The Man Who Mistook His Wife for a Hat

OLIVER SACKS

WITH AN INTRODUCTION BY WILL SELF

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Preface

'The last thing one settles in writing a book,' Pascal observes, 'is what one should put in first.' So, having written, collected and arranged these strange tales, having selected a title and two epigraphs, I must now examine what I have done – and why.

The doubleness of the epigraphs, and the contrast between them – indeed the contrast which Ivy McKenzie draws between the physician and the naturalist – corresponds to a certain doubleness in me: that I feel myself a naturalist and a physician both; and that I am equally interested in diseases and people; perhaps, too, that I am equally, if inadequately, a theorist and dramatist, am equally drawn to the scientific and the romantic, and continually see both in the human condition, not least in that quintessential human condition of sickness – animals get diseases, but only man falls radically into sickness.

My work, my life, is all with the sick – but the sick and their sickness drives me to thoughts which, perhaps, I might otherwise not have. So much so that I am compelled to ask, with Nietzsche: 'As for sickness: are we not almost tempted to ask whether we could get along without it?' – and to see the questions it raises as fundamental in nature. Constantly my patients drive me to question, and constantly my questions drive me to patients – thus in the stories or studies which follow there is a continual movement from one to the other.

Studies, yes; why stories, or cases? Hippocrates introduced the historical conception of disease, the idea that diseases have a

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course, from their first intimations to their climax or crisis, and thence to their happy or fatal resolution. Hippocrates thus introduced the case history, a description, or depiction, of the natural history of disease – precisely expressed by the old word 'pathography'. Such histories are a form of natural history – but they tell us nothing about the individual and *his* history; they convey nothing of the person, and the experience of the person, as he faces, and struggles to survive, his disease. There is no 'subject' in a narrow case history; modern case histories allude to the subject in a cursory phrase ('a trisomic albino female of 21'), which could as well apply to a rat as a human being. To restore the human subject at the centre – the suffering, afflicted, fighting, human subject – we must deepen a case history to a narrative or tale: only then do we have a 'who' as well as a 'what', a real person, a patient, in relation to disease – in relation to the physical.

The patient's essential being is very relevant in the higher reaches of neurology, and in psychology; for here the patient's personhood is essentially involved, and the study of disease and of identity cannot be disjoined. Such disorders, and their depiction and study, indeed entail a new discipline, which we may call the 'neurology of identity', for it deals with the neural foundations of the self, the age-old problem of mind and brain. It is possible that there must, of necessity, be a gulf, a gulf of category, between the psychical and the physical; but studies and stories pertaining simultaneously and inseparably to both – and it is these which especially fascinate me, and which (on the whole) I present here – may none the less serve to bring them nearer, to bring us to the very intersection of mechanism and life, to the relation of physiological processes to biography.

The tradition of richly human clinical tales reached a high point in the nineteenth century, and then declined, with the advent of an impersonal neurological science. Luria wrote: 'The power to describe, which was so common to the great nineteenth-century

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neurologists and psychiatrists, is almost gone now . . . It must be revived.' His own late works, such as *The Mind of a Mnemonist* and *The Man with a Shattered World*, are attempts to revive this lost tradition. Thus the case histories in this book hark back to an ancient tradition: to the nineteenth-century tradition of which Luria speaks; to the tradition of the first medical historian, Hippocrates; and to that universal and prehistorical tradition by which patients have always told their stories to doctors.

Classical fables have archetypal figures – heroes, victims, martyrs, warriors. Neurological patients are all of these – and in the strange tales told here they are also something more. How, in these mythical or metaphorical terms, shall we categorise the 'Lost Mariner', or the other strange figures in this book? We may say they are travellers to unimaginable lands – lands of which otherwise we should have no idea or conception. This is why their lives and journeys seem to me to have a quality of the fabulous, why I have used Osier's *Arabian Nights* image as an epigraph, and why I feel compelled to speak of tales and fables as well as cases. The scientific and the romantic in such realms cry out to come together – Luria liked to speak here of 'romantic science'. They come together at the intersection of fact and fable, the intersection which characterises (as it did in my book *Awakenings*) the lives of the patients here narrated.

But what facts! What fables! To what shall we compare them? We may not have any existing models, metaphors or myths. Has the time perhaps come for new symbols, new myths?

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Eight of the chapters in this book have already been published: 'The Lost Mariner', 'Hands', 'The Twins', and 'The Autist Artist' in the *New York Review of Books* (1984 and 1985), and 'Witty Ticcy Ray', 'The Man Who Mistook His Wife for a Hat', and 'Reminiscence' in

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the *London Review of Books* (1981, 1983, 1984) – where the briefer version of the last was called 'Musical Ears'. 'On the Level' was published in *The Sciences* (1985). A very early account of one of my patients – the 'original' of Rose R. in *Awakenings* and of Harold Pinter's Deborah in *A Kind of Alaska*, inspired by that book – is to be found in 'Incontinent Nostalgia' (originally published as 'Incontinent Nostalgia induced by L-Dopa' in the *Lancet* of Spring 1970). Of my four 'Phantoms', the first two were published as 'clinical curios' in the *British Medical Journal* (1984). Two short pieces are taken from previous books: 'The Man Who Fell out of Bed' is excerpted from *A Leg to Stand On*, and 'The Visions of Hildegard' from *Migraine*. The remaining twelve pieces are unpublished and entirely new, and were all written during the autumn and winter of 1984.

I owe a very special debt to my editors: first to Robert Silver of the *New York Review of Books* and Mary-Kay Wilmers of the *London Review of Books*; then to Kate Edgar, Jim Silberman of Summit Books in New York, and Colin Haycraft of Duckworth's in London, who between them did so much to shape the final book.

Among my fellow neurologists I must express special gratitude to the late Dr James Purdon Martin, to whom I showed videotapes of 'Christina' and 'Mr MacGregor' and with whom I discussed these patients fully – 'The Disembodied Lady' and 'On the Level' express this indebtedness; to Dr Michael Kremer, my former 'chief' in London, who in response to *A Leg to Stand On* (1984) described a very similar case of his own – these are bracketed together now in 'The Man Who Fell out of Bed'; to Dr Donald Macrae, whose extraordinary case of visual agnosia, almost comically similar to my own, was only discovered, by accident, two years after I had written my own piece – it is excerpted in a postscript to 'The Man Who Mistook His Wife for a Hat'; and, most especially, to my close friend and colleague Dr Isabelle Rapin in New York, who discussed many cases with me; she introduced me to Christina (the

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'disembodied lady'), and had known José, the 'autist artist', for many years when he was a child.

I wish to acknowledge the selfless help and generosity of the patients (and, in some cases, the relatives of the patients) whose tales I tell here – who, knowing (as they often did) that they themselves might not be able to be helped directly, yet permitted, even encouraged, me to write of their lives, in the hope that others might learn and understand, and, one day, perhaps be able to cure. As in *Awakenings*, names and some circumstantial details have been changed for reasons of personal and professional confidence, but my aim has been to preserve the essential 'feeling' of their lives.

Finally, I wish to express my gratitude – more than gratitude – to my own mentor and physician, to whom I dedicate this book.

O.W.S.

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Part One

LOSSES

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Neurology's favourite word is 'deficit', denoting an impairment or incapacity of neurological function: loss of speech, loss of language, loss of memory, loss of vision, loss of dexterity, loss of identity and myriad other lacks and losses of specific functions (or faculties). For all of these dysfunctions (another favourite term), we have privative words of every sort – Aphonia, Aphemia, Aphasia, Alexia, Apraxia, Agnosia, Amnesia, Ataxia – a word for every specific neural or mental function of which patients, through disease, or injury, or failure to develop, may find themselves partly or wholly deprived.

The scientific study of the relationship between brain and mind began in 1861, when Broca, in France, found that specific difficulties in the expressive use of speech, aphasia, consistently followed damage to a particular portion of the left hemisphere of the brain. This opened the way to a cerebral neurology, which made it possible, over the decades, to 'map' the human brain, ascribing specific powers – linguistic, intellectual, perceptual, etc. – to equally specific 'centres' in the brain. Towards the end of the century it became evident to more acute observers – above all to Freud, in his book *Aphasia* – that this sort of mapping was too simple, that all mental performances had an intricate internal structure, and must have an equally complex physiological basis. Freud felt this, especially, in regard to certain disorders of recognition and perception, for which he coined the term 'agnosia'. All adequate understanding of aphasia or agnosia would, he believed, require a new, more sophisticated science.

The new science of brain/mind which Freud envisaged came into being in the Second World War, in Russia, as the joint creation of A. R. Luria (and his father R. A. Luria), Leontev, Anokhin, Bernstein and others, and was called by them 'neuropsychology'.

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The development of this immensely fruitful science was the life-work of A. R. Luria, and considering its revolutionary importance it was somewhat slow in reaching the West. It was set out, systematically, in a monumental book, *Higher Cortical Functions in Man* (Eng. tr. 1966), and, in a wholly different way, in a biography or 'pathography' – *The Man with a Shattered World* (Eng. tr. 1972). Although these books were almost perfect in their way, there was a whole realm which Luria had not touched. *Higher Cortical Functions in Man* treated only those functions which appertained to the left hemisphere of the brain; similarly, Zazetsky, subject of *The Man with a Shattered World*, had a huge lesion in the left hemisphere – the right was intact. Indeed, the entire history of neurology and neuropsychology can be seen as a history of the investigation of the left hemisphere.

One important reason for the neglect of the right, or 'minor', hemisphere, as it has always been called, is that while it is easy to demonstrate the effects of variously located lesions on the left side, the corresponding syndromes of the right hemisphere are much less distinct. It was presumed, usually contemptuously, to be more 'primitive' than the left, the latter being seen as the unique flower of human evolution. And in a sense this is correct: the left hemisphere is more sophisticated and specialised, a very late outgrowth of the primate, and especially hominid, brain. On the other hand, it is the right hemisphere which controls the crucial powers of recognising reality which every living creature must have in order to survive. The left hemisphere, like a computer tacked onto the basic creatural brain, is designed for programmes and schematics; and classical neurology was more concerned with schematics than with reality, so that when, at last, some of the right-hemisphere syndromes emerged, they were considered bizarre.

There had been attempts in the past – for example, by Anton in the 1890s and Pötzl in 1928 – to explore right-hemisphere

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syndromes, but these attempts themselves had been bizarrely ignored. In *The Working Brain*, one of his last books, Luria devoted a short but tantalising section to right-hemisphere syndromes, ending:

> These still completely unstudied defects lead us to one of the most fundamental problems – to the role of the right hemisphere in direct consciousness . . . The study of this highly important field has been so far neglected . . . It will receive a detailed analysis in a special series of papers . . . in preparation for publication.

Luria did, finally, write some of these papers, in the last months of his life, when mortally ill. He never saw their publication, nor were they published in Russia. He sent them to R. L. Gregory in England and they will appear in Gregory's forthcoming *Oxford Companion to the Mind*.

Inner difficulties and outer difficulties match each other here. It is not only difficult, it is impossible, for patients with certain right-hemisphere syndromes to know their own problems – a peculiar and specific 'anosagnosia', as Babinski called it. And it is singularly difficult, for even the most sensitive observer, to picture the inner state, the 'situation', of such patients, for this is almost unimaginably remote from anything he himself has ever known. Left-hemisphere syndromes, by contrast, are relatively easily imagined. Although right-hemisphere syndromes are as common as left-hemisphere syndromes – why should they not be? – we will find a thousand descriptions of left-hemisphere syndromes in the neurological and neuropsychological literature for every description of a right-hemisphere syndrome. It is as if such syndromes were somehow alien to the whole temper of neurology. And yet, as Luria says, they are of the most fundamental importance. So much so that they may demand a new sort of neurology, a 'personalistic', or (as Luria liked to call it) a 'romantic', science; for the physical foundations of the *persona*, the self, are here revealed for our study. Luria thought a science of this

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kind would be best introduced by a story – a detailed case history of a man with a profound right-hemisphere disturbance, a case history which would at once be the complement and opposite of 'the man with a shattered world'. In one of his last letters to me he wrote: 'Publish such histories, even if they are just sketches. It is a realm of great wonder.' I must confess to being especially intrigued by these disorders, for they open realms, or promise realms, scarcely imagined before, pointing to an open and more spacious neurology and psychology, excitingly different from the rather rigid and mechanical neurology of the past.

It is, then, less deficits, in the traditional sense, which have engaged my interest than neurological disorders affecting the self. Such disorders may be of many kinds – and may arise from excesses, no less than impairments, of function – and it seems reasonable to consider these two categories separately. But it must be said from the outset that a disease is never a mere loss or excess – that there is always a reaction, on the part of the affected organism or individual, to restore, to replace, to compensate for and to preserve its identity, however strange the means may be: and to study or influence these means, no less than the primary insult to the nervous system, is an essential part of our role as physicians. This was powerfully stated by Ivy McKenzie:

> For what is it that constitutes a 'disease entity' or a 'new disease'? The physician is concerned not, like the naturalist, with a wide range of different organisms theoretically adapted in an average way to an average environment, but with a single organism, the human subject, striving to preserve its identity in adverse circumstances.

This dynamic, this 'striving to preserve identity', however strange the means or effects of such striving, was recognised in psychiatry long ago – and, like so much else, is especially associated with the work of Freud. Thus the delusions of paranoia were seen by him, not as primary, but as attempts (however

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misguided) at restitution, at reconstructing a world reduced to complete chaos. In precisely the same way, Ivy McKenzie wrote:

> The pathological physiology of the Parkinsonian syndrome is the study of *an organised chaos*, a chaos induced in the first instance by destruction of important integrations, and reorganised on an unstable basis in the process of rehabilitation.

As *Awakenings* was the study of 'an organised chaos' produced by a single if multiform disease, so what now follows is a series of similar studies of the organised chaoses produced by a great variety of diseases.

In this first section, 'Losses', the most important case, to my mind, is that of a special form of visual agnosia: 'The Man Who Mistook His Wife for a Hat.' I believe it to be of fundamental importance. Such cases constitute a radical challenge to one of the most entrenched axioms or assumptions of classical neurology – in particular, the notion that brain damage, *any* brain damage, reduces or removes the 'abstract and categorical attitude' (in Kurt Goldstein's term), reducing the individual to the emotional and concrete. (A very similar thesis was made by Hughlings Jackson, in the 1860s.) Here, in the case of Dr P., we see the very *opposite* of this – a man who has (albeit only in the sphere of the visual) wholly lost the emotional, the concrete, the personal, the 'real' . . . and been reduced, as it were, to the abstract and the categorical, with consequences of a particularly preposterous kind. What would Hughlings Jackson and Goldstein have said of *this*? I have often, in imagination, asked them to examine Dr P., and then said, 'Gentlemen! What do you say *now*?'

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The Man Who Mistook His Wife for a Hat

Dr P. was a musician of distinction, well known for many years as a singer, and then, at the local School of Music, as a teacher. It was here, in relation to his students, that certain strange problems were first observed. Sometimes a student would present himself, and Dr P. would not recognise him; or, specifically, would not recognise his face. The moment the student spoke, he would be recognised by his voice. Such incidents multiplied, causing embarrassment, perplexity, fear – and, sometimes, comedy. For not only did Dr P. increasingly fail to see faces, but he saw faces when there were no faces to see: genially, Magoo-like, when in the street, he might pat the heads of water-hydrants and parking-meters, taking these to be the heads of children; he would amiably address carved knobs on the furniture, and be astounded when they did not reply. At first these odd mistakes were laughed off as jokes, not least by Dr P. himself. Had he not always had a quirky sense of humour, and been given to Zen-like paradoxes and jests? His musical powers were as dazzling as ever; he did not feel ill – he had never felt better; and the mistakes were so ludicrous – and so ingenious – that they could hardly be serious or betoken anything serious. The notion of there being 'something the matter' did not emerge until some three years later, when diabetes developed. Well aware that diabetes could affect his eyes, Dr P. consulted an ophthalmologist, who took a careful history, and examined his eyes closely. 'There's nothing the matter with your eyes,' the doctor concluded. 'But there is trouble with the visual parts of

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your brain. You don't need my help, you must see a neurologist.' And so, as a result of this referral, Dr P. came to me.

It was obvious within a few seconds of meeting him that there was no trace of dementia in the ordinary sense. He was a man of great cultivation and charm, who talked well and fluently, with imagination and humour. I couldn't think why he had been referred to our clinic.

And yet there *was* something a bit odd. He faced me as he spoke, was oriented towards me, and yet there was something the matter – it was difficult to formulate. He faced me with his *ears*, I came to think, but not with his eyes. These, instead of looking, gazing, at me, 'taking me in', in the normal way, made sudden strange fixations – on my nose, on my right ear, down to my chin, up to my right eye – as if noting (even studying) these individual features, but not seeing my whole face, its changing expressions, 'me', as a whole. I am not sure that I fully realised this at the time – there was just a teasing strangeness, some failure in the normal interplay of gaze and expression. He saw me, he *scanned* me, and yet . . .

'What seems to be the matter?' I asked him at length.

'Nothing that I know of,' he replied with a smile, 'but people seem to think there's something wrong with my eyes.'

'But *you* don't recognise any visual problems?'

'No, not directly, but I occasionally make mistakes.'

I left the room briefly, to talk to his wife. When I came back Dr P. was sitting placidly by the window, attentive, listening rather than looking out. 'Traffic,' he said, 'street sounds, distant trains – they make a sort of symphony, do they not? You know Honegger's *Pacific 234*?'

What a lovely man, I thought to myself. How can there be anything seriously the matter? Would he permit me to examine him?

'Yes, of course, Dr Sacks.'

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I stilled my disquiet, his perhaps too, in the soothing routine of a neurological exam – muscle strength, co-ordination, reflexes, tone . . . It was while examining his reflexes – a trifle abnormal on the left side – that the first bizarre experience occurred. I had taken off his left shoe and scratched the sole of his foot with a key – a frivolous-seeming but essential test of a reflex – and then, excusing myself to screw my ophthalmoscope together, left him to put on the shoe himself. To my surprise, a minute later, he had not done this.

'Can I help?' I asked.

'Help what? Help whom?'

'Help you put on your shoe.'

'Ach,' he said, 'I had forgotten the shoe,' adding, *sotto voce*, 'The shoe? The shoe?' He seemed baffled.

'Your shoe,' I repeated. 'Perhaps you'd put it on.'

He continued to look downwards, though not at the shoe, with an intense but misplaced concentration. Finally his gaze settled on his foot: 'That is my shoe, yes?'

Did I mis-hear? Did he mis-see?

'My eyes,' he explained, and put a hand to his foot. '*This* is my shoe, no?'

'No, it is not. That is your foot. *There* is your shoe.'

'Ah! I thought that was my foot.'

Was he joking? Was he mad? Was he blind? If this was one of his 'strange mistakes', it was the strangest mistake I had ever come across.

I helped him on with his shoe (his foot), to avoid further complication. Dr P. himself seemed untroubled, indifferent, maybe amused. I resumed my examination. His visual acuity was good: he had no difficulty seeing a pin on the floor, though sometimes he missed it if it was placed to his left.

He saw all right, but what did he see? I opened out a copy of the *National Geographic Magazine*, and asked him to describe some

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pictures in it.

His responses here were very curious. His eyes would dart from one thing to another, picking up tiny features, individual features, as they had done with my face. A striking brightness, a colour, a shape would arrest his attention and elicit comment – but in no case did he get the scene-as-a-whole. He failed to see the whole, seeing only details, which he spotted like blips on a radar screen. He never entered into relation with the picture as a whole – never faced, so to speak, *its* physiognomy. He had no sense whatever of a landscape or scene.

I showed him the cover, an unbroken expanse of Sahara dunes.

'What do you see here?' I asked.

'I see a river,' he said. 'And a little guest-house with its terrace on the water. People are dining out on the terrace. I see coloured parasols here and there.' He was looking, if it was 'looking', right off the cover, into mid-air and confabulating non-existent features, as if the absence of features in the actual picture had driven him to imagine the river and the terrace and the coloured parasols.

I must have looked aghast, but he seemed to think he had done rather well. There was a hint of a smile on his face. He also appeared to have decided that the examination was over, and started to look round for his hat. He reached out his hand, and took hold of his wife's head, tried to lift it off, to put it on. He had apparently mistaken his wife for a hat! His wife looked as if she was used to such things.

I could make no sense of what had occurred, in terms of conventional neurology (or neuropsychology). In some ways he seemed perfectly preserved, and in others absolutely, incomprehensibly devastated. How could he, on the one hand, mistake his wife for a hat and, on the other, function, as apparently he still did, as a teacher at the Music School?

I had to think, to see him again – and to see him in his own

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familiar habitat, at home.

A few days later I called on Dr P. and his wife at home, with the score of the *Dichterliebe* in my briefcase (I knew he liked Schumann), and a variety of odd objects for the testing of perception. Mrs P. showed me into a lofty apartment, which recalled fin-de-siècle Berlin. A magnificent old Bösendorfer stood in state in the centre of the room, and all round it were music-stands, instruments, scores . . . There were books, there were paintings, but the music was central. Dr P. came in and, distracted, advanced with outstretched hand to the grandfather clock, but, hearing my voice, corrected himself, and shook hands with me. We exchanged greetings, and chatted a little of current concerts and performances. Diffidently, I asked him if he would sing.

'The *Dichterliebe*!' he exclaimed. 'But I can no longer read music. You will play them, yes?'

I said I would try. On that wonderful old piano even my playing sounded right, and Dr P. was an aged, but infinitely mellow Fischer-Dieskau, combining a perfect ear and voice with the most incisive musical intelligence. It was clear that the Music School was not keeping him on out of charity.

Dr P.'s temporal lobes were obviously intact: he had a wonderful musical cortex. What, I wondered, was going on in his parietal and occipital lobes, especially in those areas where visual processing occurred? I carry the Platonic solids in my neurological kit, and decided to start with these.

'What is this?' I asked, drawing out the first one.

'A cube, of course.'

'Now this?' I asked, brandishing another.

He asked if he might examine it, which he did swiftly and systematically: 'A dodecahedron, of course. And don't bother with the others – I'll get the eikosihedron too.'

Abstract shapes clearly presented no problems. What about faces? I took out a pack of cards. All of these he identified

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instantly, including the jacks, queens, kings, and the joker. But these, after all, are stylised designs, and it was impossible to tell whether he saw faces or merely patterns. I decided I would show him a volume of cartoons which I had in my briefcase. Here, again, for the most part, he did well. Churchill's cigar, Schnozzle's nose: as soon as he had picked out a key feature he could identify the face. But cartoons, again, are formal and schematic. It remained to be seen how he would do with real faces, realistically represented.

I turned on the television, keeping the sound off, and found an early Bette Davis film. A love scene was in progress. Dr P. failed to identify the actress – but this could have been because she had never entered his world. What was more striking was that he failed to identify the expressions on her face or her partner's, though in the course of a single torrid scene these passed from sultry yearning through passion, surprise, disgust and fury to a melting reconciliation. Dr P. could make nothing of any of this. He was very unclear as to what was going on, or who was who or even what sex they were. His comments on the scene were positively Martian.

It was just possible that some of his difficulties were associated with the unreality of a celluloid, Hollywood world; and it occurred to me that he might be more successful in identifying faces from his own life. On the walls of the apartment there were photographs of his family, his colleagues, his pupils, himself. I gathered a pile of these together and, with some misgivings, presented them to him. What had been funny, or farcical, in relation to the movie, was tragic in relation to real life. By and large, he recognised nobody: neither his family, nor his colleagues, nor his pupils, nor himself. He recognised a portrait of Einstein, because he picked up the characteristic hair and moustache; and the same thing happened with one or two other people. 'Ach, Paul!' he said, when shown a portrait of his brother. 'That square jaw, those big teeth, I would know Paul anywhere!' But was it Paul he recognised, or one or two of his features, on the basis of which he could make a reasonable

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guess as to the subject's identity? In the absence of obvious 'markers', he was utterly lost. But it was not merely the cognition, the *gnosis*, at fault; there was something radically wrong with the whole way he proceeded. For he approached these faces – even of those near and dear – as if they were abstract puzzles or tests. He did not relate to them, he did not behold. No face was familiar to him, seen as a 'thou', being just identified as a set of features, an 'it'. Thus there was formal, but no trace of personal, gnosis. And with this went his indifference, or blindness, to expression. A face, to us, is a person looking out – we see, as it were, the person through his *persona*, his face. But for Dr P. there was no *persona* in this sense – no outward *persona*, and no person within.

I had stopped at a florist on my way to his apartment and bought myself an extravagant red rose for my buttonhole. Now I removed this and handed it to him. He took it like a botanist or morphologist given a specimen, not like a person given a flower.

'About six inches in length,' he commented. 'A convoluted red form with a linear green attachment.'

'Yes,' I said encouragingly, 'and what do you think it *is*, Dr P.?'

'Not easy to say.' He seemed perplexed. 'It lacks the simple symmetry of the Platonic solids, although it may have a higher symmetry of its own . . . I think this could be an inflorescence or flower.'

'Could be?' I queried.

'Could be,' he confirmed.

'Smell it,' I suggested, and he again looked somewhat puzzled, as if I had asked him to smell a higher symmetry. But he complied courteously, and took it to his nose. Now, suddenly, he came to life.

'Beautiful!' he exclaimed. 'An early rose. What a heavenly smell!' He started to hum 'Die Rose, die Lillie . . .' Reality, it seemed, might be conveyed by smell, not by sight.

I tried one final test. It was still a cold day, in early spring, and I had thrown my coat and gloves on the sofa.

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'What is this?' I asked, holding up a glove.

'May I examine it?' he asked, and, taking it from me, he proceeded to examine it as he had examined the geometrical shapes.

'A continuous surface,' he announced at last, 'infolded on itself. It appears to have' – he hesitated – 'five outpouchings, if this is the word.'

'Yes,' I said cautiously. 'You have given me a description. Now tell me what it is.'

'A container of some sort?'

'Yes,' I said, 'and what would it contain?'

'It would contain its contents!' said Dr P., with a laugh. 'There are many possibilities. It could be a change-purse, for example, for coins of five sizes. It could . . .'

I interrupted the barmy flow. 'Does it not look familiar? Do you think it might contain, might fit, a part of your body?'

No light of recognition dawned on his face.[1]

No child would have the power to see and speak of 'a continuous surface . . . infolded on itself', but any child, any infant, would immediately know a glove as a glove, see it as familiar, as going with a hand. Dr P. didn't. He saw nothing as familiar. Visually, he was lost in a world of lifeless abstractions. Indeed he did not have a real visual world, as he did not have a real visual self. He could speak about things, but did not see them face-to-face. Hughlings Jackson, discussing patients with aphasia and left-hemisphere lesions, says they have lost 'abstract' and 'prepositional' thought – and compares them with dogs (or, rather, he compares dogs to patients with aphasia). Dr P., on the other hand, functioned precisely as a machine functions. It wasn't merely that he displayed the same indifference to the visual world as a computer but – even more strikingly – he construed the world as a computer construes it, by means of key features and schematic relationships. The scheme might be identified – in an 'identikit' way – without

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the reality being grasped at all.

The testing I had done so far told me nothing about Dr P.'s inner world. Was it possible that his visual memory and imagination were still intact? I asked him to imagine entering one of our local squares from the north side, to walk through it, in imagination or in memory, and tell me the buildings he might pass as he walked. He listed the buildings on his right side, but none of those on his left. I then asked him to imagine entering the square from the south. Again he mentioned only those buildings that were on the right side, although these were the very buildings he had omitted before. Those he had 'seen' internally before were not mentioned now; presumably they were no longer 'seen'. It was evident that his difficulties with leftness, his visual field deficits, were as much internal as external, bisecting his visual memory and imagination.

What, at a higher level, of his internal visualisation? Thinking of the almost hallucinatory intensity with which Tolstoy visualises and animates his characters, I questioned Dr P. about *Anna Karenina*. He could remember incidents without difficulty, had an undiminished grasp of the plot, but completely omitted visual characteristics, visual narrative or scenes. He remembered the words of the characters, but not their faces; and though, when asked, he could quote, with his remarkable and almost verbatim memory, the original visual descriptions, these were, it became apparent, quite empty for him, and lacked sensorial, imaginal, or emotional reality. Thus there was an internal agnosia as well.[2]

But this was only the case, it became clear, with certain sorts of visualisation. The visualisation of faces and scenes, of visual narrative and drama – this was profoundly impaired, almost absent. But the visualisation of *schemata* was preserved, perhaps enhanced. Thus when I engaged him in a game of mental chess, he had no difficulty visualising the chessboard or the moves – indeed, no difficulty in beating me soundly.

Luria said of Zazetsky that he had entirely lost his capacity to

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play games but that his 'vivid imagination' was unimpaired. Zazetsky and Dr P. lived in worlds which were mirror images of each other. But the saddest difference between them was that Zazetsky, as Luria said, 'fought to regain his lost faculties with the indomitable tenacity of the damned', whereas Dr P. was not fighting, did not know what was lost, did not indeed know that anything was lost. But who was more tragic, or who was more damned – the man who knew it, or the man who did not?

When the examination was over, Mrs P. called us to the table, where there was coffee and a delicious spread of little cakes. Hungrily, hummingly, Dr P. started on the cakes. Swiftly, fluently, unthinkingly, melodiously, he pulled the plates towards him, and took this and that, in a great gurgling stream, an edible song of food, until, suddenly, there came an interruption: a loud, peremptory rat-tat-tat at the door. Startled, taken aback, arrested, by the interruption, Dr P. stopped eating, and sat frozen, motionless, at the table, with an indifferent, blind, bewilderment on his face. He saw, but no longer saw, the table; no longer perceived it as a table laden with cakes. His wife poured him some coffee: the smell titillated his nose, and brought him back to reality. The melody of eating resumed.

How does he do anything? I wondered to myself. What happens when he's dressing, goes to the lavatory, has a bath? I followed his wife into the kitchen and asked her how, for instance, he managed to dress himself. 'It's just like the eating,' she explained. 'I put his usual clothes out, in all the usual places, and he dresses without difficulty, singing to himself. He does everything singing to himself. But if he is interrupted and loses the thread, he comes to a complete stop, doesn't know his clothes – or his own body. He sings all the time – eating songs, dressing songs, bathing songs, everything. He can't do anything unless he makes it a song.'

While we were talking my attention was caught by the pictures on the walls.

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'Yes,' Mrs P. said, 'he was a gifted painter as well as a singer. The School exhibited his pictures every year.'

I strolled past them curiously – they were in chronological order. All his earlier work was naturalistic and realistic, with vivid mood and atmosphere, but finely detailed and concrete. Then, years later, they became less vivid, less concrete, less realistic and naturalistic; but far more abstract, even geometrical and cubist. Finally, in the last paintings, the canvas became nonsense, or nonsense to me – mere chaotic lines and blotches of paint. I commented on this to Mrs P.

'Ach, you doctors, you're such philistines!' she exclaimed. 'Can you not see *artistic development* – how he renounced the realism of his earlier years, and advanced into abstract, nonrepresentational art?'

'No, that's not it,' I said to myself (but forbore to say it to poor Mrs P.). He had indeed moved from realism to nonrepresentation to the abstract, but this was not the artist, but the pathology, advancing – advancing towards a profound visual agnosia, in which all powers of representation and imagery, all sense of the concrete, all sense of reality, were being destroyed. This wall of paintings was a tragic pathological exhibit, which belonged to neurology, not art.

And yet, I wondered, was she not partly right? For there is often a struggle, and sometimes, even more interestingly, a collusion, between the powers of pathology and creation. Perhaps, in his cubist period, there might have been both artistic and pathological development, colluding to engender an original form; for as he lost the concrete, so he might have gained in the abstract, developing a greater sensitivity to all the structural elements of line, boundary, contour – an almost Picasso-like power to see, and equally depict, those abstract organisations embedded in, and normally lost in, the concrete . . . Though in the final pictures, I feared, there was only chaos and agnosia.

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We returned to the great music room, with the Bösendorfer in the centre, and Dr P. humming the last torte.

'Well, Dr Sacks,' he said to me. 'You find me an interesting case, I perceive. Can you tell me what you find wrong, make recommendations?'

'I can't tell you what I find wrong,' I replied, 'but I'll say what I find right. You are a wonderful musician, and music is your life. What I would prescribe, in a case such as yours, is a life which consists entirely of music. Music has been the centre, now make it the whole, of your life.'

This was four years ago – I never saw him again, but I often wondered how he apprehended the world, given his strange loss of image, visuality, and the perfect preservation of a great musicality. I think that music, for him, had taken the place of image. He had no body-image, he had body-music: this is why he could move and act as fluently as he did, but came to a total confused stop if the 'inner music' stopped. And equally with the outside, the world . . .[3]

In *The World as Representation and Will* Schopenhauer speaks of music as 'pure will'. How fascinated he would have been by Dr P., a man who had wholly lost the world as representation, but wholly preserved it as music or will.

And this, mercifully, held to the end – for despite the gradual advance of his disease (a massive tumour or degenerative process in the visual parts of his brain) Dr P. lived and taught music to the last days of his life.

Postscript

How should one interpret Dr P.'s peculiar inability to interpret, to judge, a glove as a glove? Manifestly, here, he could not make a cognitive judgement, though he was prolific in the production of cognitive hypotheses. A judgement is intuitive, personal, comprehensive, and concrete – we 'see' how things stand, in

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relation to one another and oneself. It was precisely this seeing, this relating, that Dr P. lacked (though his judging, in all other spheres, was prompt and normal). Was this due to lack of visual information, or faulty processing of visual information? (This would be the explanation given by a classical, schematic neurology.) Or was there something amiss in Dr P.'s attitude, so that he could not relate what he saw to himself?

These explanations, or modes of explanation, are not mutually exclusive – being in different modes they could coexist and both be true. And this is acknowledged, implicitly or explicitly, in classical neurology: implicitly, by Macrae, when he finds the explanation of defective schemata, or defective visual processing and integration, inadequate; explicitly, by Goldstein, when he speaks of 'abstract attitude'. But abstract attitude, which allows 'categorisation', also misses the mark with Dr P. – and, perhaps, with the concept of 'judgement' in general. For Dr P. *had* abstract attitude – indeed, nothing else. And it was precisely this, his absurd abstractness of attitude – absurd because unleavened with anything else – which rendered him incapable of perceiving identity, or particulars, rendered him incapable of judgement.

Neurology and psychology, curiously, though they talk of everything else, almost never talk of 'judgement' – and yet it is precisely the downfall of judgement (whether in specific realms, as with Dr P., or more generally, as in patients with Korsakov's or frontal-lobe syndromes – see below, Chapters 12 and 13) which constitutes the essence of so many neuropsychological disorders. Judgement and identity may be casualties – but neuropsychology never speaks of them.

And yet, whether in a philosophic sense (Kant's sense) or an empirical and evolutionary sense, judgement is the most important faculty we have. An animal, or a man, may get on very well without 'abstract attitude' but will speedily perish if deprived of judgement. Judgement must be the *first* faculty of higher life or

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mind – yet it is ignored, or misinterpreted, by classical (computational) neurology. And if we wonder how such an absurdity can arise, we find it in the assumptions, or the evolution, of neurology itself. For classical neurology (like classical physics) has always been mechanical – from Hughlings Jackson's mechanical analogies to the computer analogies of today.

Of course, the brain *is* a machine and a computer – everything in classical neurology is correct. But our mental processes, which constitute our being and life, are not just abstract and mechanical, but personal, as well – and, as such, involve not just classifying and categorising, but continual judging and feeling also. If this is missing, we become computer-like, as Dr P. was. And, by the same token, if we delete feeling and judging, the personal, from the cognitive sciences, we reduce *them* to something as defective as Dr P. – and we reduce *our* apprehension of the concrete and real.

By a sort of comic and awful analogy, our current cognitive neurology and psychology resembles nothing so much as poor Dr P.! We need the concrete and real, as he did; and we fail to see this, as he failed to see it. Our cognitive sciences are themselves suffering from an agnosia essentially similar to Dr P.'s. Dr P. may therefore serve as a warning and parable – of what happens to a science which eschews the judgemental, the particular, the personal, and becomes entirely abstract and computational.

It was always a matter of great regret to me that, owing to circumstances beyond my control, I was not able to follow his case further, either in the sort of observations and investigations described, or in ascertaining the actual disease pathology.

*

One always fears that a case is 'unique', especially if it has such extraordinary features as those of Dr P. It was, therefore, with a sense of great interest and delight, not unmixed with relief, that I

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2
The Lost Mariner[5]

> You have to begin to lose your memory, if only in bits and pieces, to realise that memory is what makes our lives. Life without memory is no life at all . . . Our memory is our coherence, our reason, our feeling, even our action. Without it, we are nothing . . . (I can only wait for the final amnesia, the one that can erase an entire life, as it did my mother's . . .)
>
> LUIS BUÑUEL

This moving and frightening segment in Buñuel's recently translated memoirs raises fundamental questions – clinical, practical, existential, philosophical: what sort of a life (if any), what sort of a world, what sort of a self, can be preserved in a man who has lost the greater part of his memory and, with this, his past, and his moorings in time?

It immediately made me think of a patient of mine in whom these questions are precisely exemplified: charming, intelligent, memoryless Jimmie G., who was admitted to our Home for the Aged near New York City early in 1975, with a cryptic transfer note saying, 'Helpless, demented, confused and disoriented.'

Jimmie was a fine-looking man, with a curly bush of grey hair, a healthy and handsome forty-nine-year-old. He was cheerful, friendly, and warm.

'Hiya, Doc!' he said. 'Nice morning! Do I take this chair here?' He was a genial soul, very ready to talk and to answer any questions I asked him. He told me his name and birth date, and the name of

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the little town in Connecticut where he was born. He described it in affectionate detail, even drew me a map. He spoke of the houses where his family had lived – he remembered their phone numbers still. He spoke of school and school days, the friends he'd had, and his special fondness for mathematics and science. He talked with enthusiasm of his days in the navy – he was seventeen, had just graduated from high school when he was drafted in 1943. With his good engineering mind he was a 'natural' for radio and electronics, and after a crash course in Texas found himself assistant radio operator on a submarine. He remembered the names of various submarines on which he had served, their missions, where they were stationed, the names of his shipmates. He remembered Morse code, and was still fluent in Morse tapping and touch-typing.

A full and interesting early life, remembered vividly, in detail, with affection. But there, for some reason, his reminiscences stopped. He recalled, and almost relived, his war days and service, the end of the war, and his thoughts for the future. He had come to love the navy, thought he might stay in it. But with the GI Bill, and support, he felt he might do best to go to college. His older brother was in accountancy school and engaged to a girl, a 'real beauty', from Oregon.

With recalling, reliving, Jimmie was full of animation; he did not seem to be speaking of the past but of the present, and I was very struck by the change of tense in his recollections as he passed from his school days to his days in the navy. He had been using the past tense, but now used the present – and (it seemed to me) not just the formal or fictitious present tense of recall, but the actual present tense of immediate experience.

A sudden, improbable suspicion seized me.

'What year is this, Mr G.?' I asked, concealing my perplexity under a casual manner.

'Forty-five, man. What do you mean?' He went on, 'We've won the war, FDR's dead, Truman's at the helm. There are great times

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ahead.'

'And you, Jimmie, how old would you be?'

Oddly, uncertainly, he hesitated a moment, as if engaged in calculation.

'Why, I guess I'm nineteen, Doc. I'll be twenty next birthday.'

Looking at the grey-haired man before me, I had an impulse for which I have never forgiven myself – it was, or would have been, the height of cruelty had there been any possibility of Jimmie's remembering it.

'Here,' I said, and thrust a mirror toward him. 'Look in the mirror and tell me what you see. Is that a nineteen-year-old looking out from the mirror?'

He suddenly turned ashen and gripped the sides of the chair. 'Jesus Christ,' he whispered. 'Christ, what's going on? What's happened to me? Is this a nightmare? Am I crazy? Is this a joke?' – and he became frantic, panicked.

'It's okay, Jimmie,' I said soothingly. 'It's just a mistake. Nothing to worry about. Hey!' I took him to the window. 'Isn't this a lovely spring day. See the kids there playing baseball?' He regained his colour and started to smile, and I stole away, taking the hateful mirror with me.

Two minutes later I re-entered the room. Jimmie was still standing by the window, gazing with pleasure at the kids playing baseball below. He wheeled around as I opened the door, and his face assumed a cheery expression.

'Hiya, Doc!' he said. 'Nice morning! You want to talk to me – do I take this chair here?' There was no sign of recognition on his frank, open face.

'Haven't we met before, Mr G.?' I asked casually.

'No, I can't say we have. Quite a beard you got there. I wouldn't forget *you*, Doc!'

'Why do you call me "Doc"?'

'Well, you are a doc, ain't you?'

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'Yes, but if you haven't met me, how do you know what I am?'

'You *talk* like a doc. I can *see* you're a doc.'

'Well, you're right, I am. I'm the neurologist here.'

'Neurologist? Hey, there's something wrong with my nerves? And "here" – where's "here"? What is this place anyhow?'

'I was just going to ask you – where do you think you are?'

'I see these beds, and these patients everywhere. Looks like a sort of hospital to me. But hell, what would I be doing in a hospital – and with all these old people, years older than me. I feel good, I'm strong as a bull. Maybe I *work* here . . . Do I work? What's my job? . . . No, you're shaking your head, I see in your eyes I don't work here. If I don't work here, I've been *put* here. Am I a patient, am I sick and don't know it, Doc? It's crazy, it's scary . . . Is it some sort of joke?'

'You don't know what the matter is? You really don't know? You remember telling me about your childhood, growing up in Connecticut, working as a radio operator on submarines? And how your brother is engaged to a girl from Oregon?'

'Hey, you're right. But I didn't tell you that, I never met you before in my life. You must have read all about me in my chart.'

'Okay,' I said. 'I'll tell you a story. A man went to his doctor complaining of memory lapses. The doctor asked him some routine questions, and then said, "These lapses. What about them?" "What lapses?" the patient replied.'

'So that's my problem,' Jimmie laughed. 'I kinda thought it was. I do find myself forgetting things, once in a while – things that have just happened. The past is clear, though.'

'Will you allow me to examine you, to run over some tests?'

'Sure,' he said genially. 'Whatever you want.'

On intelligence testing he showed excellent ability. He was quick-witted, observant, and logical, and had no difficulty solving complex problems and puzzles – no difficulty, that is, if they could be done quickly. If much time was required, he forgot what he was

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doing. He was quick and good at tic-tac-toe and checkers, and cunning and aggressive – he easily beat me. But he got lost at chess – the moves were too slow.

Homing in on his memory, I found an extreme and extraordinary loss of recent memory – so that whatever was said or shown or done to him was apt to be forgotten in a few seconds' time. Thus I laid out my watch, my tie, and my glasses on the desk, covered them, and asked him to remember these. Then, after a minute's chat, I asked him what I had put under the cover. He remembered none of them – or indeed that I had even asked him to remember. I repeated the test, this time getting him to write down the names of the three objects; again he forgot, and when I showed him the paper with his writing on it he was astounded, and said he had no recollection of writing anything down, though he acknowledged that it was his own writing, and then got a faint 'echo' of the fact that he had written them down.

He sometimes retained faint memories, some dim echo or sense of familiarity. Thus five minutes after I had played tic-tac-toe with him, he recollected that 'some doctor' had played this with him 'a while back' – whether the 'while back' was minutes or months ago he had no idea. He then paused and said, 'It could have been you!' When I said it *was* me, he seemed amused. This faint amusement and indifference were very characteristic, as were the involved cogitations to which he was driven by being so disoriented and lost in time. When I asked Jimmie the time of the year, he would immediately look around for some clue – I was careful to remove the calendar from my desk – and would work out the time of year, roughly, by looking through the window.

It was not, apparently, that he failed to register in memory, but that the memory traces were fugitive in the extreme, and were apt to be effaced within a minute, often less, especially if there were distracting or competing stimuli, while his intellectual and perceptual powers were preserved, and highly superior.

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Impression: probably Korsakov's syndrome, due to alcoholic degeneration of the mammillary bodies.' My note was a strange mixture of facts and observations, carefully noted and itemised, with irrepressible meditations on what such problems might 'mean', in regard to who and what and where this poor man was – whether, indeed, one could speak of an 'existence', given so absolute a privation of memory or continuity.

I kept wondering, in this and later notes – unscientifically – about 'a lost soul', and how one might establish some continuity, some roots, for he was a man without roots, or rooted only in the remote past.

'Only connect' – but how could he connect, and how could we help him to connect? What was life without connection? 'I may venture to affirm,' Hume wrote, 'that we are nothing but a bundle or collection of different sensations, which succeed each other with an inconceivable rapidity, and are in a perpetual flux and movement.' In some sense, he had been reduced to a 'Humean' being – I could not help thinking how fascinated Hume would have been at seeing in Jimmie his own philosophical 'chimaera' incarnate, a gruesome reduction of a man to mere disconnected, incoherent flux and change.

Perhaps I could find advice or help in the medical literature – a literature which, for some reason, was largely Russian, from Korsakov's original thesis (Moscow, 1887) about such cases of memory loss, which are still called 'Korsakov's syndrome', to Luria's *Neuropsychology of Memory* (which appeared in translation only a year after I first saw Jimmie). Korsakov wrote in 1887:

> Memory of recent events is disturbed almost exclusively; recent impressions apparently disappear soonest, whereas impressions of long ago are recalled properly, so that the patient's ingenuity, his sharpness of wit, and his resourcefulness remain largely unaffected.

To Korsakov's brilliant but spare observations, almost a century

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of further research has been added – the richest and deepest, by far, being Luria's. And in Luria's account science became poetry, and the pathos of radical lostness was evoked. 'Gross disturbances of the organization of impressions of events and their sequence in time can always be observed in such patients,' he wrote. 'In consequence, they lose their integral experience of time and begin to live in a world of isolated impressions.' Further, as Luria noted, the eradication of impressions (and their disorder) might spread backward in time – 'in the most serious cases even to relatively distant events.'

Most of Luria's patients, as described in this book, had massive and serious cerebral tumours, which had the same effects as Korsakov's syndrome, but later spread and were often fatal. Luria included no cases of 'simple' Korsakov's syndrome, based on the self-limiting destruction that Korsakov described – neuron destruction, produced by alcohol, in the tiny but crucial mammillary bodies, the rest of the brain being perfectly preserved. And so there was no long-term follow-up of Luria's cases.

I had at first been deeply puzzled, and dubious, even suspicious, about the apparently sharp cut-off in 1945, a point, a date, which was also symbolically so sharp. I wrote in a subsequent note:

> There is a great blank. We do not know what happened then – or subsequently . . . We must fill in these 'missing' years – from his brother, or the navy, or hospitals he has been to . . . Could it be that he sustained some massive trauma at this time, some massive cerebral or emotional trauma in combat, in the war, and that *this* may have affected him ever since? . . . was the war his 'high point', the last time he was really alive, and existence since one long anti-climax?[6]

We did various tests on him (EEG, brain scans), and found no evidence of massive brain damage, although atrophy of the tiny mammillary bodies would not show up on such tests. We received reports from the navy indicating that he had remained in the navy until 1965, and that he was perfectly competent at that time.

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Then we turned up a short nasty report from Bellevue Hospital, dated 1971, saying that he was 'totally disoriented . . . with an advanced organic brain-syndrome, due to alcohol' (cirrhosis had also developed by this time). From Bellevue he was sent to a wretched dump in the Village, a so-called 'nursing home', whence he was rescued – lousy, starving – by our Home in 1975.

We located his brother, whom Jimmie always spoke of as being in accountancy school and engaged to a girl from Oregon. In fact he had married the girl from Oregon, had become a father and grandfather, and been a practising accountant for thirty years.

Where we had hoped for an abundance of information and feeling from his brother, we received a courteous but somewhat meagre letter. It was obvious from reading this – especially reading between the lines – that the brothers had scarcely seen each other since 1943, and gone separate ways, partly through the vicissitudes of location and profession, and partly through deep (though not estranging) differences of temperament. Jimmie, it seemed, had never 'settled down', was 'happy-go-lucky', and 'always a drinker'. The navy, his brother felt, provided a structure, a life, and the real problems started when he left it, in 1965. Without his habitual structure and anchor Jimmie had ceased to work, 'gone to pieces', and started to drink heavily. There had been some memory impairment, of the Korsakov type, in the middle and especially the late Sixties, but not so severe that Jimmie couldn't 'cope' in his nonchalant fashion. But his drinking grew heavier in 1970.

Around Christmas of that year, his brother understood, he had suddenly 'blown his top' and become deliriously excited and confused, and it was at this point that he had been taken into Bellevue. During the next month, the excitement and delirium died down, but he was left with deep and bizarre memory lapses, or 'deficits', to use the medical jargon. His brother had visited him at this time – they had not met for twenty years – and, to his

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horror, Jimmie not only failed to recognise him, but said, 'Stop joking! You're old enough to be my father. My brother's a young man, just going through accountancy school.'

When I received this information, I was more perplexed still: why did Jimmie not remember his later years in the navy, why did he not recall and organise his memories until 1970? I had not heard then that such patients might have a retrograde amnesia (see Postscript). 'I wonder, increasingly,' I wrote at this time, 'whether there is not an element of hysterical or fugal amnesia – whether he is not in flight from something too awful to recall,' and I suggested he be seen by our psychiatrist. Her report was searching and detailed – the examination had included a sodium amytal test, calculated to 'release' any memories which might be repressed. She also attempted to hypnotise Jimmie, in the hope of eliciting memories repressed by hysteria – this tends to work well in cases of hysterical amnesia. But it failed because Jimmie could not be hypnotised, not because of any 'resistance', but because of his extreme amnesia, which caused him to lose track of what the hypnotist was saying. (Dr M. Homonoff, who worked on the amnesia ward at the Boston Veterans Administration hospital, tells me of similar experiences – and of his feeling that this is absolutely characteristic of patients with Korsakov's, as opposed to patients with hysterical amnesia.)

'I have no feeling or evidence,' the psychiatrist wrote, 'of any hysterical or "put-on" deficit. He lacks both the means and the motive to make a façade. His memory deficits are organic and permanent and incorrigible, though it is puzzling they should go back so long.' Since, she felt, he was 'unconcerned . . . manifested no special anxiety . . . constituted no management problem,' there was nothing she could offer, or any therapeutic 'entrance' or 'lever' she could see.

At this point, persuaded that this was, indeed, 'pure' Korsakov's, uncomplicated by other factors, emotional or organic, I wrote to

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Luria and asked his opinion. He spoke in his reply of his patient Bel,[7] whose amnesia had retroactively eradicated ten years. He said he saw no reason why such a retrograde amnesia should not thrust backward decades, or almost a whole lifetime. 'I can only wait for the final amnesia,' Buñuel writes, 'the one that can erase an entire life.' But Jimmie's amnesia, for whatever reason, had erased memory and time back to 1945 – roughly – and then stopped. Occasionally, he would recall something much later, but the recall was fragmentary and dislocated in time. Once, seeing the word 'satellite' in a newspaper headline, he said offhandedly that he'd been involved in a project of satellite tracking while on the ship *Chesapeake Bay*, a memory fragment coming from the early or mid-Sixties. But, for all practical purposes, his cut-off point was during the mid- (or late) Forties, and anything subsequently retrieved was fragmentary, unconnected. This was the case in 1975, and it is still the case now nine years later.

What could we do? What should we do? 'There are no prescriptions,' Luria wrote, 'in a case like this. Do whatever your ingenuity and your heart suggest. There is little or no hope of any recovery in his memory. But a man does not consist of memory alone. He has feeling, will, sensibilities, moral being – matters of which neuropsychology cannot speak. And it is here, beyond the realm of an impersonal psychology, that you may find ways to touch him, and change him. And the circumstances of your work especially allow this, for you work in a Home, which is like a little world, quite different from the clinics and institutions where I work. Neuropsychologically, there is little or nothing you can do; but in the realm of the Individual, there may be much you can do.'

Luria mentioned his patient Kur as manifesting a rare self-awareness, in which hopelessness was mixed with an odd equanimity. 'I have no memory of the present,' Kur would say. 'I do not know what I have just done or from where I have just come . . . I can recall my past very well, but I have no memory of my

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