KENNEDY 014466

INVESTIGATION INTERVIEW SCHEDULE

. Identifying Information:

Name Dr. Malcolm Perry
Address ~~Univ of Washington~~
City/State Medical Center
Seattle, Wash
Date of Birth
Social Security

Date 1-11-78
Place ~~Parkland Hospital~~, Univ of Washington Medical Center
Telephone
M or S M
Spouse
Children

. Physical Description:

Height
Weight
Ethnic Group

Color Eyes Hair
Special Characteristics

. Personal History:

a. Present Employment:
Address
Telephone

b. Criminal Record
1. Arrests
2. Convictions

[redacted] MD 58

. Additional Personal Information:

a. Relative(s): Name
Address

b. Area frequented:
c. Remarks:

ARRB
MD 58

Investigator D.A. Purdy, Jr. and T.M. Flanagan, Jr.
Date 1-8-78

Form #4-B

0007

Tape Transcript, January 11, 1978, 5:45 p.m.

Seattle, Washington, University of Washington Medical Center

Staff Members present: Andy Purdy, Staff Counsel
Mark Flanagan, Staff Researcher

Interview with Dr. Malcolm Perry

(Dr. Perry acknowledges this taping with his permission)

P/F: Let the record show that we have just had a discussion which began approximately 4:30, pacific time, where we went through the chronology of events of November 22, 1963, which you were involved in, and your specific recollections about the treatment and the wounds. Is that correct?

Perry: That's correct.

P/F: Dr. Perry, could you please state your present position.

Perry: I'm Professor of Surgery at the University of Washington, Vascular Consultant Chief at Harbor View Medical Center.

P/F: Could you please tell us what experience you've had with gunshot wounds since 1963?

Perry: Well, happily, it hasn't been exactly the same, but I've had quite a bit, and I remained after 1963, when I returned to Parkland and University of Texas Southwestern Medical School, from California. As Assistant Professor of Surgery I stayed there until 1974 and during that time I remained as Chief of Vascular Surgery at Parkland Hospital and the VA Hospital and had the opportunity to treat numerous traumatic wounds of all types. Gunshot, knife, blunt trauma. With

the ensuing years, up until 1974, several hundred cases. And then subsequent to arriving here, inasmuch as I run a trauma service at Harbor View Medical Center I've had the opportunity to continue to treat traumatic wounds of all types. Probably several every month. I don't keep a compilation ...those figures are available in my records of course, but I don't have it off the top of my head.

P/F: Could you describe, generally, President Kennedy's condition when you entered the room, and what treatment was underway.

Perry: When I reached the Emergency Room at Parkland that day, the President had just been brought in and the initial resuscitation was underway. There were several people in the room, the nurses and several doctors. Dr. Jim Carrico, who was the first year Surgical Resident in charge in the Emergency Room was attempting to establish an airway. He had a laryngoscope in his hand and was attempting to get an endotracheal tube in. IVs were being started and the President's clothing was being removed to permit us access to the limbs for intravenous fluids and resuscitation, the placement of various catheters and tubes. He had agonal respiration. I attempted to feel for a pulse in the left groin and didn't feel one, and Jim said he had no blood pressure, but that he was breathing and he also apprised me at that time that there was a wound of the trachea that he could see through the laryngoscope but he couldn't get the tube past it. It was too far down.

And I asked for a tracheostomy tray. And Betty Henscliff, one of the nurses had already prepared it, and I dropped my coat in the corner and put on some gloves and started to prepare to do a tracheostomy to get the airway. At that time, I noted a wound in the anterior aspect of the neck in the lower third, which was roughly round, exuding very slowly dark blood, partially obscuring its edges. The wound was somewhere probably 4 to 6 millimeters in diameter. I did not, however, wipe the blood off and inspect the wound, but gave it a cursory glance while I was putting my gloves on and preparing the trach tray. I also asked at that time that several other doctors, specifically McClellan, Baxter and Dr. Clark, be summoned from the medical school to come and help. And asked Dr. Jones to start an IV, and Dr. Carrico was also busy with another IV at the same time, I think, in the leg, as I recall. And then I took the knife and I cut directly through the anterior neck wound in an attempt to secure control of the trachea and the tracheal injury that Jim had mentioned. I noticed the head injury but I didn't examine it at that time. But I did see some evidence of brain tissue on the cart. I reached the trachea and the strap muscles which were bruised, as I previously noted in my testimony for the Warren Commission. And at

that time I secured the trachea with an allis clamp and brought it up to the field, and I saw the injury to the right lateral aspect of the trachea where it had been damaged and I cut into the trachea at that spot and started to place an endotracheal tube in. About that time, a set of hands came into the field to help me, which later I identified as Dr. McClellan's. And we completed placing the tracheostomy tube into place and hooked him up to the respirator. Because there was some bruising and also some bubbly-looking blood over on the right perietal pleura upper portion of the chest, why I thought perhaps there might also have been a hemo or pneumo thorax, I asked Dr. Baxter to put in a right chest tube which he did. And Dr. Jones put in a left one, I think, about the same time. And the respirator was going, I didn't see any other evidence of injury, and there was very little bleeding, because he had no obtainable blood pressure. There didn't seem to be anything else hitting the neck other than the trachea and some of the muscles and the tissue and the bruised apical pleura. About that stage, Dr. Clark had arrived and he had told me that the electrocardiograph indicated that cardiac arrest had just occurred, so we started close cardiac massage. And we persisted with that until it became apparent that it was futile and Kemp said it was too late, so I quit. And then I looked at the head wound briefly by leaning over the table and noticed that the parietal occipital head wound

was largely avulsive. There was visible brain tissue on the cord and some cerebellum seen, and I didn't inspect it further, I just glanced at it and went on outside. And later was summoned up to the operating room to help in the care of Governor Connally.

P/F: Could you give us a characterization of the edges of the anterior neck wound.

Perry: I previously pointed out that they were neither ragged nor clean cut and I suppose that's a misnomer because actually I didn't inspect it that well. What I meant to infer by that initial description was the fact that I couldn't see a clean punched wound. It was roughly round, the edges were bruised and a little blurred, because as I mentioned there was several big drops of old blood and some of it coagulated of course, on and about the wound. So I didn't really inspect the margins carefully. I think the terms I used before was neither ragged nor clean-cut, and that may not have been appropriate. I should have probably said, I couldn't see them that well, might have been a better answer.

P/F: You described the damage to the trachea as you saw it. Was there some further description you can give of damage? I think you stated previously, for example, that there was some bruising ...

Perry: On the right lateral side of the trachea, there was a laceration but again I don't remember exactly how I put that all these years ago. But it was on the right side of the trachea and it was incomplete and I don't remember whether it was a third or a quarter of the circumference, and I can't remember exactly. There was a laceration. The bruising / that I mentioned was in the apical pleura and the strap muscles. Trachea was clearly lacerated.

P/F: You also stated prior to the taping that there was possibly some damage in the mediastinum.

Perry: That's the same area. The mediastinum is that area that's bounded by the lungs on each side and sternum in front and the spine in back. Contains the heart and all the great vessels and various structures.

P/F: You described the use of the chest tubes to determine whether or not there was any pneumothorax or hemothorax.

Perry: Actually, not to determine, Andy, but to treat. I didn't know whether there was, and I surmised there might well be a hemothorax or a pneumothorax because, not knowing the trajectory of the missile, and when I saw the bruised avical pleura and there was some bubbly blood in that area, and I didn't know whether that blood had been frothed a little bit as a result of air coming out of the trachea in our attempts to breathe for him, or whether it was coming out of the lung. And as a result, since a tension pneumothorax or a serious chest injury could have obviously been a serious problem, why we elected to

put in a chest tube. The chest tube I later learned was not necessary because the chest cavity was not violated, but I didn't know that at the time. It wasn't done diagnostically, it was done therapeutically.

P/F: How did you determine that the pleura cavity was not violated?

Perry: I found that out later in the autopsy report.

P/F: Was your feeling at the time that you finished your treatment that the pleura cavity had been violated or . . .

Perry: Didn't know. Didn't have any idea. We didn't do any more after Dr. Clark and I decided that resuscitation failed, why, I didn't do anything else. /I didn't find that out until So I don't really know. some time later.

P/F: What did your inspection of the anterior neck area disclose to you about the condition of major vessels in the area?

Perry: Well, of course, that didn't tell me anything. As we discussed a little earlier, he had no blood pressure that was obtainable and therefore, there was essentially very little bleeding. And even if he had had a major arterial injury, why he might have bled out and there wouldn't have been much. But there was no evidence of a major arterial injury. And the artery, of course, that's closely applied to the trachea is the common carotid artery at that level. But it was not injured.

P/F: Would President Kennedy have survived if he had only suffered the injury to the neck?

Perry: Assuming the lack of complications, the odds are quite well and good that he would have. Occasionally, tracheal wounds are associated with subsequent stenosis and require repairs, but they generally, a wound such as this, is usually survivable, yes.

P/F: To what extent, if any, would the President's speech have been impaired in the short or the long term?

Perry: Well, this is again the/conjecture that got me in a lot of somewhat trouble before, but I suspect, very little. There's no reason why he couldn't talk with that particular injury, that's not enough to keep you from talking, it was below the larynx and it wouldn't have constituted enough of an air leak to make him so breathless that he couldn't speak.

P/F: Dr. Perry, could you go over and describe conversations that you subsequently had after treating the President at Parkland with Dr. Humes, the surgeon who performed the autopsy.

Perry: This won't be too accurate, Mark, because I've found out, interestingly enough, that later I had my dates a little bit fouled up. They called me twice. And I couldn't remember, I didn't write them down, I've learned to keep better records since then, and I didn't remember exactly when they called me, and about what. But I was called twice from Bethesda. And the conversation, the first one as a recall, and I should go back and look at my testimony, my notes here, and/I/should I haven't done that and I guess I have, to find out exactly what we talked about on that first one.

But we discussed the thing, I told him about the tracheostomy wound, and told him I have cut right through the small wound in the neck and Dr. Humes at that time described that they had had a little difficulty tying up that posterior entrance wound, allegedly to be an entrance wound, . . . the posterior wound with . . couldn't find out where it went. And they had surmised that during the cardiac massage and everything that perhaps the bullet had fallen out. It seemed like a very unlikely event to me, to say the least. But at any rate, when I told him that there was a wound in the anterior neck, lower third, he said that explains it, I believe was the explanation that he used. Because that tied together their findings with mine. Now, there was a second call about the chest tubes, I think, and I believe that was the next day. I'm not sure, then, maybe they called me twice that morning.

P/F: At one point in your testimony, to help clear it up for you, you said that the calls came about 30 minutes apart.

Perry: Was it twice in the same morning? It's possible. There should be some kind of record of that. They had a record of it, Andy, and I just don't remember, you know. Between Friday, and the President, and Sunday, and Oswald, and all those conferences and interviews, I got a little bit confused. Cause /Saturday morning I was asked to come up to the hospital and talk to a whole bunch of people and so I was up there Saturday too, and I don't

remember, ... was it Saturday when they called? Yeh, twice. They called twice, and they asked me about the chest tubes, or something to that effect, about the chest tubes.

P/F: Now in your testimony you say that the initial phone call was in relation to my doing a tracheotomy, and you informed them

Perry: That I'd cut right through the wound.

P/F: Right. Do you remember whether or not there was any discussion in either of the calls about whether there had been any surgical incisions made in the President's back?

Perry: I don't remember. I don't know why - he might have asked me but I didn't even look at his back. So I wouldn't have known the answer to that if there had been, but I don't recall him asking that question. He might have asked and -- I got asked so many questions along about that time, I don't remember who asked what. I didn't even look at Mr. Kennedy's back, which was another thing I wish we had done.

P/F: I have one further question along these lines. To your knowledge, did Bethesda Hospital or -- did they ever receive any, for instance, any handwritten notes that might have been taken immediately after the --

Perry: They should have. Yeah. That's a good question too, Mark. Cause we all sat down afterwards and wrote out in our own, as Lil Abner would say, hand 'writ notes, our recollection of what happened down there, knowing that we'd get a little fuzzy about it. And I think they got copies of those, I'm not sure

of that though. Those copies were available, because we made them available to the investigating committees and I know our inspector and all the guys around here, ... I mean they were available for everybody, and I think several of the people from various investigating agencies looked at them. They made a bunch of copies, and they should be widely circulated. Interestly enough is the discrepancy between what people remember, kind of like the blind man and the elephant, is what they remembered. Dr. McClellan's and some of the others are quite different from some of ours.

P/F: Is this the normal procedure that Parkland hospital to follow to write it down . . .

Perry: Well, normally yes. But normally just one of us. Normally the guy, myself for example, since I ostensibly was responsible for the surgery and the rest of it, normally the guy who is attending and who is doing the job writes a summary about it afterwards for the record. The reason all of us did was we thought it might be important, more than the usual to have a good record. I'm not sure it served its purpose. I havn't read everybody's, but I read some of them, and I found they didn't correspond with what I remember.

P/F: Do you remember any in particular?

Perry: No, but I remember the stuff about Bob McClellan's -- we talked about that later, because it talked about the thing in the temple. And we all kind of laughed about that, but that just,

you know, Bob was told when he joined in there, like me, he didn't spend much time, because he saw I needed help, and/when he started helping me with the trach, he asked where he was shot, and somebody told him he was shot in the left temple. And he accepted that as being true, when actually it wasn't true, and I think Bob wrote that down, or if he didn't write it down, he told somebody that, which was interesting. You know, you get naive and trustworthy, and that's a bad way to be.

P/F: As you recalled, your testimony says that the second conversation you had with Dr. Humes was in regard to the placement of the chest tubes for drainage of the chest cavity.

Perry: It's interesting to me, and I'm not being critical, but it's interesting to me that the pathology report does not reflect that. The autopsy/report said that those incisions were made to combat subcutaneous emphysema, which is not in the current jargon, a viable therapeutic technique.

P/F: What would have been a normal routine, if it existed at the time, after somebody had been taken into emergency and expired?

Perry: What do we usually do?

P/F: What would occur then to reports, for instance . . .

Perry: They go in the hospital record.

P/F: Hospital record, would the forensic pathologist in the area that might examine the body . . .

Perry: Yeah, they're all there. It all goes in the record. We write a narrative summary, and I must say, if I may be a little bit immodest, I'd write mine right away, I'm very good about that sort of thing. Mainly because I've found that if I'll do it right then, it's like an operative report. When I come out of the operating room, I dictate the operative report right then, because it gets progressively hazier. And I usually sit down and write it as soon as I finish, I write a short op note, anytime I do an operation, on the chart. We prepare them right then, and that's what we would do, and that would become a part of the legal hospital record.

P/F: To what extent, if any, did your observation of the nature of the President's wounds in the anterior neck convince you that a missile of some kind had gone through that area?

Perry: Well, I suppose/I could enumerate those, Andy, it's kind of like, you know, I could look at you and Mark, and/I tell, I know which one is which without enumerating the features of your physiognomy. I've got a picture of you in my head now. Well it's the same thing with this. /When I looked at that, there's an injury to the side of the trachea, there's a wound in the front of the neck, there's some concussive damage to surrounding organs -- these are the kind of things one sees with gunshot wounds, in a blast injury, that sort of thing. And with high velocity, we do see a lot. Now, the low velocity stuff, it's often just a

track, a wound track, with very little concussive or blast injury. This one was in between. There was evidence of some blast injury, but not like/one sees with a high velocity rifle, like a 3006 or 223 or something. This was quite different.

P/F: Did your observations of the nature of the wounds give you any information as to the possible trajectory of a missile through the President?

Perry: No, I really can't say/ I can speculate again, and I did speculate about that, but I -- all I can say, is if you were to tie up the wound in the neck, the wound in the trachea, and the strap muscle business, apparently something passed that way. Now, as I mentioned earlier, the pathway of bullets striking tissues of varying densities is not uniformly rectilinear, it curves and moves with it, and they may be deflected by what appears to be a relatively minor structure -- a tough faschia layer or muscle layer, or something that may deflect the bullet especially if it's down, if its energy is low and it's down near the bottom of its velocity curve, it may be deflected and travel for long distances in a circuitous fashion, so I think it's very chancey business to make conjectures about trajectory when you don't have the whole wound track exposed. And you're just looking at two points. We never probe wounds, for example, that's ridiculous, it doesn't help you a bit. You get all kinds of wounds in which you try to project where it went, and that's an exercise in futility. So I don't know the answer. That

may be more than you want to hear about that.

P/F: Do you have an opinion based on those two points that you described as to the origin of the missile that caused the damage?

Perry: No, I don't. The reason is that I didn't clearly identify either an entrance or an exit wound, and in the press conference I indicated that the neck wound appeared like an entrance wound. And I based this mainly on its size and the fact that exit wounds in general tend to be somewhat ragged and somewhat different from entrance wounds. Now this doesn't pertain, of course, in bullets that are deformable or bullets that are tumbling. And many bullets, especially fired from hand guns and this sort of thing, tend to tumble, and as a result, they may make keyhole injuries and various things. But in general, full-jacketed bullets make pretty small entrance holes , and so, I don't really know. I thought it looked like an entrance wound because it was small, but I didn't look for any others, and so that was just a guess.

P/F: Based on your observations of the wounds, was it more likely that the damage was caused by a missile or something like a small bone fragment?

Perry: Well, I think it's more likely to be a missile than bone fragment. The only reason I say that is that secondary missiles, which is what a bone fragment would be, generally don't attain the velocities that produce this sort of thing.

They can, but usually would not at that level. Do you remember that Governor Connally had some secondary missile damage as a result of a bullet striking his fifth rib, and the rib acted as a secondary missile. But that's not the usual, I think it's probably a missile.

P/F: Is it possible that the missile which caused the wound in the anterior neck could have fractured the transverse process and still resulted in the type of wound that you saw?

Perry: I suppose so. Again, you're asking me to make a lot of suppositions which get me in trouble. But I suppose so. If one had a fairly high velocity missile that was full-jacketed, it would have enough remaining velocity to go on through after striking something like a transverse process, it could get on through. You're talking now about tangential wounds and thickness of bone and all this sort of thing, and we don't even know bullet types. So these things are possible, yes, but it doesn't seem very likely. But again, that's a guess, and it's not worth any more than that, than a guess, on my part.

P/F: Based on your experience with wounds in these intervening years, have you been able to draw any firmer or any different conclusions based on the nature of the wounds you recall?

Perry: You want a short answer? Or a long answer?

P/F: What ever answer you want to give.

Perry: O.K. let me give you a medium answer, with a qualified anecdote. The answer is no, I haven't. I haven't changed my mind about any of it, and the reason is I have no new information, as I mentioned earlier, fourteen years hasn't sharpened my recall. I've told it as well as I can remember it, but I did it best when I was fresh, and things change a little bit. I was just telling you, just night before last, I had a young lady shot with a 3006. We had a multitude of wounds in that young lady, and they were hard to explain. Her right humus was shattered with an injury to the artery and the ulna nerve was transected. The whole back of her arm was blown off. She also had a fractured radius in the left arm, with no injury to the artery, but it was fractured, and there was no fragments in that wrist. She also had a wound to her neck, left neck area, but a fragment was in there. We had the devil's own time trying to figure it out. And then later we found out what happened. She was shot and with a 3006 hunting rifle, high velocity, which blasted her arm pretty good. The bullet hit the concrete, shattered, and those other two were secondary injuries from the fragments, that got her arm and got her neck. But we didn't know that. And this is the kind of thing you can get into. So I don't know.

P/F: Dr. Perry, you mentioned earlier that after you had been down in Trauma Room One, administering to President Kennedy, that you then went over to see Governor Connally in the operating room, I guess that's upstairs in Parkland Hospital.

Perry: Second floor of Parkland.

P/F: Could you relate the scope of your involvement in treating Governor Connally.

Perry: When I left downstairs, I went outside a minute and sat down, and/they called and asked me if I'd come up to/OR where Dr. Shires was operating on Governor Connally's leg. Dr. Shaw and Dr. Gregory had been involved, of course, and were working on chest and arms, and this sort of thing. He had a penetrating injury of the left thigh, as I recall, kind of anterial medial. And so I went up and got a scrub suit, changed clothes, and went back to the OR, which was my operating room, as a matter of fact, back in OR 5 where I usually worked. And talked to Shires, was looking at the wound, they'd incised the scan and were looking at the thigh wound and I just looked over his shoulder and agreed with their opinion that the wound was not serious, that it had not penetrated deeply into the leg, that the artery was not in danger, and that it wasn't necessary to expose the artery.

P/F: Could you describe the approximate size and depth of the wound?

Perry: No, I would be of no help, because the skin incision had been made, and, but the tissue looked fine. It didn't look like there was much of anything wrong with it. So, whatever it was, it was near spent, I suppose, or it was very minor because there was no, none of the type of thing one sees with any velocity in a missile, any significant velocity.

P/F: Was it your opinon that it was a full bullet, part of a bullet, or very small part of a bullet, that caused the wound?

Perry: Well, I don't know because there was so little wound, I don't think I could say that. But I was underwhelmed with what I saw, as the saying goes. It didn't look to me like much of a wound at all, when you saw it; wasn't much to it. Again, that's qualified, because I didn't see the skin before.

P/F: What was the doctors' concern, if any, over the fragment that was in the thigh of Governor Connally.

Perry: Well, the question came up whether that could possibly have come from a fragment that went zipping down through there and might have damaged some of the neurovascular bundle. As we indicated earlier, Mark, you are not really so concerned with the fragments themselves, but what may be between where they began and where they ended. And, inasmuch as where this wound was, and the size and the scope of that fragment, we deemed it highly unlikely that it caused any significant damage. And, as I said, I was underwhelmed with the whole thing. I don't even know

that that fragment wasn't there for, before. We have no previous x-rays of that area, and I guess it came then. But I've become a little more suspicious in my older age, seeing people that have injuries that you don't know about. I don't know how long that had been there. No controls.

P/F: Dr. Perry, I think that finishes the formal questions we had. We wanted to give you an opportunity to expound on any aspects of the nature of the wounds that you didn't have sufficient time or any items which perhaps have been left unresolved by previous testimony. Suggestions or comments.

Perry: I feel I've already cluttered up your tape with a lot of professorial homilies and aphorisms throughout the course of this thing and I'm sorry about that. But you know, you can make this so stilted ... but I hope not to ... no, I don't have any other comments. I wish to hell I remembered a little better, and I wish I could add something substantial to your investigation, but I fear that I have no other information. I wish I had not speculated, as to where the wounds came from. As I said, after our operation on Mr. Oswald, when I had the press conference at that time, I had a typed, prepared statement of what I'd done, when I operated on him, and I didn't answer any questions. I found that was a very much better way to do things, and there was no hypothetical questions, no suppositions. A typed statement was handed out, and I didn't get into a lot of discussions about what might have been. But I don't

have anything else to add, I don't have any new information.

P/F: One final short question. Did you or any of the doctors consider initiating any communications with the autopsy surgeons prior to the completion of the autopsy?

Perry: No we didn't, and perhaps we were remiss in not doing so. It might have been a good idea. We ordinarily do that, as you know. And your question is very germane to what's going on here, because ordinarily if I have a patient that dies for one reason or another, I usually will call the pathologist on and we'll talk about it before and usually I try to attend the autopsy, if it's a time when I'm not in the operating room, because it's an important part of our ongoing education, you always learn something. And I always tell them about what I'm worried about, and sometimes I even assist in the autopsy if its a specific case where I think perhaps the patient I operated on and the knowledge that we get from that is helpful. And perhaps we should have called Commander Humes, it would have helped a lot had we done that. But the circumstances in which Mr. Kennedy was removed from our hospital were precipitate and abrupt, and most of us, quite frankly, weren't asked or consulted or anything about any of it, and it was just all done. And as a result, we were essentially moved out of the area of environment, and involvement, and we assumed that that was it. And I, perhaps that was, our error. It would

have been nice if we had talked to them before they started. I think we could have helped them a lot, and we probably should have initiated that ourselves, knowing what we knew.

P/F: Thank you. O.K. Time is now 6:15 and this taping session is over.