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 recognize him; or, specifically, would not recognize his face. The moment the student spoke, he would be recognized 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, Mangoo-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 humor 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 be taken 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 your brain.'
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 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 nonexistent 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 around 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 it 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 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-siecle Berlin. A magnificent old Bösendorfer stood in state in the centre of the room, and all around it were music stands, instruments, scores. . . . There were books, there were paintings, but the music was central. Dr P. came in, a little bowed, 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 icosahedron, too.’

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

ation. 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 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.

'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 barney 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.*

No child would have the power to see and speak of 'a contin-

*Later, by accident, he got it on, and exclaimed, 'My God, it's a glove!' This was reminiscent of Kurt Goldstein's patient 'Lanuti', who could only recognise objects by trying to use them in action.
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.*

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 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. Hungry, hungrily, Dr P. started on the cakes. Swiftly, fluidly, 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. ‘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 canvases became nonsense, or nonsense to me—mere chaotic lines and blotches of paint. I commented on this to Mrs P.

‘Ah, 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, yet 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.

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

‘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 about 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...

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

*Thus, as I learned later from his wife, though he could not recognise his students if they sat still, if they were merely ‘images’, he might suddenly recognise them if they moved. ‘That’s Karl,’ he would cry. ‘I know his movements, his body-music.’

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 judgment, though he was prolific in the production of cognitive hypotheses. A judgment is intuitive, personal, comprehensive, and concrete—we ‘see’ how things stand, in relation to one another and oneself. It was precisely this setting, 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 ‘judgment’ in general. For Dr P. had abstract attitude—indeed, nothing else. And it was precisely this, his absurd abstractness of attitude—abused because unleavened with anything else—which rendered him incapable of perceiving identity, or particulars, rendered him incapable of judgment.

Neurology and psychology, curiously, though they talk of everything else, almost never talk of ‘judgment’—and yet it is precisely the downfall of judgment (whether in specific realms, as with Dr P., or more generally, as in patients with Korsakov’s or frontal-lobe syndromes—see below, Chapters Twelve and Thirteen) which constitutes the essence of so many neuropsychological disorders.
Judgment 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, judgment 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 judgment. Judgment must be the first faculty of higher life or 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 resemble 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 arc 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 science which eschews the judgmental, 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 found, quite by chance—looking through the periodical Brain for 1956—a detailed description of an almost comically similar case, similar (indeed identical) neuropsychologically and phenomenologically, though the underlying pathology (an acute head injury) and all personal circumstances were wholly different. The authors speak of their case as ‘unique in the documented history of this disorder’—and evidently experienced, as I did, amazement at their own findings. The interested reader is referred to the original paper, Macrae and Trolle (1956), of which I here subjoin a brief paraphrase, with quotations from the original.

Their patient was a young man of 32, who, following a severe automobile accident, with unconsciousness for three weeks, ‘... complained, exclusively, of an inability to recognise faces, even those of his wife and children’. Not a single face was ‘familiar’ to him, but there were three he could identify: these were workmates: one with an eye-blinking tic, one with a large mole on his cheek, and a third ‘because he was so tall and thin that no one else was like him’. Each of these, Macrae and Trolle bring out, was ‘recognised solely by the single prominent feature mentioned’. In general (like Dr P.) he recognised familiars only by their voices.

He had difficulty even recognising himself in a mirror, as Macrae and Trolle describe in detail: In the early convalescent phase he frequently, especially when shaving, questioned whether the face gazing at him was really his own, and even though he knew
it could physically be none other, on several occasions grimaced or stuck out his tongue "just to make sure." By carefully studying his face in the mirror he slowly began to recognise it, but "not in a flash" as in the past—he relied on the hair and facial outline, and on two small moles on his left cheek."

In general he could not recognise objects ‘at a glance’, but would have to seek out, and guess from, one or two features—occasionally his guesses were absurdly wrong. In particular, the authors note, there was difficulty with the animate.

On the other hand, simple schematic objects—scissors, watch, key, etc.—presented no difficulties. Macrae and Tolle also note that: 'His topographical memory was strange: the seeming paradox existed that he could find his way from home to hospital and around the hospital, but yet could not name streets en route [unlike Dr P., he also had some aphasia] or appear to visualize the topography.'

It was also evident that visual memories of people, even from long before the accident, were severely impaired—there was memory of conduct, or perhaps a mannerism, but not of visual appearance or face. Similarly, it appeared, when he was questioned closely, that he no longer had visual images in his dreams. Thus, as with Dr P., it was not just visual perception, but visual imagination and memory, the fundamental powers of visual representation, which were essentially damaged in this patient—at least those powers insofar as they pertained to the personal, the familiar, the concrete.

A final, humorous point. Where Dr P. might mistake his wife for a hat, Macrae’s patient, also unable to recognise his wife, needed her to identify herself by a visual marker, by ‘... a conspicuous article of clothing, such as a large hat’.

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From “The Man Who Mistook His Wife for a Hat” by Oliver Sacks.

2

The Lost Mariner*

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

*After writing and publishing this history I embarked with Dr Elkhonon Goldberg—a pupil of Luria and editor of the original (Russian) edition of The Neuropsychology of Memory—on a close and systematic neuropsychological study of this patient. Dr Goldberg has presented some of the preliminary findings at conferences, and we hope in due course to publish a full account. A deeply moving and extraordinary film about a patient with a profound amnesia (Prisoner of Consciousness), made by Dr Jonathan Miller, has just been shown in England (September 1986). A film has also been made (by Hilary Lawson) with a prosopagnosic patient (with many similarities to Dr P.). Such films are crucial to assist the imagination: ‘What can be shown cannot be said.’
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 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 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?’
‘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 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.
and drew the periodic table—but omitted the transuranic elements.

‘Is that complete?’ I asked when he’d finished.

‘It’s complete and up-to-date, sir, as far as I know.’

‘You wouldn’t know any elements beyond uranium?’

‘You kidding? There’s ninety-two elements, and uranium’s the last.’

I paused and flipped through a National Geographic on the table. ‘Tell me the planets,’ I said, ‘and something about them.’ Unhesitatingly, confidently, he gave me the planets—their names, their discovery, their distance from the sun, their estimated mass, character, and gravity.

‘What is this?’ I asked, showing him a photo in the magazine I was holding.

‘It’s the moon,’ he replied.

‘No, it’s not,’ I answered. ‘It’s a picture of the earth taken from the moon.’

‘Doc, you’re kidding! Someone would’ve had to get a camera up there!’

‘Naturally.’

‘Hell! You’re joking—how the hell would you do that?’

Unless he was a consummate actor, a fraud simulating an astonishment he did not feel, this was an utterly convincing demonstration that he was still in the past. His words, his feelings, his innocent wonder, his struggle to make sense of what he saw, were precisely those of an intelligent young man in the forties faced with the future, with what had not yet happened, and what was scarcely imaginable. ‘This more than anything else,’ I wrote in my notes, ‘persuades me that his cut-off around 1945 is genuine . . . What I showed him, and told him, produced the authentic amazement which it would have done in an intelligent young man of the pre-Sputnik era.’

I found another photo in the magazine and pushed it over to him.

‘That’s an aircraft carrier,’ he said. ‘Real ultramodern design. I never saw one quite like that.’

‘What’s it called?’ I asked.

He glanced down, looked baffled, and said, ‘The Nimitz!’

‘Something the matter?’

‘The hell there is!’ he replied hotly. ‘I know ‘em all by name, and I don’t know a Nimitz . . . Of course there’s an Admiral Nimitz, but I never heard they named a carrier after him.’

Angrily he threw the magazine down.

He was becoming fatigued, and somewhat irritable and anxious, under the continuing pressure of anomaly and contradiction, and their fearful implications, to which he could not be entirely oblivious. I had already, unthinkingly, pushed him into panic, and felt it was time to end our session. We wandered over to the window again, and looked down at the sunlit baseball diamond; as he looked at his face relaxed, he forgot the Nimitz, the satellite photo, the other horrors and hints, and became absorbed in the game below. Then, as a savoury smell drifted up from the dining room, he smacked his lips, said ‘Lunch!’, smiled, and took his leave.

And myself was wrung with emotion—it was heartbreaking, it was absurd, it was deeply perplexing, to think of his life lost in limbo, dissolving.

‘He is, as it were,’ I wrote in my notes, ‘isolated in a single moment of being, with a moat or lacuna of forgetting all round him . . . He is man without a past (or future), stuck in a constantly changing, meaningless moment.’ And then, more prosaically, ‘The remainder of the neurological examination is entirely normal. Impression: probably Korsakov’s syndrome, due to alcoholic degeneration of the mamillary 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 'chimera' 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 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. ‘Cross 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?*

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.

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

*In his fascinating oral history The Good War (1985) Studs Terkel transcribes countless stories of men and women, especially fighting men, who felt World War II was intensely real—by far the most real and significant time of their lives—everything since as pallid in comparison. Such men tend to dwell on the war and to relive its battles, comradeship, moral certainties and intensity. But this dwelling on the past and relative hebetude towards the present—this emotional dulling of current feeling and memory—is nothing like Jimmie’s organic amnesia. I recently had occasion to discuss the question with Terkel. ‘I’ve met thousands of men,’ he told me, ‘who feel they’ve just been “marking time” since ’45—but I never met anyone who, whom time terminated, like your amnesiac Jimmie.’
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 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 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 hypnotize 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 hypnotized, 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 Luria and asked his opinion. He spoke in his reply of his patient Bel,* 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 re-

tireved 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 present.’ When asked whether he had ever seen the person testing him, he said, ‘I cannot say yes or no, I can neither affirm nor deny that I have seen you.’ This was sometimes the case with Jimmie; and, like Kur, who stayed many months in the same hospital, Jimmie began to form a sense of familiarity; he slowly learned his way around the home—the whereabouts of the dining room, his own room, the elevators, the stairs, and in some sense recognised some of the staff, although he confused them, and perhaps had to do so, with people from the past. He soon became fond of the nursing sister in the Home; he recognised her voice, her footfalls, immediately, but would always say that she had been a fellow pupil at his high school, and was greatly surprised when I addressed her as ‘Sister’.

‘Gee!’ he exclaimed, ‘the damnedest things happen. I’d never have guessed you’d become a religious, Sister!’

Since he’s been at our Home—that is, since early 1975—Jimmie has never been able to identify anyone in it consistently. The only person he truly recognises is his brother, whenever he visits from Oregon. These meetings are deeply emotional and moving to observe—the only truly emotional meetings Jimmie has. He loves his brother, he recognises him, but he cannot understand why he looks so old: ‘Guess some people age fast,’ he says. Actually his brother looks much younger than his age, and has the sort of face and build that change little with the years. These are true meetings, Jimmie’s only connection of past and present, yet they do nothing to provide any sense of history or continuity. If anything they emphasise—at least to his brother, and to others who see them together—that Jimmie still lives, is fossilised, in the past.

All of us, at first, had high hopes of helping Jimmie—he was so personable, so likable, so quick and intelligent, it was difficult to believe that he might be beyond help. But none of us had ever encountered, even imagined, such a power of amnesia, the possibility of a pit into which everything, every experience, every event, would fathomlessly drop, a bottomless memory-hole that would engulf the whole world.

I suggested, when I first saw him, that he should keep a diary, and be encouraged to keep notes every day of his experiences, his feelings, thoughts, memories, reflections. These attempts were foiled, at first, by his continually losing the diary: it had to be attached to him—somehow. But this too failed to work: he dutifully kept a brief daily notebook but could not recognise his earlier entries in it. He does recognise his own writing, and style, and is always astounded to find that he wrote something the day before.

Astounded—and indifferent—for he was a man who, in effect, had no ‘day before’. His entries remained unconnected and unconnecting and had no power to provide any sense of time or continuity. Moreover, they were trivial—‘Eggs for breakfast’, ‘Watched ballgame on TV’—and never touched the depths. But were there depths in this unmemoried man, depths of an abiding feeling and thinking, or had he been reduced to a sort of Humane drive, a mere succession of unrelated impressions and events?

Jimmie both was and wasn’t aware of this deep, tragic loss in himself, loss of himself. (If a man has lost a leg or an eye, he knows he has lost a leg or an eye; but if he has lost a self—
himself—he cannot know it, because he is no longer there to know it.) Therefore I could not question him intellectually about such matters.

He had originally professed bewilderment at finding himself amid patients, when, as he said, he himself didn’t feel ill. But what, we wondered, did he feel? He was strongly built and fit, he had a sort of animal strength and energy, but also a strange inertia, passivity, and (as everyone remarked) ‘unconcern’; he gave all of us an overwhelming sense of ‘something missing,’ although this, if he realised it, was itself accepted with an odd ‘unconcern.’ One day I asked him not about his memory, or past, but about the simplest and most elemental feelings of all:

‘How do you feel?’

‘How do I feel,’ he repeated, and scratched his head. ‘I cannot say I feel ill. But I cannot say I feel well. I cannot say I feel anything at all.’

‘Are you miserable?’ I continued.

‘Can’t say I am.’

‘Do you enjoy life?’

‘I can’t say I do . . .’

I hesitated, fearing that I was going too far, that I might be stripping a man down to some hidden, unacknowledgeable, unbearable despair.

‘You don’t enjoy life,’ I repeated, hesitating somewhat. ‘How then do you feel about life?’

‘I can’t say that I feel anything at all.’

‘You feel alive though?’

‘Feel alive? Not really. I haven’t felt alive for a very long time.’

His face wore a look of infinite sadness and resignation.

Later, having noted his aptitude for, and pleasure in, quick games and puzzles, and their power to ‘hold’ him, at least while they lasted, and to allow, for a while, a sense of companionship and competition—he had not complained of loneliness, but he looked so alone; he never expressed sadness, but he looked so sad—I suggested he be brought into our recreation programs at the Home. This worked better—better than the diary. He would become keenly and briefly involved in games, but soon they ceased
to offer any challenge: he solved all the puzzles, and could solve them easily; and he was far better and sharper than anyone else at games. And as he found this out, he grew fretful and restless again, and wandered the corridors, uneasy and bored and with a sense of indignity—games and puzzles were for children, a diversion. Clearly, passionately, he wanted something to do: he wanted to do, to be, to feel—and could not; he wanted sense, he wanted purpose—in Freud’s words, ‘Work and Love’.

Could he do ‘ordinary’ work? He had ‘gone to pieces’, his brother said, when he ceased to work in 1965. He had two striking skills—Morse code and touch-typing. We could not use Morse, unless we invented a use; but good typing we could use, if he could recover his old skill—and this would be real work, not just a game. Jimmie soon did recover his old skill and came to type very quickly—he could not do it slowly—and found in this some of the challenge and satisfaction of a job. But still this was superficial tapping and typing; it was trivial, it did not reach to the depths. And what he typed, he typed mechanically—he could not hold the thought—the short sentences following one another in a meaningless order.

One tended to speak of him, instinctively, as a spiritual casualty—a ‘lost soul’: was it possible that he had really been ‘de-souled’ by a disease? ‘Do you think he has a soul?’ I once asked the Sisters. They were outraged by my question, but could see why I asked it. ‘Watch Jimmie in chapel,’ they said, ‘and judge for yourself.’

I did, and I was moved, profoundly moved and impressed, because I saw here an intensity and steadiness of attention and concentration that I had never seen before in him or conceived him capable of. I watched him kneel and take the Sacrament on his tongue, and could not doubt the fullness and totality of Communion, the perfect alignment of his spirit with the spirit of the Mass. Fully, intensely, quietly, in the quietude of absolute concentration and attention, he entered and partook of the Holy Communion. He was wholly held, absorbed, by a feeling. There was no forgetting, no Korsakov’s then, nor did it seem possible or imaginable that there should be; for he was no longer at the mercy
of a faulty and fallible mechanism—that of meaningless sequences and memory traces—but was absorbed in an act, an act of his whole being, which carried feeling and meaning in an organic continuity and unity, a continuity and unity so seamless it could not permit any break.

Clearly Jimmie found himself, found continuity and reality, in the absoluteness of spiritual attention and act. The Sisters were right—he did find his soul here. And so was Luria, whose words now came back to me: 'A man does not consist of memory alone. He has feeling, will, sensibility, moral being... It is here... you may touch him, and see a profound change.' Memory, mental activity, mind alone, could not hold him; but moral attention and action could hold him completely.

But perhaps 'moral' was too narrow a word—for the aesthetic and dramatic were equally involved. Seeing Jim in the chapel opened my eyes to other realms where the soul is called on, and held, and stilled, in attention and communion. The same depth of absorption and attention was to be seen in relation to music and art: he had no difficulty, I noticed, 'following' music or simple dramas, for every moment in music and art refers to, contains, other moments. He liked gardening, and had taken over some of the work in our garden. At first he greeted the garden each day as new, but for some reason this had become more familiar to him than the inside of the Home. He almost never got lost or disoriented in the garden now; he patterned it, I think, on loved and remembered gardens from his youth in Connecticut.

Jimmie, who was so lost in extensional 'spatial' time, was perfectly organised in Bergsonian 'intentional' time; what was fugitive, unsustainable, as formal structure, was perfectly stable, perfectly held, as art or will. Moreover, there was something that endured and survived. If Jimmie was briefly 'held' by a task or puzzle or game or calculation, held in the purely mental challenge of these, he would fall apart as soon as they were done, into the abyss of his nothingness, his amnesia. But if he was held in emotional and spiritual attention—in the contemplation of nature or art, in listening to music, in taking part in the Mass in chapel—the attention, its 'mood', its quietude, would persist for a while, and there would be in him a pensiveness and peace we rarely, if ever, saw during the rest of his life at the Home.

I have known Jimmie now for nine years—and neuropsychologically, he has not changed in the least. He still has the severest, most devastating Korsakov's, cannot remember isolated items for more than a few seconds, and has a dense amnesia going back to 1945. But humanly, spiritually, he is at times a different man altogether—no longer fluttering, restless, bored, and lost, but deeply attentive to the beauty and soul of the world, rich in all the Kierkegaardian categories—and aesthetic, the moral, the religious, the dramatic. I had wondered, when I first met him, if he was not condemned to a sort of 'Humean' froth, a meaningless fluttering on the surface of life, and whether there was any way of transcending the incoherence of his Humean disease. Empirical science told me there was not—but empirical science, empiricism, takes no account of the soul, no account of what constitutes and determines personal being. Perhaps there is a philosophical as well as a clinical lesson here: that in Korsakov's, or dementia, or other such catastrophes, however great the organic damage and Humean dissolution, there remains the undiminished possibility of reintegration by art, by communion, by touching the human spirit and this can be preserved in what seems at first a hopeless state of neurological devastation.

Postscript

I know now that retrograde amnesia, to some degree, is very common, if not universal, in cases of Korsakov's. The classical Korsakov's syndrome—a profound and permanent, but 'pure', devastation of memory caused by alcoholic destruction of the mammillary bodies—is rare, even among very heavy drinkers. One may, of course, see Korsakov's syndrome with other pathologies, as in Luria's patients with tumours. A particularly fascinating case of an acute (and mercifully transient) Korsakov's syndrome has been well described only very recently in the so-called Transient Global Amnesia (TGA) which may occur with migraines, head injuries or impaired blood supply to the brain. Here, for a few minutes or hours, a severe and
Singular amnesia may occur, even though the patient may continue to drive a car, or, perhaps, to carry on medical or editorial duties, in a mechanical way. But under this fluency lies a profound amnesia—every sentence uttered being forgotten as soon as it is said, everything forgotten within a few minutes of being seen, though long-established memories and routines may be perfectly preserved. (Some remarkable videotapes of patients during TGAs have recently [1986] been made by Dr John Hodges, of Oxford.)

Further, there may be a profound retrograde amnesia in such cases. My colleague Dr Leon Protass tells me of a case seen by him recently, in which a highly intelligent man was unable for some hours to remember his wife or children, to remember that he had a wife or children. In effect, he lost thirty years of his life—though, fortunately, for only a few hours. Recovery from such attacks is prompt and complete—yet they are, in a sense, the most horrifying of 'little strokes' in their power absolutely to annul or obliterate decades of richly lived, richly achieving, richly memoried life. The horror, typically, is only felt by others—the patient, unaware, amnesiac for his amnesia, may continue what he is doing, quite unconcerned, and only discover later that he lost not only a day (as is common with ordinary alcoholic 'blackouts'), but half a lifetime, and never knew it. The fact that one can lose the greater part of a lifetime has peculiar, uncanny horror.

In adulthood, life, higher life, may be brought to a premature end by strokes, senility, brain injuries, etc., but there usually remains the consciousness of life lived, of one's past. This is usually felt as a sort of compensation: 'At least I lived fully, tasting life to the full, before I was brain-injured, stricken, etc.' This sense of 'the life lived before', which may be either a consolation or a torment, is precisely what is taken away in retrograde amnesia. The 'final amnesia, the one that can erase an entire life' that Burgher speaks of may occur, perhaps, in a terminal dementia, but not, in my experience, suddenly, in consequence of a stroke. But there is a different, yet comparable, sort of amnesia, which can occur suddenly—different in that it is not 'global' but 'modality-specific'.

Thus, in one patient under my care, a sudden thrombosis in the posterior circulation of the brain caused the immediate death of the visual parts of the brain. Forthwith this patient became completely blind—but did not know it. He looked blind—but he made no complaints. Questioning and testing showed, beyond doubt, that not only was he centrally or 'cortically' blind, but he had lost all visual images and memories, lost them totally—yet had no sense of any loss. Indeed, he had lost the very idea of seeing—and was not only unable to describe anything visually, but bewildered when I used words such as 'seeing' and 'light.' He had become, in essence, a non-visual being. His entire lifetime of seeing, of visuality, had, in effect, been stolen. His whole visual life had, indeed, been erased—and erased permanently in the instant of his stroke. Such a visual amnesia, and (so to speak) blindness to the blindness, amnesia for the amnesia, is in effect a 'total' Korsakov's, confined to visuality.

A still more limited, but none the less total, amnesia may be displayed with regard to particular forms of perception, as in the last chapter, 'The Man Who Mistook His Wife for a Hat'. There there was an absolute 'prosopagnosia', or agnosia for faces. This patient was not only unable to recognise faces, but unable to imagine or remember any faces—he had indeed lost the very idea of a 'face', as my more afflicted patient had lost the very ideas of 'seeing' or 'light.' Such syndromes were described by Anton in the 1890s. But the implication of these syndromes—Korsakov's and Anton's—what they entail and must entail for the world, the lives, the identities of affected patients, has been scarcely touched on even to this day.

In Jimmie's case, we had sometimes wondered how he might respond if taken back to his home town—in effect, to his pre-amnesia days—but the little town in Connecticut had become a booming city with the years. Later I did have occasion to find out what might happen in such circumstances, though this was with another patient with Korsakov's, Stephen R., who had become acutely ill in 1980 and whose retrograde amnesia went back only two years or so. With this patient, who also had severe seizures, spasticity and other problems necessitating in-patient care, rare weekend visits to his home revealed
The aspects of things that are most important for us are hidden because of their simplicity and familiarity. (One is unable to notice something because it is always before one's eyes.) The real foundations of his enquiry do not strike a man at all.

—Wittgenstein

What Wittgenstein writes here, of epistemology, might apply to aspects of one's physiology and psychology—especially in regard to what Sherrington once called 'our secret sense, our sixth sense—that continuous but unconscious sensory flow from the movable parts of our body (muscles, tendons, joints), by which their position and tone and motion are continually monitored and adjusted, but in a way which is hidden from us because it is automatic and unconscious.

Our other senses—the five senses—are open and obvious; but this—our hidden sense—had to be discovered, as it was, by Sherrington, in the 1890s. He named it 'proprioception', to distinguish it from 'exteroreception' and 'interception', and, additionally, because of its indispensability for our sense of ourselves; for it is only by courtesy of proprioception, so to speak, that we feel our bodies as proper to us, as our 'property', as our own. (Sherrington 1906, 1940.)

What is more important for us, at an elemental level, than the control, the owning and operation, of our own physical selves? And yet it is so automatic, so familiar, we never give it a thought.

Jonathan Miller produced a beautiful television series, The Body
The President's Speech

What was going on? A roar of laughter from the aphasia ward, just as the President's speech was coming on, and they had all been so eager to hear the President speaking . . .

There he was, the old Charmer, the Actor, with his practised rhetoric, his histrionisms, his emotional appeal—and all the patients were convulsed with laughter. Well, not all: some looked bewildered, some looked outraged, one or two looked apprehensive, but most looked amused. The President was, as always, moving—but he was moving them, apparently, mainly to laughter. What could they be thinking? Were they failing to understand him? Or did they, perhaps, understand him all too well?

It was often said of these patients, who though intelligent had the severest receptive or global aphasia, rendering them incapable of understanding words as such, that they none the less understood most of what was said to them. Their friends, their relatives, the nurses who knew them well, could hardly believe, sometimes, that they were aphasic.

This was because, when addressed naturally, they grasped some or most of the meaning. And one does speak ‘naturally’, naturally.

Thus, to demonstrate their aphasia, one had to go to extraordinary lengths, as a neurologist, to speak and behave un-naturally, to remove all the extraverbal cues—tone of voice, intonation, suggestive emphasis or inflection, as well as all visual cues (one’s expressions, one’s gestures, one’s entire, largely unconscious, personal repertoire and posture): one had to remove all of this (which might involve total concealment of one’s person, and total depersonalisation of one’s voice, even to using a computerised voice synthesiser) in order to reduce speech to pure words, speech totally devoid of what Frege called ‘tone-colour’ (Klangfarben) or ‘evocation’. With the most sensitive patients, it was only with such a grossly artificial, mechanical speech—somewhat like that of the computers in Star Trek—that one could be wholly sure of their aphasia.

Why all this? Because speech—natural speech—does not consist of words alone, nor (as Hughlings Jackson thought) ‘propositions’ alone. It consists of utterance—an uttering-forth of one’s whole meaning with one’s whole being—the understanding of which involves infinitely more than mere word-recognition. And this was the clue to apsiasics’ understanding, even when they might be wholly uncomprehending of words as such. For though the words, the verbal constructions, *per se*, might convey nothing, spoken language is normally suffused with ‘tone’, embedded in an expressiveness which transcends the verbal—and it is precisely this expressiveness, so deep, so various, so complex, so subtle, which is perfectly preserved in aphasia, though understanding of words be destroyed. Preserved—and often more: preternaturally enhanced . . .

This too becomes clear—often in the most striking, or comic, or dramatic way—to all those who work or live closely with apsiasics: their families or friends or nurses or doctors. At first, perhaps, we see nothing much the matter; and then we see that there has been a great change, almost an inversion, in their understanding of speech. Something has gone, has been devastated, it is true—but something has come, in its stead, has been immensely enhanced, so that—at least with emotionally-laden utterance—the meaning may be fully grasped even when every word is missed. This, in our species *Homo loquens*, seems almost an inversion of the usual order of things: an inversion, and perhaps a reversion too, to something more primitive and elemental. And this perhaps is why Hughlings Jackson compared apsiasics to dogs (a comparison that might outrage both!) though when he did this he was chiefly thinking of their linguistic incompertences, rather than their remarkable, and almost infallible, sensitivity to ‘tone’ and feeling. Henry Head, more sensitive in this regard, speaks of ‘feeling-tone’
in his (1926) treatise on aphasia, and stresses how it is preserved, and often enhanced, in aphasiacs.*

Thus the feeling I sometimes have—which all of us who work closely with aphasiacs have—that one cannot lie to an aphasic. He cannot grasp your words, and so cannot be deceived by them; but what he grasps he grasps with infallible precision, namely the expression that goes with the words, that total, spontaneous, involuntary expressiveness which can never be simulated or faked, as words alone can, all too easily . . .

We recognise this with dogs, and often use them for this purpose—to pick up falsehood, or malice, or equivocal intentions, to tell us who can be trusted, who is integral, who makes sense, when we—so susceptible to words—cannot trust our own instincts.

And what dogs can do here, aphasiacs do too, and at a human and immeasurably superior level. 'One can lie with the mouth,' Nietzsche writes, 'but with the accompanying grimace one nevertheless tells the truth.' To such a grimace, to any falsity or impropriety in bodily appearance or posture, aphasiacs are preternaturally sensitive. And if they cannot see one—this is especially true of our blind aphasiacs—they have an infallible ear for every vocal nuance, the tone, the rhythm, the cadences, the music, the subtlest modulations, inflections, intonations, which can give—or remove—verisimilitude to or from a man's voice.

In this, then, lies their power of understanding—understanding, without words, what is authentic or inauthentic. Thus it was the grimaces, the histronisms, the false gestures and, above all, the false tones and cadences of the voice, which rang false for these wordless but immensely sensitive patients. It was to these (for them) most glaring, even grotesque, incongruities and improprieties that my aphasic patients responded, undeceived and undeceivable by words.

This is why they laughed at the President's speech.

If one cannot lie to an aphasic, in view of his special sensitivity to expression and 'tone', how is it, we might ask, with patients—if there are such—who lack any sense of expression and 'tone', while preserving, unchanged, their comprehension for words: patients of an exactly opposite kind? We have a number of such patients, also on the aphasia ward, although, technically, they do not have aphasia, but, instead, a form of agnosia, in particular a so-called 'tonal' agnosia. For such patients, typically, the expressive qualities of voices disappear—their tone, their timbre, their feeling, their entire character—while words (and grammatical constructions) are perfectly understood. Such tonal agnosias (or aprosodias) are associated with disorders of the right temporal lobe of the brain, whereas the aphasiacs go with disorders of the left temporal lobe.

Among the patients with tonal agnosia on our aphasia ward who also listened to the President's speech was Emily D., with a glioma in her right temporal lobe. A former English teacher, and poetess of some repute, with an exceptional feeling for language, and strong powers of analysis and expression, Emily D. was able to articulate the opposite situation—how the President's speech sounded to someone with tonal agnosia. Emily D. could no longer tell if a voice was angry, cheerful, sad—whatever. Since voices now lacked expression, she had to look at people's faces, their postures and movements when they talked, and found herself doing so with a care, an intensity, she had never shown before. But this, it so happened, was also limited, because she had a malignant glaucoma, and was rapidly losing her sight too.

What she then found she had to do was to pay extreme attention to exactness of words and word use, and to insist that those around her did just the same. She could less and less follow loose speech or slang—speech of an allusive or emotional kind—and more and more required of her interlocutors that they speak prose—'proper
words in proper places’. Prose, she found, might compensate, in some degree, for lack of perceived tone or feeling.

In this way she was able to preserve, even enhance, the use of ‘expressive’ speech—in which the meaning was wholly given by the apt choice and reference of words—despite being more and more lost with ‘evocative’ speech (where meaning is wholly given in the use and sense of tone).

Emily D. also listened, stony-faced, to the President’s speech, bringing to it a strange mixture of enhanced and defective perceptions—precisely the opposite mixture to those of our aphasics. It did not move her—no speech now moved her—and all that was evocative, genuine or false completely passed her by. Deprived of emotional reaction, was she then (like the rest of us) transported or taken in? By no means. ‘He is not cogent,’ she said. ‘He does not speak good prose. His word-use is improper. Either he is brain-damaged, or he has something to conceal.’ Thus the President’s speech did not work for Emily D. either, due to her enhanced sense of formal language use, propriety as prose, any more than it worked for our aphasics, with their word-deafness but enhanced sense of tone.

Here then was the paradox of the President’s speech. We normals—aided, doubtless, by our wish to be fooled, were indeed well and truly fooled (‘Populus vult decipi, ergo decipiatur’). And so cunningly was deceptive word-use combined with deceptive tone, that only the brain-damaged remained intact, undeceived.