KENNEDY

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INVESTIGATION INTERVIEW SCHEDULE

Identifying Information:

Name Dr. George Thomas Shires
Address
City/State

Date 1/9/78
Place New York Hospital - Rm. F739 East 70th Street New York City
Telephone

Date of Birth
Social Security

M or S
Spouse
Children

Physical Description:

Height
Weight
Ethnic Group

Color Eyes Hair
Special Characteristics

Personal History:

a. Present Employment: Cornell Medical School
Address New York, New York
Telephone

b. Criminal Record
1. Arrests
2. Convictions

Additional Personal Information:

a. Relative(s): Name
Address

b. Area frequented:
c. Remarks:

Investigator Andrew Purdy Mark Flanagan

KENNEDY

SELECT COMMITTEE ON ASSASSINATIONS

NAME Dr. George Thomas Shires Date 1/9/78 Time 11:40 a.m.

Address _____ Place New York Hospital
East 70th Street
New York City
Room F739

Interview:

Dr. Shires was interviewed by Mark Flanagan and Andy Purdy, with assistance from medical consultant Dr. Michael Baden.

Dr. Shires initially recapped the events leading up to and comprising the medical treatment of Gov. John Connally. Dr. Shires said Dr. Shaw was a thoracic surgeon, so he worked on the wound to the torso; Dr. Gregory was an orthopedist, so he worked on the wrist; and Dr. Shires worked on the thigh wound. Dr. Shires arrived after the other work had already begun, coming from a Western Surgical Association meeting in Galveston, Texas.

Dr. Shires said his work on the thigh was "...largely an exploration to insure that there was no vessel damage." Dr. Shires said the only significant wound in the thigh was a missile tract. He says he merely did a debridement. When asked if the thigh wound could have been caused by a secondary fragment, Dr. Shires said you "...can't tell anything from the size or shape of the wounds as to whether or not it is an entrance or exit wound." He said that when dealing with fragments, there are many unknowns and variables and that it's hard to differentiate fact from fiction.

Interviewer _____
(Signature)
A. Purdy/M. Flanagan
(Name)

Date Transcribed 1/24/78 by am
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Dr. Shires said the wound was small and that the thigh had very little damage and did contain a metal fragment. Dr. Shires was asked about his Warren Commission testimony that noted a peculiarity in the nature of the wound; namely, that the tissue damage seemed more significant than the size of the fragment present. He said that it is difficult to determine how the fragment entered. He said "...all you can say is that a tangential wound occurred." He said that there are a large range of possibilities for what happened. Significantly, Dr. Shires said the main issue he was seeking to resolve by the examination of the thigh was whether the missile could have hit a major vessel. He said it did not, and that he did not physically pursue the fragment that was there because it was "...not medically significant." Dr. Shires said he was able to determine that the fragment was in the thigh bone from his examination of the original Connally X-rays.

At this time, we showed Dr. Shires the three original thigh X-rays and the enhancements of these X-rays. Dr. Shires said that it doesn't make any difference whether the metal fragment is in the femur or just under the skin with regard to the issue of whether there was a full bullet striking the thigh or a fragment of a bullet. He said the wounds were probably caused by a tangential hit. He said a tangential wound could have sent the fragment anywhere into the thigh. Dr. Shires noted that on the enhancement of the thigh the

item in the bone looks more like an artifact than when he examined the original. He was open-minded about the possibility that the fragment could have been just under the skin, but preferred to reiterate his initial impressions that the fragment was in the thigh bone. Dr. Shires said that while they explored the entire track of the missile, they were not "...exploring it as a track..."; rather they were "...exploring the wound looking for a big missile injury." Dr. Shires said he found little hemorrhage, so he felt it was likely that a high velocity missile did not pass through the skin causing the wound.

Dr. Shires' recollections of the treatment conducted and the nature of the thigh wound was then tape-recorded.

TRANSCRIPT OF INTERVIEW OF DR. G. THOMAS SHIRES

Introduction to tape:

DATE: January 9, 1978

TIME: 3:55 P.M.

PLACE: Dr. G. Thomas Shires' Office
Cornell Medical School
New York, New York

Dr. Shires is Chief of Surgery, Cornell Medical School

INTERVIEWERS PRESENT: Donald A. Purdy, Jr., Staff Counsel
T. Mark Flanagan, Staff Researcher

CONSULTANT: Dr. Michael Baden (also persent)

Dr. Shires consented to taping of session.

ABBREVIATION CODE: P - Purdy
F - Flanagan
S - Shires
B - Baden

P: Okay, Dr. Shires, we have just had a general discussion of events leading up and the surgery that you performed on Governor Connally on November 22, 1963, and then had a discussion of the specific nature of the wound to the thigh which you operated on, and you have examined the original X-rays of the thigh wound and enhancements of those X-rays, is that correct?

S: Right.

P: Okay. I want to ask you about the thigh wound. Specifically, in your report of November 22, 1963, as I read to you previously, you described the wound as follows:

"There is a one centimeter punctate missile wound over the juncture of the middle and lower third, medial aspect, of the left thigh. X-rays of the thigh and leg reveal the bullet fragment which was embedded in the body of the femur in the distal third."

P: Is that a correct statement of your understanding of the wound in the Governor's thigh, and what the X-rays of that wound reveal?

S: Right.

P: I have here a report of November 29, 1963, prepared by Dr. Jack Reynolds, who was a radiologist at that time, where he also described the thigh wound. He said as follows:

"...There is, however, one density which remains constant on both films and appears to lie beneath the skin in the region of the subcutaneous fat in the medial aspect of the thigh."

He also said that this density lies

"...15.2 centimeters above the distal end of the medial femoral condyle on the AP film and on this film, lies 8 millimeters beneath the external surface of the skin. It is 6.25 centimeters medial to the femoral shaft."

Now, obviously there is a difference in terms of the location of the metal fragment. Do you believe that the metal fragment was in the thigh bone itself or do you believe Dr. Reynolds is correct, saying it's in the region of the subcutaneous fat? Or do you believe it could be either way?

S: I think it could be either way. The wound in the skin was described as a tangential wound, which means that it was larger than a direct entry of the fragment wherever it might be located, would have generally made. Therefore, the tangential nature, the long nature of the wound could have been made by the fragment on a tangent to the skin, then entering subcutaneous or bone, or it could have been made by a larger missile with a fragment coming off and lodging

in subcutaneous tissue or bone. So, I think that it could be either. Medically, the fragment was not sought. Because medically the reason for exploration of the wound was to make certain there was no injury to adjacent structures, primarily artery and vein, and none was seen. No search was made for the fragment as it generally is not, in a wound of this nature where the indication is to determine surrounding injury, so that the fragment could have been either place.

P: Did you have occasion to explore the region between the location where Dr. Reynolds said the fragment was located and the bone itself to see if there was, in fact, damage there?

S: Right. Looking for a vessel or other structure injury.

P: And, as you stated, you did not find any such injury?

S: No.

P: And it is your feeling that that does not necessarily preclude the fact that there could have been some damage there, in other words, that the fragment could have actually been in the bone itself?

S: Right. It could have been damaged. But this is a small fragment and in wounds like this, you never really look for the fragment, you're looking for significant injury that might do subsequent harm. And none was found.

P: In other words, you were not trying to remove that fragment?

S: That's right; that's right. Nor even search for it. You're searching for injury to vital structures, not for

a fragment itself.

P: Does your examination of the enhancements of the Connally X-rays affect, at all, however slight, your impression as to whether or not the metal fragment was located in the bone itself or just under the skin?

S: With the artifacts that are over the bone, I think it's very difficult to tell. On the anterior, correction, on the lateral view, it appears that the most likely defect would appear opposite bone. On the other hand, on the anterior-posterior view, it would appear it could either be bone or subcutaneous tissue. I can't really say with certainty.

P: But, either way, it is your belief that your description of the possible causes of the wound in the thigh are still as plausible as before you considered the possibility of the metal fragment being located just under the skin?

S: Exactly, I think the reason the nature of the wound was described as tangential was that it was too large for a right angle fragment or a right angle bullet to have made this, with no more evidence on X-ray of fragments than there were. So that a bullet could have hit it at an angle and left the wound, leaving the fragment behind, or the fragment could have been at such an angle that it caused a linear tangential wound in the skin and then dived either subcutaneously or in the bone, but I don't think you can preclude either possibility.

P: So you're saying the wound could have been caused by either that small fragment evident in the X-ray or by a full bullet which deposited that fragment?

S: Exactly.

P: What, if anything, can we conclude from the nature of the wound of the thigh about the velocity of the bullet, or the size of the bullet?

S: Nothing definitive. In general, a high-velocity large wound will have, will leave more evidence of tissue damage. You would conclude that in general this wound showed no evidence of large-mass, high-velocity injury at any depth at all. Again, this can be, this can be in error. For example, extremely high-velocity small calibre injury can leave a tremendous amount of damage. A large calibre low velocity injury can leave a tremendous amount of damage, so there are in the injury spectrum, it's very hard to say from the nature of the wound anything more than it's less likely that there was a large-mass, high-velocity tissue injury, less likely.

P: And in layman's terms, that means you believe that it is not likely that a high-mass, high-velocity bullet struck this thigh without first being slowed down by hitting something else?

S: I can't say that. I just don't know. I think it's, from the wound, you can say that it's less likely that a high-velocity, high-mass injury penetrated very far.

P: I see.

B: Well, let me just, to recapitulate, is there anything in your review of the original X-rays of the femur which Mr. Purdy brought from Washington today, which you reviewed, the original procedure, inconsistent with the report that Mr. Purdy read to you by Dr. Reynolds?

S: No, nothing inconsistent.

B: And, do you have an opinion or do you feel it fair to ask an opinion on the basis of the injury in the thigh and on the basis of what you knew in general about Governor Connaly, since you were the chief of service at the time, consistent or inconsistent with the wound in the chest, wrist, and thigh coming from the same missile?

S: There's nothing inconsistent about that, no.

B: They could have all happened from the same, a single missile?

S: They could.

P: Well, furthermore, can you state that it is likely that those wounds were caused by the same missile?

S: No.

P: Okay. And as the middle point between likely and anything not inconsistent with, can you say that it's unlikely that they were caused by the same missile?

S: Can I say it's unlikely they were caused by the same missile?

P: All those wounds in Governor Connally.

S: No. I mean I can't say that either way, because a tangential injury, let's assume that it was not a fragment for a moment, tangential injury could be made by any size, shape or velocity missile, and still leave a fragment and give exactly what was given here, so that I can't say that it's likely or unlikely that that bullet had been somewhere else first.

P: Did you have the opportunity to sufficiently examine the other wounds of Governor Connally to draw a conclusion as to whether those wounds, as well as the wounds in the thigh, were caused by the same bullet, or was your examination just confined to the thigh wound?

S: No, mine was just too late for that because the thoracotomy and the exploration of the arm were already underway, so I never really saw an existing wound. What I saw was a surgical wound. Attempt to repare the damage that had been done, so that's why I really, you know, can't give an opinion about it at all.

F: Well, Dr. Shires, before concluding the tape, do you have anything at all you would like to add, not only pertaining to the medical evidence of Governor Connally, but any other area at all in connection with the investigation of the assassination? Do you have any comments you would like the (something) to have at this time?

S: No, nothing that I know of has happened, you know, since the day of the assassination that would have changed our opinion from what we recorded with the attorneys at the time,

in terms of additional knowledge or subsequent developments in the care of the patient or any of that sort of thing. Realizing that our testimony was given I guess several weeks after the episode, a good many days, so that the general patient care, the fact that the Governor got well and so on had already occurred, so we really, I guess, wouldn't expect anything subsequently to have happened that would have changed anything we gave as depositions at that time, when it happened. Maybe a pertinent negative, I don't know. We didn't, we haven't learned anything subsequently that would have changed what we said.

P: Dr. Shires, from the nature of the thigh wound and your examination of the X-rays, do you believe that the metal fragment today would be in pretty much the same location or would it possibly have exited the body?

S: Now?

P: Yes.

S: I have no idea, I really don't. Perhaps you can answer this better than I can.

B: Well, I would just, my impression would be that unless it were taken out in the process of debredment, which Dr. Shires did, it was so small it could be taken out without noticing it.

S: (In background, uhum). Right; without knowing it.

B: Then it would have stayed in and be there; it wouldn't have worked it's way out, unless there was an infection or something.

S: I agree with that. It may well have been removed in the

course of the exploration because it is a tiny fragment and as I say, medically, what you're looking for is adjacent structure injury, not the fragment itself, so it could well have been, could well have come out as a part of the exploration. If not, I would assume, like you, that it would still be there. You leave fragments all the time in wounds and by and large, and there are notable exceptions, but by and large, they're there forever, for years and years, and cause no difficulty at all. That's one reason we don't chase the fragments so to speak. Now, when infection occurs usually it was carried in at the time of the injury, and came off organisms that were on the clothing or the skin and generally speaking, if there is to be infection and exclude that fragment, it will occur fairly soon. On the other hand, we've seen them years later develop infection around a fragment and exclude it. So it can always happen, many, many years later. But, as far as I know, that's not happened to him and I would assume it was either, came out in debredment, or would still be there on X-ray.

P: Was the exploration of the thigh wound sufficient that if the metal fragment was located in the femur itself, it might have come out during the surgical procedure? Did you explore that far in? (S: Poss..)

S: We weren't looking for the fragment, but again, in an exploration of a wound, it's possible. Because, you know, saying it is in a femur is what, for example, whether this was on the surface or, you really can't tell

because the films weren't made for that purpose. That was not the reason for the X-rays. So it could well have come out as part of the exploration.

B: I think just for the record, while we have the opportunity, if you can mention to the best of your recollection how the track looked when you got into it, how the wou d on the skin looked and the track looked as far as..

S: Just very, very minimal damage. Really minimal tissue damage.

B: Not much bleeding?

S: Right. Right.

B: And you explored down to the, looked at the blood vessels...

S: Right.

B: without necessarily seeing a hemorrhagic track?

S: That's right. Minimal damage, which I think we described in there as very minimal.

B: The other point about...

P: If I could ask how large was it? Do you think the one centimeter in your report is an accurate description of how large the wound in the thigh was?

S: That's what I said.

B: That's the depth of the track, Andy?

S: No. The tangential wound.

B: Tangential wound. One centimeter.

S: I described...

B: On the skin surface.

S: Right.

B: The other thing I thought would be of value is just a brief recollection that we discussed briefly before, about exactly where you were when this happened, how you, the time it took you to get to the operating room?

S: As to why I got in sort of after the others were in progress?

B: That's, yes, where you, as chief of service were, and when..

S: Yeah, the meeting of a national surgical organization, the Western Surgical Association, was meeting in Galveston, as it happened that year. This organization meets in different cities all over the country each year, and after giving a paper at that meeting that morning, I got a telephone call from Dr. Shaw, who's a thoracic surgeon, that operated on the Governor, telling me what had happened, about the President and the Governor, and saying that they were, that they had three areas of injury and they were beginning to operate on the one that was the most pressing, which was the thoracic injury, and hoped I could get back and shortly after that, some calls were made in Galveston and the Air Force actually picked me up and took me back to Dallas. So when I got to the oeprating room, the first, the President had already, body had already been removed and the two other procedures were well along, the thoracic and the orthopaedic procedure, and then this third procedure was started to make certain there was no significant vessel injury.

B: The other part about it, would you have any comment for the record, as to your recollection about the forensic

pathological aspects of what happened as far as the removal of the body, and...

S: Not firsthand, it was all resolved, hearsay. In talking to the pathologist, he thought the autopsy should have been done by him there at the time and apparently made his feelings well-known to them.

B: This was the forensic pathologist..

S: There, at the hospital..

B: Who was..., at the hospital..

S: Dr. Reynolds, who really thought that it should be done immediately, and apparently it was decided, superceded and the body was taken to Washington.

P: Any other comments or questions? (Pause)

F: Is everything over now at this time?

P: Yeah. Just...

F: The time is now 4:14. This taping session has been concluded.