations can be performed by a surgeon based at a distant hospital using video links and robotically manipulated surgical instruments.

Already, the most advanced technique of radical surgery for prostate cancer is carried out entirely by a robot operator that follows the contours of a hyper-resolution, 3-D MRI scan of the patient’s pelvis, cutting away every vestige of disease. And the transmission of televised surgery is booming: soon every celeb will have their breast enhancement or the video-colonoscopy voyage up their own arsehole viewable by millions on YouTube.

So, where are the limits on what we might wish to be shown? A couple of years ago I was asked to contribute to a photographic book on landmines; the editor had read an account in one of my books of working in Angola in Kuito, a besieged town. I submitted a description of amputation for landmine injury and documentary, black and white photographs of the surgery.

The editor wanted to use them, but at a publishers’ meeting in Berlin – the dummy was beautifully produced, with studies of mine-clearance teams at work, photographs of landmines and portraits of their victims – it was decided that my pictures should be dropped. What if someone should pick up the book in a shop, asked the designer, and open it at such violent images; they would be put off and would not buy it, missing the value of the rest of the publication. In this instance, I agree with designer’s decision. The question of what kind of images of the human body are considered suitable for publication is one that rightfully persists.

The question of which images are fit for publication on the grounds of taste is one with which picture editors grapple on a daily basis. Of course taste isn’t the only consideration, and the more you think about the subject, the more it becomes clear that the very ethics of photography is at stake in such discussions. We all know that dead American soldiers are a no-no for the US press, yet the image of a war-battered American soldier sweeps to victory at the World Press Photo Awards.

My mind is always drawn back to the front page of the Guardian in July 2003 when the decapitated heads of Uday and Qusay, Saddam’s sons, were displayed as trophy images. As a member of a society that does not regularly behead its subjects, I was shocked by the action and the more so by its (triumphant?) reproduction. An invisible line had been crossed, but this line was evidently personal to me.

At a recent conference in Leeds, in the north of England, Picturing Atrocity: Reading Photographs in Crisis, a cohort of American academics discussed (among other things) the image now referred to as The Falling Man. After a long day looking at disturbing images, one declared she just couldn’t look at this particular photograph. She issued a plea for the family of the “jumper”. Yet the same plea had not been issued on behalf of the family of the dead Taliban »
soldier, artfully photographed by Luc Delahaye.

Jonathan Kaplan, the war surgeon, author and photographer, whose words precede these agreed with the decision of the designer of the landmine book, not to publish his surgery images of amputation operations. I have since seen those images, and I instinctively concurred, too.

“I usually find that the goriest pictures don’t actually tell the story very well,” said Sophie Batterbury, picture editor of the Independent on Sunday and a contributing editor to 8, since its launch. “The gore tends to distract from any emotion or feeling other than basic revulsion at the image rather than the tragedy that is being illustrated.”

Greg Whitmore, picture editor of the Observer, used a particularly hard-hitting image that George Phippas, a photographer in Kenya filed to Reuters in February. As you can see in the spread reproduced above, the image shows a mother bleeding to death in front of her visibly distressed infant son. This image was used in black and white earlier in the week by the Daily Telegraph. To use such a harrowing image again — and in colour — several days later in that Sunday’s Observer needed justification.

Whitmore was entirely confident of that justification. The original image had inspired Observer journalist Tracy McVeigh to investigate the story further. Who was the woman? The caption didn’t say. McVeigh felt she should not be a nameless victim of the latest violence to erupt in Kenya. The journalist, says Whitmore, opened more than 30 body bags in a bid to identify the woman, which McVeigh eventually managed to accomplish: her name was Grace Mungai. After that, she was able to find her husband and son and tell the story of what happened. The shocking image was now more than merely illustrative. It received but one complaint at the Guardian and Observer Group.

The invisible line for Observer staff made an appearance most recently when reports came out that al-Qa’ida were using people with Downs Syndrome as suicide bombers.

“We were all straining our eyes as the pictures came down the wires, trying to look at the facial features on the bombers,” said Whitmore. “Bear in mind that whenever a suicide bomber hits, we always receive pictures of the severed heads, but we never publish them. There are also always pictures of crowds of locals taking pictures of the severed heads on their mobiles.”

“It was impossible to say anything at all about the facial features of the bomber, and that all of any of the images seemed to prove is what a ghoulish society we’ve become. We didn’t publish it. A line was drawn.”