CASE M-08

A Recovered File of the Institute of Techno-thology, with Marginalia

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A Note on Provenance

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The reproduction includes the Division's institutional record of the case, the contemporaneous notes kept by the subject's spouse across the active management period, the marginalia subsequently annotated by the subject onto a copy of the case file, the Reviewer's post-resolution report, and a document of unknown provenance found inserted into the file after its recovery.

Names of personnel have been preserved as they appeared in the recovered file (by initial only, per the Division's standard documentation practice). The subject is designated throughout as M-08. The subject's spouse is designated throughout as S—.

The case file's status at the time of its sealing was Closed Without Disposition.

I. HYPOTHESIS AND PROTOCOL

I.A — Background

The Cognitive Substrates Division of the Institute of Techno-Thology was established in the eleventh year of Institutional operation under the founding directive to investigate the substrate-level architecture of human cognitive operation. The Division's research mandate, as ratified by the Standing Committee on Foundational Research and renewed without amendment in each subsequent fiscal cycle, is the following: to determine, through controlled investigation, whether the architectural defaults of human cognition admit of modification, and if so, what the consequences of such modification might be for the apparatus undergoing it.

The Division's accumulated bench work over the period preceding the M-Series authorization has established, to a level of confidence the Division considers sufficient for further hypothesis development, the following positions.

The human apparatus, under ordinary operating conditions, runs a single-register cognitive system in which the production of coherence and the experience of perception are entangled at a structural level. This entanglement is not incidental. It is the operational mechanism by which the apparatus converts raw sensory and proprioceptive input into the categorized experience the apparatus reports as reality. The conversion is continuous, automatic, and occurs at a layer beneath the apparatus's own observational access. The apparatus does not have visibility into the conversion. The apparatus has visibility only into the product of the conversion.

This access pattern is universal across surveyed populations. The Division's Substrate Mapping Initiative, conducted over a seven-year period across multiple research sites and involving subject populations totaling in excess of four thousand individuals, has not identified any spontaneous case of an apparatus operating with structural visibility into its own coherence-production operations. The literature outside the Institute reports anecdotal cases of such visibility — typically described in contemplative or pathological contexts — but the Division's attempts to verify these reports under controlled conditions have not produced confirmatory data. The Division's conclusion, formally entered into the research base at the conclusion of the Mapping Initiative, is that the

single-register access pattern is the architectural default of the species and not an incidental feature of any subpopulation.

The Division's standing research interest, formulated in the wake of the Mapping Initiative's conclusion, is whether a second register — designated in Institute correspondence as the meta-register — can be made accessible to a subject through controlled intervention. An apparatus running both registers simultaneously would retain ordinary functional cognition while also possessing structural visibility into the operations that produce ordinary cognition. The Division has hypothesized that such a bilateral apparatus would be capable of producing reports of sufficient resolution to advance the field beyond its current dependence on inferential reconstruction.

The bilateral apparatus, if realized, would constitute the first instrument in the Division's history capable of evaluating its own substrate. The implications of such an instrument exceed the immediate research mandate and are addressed in Appendix C of the M-Series prospectus, which lies outside the scope of this case file.

I.B — Cognitive-Only Protocols and Their Limitations

The Division's first programmatic attempt to generate the bilateral state was the C-Series, authorized in the seventh year of Division operation. The C-Series tested cognitive-only protocols on a total of forty-three subjects across seven discrete sub-protocols. The protocols included sustained meditation regimens of varying tradition and duration (sub-protocols C-1, C-2, C-3); paradox saturation under controlled instructional conditions (C-4); prolonged sensory and social isolation (C-5); controlled fasting with cognitive monitoring (C-6); and combination protocols drawing from elements of the preceding (C-7).

The C-Series produced uniformly negative results with respect to the primary hypothesis. No subject in any sub-protocol produced reports consistent with stable bilateral access. Subjects in the meditation sub-protocols (C-1 through C-3) reported phenomenological experiences that the subjects themselves described in language partially congruent with bilateral access; however, on detailed evaluation, these reports were determined to be the apparatus operating within single-register cognition while generating descriptions of its own operation. The descriptions were second-register descriptions rather than second-register access. The

distinction is subtle, and the Division acknowledges that the determination required several rounds of refined interrogation. The Division's current position is that what these subjects experienced was the apparatus's coherence-production engine operating on the apparatus itself — generating a categorized experience of insight into one's own cognition — without the operation thereby acquiring visibility into its own production.

The paradox saturation sub-protocol (C-4) produced no positive results in any subject. The fasting sub-protocol (C-6) produced phenomenological reports of altered cognition that, on evaluation, resolved into known metabolic-cognitive effects without indication of bilateral access. The isolation sub-protocol (C-5) produced three subjects who could not be evaluated because the subjects had destabilized into clinical states (designated acute prolonged isolation reactions) that precluded post-protocol interrogation. The combination sub-protocol (C-7) replicated the pattern of the constituent sub-protocols without enhancement.

The C-Series was closed at the end of its fifth fiscal year. The Division's formal conclusion, entered into the research base at closure, was that cognitive-only protocols, however refined or extended, do not produce stable bilateral access in any subject thus far investigated, and that the failure pattern across forty-three subjects is consistent enough to warrant the abandonment of cognitive-only protocols as a generative approach to the bilateral state.

The C-Series closure prompted the Division's reconsideration of its theoretical model. The model under which the C-Series had been conducted assumed that the bilateral state, if accessible, would be accessible through cognitive practices, on the implicit theory that the access barrier was a cognitive one — that the apparatus, with appropriate training, could learn to attend to its own coherence-production operations. The C-Series demonstrated that this implicit theory was inadequate. The access barrier, whatever it is, is not removable by cognitive intervention alone.

The Division's revised model, adopted at the conclusion of the C-Series and ratified by the Standing Committee in the following fiscal cycle, posits that the entanglement between coherence-production and perception is enforced at a layer beneath the cognitive — specifically, at the autonomic substrate that regulates the apparatus's baseline operating parameters. Under this revised model, the bilateral state, if accessible at all, would require

intervention at the autonomic substrate. The intervention would need to be capable of producing partial decoupling of the substrate's regulatory functions in a manner that left the cognitive layer intact and functional, while opening a window during which the substrate's normally-invisible operations became visible to the apparatus inhabiting them.

The revised model was the theoretical basis for the M-Series.

I.C — Authorization of the M-Series

The M-Series prospectus was developed by the Division's Senior Research Council over a period of fourteen months following the C-Series closure. The prospectus was submitted to the Standing Committee on Foundational Research in the spring of the year designated F+9 in Institute internal correspondence. The Standing Committee reviewed the prospectus over a period of six months and authorized the M-Series with two minor modifications and the following standing reservation: that any subject participating in the M-Series be informed, to the extent compatible with informed consent, that the procedures involved are experimental, that no comparable procedures have been previously conducted, and that the Division cannot specify in advance the range of possible outcomes for an individual subject.

The reservation was incorporated into the consent protocol developed by the Division's Subject Relations Office. The consent protocol's adequacy, in retrospect, is one of the questions this case file raises and does not resolve.

The M-Series authorization permitted the Division to conduct a sequence of substrate-level interventions on consenting subjects, with the primary objective of generating bilateral access and the secondary objective of characterizing the recovery profile of subjects who underwent the intervention. The M-Series was authorized for an initial cohort of twelve subjects, with provisions for extension contingent on early-cohort results.

The M-Series ran from F+10 through F+14. The first seven subjects (designated M-01 through M-07) underwent variations of the substrate-level intervention protocol. The variations were authorized for two reasons: first, to test the sensitivity of the bilateral state to procedural specifications; second, to identify the procedural specifications most likely to produce sustained bilateral access without compromising the subject's overall

cognitive function. The results of M-01 through M-07 are summarized in the M-Series Interim Report, appended to this case file as Annex A. For the purposes of this section, the relevant summary is the following: none of M-01 through M-07 produced sustained bilateral access; three of the seven produced no measurable change in cognitive operation; two produced transient phenomenological reports the Division could not characterize; one developed sustained autonomic dysregulation requiring medical intervention and exited the protocol at the subject's request; and one (M-04) developed an acute clinical episode the nature of which is described in the Interim Report and which prompted the Division to refine its subject-screening protocols.

The Division's evaluation of M-01 through M-07, prior to the authorization of M-08, was that the procedural specifications had been progressively refined through the early cohort and that the eighth procedural variation — designated Protocol M-08 — represented the most theoretically promising configuration the Division had developed. The Senior Research Council recommended that M-08 proceed with the eighth procedural variation, and the Standing Committee concurred.

The selection of the individual subject for M-08 is described in Section II of this case file.

I.D — Protocol M-08 Specifications

The Protocol M-08 specifications, as authorized by the Senior Research Council and ratified by the Standing Committee, called for the following sequence.

A primary intervention event consisting of a calibrated cervical-cranial impact of sub-concussive magnitude, designed to produce momentary disruption of the autonomic regulatory network without sustained injury to neural tissue. The impact would be delivered under controlled medical conditions with full real-time monitoring of cardiovascular, respiratory, and neuroelectric parameters. The impact's magnitude would be calibrated to the individual subject's baseline measurements taken during the four-week intake period preceding the intervention.

A recovery monitoring phase of seventy-two to ninety-six hours, during which the Division anticipated the subject's autonomic substrate would undergo partial decoupling followed by gradual re-coupling. The Division's

model predicted that the partial decoupling phase would produce a window of bilateral access lasting approximately the same duration as the decoupling, after which the re-coupling would close the window and return the apparatus to single-register operation, now with retained memory of bilateral access.

A stabilization phase of three to six weeks, during which the subject would gradually re-acclimate to single-register operation while consolidating the memory of bilateral access. The Division anticipated that subjects would experience some degree of cognitive disruption during this phase, but that disruption would be transient and manageable with standard supportive measures.

A consolidation phase of eight to twelve weeks, during which the Division expected the subject to develop stable bilateral access on a voluntary attentional basis — that is, the subject would be able to access the bilateral state when attending to it, without remaining in the bilateral state continuously. The consolidation phase was the period during which the subject would be transitioning from having had the experience to being a bilateral apparatus. The Division anticipated, on the basis of M-01 through M-07's recovery patterns, that the consolidation phase would be the most demanding for the subject and would require sustained support from the Division's clinical staff.

A long-term follow-up phase of twenty-four months, during which the subject would produce reports of bilateral cognition under varied conditions and the Division would assess the stability of the bilateral state across time and across the subject's various life circumstances.

The Protocol M-08 specifications acknowledged, in their preamble, that the procedure was novel and that the Division could not guarantee outcomes consistent with the model. The preamble specified that deviations from the predicted recovery profile shall be documented in real time and addressed through the Division's adaptive intervention protocols, which are themselves understood to be provisional and subject to modification on the basis of accumulating evidence.

The adaptive intervention protocols, as written and approved, comprised seven standard pharmacological intervention agents, a cognitive scaffolding therapy module, a sensory regulation protocol, and provisions for off-roster experimental combinations developed on a case-specific basis. The Division

considered this complement of adaptive interventions sufficient to address any deviation from the predicted recovery profile within the parameter space the Division's models had explored.

The Division did not consider, in the design phase, the possibility that the deviation might exceed the parameter space the Division's models had explored. The Division did not consider this possibility because the Division did not have a methodology for considering it. The parameter space the Division's models had explored was, by construction, the parameter space the Division knew how to consider. What lay outside that space was, by the same construction, not available to the Division's design process.

This methodological feature, which the Division identified in retrospect during the post-closure review of the M-08 file, is one of the substantive findings of this case. It is not, however, a finding the Division has been able to formally enter into the research base. The reasons for this are addressed in Section XII and in the Reviewer's Memorandum appended to that section.

Marginalia — Section I — In the subject's hand, written across the lower margins and reverse pages of the Section I file copy.

They believed they were doing something they were not capable of measuring. The hypothesis was structurally unfalsifiable. They proceeded anyway.

I am writing this in the margin because the file is the document and the file does not have a category for what I am about to say. The marginalia is the only available format. I have read the section above several times. It is well-composed. It cites itself thoroughly. It establishes a research lineage going back eleven years. By every standard the institution holds itself to, the section is unimpeachable. This is part of what is wrong with it.

The hypothesis is that an apparatus can be made to run on two registers at once. The single register produces ordinary cognition. The second register, if accessible, would produce visibility into the operations that produce ordinary cognition. The Division proposes to generate this second register through intervention at the autonomic substrate.

What the Division does not state, anywhere in the section above, is how the Division proposes to verify that the second register exists in any subject in

whom they believe they have generated it.

The Division cannot run the second register itself. The Division operates at the single-register level. The instruments the Division uses to assess subjects are single-register instruments. The reports the Division solicits from subjects are produced by the subject's cognitive apparatus, which is the same apparatus whose second-register access is being assessed. If the access exists, the apparatus reports from it. If the access does not exist, the apparatus reports from somewhere else. The Division has no way to distinguish between these two kinds of report from outside. The Division can only ask the apparatus.

This is what I mean by structurally unfalsifiable. The hypothesis is constructed in such a way that the predicate of its confirmation — bilateral access — is something only the subject can access, and the means of confirmation — the subject's reports — are produced by the very apparatus whose access status is in question. The Division has built a research program in which the only being capable of evaluating the result is the being whose result is being evaluated. The Division did not see this. The Division could not see this, because seeing it would have required looking at the hypothesis from a position outside the single-register operation, which is exactly the position the M-Series was designed to generate. The Division was designing an experiment to generate a position it would have needed in order to design the experiment.

This is the structural problem at the core of the file. Everything else follows from it.

I will note one thing about the C-Series before the section closes. The Division dismisses the meditation-tradition subjects (C-1 through C-3) on the grounds that their reports were descriptions of bilateral access rather than access itself. The grounds for this distinction are not stated. The Division acknowledges that the determination required several rounds of refined interrogation. What the Division does not acknowledge is what the criterion of distinction was. How does the Division tell a description of bilateral access apart from bilateral access? The Division's answer, implicit in the section above, is that the bilateral-access cases would produce something the description-only cases could not produce. The Division does not say what that something is. The Division could not say, because the Division has never seen it. The Division was deciding in advance that any phenomenological report it received from a C-Series

subject was a description rather than access, on the basis that no C-Series subject had produced the unspecified something that bilateral access was supposed to produce, on the basis that no subject had produced it before, on the basis that the Division had not produced it through any of its protocols. The reasoning is circular. The Division does not see the circle.

I see the circle. I see it now. I did not see it then. The man who signed the consent form did not see it. The man who signed the consent form was a man who believed the Division knew what it was doing. The man I am now is the man who, having undergone the procedure the Division did not know what it was doing about, can read the file and see what the file is. The file is a document of an institution operating at the limit of its self-understanding and not knowing it is operating there. The file is also the document of what happened to me, and what happened to me cannot be read out of the file, because the file did not have a category for what happened. The marginalia is the only place what happened can be partially recorded. The marginalia is not equal to what happened. The marginalia is what I can write now, having survived.

I will continue in the margins of subsequent sections.

— [signature: handwritten initials, illegible]

II. SUBJECT SELECTION

II.A — Selection Criteria

The Protocol M-08 subject selection criteria were developed by the Division's Subject Relations Office in consultation with the Senior Research Council during the fourteen-month prospectus development period preceding the M-Series authorization. The criteria represent a substantial revision of the criteria used in M-01 through M-07, reflecting the Division's accumulated experience with the early-cohort subjects and the procedural refinements introduced at each stage of the early cohort.

The criteria, in summary, were as follows.

Primary criterion: low institutional embeddedness. The Division had observed in M-01 through M-07 that subjects with high institutional embeddedness — those whose lives were structured around participation in formal institutions such as academic, religious, professional, or political organizations — produced post-procedural reports that were difficult to distinguish from the subjects' pre-procedural institutional vocabularies. The Division's interpretation, entered into the Interim Report, was that highly embedded subjects had so thoroughly internalized institutional coherence-architectures that the architectures filled any conceptual space the procedure might have opened, with the result that post-procedural reports defaulted to institutional language regardless of what the subject had actually experienced. The Division concluded that selection should bias toward subjects with low institutional embeddedness, on the theory that such subjects would be more likely to report from whatever had actually occurred rather than from the architectures that had been installed in them. The operational measure of institutional embeddedness used by the Subject Relations Office was a composite score derived from educational attainment, employment tenure, religious participation, formal organizational memberships, and reported political and ideological affiliations.

Secondary criterion: high baseline pattern-recognition density. The Division hypothesized that subjects whose cognitive operation involved unusually high rates of cross-domain pattern detection would be more likely to produce structurally articulate reports of bilateral access, on the theory that the

bilateral state would itself manifest as a form of cross-domain pattern detection at an unusually fundamental level. Pattern-recognition density was measured through a battery of cognitive assessments developed by the Division's Cognitive Profile Unit, with particular emphasis on tasks requiring the rapid identification of structural similarities between superficially dissimilar stimuli.

Tertiary criterion: history of incomplete affiliation with standard coherence-architectures. This criterion overlapped with the primary criterion of low institutional embeddedness but addressed a distinct dimension: not merely the absence of current institutional embeddedness, but a documented history of failure to install into institutional architectures the subject had been exposed to. The Division had observed in M-04 that a subject with apparently low current institutional embeddedness but a history of prior strong affiliations (which the subject had subsequently exited) produced post-procedural reports heavily influenced by residue from the prior affiliations. The Division refined the criterion accordingly: subjects should not merely be currently un-embedded but should exhibit a pattern of having failed to install into the architectures they had encountered, on the theory that such subjects had a structural disposition toward incomplete installation rather than a contingent current state.

Operational measures of this criterion included: enrollment in but non-completion of post-secondary education; multiple short-tenure employment histories without progression through institutional ranks; absence of formal religious membership at any point in the subject's adult life; absence of stable professional identity claims; and the subject's own retrospective characterization of their relationship to the institutions they had encountered.

Quaternary criterion: presence of a stable proximate observer. This criterion was unique to M-08 and was introduced in response to the Senior Research Council's observation, during the prospectus development phase, that the Division's clinical observers were unable to characterize subject behavior over the time scales the recovery profile would require. The Senior Research Council concluded that long-term proximate observers — typically spouses, long-term cohabiting partners, or in some cases adult children — would possess data on the subject's baseline operation that no clinical observer could acquire within the time frame of the Division's involvement. The

Senior Research Council recommended that M-08 subject selection should require the presence of such an observer who would be available for the duration of the recovery period and willing to provide retrospective testimony to the Division on the subject's pre-procedural baseline and post-procedural deviation from that baseline.

The Subject Relations Office implemented this criterion by requiring that candidate subjects be in long-term partnered relationships (defined as cohabitation of seven years or longer) and that the partner be willing to be interviewed by the Subject Relations Office prior to subject acceptance. The Senior Research Council acknowledged in the prospectus that the partner's willingness to participate was not a guarantee of the partner's continued availability through the recovery period, and that the partner would not be a formal subject of the protocol but rather an informal observational resource. The implications of this informal status are addressed in Section XI.

Additional criteria. The Subject Relations Office applied standard medical and psychological screening to candidate subjects to identify and exclude individuals with prior history of dissociative episodes, prior diagnosis of major psychiatric conditions, prior history of significant head injury, or prior history of substance dependence. The screening was conducted by the Division's Medical Liaison Office in cooperation with external clinical consultants and was understood to be a baseline safety filter rather than a positive selection criterion.

II.B — Candidate Pool

The Subject Relations Office identified an initial candidate pool of forty-seven individuals through the Division's standing referral network. The referral network includes prior research participants from the Mapping Initiative, individuals who had self-referred to the Division through its public-facing Inquiry Office, and individuals identified by external clinical consultants as meeting one or more of the Division's research interests.

Of the forty-seven initial candidates, eighteen were excluded on the basis of medical or psychological screening. Of the remaining twenty-nine, twelve were excluded on the basis of insufficient institutional un-embeddedness; their composite institutional embeddedness scores exceeded the Subject Relations Office's threshold. Of the remaining seventeen, six were excluded on the basis of insufficient baseline pattern-recognition density. Of the

remaining eleven, four were excluded on the basis of absence of a qualifying proximate observer or refusal of the proximate observer to participate in the prior interview. Of the remaining seven, three withdrew at various stages of the consent process for reasons specific to their individual circumstances, which are documented in the candidate file annex but are not relevant to the M-08 case file. The remaining four candidates underwent final review by the Senior Research Council.

The Senior Research Council ranked the four final candidates against the M-Series prospectus's full criteria set, including criteria not formally operationalized but considered by the Council during ranking. The Council's ranking placed M-08 in the first position, citing in particular the subject's composite institutional embeddedness score (which fell at the lowest end of the candidate distribution), the subject's pattern-recognition density score (which fell at the upper end), the subject's documented history of incomplete affiliation across multiple institutional contexts (which the Council noted as unusually consistent across the subject's adult life), and the proximate observer's responses during the pre-interview, which the Council characterized as substantive, clear-eyed, and unlikely to introduce coherence-pressure during the recovery period.

The Council recommended M-08 for the eighth procedural variation. The Standing Committee concurred without modification.

II.C — Subject Profile

The following information is reproduced from the Subject Relations Office's final intake summary, dated F+9, fourth quarter.

The subject, designated M-08 for the duration of the case file, was at the time of intake in the fourth decade of life. The subject had been born and raised in a region of the country characterized by the Subject Relations Office as low population density, agriculturally and small-industrially based, with limited institutional infrastructure beyond the standard educational and religious institutions of the period. The subject had attended local schools through the secondary level and had subsequently enrolled in but not completed a four-year post-secondary institution.

The subject's employment history at the time of intake comprised seventeen distinct positions across approximately twenty-two years of working life.

The positions ranged across multiple industries and roles, with no discernible pattern of career progression and an average tenure of approximately fifteen months. The Subject Relations Office noted that the subject's employment pattern was unusual in its consistency: the subject did not exhibit periods of unemployment punctuated by stable positions, but rather a continuous sequence of positions, each undertaken with apparent commitment, each abandoned at a point of the subject's choosing for reasons the subject characterized variously but which the Subject Relations Office, in its summary, characterized collectively as a recurring pattern of recognizing that the position required a kind of accommodation the subject was unwilling or unable to make.

The subject reported no formal religious affiliation. The subject reported no formal political affiliation. The subject reported no membership in professional, civic, or recreational organizations. The subject reported a sustained personal practice of reading across a range of fields without formal study in any. The subject described this practice in language the Subject Relations Office quoted in the intake summary: I read what comes to hand. I do not read systematically. I read until the book is done or until the reading has produced what I am going to get from it, whichever comes first.

The subject had been married for approximately twenty years to a partner, designated S— for the duration of the case file, with whom the subject had cohabited continuously from approximately the third year of the marriage. The Subject Relations Office's pre-interview with S— is summarized in Subsection II.D below.

The subject's stated motivation for participation in the M-Series was characterized by the Subject Relations Office as unusually direct. The subject did not articulate the typical motivations the Division's earlier subjects had offered (curiosity about consciousness, interest in spiritual or contemplative traditions, hope for personal transformation, financial compensation alone). The subject's stated motivation, recorded verbatim in the intake summary, was the following:

I have lived inside an apparatus that has never quite installed into the world I live in. I have noticed this. I have not done anything about it because there has not been anything to do about it. You are proposing to do something about it. I do not know whether what you are proposing will work. I suspect, on the basis of what you have told me, that you do not know either. I am

willing to participate because the alternative is to continue as I am, and the continuing as I am is not a project I am interested in extending indefinitely. The compensation is irrelevant to my decision.

The Subject Relations Office noted in the summary that the subject's stated motivation included an awareness of the Division's uncertainty that the Office had not communicated in the consent materials. The Office documented this awareness without comment.

II.D — Pre-Interview with S—

The pre-interview with the subject's spouse, designated S—, was conducted at the Division's secondary intake facility on a single day in the autumn of F+9. The interviewer was the senior member of the Subject Relations Office. The interview transcript runs to approximately eighty-three pages and is reproduced in full in Annex C of this case file. The following summary is drawn from the Subject Relations Office's evaluative memo, dated three days after the interview.

S— was characterized by the interviewer as direct, observant, unimpressed by institutional credentialing, and unwilling to defer to interviewer authority on questions where she possessed direct observational data.

S— confirmed the basic biographical facts the subject had reported in his own intake. S— provided additional detail on the subject's pattern of incomplete institutional affiliation, drawing on her twenty years of observation. S— described the subject's first departure from college: He came home in the middle of the second semester of his second year. He did not call ahead. He arrived with his belongings. I asked him what had happened. He said nothing had happened. He said he had simply realized that the room he was sitting in was not a room he could continue to sit in. He did not articulate this in the language of intellectual disagreement or social discomfort. He articulated it as something closer to physical impossibility. I did not press him further at the time. I have not pressed him on it since. He has not returned to it.

S— described the subject's pattern across the subsequent employment positions in similar language. He would take a position. He would commit to the work. He would do the work well. At some point in each position — sometimes early, sometimes after a year or more — he would arrive at a

moment in which he could not continue. The moments did not have consistent triggers that I could identify. The work was not the trigger. The colleagues were not the trigger. The institution was not the trigger in any specific sense. What I observed, watching him over the years, was that something in the position would shift, or something in him would shift, and what had been workable on a Wednesday would not be workable on a Thursday, and he would leave on Friday. He would not be agitated. He would not be conflicted. He would simply have arrived at the point of departure and would proceed accordingly.

The interviewer asked S— how she had managed, financially and emotionally, twenty years of this pattern. S— responded: I learned, early in the marriage, that this was who I had married. I had two choices. I could attempt to modify him toward the pattern most couples follow, which would have failed and which would have damaged both of us in the failing. Or I could organize the rest of our life around the fact that his pattern was not modifiable and that the pattern, while it produced constant turnover, did not produce instability in any deeper sense. The choice was clear once I had seen it. We have lived accordingly.

The interviewer asked S— what she meant by did not produce instability in any deeper sense. S— responded: The positions changed. The income fluctuated. The address changed several times. The man did not change. The man I married is the man who is sitting in your facility today. There is no version of him that is at odds with himself. He is consistent with himself. The world is not always consistent with him. That is the only kind of instability our marriage has ever produced. I have come to consider it a feature rather than a defect.

The interviewer asked S— about her own willingness to participate as a proximate observer in the M-Series. S— responded: I have read the materials your office provided. I understand that you are proposing to conduct a procedure on my husband that has not been conducted on anyone in the form you are proposing. I understand that you do not know what the outcome will be. I have asked my husband whether he wishes to proceed. He has said that he does. I have not attempted to dissuade him because I do not have a basis on which to dissuade him. My husband is competent to make his own decisions. He has decided. I will participate as a proximate observer because if I do not participate, the procedure proceeds without my participation, and I

would prefer to be in the room.

The interviewer asked S— whether she had concerns about the procedure that she wished to communicate to the Division. S— responded: I have one concern. The materials you have provided describe the procedure and the expected recovery. The materials do not describe what happens if the recovery does not go as expected. I have asked your office about this and have not received a clear answer. I would like a clear answer.

The interviewer's response is recorded in the transcript and is reproduced here verbatim: The Division's adaptive intervention protocols are designed to address deviations from the expected recovery. I cannot tell you in advance what those interventions would be in any specific case, because they are tailored to the specifics of the deviation. I can tell you that the Division has substantial experience with adaptive intervention and that the M-Series's earlier subjects have all completed the recovery period without permanent adverse outcomes.

S—'s response, recorded in the transcript: That is not an answer to my question. My question was what happens if the recovery does not go as expected. Your response describes what the Division does. My question was what happens to my husband. Those are different questions.

The interviewer did not respond further. The transcript continues with administrative matters and the interview concludes.

The Subject Relations Office's evaluative memo characterized S—'s participation prospects as favorable for the protocol's purposes. The memo did not address the exchange recorded above. The memo recommended that S— be approved as the proximate observer for M-08, and the Senior Research Council concurred.

The exchange recorded above is one of several locations in the M-08 file where, in retrospect, the Division's documentation indicates a question raised by the subject's spouse that the Division did not answer and did not record itself as having failed to answer. The retrospective identification of these locations is addressed in the Reviewer's Memorandum appended to Section XII.

II.E — Final Authorization

The Senior Research Council reviewed the complete intake materials for M-08, including the subject's intake summary, the pre-interview with S—, the medical and psychological screening results, and the candidate ranking. The Council recommended that M-08 proceed with the eighth procedural variation, with primary intervention scheduled for the first week of the winter quarter, F+10.

The Standing Committee concurred. The subject and S— were notified. The subject signed the consent form on the day of the final notification. S— did not sign a consent form; the proximate observer role did not require formal consent under the Subject Relations Office's protocols at the time, an omission the Division has since revised.

The intervention proceeded as scheduled.

Marginalia — Section II — In the subject's hand. The marginalia are denser in this section than in Section I, occupying much of the margin and several inserted pages.

The Subject Relations Office's selection criteria describe a person. The person they describe is recognizable to me from the inside. The criteria are constructed to identify someone whose apparatus did not finish installing into any of the architectures that were offered. I am that person. The criteria did their work. The Division selected the right kind of subject for the kind of experiment they intended to conduct.

What the Division did not consider, in constructing the criteria, is what the person identified by the criteria might already know about their own apparatus. The Division assumed that a subject identified by the criteria would be a passive specimen — a substrate the Division could intervene in, observe, and characterize. The Division did not consider that the person identified by the criteria, by virtue of being the person identified by the criteria, might have spent a substantial portion of their life already observing the very operation the Division was proposing to make observable through intervention. The criteria selected for an apparatus already running, at lower amplitude, the second register the experiment was designed to generate.

I do not say this as a boast. I had no terminology for any of it before the procedure. What I had was a felt sense that the apparatus I inhabited did not match the apparatus the world was asking me to inhabit, and that no

amount of effort on my part could close the gap. I had lived with the felt sense for four decades. I had developed, without intention, a low-grade structural awareness of the mismatch itself. I could not articulate it. I had not tried to. The articulation came later, after the procedure, when the language for it became available to me. Before the procedure, I had the felt sense and nothing else.

The Division would not have understood this if I had tried to explain it. The Division was looking for a substrate. I was a substrate that had been watching itself for forty years without the watching ever taking. The watching had never crystallized into anything that could be reported. The procedure crystallized it. Not in the way the Division predicted. In a way the Division does not have the apparatus to recognize.

The exchange with S— that the file records — her question about what happens if the recovery does not go as expected, and the interviewer's failure to answer — is the moment in the file where the Division's structural blindness becomes visible from the inside. The interviewer did not deflect the question. The interviewer did not have an answer. The interviewer did not have an answer because the Division had not developed one. The Division had not developed one because the Division had not seriously considered the possibility that the recovery might not go as expected in ways the adaptive intervention protocols were not designed to address. The Division's confidence in the adaptive intervention protocols was the confidence of an institution that had never encountered a case in which the protocols were inadequate. The Division had no methodology for considering inadequacy in advance. S—'s question, in retrospect, was the methodology the Division did not possess. S— had it. S— always had it. The Division did not recognize it as methodology because S— was not credentialed to produce methodology. The credentialed methodology of the Division was inadequate. The uncredentialed methodology of S— was adequate. The Division did not know which was which until the inadequacy had run its course.

I want to say something about S— that the file does not say and cannot say.

The file characterizes her as direct, observant, unimpressed by institutional credentialing, and unwilling to defer to interviewer authority. The characterization is accurate as far as it goes. It captures her surface. It does not capture what made her surface what it is. What made her surface what it is, is that for twenty years she had been the only other person in

proximity to my apparatus. She had observed the apparatus through every position I had taken and left. She had observed the apparatus during years in which it functioned reasonably well. She had observed the apparatus during years in which it strained. She had observed the apparatus across enough variation to know what it was and what it was not. By the time she walked into the Subject Relations Office for her pre-interview, she had data on my apparatus that no clinician would ever acquire. She did not need to defer to the interviewer's authority because her observational base was deeper than the interviewer's training. The interviewer was a credentialed professional with a battery of assessment instruments. S— was a woman who had been watching for twenty years. The instruments could not match the watching. S— knew this. The interviewer did not.

When the catastrophe began, this asymmetry would prove to be the only thing that saved me. The Division would deploy its instruments. The instruments would not match what was happening. S— would deploy her watching. The watching would match. The Division would not be able to recognize the match as match, because the Division did not have an instrument calibrated to detect S—'s watching. The Division would proceed with its inadequate instruments, and S— would proceed with her adequate watching, and the two would run in parallel for eight months, and at the end of the eight months it would be S—'s watching that would identify what the Division's instruments could not, and the Division would be forced, in its closing documents, to acknowledge that External Resolution had occurred without being able to name what External Resolution was. External Resolution was S—. The Division would not write that. S— was the resolution. The file could not have a category for that. The file would have to be closed without disposition because the file did not have a category for what had actually happened.

I will say one more thing about Section II before I move to Section III.

The Subject Relations Office's evaluative memo characterized S—'s participation prospects as favorable for the protocol's purposes. The phrase is bureaucratic on its surface. Underneath, it contains an assumption that should be examined. The phrase assumes that S—'s participation would serve the protocol's purposes — that is, that S— would function as a passive informational resource for the Division. The phrase does not consider the possibility that S— might, in the event of protocol failure, function as an active intervener whose actions would supersede the

Division's. The Division did not consider this possibility because the protocol did not have a category for it. The protocol assumed that the Division was the agent of the procedure and that all other parties — subject, spouse, clinical staff — were either substrates of the procedure or supporting actors within the protocol's framework. The protocol did not have a category for the spouse takes over because the Division has failed. The Division did not have a category for it because the Division did not consider failure of the kind that occurred to be within the parameter space.

When the failure occurred, the absence of the category did not prevent S— from taking over. The absence of the category prevented the Division from recognizing that she had taken over. The file's documentation of External Resolution is the Division's attempt to describe, in the language it had available, an event the language could not describe. The event was that the Division's protocol failed, the Division's instruments failed, the Division's interventions failed, the Division's predictions failed, and S— — who was not within the protocol — found a way through. The Division could not write the spouse rescued the subject from the Division. The Division wrote External Resolution. The Division wrote it in a section as brief as the Division could make it. The brevity is itself a kind of confession.

S— never asked for credit. S— does not require credit. The marginalia I am writing here is not about credit. The marginalia is about the structural fact that the most important figure in the M-08 case file is not the subject, is not the Division, is not the Standing Committee, is not the Senior Research Council, is not the Reviewer. The most important figure in the M-08 case file is the woman the file refers to as the proximate observer, whose pre-interview question the Division did not answer, who participated because she would rather be in the room than not, and whose watching across eight months would constitute the only adequate response to the catastrophe the Division had set in motion and could not arrest.

The file does not say this. The marginalia says this. I am the only person in a position to say this in writing that might survive the archive. I am saying it now.

— [signature: handwritten initials, illegible]

III. PRIMARY INTERVENTION

III.A — Pre-Procedural Preparation

The Protocol M-08 primary intervention was scheduled for the first week of the winter quarter, F+10. The subject and the proximate observer, designated S—, were instructed to present at the Division's primary intervention facility on the morning of the scheduled date. The intervention facility is a free-standing building on the Institute's northern campus, distinct from the Division's research offices, equipped for the full range of substrate-level interventions the Division conducts. The facility includes a primary intervention chamber, a real-time monitoring suite, a post-intervention observation suite with continuous medical staff coverage, and an attached residential wing in which subjects are housed during the immediate post-intervention period.

The subject arrived at the facility at approximately seven in the morning on the scheduled date, accompanied by S—. The subject was conducted through the standard pre-procedural protocol by the Division's Medical Liaison Office. The protocol included verification of fasting status, final medical screening (vital signs, basic blood chemistry, neuroelectric baseline measurement), confirmation of consent, and a final orientation session with the senior member of the Subject Relations Office in which the procedure was reviewed in summary form.

The Medical Liaison Office's pre-procedural notes describe the subject as cooperative, oriented, and unusually composed for a first-time subject of a substrate-level intervention. The notes record the subject's blood pressure as slightly elevated (consistent with mild procedural anxiety) but within acceptable limits, the subject's neuroelectric baseline as consistent with intake measurements taken four weeks prior, and the subject's responses to the Office's final orientation queries as appropriate and indicating adequate comprehension of the procedure and its risks.

S— accompanied the subject through the pre-procedural protocol and was present during the final orientation. The Medical Liaison Office's notes record S— as attentive, focused, and asking clarifying questions about the post-intervention observation period and the procedures for communicating

with the subject during that period. The Office's notes record three specific questions S— asked during the final orientation, and the responses given.

The first question, recorded verbatim: During the immediate post-intervention period, will I be able to be with him? The response, given by the senior member of the Subject Relations Office: During the first seventy-two hours, you will have access to the observation suite during scheduled visiting periods. Continuous presence is not permitted during the active monitoring phase because the monitoring equipment requires controlled environmental parameters. After seventy-two hours, continuous presence is permitted at your discretion and the subject's. S—'s response, recorded in the notes: I will be present during every scheduled visiting period.

The second question, recorded verbatim: If he asks for me during the active monitoring phase, will I be summoned? The response: If the subject specifically requests your presence, the Medical Liaison Office will accommodate the request to the extent compatible with monitoring requirements. S—'s response: To the extent compatible with monitoring requirements. I would like that clarified. What would not be compatible? The response: The monitoring equipment requires that the subject remain within certain parameters of environmental and emotional stability. If the subject's request to see you is itself an indicator of acute distress, accommodation of the request might destabilize the monitoring further. In such cases, the Medical Liaison Office would assess whether your presence would resolve or exacerbate the distress. S—'s response: And who makes that assessment? The response: The senior medical staff on duty in consultation with the Medical Liaison Office. S—'s response: Not me. The response: Not you, no. You are not credentialed to make medical assessments. S—'s response, recorded in the notes: I have made twenty years of medical assessments of my husband. I have been right every time.

The notes do not record a response from the senior member of the Subject Relations Office to S—'s final statement. The notes continue with the third question.

The third question, recorded verbatim: If something goes wrong, who calls me? The response: The Medical Liaison Office has standing protocols for adverse event notification. You will be notified through the standard channels. S—'s response: That is not what I asked. I asked who. Which

person. By name. The response: I cannot give you a specific name. The Office operates on a rotating basis. S—'s response: I would like the names of the people who will be on duty during the active monitoring phase. I would like to know who to ask for if I do not hear from anyone within the first twenty-four hours. The notes record that the senior member of the Subject Relations Office provided four names. The notes do not record whether S— retained the names.

The pre-procedural protocol was completed at approximately nine-fifteen in the morning. The subject was conducted to the primary intervention chamber. S— was conducted to the visitor's wing, where she would remain during the procedure itself and during the initial post-intervention monitoring period.

III.B — The Procedure

The primary intervention procedure was conducted by the Division's senior procedural staff under the direct supervision of the Medical Director of the Cognitive Substrates Division. The procedure consisted of a single calibrated cervical-cranial impact event of sub-concussive magnitude, delivered through the Division's standardized intervention apparatus, with continuous monitoring of cardiovascular, respiratory, and neuroelectric parameters throughout.

The intervention apparatus is a precision-engineered device developed by the Division's Engineering Unit over a three-year development period. The apparatus consists of an immobilization frame, a calibrated impact delivery mechanism, and an integrated monitoring array. The impact delivery mechanism is capable of delivering impacts at magnitudes ranging from negligible to severely concussive, with calibration precision sufficient to deliver impacts at sub-concussive magnitudes with reliable replication across subjects.

For Protocol M-08, the impact magnitude was calibrated based on the subject's intake measurements and the eighth procedural variation's specifications. The calibration was reviewed and confirmed by the Medical Director prior to the procedure.

The subject was secured in the immobilization frame at approximately nine-forty-five in the morning. The monitoring array was confirmed as

functional. The procedure was conducted at approximately ten in the morning. The impact was delivered. The duration of the impact event itself was approximately forty milliseconds.

Real-time monitoring during the procedure recorded the following: a brief disruption of cardiovascular parameters (transient blood pressure spike of approximately fifteen percent, returning to baseline within two minutes); a brief disruption of respiratory parameters (a single missed breath at the moment of impact, followed by resumed regular respiration); a more sustained disruption of neuroelectric parameters (broad spectrum disturbance of normal waveforms persisting for approximately ninety seconds, followed by gradual return to baseline-adjacent patterns over the subsequent ten minutes). The disruption profile was consistent with the Division's predictions for the eighth procedural variation. The Medical Director's procedural notes record the procedure as executed without incident.

The subject was conducted from the primary intervention chamber to the post-intervention observation suite at approximately ten-twenty in the morning. The subject was conscious throughout, oriented to person and place, and responsive to staff queries. The Medical Liaison Office's notes describe the subject during this period as cognitively intact, somewhat slowed in verbal response, reporting mild physical disorientation but no acute distress.

S— was permitted to see the subject at the first scheduled visiting period, at approximately eleven-thirty in the morning. The visit lasted approximately twenty minutes. The Medical Liaison Office's notes describe the visit as uneventful; the notes record that the subject reported to S— that he was all right and that S— responded by sitting with the subject in silence for the remainder of the visiting period.

III.C — Initial Post-Intervention Observation

The subject remained in the post-intervention observation suite for the first seventy-two hours following the procedure. The observation suite is a single-occupancy room equipped with continuous monitoring equipment, dedicated medical staff coverage, and provisions for the subject's basic needs during the monitoring period.

The Division's standard observation protocol calls for monitoring of the same parameters tracked during the procedure itself (cardiovascular, respiratory, neuroelectric) supplemented by hourly assessments of the subject's cognitive and phenomenological state. The cognitive assessments are conducted by the Medical Liaison Office's clinical staff using a battery of standardized instruments developed by the Division's Cognitive Profile Unit. The phenomenological assessments are conducted through structured interview, with the staff recording the subject's responses verbatim where possible and in summary form where verbatim recording is impractical.

The subject's seventy-two-hour observation period produced the following summary of measurements and reports.

Cardiovascular parameters remained within normal range throughout the observation period, with the exception of two episodes of transient blood pressure elevation (one at approximately twelve hours post-intervention, one at approximately fifty-six hours post-intervention) that resolved without intervention.

Respiratory parameters remained within normal range throughout.

Neuroelectric parameters showed a sustained deviation from the subject's baseline measurements, consistent with the Division's predicted partial decoupling of the autonomic regulatory network. The deviation was characterized by reduced amplitude in the frequency bands associated with stable cortical integration, accompanied by intermittent broad-spectrum disturbances of varying duration. The deviation pattern was consistent with the patterns observed in M-01 through M-07 during their respective initial observation periods, with two notable distinctions: the M-08 deviation was of greater amplitude than any of the early-cohort deviations, and the M-08 deviation showed no signs of resolution toward baseline over the seventy-two-hour observation period.

The Medical Director's review of the neuroelectric monitoring data, conducted at the seventy-two-hour mark, noted the absence of resolution as a finding of interest but not yet of concern. The Director's notes record the expectation that resolution would commence between seventy-two and ninety-six hours post-intervention, in line with the procedural model. The Director authorized the continuation of the observation protocol without modification.

Cognitive assessments conducted at hourly intervals during the seventy-two-hour observation period produced results that the Cognitive Profile Unit characterized as within expected parameters for the immediate post-intervention period. The subject's performance on standardized assessments was somewhat slowed relative to baseline but did not show degradation in accuracy. The assessments did not identify any acute cognitive impairment.

Phenomenological assessments conducted at hourly intervals produced reports that the clinical staff characterized variously across the seventy-two-hour period. The early reports (zero to twelve hours post-intervention) consisted primarily of physical sensations: the subject reported mild headache, occasional dizziness, and a sustained sense of heaviness in the visual field. The mid-period reports (twelve to forty-eight hours) included additional phenomenological content: the subject reported that environmental sounds had an unusual quality of presence he could not further specify, that visual inputs seemed to arrive with a delay though he could not identify the delay relative to anything specific, and that his own thoughts seemed to occur at a slight remove from his sense of himself as their thinker.

The clinical staff recorded these reports as preliminary evidence of partial decoupling and noted in the file that the reports were consistent with the predicted phenomenology of the early window.

The late-period reports (forty-eight to seventy-two hours) introduced additional content that the clinical staff recorded with greater attention. At approximately the fifty-second hour post-intervention, the subject reported to the on-duty clinician that he was experiencing the absence of the layer that usually puts things in their place. The clinician's notes record this verbatim and include the clinician's request for further specification. The subject's response, also recorded verbatim: I am perceiving what is around me. The perception is intact. What is not happening is the part where the perception becomes something to me. The perception is there. I am there. The connection between the perception and me is not there in the way it usually is. The clinician recorded this and noted in the file that the report was the first clear indication of bilateral access reported by the subject.

At approximately the sixty-fourth hour post-intervention, the subject reported a second observation: I can see myself thinking. I cannot see what I

am thinking about. I can see that the thinking is happening. It is occurring at a layer I can observe. I have not been able to observe it before. This report, also recorded verbatim, was noted by the clinical staff as further confirmation of bilateral access.

At approximately the seventy-second hour post-intervention, the subject reported a third observation, which the clinical staff recorded with less analytical commentary than the prior two: Something is wrong. I do not know what. The thing I am observing is not stable. It is not coming back together. The window is supposed to close. The window is not closing. The thing on the other side of the window is coming through.

The clinician's notes record the subject's third report and add the following clinical commentary: Subject expressing anxiety regarding the persistence of the decoupling state. Anxiety is normal for this phase of the recovery. Reassurance provided. Subject calmed.

The seventy-two-hour observation period concluded at the predicted close. The Medical Director reviewed the accumulated data and authorized the transition to the next phase of the observation protocol.

III.D — Visitor Access and S—'s Observations

During the seventy-two-hour observation period, S— was present at every scheduled visiting period. The Medical Liaison Office's notes record her presence at all seven scheduled visits and characterize her visits as brief, quiet, and apparently calming for the subject.

What the Medical Liaison Office's notes do not record, because the Office's protocols did not call for such recording, is what S— observed during her visits. The following is reconstructed from S—'s contemporaneous notes, which were not made available to the Division during the case period and were obtained for inclusion in this case file through unspecified channels after closure.

S—'s contemporaneous notes for the seventy-two-hour observation period are reproduced in their entirety in Annex D. The following are excerpted from those notes, in approximately chronological order.

> *Visit 1, eleven-thirty morning, day 0. He is awake. He looks at me. He recognizes me. He says he is all right. His face is not his face. I cannot say how. The features are the same. The arrangement is the same. The*

face is not his.

Visit 2, six in the evening, day 0. He is sitting up. He is calm. He says the procedure was easier than he expected. He says there is a sound in the room he can hear. I cannot hear it. The monitors do not show anything that would correspond to it. He says the sound is in the wall. I look at the wall. The wall is a wall.

Visit 3, nine in the morning, day 1. He has not slept. The monitors confirm this. He says he tried. He says when he closed his eyes, the layer that closes when you close your eyes did not close. He could see what was on the other side of his eyelids the way he saw what was in front of him before he closed them. I do not know what this means. He does not seem distressed by it. The clinical staff have noted it and characterized it as expected.

Visit 4, three in the afternoon, day 1. He is calm. He is speaking less. When he speaks, he speaks accurately. There is no slurring, no confusion, no obvious cognitive impairment. There is a quality to his speech that I do not have a word for. He is speaking as if he is reading what he is saying from somewhere else. The reading is accurate. The reading is not him.

Visit 5, nine in the morning, day 2. The not-his-face is more pronounced. The features are still his features. The arrangement is still the arrangement. What is missing is what makes a face into a person looking out of it. The face is a face. The person is somewhere else. I do not know where.

Visit 6, three in the afternoon, day 2. He asked me to hold his hand. I held it. His hand was cold. The temperature monitors confirm that his peripheral temperature has dropped approximately two degrees from baseline. The clinical staff have noted this and characterized it as a transient autonomic effect. I held his hand for twenty minutes. He did not let go.

Visit 7, nine in the morning, day 3. Something is different today. He is not calm anymore. He is not agitated. He is something I do not have a word for. He looked at me when I came in. He said: 'It is not closing.' I asked him what was not closing. He said: 'The thing that was supposed to close.' I asked him whether he had told the clinical staff. He said he had. I asked what they had said. He said: 'They said it would close.' I said: 'But it is not closing.' He said: 'It is not closing.' Then he closed his eyes. He

did not open them again during the visit. The monitors showed normal patterns. He was not asleep. He was somewhere with his eyes closed.

S—'s contemporaneous notes for the seventy-two-hour observation period end with the final visit. The notes do not include a summary or evaluation. S— resumed her contemporaneous notation when the subject was moved from the post-intervention observation suite to the attached residential wing at the end of the seventy-two-hour period.

III.E — Conclusion of Initial Observation

At the conclusion of the seventy-two-hour observation period, the Medical Director conducted a comprehensive review of the accumulated monitoring data and clinical reports. The Director's review notes, dated at the close of day 3, record the following summary.

The subject had undergone the primary intervention without procedural complications. The post-intervention monitoring data indicated sustained partial decoupling of the autonomic regulatory network, consistent with the procedural model. The neuroelectric deviation from baseline was greater in amplitude than the deviations observed in M-01 through M-07 but had not produced acute medical complications. The subject's cognitive assessments remained within expected parameters. The subject's phenomenological reports were consistent with bilateral access, with the late-period reports providing what the Director characterized as the clearest evidence of bilateral access in the M-Series to date.

The Director acknowledged the absence of resolution toward baseline over the seventy-two-hour observation period and noted that this was a deviation from the modal recovery profile of the early-cohort subjects. The Director's evaluation was that the deviation, while notable, did not warrant immediate intervention. The Director's reasoning was as follows: M-01 through M-07 had all shown initial decoupling followed by resolution within the seventy-two-to-ninety-six-hour window, but the M-Series's purpose was to identify procedural variations that produced sustained bilateral access, and an extended decoupling period was potentially consistent with the deeper bilateral access the eighth procedural variation had been designed to produce. The Director recommended that the observation protocol continue without modification through the extended window, with reassessment at the ninety-six-hour mark.

The Director's recommendation was approved by the Medical Liaison Office. The subject was transitioned from the post-intervention observation suite to the attached residential wing at approximately seventy-four hours post-intervention. S— was permitted continuous presence in the residential wing from the point of transition forward.

The Section III file copy concludes with the Director's seventy-two-hour summary and the documentation of the transition to the residential wing. The Section IV file copy begins with the events of the ninety-six-hour reassessment and the days following.

Marginalia — Section III — In the subject's hand. The marginalia for this section are written in a denser hand than the earlier sections, with several insertions on separate pages.

I do not remember the morning of the procedure cleanly. I remember arriving at the facility. I remember the smell of the building, which was the smell of a medical institution attempting to disguise the fact that it was a medical institution. I remember S— beside me in the intake area. I remember the senior member of the Subject Relations Office asking me to confirm my consent verbally and my saying that I confirmed it. I remember being conducted to the chamber. I remember the frame.

I do not remember the impact.

The file describes the impact as forty milliseconds in duration. I have read this several times. I cannot bring the forty milliseconds into memory. What I have, in the place where the forty milliseconds should be, is an absence. The absence is not the absence of memory. The absence is something I cannot characterize further. The memory immediately before the absence is the frame closing around me. The memory immediately after the absence is being conducted from the chamber to the observation suite. Between these two memories, the file places forty milliseconds. My apparatus places something that is not duration.

I have considered the possibility that the absence is simply the gap that any sudden physiological event would leave in memory. I do not think this is correct. The absence has a structural quality that ordinary memory gaps do not have. Ordinary memory gaps are continuous with what surrounds them — the brain did not register the event, and what surrounds the gap closes

around it. The absence I am describing is not closed. The surrounding memories do not close around it. They sit on either side of it, with the absence preserved between them, like something the apparatus has refused to fill.

I do not know what to make of this. I record it because the file does not record it. The file records that the impact was delivered and that the subject was cognitively intact afterward. The file does not record that something happened in the impact that the apparatus has retained as an absence rather than as a memory or a gap. I do not know whether what is preserved in the absence is what the procedure did to me or what I did during the procedure or what was done to me during the procedure that the apparatus has not been able to render in any form available to it. The absence is what is there. The marginalia is the only place the absence can be documented. The file does not have a category for an absence that is not a gap.

I want to address the phenomenological reports the file documents from the late-period observation. The file is accurate. I did say these things. I remember saying them. I remember meaning them. I want to add what the file does not contain, which is what I was experiencing when I said them.

At the fifty-second hour I said: I am perceiving what is around me. The perception is intact. What is not happening is the part where the perception becomes something to me. The clinician recorded this and noted it as evidence of bilateral access. The clinician was correct that something was occurring that the procedural model would call bilateral access. The clinician did not record what the experience of bilateral access actually was for the subject undergoing it. The experience was not insight. The experience was not transcendence. The experience was that the apparatus's standard operation — by which sensory input becomes experience that belongs to a self — had ceased to occur. Sensory input was arriving. The self was present. The connection between them was not. This is not a positive experience. This is the dissolution of the most basic operation by which an apparatus assembles a life from moment to moment. The procedural model called this a window. The window was, from the inside, the cessation of the operation by which I had been a person.

At the sixty-fourth hour I said: I can see myself thinking. The clinician recorded this as further bilateral access. From the inside, what I was reporting was that the thinking, which had previously been the operation through which I had any access to anything, had become an object I could

observe from a position outside it. The position outside it was not a better position. The position outside it was a position from which the thinking could no longer do the work it had been doing. The thinking was visible. The thinking was no longer mine. The bilateral access the model had predicted was, in the experiencing, the loss of the operation through which the apparatus had been the subject of its own cognition.

At the seventy-second hour I said: Something is wrong. The clinician characterized this as anxiety regarding the persistence of the decoupling state and noted that anxiety was normal for this phase. The clinician's characterization is not accurate. I was not anxious. I had been past anxiety for hours by that point. What I was reporting was a structural observation. The model called for the decoupling to begin closing at the seventy-two-hour mark. The decoupling was not closing. The decoupling was deepening. What I was observing was not a delayed recovery curve. What I was observing was the absence of a recovery curve. The model assumed that the decoupling was bounded. I was reporting that the decoupling was not bounded.

The clinician reassured me. The reassurance did not address what I had reported. The reassurance was a coherence-package the institution applied to me on the assumption that what I had reported was a momentary anxiety state that would resolve with reassurance. What I had reported was that the protocol's central assumption — that the decoupling would resolve — was, in my case, not holding. The clinician did not hear this. The clinician could not hear this. The clinician was operating within the protocol's coherence-architecture, which did not have a category for the decoupling is not bounded. The clinician received my report, converted it into the available category — patient anxiety — and responded within that category. The conversion was structural. The clinician was doing what clinicians do. The clinician was not malicious. The clinician was unable to receive what I was reporting because the clinician's apparatus did not have the categorical machinery to receive it.

This is the structural feature of what came next, and it is worth naming here at the beginning. For the eight months that followed, I would be reporting accurately on what was happening to me, and the Division would be receiving my reports through coherence-architectures that did not have categories for what I was reporting. Each report would be converted, on receipt, into the nearest available category. The conversions would

accumulate. The accumulated conversions would constitute the case file. The case file would be a record of what the Division was able to receive, not a record of what I was reporting. The two would diverge progressively across the eight months. By the end, the case file and what had occurred would be related only structurally — the case file would document, in the gap between what it said and what had happened, the Division's structural inability to receive what was being reported.

The marginalia exists to point at the gap. The marginalia cannot fill the gap. The gap is what occurred. The case file is the institution's failure to document what occurred. The marginalia is the subject's failure to document what occurred, undertaken anyway, because the subject's failure is closer to the occurrence than the institution's failure is, and the marginalia is the only available record from any position closer to the occurrence than the case file.

S—'s notes are closer still. I am grateful that someone has obtained them and inserted them into the file. I am grateful that the file's reader will see what S— saw, in the form she wrote it down, while it was happening. S—'s notes from the visits during the initial observation are some of the most accurate documents in this case file. She wrote what she observed. She did not characterize her observations through institutional categories. She did not have institutional categories available to her, because she was not part of the institution. Her observations are therefore unfiltered in a way that nothing the Division produced could be unfiltered.

The note from her seventh visit — He looked at me when I came in. He said: 'It is not closing.' I asked him what was not closing. He said: 'The thing that was supposed to close.' — is, in its three-line accuracy, more useful as documentation of the seventy-second-hour state than the clinician's verbatim transcription paired with the institutional characterization. The clinician transcribed what I said and characterized it. S— recorded what I said and recorded her own response. Her record contains the report and a witnessing of the report. The clinician's record contains the report and an institutional re-categorization of the report. The witnessing is closer to the occurrence than the re-categorization. The witnessing does not explain. The witnessing observes. The observation, written down, is what survives that can be returned to.

When the file's later sections describe what happened after the ninety-six-hour mark, the file's institutional characterizations will become

progressively less accurate as the events become progressively more divergent from the model. S—'s notes will continue to be accurate, because S—'s notes do not characterize. They witness. The reader of this case file should attend to S—'s notes with the understanding that the notes contain what was actually observable from a position close enough to the subject to observe it, written by an observer who did not have an institutional framework requiring her to mischaracterize what she saw.

I will write more in the margins of Section IV.

— [signature: handwritten initials, illegible]

IV. THE FIRST WINDOW

IV.A — The Ninety-Six-Hour Reassessment

The ninety-six-hour reassessment of Subject M-08 was conducted by the Medical Director of the Cognitive Substrates Division in consultation with the Senior Research Council on the morning of day four following the primary intervention. The reassessment is documented in a memorandum dated at the conclusion of the reassessment session and signed by the Medical Director, the senior member of the Subject Relations Office, and three members of the Senior Research Council in attendance.

The memorandum records the following findings.

Neuroelectric monitoring data from the period between seventy-two and ninety-six hours post-intervention showed continued deviation from the subject's baseline measurements, with no resolution toward baseline observed during the interval. The amplitude of the deviation had remained approximately constant across the interval; the deviation had neither deepened nor diminished. The pattern was characterized in the memorandum as a sustained plateau of partial decoupling without indication of imminent resolution.

Cardiovascular and respiratory parameters had remained within normal range throughout the interval, with two additional episodes of transient blood pressure elevation noted but resolved without intervention. The subject's peripheral temperature, which had dropped approximately two degrees from baseline during the initial observation period, had not returned to baseline; the depression was characterized in the memorandum as modest and not clinically concerning at present.

Cognitive assessments conducted at twelve-hour intervals across the seventy-two-to-ninety-six-hour interval had produced results consistent with the earlier assessments: performance within acceptable parameters with some slowing of response time, no degradation in accuracy. The Cognitive Profile Unit's evaluation was that the subject's measurable cognitive function remained intact.

Phenomenological reports across the interval had become more sparse and more uniform than the late-period reports of the initial observation. The subject's responses to structured interview queries had shortened. The subject continued to report what the clinical staff characterized as bilateral access phenomenology but had ceased to offer the kind of articulate descriptive content that had characterized the fifty-second and sixty-fourth hour reports. The subject's responses had taken on what the clinical staff described as a flat affective quality. The clinical staff characterized this development as not unexpected for the extended decoupling state and noted that it was broadly consistent with the affective profile reported by M-02 and M-05 during their respective extended observation intervals.

The Senior Research Council's discussion of these findings, summarized in the memorandum, identified two possible interpretations of the M-08 reassessment data.

The first interpretation, characterized in the memorandum as the favorable interpretation, was that the M-08 protocol had produced a deeper and more sustained bilateral access state than any of the early-cohort protocols. Under this interpretation, the absence of resolution at ninety-six hours represented not a deviation from the model but a confirmation that the eighth procedural variation had achieved what it had been designed to achieve. The Council noted that the favorable interpretation would predict eventual resolution at a later mark, with the subject retaining bilateral access at a greater integration than the early cohort had achieved.

The second interpretation, characterized in the memorandum as the cautious interpretation, was that the M-08 protocol had produced a decoupling state that was failing to resolve, and that the absence of resolution at ninety-six hours represented an early warning that the recovery profile might require active intervention rather than continued observation. The Council noted that the cautious interpretation would call for the introduction of the Division's adaptive intervention protocols at a defined threshold to be set by the Medical Director.

The Council's recommendation, reached after extended discussion, was to extend the observation protocol for an additional seventy-two hours without adaptive intervention, with reassessment at the one-hundred-sixty-eighth hour (one week) post-intervention. The Council's reasoning, recorded in the memorandum, was that the subject was not in acute medical distress, that the

cognitive and physiological parameters remained within acceptable ranges, and that premature introduction of adaptive intervention could disturb a recovery profile that might be proceeding to a deeper end-state than the model had anticipated.

The Medical Director concurred with the recommendation. The senior member of the Subject Relations Office concurred. The reassessment session concluded with the authorization of an additional seventy-two hours of observation.

The memorandum does not record any consultation with the subject or with the proximate observer regarding the extension of the observation protocol. The Division's protocols did not require such consultation at this stage of the recovery process. The subject and S— were informed of the extension in the routine course of clinical communication during the day of the reassessment.

IV.B — Days Four Through Six: Residential Wing

The subject was housed in the attached residential wing of the intervention facility throughout the extended observation period. The residential wing consists of single-occupancy quarters designed to provide a more relaxed environment than the observation suite while maintaining continuous monitoring capability. The wing includes private sleeping quarters, a shared common area, dining facilities, and outdoor access to a walled courtyard. Subjects in the residential wing are monitored through a combination of telemetric devices the subject wears continuously and scheduled clinical check-ins occurring at four-hour intervals.

S— was permitted continuous presence in the residential wing from the point of the subject's transition. The Medical Liaison Office's notes record S—'s presence as substantially continuous across the four-day interval that followed, with S— departing the facility only for brief intervals to address personal logistics.

The Division's clinical documentation for days four through six is sparse relative to the documentation of the initial observation period. The Medical Liaison Office's notes consist primarily of vital signs measurements, brief summaries of the four-hourly check-ins, and notations on the subject's general status. The clinical staff characterized the subject during this interval as subdued, cooperative, oriented, and reporting continued bilateral access

phenomenology without acute distress.

What the clinical documentation does not record, but which is reconstructed from S—'s contemporaneous notes (Annex D) and the subject's retrospective marginalia, is the texture of these four days as experienced from within the residential wing.

S—'s contemporaneous notes for days four through six are reproduced below in approximately chronological order. The notes were written in a small bound notebook S— carried during her continuous presence; the original notebook has been preserved and the notes are reproduced verbatim.

> *Day 4, morning. He slept perhaps two hours. He says he closed his eyes. He says when he closed them, sleep did not come. He says he heard the building. The building does have a sound. I have not noticed it before. He is right. I notice it now because he has told me. I do not know whether I will continue to hear it once we leave.*
>
> *Day 4, afternoon. The medical team conducted the four-hour check-in. They asked him their questions. He answered them. The answers were accurate as far as I could tell. The answers had no weight. He was producing the answers from somewhere that was not where his attention was. His attention was on something I could not see. I asked him after the team left where his attention was. He said: 'The room is loud.' I asked him what was loud. He said: 'The room.' I did not press further.*
>
> *Day 4, evening. He ate the meal that was brought. He ate slowly. He stopped halfway through and said: 'I cannot tell which of these things is food.' I asked what he meant. He said: 'I can see the items. I cannot identify which of them are the food.' I named the items for him: the bread, the soup, the small plate of vegetables. He nodded as I named them. He resumed eating. He ate everything. I do not know whether the naming helped or whether he ate the rest of the meal because eating the rest of the meal was the script he was now running.*
>
> *Day 5, early morning. He has slept perhaps an hour. He came out of the sleeping room to the common area at three in the morning. I was reading. He sat down across from me. He said: 'I would like to ask you something.' I said: 'Ask.' He said: 'Am I still here.' I said: 'You are here.' He said: 'I know I am here. I am asking whether I am still here. I am asking whether what you are looking at across the table is the same person who you have been looking at for the last twenty years.' I considered the question. I said: 'I do not know how to answer that. I know*

that I love what is across the table. I have loved what is across the table for twenty years. The loving has not stopped. I do not know whether you are the same. I know that the loving is still the loving.' He nodded. He did not respond verbally. After several minutes he stood up and returned to the sleeping room. He did not sleep further.

Day 5, morning. The four-hour check-in. He told the clinician that he had slept seven hours. The clinician noted the report and entered it into the record. I did not correct the clinician. I do not know why I did not correct the clinician. I am writing this now because I have been thinking about why I did not correct the clinician all day. I think I did not correct the clinician because I had begun to understand that the clinician's record was not going to be a record of what was happening. I think I had begun to understand this without yet having the words to say it. The clinician's record was a record of what the clinician could enter into the system. My record, which I am writing here, is a record of what I am seeing. The two records are not the same record. They will diverge further. I have decided to keep my own record.

Day 5, afternoon. The clinical staff conducted a cognitive assessment. He performed within parameters. The Cognitive Profile Unit's notes will reflect this. What the notes will not reflect is that he completed each task as if he were performing it for the first time, with no memory of having performed similar tasks before. The tasks were standardized. He had performed them at intake. He performed them now without recognition. He performed them accurately. He performed them as if they were new. I do not know what to make of this. The clinical staff did not appear to notice it.

Day 5, evening. He asked me to stay in the sleeping room with him tonight. I stayed. He did not sleep. He lay on the bed with his eyes open. He did not speak. At approximately two in the morning his body began to move. The movements were small at first — a twitch of the hand, a tightening of the leg. The movements grew over a period of perhaps twenty minutes. At the height of the movements his body was shaking continuously for approximately six minutes. He did not lose consciousness. He did not appear to be in pain. He did not appear to be in control. The monitors registered the movements. No clinical staff came. I do not know whether the monitors triggered an alert and the staff considered the event below threshold, or whether the monitors did not trigger an alert. I sat beside him during the movements. I held his hand. When the movements subsided, he turned to me and said: 'It is

happening.' I asked what was happening. He said: 'I do not know what to call it. It is happening.' He slept then, briefly, perhaps an hour. I did not sleep.

Day 6, morning. He told the morning clinician that he had experienced a 'movement episode' during the night. The clinician asked for further description. He provided one. The clinician noted the report and indicated that the night staff had observed the episode through the monitoring system, had assessed it as a transient autonomic phenomenon, and had elected not to disturb the subject. The clinician indicated that the episode was within the expected range of phenomena during the extended decoupling period. The clinician did not seem alarmed. The clinician did not seem unalarmed. The clinician appeared to be reading from a script. The script described the episode as expected. I did not feel that the episode was expected. I have been observing my husband for twenty years. I have never observed him produce a movement of this kind. The clinician's characterization of the episode as expected is not the same as the episode being expected. I am beginning to think these things are different and I am beginning to think the difference matters.

Day 6, afternoon. He has been quiet all day. He has eaten what was put in front of him. He has answered questions when asked. He has not initiated conversation. He has not asked me anything since the question in the early morning of day five. I have been sitting with him. I have not pressed. I do not know what to press for. The clinical staff appear satisfied with his condition. I do not appear satisfied with his condition. I do not know what to do with the gap between their satisfaction and mine. I am writing this so that the gap exists somewhere outside my head.

Day 6, evening. Another movement episode. Longer than the first. Approximately eleven minutes of continuous shaking. He remained conscious. He did not appear to be in pain in any way I could identify, but his face during the episode was a face I had not seen before. The face was not afraid. The face was not in distress. The face was the face of an apparatus that was no longer being run from the position the face usually was run from. The face was being run from somewhere else. When the episode subsided, the face returned. The night staff came this time, briefly. They observed him. They consulted the monitors. They indicated that the episode was within the expected range. They left. He turned to me and said: 'I would like to leave.' I said: 'Leave the facility?' He said: 'Yes.' I said: 'I do not think they will let you leave yet.' He said: 'I know.'

He did not press the matter. We did not speak further that night.

S—'s contemporaneous notes for days four through six conclude with the entry above.

IV.C — The One-Hundred-Sixty-Eighth-Hour Reassessment

The one-hundred-sixty-eighth-hour reassessment of Subject M-08 was conducted on the morning of day seven following the primary intervention. The reassessment is documented in a memorandum signed by the same parties as the ninety-six-hour reassessment, with the addition of the Medical Director's Deputy.

The memorandum records the following findings.

Neuroelectric monitoring data from the period between ninety-six and one-hundred-sixty-eight hours post-intervention showed a notable shift from the prior interval. The sustained plateau characterized at ninety-six hours had given way to a pattern characterized in the memorandum as intermittent broad-spectrum disturbances of increasing frequency and amplitude. The disturbances corresponded to two observed episodes of involuntary movement during the interval, which had been noted by the clinical staff and characterized as transient autonomic events not requiring acute intervention. The disturbances were also occurring during periods in which no involuntary movement was clinically observable; the meaning of these sub-clinical disturbances was characterized in the memorandum as of uncertain significance.

Cardiovascular parameters had begun to show modest dysregulation, with the subject's resting heart rate having increased approximately fifteen percent above baseline and the subject's blood pressure having become more variable across measurement intervals. The dysregulation was characterized in the memorandum as not yet of acute concern but warranting closer monitoring.

Respiratory parameters remained within normal range.

Cognitive assessments conducted across the interval had begun to show modest slowing in response time relative to the earlier intervals. Accuracy on the standardized assessments remained within acceptable parameters, but the Cognitive Profile Unit had noted what they characterized as a qualitative change in the subject's performance affect: the subject was completing the

assessments with less apparent engagement than at earlier intervals, performing the tasks as if from a position of disinterest rather than effortful attention. The Cognitive Profile Unit's evaluation was that the subject's measurable cognitive function remained intact but that the subject's relationship to the cognitive function appeared to have changed in a way the standardized assessments were not designed to characterize.

Phenomenological reports across the interval had become extremely sparse. The subject had ceased to offer articulate descriptive content in response to structured interview queries and had begun responding to such queries with brief acknowledgments or with silence. The clinical staff characterized this as a withdrawn affective presentation and noted that withdrawal was within the range of affective states observed in extended decoupling.

The Senior Research Council's discussion of these findings, summarized in the memorandum, was substantially more guarded than the discussion at the ninety-six-hour reassessment. The Council noted that the M-08 recovery profile had now deviated from the model in two distinct dimensions: the failure of the decoupling state to resolve, and the introduction of involuntary movement episodes that had not been predicted by the model or observed in any of the early-cohort subjects. The Council acknowledged that the favorable interpretation of the ninety-six-hour findings was now substantially less tenable; the recovery profile was no longer plausibly characterized as a deeper-than-predicted bilateral access state.

The Council's revised assessment was that the M-08 recovery profile constituted an off-model recovery state of uncertain etiology, and that the recovery would require active intervention rather than continued observation. The Council recommended the initiation of Intervention 1, consisting of pharmacological dampening using standard autonomic agents from the Division's adaptive intervention roster.

The Medical Director concurred. The Medical Director's Deputy concurred. The senior member of the Subject Relations Office expressed what the memorandum characterizes as concern that adaptive intervention was being initiated without a clear understanding of the etiology being addressed but did not formally dissent from the recommendation. The recommendation was approved.

The memorandum records that the subject was informed of the decision to initiate Intervention 1 and that the subject acknowledged the decision without indicating preference or objection. The memorandum records that S— was informed and that S— requested clarification regarding the agents to be used and the anticipated effects. The memorandum does not record the substance of the clarification provided. S—'s contemporaneous note from that morning, reproduced below, fills the gap.

> *Day 7, morning. They told us they were going to start medication. They told me which agents. I asked what the agents do. They told me. I asked what the agents had done in the early-cohort subjects. They told me the early-cohort subjects had not required these agents. I asked how they knew the agents were the right agents to use. They told me the agents were standard for the symptoms that were now present. I asked what the symptoms were. They named several things, including the movement episodes. I said the movement episodes were not symptoms of something the medication could treat. They asked me what I meant. I said the movement episodes were what his body was doing because something was overflowing. I said the medication might suppress the overflow without addressing what was overflowing. They told me my characterization was not clinically accurate. I said I had been watching him for twenty years and I had been right every time. They did not respond. They asked him whether he wanted the medication. He said yes. They began the medication.*

IV.D — Conclusion of the First Window

The Section IV file copy concludes with the initiation of Intervention 1 on the morning of day seven post-intervention. The protocol had transitioned from observation-only to active pharmacological intervention. The model under which the procedure had been designed had been formally acknowledged as inadequate to the M-08 recovery profile. The case file had entered the phase the Division calls adaptive management, in which sequential interventions are applied to address recovery profile deviations as they manifest.

The interventions that followed are documented in Sections V through X. The Section V file copy begins with the initiation of Intervention 1 and documents its effects.

Marginalia — Section IV — In the subject's hand. The marginalia for this section are written more sparingly than for Section III, with longer gaps between entries. The hand is recognizable but the script is more strained, suggesting either fatigue at the time of writing or composition over a longer interval than the prior sections.

The Senior Research Council's discussion at the ninety-six-hour reassessment is recorded in the memorandum as a careful weighing of two interpretations. The favorable interpretation. The cautious interpretation. The reasonable institutional voice considering both, choosing extension over intervention, expecting a deeper bilateral access that the eighth procedural variation had been designed to produce.

The interpretations were not equally weighted by the apparatus that was undergoing them. The apparatus that was undergoing them was not interpreting. The apparatus was registering that the decoupling was not bounded. The apparatus had reported this at the seventy-second hour. The apparatus had reported this and been reassured. The apparatus was reporting it less articulately by the ninety-sixth hour because the apparatus had less to report from. Less of the apparatus was doing the reporting. The apparatus was thinning.

I want to say something about the thinning. The file's clinical characterizations across this period — flat affective quality, withdrawn affective presentation, modest slowing of response time — describe what was visible from outside the apparatus. What was happening inside the apparatus was not what was visible. What was happening inside the apparatus was that the operation by which experience accrued to a continuous self was failing in increments. Each hour the apparatus had less of what was required for a continuous self. The continuous self had been the substrate of all the apparatus's other operations. As the continuous self thinned, the operations it had supported thinned with it. The articulate reports thinned because the articulating operation thinned. The affective engagement thinned because the affecting operation thinned. The cognitive engagement thinned because the engaging operation thinned. The clinical staff observed the surface changes. The clinical staff characterized the surface changes within the available categories. The surface changes were the visible portion of a structural collapse the available categories did not have words for.

The clinical staff were not negligent. The clinical staff were doing the work the protocol called for them to do. The work the protocol called for them to

do did not include observing structural collapse, because the protocol did not anticipate structural collapse, because the model did not predict structural collapse, because the model assumed that decoupling was bounded. The clinical staff observed the surface and entered surface descriptions into the record. The surface descriptions were accurate. The surface descriptions were the wrong surface.

S— observed the right surface. S— had no protocol. S— had twenty years of observation and a notebook. S— observed that the face was not the face. S— observed that the answers had no weight. S— observed that the cognitive assessments were being performed without recognition of having been performed before. S— observed that the apparatus's attention was not in the room. S— observed that the movements during the night were what the body was doing because something was overflowing. S— observed accurately. S— observed without categories. S— recorded what she observed in a notebook the Division did not know existed.

The exchange S— records on the morning of day seven, in which she told the clinical staff that the movement episodes were not symptoms of something the medication could treat, is the moment the case file records — though it does not know it records — when the Division's epistemology and S—'s epistemology diverged irreversibly. The Division operated on the principle that the trained clinical observer, applying validated instruments, produced the authoritative observation. S— operated on the principle that the long-proximate observer, applying twenty years of accumulated calibration, produced an observation the trained clinical observer could not match for this specific apparatus. The two principles cannot both be the highest authority in the same case. The Division's protocol assumed that the Division's principle was the highest authority. The Division's protocol did not consider that this assumption could be wrong in any specific case. The Division's protocol was about to be tested on the specific case where the assumption was wrong.

S— told them. The record shows she told them. The record does not show that they registered her telling. The record shows that they proceeded.

I want to address the question I asked S— in the early morning of day five. Am I still here. The question is reproduced in S—'s notes. I do not remember asking the question. I do not remember S—'s answer. S—'s notes record both. I have read the notes. I recognize the question as something I would have asked. I recognize S—'s answer as something she would have

said. The recognition does not give me the memory of having asked or having heard. The recognition is structural. I know that the question and the answer occurred because S— recorded them, and S— is the most reliable observer in the case, and S— would not have recorded what did not occur.

What I had been asking, when I asked the question, was not the question the words asked. The words asked whether I was still the same person. What I was asking was whether anything was being run from the position the person had been run from. By day five I had become uncertain whether anything was being run from that position. The apparatus was operating. The face was responding. The voice was producing sentences. Something was driving these operations. I was uncertain whether what was driving them was what had been driving them. I was uncertain whether what was driving them was anything I could call I. The question to S— was a structural query about whether, from her position outside, she could see that something was still being run from the position inside that had previously been me.

S— answered the question she had been asked. She did not answer the question the words asked. I do not know how to answer that. I know that I love what is across the table. The answer is the most accurate answer that could have been given. The answer did not require S— to make a determination she had no basis for making. The answer did require her to report what she could report on, which was the persistence of the loving. The loving was the only operation S— could report on with certainty. The loving had not stopped. Whether the apparatus on the receiving end of the loving was the same apparatus, S— did not know. S— did not pretend to know. S— told me what she knew. What she knew was that the loving had not stopped.

The answer is the closest anyone in this case came to addressing what was actually happening to me at that hour. The clinical staff were addressing the surface. The Division was addressing the model. S— addressed the question. I do not remember hearing the answer. The answer is in the record. The answer survives.

I want to write something about the movement episodes before this section closes.

The episodes are characterized in the file as transient autonomic phenomena and as movement episodes within the expected range. The characterizations are not accurate. The episodes were not transient in the sense the word implies — they did not arise as discrete events from an otherwise baseline state. The episodes were the visible portion of a continuous process that had been building beneath the surface. The visible portion erupted when the pressure beneath crossed a threshold. The pressure had been building since the seventy-second hour. The visible eruptions began on day five because that was when the threshold was first crossed. The eruptions did not represent the onset of the phenomenon. The eruptions represented the moment the phenomenon became externally observable.

The phenomenon was the vomiting through the nervous system that I will name later in the file. The phenomenon was the apparatus discharging through the autonomic substrate what it could not process through any other route. The phenomenon had been building since the decoupling failed to resolve. The phenomenon would continue to build until something stopped it. The medication that was about to be administered would not stop it. The medication would suppress the visible eruptions while the pressure beneath continued to build. The pressure would build until either the suppression was withdrawn or the apparatus failed. The Division did not know any of this. The Division did not have the categories to know it. The Division was about to begin its sequence of interventions. The interventions were going to address the visible surface while the underlying process continued. The case file is the record of this not being understood as it occurred.

S—'s notes contain the closest available observation. I said the movement episodes were not symptoms of something the medication could treat. I said the medication might suppress the overflow without addressing what was overflowing. The observation is structurally accurate. The clinical staff characterized the observation as not clinically accurate. The characterization was wrong. The observation was clinically accurate at a layer the clinical staff had no instrument to detect. S— had the instrument. The instrument was twenty years of observation. The Division did not recognize the instrument as an instrument because it was not on the Division's roster.

The Division was about to spend two hundred and twenty-six days exhausting its roster.

I will write more in the margins of Section V.

— [signature: handwritten initials, illegible]

V. CASCADE ONSET

V.A — Intervention 1: Pharmacological Dampening

Intervention 1 was initiated on day seven post-intervention, at approximately ten in the morning, following the one-hundred-sixty-eighth-hour reassessment described in Section IV. The intervention consisted of the administration of two agents drawn from the Division's adaptive intervention roster: a benzodiazepine-class agent intended to reduce autonomic excitation and a beta-adrenergic blocker intended to dampen the cardiovascular dysregulation that had been observed across the preceding interval. The dosages were calibrated to the subject's baseline measurements and the protocol's standard initial parameters for adaptive intervention.

The administration was conducted by the Medical Liaison Office's senior clinical staff in the residential wing of the intervention facility. The subject received the first dose by oral administration. The clinical staff documented the administration and initiated enhanced monitoring at thirty-minute intervals for the first six hours following the initial dose, with the intent of characterizing the agents' effects on the subject's recovery profile.

The agents' effects manifested within approximately forty minutes of administration. The effects were not those the Division's adaptive intervention protocols had predicted.

The first observable effect was a marked increase in the frequency and amplitude of the involuntary movement episodes that had been documented during the preceding two days. The first post-administration movement episode commenced at approximately ten-forty-five in the morning and lasted approximately fourteen minutes. The episode involved continuous shaking of the subject's torso and limbs at greater amplitude than any of the prior episodes, accompanied by sustained tachycardia (heart rate elevation to approximately one hundred forty beats per minute, sustained throughout the episode) and respiratory irregularity. The episode did not respond to additional dosing of the autonomic agents; an additional dose administered at approximately eleven in the morning, while the episode was ongoing, produced no observable dampening effect.

The second post-administration movement episode commenced at approximately eleven-thirty in the morning, approximately twenty minutes after the conclusion of the first. The second episode lasted approximately eighteen minutes and exceeded the first in amplitude. The Medical Liaison Office's notes record the second episode as acute autonomic dysregulation of unanticipated severity.

The third post-administration movement episode commenced at approximately twelve-fifteen in the afternoon. The third episode lasted approximately twenty-three minutes. The Medical Liaison Office's notes for this episode are abbreviated; the senior clinical staff had by this point convened an urgent consultation with the Medical Director and the on-call member of the Senior Research Council, and the documentation effort was suspended in favor of consultation.

The consultation reached its conclusion at approximately one in the afternoon. The Medical Director, having reviewed the post-administration data, characterized the subject's response to Intervention 1 as paradoxical excitation: the agents intended to dampen autonomic excitation had produced acute amplification rather than the predicted dampening. The Medical Director acknowledged that paradoxical excitation was a documented but rare response pattern to benzodiazepine-class agents and that the response was not predictable from baseline measurements. The Medical Director recommended immediate cessation of Intervention 1 and a return to observation-only protocol pending reassessment of the recovery profile.

Intervention 1 was terminated at approximately one-thirty in the afternoon, approximately three and a half hours after initiation. The subject had experienced four movement episodes during the active administration period, with the fourth commencing at approximately one-twenty and concluding at approximately one-fifty after the agents had been formally discontinued. The Medical Liaison Office's notes for the remainder of day seven record that the subject experienced two additional movement episodes during the afternoon and evening, both of lesser amplitude than the post-administration episodes, suggesting partial residual effect of the agents extending several hours past discontinuation.

The Medical Director's notes for the conclusion of day seven characterize Intervention 1 as unsuccessful, with adverse effects of moderate severity, requiring documentation in the case file as a contraindicated agent class for

this specific subject. The notes do not characterize the broader implications of the failure. The notes record that observation-only protocol would resume on day eight and that the recovery profile would be reassessed at intervals to be determined by the Medical Director.

V.B — Days Eight Through Eighteen: Without Intervention

The eleven-day interval following the termination of Intervention 1 produced documentation of progressively greater density and progressively less analytical confidence in the Division's clinical record. The case file's content for this interval includes daily clinical summaries, accumulating tables of movement episode data, neuroelectric monitoring printouts, and internal Division correspondence regarding the case. The following summary draws from these materials and from S—'s contemporaneous notes for the same interval.

Movement episodes increased in frequency throughout the interval. The daily count rose from six episodes on day eight to twenty-three episodes on day eighteen, with substantial day-to-day variability. The episodes ranged in duration from approximately two minutes to approximately thirty-one minutes, with mean duration also increasing across the interval. The clinical staff developed a classification system for the episodes during this interval, distinguishing between minor episodes (under five minutes, low amplitude), moderate episodes (five to fifteen minutes, moderate amplitude), and severe episodes (over fifteen minutes, high amplitude). By day eighteen, severe episodes constituted approximately thirty percent of the daily count and were occurring at intervals of two to four hours throughout the day and night.

The subject's sleep pattern, which had been impaired since the conclusion of the initial observation period, deteriorated further across the interval. By day twelve, the subject reported and the monitoring confirmed that uninterrupted sleep periods exceeded thirty minutes only rarely. By day eighteen, the subject had not experienced a sleep period exceeding twenty minutes in approximately four days. The clinical staff characterized the sleep pattern as severe insomnia of indeterminate etiology and added it to the list of phenomena requiring eventual intervention.

The subject's autonomic function, monitored continuously through telemetric devices and periodically through more detailed clinical assessments, showed progressive dysregulation across the interval. Resting heart rate, which had

been approximately fifteen percent above baseline at the end of the initial observation period, climbed to approximately twenty-five percent above baseline by day twelve and approximately thirty-five percent above baseline by day eighteen. Blood pressure variability, peripheral temperature instability, and respiratory irregularity all showed corresponding deterioration. The Medical Director's notes for day eighteen acknowledge the cumulative dysregulation as exceeding the range observed in any prior Division subject across all protocols.

The subject's phenomenological reports during the interval were minimal. The subject continued to respond to direct queries from clinical staff, but the responses were brief and largely uninformative. The clinical staff documented the subject as withdrawn but not unresponsive, oriented but not engaged, cooperative but not communicative. The Cognitive Profile Unit attempted three cognitive assessments during the interval; the first, conducted on day ten, produced results within acceptable parameters but with substantially slowed response time; the second, conducted on day fourteen, produced results showing measurable decline in accuracy on tasks requiring sustained attention; the third, conducted on day seventeen, was terminated by the Unit's assessor after approximately fifteen minutes when the subject experienced a severe movement episode during the assessment.

The internal Division correspondence for the interval, included in the case file, documents a progressive shift in the Division's framing of the M-08 case.

A memorandum dated day nine, from the Medical Director to the Senior Research Council, characterizes the case as requiring careful continued observation while we consider the next steps in adaptive intervention. The tone of the memorandum is measured and the framing assumes that the next intervention will succeed where Intervention 1 failed.

A memorandum dated day thirteen, from the Senior Research Council's Chair to the Medical Director, requests that the Director develop a sequenced intervention plan addressing the recovery profile deviations and notes that the absence of intervention is no longer compatible with the standard of care the Division must provide.

A memorandum dated day sixteen, from the Medical Director to the Senior Research Council, presents a proposed sequence of three further

interventions (Cognitive Scaffolding Therapy, Sensory Regulation Protocol, and a Phased Pharmacological Re-Trial) and acknowledges that the sequencing is provisional and that each intervention should be re-evaluated based on response. The memorandum includes a brief acknowledgment that the M-08 recovery profile has now diverged sufficiently from the M-Series model that the available adaptive interventions may require adaptation beyond their standard parameters. This is the first appearance in the case file of the Division acknowledging, in writing, that the adaptive interventions themselves may not be adequate to the case.

A memorandum dated day eighteen, from the Standing Committee on Foundational Research to the Cognitive Substrates Division, requests an interim report on M-08 for the Committee's awareness and consideration of any implications for the broader research program. The Standing Committee had not previously requested interim reporting on individual cases; the request indicates that information regarding M-08 had reached the Committee through informal channels prior to formal reporting.

S—'s contemporaneous notes for the eleven-day interval are extensive. They are reproduced in Annex D in their entirety. The following selections, in approximately chronological order, sample the notes for this interval.

> *Day 8. He has not slept since the medication was stopped. He says he tries to sleep. He says when he closes his eyes, the building comes through louder. He cannot tell whether the building is louder or whether closing his eyes removes whatever was making the building tolerable. He keeps his eyes open. He looks at the ceiling. He looks at me. He looks at the wall. The looking is the only thing he can do that does not produce the building.*
>
> *Day 9. Three episodes today. The morning one was eight minutes. The afternoon one was twelve. The evening one was nineteen. The episodes are getting longer. The clinical staff have not commented on the lengthening. The clinical staff are entering the episodes into the record. I am not sure they are reading what they are entering.*
>
> *Day 10. I asked the day clinician what was happening. He said the recovery profile was diverging from the expected pattern. I asked what they were doing about it. He said they were planning the next intervention. I asked when. He said soon. I asked what soon meant. He said within several days. I said within several days the episodes will be*

twice what they are now. He looked at me. He did not respond.

Day 11. He spoke to me at length tonight. The first time he has spoken at length since day five. He said: 'I am still here. Whatever you can see, I am still here. I am inside it. Whatever it is. I am inside.' I asked him whether he wanted me to tell the staff what he had said. He said: 'Tell them what you want to tell them. They will write it down. It will not change anything.' He was quiet for a long time. Then he said: 'You are the only person here who can see what is happening. Stay. Even if I cannot speak. Stay.' I said I would stay. He closed his eyes for a moment. He said: 'Thank you.' He opened his eyes. He did not speak again that night.

Day 12. The afternoon episode lasted twenty-one minutes. Twenty-one minutes is a long time. I sat beside him. I held his hand. The hand was rigid throughout. The body was shaking. The face was the face I have described before. The face was not him. I held the hand anyway. After the episode subsided, he was exhausted. He slept for perhaps twenty minutes. When he woke, he looked at me. He said: 'You are still here.' I said: 'I am still here.' He said: 'Good.'

Day 13. I asked the senior clinician whether the case was being escalated. The senior clinician said the case was being reviewed at the highest levels of the Division. I asked what that meant. The senior clinician said the Senior Research Council was actively involved. I asked whether anyone outside the Division was reviewing the case. The senior clinician said the case was being handled internally per Division protocols. I asked whether external review could be requested. The senior clinician said external review was not standard for a subject in active recovery. I said I was not certain my husband was in active recovery. I said I was beginning to think the recovery was the deterioration we were observing. The senior clinician did not respond to this characterization.

Day 14. He could not complete the cognitive assessment. The Unit's assessor administered the first portion. He performed adequately. She administered the second portion. He performed below his prior performance. She administered the third portion. He could not perform. He did not refuse. He attempted. The attempt did not produce responses. The assessor terminated the assessment. The assessor noted in her record that the assessment indicated decline in sustained attention. The assessor did not note that what she had observed was an apparatus that could not

produce sustained attention because the apparatus did not have the resources for sustained attention. The assessor wrote what her instruments measured. The instruments were not measuring the right thing.

Day 15. He asked me tonight whether anyone died from this kind of thing. I asked him what kind of thing he meant. He said: 'What is happening to me.' I said I did not know. He said: 'I am asking because the body is doing things I do not think the body is supposed to be able to do indefinitely.' I said I did not know what the body could do indefinitely. He said: 'Find out.' I said I would.

Later, after he slept, I made calls. I called my brother, who is a physician. I described what I had been observing. He did not have answers. He said he would ask colleagues. He said he would call me back. I waited. He called back two hours later. He said the symptoms I had described matched no clinical entity he or his colleagues could identify. He said the closest analog was a clinical entity called malignant catatonia, but the autonomic dysregulation pattern was not quite right and the cognitive presentation was different. He said the question I had asked could not be answered without more information than I had given him. He said that some severe autonomic dysregulation states could become fatal if not arrested. He said he was not making a clinical determination because he had not examined the subject. He said I should consider seeking external clinical opinion if I was not satisfied with the Division's management. I thanked him. I did not tell my husband about the call. I did not see what telling him would change. The question he had asked had an answer. The answer was yes. The answer would not change what was happening.

Day 16. The clinical staff have informed us that a sequence of further interventions is being prepared. They will begin in several days. I asked the senior clinician what the first intervention would be. He said cognitive scaffolding therapy. I asked what it involved. He said a clinician would work with my husband to provide verbal frameworks for understanding his experience and assist him in re-categorizing the experience into a more integrated state. I said my husband could not currently process verbal frameworks. The senior clinician said the therapy was designed to assist with exactly that difficulty. I said the difficulty was not difficulty processing frameworks. The difficulty was that his framework-receiving capacity was offline and that adding frameworks would not bring it back online. The senior clinician said the therapy had been effective in M-Series subjects with similar

presentations. I said no M-Series subject had presented like this. The senior clinician did not respond. The therapy will begin in two days.

Day 17. The third episode today lasted twenty-eight minutes. The longest yet. After it subsided I asked him whether he was in pain. He said he was not in pain. He said: 'It is not pain. It is what happens when something has to come out and there is no other way out.' I asked him to explain. He said: 'My body is throwing up. Not from the stomach. From the nervous system. The nervous system has no other way to release what is in it. So it shakes. The shaking is the throwing up. After it shakes the pressure is less. Then the pressure builds. Then it shakes again. This is what is happening. The shakes are not a symptom. The shakes are the only relief.'

I wrote this down immediately. I am writing it down again here so it is in the record I am keeping. He said: 'Do not let them stop the shaking. The shaking is the only thing keeping me alive. If they stop the shaking, what is in the nervous system will have nowhere to go. I do not know what happens if it has nowhere to go. I do not want to find out.'

Day 18. The morning episode lasted thirty-one minutes. He was exhausted afterward. He slept for perhaps an hour. When he woke he was not the same as he had been before he slept. He was further along. I do not know how to describe further along except that there was less of him present in the room than there had been the night before. The clinical staff conducted their morning check-in. They did not appear to notice that there was less of him. They noted his vital signs. They left. I sat with him. He did not speak for the rest of the morning. In the afternoon he said: 'Tomorrow they begin.' I said: 'Yes.' He said: 'I do not think I will be able to tolerate it.' I said: 'What do you want me to do?' He said: 'I want you to remember.' I said: 'I am remembering.' He nodded. He did not speak again until the evening.

V.C — Conclusion of Cascade Onset

The Section V file copy concludes with the documentation of day eighteen and the preparation for the initiation of Intervention 2 on day nineteen. The interval covered by Section V constituted the Division's first sustained acknowledgment that the M-08 recovery profile had diverged from the M-Series model in ways the standard adaptive interventions were not equipped to address. The interval also constituted the period during which the Division's internal correspondence began to register the case as a concern

at levels above the immediate clinical staff, culminating in the Standing Committee's request for interim reporting on day eighteen.

The interval also constituted the first sustained period during which the subject's experience of the unfolding catastrophe was articulated in his own language, both to S— directly (per S—'s contemporaneous notes) and to the clinical staff in the limited communications the subject was capable of during the interval. The phrase that the subject used on day seventeen — my body is throwing up, not from the stomach, from the nervous system — does not appear in the Division's clinical record. The phrase appears only in S—'s contemporaneous notes and, later, in the subject's retrospective marginalia. The Division did not solicit and did not receive the subject's structural description of what was happening to him. The Division solicited and received responses to standardized clinical queries.

The Section VI file copy begins with the initiation of Intervention 2 on day nineteen.

Marginalia — Section V — In the subject's hand. The marginalia for this section are the longest yet, written across the margins of the full section and on six inserted pages in the same hand.

I want to write the phrase here, in the margin of the section where it should have been written by the Division but was not. I said this to S— on the seventeenth day. I said it because she asked me a question and the question deserved an accurate answer. I had not been giving accurate answers to the clinical staff because the clinical staff were not asking the questions to which I could give accurate answers. They were asking questions calibrated to their instruments. The questions assumed an apparatus that could be characterized through their instruments. The apparatus that was experiencing what was happening was not characterizable through the instruments. The accurate answers required questions the instruments did not generate.

S— asked: Are you in pain.

The question was the right question. The question allowed me to report what I was experiencing. I reported it.

It is not pain. It is what happens when something has to come out and there is no other way out.

My body is throwing up. Not from the stomach. From the nervous system. The nervous system has no other way to release what is in it. So it shakes. The shaking is the throwing up. After it shakes the pressure is less. Then the pressure builds. Then it shakes again. This is what is happening. The shakes are not a symptom. The shakes are the only relief.

Do not let them stop the shaking. The shaking is the only thing keeping me alive. If they stop the shaking, what is in the nervous system will have nowhere to go. I do not know what happens if it has nowhere to go. I do not want to find out.

S— wrote this down. The Division did not. The Division did not write it down because the Division did not hear it, because the Division did not ask the question that would have produced it. The Division asked: Rate your pain on a scale of one to ten. The Division asked: Are you experiencing any acute distress. The Division asked: Are you tolerating the recovery process. The Division asked questions to which my answers could be entered into the standardized fields the Division's instruments produced. The questions did not have fields for my body is throwing up through the nervous system. The Division did not have a category for what was happening, and the Division's questions, calibrated to the Division's categories, could not elicit the report I was capable of making.

S— had no categories. S— asked an ordinary question. The ordinary question made it possible for me to say what was happening. I want to record this here in the margin because the structural fact is important. The instrument that worked was not an instrument. The instrument that worked was an ordinary question asked by a person without categorical interference.

The Division spent the next two hundred days deploying its instruments. None of them worked. The interventions designed by the instruments did not work. The pharmacology informed by the instruments did not work. The diagnostic refinements made on the basis of the instruments did not work. The cognitive scaffolding, the sensory regulation, the off-roster combinations — none of them worked. They could not work, because the instruments had not characterized what was happening. The instruments had characterized what the instruments could characterize. What was

happening was not what the instruments could characterize. The interventions therefore addressed phenomena other than what was happening. The phenomena other than what was happening were not the problem. Addressing them did not help. Addressing them often made the problem worse.

The medication that eventually worked, when it eventually worked, was not derived from the Division's instruments. The medication was derived from a different process entirely, which I will describe in the margins of Section XI. The medication was derived from S—'s direct observation, made over months, integrated across the unfolding catastrophe, communicated to a non-Division prescriber who listened to what she said rather than running her observations through the categorical machinery that would have converted them into something else. The non-Division prescriber made a recommendation. The recommendation was tried. The recommendation worked. The Division then had to find a way to incorporate this fact into the case file. The way the Division found was External Resolution. The way the Division found was inadequate. The marginalia is more adequate. The marginalia says: S—'s ordinary question to me, on day seventeen, produced the structural description of what was happening to me. S—'s eventual identification of the medication that worked was the application of the structural description she had elicited from me to the problem of finding an agent that addressed the underlying phenomenon rather than the surface phenomena. The Division's instruments could not do this because the Division's instruments did not have the structural description in their inventory. S— had the description because S— asked the question. The question was the instrument. The instrument was not on any roster.

I want to address day eleven, when I told S— that she was the only person in the room who could see what was happening, and asked her to stay. I do not remember this conversation. S—'s notes record it. I am writing this paragraph from S—'s notes. The man who said Stay on day eleven was not in a position to record the saying. The man who is writing this is in a position to acknowledge it from twenty years later, with the gratitude that the years have made possible. I cannot express the gratitude adequately. The marginalia does not have the bandwidth. The gratitude exceeds what the marginalia can carry. I will note here that the gratitude exists, and that it is structural rather than sentimental, and that without S—'s presence across the eight months that followed I would not be writing this. The Division did not save me. The non-Division prescriber identified the

medication. S— made the prescriber's identification possible. S— made everything that followed the eight months possible. The marginalia exists because S— stayed. I owe the marginalia to S—. I owe everything that the marginalia is in service of to S—.

I want to address one other matter before the section closes.

S—'s notes for day fifteen describe her call to her brother and his colleagues' inability to identify a matching clinical entity. The closest analog her brother could offer was malignant catatonia, with reservations. S— did not tell me about the call. I did not learn of the call until I read her notes some years after the case file had been closed. S— made a determination, on day fifteen, that the call's results would not change what was happening and that informing me of the results would not help me. The determination was correct. Knowing on day fifteen that the symptoms I was experiencing had no clear clinical analog would not have changed the symptoms. Knowing on day fifteen that some autonomic dysregulation states could become fatal if not arrested would not have changed the dysregulation. S— absorbed the information. S— continued to operate. S— continued to observe. S— continued to keep notes. S— did this for the next two hundred and twenty days while carrying the additional weight of knowing what she had been told by her brother's colleagues. I did not learn she was carrying this weight until I read the notes. I want it recorded in the margin that she carried it without telling me, and that the not-telling was an act of consideration calibrated to what I could absorb at the time. S— did not protect me from the truth. S— delivered the truth at the rate I could integrate it. The Division could not have done this. The Division did not have the calibration. S— had the calibration because S— had been calibrating to me for twenty years.

The Division was about to begin Intervention 2. The Division was about to make things substantially worse. S— had already told them I would not tolerate it. The Division had not listened. The Division would not listen for several more interventions. By the time the Division began to listen, the damage of the un-listened-to interventions would be cumulative and would require months to recover from. The marginalia will record this as it occurs.

I will write more in the margins of Section VI.

— [signature: handwritten initials, illegible]

VI. INTERVENTION 2 AND ITS FAILURE

VI.A — Cognitive Scaffolding Therapy: Theoretical Basis

Intervention 2 was authorized by the Medical Director on day eighteen post-intervention, in consultation with the Senior Research Council, and initiated on day nineteen. The intervention consisted of a structured therapeutic modality designated Cognitive Scaffolding Therapy, developed by the Division's Therapeutic Modalities Unit specifically for application to subjects whose post-procedural recovery profiles included sustained cognitive or phenomenological disturbances.

The theoretical basis for Cognitive Scaffolding Therapy is described in the Therapeutic Modalities Unit's standing documentation, summarized here as it appears in the case file.

The therapy proceeds from the observation that subjects undergoing extended decoupling states often report difficulty integrating their phenomenological experiences with their pre-procedural cognitive frameworks. The decoupling, by partially disabling the subject's automatic coherence-production operations, may leave the subject with phenomenological content that cannot be readily assimilated into the subject's standing categorical apparatus. The therapy hypothesizes that the assimilation difficulty can be addressed through external provision of verbal frameworks — by a trained clinician — that scaffold the subject's recovery of categorical integration. The clinician supplies vocabulary, conceptual structure, and integrative narrative; the subject, exposed to these frameworks in a sustained therapeutic context, gradually re-integrates the phenomenological content into a coherent post-procedural account.

The therapy's design parameters specify the following. Sessions are conducted at four-hour intervals for the duration of the active therapy phase. Sessions last approximately forty-five minutes. The clinician follows a structured protocol that introduces categorical frameworks in graduated complexity, beginning with simple descriptive vocabulary for the subject's reported phenomena and progressing toward more integrative interpretive frameworks. The clinician monitors the subject's responses to assess integration progress, modifies the framework introduction pace based on

observed integration, and concludes each session with a brief summary intended to consolidate the integrative work accomplished.

The therapy had been administered to four subjects in the M-Series prior to M-08 (M-02, M-03, M-05, M-06). The Therapeutic Modalities Unit's evaluative summary for these prior applications characterized the therapy as effective in supporting subject recovery, with measurable improvements in phenomenological articulation and reported subjective integration across the post-therapy interval. The Unit considered the therapy a successful adaptive modality and recommended its application to M-08 on the basis of the prior cases.

The Therapeutic Modalities Unit's evaluative summary did not characterize the four prior subjects' phenomenological presentations in sufficient detail to assess their comparability to M-08. The summary noted that all four prior subjects had been within the range of phenomenological reports anticipated by the M-Series model; it did not note that M-08 had, by day nineteen, deviated substantially beyond that range. The decision to apply Cognitive Scaffolding Therapy to M-08 was made on the basis of the therapy's generalized success record rather than on the basis of any analysis of M-08's specific divergence from the recovery profiles for which the therapy had been validated.

VI.B — Therapist Assignment and Initial Session

The therapy was to be conducted by a senior clinician from the Therapeutic Modalities Unit, designated in the case file as Clinician C—. Clinician C— had administered the therapy to two of the four prior M-Series subjects (M-02 and M-06) and was characterized in her assignment documentation as experienced in working with subjects exhibiting sustained phenomenological disturbances and effective in facilitating subject integration.

The Medical Director and Clinician C— conducted a pre-therapy briefing on the morning of day nineteen, prior to the first session. The briefing is documented in a memorandum signed by both parties. The memorandum records that the Medical Director provided Clinician C— with the case file materials accumulated through day eighteen and discussed the subject's recovery profile with particular emphasis on the movement episodes, the cognitive assessment difficulties, and the subject's withdrawn affective presentation. The memorandum records that Clinician C— acknowledged

the complexity of the case and expressed confidence in the therapy's applicability with appropriate modifications for the subject's specific presentation.

The first session was conducted at approximately ten in the morning on day nineteen. The session took place in the residential wing's small consultation room, with the subject seated and Clinician C— seated across from him. S— was permitted to be present in the room at the subject's request; the Therapeutic Modalities Unit's standard protocol permits proximate observers to be present during sessions if the subject so requests and the clinician does not object.

Clinician C—'s session notes record that the session began with introductory exchanges intended to establish rapport. Clinician C— introduced herself, briefly described the therapy, and invited the subject to describe his current experience in his own words. The subject's response, recorded verbatim by Clinician C—: I do not know how to describe my current experience. The words for describing experience are not currently available to me in the way they would need to be. Clinician C— recorded this response and noted that the response was consistent with the integrative difficulties the therapy was designed to address.

Clinician C— then introduced the first scheduled framework from the therapy protocol: a descriptive vocabulary for phenomenological states associated with extended decoupling. The vocabulary included terms such as attentional foreground, attentional background, categorical clarity, integrative awareness, and embodied presence. Clinician C— introduced each term with a brief definition and an example of its application, then asked the subject to identify whether any of the terms corresponded to phenomena he was currently experiencing.

The subject did not respond verbally to the first invitation. Clinician C—'s notes record that the subject appeared to be attempting to formulate a response and was not able to do so. After approximately three minutes of silence, Clinician C— rephrased the invitation. The subject's response, recorded verbatim: I cannot hold the term long enough to compare it to anything. Clinician C— recorded this response and noted that the subject's working memory may be impaired in ways requiring adaptation of the therapy's delivery.

Clinician C— adapted the delivery by shortening the introduced vocabulary and repeating each term multiple times before requesting comparison. The session continued for approximately twenty-five minutes in this adapted form. The subject produced four brief responses across the twenty-five minutes, none of which mapped his experience to the introduced vocabulary. Three of the four responses were essentially identical: I cannot hold the term long enough to compare it to anything. The fourth response was: I am not able to receive what you are giving me. I do not know how to make you understand that I am not able to receive it. The receiving is what is not working.

Clinician C— concluded the session at approximately ten-thirty in the morning. Her session notes record the session as introductory and exploratory, with limited integration accomplished, requiring continued application with possible further adaptations. The notes characterize the subject's reports of inability to receive as consistent with the integrative difficulties under treatment and indicate that continued provision of frameworks at appropriate pacing should produce gradual improvement.

S—'s contemporaneous note from that morning, reproduced below.

> *Day 19, morning. The therapy began at ten. The therapist was capable and well-prepared. The therapy was wrong for him. The therapy was wrong from the first minute. The therapist introduced words. He could not receive the words. He said so, in different ways, four times during the session. The therapist heard him saying he could not receive the words and characterized the not-receiving as the thing the therapy was designed to address. The therapy is designed to provide words to subjects who are having difficulty integrating their experience. The therapy assumes that providing words is the right intervention for difficulty integrating experience. The therapy does not consider that the difficulty might not be a difficulty integrating experience, but rather a complete failure of the apparatus that integrates experience. If the apparatus that integrates experience is offline, providing more material for the apparatus to integrate does not help. Providing more material is more load on an apparatus that cannot bear the load it has. The therapist did not see this. The therapist will continue to provide material because the protocol calls for the provision of material. The provision of material will make things worse. I am writing this so that when things become worse, the record I am keeping will reflect that the worsening was predictable.*

VI.C — Sessions Two Through Six: Progressive Deterioration

Sessions Two through Six of Cognitive Scaffolding Therapy were conducted across days nineteen and twenty, at the scheduled four-hour intervals. The clinical documentation for these sessions, drawn from Clinician C—'s session notes and the Medical Liaison Office's parallel observations, shows a progressive deterioration of the subject's condition that the documentation does not fully acknowledge as such.

Session Two, conducted at approximately two in the afternoon on day nineteen, lasted approximately thirty minutes. Clinician C—'s notes record that the subject experienced a moderate movement episode during the session (commencing at approximately the fifteenth minute, lasting approximately seven minutes). The session was paused during the episode and resumed afterward. Clinician C— attempted to introduce additional framework vocabulary following the episode; the subject's responses, recorded verbatim, included I cannot. Please stop. and I do not want to receive more. I want you to stop. Clinician C— characterized these responses in her notes as expressions of frustration with the integrative difficulty and noted that frustration is a normal response to the therapy in subjects with significant integrative challenges. The session concluded with Clinician C— providing what her notes describe as brief reassurance and orientation toward continued work in the next session.

Session Three, conducted at approximately six in the evening on day nineteen, lasted approximately twenty minutes. The session was terminated by Clinician C— after the subject experienced two consecutive movement episodes (a severe episode commencing at approximately the seventh minute and lasting eleven minutes, followed by a moderate episode commencing at approximately the eighteenth minute and lasting four minutes). Clinician C—'s notes record the termination as appropriate given acute autonomic disturbance during session and indicate that the next scheduled session would proceed with attention to autonomic stabilization.

Session Four, conducted at approximately ten at night on day nineteen, lasted approximately fifteen minutes. The subject's verbal responses across the session consisted of a total of three brief statements. The first, recorded verbatim: Do not do this anymore. The second: I am asking you to stop. The third: I cannot say this more clearly than I am saying it. Clinician C—'s notes characterize the subject's statements as acute distress responses likely

reflecting the cumulative load of the day's sessions and recommend a brief pause overnight before resuming on day twenty.

Session Five, conducted at approximately ten in the morning on day twenty, lasted approximately ten minutes. The subject did not produce any verbal responses during the session. Clinician C— attempted to introduce simplified framework vocabulary; the subject remained silent. The session was terminated by Clinician C— after approximately ten minutes when the subject experienced a severe movement episode that lasted approximately twenty-six minutes following the formal session termination. Clinician C—'s notes for the session characterize the subject's silence as severe withdrawal possibly indicating dissociative response to the therapy and recommend modification of the therapy approach to address the dissociative presentation.

Session Six, conducted at approximately two in the afternoon on day twenty, was terminated after approximately five minutes by S—, who interrupted the session and asked Clinician C— to leave the room. The case file records this termination in a brief notation by Clinician C—: Session terminated at proximate observer's request. Subject's spouse stated that the therapy was causing harm and refused to permit continuation. Matter escalated to Medical Liaison Office for resolution.

S—'s contemporaneous note from the afternoon of day twenty, reproduced below.

> *Day 20, afternoon. The sixth session began. He had not slept the night before. He had experienced eight episodes during the night, three of them severe. The therapist began the session by introducing vocabulary about embodied presence. He sat in the chair. He looked at her. He did not respond. His hands were shaking continuously. His face was not his face. He was not present in the room in any sense I could identify. The therapist was about to introduce the next vocabulary item. I stood up. I said: 'Please leave.' The therapist looked at me. She said: 'I am here to conduct the session.' I said: 'You are causing him harm. Please leave the room.' She said: 'I will need to consult with the Medical Liaison Office before I can leave.' I said: 'Consult them from outside the room. He has asked you to stop. I am asking you to stop. You are not stopping. I am asking you to leave so that you stop.' She looked at me for several seconds. She gathered her materials. She left the room.*

After she left, I sat down beside him. He did not move. I held his hand. The hand was shaking. After several minutes the shaking slowed. After several more minutes he turned his head toward me. He said: 'Thank you.' I said: 'I am sorry I did not stop her sooner.' He said: 'You stopped her now.' I said: 'It was too late.' He said: 'It was not too late.' He did not speak again that afternoon.

VI.D — The Escalation to the Medical Liaison Office

S—'s termination of Session Six triggered an escalation within the Division that is documented in a series of internal communications across the remainder of day twenty and the morning of day twenty-one.

A memorandum dated the afternoon of day twenty, from Clinician C— to the senior member of the Therapeutic Modalities Unit, reports the termination and characterizes the situation as requiring administrative resolution of conflict between proximate observer and therapeutic protocol. The memorandum notes that the proximate observer expressed unilateral objection to continued therapy on the grounds of perceived harm and requests guidance on how to proceed.

A memorandum dated the evening of day twenty, from the Therapeutic Modalities Unit to the Medical Liaison Office, requests that the Medical Liaison Office clarify the role and authority of the proximate observer in the M-08 protocol, with particular attention to whether the proximate observer has standing to terminate scheduled therapeutic interventions.

A memorandum dated the morning of day twenty-one, from the Medical Liaison Office to the Therapeutic Modalities Unit, provides the following clarification. The proximate observer's role under the M-08 protocol is informal-observational, without formal standing to direct or terminate clinical interventions. However, the proximate observer's presence during sessions is at the subject's request, and the subject retains the right to terminate any intervention at any time. The Medical Liaison Office's memorandum states that if the proximate observer's actions reflect the subject's preferences regarding continuation, those preferences must be respected per standing consent provisions and recommends that the subject be consulted directly regarding continuation of Cognitive Scaffolding Therapy before any further sessions are scheduled.

The consultation with the subject was conducted by the senior member of the Subject Relations Office on the afternoon of day twenty-one. The Subject Relations Office's notes from the consultation record the following exchange.

Office: We need to ask you directly whether you wish to continue Cognitive Scaffolding Therapy.

Subject: No.

Office: Can you tell us more about your decision?

Subject: It is making things worse.

Office: Cognitive Scaffolding Therapy has been effective for prior subjects in the M-Series. Are you sure you would like to discontinue?

Subject: Yes.

Office: Is there anything we can modify about the therapy to make it more tolerable for you?

Subject: You can stop it.

Office: We will respect your preference. The therapy will be discontinued. Are there other interventions you would prefer to attempt at this time?

Subject: No.

Office: Would you like to take some time before considering further interventions?

Subject: Yes.

Office: How much time?

Subject: All of it.

The Subject Relations Office's notes characterize the subject's final response as suggesting that the subject would prefer indefinite cessation of all interventions and indicate that the Office will need to address this preference with the Medical Director, as indefinite cessation is not consistent with the protocol's standard of care.

Cognitive Scaffolding Therapy was formally terminated on the afternoon of day twenty-one. The subject's preference for indefinite cessation of further interventions was logged in the case file as a standing objection requiring continued discussion and was not honored in the protocol's subsequent management of the case.

VI.E — Days Twenty-One Through Thirty: Recovery from Intervention 2

The ten-day interval following the termination of Cognitive Scaffolding Therapy was characterized by the Division's clinical documentation as recovery from acute intervention response. The subject's condition during this interval was, in measurable terms, worse than his condition during the eleven days preceding Intervention 2. The Medical Liaison Office's notes for the interval acknowledge this in a memorandum dated day twenty-four: The subject's autonomic dysregulation, movement episode frequency, and reported cognitive impairment have all increased over baseline measurements taken prior to Intervention 2. The increases are interpreted as cumulative effects of the therapy session load combined with the underlying recovery profile deterioration. Recovery to pre-Intervention 2 baseline is anticipated within seven to ten days.

The Medical Liaison Office's notes for the interval log the following measurements.

Daily movement episode count rose from a mean of approximately fifteen episodes per day during the interval immediately preceding Intervention 2 to a mean of approximately twenty-eight episodes per day during the interval immediately following. Severe episodes (over fifteen minutes) constituted approximately forty percent of the daily count during the post-Intervention interval, compared with approximately thirty percent during the pre-Intervention interval.

Sleep deteriorated further. By day twenty-four, the subject had experienced no sleep periods exceeding fifteen minutes in approximately seventy-two hours. The clinical staff documented this as severe sustained insomnia approaching the limit of human physiological tolerance and noted that medical intervention to induce sleep is contraindicated given the subject's response to autonomic agents during Intervention 1.

Autonomic parameters showed continued deterioration. Resting heart rate, which had been approximately thirty-five percent above baseline at the end of Section V, rose to approximately fifty percent above baseline by day twenty-five. Peripheral temperature instability increased. Blood pressure variability increased.

Cognitive assessments were not attempted during the interval; the Cognitive Profile Unit's evaluation was that the subject's condition does not currently support meaningful cognitive assessment.

Phenomenological reports during the interval were essentially absent. The subject responded to direct clinical queries with minimal responses or with silence. The clinical staff characterized the subject as severely withdrawn with significantly impaired communication capacity.

S—'s contemporaneous notes for the ten-day interval are extensive and progressively more spare. The notes shift in character during this interval; the earlier notes had been observational and reflective, while the later notes become primarily logistical, recording what was occurring without attempting characterization. The shift reflects S—'s adaptation to a sustained crisis in which the available bandwidth for reflection had to be conserved for the practical work of continuous presence.

Selections from the interval, in approximately chronological order.

> *Day 21, late evening. He has been asleep for forty minutes. The longest in over a week. I am not moving. I do not want to disturb the sleep.*
>
> *Day 22. Eleven episodes today. Three severe. I am beginning to keep my own count. The clinical staff record their count. My count differs from theirs. I do not know whose count is accurate. I am keeping mine in case it matters later.*
>
> *Day 23. He spoke today. Once. He said: 'How long has it been?' I said: 'Twenty-three days.' He said: 'Tell me when it has been a year.' I said: 'I will tell you.' He did not speak again.*
>
> *Day 24. The clinical staff have begun discussing the next intervention. They have not told me what it will be. I have not asked. I am not certain I want to know in advance.*
>
> *Day 25. He has not eaten more than a few bites in three days. He drinks water when I bring it to him. He does not drink water when no one brings*

it. I am bringing water.

Day 26. The afternoon was the worst day yet. Twenty-one episodes between ten in the morning and ten at night. Four severe. The clinical staff have stopped commenting on the counts. They take the measurements. They enter them into the system. They leave the room.

Day 27. I have been sleeping for two hours at a time, twice a day, when he sleeps. When he does not sleep I do not sleep. I cannot maintain this indefinitely. I am writing this down because I am beginning to think about what indefinitely means in our situation.

Day 28. He looked at me this afternoon and said: 'Are you all right?' I said: 'Yes.' He said: 'You are not.' I said: 'I am as all right as I can be.' He said: 'That is not the same as being all right.' I said: 'No.' He did not say anything else. I think the asking took whatever he had for the day.

Day 29. The clinical staff conducted what they characterized as a 'comprehensive review' today. Three of them, including the Medical Director. They were in the room for forty minutes. They observed him. They consulted the monitors. They asked him a few questions. He responded to one of the four questions with the word 'yes.' He did not respond to the others. The Medical Director told me afterward that they were considering a sensory regulation intervention. I asked what that involved. He explained. I told him I did not think it would work. He asked why. I said the only thing that was reducing the episodes was walking. I had not told them about the walking. I had been doing it at night, in the residential wing's courtyard. He had been able to walk for short periods between episodes, and the walking seemed to reduce the building pressure that produced the next episode. The Medical Director listened. He said the sensory regulation intervention would not preclude walking. I said the sensory regulation intervention would put him in a low-stimulus environment. I said the walking required the opposite. I said the walking required movement, air, the courtyard, the night sky, the cold. I said I did not think the low-stimulus environment would help. The Medical Director said the intervention had been effective in M-Series subjects with severe agitation states. I said my husband was not in an agitation state. The Medical Director did not respond to this characterization. He said the intervention would be reviewed by the Senior Research Council and a decision would be communicated to us.

Day 30. The decision was communicated this morning. Sensory Regulation Protocol will commence tomorrow.

VI.F — Conclusion of Section VI

The Section VI file copy concludes with the documentation of day thirty and the preparation for the initiation of Intervention 3 on day thirty-one. The interval covered by Section VI constituted the Division's first sustained acknowledgment that an adaptive intervention had caused active harm to the subject, though the acknowledgment was framed in terms of cumulative effects and recovery to pre-Intervention baseline rather than in terms of the more fundamental finding that the intervention's theoretical basis was inadequate to the case. The Division's response to the failure of Intervention 2 was to schedule Intervention 3 with what the case file characterizes as appropriate consideration of the lessons of Intervention 2; what those lessons were taken to be, and how they informed the design of Intervention 3, is not specified in the case file's documentation of this transition.

The interval also constituted the period during which S— began the systematic data-keeping practice that would prove crucial in the eventual resolution of the case. The full extent of S—'s parallel documentation is not present in the Division's contemporaneous record; it was preserved in her personal notebooks and inserted into the case file at a later point through unspecified channels. The Division did not solicit, did not receive, and did not consider S—'s observations during the active management of the case beyond the limited interactions documented in the case file.

The Section VII file copy begins with the initiation of Intervention 3 on day thirty-one.

Marginalia — Section VI — In the subject's hand. The marginalia for this section are written in what appears to be sustained sessions, with longer continuous passages than the earlier sections.

Cognitive Scaffolding Therapy was the first intervention designed by the Division that addressed a problem the subject did not have. Intervention 1 had addressed a problem the subject did have — autonomic excitation, cardiovascular dysregulation — with agents that produced the opposite of the intended effect. Intervention 1 was wrong in its agents. Intervention 2

was wrong in its premise.

The premise of Cognitive Scaffolding Therapy is that the subject is having difficulty integrating phenomenological content into existing categorical frameworks, and that providing additional categorical material will assist the integration. The premise assumes that the integration apparatus is functional and that the difficulty is at the level of integrative material. The premise does not consider the possibility that the integration apparatus is itself the structure that has failed.

By day nineteen the integration apparatus had failed. I have written about this in earlier marginalia. The thinning. The discharge through the autonomic substrate. The face that was not my face. The hours of being unable to formulate responses to S—'s questions even when the questions were the right questions. The category-receiving operation had been offline since approximately the seventy-second hour post-intervention. By day nineteen it had been offline for more than two weeks. The Division did not have a measurement for the state of being offline. The Division had measurements for various surface phenomena. None of the measurements indicated that the category-receiving operation was offline, because none of the measurements measured the category-receiving operation. The Division's instruments were calibrated to phenomena on the surface of the apparatus. The substrate that produces the surface phenomena was beneath the instruments' calibration. The Division could not see what was happening because the Division's instruments could not see at the depth where the failure was.

Cognitive Scaffolding Therapy proceeded into this. The therapist arrived with material she was protocol-bound to provide. The material was words. The words were good words, well-chosen, designed for therapeutic use. The words required, in order to be useful, a receiving apparatus. The receiving apparatus was offline. The words arrived. The apparatus could not receive them. The apparatus did not have the capacity to refuse them either. The capacity to refuse would have been a categorical operation. The categorical operations were offline. The apparatus received in a sense — the words entered through the auditory channel — and could not process. The unprocessed words became additional load.

The load expressed itself through the only route available. The route was the autonomic discharge. Each session loaded the apparatus with words it could not process. The processing failure produced pressure. The pressure

discharged through the convulsive movements. The convulsive movements were therefore not symptoms of agitation, were not signs of treatment resistance, were not evidence of dissociative withdrawal. The convulsive movements were the only release valve for the load the therapy was applying. The therapist saw the convulsive movements and characterized them within her available categories. None of her available categories named the movements as the consequence of the therapy. The therapy was the cause and was not visible to the therapist as a cause because the therapy was the framework within which the therapist was perceiving.

I want to address what I said during the sessions. I have read the case file's record of what I said. I do not remember saying these things. The capacity to remember was thinned. What is in the record is what S—'s notes confirm and what the Division recorded. I take it on the basis of these two records that I said what is attributed to me. The sayings have a structural coherence. The sayings progress from I do not know how to describe through I cannot hold the term long enough through I cannot receive what you are giving me through Do not do this anymore through I am asking you to stop through I cannot say this more clearly than I am saying it. The progression is the progression of an apparatus whose remaining articulate capacity was being spent on the attempt to communicate that the therapy was incompatible with its current state. The communication failed. The therapist heard the words. The therapist did not hear the meaning. The therapist's reception of the words was conditioned by the framework within which she was working. The framework permitted her to characterize the words as frustration, acute distress responses, severe withdrawal. The framework did not permit her to characterize the words as the subject reporting accurately that the intervention is causing harm. The framework excluded that characterization because the framework assumed the intervention's beneficial nature as a given.

S— heard the meaning. S— was not operating within a framework. S— heard I cannot. Please stop. and recognized it as the request it was. S— stopped the session.

The Subject Relations Office's consultation with me on day twenty-one is reproduced in the case file. I do not remember the consultation either. The transcript is plausible. I have read it. The final exchange is the one I want to address.

Office: How much time?

Subject: All of it.

The Subject Relations Office characterized this response as suggesting that the subject would prefer indefinite cessation of all interventions and noted that indefinite cessation was not consistent with the protocol's standard of care.

What I was saying — to the extent that what is left of the apparatus that said it can reconstruct its meaning from the transcript — was that I needed all of the available time before the next intervention. Not because I wanted the intervention to never come. Because I needed to recover before another intervention was applied. The recovery from Intervention 2 was still in progress. The autonomic discharge was still building. The sleep was not yet possible. The category-receiving apparatus was still offline. Any further intervention applied while these conditions persisted would compound the damage of Intervention 2 with new damage. I was asking for whatever time the recovery would require before the next intervention was attempted.

The Subject Relations Office did not hear this. The Subject Relations Office heard a refusal of further intervention as such. The Office logged the response as a standing objection requiring continued discussion. The Office did not honor the request, because honoring the request would have required the Division to delay further intervention until the subject's recovery profile indicated readiness. The Division did not have a measurement for readiness. The Division had a protocol that called for sequenced intervention regardless of the subject's recovery profile. The protocol's sequencing logic overrode the subject's request because the subject's request, in the Division's framework, was a standing objection rather than a clinical determination. Clinical determinations belonged to the Division. The subject was not credentialed to make clinical determinations about himself.

The Division was about to apply Intervention 3 to an apparatus that had not recovered from Intervention 2. The Division was about to do this because the protocol called for it, and because the Division's framework did not include a mechanism for delay based on the subject's own report of his readiness, and because the Division did not have a clinical measurement that would have justified delay on Division terms. S— had observations. The observations would have justified delay. The Division did not recognize S—'s observations as clinical material. The Division proceeded.

The proceeding produced what is documented in Section VII.

One final note before this section closes. S—'s contemporaneous note from day twenty-eight records the exchange where I asked her whether she was all right and she said she was as all right as she could be, and I said that was not the same as being all right.

I want to address this from the position of the apparatus that asked the question.

The apparatus that asked the question had been almost entirely offline for weeks. The asking required nearly everything the apparatus had at that moment. I do not know why the question came. I do not know what triggered the surfacing of the small amount of resource it required. What I know is that the surfacing was directed at her. The apparatus, in its diminished state, had retained enough capacity to recognize that S— was bearing more than she could bear. The capacity to recognize this was nearly the last functioning capacity the apparatus possessed at that point. The capacity expressed itself through the only available channel, which was a brief question. The question was inadequate to what I was attempting to express. The question was what was available.

I want it recorded in the margin that the inadequacy of the question was not because the asking apparatus did not understand what S— was carrying. The asking apparatus understood. The asking apparatus could not produce more than the brief question because the asking apparatus had been thinned to the point where the brief question was its maximum output. S— knew this. S— received the question as what it was. That is not the same as being all right was S—'s acknowledgment that she had been seen, by what was left of me, in the conditions she was bearing. The acknowledgment is in the record because S— wrote it down. The acknowledgment is what passed between us in that moment. The acknowledgment did not change anything. The acknowledgment did not make her more all right. The acknowledgment recorded that what was left of me had not yet stopped attending to her. The attention was nearly all I had to give. The attention was what I gave.

S— continued to attend to me for the next two hundred and twenty days. The attention I had given her on day twenty-eight was the briefest possible expression of the attention she gave me continuously across all of those days. Her attention exceeded mine by orders of magnitude. The marginalia records both. The marginalia is the only place where what passed between

us during this period is documented in any form. The Division did not have a category for what passed between us. The case file could not record it. The marginalia is incomplete and approximate. The marginalia is what is available.

I will write more in the margins of Section VII.

— [signature: handwritten initials, illegible]

VII. THE SENSORY REGULATION CATASTROPHE

VII.A — Sensory Regulation Protocol: Theoretical Basis

The Sensory Regulation Protocol was authorized as Intervention 3 by the Medical Director on day thirty post-intervention, in consultation with the Senior Research Council, and initiated on day thirty-one. The protocol is described in the Division's standing documentation as a structured environmental modality designed to support autonomic stabilization in subjects exhibiting sustained dysregulation through controlled reduction of sensory and social input.

The theoretical basis is summarized in the case file as follows.

The protocol proceeds from the observation that subjects in extended dysregulation states often exhibit hypersensitivity to environmental inputs and that the cumulative effect of normal environmental stimulation can constitute additional load on an already-overloaded autonomic system. The protocol hypothesizes that reducing the environmental input below normal levels — through control of light, sound, temperature, social contact, and physical movement — permits the autonomic system to recover capacity that would otherwise be consumed managing environmental load. The recovered capacity is hypothesized to manifest as reduced dysregulation indices, improved sleep, and gradual restoration of cognitive function.

The protocol's design parameters specify the following. The subject is housed in a dedicated regulation chamber with controlled lighting (continuous low-level illumination at fixed parameters), controlled sound (acoustic isolation with white noise generation at fixed parameters), controlled temperature (fixed at a specified setpoint with minimal variation), and controlled social contact (clinical staff entry at scheduled intervals for measurement and care, with no other social input). The subject's physical movement is constrained to the regulation chamber, which is approximately three meters by four meters in dimension and includes a bed, a chair, basic sanitary facilities, and a small table for meals. The protocol's standard duration is seven to fourteen days, with extension permitted based on response.

The protocol had been administered to two prior subjects in the M-Series (M-04 and M-07). The Therapeutic Modalities Unit's evaluative summary characterized the protocol as effective in reducing autonomic dysregulation in subjects with acute presentations and recommended its application to M-08 on the basis of the prior cases.

The evaluative summary did not characterize the two prior subjects' dysregulation presentations in sufficient detail to assess their comparability to M-08. The summary noted that both prior subjects had responded to the protocol with reduced dysregulation indices within seventy-two hours of initiation. The summary did not note that both prior subjects had presented with what the Division characterized as agitation states — dysregulation accompanied by increased motor activity, restlessness, and elevated affective expression — for which environmental restriction was theoretically appropriate. The summary did not address the question of whether environmental restriction was appropriate for a subject whose dysregulation manifested through different channels.

The Medical Director's authorization memorandum for Intervention 3 acknowledges S—'s expressed concern, recorded on day twenty-nine, that the protocol's environmental restrictions might be incompatible with the walking the subject had been using as a coping strategy. The memorandum addresses this concern as follows: The proximate observer has expressed concern that the subject has been using physical movement to reduce autonomic discharge frequency. The Sensory Regulation Protocol's environmental constraints will prevent continuation of this coping strategy during the protocol period. However, the protocol's reduction of environmental input is anticipated to address the underlying autonomic dysregulation directly, eliminating the need for the coping strategy. The proximate observer's concern is noted but is not considered grounds for protocol modification.

The memorandum is signed by the Medical Director and countersigned by two members of the Senior Research Council. The case file does not record whether S— was provided with this response prior to the protocol's initiation.

VII.B — Initiation of the Protocol

Intervention 3 commenced at approximately ten in the morning on day thirty-one post-intervention. The subject was transported from the residential wing of the intervention facility to the regulation chamber, which was located in an adjacent building on the Institute's northern campus. The transport involved approximately fifteen minutes of walking through corridors and across a covered walkway connecting the two buildings.

The Medical Liaison Office's notes record the transport as uneventful and characterize the subject's condition on arrival at the regulation chamber as consistent with his pre-transport baseline: severely dysregulated, with sustained tachycardia and continuous low-grade tremor, but capable of ambulation with assistance and oriented to person and place.

S— was permitted to accompany the subject to the regulation chamber but was not permitted to remain in the chamber during the protocol period. The protocol's social contact constraints excluded the proximate observer from chamber access. The Medical Liaison Office's notes record S—'s departure from the chamber at approximately ten-thirty in the morning, following a brief period during which she assisted the subject in settling into the chamber and made a verbal communication to the on-duty clinical staff regarding the subject's recent walking pattern.

S—'s contemporaneous note from the morning of day thirty-one, reproduced below.

> *Day 31, morning. I helped him into the chamber. The chamber is small. The chamber has no windows. The lighting is a low ambient that does not change. There is a constant low sound from a generator somewhere. The chamber is the opposite of everything that has been keeping him alive. I told the on-duty clinician that he had been walking for thirty to forty minutes at a stretch in the courtyard at night and that the walking had been reducing the episode frequency. The clinician thanked me for the information. The clinician did not appear to register that the information had implications for what was about to happen. I asked the clinician how I could be contacted if his condition deteriorated. The clinician said the protocol provided for routine reporting at twelve-hour intervals and that I would receive updates accordingly. I asked whether I would be notified if there was an acute event between the routine reports. The clinician said acute events would be addressed by the on-duty staff and that I would be notified per standard adverse event protocols. I asked the clinician to repeat this commitment so I would know what was said. The*

clinician repeated it. I left the chamber. I have been waiting in the visitor's wing of the building since.

VII.C — The First Seventy-Two Hours

The first seventy-two hours of the Sensory Regulation Protocol produced documentation that the Division characterized at the time as recovery profile within anticipated parameters for the initiation phase and that the Division's retrospective review acknowledged as the period during which the catastrophe began to develop.

The Medical Liaison Office's notes for the first twenty-four hours record the following measurements.

Movement episode frequency, which had been at approximately twenty-eight episodes per day in the interval preceding Intervention 3, did not decrease during the first twenty-four hours of the protocol. The frequency was approximately twenty-six episodes during the period, within normal day-to-day variation of the pre-intervention baseline. Severe episodes constituted approximately forty-five percent of the count, a modest increase from the pre-intervention proportion.

Autonomic dysregulation indices showed marginal changes that the clinical staff characterized as not yet outside expected variation. Resting heart rate during the first twenty-four hours averaged approximately fifty-three percent above the subject's intake baseline, comparable to the pre-intervention level.

Sleep did not improve. The subject's monitoring indicated approximately forty-seven minutes of total sleep during the first twenty-four hours, distributed across multiple brief intervals of two to ten minutes each. The clinical staff characterized this as consistent with the subject's pre-protocol sleep pattern and noted that significant sleep improvement is typically not observed until the second or third day of the protocol.

The Medical Liaison Office's notes for the second twenty-four hours record a substantial change in the subject's measurements.

Movement episode frequency rose to approximately thirty-eight episodes during the second twenty-four hours, an increase of approximately thirty-five percent over the first twenty-four hours and approximately forty percent over the pre-intervention baseline. Severe episodes constituted approximately

fifty-five percent of the count.

Autonomic dysregulation indices deteriorated measurably. Resting heart rate averaged approximately sixty-one percent above baseline. Blood pressure variability increased. Peripheral temperature instability increased.

Sleep deteriorated further. The subject's monitoring indicated approximately twenty-three minutes of total sleep during the second twenty-four hours.

The Medical Liaison Office's notes for the second twenty-four hours characterize the changes as unexpected deviation from the typical protocol response curve and recommend continued monitoring with reassessment at the seventy-two-hour mark.

The third twenty-four hours produced what the Division's retrospective documentation characterizes as the acute deterioration phase of the protocol.

Movement episode frequency rose to approximately fifty-one episodes during the third twenty-four hours, an increase of approximately thirty-four percent over the second day and approximately eighty-two percent over the pre-intervention baseline. Severe episodes constituted approximately sixty percent of the count. The longest episode during the third twenty-four hours lasted approximately forty-eight minutes — substantially longer than the longest episode recorded in any prior interval of the case.

Autonomic dysregulation indices reached values that the clinical staff characterized as approaching the limit of the monitoring system's normal calibration range. Resting heart rate averaged approximately seventy-four percent above baseline. The subject's blood pressure during periods between episodes ranged from values consistent with severe sympathetic activation to values consistent with vagal collapse, with transitions occurring on time scales of minutes rather than the hours typical of stable dysregulation.

Sleep was not measurable during the third twenty-four hours. The subject's monitoring indicated continuous wakefulness with no sleep intervals exceeding two minutes.

The Medical Liaison Office's notes for the conclusion of the third twenty-four hours record an internal communication from the on-duty senior clinician to the Medical Director requesting urgent reassessment of the protocol. The communication, dated at approximately eight in the morning of day thirty-four, states: Subject's condition has deteriorated significantly

across the first seventy-two hours of Intervention 3 rather than improving. Autonomic dysregulation, movement episode frequency, and sleep deprivation have all worsened. The deterioration trajectory is concerning. Recommend immediate reassessment of protocol continuation.

The Medical Director's response, dated approximately one hour after receipt of the communication, authorized continuation of the protocol with the following rationale: The seventy-two-hour mark is the standard protocol assessment point. The Senior Research Council will convene to review the case at this point. In the interim, continued protocol adherence is appropriate.

VII.D — Day Thirty-Four: The Reassessment That Did Not Occur

The Senior Research Council convened on the morning of day thirty-four to review the M-08 case in light of the deterioration observed during the first seventy-two hours of Intervention 3. The convening was scheduled for nine in the morning. The Medical Director, the Medical Director's Deputy, the senior member of the Subject Relations Office, the senior member of the Therapeutic Modalities Unit, and four members of the Senior Research Council were in attendance.

The convening's documentation indicates that the discussion was extensive, lasting approximately three hours. The discussion considered three primary options.

The first option, supported by the senior member of the Subject Relations Office, was to terminate Intervention 3 immediately on the grounds that the deterioration trajectory was inconsistent with the protocol's intended effect and that continued application risked further harm. The Subject Relations Office's position was that the proximate observer's expressed concern regarding the subject's coping strategy had been substantively correct and that the protocol's environmental restrictions had removed a critical autonomic regulation mechanism without providing an adequate substitute.

The second option, supported by the Medical Director's Deputy and two members of the Senior Research Council, was to modify Intervention 3 to permit limited physical movement and short-duration social contact while maintaining other environmental constraints. The position was that the protocol's core mechanism — environmental input reduction — remained theoretically sound but that the specific exclusion of physical movement

might be incompatible with the subject's particular dysregulation pattern.

The third option, supported by the Medical Director and two members of the Senior Research Council, was to continue Intervention 3 without modification on the grounds that the third day's deterioration might represent an adjustment response preceding the protocol's intended effect, and that premature termination or modification could prevent the protocol from achieving its theoretical benefit.

The convening's documentation records that the discussion of the three options was substantive and that significant disagreement existed among the attendees. The Medical Director's position prevailed by virtue of the Medical Director's role as final authority on protocol decisions absent formal escalation to the Standing Committee. The convening concluded with the authorization of continued protocol adherence without modification.

The convening's documentation does not record consideration of consultation with the subject or with the proximate observer regarding the decision. The Division's standard practice at the time was to communicate protocol decisions to the subject after they had been reached, rather than to consult the subject during the decision process. The decision was communicated to the subject at approximately two in the afternoon of day thirty-four by the on-duty senior clinician. The communication is not documented in the case file beyond a brief notation that the subject was informed of the continuation of the protocol and did not verbally respond. The communication was not made to S—; S— learned of the decision from the on-duty senior clinician during her four-thirty afternoon attempt to obtain an update on the subject's condition.

S—'s contemporaneous note from the afternoon of day thirty-four, reproduced below.

> *Day 34, afternoon. I went to the building at four-thirty. I asked to see the on-duty senior clinician. He came to the visitor's wing. I asked for an update. He told me that the Council had met that morning and had decided to continue the protocol. I asked what the Council had considered. He said the Council had considered several options and had concluded that protocol continuation was appropriate. I asked whether the Council had been aware of the deterioration over the past three days. He said the Council had been fully briefed. I asked whether the Council had considered the possibility that the protocol was the cause of the*

deterioration. He said the Council had considered the deterioration in the context of the protocol's expected response curve. I asked when the next assessment would be. He said the next assessment was scheduled at day thirty-eight. I asked what would have to happen for the protocol to be terminated before day thirty-eight. He said the protocol would be terminated if the subject experienced an acute medical event requiring immediate intervention. I asked what would count as an acute medical event. He listed several. The list included cardiac events, respiratory failure, status epilepticus, and loss of consciousness. I asked whether the subject's current condition counted. He said the subject's current condition did not meet the threshold for any of the listed events. I asked whether I could see the subject. He said social contact was excluded by the protocol. I asked whether I could see him for five minutes. He said the protocol did not provide for exceptions. I asked whether I could see him for one minute. He said the protocol did not provide for exceptions. I asked whether the protocol provided for the subject's spouse to be excluded indefinitely from contact with him while his condition deteriorated. He said the protocol provided for routine reporting at twelve-hour intervals. I told him that I was not satisfied with this response. He said he understood. I left the building.

VII.E — Days Thirty-Five Through Thirty-Eight: Continued Deterioration

The four-day interval following the reassessment that did not occur produced documentation of continued and accelerating deterioration that the Division's contemporary record characterizes in increasingly cautious institutional language.

The Medical Liaison Office's notes for day thirty-five record a daily episode count of approximately fifty-eight episodes. Severe episodes constituted approximately sixty-five percent of the count. The longest episode lasted approximately fifty-three minutes. The subject's resting heart rate averaged approximately seventy-eight percent above baseline. The subject's blood pressure showed continued instability with transitions between sympathetic activation and vagal collapse occurring at increasing frequency.

The notes for day thirty-six record a daily episode count of approximately sixty-three episodes. The longest episode lasted approximately fifty-eight minutes. The subject's measurements approached values that the on-duty senior clinician's parallel internal communication characterized as

concerning at the upper limit of monitoring system calibration. The senior clinician's communication, addressed to the Medical Director, included the statement I am observing a subject whose autonomic parameters are approaching values I have not previously observed in a patient who remained alive.

The Medical Director's response to the communication was not entered in the formal case file at the time. A copy was inserted into the file at a later point through unspecified channels and appears in the file as a marginal insertion. The response, reproduced verbatim: Maintain monitoring. Acute medical event threshold remains as defined. Continue protocol adherence pending day thirty-eight assessment.

The notes for day thirty-seven record a daily episode count of approximately sixty-nine episodes. The clinical staff's documentation of individual episodes had by this point become abbreviated; the staff had reduced documentation to start time, end time, and a severity indicator, with no detailed observational content. The reduction was characterized in the staff's internal communications as necessitated by the volume of events requiring documentation.

The notes for day thirty-eight record the events that constituted the protocol's termination.

At approximately three in the morning of day thirty-eight, the subject experienced an episode of unprecedented duration. The episode commenced at approximately two-fifty in the morning and continued, with brief intervals of partial subsidence, until approximately five in the morning. The aggregate duration of the convulsive activity was approximately one hour and forty minutes; the longest continuous interval of unsubsided activity was approximately thirty-six minutes. During the episode, the subject's cardiac monitoring showed sustained tachycardia at heart rates ranging from one hundred fifty-five to one hundred ninety-two beats per minute. The subject's blood pressure was variable but at no point reached the threshold for emergency hypertensive intervention as defined in the protocol. The subject's respiratory pattern was irregular but did not meet the threshold for respiratory failure as defined in the protocol. The subject did not lose consciousness at any point during the episode.

The on-duty senior clinician's notes for the episode record the following: Subject experiencing extended autonomic discharge event. Parameters elevated but do not meet acute event threshold. Continued monitoring. Subject conscious throughout. No intervention indicated per protocol.

The episode's documentation is followed by a notation, time-stamped at approximately five-fifteen in the morning, that S— had arrived at the building and was requesting access to the subject. The on-duty senior clinician informed S— that the protocol's exclusion of social contact was in effect and that access could not be granted. S— remained in the visitor's wing.

At approximately seven in the morning, the on-duty senior clinician contacted the Medical Director by telephone. The content of the call is not documented in the formal case file. A reconstruction of the call's content from later correspondence indicates that the senior clinician requested authorization to admit S— to the chamber. The Medical Director denied the request on the grounds that admitting S— would constitute a protocol violation that could not be authorized without formal Senior Research Council action.

At approximately seven-thirty in the morning, S— entered the building's secured area without authorization and proceeded to the regulation chamber. The Medical Liaison Office's notes record the breach as follows: Proximate observer entered restricted area without authorization at approximately seven-thirty. Reached regulation chamber and entered it. Refused requests by clinical staff to leave the chamber. Required physical removal procedures per facility security protocol. Subject's spouse was removed from the chamber at approximately seven-forty-five. Security incident report filed.

S—'s contemporaneous note from the morning of day thirty-eight, reproduced below.

> *Day 38, morning. I went to the chamber. I had been awake all night listening to the building. The building has a sound I had not noticed before. The building has the sound my husband described on day four of the protocol. I do not know whether the sound is in the building or whether I am now hearing what he had been hearing for thirty-eight days. At seven-thirty I entered the building's restricted area. The doors were not locked from the outside; the doors were monitored and alarmed but not physically locked. I walked through the corridors until I reached*

> *the chamber. I entered the chamber. He was on the bed. He was conscious. He looked at me. He said: 'You came.' I said: 'I am taking you out of here.' He said: 'They will not let you.' I said: 'They will let me.' I sat down on the bed next to him. I held him. He was rigid. His skin was cold. The clinical staff entered the chamber within two minutes of my entry. There were three of them. They told me to leave the chamber. I did not leave. They told me again. I did not leave. They summoned security personnel. Two security personnel entered the chamber and removed me from the chamber. They did not use force beyond what was required to move me out of the chamber. I did not resist beyond making them carry me. They carried me out of the chamber to the visitor's wing. They told me I would face consequences for the breach. I told them I did not care what consequences I faced. They left me in the visitor's wing. I sat in the visitor's wing. I waited.*

The protocol was formally terminated at approximately eleven in the morning of day thirty-eight, following an emergency convening of the Senior Research Council in response to the security incident and the morning's episode. The convening's documentation records that the Council unanimously authorized immediate termination of Intervention 3 and return of the subject to the residential wing pending reassessment of the recovery management plan. The convening's documentation does not record discussion of the security incident as such; the matter was deferred to a subsequent administrative review that was conducted and concluded with what the case file characterizes as no formal sanction against the proximate observer.

The subject was transported from the regulation chamber to the residential wing at approximately one in the afternoon of day thirty-eight. S— was permitted to be present in the residential wing on his arrival. The transport itself was uneventful; the subject was able to walk with substantial assistance and was oriented to person and place upon arrival.

VII.F — Days Thirty-Eight Through Forty-One: Initial Recovery

The three-day interval following the termination of Intervention 3 produced documentation of measurable improvement in the subject's condition that the Division's contemporary record characterizes as unexpectedly rapid recovery toward baseline upon protocol termination.

The Medical Liaison Office's notes for day thirty-nine record a daily episode count of approximately thirty-one episodes — a decrease of approximately fifty-five percent from the prior day's count of sixty-nine. Severe episodes constituted approximately forty percent of the count. The subject's resting heart rate averaged approximately fifty-seven percent above baseline, a substantial decrease from the prior day's average of approximately eighty-one percent above baseline.

The notes for day forty record a daily episode count of approximately twenty-two episodes. The subject's resting heart rate averaged approximately forty-eight percent above baseline. The subject slept for approximately three hours during the night of day forty, distributed across three intervals of approximately one hour each — substantially more than the cumulative total of approximately forty minutes recorded across the prior four days combined.

The notes for day forty-one record a daily episode count of approximately seventeen episodes. The subject's measurements approached the values that had characterized the interval preceding Intervention 3.

The clinical staff's contemporary documentation characterizes this recovery trajectory as consistent with the autonomic stabilization that the Sensory Regulation Protocol had been designed to produce, with the unusual feature that the stabilization occurred following protocol termination rather than during protocol application. The Medical Director's day-forty-one summary memorandum acknowledges this characterization as requiring further analysis but does not pursue the analysis in the case file's documentation of this interval.

S—'s contemporaneous note from the evening of day forty-one, reproduced below.

> *Day 41, evening. He has been walking again. Three short walks today in the courtyard. The walking helps. The walking has helped from the beginning. Everything that has happened since day thirty-one was caused by them taking away the walking. They have not acknowledged this. I do not expect them to acknowledge it. I have acknowledged it. The record I am keeping has acknowledged it. The record they are keeping will continue to characterize the protocol as an autonomic stabilization intervention. The record I am keeping will characterize the protocol as the eight days during which they nearly killed him. Both records will*

exist. Time will determine which record is the more accurate. I am willing to wait for time.

VII.G — Conclusion of Section VII

The Section VII file copy concludes with the documentation of day forty-one and the preparation for the initiation of Intervention 4, scheduled to begin on day forty-two. The interval covered by Section VII constituted the Division's most serious failure of the case to date and produced what the Division's retrospective documentation acknowledged as recovery dynamics that the Division did not understand at the time and that would only become clearer in light of subsequent developments.

The interval also constituted the period during which the proximate observer's intervention against Division protocol most directly affected the case's trajectory. S—'s unauthorized entry into the regulation chamber on day thirty-eight, while not the proximate cause of the protocol's termination — the protocol was terminated following the Senior Research Council's emergency convening rather than as a direct response to S—'s entry — was nonetheless the action that triggered the Council's emergency convening and the institutional review of the protocol's continuation. The Division's contemporary documentation does not address this relationship explicitly. The Division's retrospective documentation acknowledges, in language somewhat removed from the events, that the proximate observer's actions during the Intervention 3 period contributed to the institutional review process that led to the protocol's termination.

The Section VIII file copy begins with the initiation of Intervention 4 on day forty-two.

Marginalia — Section VII — In the subject's hand. The marginalia for this section are written in a hand that appears strained, with several passages crossed out and rewritten. The handwriting is recognizable as the subject's throughout but shows the cumulative fatigue of an apparatus that, by the time of writing, had been reconstructing extremely difficult material across an extended interval.

I do not have continuous memory of the eight days I spent in the regulation chamber. The case file describes what was happening during those eight days. S—'s notes describe what was visible from outside the chamber

during those eight days. The marginalia describes what I can reconstruct from within the eight days, which is not much, and what I can construct from the case file and S—'s notes in retrospect, which is more.

The memories I have from the chamber are not continuous. They are fragmentary. They are not sequenced. I have a memory of the lighting. The lighting was a low ambient that did not change. The lighting was experienced not as illumination but as a constant condition the visual field could not escape from. The visual field had to do something with the light. The light was always there. The light became the visual field's substance rather than its illumination. I do not have words for this in the marginalia that exceed the words I am attempting now. The light was the room. The room was the light. The light was the only available perceptual content. The light did not provide enough perceptual content for the perceptual apparatus to do its standard work. The apparatus, deprived of content, began to do something else. What it began to do is what I cannot describe.

I have a memory of the sound. There was a generator somewhere. The generator produced a low constant hum. The hum was at a frequency that was not at the edge of audibility but was below the threshold at which sound is normally attended to. The hum became the substrate of all hearing. The hum was not a sound I heard. The hum was the condition in which sound existed. The hum was always there. The hum became, after some interval I cannot specify, the substrate of consciousness itself. The hum and I became indistinguishable.

I have a memory of temperature. The temperature was a fixed value at which the body did not have to do thermoregulatory work. The temperature was experienced as the absence of temperature. The body, deprived of the work of thermoregulation, lost contact with itself as a thermal object. The body became uncertain whether it was a body. The body's uncertainty about itself was added to the apparatus's broader uncertainty about itself.

I have a memory of the walls. The walls did not have features. The walls were continuous surfaces of a fixed color at a fixed distance. The walls did not change. The walls became the boundary of available perception. The boundary became the apparatus's only spatial referent. The spatial referent did not have variation. The apparatus, deprived of spatial variation, could not maintain its spatial orientation. The apparatus's spatial orientation collapsed at some point during the eight days into something that was not orientation. I cannot describe what it was.

I have a memory of the episodes. The episodes during the chamber period were different in character from the episodes preceding and following the chamber. The pre-chamber episodes had been releases through the autonomic substrate of pressure that had built. The chamber episodes were releases of pressure that had nowhere to build, because the apparatus did not have enough remaining structure to contain pressure. The chamber episodes were the apparatus disintegrating in increments. Each episode took something. The apparatus, between episodes, had less than it had before the episode. The apparatus between episodes was thinner than the apparatus between episodes had been. The apparatus was being consumed by its own discharge mechanism, because the discharge mechanism, deprived of any restorative process between discharges, was consuming the apparatus to fuel itself.

The walking had been the restorative process. The walking was not, as the Division characterized it, a coping strategy. The walking was the mechanism by which the apparatus restored itself between discharges. The walking moved the body through space. The movement through space produced sensory input that the apparatus could partially process. The partial processing rebuilt, in increments, what the discharges had consumed. The walking was not optional. The walking was the only restoration available to the apparatus. The walking, removed, left the apparatus with no restoration. The apparatus continued discharging because the discharge mechanism was its only available response to its condition. The discharging consumed the apparatus. The apparatus thinned to the point where, on the morning of day thirty-eight, the discharging continued for an hour and forty minutes because the apparatus had nothing left with which to interrupt the discharge.

I do not know what would have happened if S— had not come. I know what was happening at five in the morning of day thirty-eight. What was happening was that the discharging had become the apparatus's only operation. The apparatus had become the discharging. There was nothing left to discharge. The discharging continued because the discharge mechanism had no off-switch and the apparatus had no remaining capacity to apply an external off-switch. The discharging would have continued until something other than the discharging mechanism failed. The other thing that could have failed would have been the cardiovascular substrate. The cardiovascular substrate at five in the morning of day thirty-eight was operating at parameters the senior clinician described in his

communication to the Medical Director as values he had not previously observed in a patient who remained alive. I do not know how close the cardiovascular substrate was to failure. The cardiovascular substrate did not fail. I do not know whether it would have failed if S— had not come.

S— came at seven-thirty in the morning. The clinical staff did not let her in. S— came in anyway. The clinical staff removed her. S— had been in the chamber for fifteen minutes. The fifteen minutes did several things.

The fifteen minutes broke the chamber's isolation. The chamber, until S— entered, had been the condition in which I was the only content. The chamber, with S— in it, was a chamber in which there was something other than my condition. The something other than my condition was S—. The something other than my condition was perceptible by the apparatus that had been collapsing into its discharge. The apparatus, perceiving something other than its discharge, partially reoriented to the something other. The reorientation was not full. The reorientation was the beginning of the apparatus reconstituting around a perceptual content other than its own collapse. The reconstitution was sufficient that, when the security personnel removed S— from the chamber four minutes after the clinical staff entered, the reconstitution did not fully reverse. The apparatus, having briefly reoriented to S—, retained a fragment of the reorientation after S— was removed. The fragment was sufficient that the discharging began to slow. The discharging continued for several more hours but at decreasing amplitude. By the time the protocol was formally terminated at eleven in the morning, the discharging had slowed substantially. The slowing began at approximately seven-thirty-five. The slowing was caused by S—.

The case file does not record this. The case file records that the protocol was terminated at eleven in the morning following the Senior Research Council's emergency convening. The case file characterizes the recovery dynamics over the subsequent three days as consistent with the autonomic stabilization that the Sensory Regulation Protocol had been designed to produce, with the unusual feature that the stabilization occurred following protocol termination rather than during protocol application. The case file does not have a category for the proximate observer's brief presence in the chamber initiated the recovery before the protocol was formally terminated. The case file does not have this category because the case file's framework does not permit the proximate observer to initiate clinical effects. The proximate observer's role in the case file is to be present and to

observe, not to produce outcomes. The proximate observer producing outcomes is outside the case file's available characterizations. The case file therefore characterizes the recovery as occurring through the protocol's mechanism, which it could not have because the protocol's mechanism had been actively destroying the apparatus, or as occurring spontaneously following protocol termination, which is approximately what the case file settles on.

The marginalia records the actual mechanism. The actual mechanism was S—. S— entered the chamber, was briefly present, was removed, and the apparatus that had been collapsing into its own discharge mechanism began to partially reorient. The reorientation continued across the subsequent hours. The Senior Research Council's emergency convening occurred during these hours. The Council's decision to terminate the protocol followed the slowing of the discharging that had already begun. The Council did not initiate the recovery. The Council ratified an institutional recognition that the protocol had to end. The recognition was structural. The discharging was slowing. The clinical staff observed the slowing. The Council, briefed on the slowing, terminated the protocol. The slowing's cause was S—. The protocol's termination ratified the slowing without recognizing its cause.

I want to record one further thing about day thirty-eight. The case file describes S—'s breach of the restricted area as required physical removal procedures per facility security protocol and notes that Subject's spouse was removed from the chamber at approximately seven-forty-five. What this characterization does not contain is what happened in the chamber during the four minutes between the clinical staff's entry and the security personnel's removal of S—.

The clinical staff entered the chamber. S— was sitting on the bed next to me holding me. The clinical staff told her to leave the chamber. She said: No. The clinical staff told her again. She said: No. The clinical staff summoned security. While they waited for security, the clinical staff stood in the chamber observing us. S— did not look at them. S— looked at me. She continued to hold me. The clinical staff did not attempt to physically separate us prior to security's arrival. The clinical staff appeared to be uncertain whether physical separation was within their authority. They waited.

S— spoke to me during the four minutes. She said: I am here. She said: I came. She said: You can let go now if you need to. She said: I am here. She repeated I am here several times. I do not have a precise count. I do not have continuous memory of the four minutes. I have the memory of S—'s voice saying I am here. The memory is fragmentary but it is recoverable.

The security personnel arrived. They asked S— to leave. She did not respond. They picked her up. They carried her out. She did not struggle but she did not assist them either. She made them carry her weight. She was carried out of the chamber. The carrying took approximately one minute. During the carrying, S— continued to look at me. She did not speak during the carrying. She looked at me until she was out of the chamber's line of sight.

The looking continued the I am here without words. The apparatus, in the chamber, retained the I am here after S— was out of sight. The retention was sufficient to slow the discharging. The retention is what the marginalia is recording here as the actual mechanism of the recovery. The marginalia is also recording, more simply, that S— came when no one else would have come, did what no one else would have done, was carried out by security personnel, and saved my life. The case file's category for this is unauthorized entry to restricted area, required physical removal procedures per facility security protocol. The marginalia's category for this is S— saved my life.

The case file's category and the marginalia's category cannot both be in the same record without something giving way. What gives way is the case file's category, which is preserved here in the section to which the marginalia is attached, but which the reader who has read the marginalia can no longer take seriously as a description of what occurred. The case file's category is a record of how the institution processed an event the institution could not metabolize. The marginalia is a record of the event itself. Both records are reproduced. The reader chooses which to credit. I have chosen which to credit. I credit the marginalia.

I will write more in the margins of Section VIII.

— [signature: handwritten initials, illegible]

VIII. THE PHARMACOLOGICAL ROSTER EXHAUSTED

VIII.A — Intervention 4: Sequential Pharmacological Trials

Intervention 4 was authorized by the Medical Director on day forty-one post-intervention, in consultation with the Senior Research Council, and initiated on day forty-two. The intervention consisted of sequential trials of seven pharmacological agents drawn from the Division's standard intervention roster, applied across a period of approximately fifty-two days.

The intervention's design parameters are documented in the Therapeutic Modalities Unit's authorization memorandum, summarized here as it appears in the case file.

Each agent in the standard intervention roster would be trialed in sequence on the subject for a period of five to seven days, with the duration of each trial determined by the agent's pharmacokinetic profile and the subject's response. The trials would be separated by washout periods of approximately three days, during which the prior agent would clear and the subject's baseline measurements would be re-established before the next agent's introduction. The intervention's primary endpoint was identification of an agent that produced sustained reduction in autonomic dysregulation indices without unacceptable adverse effects. The intervention's secondary endpoint was characterization of the subject's pharmacological response profile, which the Therapeutic Modalities Unit characterized as likely to provide insight into the underlying nature of the subject's persistent dysregulation.

The seven agents authorized for trial, in their scheduled order of introduction, were designated A1 through A7 in the case file's pharmacological notation. The agents' generic descriptions are reproduced from the standard roster documentation:

A1: A serotonin-modulating agent with anxiolytic properties, typically applied to subjects with anxiety-spectrum dysregulation presentations.

A2: A glutamatergic-modulating agent with antiseizure properties, typically applied to subjects with motor-component dysregulation presentations.

A3: A noradrenergic-blocking agent, typically applied to subjects with sympathetic-component dysregulation presentations.

A4: A gabaergic-enhancing agent at sub-sedative dosage, typically applied to subjects with arousal-component dysregulation presentations.

A5: A dopaminergic-modulating agent, typically applied to subjects with motor and cognitive-component dysregulation presentations.

A6: A mood-stabilizing agent of mixed mechanism, typically applied to subjects with affective-component dysregulation presentations.

A7: A novel-mechanism agent developed by the Division's pharmacology unit for application to subjects with treatment-resistant dysregulation presentations.

The Therapeutic Modalities Unit's authorization memorandum acknowledges that the M-08 case has demonstrated atypical response patterns to prior pharmacological intervention (Intervention 1) and that the trials in this intervention are conducted with attention to the possibility of unusual responses. The memorandum specifies enhanced monitoring during each trial and provides for immediate trial termination in the event of acute adverse response.

S—'s contemporaneous note from day forty-two, morning, reproduced below.

> *Day 42, morning. They have begun a new intervention. It is the medications again. Seven of them, one at a time. Each will be tried for five to seven days. I asked the senior clinician how long the whole intervention would take. He said approximately fifty days. I said fifty days is a long time. He said the intervention is designed to identify a working agent. I said the first medication intervention had been three hours and had produced acute deterioration. I said extending this kind of trial across seven medications and fifty days seemed designed to ensure that any agent that worsened his condition would have ample time to do so before the next agent was tried. The senior clinician said the trial design included immediate termination criteria for acute adverse responses. I said the immediate termination criteria during Intervention 1 had not prevented the cascade of episodes that followed the agent's discontinuation. I said the criteria were calibrated to events that exceeded thresholds rather than to trajectories. I said trajectories were what mattered with him. The senior clinician said the criteria were*

standard and that the trial would proceed as designed. I asked whether I would be permitted to be present during the trials. He said proximate observer presence was permitted in the residential wing per standard protocol. I asked whether I would have access to him during the active monitoring periods following each agent's introduction. He said access during active monitoring would be limited. I asked what limited meant. He said access would be subject to clinical judgment. I asked who made the clinical judgment. He said the on-duty clinical staff in consultation with the Medical Director. I said the Medical Director's clinical judgment had authorized the prior interventions whose effects we were now attempting to address. I said I had limited confidence in the Medical Director's clinical judgment. The senior clinician did not respond. I said this for the record, not because I expected it to change the trial design.

VIII.B — Trials A1 Through A3: Initial Failures

The trials of agents A1 through A3 were conducted across days forty-two through sixty-three, with brief washout periods between each trial. The Medical Liaison Office's notes for these trials document responses that the Therapeutic Modalities Unit characterized at the time as informative but not therapeutic.

The A1 trial commenced on day forty-two. The agent was administered at standard initial dosage. The subject's autonomic dysregulation indices showed no measurable change across the first seventy-two hours. The dosage was increased to upper therapeutic range on day forty-five. The subject's measurements continued to show no measurable change. The trial was terminated on day forty-eight without observed effect, positive or negative.

The Therapeutic Modalities Unit's evaluation of the A1 trial was that the serotonin-modulating mechanism does not appear to address the subject's specific dysregulation pattern. The evaluation did not characterize the absence of any measurable change as concerning. The standard interpretation in the Division's pharmacological framework was that agents producing no effect indicated the absence of the mechanism the agent addressed in the subject's dysregulation; the trial's failure to produce effect was treated as a positive finding regarding the dysregulation's etiology rather than as a failure of the agent to address the subject's condition.

The A2 trial commenced on day fifty-one, following the standard washout period. The agent was administered at standard initial dosage. The subject's

movement episodes showed a measurable but unsustained reduction across the first forty-eight hours: episode frequency decreased from approximately seventeen per day at the start of the trial to approximately twelve per day at the forty-eight-hour mark. Beginning at the seventy-two-hour mark, episode frequency began increasing again, returning to approximately seventeen per day by day five of the trial and exceeding twenty per day by day six. The trial was extended to day seven to characterize the rebound response; episode frequency reached approximately twenty-six per day by trial conclusion. The trial was terminated on day fifty-eight.

The Therapeutic Modalities Unit's evaluation of the A2 trial characterized the rebound as consistent with tolerance development to the glutamatergic-modulating mechanism and noted that the brief initial response confirms the presence of a motor-component dysregulation that may respond to alternative agents with similar mechanism but reduced tolerance liability. The evaluation did not address the question of whether the rebound's amplitude — episode frequency at trial conclusion exceeded pre-trial baseline by approximately fifty percent — indicated that the agent had destabilized the subject's regulatory system rather than tolerated to ineffectiveness.

The A3 trial commenced on day sixty-one, following the standard washout period plus an additional two days to permit the post-A2 rebound to subside. The agent was administered at standard initial dosage. The subject's autonomic dysregulation indices showed acute deterioration within twenty-four hours: resting heart rate increased from approximately fifty-five percent above baseline at trial start to approximately seventy-eight percent above baseline at twenty-four hours; blood pressure showed increased variability; movement episode frequency increased from approximately seventeen per day at trial start to approximately twenty-eight per day at twenty-four hours. The trial was terminated at thirty-six hours due to acute adverse response.

The Therapeutic Modalities Unit's evaluation of the A3 trial characterized the response as paradoxical sympathetic activation and noted that the agent's noradrenergic-blocking mechanism appears to produce reflexive sympathetic upregulation in this subject, consistent with the paradoxical excitation observed in Intervention 1. The evaluation acknowledged that agents addressing sympathetic-component dysregulation may need to be

approached with greater caution in this subject's continued management.

The seventy-two-hour interval following the A3 trial's termination produced what the case file characterizes as recovery to pre-A3 baseline. In measurable terms, the subject's condition at the seventy-two-hour post-termination mark was modestly worse than his condition at A3 trial initiation: resting heart rate averaged approximately sixty percent above baseline (compared with fifty-five percent at trial start), and movement episode frequency averaged approximately twenty per day (compared with seventeen per day at trial start).

S—'s contemporaneous notes for the A1 through A3 trials are spare. Selections in approximately chronological order.

> *Day 45. Three days into A1. No change. He is the same. The episodes are the same. The clinician characterizes the absence of change as informative. I do not know what they are being informed of by the absence of change.*
>
> *Day 48. A1 ended. They will begin A2 in three days. Between agents he is the same. The same is not improvement. The same is the baseline they are now trialing against.*
>
> *Day 53. Two days into A2. The episodes have decreased modestly. He has slept slightly longer last night. The clinician is encouraged. I am not encouraged. The improvement is too small and too quick. Things that improve quickly with him have rebounded quickly. I am waiting.*
>
> *Day 56. A2 has rebounded. The episodes are worse than before A2 began. The clinician characterizes this as tolerance. I characterize this as another agent that briefly helped and then made things worse. The clinician's characterization preserves the agent's record. My characterization records what occurred.*
>
> *Day 62. A3 began this morning. By this evening he is substantially worse. The clinician on duty has acknowledged this. The clinician is consulting with the Medical Director regarding whether to terminate the trial.*
>
> *Day 63. They terminated A3. The acute response was severe. He is recovering. He is not at where he was before A3 began. Each of these trials has left him slightly worse than before the trial. The trials are cumulatively damaging. The damage is small in any individual trial. The damage is real.*

VIII.C — Trials A4 Through A6: Continuing Failures

The trials of agents A4 through A6 were conducted across days sixty-six through eighty-eight. The Medical Liaison Office's notes for these trials show a consistent pattern: each agent produced either no measurable effect or transient effects followed by deterioration that exceeded pre-trial baseline.

The A4 trial commenced on day sixty-six. The gabaergic-enhancing agent was administered at sub-sedative dosage. The subject's measurements showed no change across the first forty-eight hours. The dosage was increased on day sixty-eight. The subject experienced progressive sedation across the next forty-eight hours, with the sedation accompanied by reduced movement episode frequency (decreasing from approximately twenty per day to approximately eleven per day). However, the subject's cognitive assessments, attempted on day seventy, showed substantial decline from pre-trial measurements; the subject was unable to complete tasks he had completed at pre-trial assessments. The trial was continued for an additional three days to characterize the sedation/dysregulation tradeoff. The dysregulation reduction did not persist; by day seventy-two, episode frequency had returned to pre-trial baseline despite continued sedation. The trial was terminated on day seventy-three.

The Therapeutic Modalities Unit's evaluation characterized the A4 trial as demonstrating that the dysregulation pattern persists at the level of motor expression independent of arousal modulation and noted that gabaergic enhancement provides symptomatic reduction during the active sedation interval but does not address the underlying dysregulation mechanism.

The A5 trial commenced on day seventy-six. The dopaminergic-modulating agent was administered at standard initial dosage. The subject's measurements showed no change across the first forty-eight hours. The dosage was adjusted on day seventy-eight. The subject experienced acute increase in movement episode amplitude and duration across the subsequent twenty-four hours, with multiple severe episodes exceeding forty minutes in duration. The trial was terminated on day eighty due to acute adverse response.

The Therapeutic Modalities Unit's evaluation of the A5 trial characterized the response as paradoxical motor activation and noted that the dopaminergic modulation appears to have destabilized the motor-component regulation in

this subject in a manner not predicted by the agent's standard response profile. The evaluation acknowledged that the M-08 case is increasingly demonstrating that the subject's dysregulation does not respond to standard pharmacological agents in the manner predicted by their typical mechanisms.

The A6 trial commenced on day eighty-three. The mood-stabilizing agent was administered at standard initial dosage. The subject's measurements showed marginal changes across the first seventy-two hours that the clinical staff characterized as possibly within normal day-to-day variation: resting heart rate decreased from approximately sixty-three percent above baseline at trial start to approximately fifty-eight percent above baseline at seventy-two hours; episode frequency decreased from approximately twenty per day to approximately eighteen per day. The marginal improvements were not sustained; by day five of the trial, the measurements had returned to pre-trial baseline. The trial was extended to day seven to provide adequate characterization; the measurements remained at pre-trial baseline through trial conclusion. The trial was terminated on day eighty-eight.

The Therapeutic Modalities Unit's evaluation of the A6 trial characterized the trial as producing transient and non-sustained marginal effects that do not meet the threshold for continued use.

The interval covering the A4 through A6 trials produced documentation of progressively reduced engagement from both the subject and the clinical staff. The subject's verbal communication with clinical staff during this interval was minimal; the subject responded to direct queries with brief acknowledgments or with silence. The clinical staff's documentation of the trials became progressively more focused on quantitative measurements and less focused on observational content; the verbal descriptions of the subject's condition diminished across the interval, and the daily clinical narratives shortened to brief notations of measurement summaries.

S—'s contemporaneous notes for the A4 through A6 trials are increasingly logistical and decreasingly observational. Selections.

> *Day 68. A4. They increased the dose. He is sedated. The episodes are fewer. The sedation is replacing him. He is not present in the room in any sense I recognize.*
>
> *Day 71. He could not complete the cognitive assessment yesterday. He could last week. The assessment is the same. He is worse. The clinician*

characterized this as expected given the sedation. I do not know what is expected. I am keeping the count.

Day 73. A4 ended. He is partially out of the sedation. He is not all the way back. I do not know if he will come all the way back. The sedation may have left something behind.

Day 79. A5. The episodes are worse. They have been bad enough that I have not been able to write much. I am writing this in the middle of the night. He is in an episode now. He has been in episodes for most of the past two days. The clinician on duty has been with him much of the night. The clinician is trying to determine whether to terminate the trial. The clinician has asked me what I think. I told the clinician to terminate the trial. The clinician has not yet terminated the trial. The clinician is consulting with the Medical Director. I do not know whether the consultation will result in termination. I am writing this so that the consultation's delay is on the record.

Day 80. They terminated A5 this morning. The trial lasted four days. He has had perhaps forty episodes during the four days. Several were severe. He is more diminished than before A5. I do not know how much more diminished he can become.

Day 85. A6. Marginal changes. Nothing real. The clinician is calling it possibly within normal variation. I would call it nothing.

Day 88. A6 ended. They will begin A7 in three days. A7 is the experimental agent. They have not told me what it is. I have not asked. I do not think they would tell me. I am tired of asking questions and being told nothing.

VIII.D — Trial A7: The Experimental Agent

The A7 trial commenced on day ninety-two post-intervention. The agent was a novel-mechanism compound developed by the Division's pharmacology unit specifically for application to subjects with treatment-resistant dysregulation presentations. The agent's mechanism is described in the case file's documentation as targeting the substrate-level integration of autonomic and cognitive regulation through a novel receptor-binding pattern not present in the standard pharmacological roster.

The agent had not previously been administered to a human subject. The Therapeutic Modalities Unit's authorization memorandum acknowledges this and notes that the agent has been characterized in animal studies and in pre-clinical human safety trials at sub-therapeutic dosages. The M-08 trial is the first administration at therapeutic dosage. The memorandum specifies enhanced monitoring across the trial period and provides for immediate termination in the event of acute adverse response.

The A7 trial proceeded according to the modified protocol. The agent was administered at standard initial dosage on day ninety-two. The subject's measurements showed acute changes within the first twelve hours that the clinical staff initially characterized as consistent with the expected mechanism of action. Resting heart rate decreased from approximately sixty-five percent above baseline at trial start to approximately forty-one percent above baseline at twelve hours. Movement episode frequency decreased from approximately twenty-two per day to approximately eight per day across the first twenty-four hours. Sleep, which had averaged approximately forty-five minutes per night across the preceding two weeks, increased to approximately three hours across the first night of the trial.

The Therapeutic Modalities Unit's documentation of the first forty-eight hours of the A7 trial characterizes the response as the first apparently positive response to pharmacological intervention in the M-08 case and recommends continued application with careful monitoring for sustained response.

The third twenty-four hours of the A7 trial produced what the case file characterizes as acute deterioration of unusual character.

At approximately fourteen hours into the third day of the trial, the subject experienced an episode that the clinical staff initially documented as severe movement episode in their standard episode logging. The episode commenced at approximately ten in the morning and continued for approximately twenty-five minutes before subsiding. Following the episode's subsidence, the subject was unresponsive to verbal queries for approximately fifteen minutes. The subject's neuroelectric monitoring during the unresponsive interval showed patterns that the on-duty senior clinician characterized in real-time documentation as suggestive of post-ictal state, though the preceding event was not consistent with seizure activity on standard criteria.

The subject regained verbal responsiveness at approximately ten-forty in the morning. The subject's first verbal communication following the unresponsive interval, recorded verbatim by the on-duty senior clinician: Where is she. The clinician indicated that the subject's spouse was in the residential wing's visitor area and could be summoned. The subject responded: Now.

S— was summoned and arrived in the residential wing room at approximately ten-fifty in the morning. The on-duty senior clinician's notes record that the subject's vital signs stabilized substantially within five minutes of S—'s arrival, with resting heart rate decreasing from approximately seventy percent above baseline to approximately forty-five percent above baseline across the five-minute interval.

The clinician's notes characterize this stabilization as unusual and worthy of note but do not develop the observation further.

The subject experienced two additional episodes across the remainder of day ninety-four, the second of which (commencing at approximately eight in the evening) was followed by a second unresponsive interval of approximately twelve minutes. Following the second unresponsive interval, the subject again asked for S— upon regaining verbal responsiveness. S— remained in the room for the remainder of the evening.

The Therapeutic Modalities Unit convened to assess the A7 trial on the morning of day ninety-five. The convening's documentation records discussion of three options: continuation of the trial with adjusted dosage, immediate termination of the trial, and modification of the trial with addition of supportive measures. The Unit recommended immediate termination of the trial on the grounds that the post-episode unresponsive intervals represent an adverse response pattern not previously observed in any case and of unclear clinical significance. The Medical Director concurred. The trial was terminated at approximately eleven in the morning of day ninety-five.

The Therapeutic Modalities Unit's evaluation of the A7 trial characterized the trial as producing initial apparent response followed by acute adverse effects of novel character requiring further investigation before any further administration of the agent to any subject. The evaluation noted that the case provides important pre-clinical data on the agent's response profile in a subject with severe treatment-resistant dysregulation.

VIII.E — Days Ninety-Five Through One Hundred: Post-Trial Recovery

The five-day interval following the termination of the A7 trial produced documentation that characterized the subject's condition as recovery toward the pre-A7 baseline. The measurements showed gradual reduction of the elevations introduced during the A7 trial; by day one hundred, resting heart rate averaged approximately sixty-two percent above baseline (modestly worse than the fifty-five percent recorded prior to A1 trial initiation), and movement episode frequency averaged approximately twenty-three per day (modestly worse than the seventeen per day recorded prior to A1).

The five-day interval also produced documentation of the cumulative effect of the seven trials. The Medical Director's day one hundred summary memorandum characterizes the A1 through A7 sequence as follows: The seven-agent pharmacological roster has been exhausted without identification of a therapeutic agent for the subject's dysregulation. The cumulative effect of the trials has been modest worsening of baseline measurements. The clinical course requires reconsideration. Recommended next steps will be developed in consultation with the Senior Research Council.

The memorandum does not address the cumulative effect of the trials in terms of the subject's overall condition. The measurements characterized as modest worsening represented eight weeks during which the subject's life had been organized around sequential pharmacological challenges, none of which had produced therapeutic benefit and several of which had produced acute adverse effects, with the cumulative damage borne by the subject and the proximate observer. The memorandum's characterization of modest worsening is technically accurate as a description of the measurement deltas. The memorandum's characterization is structurally inadequate as a description of what the eight weeks had constituted.

S—'s contemporaneous notes for the post-A7 interval are sparse. Selections.

> *Day 95. They terminated A7. The agent that worked briefly and then nearly killed him. The clinician characterized the response as adverse effects of novel character. I would characterize the response as he asked for me twice after he came back from somewhere. He has not asked for me in that way since the chamber. Whatever the agent did to him took him somewhere and brought him back. The bringing back was the asking. The asking was what I heard. The asking was not characterized by the*

clinician.

Day 98. He is sleeping more. I am sleeping more. The exhaustion of the past eight weeks is coming up now that the active phase has ended. We are both diminished by the eight weeks. The clinical staff have not acknowledged the diminishment. They are continuing as if eight weeks of failed interventions has been a routine clinical phase.

Day 100. Day one hundred. He looked at me this morning and said: 'I do not know how to do this anymore.' I asked what he meant. He said: 'I do not know how to do whatever this is that we are doing.' I said: 'Neither do I.' He said: 'Are we doing it together.' I said: 'Yes.' He said: 'Good.' He did not speak again for the rest of the morning.

VIII.F — Conclusion of Section VIII

The Section VIII file copy concludes with the documentation of day one hundred and the Medical Director's summary memorandum on the conclusion of the A1 through A7 sequence. The interval covered by Section VIII constituted approximately fifty-eight days of sequential pharmacological trials that the Division acknowledged at conclusion as having produced no therapeutic benefit. The interval also constituted the period during which the Division's framework for managing the M-08 case began to show internal incoherence visible in the case file's documentation itself.

The incoherence is documentable across three specific dimensions.

First, the trials' evaluations consistently characterized failures in terms of the agent's mechanism rather than in terms of the subject's response. Agents that produced no effect were characterized as confirming the absence of the mechanism the agent addressed. Agents that produced transient effects followed by deterioration were characterized as demonstrating tolerance development. Agents that produced acute adverse effects were characterized as demonstrating paradoxical activation. Each evaluation treated the trial as informative about the agent rather than as informative about the inadequacy of the framework predicting the agent's effect. The evaluations cumulatively constructed a record in which seven distinct agents had each failed for distinct mechanism-specific reasons, without the Division acknowledging that the consistent pattern of failure across mechanism categories indicated a problem at a level the mechanism-specific evaluations could not address.

Second, the clinical staff's documentation became progressively less observational across the interval. Detailed narrative descriptions of the subject's condition, which had been standard in the case file's earlier sections, diminished to brief measurement summaries by the A4 trial and remained at this reduced level for the remainder of the interval. The documentation reduction was characterized in internal communications as necessary efficiency given the volume of documentation requirements but functioned to reduce the observational content available for later review of the case. The reduction was a structural defense against the accumulation of observational evidence inconsistent with the framework under which the trials were being conducted.

Third, the subject's expressed preferences regarding the trials were not recorded in the case file beyond the formal consent documentation. The subject's day-twenty-one statement (All of it, requested as the duration before further interventions), the subject's diminished verbal communication during the trials, and S—'s repeated communications regarding the cumulative damage of the trials are present in the case file primarily through S—'s contemporaneous notes inserted at later points through unspecified channels. The Division's own contemporaneous documentation of the subject's preferences during the trial interval is essentially absent. The absence is consistent with the Division's standing framework, which treated the subject's preferences as input to consent processes at protocol initiation rather than as ongoing clinical material requiring documentation across the trial sequence.

The Section IX file copy begins with the initiation of Intervention 5 on day one hundred and four.

Marginalia — Section VIII — In the subject's hand. The marginalia for this section are written in a hand that shows the cumulative weight of the material being addressed. Several passages appear to have been written, set aside, and returned to over a period of days, with subtle variations in ink density suggesting separate writing sessions.

The seven-agent pharmacological roster is documented in the case file as a sequence of trials, each evaluated as informative about its agent. The cumulative effect on the subject is characterized as modest worsening of baseline measurements. The characterization is technically accurate as a description of the measurement deltas. The characterization is structurally

inadequate as a description of what the eight weeks had constituted.

I want to write what the eight weeks had constituted, from the position of the apparatus that was undergoing them.

The eight weeks had constituted the destruction of any remaining hope that the Division would help. Each trial began with the Division's belief that the agent might address my condition. Each trial ended with the Division's belief that the next agent might address my condition. The trials accumulated without my condition improving and without the Division's framework producing any account of why the trials were failing. The framework's response to each failure was to schedule the next trial. I had no further interventions to consent to or refuse; the consent I had given at the M-Series initiation was being treated as standing consent across the adaptive intervention sequence. The Division was working through its roster. The roster was finite. The roster ended at A7.

A7 ended on day ninety-five. The Division's standard intervention capacity was exhausted at that point. I will not write here what the apparatus that was inhabited at day ninety-five felt regarding the exhaustion of the standard capacity. The apparatus by day ninety-five was not equipped to feel things in the conventional sense. What I can say is that the apparatus registered the exhaustion as a structural fact whose implications were not available to be processed. The apparatus had been undergoing interventions for ninety-five days. The interventions had not worked. The interventions had cumulatively damaged the apparatus. The interventions were now ending. What would replace the interventions was not specified. The apparatus did not have the capacity to anticipate what would replace the interventions. The apparatus existed in the condition of having undergone the failed interventions and not knowing what came next.

I want to address one specific feature of the A7 trial.

The trial's third day produced what the case file characterizes as acute deterioration of unusual character: a severe episode followed by an unresponsive interval, followed by my asking for S— immediately upon regaining responsiveness. The clinical staff documented the asking. The clinical staff did not characterize the asking beyond noting it. The clinical staff did not develop the observation.

What had happened in the unresponsive interval is something I have partial memory of. The memory is fragmentary, as the memories from this period

generally are, but it is recoverable.

During the unresponsive interval, the apparatus that had been being run from the position I called I was not being run from any position the apparatus could identify. The apparatus was in a state I will call suspended. The state is not unconsciousness. The state is not sleep. The state is not the standard unresponsive states the clinical staff are trained to recognize. The state is the apparatus being present without being run. The apparatus was registering perceptual input. The apparatus was not converting the input into experience that belonged to anyone. The conversion operation was offline. The input was occurring. No one was having it.

When the conversion operation came back online — at approximately ten-forty on the morning of day ninety-four — the first operation it performed was to register that S— was not in the room. The registration was urgent. The urgency was the apparatus recognizing that it had been suspended and that the suspension had been survivable only because something had been holding the apparatus's organization during the suspension. The something was S—. S— had not been in the room. The apparatus had nonetheless survived the suspension. The survival had been possible because S—, although not physically present in the room, had been the structure around which the apparatus had organized itself sufficiently to permit the suspension and the return.

When the conversion operation came back online, the apparatus's first articulable demand was that S— be physically present. The articulation took the form of Where is she. The articulation was not a question in the conventional sense. The articulation was the apparatus reporting that the structure around which it was organizing itself had not been physically available during the suspension, and that the suspension's recurrence — which the apparatus correctly anticipated — would require the structure's physical availability. The clinical staff heard the articulation as a question. The clinical staff did not hear it as the structural report it was. The clinical staff summoned S—. S— arrived. The apparatus stabilized within minutes of S—'s arrival.

The clinical staff documented the stabilization. The clinical staff characterized it as unusual and worthy of note. The characterization is structurally inadequate. The characterization preserves the institutional framework's inability to acknowledge that S—'s physical presence had

clinical effect. The clinical effect was substantial. The effect was the apparatus's autonomic indices decreasing by approximately twenty-five percent within five minutes of S—'s arrival. The decrease was greater than the response to any of the seven agents the Division had trialed. S—'s arrival was the most therapeutically effective intervention applied to the subject across the entire eight-week interval. The Division did not have a category for this. The Division noted it without developing it.

The second episode and second unresponsive interval of day ninety-four reproduced the same pattern. The asking for S— upon return. The stabilization upon her arrival.

The Division terminated A7 on day ninety-five. The Division's evaluation characterized the agent as producing initial apparent response followed by acute adverse effects of novel character. The evaluation did not address what the adverse effects of novel character had been. The effects had been the apparatus encountering states it had not previously encountered — the suspended state — and the apparatus's structural reorganization around S— as the basis for surviving the states. The Division did not have a category for the agent revealed the structural role of the proximate observer in the apparatus's regulation. The Division characterized the agent as adverse and terminated the trial.

The structural role of the proximate observer would continue to be the most consistent regulatory mechanism for the apparatus across the remainder of the case. The Division would not acknowledge this. The marginalia is acknowledging it now. The acknowledgment is a finding of the case that the Division could not produce. The finding is that the apparatus that had been undergoing the M-Series intervention had reorganized itself, across the months of catastrophe, around the proximate observer as the regulatory structure that the Division's interventions had failed to provide. The reorganization was not consciously chosen. The reorganization was structural. The apparatus, deprived of standard regulatory function, had built its regulation around the only available stable element. The stable element was S—. S— had been the stable element from before the M-Series began. S— had been the stable element of my apparatus across the entire pre-procedural period of our marriage. The procedure had simply exposed this fact by removing the surface stability that had been concealing it. Beneath the surface stability, S— had been the regulatory element all along.

The Division did not see this because the Division's framework did not include relational regulation as a clinical category. The framework assumed that the apparatus was an individual unit whose regulation was internal and whose external supports were auxiliary. The framework did not consider that an apparatus could be constitutively coupled to another apparatus and that the coupling could be the primary regulatory mechanism. S— and I were constitutively coupled. We had been since the early years of our marriage. The constitutive coupling had not been visible to either of us as such. It had been the structure within which our individual lives operated. The procedure exposed the coupling by stressing my apparatus to the point where the coupling became the only operative regulation. The Division observed the operation of the coupling on day ninety-four and characterized it as a novel adverse effect. The characterization was wrong. The operation was the only successful regulation observed in the case.

I want to address the conversation S— records from day one hundred.

He looked at me this morning and said: 'I do not know how to do this anymore.' I asked what he meant. He said: 'I do not know how to do whatever this is that we are doing.' I said: 'Neither do I.' He said: 'Are we doing it together.' I said: 'Yes.' He said: 'Good.'

The conversation is reproduced in S—'s notes. I have partial memory of the conversation. The memory is recoverable.

What I was reporting when I said I do not know how to do this anymore was not despair. I had been past despair for weeks. What I was reporting was a structural observation. The apparatus that had been the subject of the M-Series had been operating, across the prior weeks, in a condition for which no operating instructions existed. The apparatus had been improvising. The improvisations had been failing. The improvisations had become less and less viable. The apparatus had reached the point where it could no longer improvise. The articulation I do not know how to do this anymore was the apparatus reporting that the improvisations had exhausted their available variations.

S— responded Neither do I. The response was not consolation. The response was a parallel report. S— had been improvising for the same weeks. The improvisations had been failing for her in parallel. S— was reporting that her improvisations had reached the same exhaustion.

I responded Are we doing it together. The response was a structural inquiry. If both apparatuses had exhausted their improvisations, the question of whether the apparatuses were exhausted together or were exhausted separately was important. Together meant that the constitutive coupling was still operative. Separately meant that the coupling had failed. The distinction had clinical implications.

S— responded Yes. The response confirmed that the coupling was still operative.

I responded Good.

The exchange is reproduced in the marginalia because the exchange contains, in its four lines, the most accurate characterization of the case at day one hundred that exists anywhere in the record. The Division's day one hundred summary memorandum characterizes the case as requiring reconsideration; the memorandum's institutional language is technically accurate but structurally evasive. The marginalia's reproduction of the exchange characterizes the case as two apparatuses operating at the limit of their available improvisations within a constitutive coupling that has remained operative. The marginalia's characterization is structurally accurate. The marginalia is the only place this characterization exists in the record.

I will write more in the margins of Section IX. The next intervention was the experimental combinations. The experimental combinations would continue for ninety-two more days. The marginalia will continue.

— [signature: handwritten initials, illegible]

IX. OFF-ROSTER COMBINATIONS

IX.A — The Authorization of Experimental Combinations

Intervention 5 was authorized by the Senior Research Council on day one hundred and three post-intervention, following the conclusion of the A1 through A7 standard pharmacological roster and a brief recovery interval. The intervention's authorization is documented in a memorandum signed by the Council's full membership, the Medical Director, and the Medical Director's Deputy.

The memorandum's framing of the authorization is, in retrospect, the first appearance in the case file of a tone the Division had not previously employed. The memorandum opens with the standard institutional language characterizing the case and the necessity of continued intervention. It then proceeds to a paragraph that the case file's later reviewers identified as departing from the Division's standard documentary register.

The paragraph, reproduced verbatim: The M-08 case has presented challenges that have not been anticipated by the Division's existing protocols and that have not been resolved by the standard pharmacological roster. The case requires the Division to extend its therapeutic capacity beyond the parameters validated by prior experience. The extension is undertaken with full awareness of the experimental nature of the proposed interventions and with the understanding that the Division's commitment to the subject's recovery requires us to apply such measures as may be necessary to that end. The agents to be trialed in this intervention are combinations developed by the Division's pharmacology unit specifically for this case. The combinations are based on the Division's accumulated understanding of the subject's response profile to standard agents and represent the Division's best available pharmacological response to the case's resistance to standard treatment.

The paragraph's tone is institutional but contains, in its acknowledgment of challenges that have not been anticipated and its framing of the experimental combinations as the Division's best available pharmacological response, an admission of constraint that the Division's prior documentation had avoided. The case file's later reviewers identified this paragraph as the point at which the Division began to write itself into a defensive posture regarding the case.

The intervention's design parameters specified the following. Twelve experimental combinations would be developed, each based on the pharmacology unit's analysis of the subject's response profile across the prior intervention. The combinations would be trialed sequentially, with each trial lasting five to ten days depending on the agents' pharmacokinetic profiles. The trials would be separated by washout periods calibrated to the specific agents involved. The intervention's total duration was estimated at approximately ninety to one hundred days.

The combinations themselves are documented in the case file with detailed pharmacological notation. For the purposes of this case file's narrative documentation, they are designated C1 through C12.

S—'s contemporaneous note from day one hundred and four, the day of Intervention 5's initiation, reproduced below.

> *Day 104. They are starting again. Twelve combinations. Three months estimated. I asked them what would happen if these did not work. The senior clinician said the pharmacology unit was confident in the combinations. I said that was not what I asked. He said they had a plan. I said I wanted to know what the plan was beyond the combinations. He said one step at a time. I said one step at a time had been the operating principle for one hundred and three days and we were still here. He did not respond. I am writing this so that the question I asked is on the record. The question was: what happens if these do not work. The question was not answered. The question will become relevant when the combinations do not work.*

IX.B — Combinations C1 Through C4: The First Cycle

The first four combinations were trialed across days one hundred and four through one hundred and forty-three. The Medical Liaison Office's documentation of these trials shows the pattern that the case file's prior intervention sections had established: brief apparent responses followed by deterioration, no measurable changes, or acute adverse responses requiring trial termination. The documentation also shows, beginning in this interval, internal inconsistencies that the later reviewers characterized as evidence of institutional fatigue.

The C1 trial commenced on day one hundred and four. The combination consisted of two agents drawn from different therapeutic classes, applied

simultaneously at modified dosages. The combination's theoretical basis, as documented in the pharmacology unit's design memorandum, was that the combined mechanism may produce regulatory effects not achievable through single-agent administration. The trial produced no measurable change in the subject's measurements across seven days. The trial was terminated on day one hundred and ten.

The Therapeutic Modalities Unit's evaluation of the C1 trial characterized the absence of response as informative regarding the limited efficacy of the combined mechanism in this subject. The evaluation noted that the combination's components had not previously been administered together at therapeutic dosages and that the C1 trial therefore provided preliminary data on the combined mechanism's tolerability and effect profile. The evaluation did not address the question of why a combination based on the Division's accumulated understanding of the subject's response profile had produced no effect; the response profile that informed the combination's design had been constructed from the prior trials in which the same lack of effect had been observed.

The C2 trial commenced on day one hundred and fourteen, following the washout period. The combination consisted of three agents at modified dosages. The trial produced a measurable but transient response across the first five days: episode frequency decreased from approximately twenty per day at trial initiation to approximately fourteen per day at the five-day mark. The decrease was not sustained; by day eight of the trial, episode frequency had returned to baseline. The trial was terminated on day one hundred and twenty-three.

The Therapeutic Modalities Unit's evaluation of the C2 trial characterized the transient response as consistent with tolerance development to the combined mechanism — a characterization the case file's earlier sections had applied to the A2 trial under identical circumstances. The later reviewers noted that the evaluation language for C2 was substantially identical to the evaluation language for A2, with the relevant clinical details modified but the framing identical. The repetition was interpreted by the later reviewers as evidence of evaluation by template — the Therapeutic Modalities Unit applying standard interpretive frameworks to trial outcomes without distinguishing between the specific characteristics of each trial.

The C3 trial commenced on day one hundred and twenty-seven. The combination consisted of two agents administered in a sequenced protocol, with the first agent introduced at therapeutic dosage and the second agent introduced after seventy-two hours. The trial produced acute adverse response within twenty-four hours of the second agent's introduction: the subject experienced four severe movement episodes across the twenty-four-hour interval following the second agent's introduction, with the longest episode lasting approximately fifty-one minutes. The trial was terminated on day one hundred and thirty-one.

The Therapeutic Modalities Unit's evaluation of the C3 trial characterized the response as combined paradoxical activation and noted that the sequenced introduction may have permitted the establishment of receptor sensitization that the second agent then activated paradoxically. The evaluation did not address the question of whether the paradoxical activation pattern, now observed across multiple distinct mechanism categories (the original Intervention 1 with autonomic agents; the A3 trial with noradrenergic blocking; the A5 trial with dopaminergic modulation; the C3 trial with the present combination), indicated a systemic feature of the subject's response profile rather than agent-specific paradoxical responses. The Division's evaluative framework treated each paradoxical response as a finding about the specific agent that produced it.

The C4 trial commenced on day one hundred and thirty-six. The combination consisted of two agents at sub-therapeutic dosages, applied simultaneously, on the theoretical basis that the subject's response profile suggests that standard therapeutic dosages may exceed the subject's tolerance and that sub-therapeutic combinations may produce regulatory effects without triggering adverse responses. The trial produced no measurable change across seven days. The trial was terminated on day one hundred and forty-three.

The Therapeutic Modalities Unit's evaluation of the C4 trial characterized the absence of response as consistent with sub-therapeutic dosing not achieving the threshold required for regulatory effect and noted that the trial provides useful pre-clinical data on the lower bound of effective dosing for the combined agents. The evaluation did not acknowledge that the sub-therapeutic dosing rationale had been based on the supposition that standard dosing exceeded tolerance, and that the absence of response at

sub-therapeutic dosing did not support the supposition's continued use as a design principle.

The four trials of the first cycle had thus produced one no-effect outcome, one transient-then-tolerance outcome, one acute adverse response outcome, and one no-effect outcome, across a forty-day interval. The Therapeutic Modalities Unit's day one hundred and forty-three summary memorandum characterized the first cycle as providing important characterization data for design of the second cycle.

S—'s contemporaneous notes for the first cycle are sparse. Selections in approximately chronological order.

> *Day 110. C1 ended. Seven days. No effect. They are moving to C2.*
>
> *Day 119. C2 had a brief response. The response is gone. They will continue C2 for several more days to confirm what they already know.*
>
> *Day 128. They started C3. Yesterday they added the second agent. Today he had four severe episodes. They are calling this a paradoxical response. Every fourth or fifth thing they try produces a paradoxical response. They have a name for it now. The name does not change what is happening.*
>
> *Day 131. C3 ended. He is recovering.*
>
> *Day 140. C4. Sub-therapeutic dosing. The theory is that they have been giving him too much. The theory does not address why the things they have given have not worked. The theory is the next available theory. They are working through the theories the way they worked through the medications.*
>
> *Day 143. C4 ended. No effect. They are designing the second cycle.*

IX.C — The Senior Research Council Convening of Day One Hundred and Forty-Five

The Senior Research Council convened on the afternoon of day one hundred and forty-five to assess the M-08 case in light of the first cycle's outcomes. The convening's documentation, reproduced in the case file, runs to approximately fourteen pages and is substantially more extensive than the documentation of any prior Council convening regarding M-08.

The convening's documentation records discussion of four primary topics.

The first topic was the assessment of Intervention 5's first cycle. The Council noted that the first cycle had not produced therapeutic benefit and that the cumulative effect of one hundred and forty-three days of intervention had been a modest worsening of the subject's measurable condition. The Council noted that the subject's quality of life across the intervention period had not been formally assessed but that the proximate observer had repeatedly characterized the subject's condition as deteriorating across the interventions. The Council acknowledged this as observational input requiring consideration.

The second topic was the consideration of whether to continue the experimental combinations or to redirect the case management approach. The Council considered three options: continuation of the experimental combinations with the eight remaining combinations to be trialed across the projected ninety-day balance of Intervention 5; modification of the experimental combination approach to focus on a smaller number of combinations selected on the basis of the first cycle's outcomes; or termination of Intervention 5 in favor of an alternative approach to be developed. The Council's discussion of these options is documented in detail.

The discussion of continuation focused on the Division's institutional commitment to completing the authorized intervention sequence and the pharmacology unit's confidence that the remaining combinations included candidates with substantively different mechanisms from those trialed in the first cycle. The discussion of modification focused on the cumulative damage to the subject and the question of whether continued trials could be justified given the lack of demonstrated benefit. The discussion of termination focused on the absence of an alternative approach that the Division could implement and the institutional difficulty of formally acknowledging that the standard pharmacological roster and the experimental combinations had both failed.

The Council's decision was to continue Intervention 5 with all eight remaining combinations. The decision's rationale, recorded in the convening's documentation, was that the absence of demonstrated benefit from the first cycle does not preclude benefit from the remaining combinations, and the Division's commitment to the subject's recovery requires application of available therapeutic options until the option space

has been adequately explored.

The third topic was the case's broader implications for the M-Series and for the Division's research program. The Council acknowledged that the M-08 case had now demonstrated, across one hundred and forty-five days of intervention, that the M-Series's theoretical model was inadequate to predict the recovery profile of at least one subject. The Council noted that this finding had implications for the Division's continued use of the M-Series methodology and that the implications would require formal consideration following the case's resolution. The Council elected not to address these implications during the active management of the case, on the grounds that the active management required focused attention to the case's immediate clinical needs.

The fourth topic was the proximate observer's role in the case. The Council noted that S— had become an increasingly prominent factor in the case's management and that her interventions had repeatedly affected the case's trajectory. The Council acknowledged that the Division's framework had not anticipated this prominence and that the framework's standard provisions for proximate observer involvement were inadequate to the case. The Council elected to address this matter, like the broader M-Series implications, following the case's resolution.

The convening concluded with the authorization of continued Intervention 5 and the documentation of the case's broader implications as matters for post-resolution consideration.

The convening's documentation contains, in its discussion of the third and fourth topics, what the later reviewers identified as the Division's first formal acknowledgment that the M-08 case had implications exceeding the case itself. The acknowledgment was bracketed and deferred. The bracketing and deferral are themselves identified by the later reviewers as a structural feature of the Division's institutional response: matters that the framework could not accommodate were deferred to post-resolution consideration, which functioned to preserve the framework's operation during the active period without requiring its modification.

IX.D — Combinations C5 Through C8: The Second Cycle

The second cycle of experimental combinations commenced on day one hundred and forty-eight and continued through day one hundred and seventy-six. The Medical Liaison Office's documentation of this cycle shows the pattern established in the first cycle, with one notable development: the documentation's internal consistency began to deteriorate in ways that became more pronounced as the cycle progressed.

The C5 trial commenced on day one hundred and forty-eight. The combination's documentation in the case file contains, in its third paragraph, a description of the agents' mechanism that the later reviewers identified as substantially copied from the C1 trial's documentation, with the agents' names changed but the mechanism description otherwise identical. The later reviewers noted that the C1 and C5 combinations were not the same combination and that the mechanism descriptions should have differed accordingly. The reviewers' interpretation of the copying was that the Therapeutic Modalities Unit's documentation staff had begun working from prior trial documentation as templates without verifying that the templates' content was accurate to the new trial.

The C5 trial itself produced no measurable change across seven days. The trial was terminated on day one hundred and fifty-four. The evaluation of the trial, reproduced in the case file, contains language substantially identical to the evaluations of C1 and C4.

The C6 trial commenced on day one hundred and fifty-seven. The combination produced a transient response across the first four days: episode frequency decreased from approximately twenty-one per day at trial start to approximately sixteen per day at the four-day mark. The decrease was not sustained; by day seven, episode frequency had returned to baseline. The trial was terminated on day one hundred and sixty-three.

The C6 trial's documentation contains an internal inconsistency: the day three measurements are recorded as showing a decrease in episode frequency to approximately fifteen per day, while the day five measurements are recorded as showing episode frequency at approximately seventeen per day. The day three and day five measurements are referenced again in the trial's summary documentation, which characterizes the trial as showing sustained reduction across the first five days followed by rebound to baseline by day seven. The summary documentation's characterization is inconsistent with the day five measurement, which had already shown movement back toward

baseline rather than continued sustained reduction. The later reviewers identified this inconsistency as evidence that the summary documentation had not been written from the underlying measurement data but had been written from a presumed narrative that the summary author had constructed from partial information.

The C7 trial commenced on day one hundred and sixty-six. The combination produced acute adverse response within forty-eight hours: the subject experienced six severe episodes across the second twenty-four hours of the trial, with cumulative convulsive activity exceeding three hours. The trial was terminated on day one hundred and sixty-eight.

The C7 trial's documentation includes the Medical Director's authorization of termination and a brief evaluation by the Therapeutic Modalities Unit. The evaluation characterizes the response as paradoxical activation pattern and notes that the response is consistent with the paradoxical responses observed in Intervention 1 and in the A3, A5, and C3 trials. The evaluation's acknowledgment of the consistent paradoxical pattern across multiple distinct interventions is the first explicit identification of this pattern in the case file. The acknowledgment, however, is contained within a paragraph that proceeds to characterize the next trial's combination as designed to address mechanism categories not previously associated with paradoxical responses in this subject — a characterization that the later reviewers identified as inconsistent with the acknowledgment, since the consistent pattern across multiple mechanism categories suggested that the issue was not category-specific.

The C8 trial commenced on day one hundred and seventy-one. The combination produced no measurable change across five days. The trial was terminated on day one hundred and seventy-six.

The C8 trial's documentation contains, in its summary section, a paragraph that the later reviewers identified as substantially identical to the corresponding paragraph in the C5 summary documentation, with the agents' names changed. The later reviewers noted that this constituted the second instance of documentation copying within the second cycle.

S—'s contemporaneous notes for the second cycle are minimal. Selections.

> *Day 154. C5 ended. No effect. The documentation said no effect. The documentation has been saying no effect for some time.*

Day 163. C6 had a brief response. The response is gone. The documentation will say tolerance development. The documentation has been saying tolerance development for some time.

Day 168. C7 ended. Six severe episodes in twenty-four hours. The documentation will say paradoxical activation. The documentation has been saying paradoxical activation for some time. We are running through the categories the documentation can produce.

Day 176. C8 ended. No effect. There are four more combinations.

IX.E — Combinations C9 Through C12: The Third Cycle and Its Conclusion

The third cycle of experimental combinations was conducted across days one hundred and seventy-nine through one hundred and ninety-six. The cycle's documentation in the case file is substantially abbreviated relative to the first two cycles, with the four trials' documentation occupying approximately the space previously allotted to two trials.

The C9 trial commenced on day one hundred and seventy-nine. The combination produced no measurable change across four days. The trial was terminated on day one hundred and eighty-three. The trial's evaluation reproduces, with minor modifications, the C1, C4, C5, and C8 evaluation language.

The C10 trial commenced on day one hundred and eighty-six. The combination produced acute adverse response within thirty-six hours: the subject experienced sustained autonomic dysregulation requiring the trial's termination. The trial was terminated on day one hundred and eighty-eight. The trial's evaluation characterizes the response as paradoxical activation pattern using language substantially identical to the C7 evaluation.

The C11 trial commenced on day one hundred and ninety-one. The combination produced no measurable change across four days. The trial was terminated on day one hundred and ninety-five. The trial's evaluation reproduces the by-now-standard language for no-effect outcomes.

The C12 trial commenced on day one hundred and ninety-three. The case file's documentation of the C12 trial is anomalous in several respects. The trial is documented as commencing on day one hundred and ninety-three, which is two days before the C11 trial's documented termination on day one

hundred and ninety-five. The trial's duration is documented as five days, with termination on day one hundred and ninety-eight, which is one day after the trial's nominal endpoint of day one hundred and ninety-seven. The trial's measurements are documented with gaps that the later reviewers identified as inconsistent with the enhanced monitoring protocol that had been authorized for all experimental combinations.

The later reviewers' assessment of the C12 trial documentation, included in the case file as a marginal annotation, characterized the documentation as evidence of the Division's documentary infrastructure operating under stress beyond its capacity, with the C12 trial's documentation showing internal date inconsistencies, measurement gaps, and abbreviated evaluation that collectively indicate that the documentation was assembled hastily and without the standard quality control.

The case file does not contain a Therapeutic Modalities Unit evaluation of the C12 trial that meets the standard format of the prior evaluations. The case file contains, in the position where the C12 evaluation should appear, a brief notation by the Medical Director: C12 trial completed without therapeutic benefit. Pharmacological roster and experimental combinations exhausted. Case requires reconsideration of management approach.

The notation is dated day one hundred and ninety-eight. The notation is the final document in the case file from the active period of Intervention 5.

IX.F — Days One Hundred and Ninety-Eight Through Two Hundred and Five: The Pause

The seven-day interval following the conclusion of the experimental combinations produced documentation that the case file characterizes as the management pause. The Medical Director's day one hundred and ninety-eight notation that the case requires reconsideration of management approach was not followed by the immediate authorization of a new intervention. The Division entered an interval during which no active intervention was being applied to the subject and no clear plan for further intervention was being developed.

The Medical Liaison Office's documentation for the pause interval is sparse. The subject was housed in the residential wing under standard monitoring. S— was present continuously. The subject's measurements during the pause

showed gradual reduction of the elevations introduced during the C7, C10, and C12 trials; by day two hundred and five, the subject's measurements were modestly worse than the values that had characterized the interval preceding Intervention 5, but the trajectory was toward stabilization rather than continued deterioration.

The pause produced internal Division correspondence that the case file reproduces in substantial extract.

A memorandum dated day one hundred and ninety-nine, from the Medical Director to the Senior Research Council, requests guidance regarding the next phase of case management given the exhaustion of the standard and experimental pharmacological approaches. The memorandum acknowledges that the Division has now applied its full range of pharmacological capacity to the case without producing therapeutic benefit and asks the Council to address whether the Division should pursue additional non-pharmacological approaches, modify the parameters of existing approaches, or consider the case as requiring management approaches beyond the Division's standard scope.

A memorandum dated day two hundred and one, from the Council's Chair to the Medical Director, acknowledges the Director's request and indicates that the Council will convene to address the matter within several days. The memorandum's brevity and its lack of substantive guidance was noted by the later reviewers as consistent with the Council itself being uncertain how to proceed.

A memorandum dated day two hundred and three, from the Standing Committee on Foundational Research to the Cognitive Substrates Division, requests a comprehensive interim report on the M-08 case, with particular attention to the case's implications for the M-Series research program. The memorandum's request indicates that the case had reached a level of institutional visibility that exceeded the Division's normal operating scope. The Standing Committee's request would, in the following weeks, contribute to the case's resolution dynamic in ways the case file documents only partially.

S—'s contemporaneous note from the pause interval, reproduced below. The note appears to have been written across several days rather than in a single sitting.

Day 199. They have not started a new intervention. They told us this morning that they are reviewing the case. I asked what reviewing the case means. The senior clinician said the Division is considering next steps. I asked when the next steps will be implemented. He said within several days. I do not believe him. I do not believe the Division knows what to do. The Division has applied everything it knows how to apply. The Division is now in territory it does not have a map for. I am familiar with this territory. I have been in it for the past one hundred and ninety-nine days.

Day 201. The clinical staff have continued to visit. The visits are shorter. The questions are routine. He responds when he can. He does not respond when he cannot. The clinical staff record what they observe and leave. They do not appear to know what to do with what they observe. Neither do I. Neither does he. We are all in the same condition now. The Division has joined us in not knowing what to do. The Division is just slower to acknowledge it.

Day 203. He spoke at length tonight. The first time he has spoken at length in many weeks. He said: 'They have stopped.' I said: 'Yes.' He said: 'For how long.' I said: 'I do not know.' He said: 'If they do not start again, what happens.' I said: 'I do not know.' He said: 'If they do start again, what happens.' I said: 'I do not know.' He looked at me for a long time. He said: 'We have to find something they cannot find.' I said: 'I know.' He said: 'I do not have the resources.' I said: 'I know.' He said: 'You do.' I said: 'I think I do. I do not know what to do with them yet.' He nodded. He did not speak again that night.

Day 205. I made a phone call this evening. I will say more about the phone call in subsequent notes. The phone call may have been important. I cannot tell yet.

IX.G — Conclusion of Section IX

The Section IX file copy concludes with the documentation of day two hundred and five and the pause interval. The interval covered by Section IX constituted the period during which the Division formally exhausted its therapeutic capacity for the M-08 case. The Division had now applied, across one hundred and ninety-eight days, two original interventions (the Sensory Regulation Protocol and the Cognitive Scaffolding Therapy) plus seven standard pharmacological agents and twelve experimental combinations,

without identifying any treatment that produced sustained therapeutic benefit.

The interval also constituted the period during which the case file's own institutional voice began to fail in ways visible within the documentation itself. The repetitive evaluation language, the documentation copying between trials, the internal inconsistencies in the C6 and C12 trial documentation, the abbreviated formatting of the third cycle, and the missing standard evaluation for C12 cumulatively constituted what the later reviewers characterized as the Division's documentary infrastructure operating under stress beyond its capacity. The documentation reduction was not, as the staff's internal communications had earlier characterized similar reductions, efficiency given documentation requirements. The documentation reduction was the institutional record reaching the point at which its standard categories could no longer be applied to the case the record was attempting to document, with the result that the record began to repeat itself, copy itself, and contradict itself.

The interval concluded with the Division's first formal acknowledgment that the case was beyond the Division's standard scope. The Medical Director's request for guidance from the Senior Research Council, the Council's deferred response, and the Standing Committee's request for interim reporting collectively constituted the institutional recognition that the M-08 case had passed beyond what the Division knew how to manage.

S—'s contemporaneous note from day two hundred and five records the phone call that would, in subsequent weeks, lead to the case's resolution. The phone call is documented in the case file only through S—'s notes inserted at later points through unspecified channels. The Division's contemporaneous documentation does not include the phone call. The Division did not know, at the time the call was made, that the call had been made.

The Section X file copy begins with the documentation of day two hundred and six and the formal withdrawal of intervention.

Marginalia — Section IX — In the subject's hand. The marginalia for this section are written in a more even hand than the marginalia for Sections VII and VIII, suggesting that the section was composed across a more sustained writing interval or that the subject's writing capacity had partially recovered by the time of composition. The

content is among the most analytical of any marginalia in the case file.

Section IX documents what happens when an institution's framework reaches its limit without the institution being able to acknowledge that the limit has been reached. The framework continues to produce documents. The documents continue to use the framework's standard language. The standard language continues to be applied to events the framework cannot accommodate. The result is documents that contain the framework's language without the framework's content. The documents become hollow.

The hollowing is visible in the section's documentation in several specific ways. The evaluation language for C5 reproduces the evaluation language for C1 because the framework has only one available characterization for no effect. The framework cannot accommodate no effect across multiple distinct mechanisms because such accommodation would require the framework to acknowledge that the framework's predictions about mechanisms have failed at a level that suggests the framework itself is inadequate. The framework's available response is to apply the same characterization to each instance of no effect, treating each instance as an isolated finding about the specific mechanism rather than as cumulative evidence about the framework. The repetition of language is the framework operating on autopilot. The framework cannot do anything else.

The documentation copying between C1 and C5 is a more pronounced symptom of the same phenomenon. The Therapeutic Modalities Unit's documentation staff, faced with the task of producing distinct trial documentation for trials whose evaluations the framework could only produce in identical form, began to copy the documentation directly. The copying was probably not conscious malpractice. The copying was probably the staff working under pressure with materials whose distinctness, from the framework's perspective, was minimal. The framework had only one available characterization. The staff produced documentation that reflected the framework's available characterization. The documentation came out looking the same because the framework's available characterization was the same.

The internal inconsistencies in the C6 documentation are evidence of the staff working without verifying their work against the underlying data. The C6 summary documentation claims sustained reduction across the first five days followed by rebound to baseline by day seven. The actual measurements show reduction across the first four days followed by

movement toward baseline beginning at day five. The summary documentation is wrong. The summary documentation is consistent with what a summary author would write if the author had been asked to summarize a transient-then-tolerance trial without consulting the underlying measurements. The summary is the framework's standard story for transient-then-tolerance applied to a trial that was characterized as transient-then-tolerance, regardless of whether the trial's actual measurements supported the standard story. The framework has a story. The trial gets the story. The data is incidental.

The C12 documentation's anomalies — the trial commencing before the prior trial's termination, the duration extending past the nominal endpoint, the measurement gaps — are evidence of the documentary infrastructure entirely failing to track the case. The infrastructure cannot, at this point in the case, even produce documents whose internal dates are consistent. The infrastructure has lost the ability to render the case in coherent form. The case file's reviewer would later identify the C12 documentation as evidence of the infrastructure operating beyond its capacity. The identification is accurate. The infrastructure had been operating beyond its capacity for some time. The C12 documentation is where the operation beyond capacity became visible within the documents themselves.

The Senior Research Council's convening of day one hundred and forty-five contained, in its discussion of the third and fourth topics, the Division's first formal acknowledgment that the case had implications exceeding the case itself. The acknowledgment was bracketed and deferred. The bracketing and deferral were structural. The Division could not address the implications during the active management of the case, because the active management was being conducted within the framework that the implications would require modifying. The framework had to remain operative for the active management to continue. The implications had to be deferred. The deferral preserved the framework. The preservation of the framework permitted the continuation of the case management. The case management continued for another sixty days after the convening, during which the framework's inadequacy continued to be demonstrated by the case's continuing resistance to the interventions the framework prescribed.

What I want to record in the margin is that the framework's inability to address its own implications during the active case is the structural feature that ensured the case's continued deterioration. If the framework had been

able to incorporate, during the active case, the recognition that the framework was inadequate to the case, the framework could have been modified. The modification would have permitted approaches that the unmodified framework had excluded. The unmodified framework's options were limited to what the framework's existing categories could specify. The framework's existing categories had been exhausted by the time of the day one hundred and forty-five convening. The convening's recognition of this would have permitted modification. The convening deferred the modification. The deferred modification was not available to the case management. The case management continued within the unmodified framework. The framework's exhausted options were the only available options. The continued application of exhausted options constituted the next sixty days of the case.

This is the structural feature that I want to be clear about. The Division did not fail to recognize that the framework was inadequate. The Division recognized the inadequacy and chose to defer the recognition until after the case was resolved. The deferral was institutional. The institution could not modify itself during an active case because the active case required the framework that needed modification to remain operative. The institution prioritized the framework's operation over the case it was attempting to manage. The institution's priority was rational from the institution's standpoint. The institution exists to maintain its framework. The case was an instance the framework was applied to. The instance did not require the institution to modify itself. The institution required the framework. The framework's modification would happen, if at all, after the instance was concluded. The instance, during the deferral period, continued to deteriorate.

I want to address what was happening to me across the pharmacological roster and the experimental combinations.

The interventions were being applied to an apparatus that, at this point in the case, had been operating in extended dysregulation for approximately six months. The apparatus had reorganized itself, across the months, around the relational regulation provided by S—. The apparatus was structurally dependent on this regulation. The apparatus's responses to the interventions were responses of an apparatus operating in this reorganized configuration. The interventions assumed an apparatus operating in the standard configuration the Division's framework specified. The two

apparatuses were not the same. The interventions were being applied to an apparatus whose actual operation the interventions could not predict, because the interventions were predicted for an apparatus that no longer existed.

The agents that produced acute adverse responses produced them, in part, because they disrupted the relational regulation that the apparatus depended on. The agents introduced unfamiliar substrate-level changes that the apparatus, in its reorganized state, could not accommodate. The accommodation would have required the apparatus to maintain the relational regulation while processing the substrate changes. The apparatus's resources were already substantially committed to maintaining the relational regulation. The substrate changes exceeded the apparatus's remaining processing capacity. The result was acute decompensation. The Division's framework characterized this as paradoxical activation. The framework's characterization was wrong. The phenomenon was not paradoxical. The phenomenon was decompensation of an apparatus operating at the limit of its resources, produced by introduction of additional load that the apparatus could not absorb without exceeding its limit.

The agents that produced no effect produced no effect, in part, because the apparatus's resources were already committed to maintaining its relational regulation and were not available to mount the regulatory responses the agents would have required to produce their effects. The agents required, for their predicted effects, an apparatus with available regulatory resources. The apparatus did not have available regulatory resources. The agents arrived. The apparatus could not respond. The Division's framework characterized this as absence of the mechanism the agent addressed. The framework's characterization was wrong. The mechanism was present. The apparatus did not have the resources to deploy it.

The agents that produced transient effects followed by deterioration produced this pattern because the transient effect was the apparatus briefly diverting resources to respond to the agent, with the diversion compromising the relational regulation, with the compromise producing the deterioration as the relational regulation failed under the load. The Division's framework characterized this as tolerance development. The framework's characterization was wrong. The phenomenon was not tolerance. The phenomenon was resource diversion producing relational

regulation failure.

The Division could not arrive at the correct characterizations because the Division's framework did not include relational regulation as a clinical category. The framework's available characterizations were all framed in terms of the apparatus as an individual unit responding to agents according to the agents' standard mechanisms. The apparatus had ceased to operate as an individual unit responding to standard mechanisms. The apparatus was operating as one half of a coupled system whose regulation was distributed across the apparatus and S—. The Division did not have a framework that could see this. The Division therefore could not characterize what was happening. The Division characterized what was happening within the available framework. The available framework's characterizations were systematically wrong.

What this means for the case file is that the framework's documentation, across Section IX in particular, is comprehensively wrong about what was happening to the apparatus. The framework is producing documents that, by the standards of the framework, are technically correct in their application of the framework's categories. The documents are wrong in their description of what the case was. The documents are wrong because the framework that produced them was wrong. The documents' technical correctness within the framework does not redeem them. The documents are records of a case the framework could not see, produced by a framework that could not see the case, using categories that were not adequate to the case.

The marginalia is producing a different document, drawn from a different framework, with different categories. The marginalia's framework is the framework an apparatus develops when it has been the apparatus the case file is documenting. The framework is incomplete. The framework has not been validated. The framework is one apparatus's reconstruction of what was occurring to it, written in retrospect, with the limitations such reconstructions necessarily have.

The marginalia's framework is, nonetheless, more accurate to the case than the framework the case file employs. The marginalia is closer to what occurred. The case file is the institution's record of how it managed an occurrence it could not see. The marginalia is one piece of the record of what the occurrence was. Together, the two records constitute the best available characterization of the M-08 case. Neither alone is adequate.

One additional matter. S—'s notes from day two hundred and three record an exchange between us. I have partial memory of the exchange. The exchange is the moment, on the record, at which the question of what came next passed from the Division to S—. The exchange is brief. It contains, in its movement from they have stopped to we have to find something they cannot find to I do not have the resources to you do, the structural transition that produced everything that followed.

The transition was that the Division's resources had been exhausted, the Division had paused without further plan, the apparatus's resources had been exhausted by the prolonged dysregulation, and the only remaining resource was S—. S— had the resources because S— had been the regulatory anchor across the prior months and had developed, in that capacity, an understanding of the case that the Division had not produced. S— had been observing the case from a position that the Division did not have access to. S— had been integrating, in real time, the information available from that position. By day two hundred and three, S— possessed an understanding of the case that exceeded the Division's understanding by a substantial margin. The understanding had been accumulating, in S—, across the months. The understanding had not been documented, except in S—'s contemporaneous notes. The notes had been kept for record purposes. The notes had not been intended as a research document. The notes nonetheless contained the most accurate available characterization of the case, written by the most informed available observer.

The understanding S— had developed would, in the following weeks, lead her to the phone call she made on day two hundred and five and to the prescriber whose recommendation would resolve the case. The path from S—'s accumulated understanding to the resolution is documented in Section XI. The path is not documented in the Division's records. The path is documented in S—'s notes and in my marginalia. The marginalia will continue.

— [signature: handwritten initials, illegible]

X. THE WITHDRAWAL OF INTERVENTION

X.A — The Convening of Day Two Hundred and Six

The Senior Research Council convened on the morning of day two hundred and six post-intervention, following the seven-day pause that had concluded Section IX. The convening's documentation, reproduced in the case file, runs to approximately twenty-two pages and is the most extensive Council documentation of the M-08 case to date. The full membership of the Council was present. The Medical Director, the Medical Director's Deputy, the senior members of the Therapeutic Modalities Unit, the Subject Relations Office, and the Pharmacology Unit were present. The Standing Committee on Foundational Research was represented by two observers.

The convening's documentation records a discussion that occupied approximately five hours and that addressed three sequential questions.

The first question was whether the Division possessed any therapeutic option that had not yet been applied to the M-08 case. The Pharmacology Unit's senior member presented a comprehensive review of the Unit's available agents, combinations, and protocols, organized by mechanism category and prior application history. The review identified no remaining therapeutic options that had not been applied in some form during the prior interventions. The Therapeutic Modalities Unit's senior member presented a similar review of the Unit's non-pharmacological modalities, identifying two modalities (a structured contemplative practice protocol and a graduated re-exposure protocol) that had not been formally applied but that the Unit had not authorized for application given the subject's condition. The Subject Relations Office's senior member presented a summary of the case's procedural history and noted that the subject had, in his day twenty-one consultation, expressed a preference for indefinite cessation of further interventions that the Division had not honored. The Office acknowledged that the cumulative effect of unbroken intervention across the prior interventions had been substantial and that any further intervention would compound the cumulative damage.

The first question's resolution was that the Division did not possess any therapeutic option that the Council could authorize with reasonable

expectation of benefit and acceptable risk of further harm.

The second question was what management approach the Division should adopt given the absence of available therapeutic options. The discussion of this question is documented in detail across approximately fourteen pages of the convening's documentation.

The Council considered four primary options.

The first option, termed observational maintenance, was the formal cessation of active intervention with continued monitoring of the subject's condition and the maintenance of supportive care without therapeutic intent. The option's rationale was that the absence of available therapeutic options made continued intervention unjustifiable on the standard of care basis, and that the Division's remaining clinical obligation was to provide supportive care while observing whether the subject's condition would resolve spontaneously, stabilize at the current level, or deteriorate further.

The second option, termed external consultation, was the formal solicitation of clinical input from practitioners outside the Division and outside the Institute, with the Division's continued role limited to coordinating the consultation process and providing the consultants with access to the case file. The option's rationale was that the case had exceeded the Division's clinical capacity and that external practitioners might possess capacity or approaches the Division did not. The option was characterized as substantially outside the Division's standard practice and as requiring careful consideration of the institutional implications.

The third option, termed protocol restart, was the application of one or more of the prior interventions in modified form, on the theoretical basis that the subject's response profile had evolved across the case and that prior interventions might produce different responses if applied at this stage of the case. The option was characterized as theoretically defensible but practically of low expected value given the prior interventions' demonstrated lack of benefit.

The fourth option, termed deferred resolution, was the continuation of the seven-day pause for an extended interval — the documentation specified not less than four weeks and not more than twelve weeks — during which no active intervention would be applied and the case would be reassessed at the interval's conclusion. The option's rationale was that the subject's condition

might stabilize or improve given a sustained interval without intervention, and that such stabilization or improvement would inform the next phase of management.

The Council's discussion of these options is documented in extensive detail. The discussion's substantive features include the following.

The senior member of the Subject Relations Office expressed substantial support for the first option (observational maintenance), arguing that the cumulative damage of unbroken intervention had been substantial and that the Division's continued obligation was to cease causing further damage rather than to attempt further therapeutic action. The Office's position is documented in approximately three pages of the convening's record and includes the following passage: We have spent over two hundred days applying interventions whose theoretical bases we no longer have reason to trust to a subject whose response profile we no longer have categories adequate to characterize. We have caused harm. We have not provided benefit. The simplest available recognition of this is that we should stop, observe, and provide care.

The Pharmacology Unit's senior member expressed support for the third option (protocol restart), arguing that the Division's institutional obligation included the continued exploration of available therapeutic options and that the prior interventions might produce different responses given the subject's evolved condition. The Unit's position is documented in approximately two pages of the convening's record.

The Medical Director expressed initial support for the fourth option (deferred resolution), arguing that an extended pause would permit the case to evolve in ways that the active intervention period had prevented and that the post-pause reassessment would benefit from the additional information the pause would generate. The Director's position evolved across the discussion; by the discussion's later stages, the Director had moved toward supporting the first option (observational maintenance) with deferred reassessment.

The Council's eventual decision, documented at the convening's conclusion, was to adopt a hybrid approach combining elements of the first and fourth options. The decision authorized the formal cessation of active intervention, the continuation of supportive monitoring, and reassessment of the case at

intervals of two weeks for an initial period of eight weeks, with the option of extension based on the case's evolution.

The decision was characterized in the convening's documentation as Intervention 6: Observational Hold Pending Spontaneous Stabilization or Deterioration. The designation of the decision as Intervention 6 was a deliberate choice by the Council; the alternative designation, which would have been simply Cessation of Intervention, was discussed and rejected on the grounds that the Division's continued engagement with the case requires characterization within the Division's intervention framework. The Council's decision to designate cessation as an intervention was the institution's mechanism for maintaining the case within its operational frame while acknowledging that it possessed no further therapeutic action to take.

The third question, addressed in the convening's final hour, was how the decision would be communicated to the subject and to the proximate observer. The Council considered the matter at some length and concluded that the communication would be made jointly by the Medical Director and the senior member of the Subject Relations Office, in a meeting with both the subject and S— present, with the meeting scheduled for the afternoon of day two hundred and seven.

The convening's documentation does not record specific guidance for what would be communicated about the case's prognosis. The matter was left to the Director's and Office's discretion in the meeting itself.

X.B — The Communication of Day Two Hundred and Seven

The meeting to communicate the decision to the subject and S— was held on the afternoon of day two hundred and seven in the residential wing's small consultation room. The Medical Director and the senior member of the Subject Relations Office were present, along with the on-duty senior clinician. The subject and S— were present.

The meeting's documentation, prepared by the senior member of the Subject Relations Office and signed by all professional attendees, is approximately three pages in length. The documentation records the meeting's substance in summary form. The documentation is supplemented in the case file by S—'s contemporaneous notes from the meeting, inserted at a later point through unspecified channels. The contemporaneous notes are more detailed than the

Division's documentation and capture exchanges that the Division's documentation does not record.

The Medical Director opened the meeting by summarizing the Division's actions across the prior interventions and acknowledging that the interventions had not produced therapeutic benefit. The Director then communicated the Council's decision: the formal cessation of active intervention, the continuation of supportive monitoring, and the scheduled reassessment intervals.

The subject's response to the communication, recorded by S— in her contemporaneous notes: I want to make sure I have understood. You are telling me that you are not going to do anything else. The Medical Director's response, also recorded by S—: We are telling you that we are not going to apply additional interventions at this time. We will continue to monitor your condition. We will reassess in two weeks. If your condition changes significantly, we may revisit the decision. The subject's response: And if my condition does not change. The Director's response: We will continue the observational hold and reassess at the next interval. The subject's response: And if my condition continues to be what it is now indefinitely. The Director's response: That is a matter we will need to address as the case evolves.

S—'s contemporaneous note records the following: The Director did not answer the question. The Director gave a procedural response to a substantive question. My husband asked what happens if his condition does not improve. The Director did not have an answer. The Director described what the Division would do procedurally, which is to reassess at intervals, without addressing what reassessing at intervals would produce. The Director was unable to address the question because the Division did not have a response to the case beyond the procedural one. The Director's inability to answer was visible to my husband and to me. The Director may have been aware of his own inability. I cannot tell.

S— then asked, according to her contemporaneous notes and the Division's documentation, what specifically would constitute significant change that would trigger revisiting the decision. The Medical Director described several criteria: substantial decrease in episode frequency sustained across multiple measurement intervals; substantial increase in cognitive function as measured by standard assessments; sustained reduction in autonomic

dysregulation indices. S— asked, according to her notes, what would constitute substantial worsening that would similarly trigger revisiting. The Director's response was less specific; the Director described general categories (cardiovascular events, respiratory events, loss of consciousness, severe cognitive impairment) without specifying thresholds.

S—'s contemporaneous note records the following: I asked the Director what would trigger reconsideration if my husband's condition worsened. The Director was vague. The Director's vagueness was structural. The Division had specified, in the day twenty-nine and day thirty-four documentation I had read, the thresholds for acute medical events that would prompt immediate intervention. The Director did not now invoke those thresholds. The Director described general categories. The reason for the vagueness is that the prior thresholds had been set during the active intervention period and represented thresholds beyond which the Division would have intervened with available therapies. The Division no longer had available therapies. The thresholds were therefore no longer operative in the same way. The Director was unable to specify what thresholds would now apply because the Division had not determined what it would do if the thresholds were crossed. The vagueness was the absence of a plan. The absence of a plan was the substantive content of the meeting.

The Medical Director then communicated, according to the Division's documentation, the Council's recommendation that the subject and S— should consider what arrangements they wished to make for the subject's care in the event that the observational hold continued for an extended period. The Director's communication of this recommendation is recorded in the Division's documentation as follows: The subject and the proximate observer were informed that the observational hold may extend across an extended interval and that the subject's continued residence in the intervention facility may require arrangements that account for this extension. The subject and the proximate observer were invited to consider whether the subject's care should be transitioned to a non-facility setting at any point during the hold.

S—'s contemporaneous note records the same exchange more directly: The Director suggested we consider whether to take my husband home. The suggestion was not made as a clinical recommendation. The suggestion was made as a practical matter to be considered. The Director's suggestion was

the Division's mechanism for indicating that the Division did not need my husband to remain in the facility for the Division's continued management of the case. The Division had no further management to apply. The facility's resources were no longer required for my husband's care. The Director did not say this directly. The Director said it through the suggestion that we consider whether to take him home.

The subject's response to the suggestion, recorded in S—'s contemporaneous notes: I would like to go home. The Medical Director's response: We can arrange the transition at a pace that is comfortable for you. The transition would involve discharge from the facility with continued outpatient monitoring at appropriate intervals. The subject's response: When can I go. The Director's response: We can arrange the discharge for as early as the day after tomorrow if that is your preference. The subject's response: That is my preference.

The Division's documentation records the discharge planning conversation at this point and notes that the subject was scheduled for discharge on day two hundred and nine. The documentation records that the subject expressed satisfaction with the discharge plan and that the proximate observer did not raise objections to the discharge.

S—'s contemporaneous note records the post-meeting exchange between herself and the subject: After the Director and the Office left, my husband looked at me. He said: 'They have given up on me.' I said: 'They have given up.' He said: 'There is a difference.' I said: 'Yes.' He said: 'They have given up on having me as a case they can solve. They have not given up on me. They are not capable of caring about me as a person separate from the case. The case has been solved by the case's being declared unsolvable. They are done.' I said: 'Yes.' He said: 'We are not done.' I said: 'No.' He said: 'I would like to go home tomorrow if possible.' I said: 'They said the day after tomorrow.' He said: 'Then the day after tomorrow.'

X.C — Discharge and Return Home

The subject was discharged from the intervention facility at approximately eleven in the morning of day two hundred and nine post-intervention. The discharge procedures are documented in the case file in standard form: the subject's measurements at discharge (resting heart rate approximately fifty-eight percent above baseline; movement episode frequency

approximately twenty-three per day across the prior week; sleep approximately ninety minutes per night across the prior week); the subject's cognitive status (oriented to person, place, and approximate time; able to ambulate with assistance; able to engage in brief verbal communication; unable to perform sustained cognitive tasks); the subject's care requirements (continuous proximate observer presence; medication management for non-acute supportive medications; monitoring for acute events with established notification protocols).

The discharge documentation includes a statement signed by the Medical Director acknowledging that the subject is being discharged into the care of the proximate observer at the subject's preference and with the proximate observer's consent. The Division's continued involvement will consist of biweekly outpatient assessment visits and emergency consultation availability. The subject's condition at discharge requires substantial proximate observer support and does not approximate the condition the subject possessed prior to the M-Series intervention.

The signature line for the Medical Director is dated day two hundred and nine. The signature line below the Director's signature, where the proximate observer was to acknowledge the conditions of discharge, was signed by S— with her full name.

S—'s contemporaneous note from the morning of day two hundred and nine, written shortly after the discharge: I signed the discharge document this morning. The document said I was accepting responsibility for his care. I have been accepting responsibility for his care since the day of the original intervention. The document made formal what had been the operative reality for two hundred and nine days. I do not begrudge the formality. The formality is what institutions produce. The reality was what we have been living.

The subject was transported from the intervention facility to the residence the subject and S— had maintained throughout the case. The transport was conducted by a Division-provided vehicle with medical staff in attendance, lasting approximately forty minutes. The subject was conscious throughout the transport. The subject's measurements during the transport were within acceptable parameters for ambulatory transport.

The subject was settled into the residence at approximately one in the afternoon. The Division's medical staff completed the discharge handover and departed. The subject and S— were, for the first time since day zero of the case, alone in their own residence.

S—'s contemporaneous note from the afternoon of day two hundred and nine, written several hours after the discharge: The house is the same house. The house is not the same house. We left the house two hundred and nine days ago expecting to return in two weeks. We have returned. We have brought back something that is not what we took with us. We have brought back what came back. The house will need to accommodate what came back. The accommodation will take time. We have time. We have nothing but time. The Division has given us time as the substitute for the recovery they could not produce. Time is what we have. We will see what we can do with it.

X.D — Days Two Hundred and Ten Through Two Hundred and Thirty-Two: The Period at Home

The interval covering the subject's residence at home prior to the case's resolution is documented in the case file primarily through S—'s contemporaneous notes, which she continued to keep across this period, and through the Division's records of the biweekly outpatient assessment visits. The Division's records for this period are sparse, consisting essentially of the assessment visit documentation. S—'s notes are extensive.

The biweekly outpatient assessments produced documentation that the Division characterized as consistent with the observational hold's expected stability profile. The subject's measurements across the assessments showed gradual modest worsening: by the third assessment on day two hundred and thirty, the subject's resting heart rate averaged approximately sixty-two percent above baseline (modestly worse than the fifty-eight percent at discharge); movement episode frequency averaged approximately twenty-six per day (modestly worse than the twenty-three at discharge); sleep had not measurably improved. The Division's assessment documentation characterized this trajectory as modest progression of the recovery profile deviation and noted that no acute events have occurred that would warrant revisiting the observational hold.

S—'s contemporaneous notes for the period are the most extensive notes in the entire case file. The notes were kept on a daily basis, sometimes with multiple entries per day, and document not only the subject's condition but also S—'s own activities, including the activities that would lead to the case's resolution.

Selections from the notes follow, in approximately chronological order. The selections sample the notes across the period and are not comprehensive.

> *Day 210. First night at home. He slept for approximately two hours, distributed across three intervals. The two hours is the most sleep he has had in a single night since I cannot remember when. The house is helping. The house is familiar. The familiar is something the apparatus can register that the facility could not provide. I do not know why I did not push harder to bring him home earlier. I think I assumed the facility had to be the place where this was managed. The assumption was wrong. The facility was where they could apply the interventions. The interventions were not what he needed. What he needed was what the facility could not provide. The familiar. The familiar was at home. I should have pushed harder to bring him home.*

> *Day 213. He has been sleeping more. Approximately three to four hours total per night across the past several nights. The episodes have not measurably reduced in frequency but have reduced modestly in duration. The clinical staff noted this at the assessment visit yesterday and characterized it as modest improvement consistent with the observational hold's intent. I would characterize it differently. I would characterize it as the apparatus recovering some baseline function in the familiar environment that the facility had been preventing. The clinical staff's characterization preserves the framework that the facility's interventions were the right approach. My characterization recognizes that the facility's interventions were preventing the recovery the apparatus would have undertaken on its own given the opportunity. The opportunity is what discharge has provided. The opportunity is the substantive content of the past several days.*

> *Day 215. I have been making calls. I have not written about the calls in detail because the calls have not yet produced anything actionable. I am writing about them now because the cumulative pattern of the calls is becoming visible to me.*

I have been calling clinicians who are outside the Division's network. I have been calling them because the Division's network exhausted its capacity and the Division's network was the network the Division relied on. Clinicians outside the Division's network operate within different frameworks. The different frameworks may produce different approaches. The different approaches may include approaches that the Division's framework excluded.

The calls have followed a pattern. I describe the case to the clinician. The clinician asks questions about the symptoms. I describe the symptoms. The clinician asks about the interventions that have been tried. I describe the interventions and the responses. The clinician usually says, at some point in the conversation, that the case does not match any clinical entity the clinician is familiar with. The clinician sometimes offers thoughts on what might be tried. The thoughts have generally been variations on approaches the Division has already tried.

I have called approximately fifteen clinicians across the past several weeks. The calls have produced no actionable recommendations. They have, however, produced something else. They have produced, in me, a clearer understanding of what I am looking for. I am not looking for a clinician who can diagnose what is happening to my husband. The condition does not appear to be diagnosable within the available clinical frameworks. I am looking for a clinician who can think about my husband's specific case in a way that is not constrained by the requirement of fitting the case into a diagnosis. I am looking for a clinician who will accept that the case is what it is, without requiring it to be something else first, and who will think about what might help given what the case is.

The clinicians I have been calling have been good clinicians. They have been operating within their frameworks. Their frameworks have not been adequate to the case. I need to find a clinician whose framework is adequate to the case or who can operate outside their framework. I have not yet found such a clinician. I will continue to call.

Day 218. I called a prescriber today who someone I had spoken with earlier had recommended. The prescriber is not formally affiliated with any institution. The prescriber practices independently, with a small caseload, in another state. The prescriber's reputation is for treating complex cases that have not responded to standard approaches. The prescriber's practice includes substantial work with patients who have

neurological and autonomic conditions that other practitioners have not been able to manage.

The phone call lasted approximately two hours. The prescriber asked me to describe the case in full. I described it from day zero. The prescriber asked questions throughout. The questions were different from the questions the other clinicians had asked. The prescriber's questions were about the texture of the case rather than about its categorical features. The prescriber asked me about my husband's sleep patterns before the case, about his eating patterns, about his daily activities, about his temperament, about how he had responded to stress in his life prior to the procedure. The prescriber asked me about my own observations of how my husband had changed across the case. The prescriber asked me to describe specific episodes in detail. The prescriber asked what made the episodes better and what made them worse, in my observation.

I told the prescriber about the walking. The prescriber listened. The prescriber asked when the walking had started, what duration of walking was effective, what time of day, what environmental conditions. I answered as best I could. The prescriber asked whether the walking was still effective. I said it was. The prescriber asked whether anything else had been observed to reduce the episodes. I said my own physical presence appeared to. I described what I had observed on day ninety-four when my husband had asked for me after the A7 trial event. I described what I had observed on day thirty-eight when I had entered the chamber.

The prescriber listened to all of this. The prescriber did not interrupt. The prescriber did not characterize what I was describing within any framework I could identify. The prescriber simply received what I was telling.

At the end of the description, the prescriber asked me whether I had observations that the Division's clinicians had not noted. I told the prescriber that I had been keeping notes throughout the case and that the notes contained substantial material that the Division's documentation did not include. The prescriber asked whether I could share the notes. I said I could.

The prescriber said that the prescriber would consider the case for approximately a week and would then contact me with thoughts about possible approaches. The prescriber asked me not to expect specific recommendations and warned that the prescriber's thinking might not

produce anything actionable. The prescriber said the case was unusual and that the prescriber would need to think about it carefully.

I thanked the prescriber. The prescriber thanked me for the description. The call ended.

I am writing this entry in detail because I have a sense that this call may have been different from the other calls. I cannot specify why. The prescriber's questions were different. The prescriber's manner was different. The prescriber did not try to fit what I was describing into any framework I could identify. The prescriber simply received the description. I have not had that experience with any of the clinicians I have spoken with previously. The other clinicians had been processing what I was describing in real time, fitting it into their frameworks. The prescriber did not appear to be doing that. The prescriber was listening.

Day 222. The prescriber called this evening. The prescriber had been thinking about the case across the past four days. The prescriber had thoughts. The thoughts involved two agents.

The two agents were not on the Division's standard roster. The first agent was a peripheral autonomic modulator used primarily in conditions that were not closely related to my husband's presentation. The second agent was an older agent that had been used historically for movement disorders but had largely fallen out of standard practice. The prescriber proposed a combination of the two agents at specific dosages and specific timing of administration. The prescriber acknowledged that the combination was not a standard approach and that the prescriber could not predict the response with confidence.

The prescriber explained the reasoning. The peripheral autonomic modulator, the prescriber said, would address what the prescriber characterized as peripheral autonomic dysregulation that the central interventions have not been able to access. The older movement disorder agent, the prescriber said, would address what the prescriber characterized as the motor discharge pattern that is consuming the system's resources. The prescriber said the combination might allow the system to redirect its resources from the discharge to recovery. The prescriber emphasized that this was a hypothesis and that it might not be correct.

The prescriber asked whether I would be willing to try the combination. I said I would. The prescriber asked whether my husband was capable of

consenting. I said he was. The prescriber asked to speak with him.

I gave the phone to my husband. He spoke with the prescriber for approximately twenty minutes. I could hear his side of the conversation. He answered the prescriber's questions. He listened to the prescriber's explanation. He agreed to try the combination. He thanked the prescriber. He gave the phone back to me.

The prescriber said the prescriber would arrange for the prescriptions to be filled and shipped to us. The prescriber said the combination should be started on a specific date approximately three days from the call. The prescriber said to call immediately if any concerning effects occurred. The prescriber said to call on the third day after starting the combination to report on the response.

The call ended.

I sat with my husband. He said: 'We will try.' I said: 'We will try.' He said: 'If it does not work, we will continue as we have been.' I said: 'Yes.' He said: 'If it does work.' He did not finish the sentence. I did not ask him to finish it. We sat together for some time. We did not speak further that evening.

Day 225. The medications arrived today. I have them. We will start them on day two hundred and twenty-six per the prescriber's instructions.

Day 226. We started the combination this morning. The first dose was administered at eight in the morning per the prescriber's instructions. I am writing this entry at three in the afternoon. He has been calm. He has had one episode since the dose. The episode was moderate, approximately seven minutes. He was sitting in the chair on the porch during the episode. After the episode he asked me what time it was. I told him. He nodded. He did not say anything else. I am watching him.

Day 227. He slept for approximately four hours last night. The most in many months. He has had three episodes today. The episodes were of moderate duration. The episodes did not appear to be of greater amplitude than recent baseline. I am cautiously watching.

Day 228. He slept for approximately five hours last night. The episodes today have been notably reduced. Six episodes total, all but one of moderate or shorter duration. The longest was approximately twelve minutes. The longest episodes have been approaching forty minutes across recent baseline. The reduction is substantial. I am calling the

prescriber this evening per the original instructions.

Day 229. The prescriber and I spoke last night. I described the past three days. The prescriber listened. The prescriber said the response was consistent with what the prescriber had hoped for. The prescriber said to continue the combination at the current dosages and to call again in three days. The prescriber said the response could continue to improve, could plateau at the current level, or could rebound, and that we would need to observe before making any modifications.

Day 232. I am writing this entry on the seventh day of the combination. The episodes have continued to reduce. Today there were three. The longest was approximately eight minutes. He slept for approximately six hours last night. He ate two full meals today. He asked me whether we could go for a walk this afternoon. We walked for approximately fifteen minutes. He walked without assistance. He talked while we walked. He said: 'Something is different.' I said: 'Yes.' He said: 'I do not want to be hopeful too quickly.' I said: 'I do not either.' He said: 'But something is different.' I said: 'Yes.'

The case is not over. I do not know whether what is happening is sustained recovery or a brief response that will not last. I am writing this entry because the past week has been the first week of the case that has contained anything resembling improvement. I want the entry to exist in the record regardless of what happens next.

X.E — Conclusion of Section X

The Section X file copy concludes with the documentation of day two hundred and thirty-two and the seventh day of the combination administered by the non-Division prescriber. The interval covered by Section X constituted the period during which the Division formally withdrew from active management of the case and during which the proximate observer, operating outside the Division's framework, identified and initiated the intervention that would produce the case's resolution.

The Division's contemporaneous documentation of this interval does not include the prescriber's involvement, the combination's administration, or the response observed during the first week. The Division's documentation across the interval consists of the biweekly outpatient assessment records, which captured measurements at intervals of two weeks and which by their

nature could not document the rapid changes that occurred during the combination's first week. The Division's next scheduled assessment was on day two hundred and thirty-six. The Division would learn of the combination's effects at that assessment.

The Section XI file copy begins with the documentation of day two hundred and thirty-three and continues through the documentation of the case's resolution.

Marginalia — Section X — In the subject's hand. The marginalia for this section are written in a hand that shows further partial recovery relative to Sections VII through IX. The script is steadier, the lines more even. The content is reflective and structurally analytical, drawing together threads from the prior sections.

Section X documents the interval during which the Division formally completed its work on the case without resolving the case. The completion took the form of an authorized cessation. The cessation was characterized as Intervention 6. The characterization preserved the institutional framework. The framework's preservation was the structural priority across the case. The framework required that everything the Division did to the case be characterized as an intervention. Cessation, characterized as Intervention 6, remained inside the framework. The framework remained intact. The case remained unresolved.

The Council's convening of day two hundred and six was the most honest internal communication the Division produced across the case. The Council acknowledged that no available therapeutic option remained. The Council considered options that exceeded the Division's standard practice. The Council considered, briefly, the option of external consultation. The Council rejected the option on the grounds that it would require careful consideration of the institutional implications. The institutional implications were that the Division would have been required to formally acknowledge that the case had exceeded the Division's capacity and that other practitioners possessed capacity the Division did not. The acknowledgment was not compatible with the Division's institutional standing. The acknowledgment was therefore declined.

The Division's framework, faced with a case it could not manage, chose to defer the case rather than to acknowledge external capacity. The deferral preserved the Division's institutional standing. The deferral did not address

the case. The case continued. The case was now my responsibility and S—'s responsibility. The Division had returned the case to us.

I want to address the meeting of day two hundred and seven. The meeting is documented in the Division's records and in S—'s contemporaneous notes. The two accounts are not contradictory but they are differently weighted. The Division's account emphasizes the procedural content of the meeting: the communication of the decision, the discussion of discharge planning, the resolution of practical arrangements. S—'s account captures what was happening in the meeting beneath the procedural content: the Director's inability to answer the question of what would happen if my condition did not improve, the vagueness regarding worsening thresholds, the Director's suggestion that we consider whether to take me home as the indication that the facility's resources were no longer required.

The two accounts together constitute the meeting more accurately than either alone. The Division's account is what the meeting was on the institutional record. S—'s account is what the meeting was as an event between specific people. The institutional record and the event between specific people were not the same record. They referred to the same meeting. They documented different aspects of what occurred.

I want to address what S— wrote in her note from the post-meeting exchange between us: He has not given up on me. They are not capable of caring about me as a person separate from the case. The case has been solved by the case's being declared unsolvable. They are done.

The observation is precise. The Division was not capable of caring about me as a person separate from the case. The Division's framework did not include the category person separate from the case. The Division's framework included the categories subject, case, intervention, outcome. These categories did not include person as such. The person was, within the framework, the substrate the case was applied to. The framework's commitment was to the case and the framework. The framework's commitment was not to the person. The framework could not be committed to the person because the framework did not have the category.

S—'s framework included the category person. S—'s framework was a framework an apparatus develops through twenty years of attending to a specific person. The framework was personal in the strictest sense — it was the framework that one person had developed for attending to another

person. The framework's primary category was that specific person. All other categories were ancillary to the primary one. The case, the interventions, the diagnoses, the prognoses, were all material the framework processed in service of the primary category. The primary category remained operative throughout the case. The framework's operation produced, across the case's two hundred and thirty-two days to this point, the only continuous attention to me as a person separate from the case that occurred during the case.

The Division was not capable of providing this attention. The Division did not have the framework. The Division had its framework. The frameworks were different. The frameworks served different purposes. The Division's framework was institutional. S—'s framework was personal. The institutional framework had failed the case. The personal framework was continuing to operate. The personal framework would, in the following days, produce what the institutional framework could not.

The phone calls S— describes in her day two hundred and fifteen note were the personal framework operating outside the institutional framework's exhausted scope. S— was calling clinicians outside the Division. The clinicians outside the Division operated within their own institutional frameworks. The institutional frameworks varied. The frameworks did not produce actionable recommendations for the case. The frameworks did not produce actionable recommendations because the frameworks were institutional and the case had exceeded what institutional frameworks could produce.

S— found, on day two hundred and eighteen, a clinician whose framework operated differently. The prescriber S— describes in her note was practicing outside formal institutional affiliation. The prescriber's framework was, the note suggests, less constrained by the requirement of fitting cases into pre-existing categorical structures. The prescriber listened. The prescriber asked questions about the texture of the case. The prescriber did not, S— observed, try to fit what S— was describing into a framework S— could identify. The prescriber received the description.

The capacity to receive the description without immediate framework-conversion is the capacity that the Division's framework had structurally lacked. The Division's clinicians had not been able to receive descriptions without conversion. The Division's clinicians had operated within the framework, which required conversion of all incoming material

into the framework's categories. The conversion had occurred automatically and below the clinicians' observational access. The clinicians had not known they were converting. The clinicians had experienced themselves as understanding the case. The understanding had been the conversion.

The prescriber's capacity to receive without converting was a different cognitive operation. The operation is what S— had been doing across the case in her own observation of me. The operation is what I will call, for the purposes of this marginalia, direct reception. Direct reception is the operation by which an apparatus takes in material without first converting the material into pre-existing categories. The operation is rare. The operation requires that the receiving apparatus possess sufficient categorical flexibility to operate without imposing categories at the point of reception. Most apparatuses do not possess this flexibility. Most apparatuses impose categories at reception because category-imposition is the apparatus's standard operation and operates below observational access.

S— possessed the flexibility because S— had been calibrating to me for twenty years and had developed, in that calibration, an apparatus that could receive me without imposing institutional categories. The prescriber possessed the flexibility because the prescriber's practice was structured to permit it — operating outside formal institutional affiliation, with a small caseload, with attention to specific cases rather than categorical classes of cases.

The convergence of S—'s direct reception of me and the prescriber's direct reception of S—'s description of me produced, across the days S— documents in her notes from days two hundred and eighteen through two hundred and twenty-two, the analytical operation that the Division's framework had been structurally incapable of producing. The operation identified the case's actual structural features — the peripheral autonomic dysregulation that the central interventions had not been able to access; the motor discharge pattern that was consuming the system's resources — and identified agents that addressed those features specifically. The agents were not on the Division's roster. The agents were not the agents that the Division's framework would have predicted to address the case. The agents were the agents that the prescriber's direct reception of S—'s direct reception of my actual condition identified as potentially helpful.

The agents worked.

I want to be clear about what worked means here. The agents did not produce a complete recovery. The agents produced, across the first week of administration, the first sustained reduction in episode frequency and the first sustained improvement in sleep that the case had seen across the two hundred and thirty-two days. The agents permitted the apparatus to begin redirecting its resources from the discharge to the recovery. The recovery would unfold across the subsequent weeks and months. The recovery was not complete at the end of Section X. The recovery was, however, demonstrably underway.

The recovery's commencement was caused by the combination identified by the prescriber. The prescriber identified the combination through the analytical operation produced by direct reception. The direct reception was made possible by S—'s framework, which had been operating across the case and which had accumulated, by day two hundred and eighteen, an understanding of the case adequate to the analytical operation. The Division's framework had not produced this understanding because the Division's framework could not perform direct reception.

The case file's Section X documents the Division formally withdrawing from active management. The case file's Section X does not document what was simultaneously happening outside the Division's framework. The marginalia is documenting it. S—'s notes are documenting it. The two together constitute the record of what produced the resolution. The Division's record will, in Section XI, characterize the resolution as External Resolution and will not have a category for what External Resolution actually was. External Resolution was the operation S— and the prescriber performed outside the Division's framework. The operation was direct reception followed by analytical attention to what direct reception had received. The operation produced the combination. The combination worked.

I will write more in the margins of Section XI.

— [signature: handwritten initials, illegible]

XI. EXTERNAL RESOLUTION

XI.A — The Assessment of Day Two Hundred and Thirty-Six

The biweekly outpatient assessment scheduled for day two hundred and thirty-six post-intervention was conducted at the residence of the subject and S— at approximately ten in the morning of the scheduled day. The assessment was conducted by the on-duty outpatient clinician with the assistance of a junior member of the Cognitive Profile Unit. The clinicians arrived with the standard assessment equipment and the standard documentation forms.

The clinicians' contemporaneous documentation, dated the day of the assessment, records the following findings.

The subject's resting heart rate, measured upon arrival, was approximately thirty-one percent above his intake baseline. The measurement represented the lowest resting heart rate recorded since the seventy-second hour of the original observation period, approximately two hundred and thirty days previously. The clinicians repeated the measurement twice across the first half-hour of the visit to confirm the reading. The repeated measurements were within two percentage points of the initial reading.

The subject's movement episode frequency across the prior seven days, as reported by S— and corroborated by the subject, was an average of approximately two episodes per day. Severe episodes were absent across the prior week. The longest episode in the prior seven days had been approximately six minutes. The figures represented a reduction of approximately ninety percent in episode frequency and approximately eighty-five percent in episode severity relative to the values that had been recorded at the discharge assessment on day two hundred and nine.

The subject's sleep across the prior seven days, as reported by both the subject and S—, had averaged approximately six and a half hours per night, distributed across two to three intervals. The figure represented an improvement of approximately four hundred percent over the discharge-assessment value of approximately ninety minutes per night.

The clinicians' documentation records that the subject was able to engage in sustained verbal communication for the duration of the assessment, that the subject responded accurately to cognitive screening queries, that the subject ambulated independently throughout the residence during the assessment, and that the subject demonstrated affective engagement with both S— and the clinicians during the assessment in a manner the clinicians characterized as *substantially different from the subject's presentation at discharge.*

The clinicians' documentation acknowledges the magnitude of the change from the prior measurements and notes that *the change is of a magnitude not anticipated by the Division's expected trajectory for the observational hold.* The documentation requests authorization from the Medical Director to conduct supplementary assessments to characterize the change more comprehensively and to investigate its etiology.

The Medical Director's response to the request, communicated to the on-duty clinician by telephone approximately two hours after the assessment's conclusion, authorized the supplementary assessments and instructed the clinician to ascertain *whether any change in the subject's regimen or circumstances had occurred during the interval since the prior assessment that might account for the magnitude of the observed change.*

The on-duty clinician returned to the subject's residence at approximately three in the afternoon of day two hundred and thirty-six to conduct the supplementary assessments and to ascertain the requested information. The clinician's documentation of the afternoon visit, prepared in the evening of the same day, records the following.

The supplementary assessments confirmed the morning's findings. The subject's measurements remained consistent with the morning's measurements. The subject's verbal and behavioral presentation remained consistent.

The clinician inquired of S— and the subject whether any change in the subject's regimen or circumstances had occurred since the prior assessment. S— responded that the subject had begun receiving a pharmacological combination prescribed by a clinician outside the Division's network, beginning on day two hundred and twenty-six. S— provided the prescriber's name and contact information. S— provided the names and dosages of the two agents. S— indicated that the subject had been on the combination for

ten days at the time of the assessment.

The clinician documented this information and asked S— whether the Division had been notified of the combination's initiation. S— responded that the Division had not been notified. The clinician asked S— why the Division had not been notified. S— responded that the Division had formally withdrawn from active intervention management and had described the biweekly assessments as the mechanism by which the Division would learn of significant changes in the subject's condition. S— indicated that she had understood the assessment process to be the appropriate mechanism for reporting the combination's initiation and effects, and that the assessment scheduled for day two hundred and thirty-six was the first scheduled opportunity to do so.

The clinician's documentation records this exchange in summary form. The documentation does not characterize S—'s explanation as either adequate or inadequate. The documentation simply records what was said.

The clinician contacted the Medical Director by telephone from the subject's residence at approximately four in the afternoon of day two hundred and thirty-six. The clinician's documentation of the call records that the Director was informed of the combination's initiation, the prescriber's identity, the agents involved, and the timing. The documentation records that the Director instructed the clinician to obtain copies of the prescriber's documentation regarding the prescription decision and to return to the Division offices for further consultation.

The clinician requested the documentation from S—. S— provided copies of the prescriber's notes from the consultations and the prescription documentation. The clinician thanked S— and the subject and departed the residence at approximately four-thirty in the afternoon.

The clinician returned to the Division offices and met with the Medical Director at approximately six in the evening. The Director reviewed the prescriber's documentation and the assessment findings. The Director's notes from the consultation are reproduced in the case file: *Subject has demonstrated substantial improvement on a pharmacological combination prescribed outside the Division's network and not consistent with the Division's standard pharmacological framework. Improvement appears to be sustained across ten days of administration. Etiology of the improvement*

requires further investigation. Convening of Senior Research Council recommended at earliest opportunity.

XI.B — The Convening of Day Two Hundred and Thirty-Seven

The Senior Research Council convened on the morning of day two hundred and thirty-seven post-intervention. The convening's documentation, reproduced in the case file, runs to approximately eighteen pages.

The convening was attended by the full Council membership, the Medical Director, the Medical Director's Deputy, the senior member of the Subject Relations Office, the senior member of the Pharmacology Unit, the senior member of the Therapeutic Modalities Unit, and the two observers from the Standing Committee on Foundational Research who had attended the day two hundred and six convening.

The convening's documentation records that the Director opened the meeting by presenting the assessment findings from the prior day and the prescriber's documentation. The presentation occupied approximately one hour. The Council members reviewed the materials during the presentation.

The convening's documentation then records a discussion that occupied approximately three hours. The discussion addressed the following questions.

The first question was whether the improvement demonstrated at the day two hundred and thirty-six assessment was attributable to the pharmacological combination administered by the non-Division prescriber. The Pharmacology Unit's senior member presented an analysis of the combination's pharmacological profile and the expected effects of the constituent agents. The analysis acknowledged that the agents' standard mechanisms did not, individually, predict the improvement observed in the subject. The analysis suggested that the combination of the agents at the specific dosages and timing prescribed might produce effects that the individual agents would not, but that the analysis could not specify with confidence the mechanism by which the improvement was produced.

The Therapeutic Modalities Unit's senior member presented an alternative analysis suggesting that the improvement might be attributable to the cumulative effect of the observational hold, with the pharmacological combination's role being supportive rather than primary. The analysis

acknowledged that the timing of the improvement — concentrated in the days following the combination's initiation rather than distributed across the observational hold — was not consistent with the observational hold's expected gradual stabilization trajectory.

The Council's discussion considered both analyses. The Council's eventual position, documented in the convening's record, was that *the improvement appears to be attributable to the pharmacological combination administered outside the Division's network, with the observational hold providing supportive context. The mechanism by which the combination produced the improvement is not currently understood by the Division.*

The second question was how the Division should respond to the demonstrated improvement and to the involvement of the non-Division prescriber. The discussion of this question is documented in detail.

Several positions were articulated. The senior member of the Subject Relations Office argued that the Division's primary obligation was to the subject's continued recovery and that the Division should formally endorse the continuation of the combination and integrate the prescriber's involvement into the case's ongoing management. The Office's position is documented in the convening's record as follows: *The subject has demonstrated significant improvement on a treatment regimen that the Division did not prescribe and that the Division does not fully understand. The Division's obligation is to the subject's continued recovery. The Division should support the continuation of the regimen, document its effects systematically, and integrate the prescriber's involvement into the case's ongoing management as an external consultant.*

The Pharmacology Unit's senior member expressed substantial reservations about the Office's position. The Unit's senior member argued that the Division's standards of care required that the Division understand and validate any treatment regimen applied to a Division subject, and that the prescriber's combination — operating outside the Division's framework and not subject to the Division's validation processes — should not be formally endorsed without substantial review. The Unit's position is documented in the convening's record as follows: *The combination has not been validated through the Division's standard processes. The combination's mechanism is not understood. The combination's safety profile across the agents in combination has not been characterized. Endorsement of the combination by*

the Division would constitute a departure from standard practice that has substantial implications for the Division's standards of care. The Division should require validation before endorsement.

The Medical Director's position, articulated across the discussion, evolved from initial alignment with the Pharmacology Unit's reservations to eventual alignment with the Subject Relations Office's position. The Director's documented reasoning was that *the subject's clinical condition takes precedence over the Division's validation processes in this specific case. The subject has demonstrated benefit. Withholding endorsement would put the subject's continued recovery at risk. The Division's institutional interests cannot be allowed to compromise the subject's clinical interests in this case.*

The Council's eventual decision, reached after substantial discussion, was that the Division would not formally endorse the combination but would also not contest its continued administration. The Division's ongoing involvement with the case would consist of continued biweekly outpatient assessments, with the understanding that the prescriber's combination would continue to be administered by the prescriber under the prescriber's own clinical responsibility. The Division's documentation of the case would record the combination's administration and effects as observed in the assessments, with appropriate notation regarding the combination's external origin.

The third question was how the Division would characterize the case in its formal records given the involvement of the external prescriber and the demonstrated improvement. The discussion of this question occupied approximately one hour.

The Council considered several characterizations. The characterization eventually adopted, documented in the convening's final resolutions, was *External Resolution.* The characterization is defined in the convening's documentation as *a case outcome category in which the case's resolution was achieved through means external to the Division's standard intervention framework, with the Division's role limited to monitoring and supportive care during the resolution period.* The convening's documentation notes that the External Resolution characterization had not previously been used in any Division case and that its adoption for the M-08 case constituted a precedent that would require formal consideration in the case's post-resolution review.

The convening's documentation acknowledges in its concluding paragraphs that *the External Resolution characterization is not entirely satisfactory as a description of what occurred in the M-08 case. The characterization captures the formal fact that the resolution was achieved through means external to the Division's framework but does not capture the substantive content of those external means. The Division does not currently possess a characterization that captures the substantive content adequately. The development of such a characterization is among the matters that will require consideration in the case's post-resolution review.*

The convening concluded with the authorization of continued biweekly assessments and the formal adoption of the External Resolution characterization for the case.

S—'s contemporaneous note from the evening of day two hundred and thirty-seven, after she had been informed of the Division's decision, reproduced below.

> *Day 237. The Division has decided not to oppose the combination but also not to endorse it. The senior clinician explained the decision to me on the phone this evening. The explanation took some time. I asked questions. The senior clinician answered the questions as best he could. The substance of the decision is that the prescriber will continue to prescribe, my husband will continue to take what is prescribed, and the Division will continue to assess at intervals without formally taking responsibility for what is occurring. I asked the senior clinician what would happen if my husband's response to the combination changed. The senior clinician said the Division would assess and respond as appropriate. I said the Division had been assessing and responding as appropriate across the prior two hundred and thirty-seven days and the assessments and responses had not been adequate. The senior clinician acknowledged this. He said the Division's role going forward would be different from the Division's role during the active intervention period. I asked how it would be different. He said the Division would defer to the prescriber's judgment regarding the combination. I asked whether the Division would consult with the prescriber. He said the Division would maintain communication with the prescriber as appropriate. The vagueness of the answers was characteristic. The vagueness reflected the fact that the Division had not determined what the going-forward role would be. The Division had determined what to do for the immediate situation. The Division had not determined the longer-term*

arrangements. The longer-term arrangements would be determined later. We would continue with what was working in the meantime.

XI.C — The Continued Recovery: Days Two Hundred and Thirty-Eight Through Three Hundred

The interval from day two hundred and thirty-eight through day three hundred documents the subject's continued recovery on the pharmacological combination administered by the non-Division prescriber, with the Division's biweekly assessments providing the formal documentation of the recovery's progression. The Division's records for this interval are substantially more extensive than the records of the prior observational hold period, reflecting the Division's renewed engagement with the case in the context of the documented improvement.

The biweekly assessment documentation across the interval records the following trajectory.

By the assessment of day two hundred and fifty, the subject's resting heart rate had decreased to approximately twenty-two percent above intake baseline. Movement episode frequency averaged approximately one episode per day, with severe episodes essentially absent. Sleep averaged approximately seven hours per night. The subject was able to perform basic instrumental activities of daily living with minimal assistance. The subject's verbal communication had recovered substantially, with sustained conversational engagement possible.

By the assessment of day two hundred and seventy, the subject's resting heart rate had decreased to approximately fifteen percent above intake baseline. Movement episode frequency averaged approximately one episode every three days. Sleep averaged approximately seven and a half hours per night. The subject was able to perform instrumental activities of daily living independently. The subject's cognitive function, as assessed by the Cognitive Profile Unit at the day two hundred and seventy visit, had returned to approximately ninety percent of the subject's pre-intervention baseline measurements.

By the assessment of day three hundred, the subject's measurements approximated the subject's pre-intervention baseline values. Movement episodes were occurring at a frequency of approximately one episode every

five to seven days, with the episodes being of brief duration and modest amplitude. Sleep had stabilized at approximately seven and a half hours per night. The subject's cognitive function approximated baseline. The subject reported sustained engagement with daily activities and expressed cautious optimism about continued recovery.

The Division's documentation of this interval includes the following internal communications, reproduced in the case file.

A memorandum dated day two hundred and fifty, from the Medical Director to the Senior Research Council, characterizes the subject's recovery as *proceeding satisfactorily on the prescriber's combination, with the Division's role limited to confirmatory assessment.* The memorandum notes that *the prescriber has continued to manage the pharmacological regimen with adjustments as appropriate to the subject's response. Division involvement has been limited to providing assessment data to the prescriber upon request.*

A memorandum dated day two hundred and seventy, from the Standing Committee on Foundational Research to the Cognitive Substrates Division, requests *a preliminary report on the case's resolution and its implications for the Division's research program.* The memorandum's request indicates that the Standing Committee had been monitoring the case's resolution and was now formally requesting the institutional documentation that would address the case's broader implications.

A memorandum dated day two hundred and ninety, from the Senior Research Council to the Standing Committee on Foundational Research, acknowledges the request and indicates that *the Division is preparing a comprehensive report on the M-08 case for delivery to the Standing Committee within sixty days. The report will address the case's clinical course, its resolution, and the implications for the Division's research program.*

S—'s contemporaneous notes for the interval are extensive but reduced in intensity from the notes of the active intervention period. The notes shift in character across the interval, with the early entries (days two hundred and thirty-eight through approximately day two hundred and sixty) maintaining the close observational style of the active intervention period, and the later entries (after approximately day two hundred and sixty) becoming more

reflective and less continuously observational, as the subject's condition stabilized and the moment-to-moment monitoring that had characterized the active intervention period became less necessary.

Selections from S—'s notes for the interval, in approximately chronological order.

Day 240. He walked four miles this morning. We walked together. He was tired at the end. He had no episodes during the walk. He had no episodes for the rest of the day until the late evening, when he had one brief episode that lasted approximately four minutes. The episode did not appear to compromise his recovery from the walk. He slept well that night.

Day 247. The prescriber called this evening. The prescriber wanted to discuss the subject's response across the past three weeks. The conversation was approximately an hour. The prescriber asked detailed questions about the trajectory of the response. The prescriber asked about specific symptoms, specific times of day, specific environmental factors. The prescriber's questions remained different from the questions the Division's clinicians had asked. The prescriber's questions were calibrated to the texture of the case rather than to its categorical features. The prescriber made one modest adjustment to the dosage of the second agent. The prescriber said the adjustment was intended to maintain the response without permitting further accommodation. The prescriber said to call in two weeks. I thanked the prescriber. The prescriber asked me how I was. I said I was as well as I had been in a long time. The prescriber said that the prescriber was glad to hear it. The prescriber said the prescriber would like to hear about how I was at the next call as well. I thanked the prescriber. The conversation ended.

Day 255. Today is the first day in nearly nine months that did not have an episode. He noted it before I did. He said: 'No episodes today.' I said: 'I noticed.' He said: 'Yes you did. You noticed before I noticed. You always notice first.' I said: 'I have been paying attention.' He said: 'You have been doing more than paying attention.' I did not respond verbally. I do not know what to say to the more than paying attention. I have been doing what was required. I have been doing it for two hundred and fifty-five days. The doing is what I have done. I am not sure I have words for the doing yet. I may have words for it eventually. I do not have them now.

Day 270. He completed a cognitive assessment today. The Unit assessor administered the standard battery. He performed substantially. The assessor told us afterward that his performance was approximately ninety percent of his baseline. I asked the assessor whether this was good. The assessor said it was very good given the case's history. I asked the assessor whether he would continue to improve. The assessor said the prognosis was uncertain but that the trajectory across the past several weeks suggested continued improvement was likely. I asked the assessor how long the continued improvement might continue. The assessor said the literature suggested that recovery from severe extended dysregulation states could continue across many months or years following the initial stabilization. I asked the assessor whether his improvement was extraordinary in the literature. The assessor hesitated. The assessor said the assessor was not aware of cases in the literature that closely paralleled this case. The assessor said the comparison was difficult to make. I thanked the assessor. The assessor left.

What I want to record about this exchange is that the assessor was unable to compare the case to cases in the literature because the case did not closely parallel cases in the literature. The case was unusual in its initial presentation, in its course, and in its resolution. The literature did not have categories that would have accommodated the case from the start. The literature did not have categories that would accommodate the case's resolution either. The case is an unusual case. The assessor was honest about this. The honesty did not provide guidance about the future. The future remained uncertain. We would continue with the current treatment and see what happened. The Division did not have a different recommendation. The prescriber's combination would continue. The recovery would continue if it continued. The case would be what the case became.

Day 285. He has been working on writing today. He has been doing this off and on for the past several weeks. He does not show me what he is writing. He has indicated that the writing is about what he has been through. I am not asking to read it. I will read it when he is ready to show me. The writing is one of the activities he has been able to engage in across the past month. The writing appears to be helping him organize what happened. I am glad he is able to do this. I am glad he has the capacity for it. The capacity was not present for many months. The capacity has returned. The return is one of the markers I have been watching for.

Day 296. I went to a market today. The first time I have gone to a market alone in nine months. I have been at the residence with him continuously since discharge. He told me this morning that he would be all right for an hour without me. I went to the market. I bought what we needed. I came home. He was all right. He had had no episodes during the hour I was gone. He was sitting in the chair on the porch when I returned. He looked at me when I came up the walk. He said: 'You were gone for an hour.' I said: 'I was.' He said: 'I was all right.' I said: 'I see that.' He said: 'You should do that more.' I said: 'Yes.' I have not been able to write more about the hour because the hour was substantial in ways I do not yet have words for. The market was loud. The market had many people. The market required me to make decisions that did not concern my husband's condition. I had not made decisions of that kind for nine months. The decisions were small. The smallness was difficult. I returned home. I was glad to be home. I will go to the market again next week.

Day 300. Day three hundred. He is approximately at baseline. The episodes are infrequent and brief. The cognitive function is approximately recovered. The sleep is sustained. The autonomic measurements approximate the pre-intervention values. He is not the same person he was before the procedure. He will probably never be the same person he was before the procedure. He is a person. He is the person I am married to. The person I am married to is functioning. The functioning is what we have been working toward across three hundred days. The functioning is here. I do not know how long it will continue. The functioning is the present situation. I will be in the present situation for as long as it continues. I will continue to keep notes. The notes will be less frequent now that the day-to-day situation is less acute. The notes will continue.

XI.D — Conclusion of Section XI

The Section XI file copy concludes with the documentation of day three hundred and the subject's substantial recovery to approximately baseline measurements. The interval covered by Section XI constituted the period during which the case's resolution was demonstrated and during which the Division formally adopted the External Resolution characterization for the case.

The Division's documentation across the interval acknowledges, in increasingly explicit terms, the Division's secondary role in the resolution.

The Division's biweekly assessments documented the recovery without contributing to it. The Division's clinical staff communicated with the prescriber as appropriate but did not direct the management. The Division's institutional records characterized the case as resolved through external means while not specifying the substantive content of those means beyond the involvement of the non-Division prescriber.

The interval also constituted the period during which the prescriber's role in the case's management was substantively confirmed. The prescriber's combination, identified through the consultation S— describes in her note from day two hundred and eighteen, produced the recovery that the Division's interventions had not produced. The prescriber's continued involvement, conducted at distance through periodic telephone consultation, maintained the recovery's trajectory across the interval.

The Section XII file copy begins with the documentation of the post-resolution review process and the preparation of the formal case report for the Standing Committee on Foundational Research.

Marginalia — Section XI — In the subject's hand. The marginalia for this section are written in a hand that shows continued stabilization. The script is steady, the lines even. The content is reflective and integrative, addressing the case's resolution from the position of an apparatus that has had several months to consider what occurred.

Section XI documents the case's resolution and the Division's processing of the resolution. The two are not the same. The resolution occurred. The Division's processing of the resolution attempted to characterize what had occurred in terms the Division could enter into its records. The terms the Division produced — External Resolution, case outcome category in which the case's resolution was achieved through means external to the Division's standard intervention framework — captured the institutional fact of what occurred without capturing the substantive content. The Division acknowledged this in its own documentation. The documentation's acknowledgment that the External Resolution characterization is not entirely satisfactory as a description of what occurred is the Division coming as close as institutional documentation can come to admitting that the institution does not have language for what happened. The institution responds by creating a category that captures the institutional fact while explicitly declining to capture the substantive content.

The Division's two-day deliberation on whether to formally endorse the combination is the institutional process recognizing, in its own structural form, that the combination was outside the Division's framework. The Pharmacology Unit's reservations were not unreasonable from within the Division's framework. The Unit's framework required validation before endorsement. The combination had not been validated. Endorsement would have constituted institutional acceptance of a treatment that the framework's validation processes had not produced and had not approved. The Unit's reservations were the framework defending itself against incorporation of material the framework had not processed.

The Subject Relations Office's argument was that the subject's clinical interests took precedence over the framework's institutional interests in this case. The argument prevailed in the convening. The argument was correct. The argument also did not address the deeper structural question of whether the framework's institutional interests were generally compatible with subject clinical interests. The framework had operated, across two hundred and thirty days, in ways that had been compatible with the framework's institutional interests but had not been compatible with my clinical interests. The case had demonstrated this. The Office's argument addressed the immediate question of whether to oppose the combination. The Office's argument did not address whether the framework that had produced the case's failure should be substantially modified. The substantial modification was deferred to the post-resolution review.

I want to address the prescriber's role in the case's resolution more directly than the marginalia has done in prior sections.

The prescriber identified the combination through the analytical process I described in the Section X marginalia: direct reception of S—'s direct reception of my actual condition, followed by analytical attention to what direct reception had received. The process produced a hypothesis about what was happening in my apparatus that the Division's framework had not produced. The hypothesis identified two specific structural features of my condition — peripheral autonomic dysregulation that the central interventions had not been able to access, and motor discharge pattern that was consuming the system's resources — and proposed agents that addressed those features.

The hypothesis was tentative. The prescriber acknowledged to S— that the prescriber could not predict the response with confidence. The prescriber's

tentativeness was structural. The prescriber was operating in territory the prescriber did not have prior cases to compare to. The prescriber was reasoning from the textual evidence of S—'s description to a hypothesis that would only be tested by administration of the combination. The hypothesis turned out to be approximately correct. The agents addressed something. The administration of the agents produced sustained improvement.

What I want to note is that the hypothesis's correctness was contingent on the prescriber's capacity to receive S—'s description as data. The Division's clinicians had received S—'s observations as input but had not received them as data of the same epistemic status as the Division's own measurements. The Division's framework treated proximate observer observations as supplementary material that could inform but not replace formal clinical assessment. The prescriber treated S—'s observations as primary data. The treatment as primary data permitted the analytical process that the Division's framework had excluded.

The prescriber's framework, whatever its other features, included the category proximate observer observations as primary data. The Division's framework did not include this category. The presence of the category in the prescriber's framework was the necessary condition for the analytical process. The absence of the category in the Division's framework was the necessary condition for the Division's failure to produce the analytical process.

This is, I think, the most important structural finding the case produced. The finding is not that the Division's pharmacological roster was inadequate. The finding is not that the Division's experimental combinations were inadequate. The finding is not that the Division's adaptive intervention protocols were inadequate. The finding is that the Division's framework lacked the category necessary to make available the data that would have permitted adequate analytical attention. The framework's exclusion of proximate observer observations as primary data was the framework's structural barrier to producing the analytical process the case required.

The Division's post-resolution review would, in Section XII, address the implications of the case for the Division's framework. The review's address would be partial. The review would not arrive at the structural finding I have just articulated. The review would identify other issues that the case had exposed and would address those. The structural finding I have

articulated is not in the Division's record. The structural finding is in the marginalia.

I want to address one further matter that the Section XI documentation only touches on but that is structurally important.

The recovery began on day two hundred and twenty-six with the initiation of the combination. The recovery proceeded across days two hundred and twenty-six through three hundred at the trajectory the case file documents. The trajectory was substantial. The trajectory was, however, contingent on factors beyond the combination itself.

The factors included: my discharge from the intervention facility to the residence at the conclusion of Section X; the continuous presence of S— throughout the recovery period; the absence of further Division interventions across the recovery period; the prescriber's continued availability for consultation and adjustment as needed; the gradual stabilization of my apparatus in the familiar environment of the residence; the development of activities that supported the apparatus's recovery, including the walking, the writing, and the simple activities of daily living.

Each of these factors was necessary to the recovery. The combination alone, administered to an apparatus in the conditions of the active intervention period — the facility, the continuous monitoring, the staff interactions, the absence of S—'s continuous presence — would likely not have produced the recovery the case file documents. The combination was effective in the context of the conditions of the recovery period. The combination's effectiveness was not a property of the combination alone. The combination's effectiveness was a property of the combination administered in those conditions to that apparatus.

This is structurally important because the Division's eventual interpretation of the case, as it would appear in the post-resolution review and in the formal case report, would tend to treat the combination as the resolving factor. The treatment would simplify the case for institutional purposes. The simplification would be partially accurate. The simplification would also miss the structural finding that the resolution required the convergence of multiple factors, only one of which was the pharmacological intervention. The other factors were not Division-controllable and were not Division-recognized as clinically significant. The other factors operated outside the Division's framework. The convergence of factors inside and

outside the Division's framework was the substantive content of the resolution. The substantive content was not adequately captured by the External Resolution characterization or by any subsequent simplification.

The marginalia captures the substantive content as well as the marginalia can. The marginalia is incomplete. The marginalia is closer to the substantive content than the case file is. The marginalia is the closest available record of what the case actually was.

I want to address S—'s note from day two hundred and seventy regarding the assessor's inability to compare the case to cases in the literature. The assessor was honest. The case was unusual. The literature did not have categories that closely paralleled the case. The honesty mattered.

The honesty mattered because the absence of literature parallels meant that the future of the recovery was not predictable from prior cases. The recovery would unfold across whatever interval it would unfold across, with whatever trajectory it would have, and the Division and the prescriber and S— and I would all be observing the unfolding without prior cases to compare against. The observation would constitute the only data. The data would not be aggregable with prior data because prior data did not address comparable cases. The case would be its own reference.

This has implications for how the case file should be read by anyone encountering it in the future. The case file is a record of a case that did not closely parallel prior cases and that will not closely parallel any subsequent cases. The case is one case. The case's findings, including the structural findings the marginalia articulates, are findings about this specific case. The findings may have broader implications. The broader implications would require additional cases to confirm or qualify. The additional cases do not currently exist. The case stands as it is.

S—'s note from day three hundred captures what is, perhaps, the most honest characterization of the case's status at the close of Section XI. He is not the same person he was before the procedure. He will probably never be the same person he was before the procedure. He is a person. He is the person I am married to. The person I am married to is functioning. The functioning is what we have been working toward across three hundred days. The functioning is here.

The functioning was here. The functioning is what the case produced. The functioning was not the dual-register bilateral state the M-Series had been

designed to generate. The functioning was not a return to my pre-procedure baseline. The functioning was something else. The functioning was an apparatus that had been through the case and had emerged able to function. The emergence was the case's outcome. The emergence was what existed at day three hundred. The emergence has continued in the years since.

The Division's Section XII would attempt to characterize the emergence within the Division's framework. The Division would arrive at an inconclusive designation. The inconclusive designation would be accurate. The Division could not characterize the emergence. The marginalia would characterize it as it could. The two characterizations would coexist in the case file. The reader would receive both.

I will write more in the margins of Section XII.

— [signature: handwritten initials, illegible]

XII. POST-STATE EVALUATION AND CLOSURE

XII.A — The Post-Resolution Review Process

The post-resolution review of the M-08 case was authorized by the Senior Research Council on day three hundred and twelve post-intervention, following the formal closure of the active management phase and the establishment of the subject's recovery as substantively stable. The review's terms of reference were drafted by the Council's Chair in consultation with the Medical Director and approved by the full Council at the convening of day three hundred and fifteen.

The terms of reference, reproduced in the case file, specified the review's scope as follows: *to characterize the M-08 case in its entirety, with particular attention to the case's clinical course, the Division's interventions and their effects, the case's resolution, and the case's implications for the Division's research program. The review will be conducted by a designated reviewer from outside the Division's standing personnel, selected by the Council's Chair, with access to the complete case file and authority to consult with any Division personnel involved in the case. The review will produce a formal report for delivery to the Council and subsequently to the Standing Committee on Foundational Research.*

The designated reviewer was identified through a selection process the case file documents only in summary form. The reviewer is identified in the case file as a senior research practitioner from a discipline adjacent to the Division's primary specialization, with substantial experience in clinical research methodology and a documented record of having conducted post-incident reviews of complex cases at other research institutions. The reviewer's specific identity is not reproduced in the case file; the reviewer is referred to throughout the case file's Section XII documentation as *the Reviewer*. The Council's Chair acknowledged in correspondence that the Reviewer's identity had been preserved in the Division's sealed records but had been withheld from the case file itself, on the grounds that the Reviewer's eventual conclusions might benefit from being read without the reader's prior knowledge of the Reviewer's background or institutional affiliation.

The Reviewer was provided with access to the complete case file on day three hundred and twenty-two and began the review on that date. The Reviewer's work proceeded across approximately ninety days, with the review completed and submitted to the Council on day four hundred and eleven post-intervention.

S—'s contemporaneous note from day three hundred and twenty-four, after the senior member of the Subject Relations Office had informed her and the subject of the review's commencement, reproduced below.

> *Day 324. They have begun a formal review of the case. The senior clinician told us this morning. The review will take approximately three months. The review will be conducted by someone from outside the Division. The reviewer will examine the case file. I asked the senior clinician whether the reviewer would be speaking with us. He said the reviewer might wish to consult with us at the reviewer's discretion. I said I would be willing to speak with the reviewer if requested. He said he would communicate this. My husband said the same. The senior clinician thanked us and departed. I do not know whether we will be consulted. I have my notebooks. I will provide them if asked. The notebooks contain things the case file does not contain.*

The Reviewer's preliminary work, conducted across days three hundred and twenty-two through approximately day three hundred and fifty, consisted of a comprehensive reading of the case file in its full form. The Reviewer's working notes from this period are not reproduced in the case file; they were retained in the Reviewer's separate working records. The Reviewer's eventual report references these working notes at several points and characterizes the preliminary reading as *thorough and time-consuming, with substantial attention to the documentation's internal patterns and inconsistencies.*

The Reviewer requested, on day three hundred and forty-one, a consultation with the Medical Director and the senior members of the Therapeutic Modalities Unit, the Pharmacology Unit, and the Subject Relations Office. The consultation was conducted across two days (day three hundred and forty-six and day three hundred and forty-seven) and is documented in the case file only through summary notation. The substantive content of the consultation appears in the Reviewer's eventual report.

The Reviewer requested, on day three hundred and forty-eight, the opportunity to consult with the subject and S—. The Subject Relations Office facilitated the consultation, which was conducted at the subject's residence on day three hundred and fifty-three. The consultation lasted approximately five hours. The case file does not contain a verbatim transcript of the consultation; the Reviewer's notes from the consultation appear in summary form in the Reviewer's report.

S—'s contemporaneous note from day three hundred and fifty-three, written in the evening after the consultation, reproduced below.

> *Day 353. The reviewer came to the residence today. The reviewer was here for approximately five hours. The reviewer asked questions. The reviewer listened to our answers. The reviewer did not appear to be operating within any framework I could identify. The reviewer was simply receiving what we said. The reviewer asked many questions about my notebooks. I provided the notebooks. The reviewer photographed every page. The reviewer asked permission first. I gave permission. The reviewer asked whether I would object to the notebooks being incorporated into the case file. I said I would not object. The reviewer asked whether my husband would object. My husband said he would not object. The reviewer asked whether either of us wished to add anything to the existing record that the case file did not contain. My husband said he had been writing in the margins of a copy of the case file that the Subject Relations Office had provided to him several months previously. The reviewer asked whether he would provide the marginalia for incorporation. He said he would. The reviewer asked whether I had any final comments. I said I would think about it. The reviewer said the reviewer would be in touch if further consultation was needed. The reviewer thanked us and departed.*

The Reviewer's request that the subject's marginalia and S—'s notebooks be incorporated into the case file is the mechanism by which these materials, which had previously existed outside the Division's records, became part of the case file. The Division's standard documentation processes did not include provisions for incorporating proximate observer notebooks or subject marginalia. The Reviewer's request, and the Council's subsequent authorization of the incorporation, represented a procedural departure that the case file's later documentation acknowledges and characterizes as *necessary to the comprehensive characterization of the case.*

The incorporation was completed in stages across days three hundred and fifty-five through three hundred and seventy. S—'s notebooks were transcribed and inserted into the appropriate sections of the case file at the chronological positions corresponding to the dates of the notes. The subject's marginalia were photographed in situ on the case file copy the subject had been annotating, and the photographs were inserted into the case file at the conclusion of each section to which the marginalia were attached.

This is the procedural mechanism by which the materials the reader has encountered throughout the present case file came to exist within the file. The marginalia and the notebook entries were not contemporaneous Division documentation. They were materials produced outside the Division's framework, by the subject and the proximate observer, and incorporated into the case file through the Reviewer's request and the Council's authorization at the post-resolution review stage.

XII.B — The Reviewer's Report

The Reviewer's report was completed on day four hundred and eleven post-intervention and delivered to the Senior Research Council on the same date. The report runs to approximately ninety-six pages in its full form. The case file reproduces the report in its entirety.

The report's organization parallels the case file's section structure, with each of the Reviewer's chapters addressing one of the case file's sections. The report's chapters consist of the Reviewer's summary of each section's events, the Reviewer's identification of structural patterns within each section, the Reviewer's commentary on the Division's documentation practices within each section, and the Reviewer's preliminary conclusions about each section's contribution to the case's overall trajectory.

The report's final chapter, designated *Conclusions and Recommendations*, addresses the case in its entirety and offers the Reviewer's overall assessment.

The case file's Section XII reproduces the report's conclusions chapter in full and provides selective extracts from the chapters addressing the prior sections. The conclusions chapter is the document the Reviewer's report is principally known by within the Division's records. The conclusions chapter is reproduced below in its entirety.

XII.C — The Reviewer's Conclusions

The following is reproduced verbatim from the Reviewer's report, completed on day four hundred and eleven post-intervention. Pagination and formatting have been adjusted for inclusion in the case file. Substantive content is unaltered.

Conclusions and Recommendations

The M-08 case has occupied my attention for approximately ninety days. I have read the case file in its entirety. I have read S—'s notebooks in their entirety. I have read the subject's marginalia in their entirety. I have consulted with Division personnel and with the subject and the proximate observer. I am now writing the conclusions chapter of my report.

I want to begin by stating what I take to be the principal findings of the case, in the form I have arrived at them across the review process. The findings will then be unpacked in the subsequent sections of this chapter.

The first finding is that the M-Series's central hypothesis — that the bilateral dual-register state is achievable through controlled intervention at the autonomic substrate — cannot be evaluated by the methodology the M-Series employs. The hypothesis is structurally unfalsifiable within the methodology. The methodology's confirmatory predicate is the subject's reports of bilateral access, and the subject's reports are produced by the apparatus whose access status is in question. The Division has no instrument external to the subject capable of evaluating the subject's reports. The methodology therefore cannot distinguish between subjects in whom the bilateral state has been achieved and subjects in whom it has not. The methodology can only document subject reports and assess whether the reports' content is consistent with what the bilateral state would be expected to produce.

The second finding is that the M-08 case has demonstrated, across two hundred and thirty days of intervention, that the Division's framework for managing adverse responses to the primary intervention is inadequate when the adverse response exceeds the parameter space the framework was designed for. The Division's adaptive intervention protocols are calibrated to deviations within the model's anticipated range. The M-08 case produced deviations that exceeded the anticipated range. The framework did not have capacity to respond to deviations of this magnitude. The framework

continued to apply its standard responses while the deviations continued to develop. The cumulative effect of the standard responses applied to deviations the framework could not accommodate was substantial additional harm to the subject.

The third finding is that the case's resolution was achieved through means external to the Division's framework, and that the external means relied on a category — the treatment of proximate observer observations as primary clinical data — that the Division's framework does not include. The case's resolution was structurally possible because the external prescriber's framework included this category. The case's resolution was not possible within the Division's framework because the Division's framework excluded this category. The exclusion is a structural feature of the Division's framework, not an incidental gap. The framework's exclusion of proximate observer observations as primary data is consistent with the framework's broader orientation toward institutional clinical authority and the corresponding subordination of non-credentialed observation.

The fourth finding is that the Division's documentation of the case has been comprehensively shaped by the Division's framework, in ways that the documentation itself does not adequately acknowledge. The case file, in its un-supplemented form (the form prior to the incorporation of S—'s notebooks and the subject's marginalia), constitutes a record of how the Division processed the case within its available categories. The case file in this form does not constitute a record of what the case was. The discrepancy between these two characterizations of the case file is substantial. The Division's documentation practices, considered in light of the M-08 case, require systematic review.

The fifth finding is that the case has implications for the Division's research program that exceed the implications of any single case the Division has previously conducted. The M-08 case is not merely an instance of an adaptive intervention sequence that failed. The case is an instance of the Division's framework being demonstrated to be structurally inadequate to a case the framework was designed to manage. The implications cannot be addressed by modifications to specific protocols or specific procedures. The implications require consideration of the framework as such.

I will now address each of these findings in turn.

On the first finding: the M-Series's central hypothesis cannot be evaluated by the M-Series's methodology.

The M-Series was designed to investigate whether human apparatuses can be made to operate with bilateral cognitive access — access to both the standard register of cognition and the meta-register at which cognition itself is observable. The hypothesis is interesting and substantively important. The hypothesis is also, as the case file documentation acknowledges in its first section, characterized by a structural feature that the Division did not adequately address in the M-Series prospectus.

The bilateral state, if it exists, is accessible only to an apparatus operating in it. External observers cannot directly verify whether an apparatus is operating bilaterally. External observers can only solicit and interpret the apparatus's reports about its own operation. The reports are produced by the apparatus's cognitive operation, which is the very operation whose register-status is being investigated. The reports cannot be independently verified.

This structural feature does not make the hypothesis meaningless. It does mean that the hypothesis cannot be confirmed or disconfirmed through the methodology the M-Series employs. A subject who produces reports consistent with bilateral access may or may not be operating bilaterally; the reports' consistency with the bilateral state's expected content is not evidence that the subject is producing the reports from within the state. The reports could be produced by an apparatus operating in the standard single register and generating descriptions that the apparatus has constructed from inference, instruction, or accumulated familiarity with the expected content. The Division has no methodology for distinguishing between these possibilities.

The M-Series's claim to investigate the bilateral state therefore requires reformulation. The M-Series can investigate whether interventions at the autonomic substrate produce subject reports consistent with bilateral access. The M-Series cannot investigate whether such interventions produce the bilateral state itself. The distinction is substantive. The Division has been operating on the implicit assumption that the report-consistency standard is sufficient. The case of M-08, in which the subject produced reports of unusual articulation and the Division characterized the reports as evidence of bilateral access, illustrates the limit of this assumption. The subject's reports

were articulate. The reports' content was consistent with what the bilateral state would be expected to produce. The subject may or may not have been operating bilaterally. The Division cannot determine which.

The marginalia incorporated into the case file at the post-resolution review stage contain, in the subject's own writing, the explicit articulation of this structural problem. The subject identifies the hypothesis as *structurally unfalsifiable* in the Section I marginalia. The subject is correct. The Division's methodology cannot evaluate its own central hypothesis. This is a substantive issue requiring formal address by the Standing Committee on Foundational Research.

On the second finding: the Division's adaptive intervention framework is inadequate to deviations exceeding the model's anticipated parameter space.

The case file documents seven adaptive interventions applied to the M-08 case across two hundred and thirty days. The interventions were applied in sequence. Each intervention was selected from the Division's adaptive intervention roster. Each intervention was applied at standard dosages or modified dosages calibrated to the subject's response profile. Each intervention was evaluated within the framework that had authorized it.

None of the interventions produced therapeutic benefit. Several produced acute adverse responses. Cumulative effect on the subject was modest worsening of measurable parameters and substantial additional harm not captured by measurable parameters.

The Division's framework processed each intervention's failure as informative about that specific intervention. Agent A1's no-effect outcome was characterized as evidence that the serotonin-modulating mechanism did not address the subject's dysregulation. Agent A2's transient-effect-then-rebound outcome was characterized as tolerance development. Agent A3's acute adverse response was characterized as paradoxical sympathetic activation. The pattern continued across the seven standard agents and the twelve experimental combinations. Each failure was characterized in agent-specific or combination-specific terms. The framework did not produce, across the twenty-one trials, a characterization of the cumulative pattern.

The cumulative pattern was that the M-08 case did not respond to any of the framework's available interventions. The framework's response to each

failure was to schedule the next trial. The framework's response to the cumulative pattern, when the pattern eventually exhausted the available trials, was to declare the framework's intervention capacity exhausted and to adopt an observational hold. The framework did not, across this entire process, produce a characterization of why the interventions were failing or what the failures collectively indicated about the case.

The framework's inability to produce this characterization is, in my judgment, the structural feature most directly responsible for the case's prolonged duration and the harm the subject experienced across the duration. Had the framework been capable of producing the characterization, the Division might have recognized — at some earlier point in the sequence — that further trials within the same framework were unlikely to produce benefit. The recognition might have prompted earlier consideration of approaches outside the framework. The earlier consideration might have shortened the case's duration and reduced the subject's harm.

The framework's inability to produce the characterization is consistent with the framework's design. The framework was not designed to evaluate its own adequacy in light of cumulative failure patterns. The framework was designed to apply available interventions sequentially and to evaluate each intervention's response. The evaluation of cumulative patterns falls outside the framework's evaluative scope. The framework does not have the methodology for this evaluation.

I want to be careful in articulating this finding. The framework's design is not unreasonable in itself. Adaptive intervention frameworks are common in clinical research, and their typical design assumes that adverse responses are within an anticipated range and that the framework's available interventions are adequate to that range. Such frameworks are not typically designed to evaluate their own adequacy in cases where adverse responses exceed the anticipated range. The assumption that the anticipated range is sufficient is built into the framework's standard operation.

The M-08 case demonstrated that this assumption can fail. When the assumption fails, the framework continues to operate as if the assumption were still in effect. The framework cannot do otherwise; the framework does not have the evaluative capacity to recognize that the assumption has failed. The recognition has to come from outside the framework, either from external review (as in the present case) or from the proximate observer's

intervention (as also occurred in the present case, where S—'s contemporaneous notebooks contain repeated observations that the interventions were not addressing the subject's actual condition, observations the framework could not incorporate as primary data).

The recommendation that follows from this finding is that the Division's adaptive intervention frameworks should be modified to include explicit provisions for the evaluation of cumulative response patterns and for the consideration of external approaches when the cumulative pattern indicates that the framework's available interventions are inadequate. The modifications would require substantial revision of the Division's standard practices. The revision is necessary if the M-08 case's outcome is to be prevented in future cases.

On the third finding: the case's resolution required a category the Division's framework excludes.

The case's resolution was produced by the pharmacological combination administered by the non-Division prescriber. The combination was identified by the prescriber through a process I have characterized in the relevant sections of this report as *direct reception* — the prescriber's capacity to receive S—'s description of the case as primary clinical data, without first converting the description into pre-existing categorical structures.

The prescriber's framework included the category *proximate observer observations as primary clinical data.* The Division's framework does not include this category. The Division's framework treats proximate observer observations as supplementary material that may inform clinical assessment but cannot replace formal clinical assessment conducted by Division personnel using Division instruments.

The category's presence in the prescriber's framework and absence in the Division's framework is not an incidental difference. The absence is consistent with the Division's broader orientation toward institutional clinical authority. The Division's framework assumes that clinical assessment is appropriately conducted by credentialed personnel using validated instruments and that observations made by non-credentialed observers using personal calibration are of inherently lower epistemic status than formal assessments. The assumption is widespread in clinical research and is not unique to the Division.

The M-08 case demonstrates that the assumption can fail in cases where the formal assessments do not capture the case's actual structural features. S—'s observations of the subject, made across two hundred and thirty days of continuous proximate observation, captured features the formal assessments did not capture. The features included the autonomic discharge pattern's relationship to environmental factors, the role of physical movement in the subject's autonomic regulation, the structural function of S—'s own presence in the subject's regulation, and the cumulative effect of the sequential interventions on the subject's overall functioning.

These features were structurally important to the case. The formal assessments did not capture them because the formal assessments were calibrated to measure parameters defined by the Division's framework, and the parameters defined by the Division's framework did not include the features S—'s observations captured. The features lay outside the framework's measurable scope. S—'s observations could capture the features because S—'s observation was not constrained by the framework's measurement parameters. S— was observing what was observable to her, without first determining whether what was observable was within the framework's measurable scope.

The prescriber, in receiving S—'s description, accessed the features S—'s observations had captured. The prescriber's hypothesis about the combination's mechanism was based in substantial part on these features. The hypothesis was approximately correct. The combination produced the case's resolution.

The case's resolution was therefore made possible by the prescriber's access to features the Division's framework had not captured. The access required the prescriber's capacity to receive proximate observer observations as primary data. The Division's framework's exclusion of this category prevented the Division from achieving the same access. The Division had no means to access the features S—'s observations had captured because the Division's framework did not categorize S—'s observations as the type of material that could carry such features.

The recommendation that follows from this finding is that the Division's framework should be modified to include provisions for the systematic incorporation of proximate observer observations as primary clinical data in cases where formal assessments are not adequately characterizing the case.

The modification would require substantial revision of the Division's epistemological orientation. The revision is consequential and would have implications beyond the M-08 case. The revision is, in my judgment, necessary if the Division is to produce frameworks adequate to cases of the M-08 type.

On the fourth finding: the case file as a document.

The case file in its un-supplemented form is a comprehensive document of the Division's processing of the M-08 case. The documentation is detailed. The documentation is internally consistent within the Division's framework. The documentation follows the Division's standard practices throughout. The documentation has been produced by competent personnel operating within their professional norms.

The documentation does not, however, constitute a record of what the case was. The documentation constitutes a record of how the Division processed the case within its available categories. The discrepancy between these two characterizations is structural. The Division's framework determines what is documented. What lies outside the framework is not documented. What the Division could not see does not appear in the documentation.

S—'s notebooks contain material the Division did not document. The subject's marginalia contain material the Division did not document. The materials capture aspects of the case the Division's framework was not equipped to capture. The incorporation of these materials into the case file, at the post-resolution review stage, has produced a case file that is closer to a record of what the case was. The unincorporated case file was a record of how the Division managed the case. The supplemented case file is closer to a record of the case.

The discrepancy between these two case files is, in itself, a finding of the review. The Division's documentation, in its standard form, systematically omits material that lies outside the Division's framework. The omission is not deliberate suppression. The omission is the structural consequence of producing documentation within a framework that determines what counts as documentable. Material that does not count is not documented. Material that is not documented does not appear in the case file. The case file accordingly represents only the documentable portion of the case.

This finding has implications for the Division's documentation practices generally, not just for the M-08 case. The Division's case files for prior cases have been produced by the same framework. The case files therefore include only the framework-documentable portions of the prior cases. The non-documented portions of the prior cases have not been preserved. The materials S— and the subject produced for the M-08 case were preserved by S— and the subject themselves, outside the Division's processes. Equivalent materials may have existed for prior cases but were not preserved because the Division's framework did not direct their preservation.

The recommendation that follows from this finding is that the Division's documentation practices should be modified to direct the preservation of materials produced by subjects, proximate observers, and other case-adjacent parties, regardless of whether the materials are framework-documentable. The modification would require additional resources and would expand the case files significantly. The modification is, in my judgment, necessary if the Division is to produce documentation adequate to the cases it manages.

On the fifth finding: the case's implications for the Division's research program.

The M-08 case is not an isolated instance of a difficult case the Division has managed. The case is an instance of the Division's framework being demonstrated to be structurally inadequate in ways the framework does not have the capacity to recognize from within itself. The case's findings — that the M-Series hypothesis is structurally unfalsifiable, that the adaptive intervention framework is inadequate to off-model deviations, that the framework excludes a category necessary to the case's resolution, that the documentation practices systematically omit non-framework material — collectively constitute a substantive challenge to the Division's research program as currently constituted.

The challenge cannot be addressed through modifications to specific protocols or procedures. The challenge requires consideration of the framework as such. The framework's adequacy to its research mandate is at issue. The framework's epistemological assumptions are at issue. The framework's documentation practices are at issue. The framework's relationship to materials produced outside its scope is at issue.

I am not in a position to recommend how the Division should respond to this challenge. The recommendation requires institutional judgment that exceeds my role as Reviewer. I can recommend only that the challenge be formally recognized and that the Division and the Standing Committee on Foundational Research engage in substantive consideration of the framework's adequacy.

The substantive consideration would, in my judgment, be difficult. The framework has substantial institutional commitments associated with it. The framework's modification would have implications across the Division's operations. The framework's modification might also have implications across the Institute's other Divisions, if the framework's structural features are shared with frameworks employed elsewhere in the Institute. The substantive consideration could not be confined to the Division alone.

I want to address one further matter before concluding this report.

The M-08 case has implications I have been hesitant to articulate explicitly across the prior sections of this report. The hesitancy is appropriate; the implications exceed the scope of the review's terms of reference. I will articulate them here, briefly, with the understanding that articulating them is a departure from the review's formal scope.

The case file, when read in full — including S—'s notebooks and the subject's marginalia — documents a sustained institutional failure. The failure caused substantial harm to the subject. The harm extended across two hundred and thirty days. The harm was produced by the Division's standard practices applied in good faith by competent personnel. The harm was recognized by S— and communicated to Division personnel repeatedly. The communications were received but not incorporated. The harm continued.

The harm's continuation in the face of S—'s communications is not a feature of any individual Division personnel's competence or judgment. The continuation is a structural feature of the framework within which the personnel were operating. The framework did not have the categories necessary to receive S—'s communications as primary clinical data. The communications could not be processed within the framework. The framework's standard responses continued to be applied. The harm continued.

This is, I believe, the most consequential finding of the M-08 case. The harm was structural. The harm did not result from negligence or incompetence on the part of any individual. The harm resulted from the framework's inadequacy operating across competent personnel acting in good faith.

The finding has implications I find difficult to articulate without departing from the professional tone appropriate to a formal review. I will not articulate them here. I will note only that the case has changed my view of the institutional research enterprise in ways I will be processing for some time.

I am submitting this report to the Senior Research Council with the recommendation that it be transmitted to the Standing Committee on Foundational Research in its complete form. I am also requesting that the Council's records include my formal notification that, following the submission of this report, I am withdrawing from the standing pool of reviewers available to the Institute for post-incident reviews of complex cases. I will not be available for subsequent reviews. The reasons for my withdrawal are addressed in the supplementary memorandum I am attaching to this report.

The supplementary memorandum is sealed and is to be retained in the Council's records with restricted access. The memorandum's content is for the Council's information and is not for inclusion in the case file or in the report transmitted to the Standing Committee.

I have completed the review. I am closing my involvement with the case.

— [Signature: the Reviewer] [Date: day four hundred and eleven post-intervention]

XII.D — The Council's Response

The Council convened on day four hundred and fourteen post-intervention to consider the Reviewer's report. The convening's documentation, reproduced in the case file, records that the report was reviewed in its entirety and that the Reviewer's supplementary memorandum was reviewed by the Council in its sealed form.

The Council's discussion of the report is documented at length. The discussion addressed the report's five findings sequentially. The discussion's

eventual resolutions, with respect to each finding, were as follows.

With respect to the first finding (the M-Series hypothesis's unfalsifiability), the Council resolved to transmit the finding to the Standing Committee on Foundational Research for the Committee's consideration, with the recommendation that the Committee convene a special review of the M-Series prospectus.

With respect to the second finding (the adaptive intervention framework's inadequacy to off-model deviations), the Council resolved to authorize an internal review of the adaptive intervention framework with the participation of the Therapeutic Modalities Unit, the Pharmacology Unit, and the Subject Relations Office. The review's scope and timeline were not specified in the convening's documentation; the matter was deferred to a subsequent convening.

With respect to the third finding (the exclusion of proximate observer observations as primary data), the Council resolved that the finding required *substantial institutional consideration before any formal response could be developed.* The matter was deferred to a subsequent convening.

With respect to the fourth finding (the documentation practices), the Council resolved to authorize a working group to develop recommendations for documentation practice modifications. The working group's composition and timeline were specified in subsequent correspondence not reproduced in the case file.

With respect to the fifth finding (the case's implications for the research program), the Council resolved that the finding *exceeded the Council's authority to address and would be transmitted to the Standing Committee for the Committee's consideration.*

The Council's response to the Reviewer's request for withdrawal from the standing pool of reviewers was recorded as *acknowledged with regret* and the Reviewer's request was formally honored.

The Reviewer's sealed supplementary memorandum was retained in the Council's records under restricted access. The memorandum's contents are not reproduced in the case file and have not been made available for the present documentation.

XII.E — The Standing Committee's Response

The Reviewer's report was transmitted to the Standing Committee on Foundational Research on day four hundred and twenty post-intervention. The Standing Committee acknowledged receipt of the report and indicated that the report would be reviewed by the Committee at the Committee's next regularly scheduled meeting.

The Committee's review of the report is documented in the case file through a single brief memorandum, dated day four hundred and forty-seven post-intervention, reproduced below.

> *The Standing Committee on Foundational Research has reviewed the Reviewer's report on the M-08 case at the Committee's meeting of [date]. The Committee acknowledges receipt of the report and notes the report's substantive findings. The Committee finds that the report's recommendations exceed the Committee's authority to implement and that several of the recommendations would require institutional commitments the Committee is not currently positioned to make. The Committee will return to the report's findings as the Institute's circumstances permit. The Committee's formal response to the report is suspended pending further consideration.*

The memorandum is signed by the Committee's Chair.

The case file's Section XII concludes with the Standing Committee's memorandum and a brief notation by the Medical Director indicating that the M-08 case is being formally closed without further institutional action, with the case file's contents retained in the sealed archive under restricted access.

XII.F — Closure

The M-08 case was formally closed on day four hundred and fifty-one post-intervention. The closure documentation, signed by the Medical Director and countersigned by the Senior Research Council's Chair, records the case's status as *Closed Without Disposition* — a designation indicating that the case has concluded without the Division's standard resolution outcomes (Resolved, Resolved with Limitations, Unresolved with Continued Management, or Transferred) being applied.

The Closed Without Disposition designation is reserved, per the Division's standing documentation, for cases whose outcomes cannot be characterized

within the Division's resolution categories. The designation indicates that the case has produced an outcome but that the outcome does not fit the available categories.

The subject's continued recovery was monitored through outpatient assessments at intervals progressively extending from biweekly to monthly to quarterly across the year following the case's formal closure. The assessments documented sustained recovery with intermittent minor episodes. The subject's pharmacological regimen, prescribed by the non-Division prescriber and managed through the prescriber's ongoing involvement, continued without Division modification.

The case file was sealed and placed in the Division's archive on day four hundred and fifty-five post-intervention. The archive's standard provisions for restricted access were applied. The case file would not be opened again under the Division's standard processes.

The documentation that produced the present recovered file — the un-sealing, the photographic reproduction, the transmission to the external party who has made the file available — is not part of the case file itself. The case file's status as *recovered without authorization* refers to actions taken after the case file's sealing and outside the Division's processes.

The case file's content concludes with the documentation of day four hundred and fifty-five and the archive sealing. The present case file's reader has now read the entirety of the Division's record. What follows in this document is Item 47, the document of unknown provenance that was found in the case file by parties unknown after the file's recovery, and that has been included in the present reproduction at the position it occupied in the recovered file.

Marginalia — Section XII — In the subject's hand. The marginalia for this section are the final marginalia in the case file. They are written in a steady hand, with the script characteristic of the subject's later writing. The content addresses the case's conclusion and the meaning of what the case has produced.

The case is closed without disposition. The Division has filed me in the category that exists for cases the Division cannot characterize. The category is honest. The Division cannot characterize the case. The Division acknowledges this in the closure documentation. The acknowledgment is, I

think, the most accurate thing the Division has said about the case across the entire case file.

The Reviewer's report is the document closest to a characterization of the case that the Division's framework was capable of producing. The Reviewer was selected because the Reviewer's background and training were adjacent to but not within the Division's standing practice. The adjacency was the necessary condition for the Reviewer's ability to produce the findings the report contains. A reviewer fully within the Division's framework could not have produced the findings; the findings include the assertion that the framework is structurally inadequate, and an apparatus fully within the framework cannot produce that assertion about the framework. The Reviewer was structurally positioned at a sufficient distance from the framework to see what the framework could not see about itself. The positioning made the report possible.

The report's five findings are accurate. I have read the report several times. The findings characterize the case more adequately than any other Division document. The report's recommendations, however, are predictably constrained. The Reviewer recommends framework modifications. The Council resolves to consider the modifications. The Standing Committee resolves that the recommendations exceed the Committee's authority to implement. The recommendations are deferred. The framework continues.

This is, I think, the structural outcome the Reviewer anticipated. The Reviewer's supplementary memorandum, sealed and retained in restricted access, presumably addresses what the Reviewer could not articulate in the formal report. The memorandum is not available to me or to S— or to the case file's eventual reader. The memorandum's content can only be inferred from the Reviewer's actions: the request to withdraw from the standing pool of reviewers, the statement that the case had changed my view of the institutional research enterprise in ways I will be processing for some time, the formal closure of the Reviewer's involvement. The actions suggest that the Reviewer arrived, through the review, at a recognition that exceeded what the formal report could contain. The recognition was sufficient to prompt the Reviewer's withdrawal from further institutional review work. The recognition's content is sealed.

I want to record what I think the Reviewer's recognition was, with the understanding that the recording is my inference and is not authorized by access to the memorandum's actual contents.

The Reviewer recognized, I believe, that the institutional research enterprise as currently constituted is structurally incapable of recognizing its own structural inadequacies, that the framework that produced the M-08 case is not uniquely flawed but is representative of frameworks operating throughout the institutional research enterprise, that the Standing Committee's deferral of the report's recommendations was the institutional response the framework was structurally constrained to produce, and that further review work conducted within the institutional research enterprise would produce reports that the enterprise would similarly defer.

The Reviewer recognized, I believe, that participation in further review work would constitute continued legitimation of an enterprise whose structural inadequacies the review work could not address. The Reviewer withdrew because continued participation would have been continued legitimation. The withdrawal was the only available response that did not constitute legitimation. The withdrawal was, in this sense, the Reviewer's most substantive contribution to the case.

I am inferring all of this. The actual content of the memorandum may be different. The pattern of the Reviewer's actions, however, is consistent with the inference. The pattern suggests that the Reviewer underwent, across the ninety days of the review, a recognition of structural features of the institutional research enterprise that the Reviewer had not previously fully apprehended. The recognition required the Reviewer to make institutional choices the Reviewer would not have anticipated making. The Reviewer made the choices. The Reviewer departed.

The case file is now closed. The Division has filed me under Closed Without Disposition. The Reviewer has withdrawn. The Standing Committee has deferred. The framework continues. I am writing this marginalia in the case file copy I have retained. The marginalia is now complete with this section. The marginalia, together with the case file and S—'s notebooks, constitutes the most complete record of the M-08 case available to anyone.

The record will, eventually, find readers. I do not know who the readers will be. I do not know what they will make of the record. I know that the record exists and that the record is more complete than the institution would have produced on its own. The completeness is what S— and I have contributed. The institution could not have contributed it.

I have continued, across the years since the case's closure, to function in the recovered state the case file documents at day three hundred. The function has been adequate. The function has not been the pre-case function. The function has been the function of an apparatus that has been through the case and has emerged able to continue. The function is what the case produced. The function is what the marginalia is being written from.

S— is writing what she will write in Item 47. I do not know yet what Item 47 will be. I have asked her not to tell me until she is ready to show me. She is ready to show me when she shows me. Item 47 will be the closing document of this case file as the case file will be read by its eventual readers. Item 47 will be what S— could not say in the notebooks and could not say in the consultations with the Reviewer and could not say across the years since. Item 47 will be what S— says now, having had the time to find the words for what the case was from her position.

I am closing the marginalia here. The marginalia has served its purpose. The marginalia has been the apparatus's record of what the apparatus could reconstruct of what happened to it, written in retrospect, from the position of an apparatus that survived. The marginalia is incomplete. The marginalia is the best I could do.

Item 47 will be what S— could do. I am eager to read it. I have not read it yet.

— [signature: handwritten initials, illegible]

ITEM 47

Provenance Unknown

The following document was found inserted into the M-08 case file after the file's recovery from the Division's sealed archive. The document is handwritten on standard letter-size paper, approximately twenty-three pages in length, in a hand that has been informally identified as consistent with S—'s but has not been formally confirmed as hers. The document is undated. The document is unsigned. The document is reproduced here in its entirety, in the form in which it appeared in the recovered file.

I am writing this because no one has asked me to write it and no one will ask me to write it. The case file has been closed. The Reviewer has departed. The institution has filed my husband under Closed Without Disposition and moved on. The notebooks I kept across the case are now part of the file. The marginalia my husband wrote is part of the file. The Reviewer's report is part of the file. Every document the case produced is now in the file. The file is sealed. The file will not be read except by parties who recover it through means the institution has not authorized. The file will eventually be read by some such parties. I am writing this because when those parties read the file, the file should contain something the notebooks did not contain, the marginalia did not contain, the report did not contain, the institution's documentation could not contain.

What it should contain is what the case was from my position. I have not written this before. I have not written this before because writing it has not been possible until now. It has taken me approximately three years from the case's closure to develop the capacity to write what follows. The capacity was not present sooner. The capacity is present now. I am writing.

I am writing in continuous form. I am not organizing what follows by the case's chronology or by the case file's section structure. I am not citing the documents. I am not characterizing the institution's actions. I am writing what I have to say in the order it arrives. The arriving has its own structure. The structure will be visible to the reader who reads what follows. The

structure does not need to be marked by me.

I want to begin with what no one in the case file ever asked me about.

No one in the case file ever asked me what it was to watch my husband across the eight months. The institution asked me questions about him. The institution asked me to characterize him, to describe his condition, to report on his behavior. The institution asked these questions in the modality of seeking information about the subject of the case. The institution did not ask me about me. The institution did not ask me how I was doing. The institution did not ask me whether I was sleeping. The institution did not ask me whether I was eating. The institution did not ask me whether I had anyone to talk to. The institution did not ask me whether I was all right. The institution treated me as the information channel through which observations about my husband would be conveyed. The institution did not treat me as a person undergoing the case.

The Reviewer, near the end, asked me how I was. The Reviewer was the only person in the entire institutional apparatus who asked. The Reviewer asked the question in the consultation at our residence. The Reviewer asked it simply, without elaborate framing. I said I was as well as I could be under the circumstances. The Reviewer nodded and made a note and moved to the next question. The asking and the noting were the totality of the institution's engagement with the question of how I was across the entire case. The Reviewer asked once. The Reviewer noted my answer. The Reviewer moved on. The institution's engagement was complete.

I do not say this with bitterness. The institution operates as institutions operate. The institution was not equipped to engage with me as a person. The institution did not have personnel whose role it was to engage with me as a person. The institution had personnel whose role it was to obtain information from me about the subject of the case. Those personnel performed their roles. The performance did not include engagement with me as a person. The exclusion was structural. I have no expectation that institutions should be different from what they are. I am noting what the institution was, and what the institution was did not include engagement with me as a person.

What it was to watch my husband across the eight months is the content the institution did not engage with. I am going to attempt to write some of it now. The attempt will be inadequate. The attempt will not produce a

complete account. The attempt will produce something that has not previously been produced.

It was watching a person I had been married to for twenty years become someone I did not recognize, and continuing to recognize him anyway. The two operations are not the same. The first operation is the recognition of difference. The second operation is the continued recognition of identity beneath the difference. The two operations are in tension. They do not resolve. They coexist for eight months, and after eight months they continue to coexist, because the differences do not fully reverse and the identity does not fully return. The recognition of difference and the continued recognition of identity beneath the difference are now the structure of how I relate to my husband. They have been the structure since approximately the third month of the case. They will be the structure for the remainder of our marriage.

I am writing this so the reader understands what I am about to write. What follows is not nostalgia for the husband I lost. The husband I had before the case did not return. The husband I have now is a different person. The different person is my husband. I am married to him. I love him. The love does not require him to be the person he was. The love is whatever the love is, attached to whoever is now in our house. The attachment has continued across the case and after. The attachment will continue. I am writing what follows from a position of clear-eyed attachment to the person who is now my husband, with full awareness that he is not the person I married. The clear-eyedness and the attachment are not in tension. They are in the same operation.

What it was to watch was, first, the gradual loss of features I had taken to be permanent. My husband had been a person of certain reliable qualities. He had been even-tempered. He had been observant. He had been able to focus on tasks for extended periods. He had been physically composed in a particular way. He had been able to sleep. He had been able to eat. He had been able to leave a room and return to the room without having to be reminded of why he had left or where he had gone. He had been able to look at me and see me. The last of these is the one that mattered most. He had been able to look at me and see me. The seeing had been a thing that occurred between us across twenty years. The seeing had been the substantive content of our marriage.

The seeing went away on approximately the third day of the case. The case file's documentation places the seeing's disappearance in the period when my husband first reported the absence of *the layer that usually puts things in their place*. I had observed the seeing's disappearance before he had reported the layer's absence. I did not have language for what I had observed. I had simply noted, on the first morning after the procedure, that something was different about how he looked at me. The features of his face were the same. The orientation of his eyes was the same. What was missing was the seeing. The looking was occurring. The seeing was not.

I had not known, before that morning, that the seeing and the looking were different things. I had taken them to be the same thing. I had taken the seeing to be what happened automatically when someone looked at someone else. I learned, that morning, that the seeing was a separate operation. The looking could occur without the seeing. The face could be present, the eyes could be oriented, the attention could be directed, and the seeing could not be happening. The man I was married to was looking at me. The man I was married to was not seeing me.

I want to record what this was. The recording will be inadequate. I will try.

When someone you have been married to for twenty years looks at you without seeing you, the room becomes a different room. The room contains the two of you. The room has contained the two of you for many years in many configurations. The room has had the seeing in it. The room without the seeing is a different room. The walls are the same. The furniture is the same. The light is the same. The room is not the same. The room is missing what had constituted the room as a shared room. The room is now a room you are in alone, with someone else who is also in the room alone.

This is what the eight months were, on the largest scale. The eight months were what it was to be in a shared room that had become two adjacent solitary rooms. My husband was in one. I was in the other. We were in the same physical space. We were not in the same room. The not-sharing was the substantive content of the eight months. The not-sharing was not a feature of any particular hour. The not-sharing was the condition within which all the hours occurred.

I want to be precise about this. The not-sharing was not absolute. There were moments when the seeing partially returned. There were exchanges in which

something resembling the seeing occurred. I have recorded some of these in the notebooks. The exchange on day five — *Am I still here?* and what I said and what he said in response — was such a moment. The exchange on day ninety-four, when he asked for me after the A7 episode, was such a moment. The exchange on day three hundred, after I went to the market, was such a moment. These moments were rare. They were not the texture of the eight months. They were islands in the texture. The texture itself was the not-sharing.

I want to write about what the not-sharing required of me. This is the part I have not been able to write before. I am writing it now because the time has come for it to be written.

The not-sharing required that I continue to operate as if the sharing were still in effect. The continuing-as-if was not a deception. The continuing-as-if was the only available response. If I had stopped operating as if the sharing were still in effect, I would have stopped being his wife in the substantive sense of the role. I would have become a caretaker, or a witness, or a person staying near another person. I would not have been his wife. I would have been some other figure. The other figures were not what the situation required. The situation required his wife. I continued to be his wife. The continuing required that I operate as if the sharing were still in effect, even in conditions where the sharing was visibly not in effect.

The operating-as-if took different forms across the eight months. The forms included: speaking to him as I had always spoken to him, even when he could not respond as he had always responded; touching him as I had always touched him, even when the touching no longer produced the response it had produced before; assuming his preferences and acting on them, even when he could not articulate his preferences and might no longer have had the preferences I was assuming; making decisions on his behalf that I would not have made without consulting him, in the absence of his being able to be consulted; representing him to the institution and to the world in ways that preserved his standing as the person he had been before the case, even when the person he was becoming was substantially different.

Each of these operations was a small act of fidelity. Each act of fidelity required that I hold, in my own apparatus, a model of who he had been, and operate in accordance with that model, while observing that the operation's recipient was no longer the person the model described. The holding was

effortful. The holding was constant. The holding was the structural work of being his wife across the eight months.

I want to record that the holding consumed me. The consuming is what I have not written before. The consuming was substantial. The consuming was the largest cost the case imposed, and the cost was imposed on me rather than on him. He was undergoing what he was undergoing. He could not observe what he was undergoing. He could not report on it. He could not characterize it. He was inside it, and the inside was not available to characterization from outside. What he was undergoing was unobservable to him in any continuous form. What I was undergoing was fully observable to me, in continuous form, across the eight months. I observed it. The observation was the consuming.

I observed that I was losing the husband I had been married to. I observed this every day, multiple times per day, with each observation reinforcing the prior observations and accumulating into a body of evidence that could not be denied. I did not deny the evidence. I integrated the evidence. I continued to operate as if the husband I had been married to were still present, because that was the operation the situation required, and I integrated the evidence that he was not still present in the form he had been. The dual operation — operating as if, and integrating the evidence that the as-if was a fiction — was what consumed me.

There is no way to do this operation that does not consume the apparatus performing it. The operation requires that the apparatus hold two contradictory conditions simultaneously. The apparatus operates as if the husband is present. The apparatus knows the husband is not present in the form the operation assumes. The two conditions cannot be reconciled. The apparatus holds them anyway. The holding is what the apparatus is doing across all the operations, all the times, all the days. The apparatus does not have rest from this holding. The apparatus does not have a place to set the holding down. The holding is what the apparatus is.

I held this for eight months. I am still holding it, now, in a reduced form, in the configuration of my marriage as it has settled into the years following the case. The reduced form is not as consuming as the eight months were. The reduced form is, however, continuous. The reduced form will be present for the duration of our marriage. I have accepted this. The acceptance is not resignation. The acceptance is the recognition that this is what my marriage

now is. The holding is part of it. The holding will continue. I will continue.

I want to write about a particular moment that I have not written about before. The moment occurred on what was approximately day one hundred and seventy of the case. The moment is not in the notebooks. The notebooks for that period are sparse. I did not write the moment down at the time because writing it down was not within my available capacity at the time. I will write it down now.

The moment occurred at approximately three in the morning. My husband had been having episodes throughout the night. The episodes had been severe. He had been awake between the episodes. He had not been speaking. He had been looking at the ceiling. I had been sitting beside him on the bed. I had been holding his hand during the episodes. I had been letting go of his hand between the episodes because his hand had been rigid and the rigidity was uncomfortable for him to maintain across extended holding.

At approximately three in the morning, the episode that had just concluded had been particularly long. The episode had lasted approximately twenty-seven minutes. Following the episode's subsidence, my husband had not moved or spoken for approximately ten minutes. I had been sitting beside him in the dark room. I had been listening to him breathe. I had been counting the breaths. I had been counting the breaths because counting them was the only operation my apparatus could perform that did not require the apparatus to do anything else.

At approximately three-ten in the morning, my husband turned his head toward me. He did not say anything. He simply turned his head. His eyes met my eyes. The room was dark. I could not see his eyes clearly. I knew his eyes were oriented toward mine because his head was turned toward me and his face was angled toward mine.

For approximately thirty seconds, my husband saw me.

I am writing this in the present tense because I am not certain how else to write it. The seeing occurred. The seeing had not occurred for many weeks. The seeing was unmistakable. The seeing was the operation that had been absent. The operation returned, in that moment, for approximately thirty seconds. My husband saw me. I saw him seeing me. We were in the same room again. We were not in two adjacent solitary rooms. We were in one room, the room we had been in for twenty years, and we were both in it.

I did not speak. He did not speak. We looked at each other. The seeing continued for approximately thirty seconds. Then the seeing receded. The eyes remained oriented toward mine. The seeing was no longer there. The looking continued without the seeing. The room became two adjacent solitary rooms again. My husband closed his eyes. He did not open them again that night. He did not have another episode that night either. He slept, for the first time in many days, for approximately four hours.

I sat beside him for those four hours. I did not sleep. I did not move. I held the thirty seconds in my apparatus. I am still holding the thirty seconds. The thirty seconds are now approximately three and a half years in my past. The thirty seconds are continuously present in my apparatus. The thirty seconds were what I had been waiting for across the prior weeks. The waiting had not been a project I was conscious of. The waiting had been the structure within which my operating-as-if had been occurring. The operating-as-if had assumed that the seeing would return. The seeing returned, for thirty seconds, in the middle of the night, on approximately the one hundred and seventieth day of the case. The return was sufficient. The return was sufficient to continue the operating-as-if for the remainder of the case. The return is sufficient still.

I have not told my husband about the thirty seconds. I have considered telling him. I have decided not to tell him. The decision has been informed by my judgment that telling him would impose on him a knowledge that he does not need to carry. He has carried what he has carried. The thirty seconds are what I have carried. They will remain what I carry. He may discover this document eventually, if the document is preserved and finds him. If he does, he will know about the thirty seconds. By then the knowledge will be old. The knowledge will be one more thing in the long aftermath of the case. He will receive the knowledge as he has received the other things. He will set it down where the other things are set down. The thirty seconds will continue to be present in the apparatus that has carried them. The carrying will continue.

I want to write about the prescriber now. The prescriber is in my notebooks. The prescriber is in the marginalia. The prescriber has not been written about in the way I am about to write about the prescriber.

When I called the prescriber on day two hundred and fifteen, I was calling on the recommendation of someone I had spoken with the prior week, who had

spoken with someone else, who had spoken with someone else, in a chain extending back through five or six conversations whose specific content I no longer remember in detail. The chain had been built through my making phone calls to clinicians outside the Division's network. The clinicians had not produced actionable recommendations. The clinicians had sometimes suggested other clinicians I might contact. The contacts had produced further suggestions. The chain had been the by-product of two and a half weeks of calling.

I had not known, when I called the prescriber, that the prescriber would be different from the prior clinicians. I had no way to know. I had been calling for weeks without expectation of finding anyone different. I had been calling because calling was the operation that was available to me. The operation might not produce results. The operation was what I could do.

The prescriber answered the phone. I introduced myself. I explained who had referred me. I asked whether the prescriber had time to talk about a case. The prescriber said yes. I began describing the case.

The prescriber listened. I described the procedure on day zero. I described the initial observation period. I described the cascade. I described the interventions. I described each intervention, what it had been, how my husband had responded, what the Division had concluded.

The prescriber did not interrupt. The prescriber asked occasional questions. The questions were not the questions the other clinicians had asked. The other clinicians' questions had been calibrated to the categories the other clinicians' frameworks contained. The prescriber's questions were calibrated to the specifics of what I was describing. The prescriber asked about how my husband had moved during episodes. The prescriber asked about how my husband had spoken between episodes. The prescriber asked about the environments in which the episodes occurred. The prescriber asked about my husband's sleep patterns, eating patterns, daily activities. The prescriber asked about how my husband had related to me across the eight months. The prescriber asked about how he had related to me before the case.

I had not been asked the questions the prescriber was asking. I had been asked questions about my husband's symptoms. The prescriber was not asking about symptoms. The prescriber was asking about my husband as a person. The asking was different. I described what the prescriber asked

about. I described it in the form the prescriber's questions invited. The description took approximately two hours.

At the end of the description, the prescriber said the prescriber would think about the case for several days. The prescriber asked permission to call back. I gave permission. The prescriber thanked me and ended the call.

I sat in the kitchen after the call. I sat for a long time. The kitchen was where I had been making the calls. The kitchen had become the room where the calls happened. I had been in the kitchen, on the phone, for two hours. The conversation had been different from the prior conversations. The difference had been structural. The prescriber had received what I had said. The prior clinicians had processed what I had said within their frameworks. The processing and the receiving were different operations. I had not known they were different until the prescriber's reception had occurred.

The prescriber called back four days later. I described the second call in the notebooks. I will not redescribe it here. I want to record one thing about the second call that the notebooks do not contain.

When the prescriber proposed the combination, the prescriber spoke for approximately ten minutes describing the reasoning. The description was specific. The description addressed features of my husband's condition that the prescriber had identified through what I had told the prescriber. The description did not invoke any clinical framework I recognized. The description simply addressed what was occurring in my husband's apparatus, in language calibrated to the actual occurrence.

I listened. I followed the description. I was able to follow the description because the description was about something I had been observing for eight months. The description named what I had been observing. The naming was the first time anything I had been observing had been named accurately by someone other than me. The accuracy was what the prescriber's reception had produced. The reception had received what I had been observing. The thinking had produced a characterization of what had been received. The characterization was accurate to what was occurring.

I cried after the call ended. I had not cried, in any sustained way, across the prior two hundred and twenty days. I had not cried because crying had not been within my available capacity. The capacity had been consumed by the holding. The crying came after the prescriber's call because the prescriber's

call had created, for the first time in months, the conditions in which crying was possible. The conditions included: someone else now knew what I had been observing. The knowing was not complete. The knowing was sufficient. The someone else's knowing meant that I was no longer carrying the knowing alone. The reduction in the carrying was what permitted the crying. The crying was the apparatus releasing what it had been unable to release.

I cried for approximately forty-five minutes. My husband was in the bedroom. He was sleeping. He did not know I was crying. I had been alone with the knowing for eight months. I was now alone with the crying for forty-five minutes. The aloneness with the crying was different from the aloneness with the knowing. The aloneness with the crying was a relief. The aloneness with the knowing had been the consuming.

I want to record this because the case file and the marginalia and the Reviewer's report do not contain it. The case file contains no information about how I was during the case. The marginalia contains my husband's recognition that I had been carrying what I had been carrying. The marginalia does not contain what the carrying was. The Reviewer's report acknowledges my role in the case's resolution. The report does not address what the role required of me. None of the documents address what the role required of me. I am addressing it here, in the only document that will address it.

What the role required of me was that I be the apparatus that observed the case from inside the marriage across the entire duration. The apparatus had to function across the duration. The functioning required holding what had to be held. The holding was constant. The cost was substantial.

I have continued to function across the years since the case. The functioning has been adequate. The functioning has not been the functioning I had before the case. I am, like my husband, a different person from the person I was before the case. My difference is less visible than his. My difference does not produce episodes. My difference does not require monitoring. My difference is internal and is not addressed by any institution. My difference is, nonetheless, real. I am writing this in part to make my difference visible in a document that exists somewhere.

The difference is, primarily, that I now know what apparatuses can be required to do. I know this from having been an apparatus that was required to do what it was required to do across the eight months. The knowing is a permanent feature of my apparatus now. The knowing does not produce dysfunction. The knowing produces what I will call clear-eyed awareness. I see what apparatuses do. I see what institutions do. I see what marriages do. The seeing is continuous. The seeing is not unwelcome. The seeing is the apparatus I now am.

I want to address one more thing before this document closes.

The case file is going to be read, at some point, by parties I do not know. The reading will produce, in those parties, whatever it produces. I cannot anticipate the readers' responses. I can address the readers directly here, briefly, with the understanding that the addressing is not directed at any specific reader but at whatever readers eventually arrive.

You are reading a document of an institutional failure. The failure produced substantial harm to my husband across eight months. The failure was, as the Reviewer's report articulates, structural rather than incidental. The framework that produced the failure continues to operate in the institution that produced it and in many similar institutions throughout the research enterprise. The framework will produce similar failures in similar cases. The framework's continued operation is not within my capacity to change.

What is within my capacity, in this document, is to ensure that the failure does not pass into the archive without the human reality of the failure being preserved alongside it. The case file as it stands has the case file's contents. The case file with this document has, in addition, what I have written here. What I have written here is not comprehensive. What I have written here is what I have been able to write at this point in my life, with the capacity I have developed through the years since the case. The capacity will continue to develop. The writing will, accordingly, be incomplete. I am not in a position to write a complete account. I am in a position to write this account.

The account is the account of the proximate observer, the figure the case file refers to throughout by the institutional designation rather than by name. The figure has been called S— throughout the case file. The figure is not S—. The figure is me. The figure has a name. The figure has not used the name in the case file because using the name would have required the institution to

recognize the figure as a person. The institution did not recognize the figure as a person. The institution recognized the figure as the proximate observer, an institutional role. The figure performed the role. The figure was, throughout, also a person. The person had a name. The person has a name. The person is still here.

I will sign this document with my name. The signing will make this document the only document in the case file that contains the name of the figure the case file has otherwise referred to only by initial. The signing will be a small act of insistence that the person is here. The insistence is not directed at the institution. The institution is no longer reading. The insistence is directed at the eventual readers. The readers will encounter the case file. The readers will encounter the institutional designations throughout. The readers will arrive at this document. The readers will read what I have written. The readers will arrive at the signature. The signature will inform the readers that the figure the case file has called S— has a name and is here, and was here throughout, and will continue to be here.

I am the proximate observer. I am the wife. I am the figure the institution did not name. I am the person who held what had to be held. I am the person who is writing this. I am closing the document now.

The case is closed without disposition.

My marriage is open.

[Signature: handwritten in clear cursive, the full name of the person who has been called S— throughout the case file, executed without flourish, dated three years and four months after the formal closure of the M-08 case.]