

November 22, 1963
1630

To: Dr. A. J. Gill, Dean
The University of Texas Southwestern Medical School

From: M. T. Jenkins, M.D., Professor and Chairman
Department of Anesthesiology

Subject: Statement concerning resuscitative efforts for
President John F. Kennedy

Upon receiving a stat alarm that this distinguished patient was being brought to the emergency room at Parkland Memorial Hospital, I dispatched Doctors A. H. Giesecke and Jackie H. Hunt with an anesthesia machine and resuscitative equipment to the major surgical emergency room area, and I ran down the stairs. On my arrival in the emergency operating room at approximately 1230 I found that Doctors Carrico and/or Delaney had begun resuscitative efforts by introducing an orotracheal tube, connecting it for controlled ventilation to a Bennett intermittent positive pressure breathing apparatus. Doctors Charles Baxter, Malcolm Perry, and Robert McClelland arrived at the same time and began a tracheostomy and started the insertion of a right chest tube, since there was also obvious tracheal and chest damage. Doctors Paul Peters and Kemp Clark arrived simultaneously and immediately thereafter assisted respectively with the insertion of the right chest tube and with manual closed chest cardiac compression to assure circulation. (As evidence of the clear thinking of the resuscitative team, the patient received 300 mg. hydrocortisone intravenously in the first few minutes.)

For better control of artificial ventilation, I exchanged the intermittent positive pressure breathing apparatus for an anesthesia machine and continued artificial ventilation. Doctors Gene Akin and A. H. Giesecke assisted with the respiratory problems incident to changing from the orotracheal tube to a tracheostomy tube, and Doctors Hunt and Giesecke connected a cardioscope to determine cardiac activity.

During the progress of these activities, the emergency room cart was elevated at the feet in order to provide a Trendelenburg position, a venous cutdown was performed on the right saphenous vein, and additional fluids were begun in a vein in the left forearm while blood was ordered from the blood bank. All of these activities were completed by approximately 1245, at which time external cardiac massage was still being carried out effectively by Doctor Clark as

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judged by a palpable peripheral pulse. Despite these measures there was no electrocardiographic evidence of cardiac activity.

These described resuscitative activities were indicated as of first importance, and after they were carried out attention was turned to all other evidences of injury. There was a great laceration on the right side of the head (temporal and occipital), causing a great defect in the skull plate so that there was herniation and laceration of great areas of the brain, even to the extent that the cerebellum had protruded from the wound. There were also fragmented sections of brain on the drapes of the emergency room cart. With the institution of adequate cardiac compression, there was a great flow of blood from the cranial cavity, indicating that there was much vascular damage as well as brain tissue damage.

It is my personal feeling that all methods of resuscitation were instituted expeditiously and efficiently. However, this cranial and intracranial damage was of such magnitude as to cause the irreversible damage. President Kennedy was pronounced dead at 1300.

Sincerely,

M. T. Jenkins, M.D.

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