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STATE OF ILLINOIS)
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COUNTY OF C O O K)

ORIGINAL

IN THE CIRCUIT COURT OF BROWARD COUNTY,
17TH JUDICIAL CIRCUIT
BROWARD COUNTY, FLORIDA

BRYAN CORT, et al.,

Plaintiffs,

-vs-) No. 94 - 9230 (18)

BROWARD COUNTY SHERIFF'S DEPARTMENT, et al.,

Defendants.

The evidence deposition of FRANK J. BAKER, 11, M.D., taken before Elizabeth R. Mala-Skwarek, Certified Shorthand Reporter and Notary Public, pursuant to the provisions of the Rules of Civil Procedure of the State of Florida and the Rules of the Supreme Court at 6155 North River Road, Rosemont, Illinois, commencing at the hour of 9:10 o'clock on the 15th day of August, A.D. 1997.

INDEX

EXHIBITS

WHEREUPON:

FRANK J. BAKER, 11, M.D.,

called as a witness herein, having been first duly sworn, was examined upon oral interrogatories and testified as follows:

THE VIDEOGRAPHER: This is Kathleen Dominiak of Legal Video Services, Incorporated, 3180 North Lake Shore Drive, Chicago, Illinois.

I am the operator of this camera. This videotaped deposition of Dr. Frank Baker, III, (sic) is being taken pursuant to Florida Rules of Civil Procedure in 6155 North River Road, Rosemont, Illinois, on August 16, 1997, in 9:10 AM as indicated on the video screen.

The case is captioned Cort, et al., versus Broward County Sheriff's Department, et al., Case No. 94 - 09230 (18).

Would the court reporter please identify herself and swear in the witness?

THE COURT REPORTER: My name is Lisa Mala-Skwarek.

(Witness duly sworn.)

WHEREUPON:

FRANK J. BAKER, II, M.D.,

called as a witness herein, having been first duly sworn, was examined upon oral interrogatories and testified as follows:

THE VIDEOGRAPHER: Counselor, would you please identify yourself for the video record?

MR. LUCAS: My name is Paul Lucas. I represent the plaintiffs, and I will be taking this deposition for purposes of trial today.

MR. JOLLY: I'm Bruce Jolly, and I represent the defendant sheriff.

THE VIDEOGRAPHER: Thank you. Please proceed, sir.

DIRECT EXAMINATION

BY MR. LUCAS:

Q. Doctor, for the record, **would** you please state your full name?

A. Dr. Frank Baker.

Q. And what is your business address?

A. My business address is 3249 **South** Oak Park Avenue in Berwyn, Illinois, which is

MacNeal Hospital.

Q. What do you do in that hospital?

A. I am an emergency physician.

Q. How long have you been an emergency physician?

A. I have been an emergency physician since 1974.

Q. Doctor, could you please tell us exactly what an emergency physician is?

A. Sure. An emergency physician is an individual who practices emergency medicine.

Emergency medicine is the specialty that involves seeing patients in the emergency department and it really encompasses seeing or taking care of the initial diagnosis, treatment, and management of all patients who present to emergency departments.

Q. Now, Doctor, would you be considered in the primary or first line of medical care to those who are requiring your services?

A. Yes, sir.

Q. Do you then refer patients who need additional care or secondary care to other physicians?

A. Yes.

Emergency physicians generally will do one of two things. They will either primarily provide care to the patient and discharge the patient to be followed up by another physician, or they will provide initial management and subsequently admit the patient to another physician in the hospital, usually a specialist of one sort or another to provide definitive care for the patient.

Q. Is it fair to say that one of the tasks that you have -- or dual tasks initially is to diagnose and stabilize patients when they come to you?

A. Yes, sir.

Actually, the very first thing that we do in emergency medicine is to define whether or not there is a life threat.

My job is to define whether there is a life threat and stabilize the life threat sometimes even before making a definitive diagnosis in order that we can keep the patient alive long enough for us to make a diagnosis and to obtain the services of other specialists to

provide definitive care for the patient.

Q. This case is going to involve what might be considered an orthopedic or neurological injury that was suffered by Brian Cort.

Are neurological -- I mean neurosurgical physicians and orthopedic physicians/surgeons, are these generally considered first line physicians or primary care physicians?

A. No, sir.

Orthopedic surgeons and neurosurgeons are not first line or primary care physicians. It is very unusual for them to see the type of injury that Mr. Cort had initially.

Usually the patient is seen by another type of physician, usually an emergency physician, who makes the initial diagnosis and then requests the consultation of a specialist such as an orthopedic surgeon or neurosurgeon.

Q. Now, in a previous deposition you indicated that you did not perform orthopedic or neurological surgery in your present occupation; is that correct?

A. Yes, sir. That is true.

It is my job to keep the patient alive long enough for the orthopedic surgeon or neurosurgeon to take the patient to the operating room or to the intensive-care unit to provide the definitive care.

Q. Notwithstanding that fact, are you required still to have the same basic knowledge of anatomy, physiology, the knowledge of the muscles, bones, the vessels than an orthopedic or a neurological surgeon would?

A. Well, we have fundamentally the same background and training in anatomy. Obviously because they operate in the area, their knowledge of the anatomy is considerably more detailed than that of the emergency physician.

What we need to know is just enough to be able to make the diagnosis in order to obtain the services of the specialist.

Q. Does your background include hands-on experience with a patient?

A. Oh, sure.

I have been taking care of patients actively in the emergency department

since 1974. Actually, part of that was since finishing school in 1971.

Q. Can you estimate in all how many patients you have seen with neurological, neurosurgical orthopedic injuries?

A. Not with any significant accuracy.

I have seen dozens of patients with fractured cervical vertebrae, that is, broken necks.

I have seen thousands of patients with orthopedic injuries because that's a very common presentation to the emergency department.

Q. Doctor, I notice that in your background that you have been board certified in a certain number of areas. And before I go into your college education, I would like to discuss that first.

Explain to the jury, if you will, what board certification means?

A. Board certification means that your colleagues have recognized that you have some special expertise in the area in which you are board certified.

Board certification, generally

speaking, requires that you meet some criteria for sitting and taking an examination and that you subsequently take and pass that examination.

Some of these examinations are written, some of them are oral, and some of then are both, and occasionally the examinations are are waived if you have preeminence in a field.

Q. I notice that one of the first boards which you had taken and passed apparently was internal medicine.

Could you explain what that is?

A. Internal medicine really is the specialty that covers all the diseases that are fundamentally nonsurgical. They involve adults rather than children and they do not involve obstetrics.

Q. Another area was the emergency medicine, and I think you have explained that, but you also have indicated that you are a member of the Board of Forensic Examiners and Forensic Medicine.

Can you explain what those are?

A. Sure.

I'm a diplomat of the American Board of Forensic Medicine. Forensic medicine is the science of the sort of interplay between medicine and law.

It involves areas such as one frequently sees in the emergency department where a crime has been committed and it is our job as physicians to be able to identify the medical aspect of the particular crime.

The American Board of Forensic Examiners is a much larger group of people. It consists of individuals who have specialty interests in a nonmedical area who also deal with the legal system such as forensic accountants and auditors, accident reconstruction specialists, people who deal with causes of accidents, and other issues that interplay with the legal system.

Q. Prior to passing these boards, I assume that you had to obtain a college and medical education. If you would explain what your educational background is?

A. Yes, sir.

In order to go to medical school

you have to have either three or four years of college. I have a Bachelor of Arts degree 'in chemistry from Elmhurst College in Elmhurst, Illinois.

I subsequently went to Loyola Stritch School of Medicine which is in Chicago. I graduated in 1971.

Subsequent to that, I did three years of specialty training in internal medicine at the University of Chicago. I completed that in 1974, after which time I joined the faculty at the University of Chicago with a co-appointment in the newly formed Department of Emergency Medicine with a co-appointment in internal medicine.

Q. Doctor, I also notice that you obtained a Master's degree. Can you explain what that was in?

A. Yes, sir.

While I was on the faculty of the University of Chicago in 1977, I became the department chairman. As a department chairman, I was responsible for a multimillion dollar budget and at that point decided that I needed

to get some business training.

So I obtained a Master's in Business Administration, an MBA, from the University of Chicago Graduate School of Business.

Q. It is my understanding that while you were at the University of Chicago on the faculty you were an assistant professor and then an associate and then the chairman of the department?

A. And then a full professor as well.

When I had left the university after being the chairman of the department for ten years, I had been promoted to a full professor in both the Department of Emergency Medicine and the Department of Internal Medicine.

Q. Notwithstanding the fact that you were an academician in least to the extent that you were teaching students at the University particularly in medicine, you continued to -- your practice with hands-on care to emergency room patients?

A. Oh, sure. A part of being a clinical

faculty, that is, a physician in a medical school includes the fact that you will cont'inue to give patient care.

Most of the teaching is not done in the classroom. That's a very small part of the teaching of medical students in their third and fourth year as well as resident staff.

Most of that teaching is done at the bedside involving real patients.

Q. Now, I am going to ask you to review in just a moment the CV which you provided to us to see whether it is current, but if I am correct this CV indicates you taught a number of different courses involving some aspect of emergency room medicine, about 15 courses; is that correct?

A. Yes, sir.

Q. And involving cardiac life support courses, an additional 29 courses?

A. Yes.

Q. And panel discussions with other physicians approximately 15?

A. Yes.

Q. I understand you have also coauthored

an emergency medicine textbook?

A. I am a coauthor, a coeditor of an emergency medicine textbook, yes.

Q. In least two volumes of that?

A. Two editions.

Q. Two editions?

A. Of that textbook one released in 1983 and another one was released in 1987.

Q. And journal articles, if I read correctly, approximately 20 of those in areas involving emergency room medicine?

A. Yes, sir.

Q. And lectures and scientific presentations, something like 139?

A. Yes.

Q. I want to ask you if you could look this over and see if this is an accurate copy of your CV. And if it is, we will mark it as Exhibit A for the plaintiff to this deposition.

A. Yes, that's an accurate copy that was last revised in January of this year.

(Said document was marked for identification as Plaintiff's Exhibit Number A.)

BY MR. LUCAS:

Q. Doctor, our firm employed you in this case involving Brian Cort versus the Sheriff of Broward County, did we not?

A. Yes.

Q. And could you please explain to the jury essentially what we asked you to do when we did employ you?

A. Well, you asked me to review the circumstances that occurred between the 11th of March, 1993, and roughly the 13th of that month, a period of about 48 hours, during which time Brian Cort was incarcerated in Florida.

I was asked to look at the case specifically vis-a-vis an explanation of the circumstances of how it was that Mr. Cort walked into a correctional facility under his own control and subsequently became paraplegic and eventually a quadriplegic when he was discharged on the 13th of March some two days later.

Q. Did we ask you to evaluate the probable cause of what caused the broken neck, particularly in the C5 level of the neck?

A. Yes.

MR. JOLLY: Let me just object, leading.

BY MR. LUCAS:

Q. Did we ask you to discuss any effect that a delay in treatment from the original injury until his release from the hospital might have had upon Brian Cort, injury and recovery?

MR. JOLLY: Same objection.

THE WITNESS: Yes.

BY MR. LUCAS:

Q. Doctor' before I ask you the next question, I'm going to give you some hypothetical facts and I'm doing that, and I'll explain that to opposing Counsel, because we're not sure exactly when this deposition will be shown in the course of a trial.

And to give some background from our viewpoint, I want you to assume the following facts to be true.

Assume for the purpose of the following questions these facts to be true: On March 10, 1993, Brian Cort was arrested for a misdemeanor and placed in the custody of the Broward County jail late that evening.

He was in good physical condition and he was ambulatory, although asked and requested that he be held over for a psychological evaluation in a special cell of the jail.

He was instead placed in the general population. He remained in the general population and in good health for approximately 17 hours.

In about 5:00 PM on March 12 -- March 11, 1993, he was transferred to the stockade, a separate holding facility of the Sheriff of Broward County and he arrived in good physical condition. He was walking, talking, ambulating.

In some time between 5:30 PM and 7:00 PM after changing into an orange uniform and being asked to strip search and before being placed into the general population of the stockade, Brian Cort suffered an injury that caused multiple fractures of his cervical vertebra number five.

Assume also that no medical attention was given to Brian Cort for this

injury until approximately 12:30 PM on March 12, 1993, some 12 to 18 hours later.

Assume that during that time Cort was not stabilized in any way, that he was moved by stretcher or wheelchair by deputies on several occasions moving the neck, shoulders, all four extremities, and the spinal column over a period of 12 to 15 hours.

Assume that he was not then taken to a hospital for yet another 12 hours. Finally assume that when finally operated upon by a neurosurgeon, a well-developed epidermal hematoma was found in the spinal column, that subluxation had occurred on the C4, C5, and C6 levels of the spinal column, that bone fragments from the C5 vertebra and the epidermal hematoma were compressing the spinal cord.

Assume there was no compression of the bone indicating a compressive fracture but there was retropulsed fragmentation of the bone impeding upon or compressing the spinal cord.

Now, later we may have give additional facts or additional questions, but

assume those facts to be true.

With that in mind, could you' please give the Court your opinions and the jury the opinions that you have formulated.

MR. JOLLY: Let me make my objection. Number 1, the predicate. Number 2, it is a -- the hypothetical which you are being asked to provide is based upon an incomplete and inaccurate factual scenario. Number 3, qualifications. Please continue.

THE WITNESS: Well, there is some differing testimony regarding the circumstances during part of the period preceding the recognition of the injury.

There is no question but that a review of the records shows that Mr. Cort was, indeed, ambulatory and was capable of walking when he entered the facility.

And there is also no disagreement that subsequently when he arrived eventually in a hospital he had a fracture of one of the vertebral bodies, that is, the bones in his neck, the spine, which basically had been pulverized and was in many fragments.

The question comes up as to how these injuries occurred, and there is some disagreeing testimony about how and when they could have occurred.

Mr. Cort has said that he doesn't remember anything, in least in his deposition, anything after he was taken out of the general population for the purposes of taking him to a special cell for a strip search.

His mother states that when she first talked --

MR. JOLLY: Let me object to anything that the mother has said. Please continue. It is hearsay.

THE WITNESS: His mother --

MR. JOLLY: I understand. Re is going to go forward. I made my objection.

MR. LUCAS: Okay.

THE WITNESS: His mother has stated in her deposition that when she first talked to her son that he related that he had been kicked and beaten some time during that period when he was supposed to be strip searched.

The deputies at the correctional

facility have testified that he was walking and walked into a van sometime around 5:00 o'clock on the afternoon of the 11th in that he was in the van by himself, that there was some commotion in the back of the van related to his apparently striking himself against the side of the van allegedly with his shoulder, or in least that's what was reported, and that the van was subsequently turned around actually without leaving the stockade or correctional facility.

And when the van was opened up, he was on the floor, not responding, and had to be physically carried out of the van.

Taking those things into consideration, the question comes as to exactly when and what kind of an injury he had.

After reviewing the testimony of all the individuals involved and reviewing the x-rays, I think it is unlikely, highly unlikely, that he had a vertical compression fracture from axial loading of his cervical spine, that is, his spinal column in his neck that could have resulted simply from his butting his head against the back of the inside of the van.

The inside of the van is constructed in a way in which there is a chain linked fence type of material backed up by Plexiglas.

And had he broken his own neck by butting his head on the inside of the van, one would have expected to see damage in the way of lacerations and blood under the skin called a hematoma on the head, and no such injuries were ever described.

The other two mechanisms of injury that are in least potentially the cause of his eventual broken vertebral body would be a blow from the front of the neck or a blow from the back.

A blow from the front of the neck to cause the substantial injury to his -- the bones in his neck would require that the soft tissues of the neck, including the trachea, would sustain some damage.

There was never any damage observed, and that particular area of the neck was, indeed, seen by several physicians, including the emergency physician, Dr. Isaacson.

who first saw him on the 13th and the neurosurgeon who eventually did the neurosurgery from the front of the neck also done on the 13th, Dr. Gelbard.

The other possible mechanism of injury would be from the back, again, both being done with a blunt object -- I'm sorry, the back of the neck.

Such an injury would cause bruising to the back of the neck but could easily fracture the vertebrae involved because there are only muscle and skin separating a blunt object from the vertebral body and one wouldn't have to do any lethal damage to other structures such as the trachea or windpipe.

That area was never examined by a physician until sometime around when the definitive surgery was done in that area of the neck which was the 18th, some one week later.

And Mr. Cort is an Afro-American, and it is possible that it would be difficult to see bleeding under the skin, the usual black and blue mark in an individual who is, indeed, black.

Taking all of the evidence as it presents itself, and I am talking about the medical evidence, into existence, I think it is most probable that this injury resulted from a direct blow to the back of the neck.

I'm unable on the basis of the evidence that I have been presented to tell you exactly when that occurred or how it occurred, but I think this is highly unlikely to have been a head butting vertical compression injury.

The other specific issue that I was asked to look in was whether or not any delay in receiving definitive medical care caused or contributed to his current injuries.

There is considerable evidence presented by many deputies that after the initial injury that was reported in the van that he was unable to move his legs, but, indeed, was able to move his arms.

And, in fact, Nurse Hinson who did an examination of him at the time reported that he was able to move his arms when she tried to shine a light in his eyes.

Subsequently, he was transferred

to a psychiatric holding cell where he wasn't reexamined by a physician or other medical personnel for another 18 hours, during which time he basically laid on the floor, begged for water, begged for food, requested that he be taken to an infirmary and was ignored.

During that period of time, he clearly got worse. His injury progressed from being a simple paraplegia involving just paralysis of his legs to the point when he was finally taken to the hospital he was noted to have paralysis of not only his lower legs but most of his upper extremities as well with possibly the exception of the ability to move some fingers or maybe his wrist.

That 18-hour delay in his receiving definitive care was, I think, a major part in producing his current clinical condition in which he is now quadriplegic and he is unable to move his arms or legs.

BY MR. LUCAS:

Q. Doctor, during your recitation, you mentioned once or twice and you referred to a couple of the items on which you relied such as

x-rays and reports.

This might be a very good time to ask you exactly what it, was what things did you review in arriving in your opinions?

A. Well, I reviewed the depositions of Brian and his mother and his wife. I have seen the depositions of many of the deputies. I have, in particular, seen the depositions of deputies who were responsible for driving the van that was to take him from the stockade back to the main jail.

I seen the depositions of some of the deputies who carried him out of the van. I have seen the depositions of deputies who brought him subsequently in a police car from the stockade eventually back to the main jail.

I've seen the depositions of deputies who subsequently carried him into a wheelchair and discharged him from the jail facility by literally placing him on the ground outside and eventually placing him in his mother's car, a period of some about 24 to 36 hours during in which time he was unable to walk.

I have seen the prison health records. I have seen the records of the investigations that were done by the Sheriff's Department.

I have seen the emergency department records from when he was first taken to an emergency department on the 13th by his mother after release from the detention facility.

I have seen the depositions of Dr. Isaacson, the emergency physician, during that first visit, of Dr. Schultz who eventually provided the general surgical care for him, of Dr. Gelbard, who was the neurosurgeon, and of another physician who is a specialist in rehabilitation who has subsequently been involved in his care.

Q. Now, Doctor, earlier *you* mentioned that in your opinion the more probable cause of the injury was a blunt blow to the back of the neck or a blow with a blunt instrument.

What do *you* mean by a blunt instrument? What could that include?

MR. JOLLY: Objection, predicate. Go

ahead.

THE WITNESS: What we are really talking about is that we differentiate sharp piercing objects from blunt trauma, that is, penetrating versus blunt trauma.

Blunt trauma can be caused by any blunt object anywhere from a pipe to a fist to a baseball bat to a black jack. I mean, there are all sorts of things that can cause damage to the neck, but we are talking about instruments that are not going to break the skin or penetrate the skin.

BY MR. LUCAS:

Q. Would that include any type of -- the use of the hands by somebody trained in martial arts?

A. Oh, sure.

Q. Would that include a baton or something wooden?

A. It could.

Q. Doctor, before we go further, I want to say up to this point the medical opinions which you have offered have been stated within a reasonable degree of medical probability, that

being the standard that is used in the State of Florida?

MR. JOLLY: Objection, form, leading. Go ahead.

THE WITNESS: Yes.

BY MR. LUCAS:

Q. You mentioned that Brian Cort has been seen by Sue Hinson.

In the record, was there any indication in all that when Sue Hinson, the nurse, saw Brian Cort that she was ever informed by anybody that he could not walk?

A. There is no indication in the prison records that she knew he couldn't walk, and she denies in her deposition that she wasn't told he couldn't walk.

Q. Is there any indication of what she was told concerning his injury?

A. Yes.

She says specifically, both in prison records and her deposition, that she was told he had hit his shoulder against the inside of the van.

Q. Was there an indication of how this

chart that there were no signs in all whatsoever of any injury.

Q. Doctor, with the understanding that we are dealing with probabilities, reasonable medical probabilities, not certainties according to Florida standard, if they're more probable than not that had medical care been given to Brian Cort in an early stage that it would have improved his chances of surviving a paraplegic, perhaps even not suffering it permanently, and, secondarily, not suffering quadriplegia?

MR. JOLLY: Objection. An opinion is being sought based upon an incomplete and inaccurate hypothetical in addition to that predicate and in addition to those qualifications.

Please continue, Doctor.

BY MR. LUCAS:

Q. And let me -- at this point we re asking here a medical opinion based on your. medical knowledge of research concerning cases of this kind and rapid recovery versus slow recovery including but not limited to

Brian Cort.

MR. JOLLY: Same objection.

Go ahead, Doctor.

THE WITNESS: There are two things that I think are clear. One is that the permanent damage that results from an injury to the spinal cord is partly a result of the direct blow but also partly a result of what occurs on a cellular level associated with swelling and edema subsequent to the injury.

For that reason, we treat such patients with a drug called Methylprednisolone, which we know in 20 percent of the cases will substantially improve the patient's outcome.

In this case, there is an another factor, and, that is, that subsequently when Dr. Gelbard performed surgery on the spinal cord he found an old blood clot.

The old blood clot was compressing the spinal cord and had that blood clot been evacuated early or, indeed, had the patient been treated in such a manner that that bleeding did not occur, more likely than not he would not have suffered the extensive injuries

that he currently suffered.

There was clearly a period of time when he was only paraplegic and subsequently got worse and became quadriplegic. Early intervention may well have prevented the development of the quadriplegia.

BY MR. LUCAS:

Q. In cases in which broken necks, broken vertebra, are not stabilized, are not diagnosed, are not treated in an early stage, what is the probability of their causing long-term permanent damage?

MR. JOLLY: Objection. Form, leading -- it is not leading.

Objection, it is asking for an opinion based upon an incomplete and inaccurate hypothetical. It is vague, qualifications.

Please answer, Doctor.

THE WITNESS: Very high actually.

In this particular type of an injury in which we have an unstable fracture, that is, we not only have a broken bone but we have a broken bone with many pieces that can move around and in moving around can cause

compression of the spinal cord which runs down the middle of the vertebral column.

It is the subsequent movement of this that can cause just as much damage as the initial injury.

This is a patient who has a bone in his spine, a vertebra, that was broken into so many pieces that it could freely move about.

In a patient such as this in order to prevent additional injury, what we do is to immobilize their neck, and we do so by putting them on a backboard and taping their head down and using various kinds of devices to make sure that they can't move their head to the side, they can't flex it, and they can't extend it.

This did not occur in his case until he finally was taken by his mother after discharge to the hospital.

There are many descriptions in the prison records concerning how he was moved from one place to another. He was lifted by his arms and legs, presumably with no support or certainly not adequate support for his neck and

head.

So it is clear with this type of an unstable fracture additional injury most certainly occurred as a result of subsequent movement without protection of his neck.

BY MR. LUCAS:

Q. Doctor, I am going to ask you what we will mark as Plaintiff's B and C, which are two Broward County Sheriff's office standing operating procedures, 7.12 and 7.123.

While you look in those, I am going to also ask you to assume the following to be --

MR. JOLLY: What exhibits are those?

MR. LUCAS: Plaintiff's B and C.

MR. JOLLY: The CV was not an exhibit?

MR. LUCAS: That was A.

MR. JOLLY: Got you. I thought there was one more in between.

MR. LUCAS: Not yet.

(Said document was marked for identification as Plaintiff's Exhibit Numbers B and C.)

BY MR. LUCAS:

Q. I'll go ahead and read this while you look those over.

Now, Doctor, assume that the Sheriff of Broward County, based on his published procedures, number 7.12 and 7.123 has established policy, quote, "To provide proper care and protection to inmates who are mentally, physically, or developmentally disabled by direct communication between detention personnel and medical personnel when an inmate is suspected as having a physical disability and to determine a course of action for treatment or the handling of the inmate by referring the disabled to an appropriate community service agency or facility, when necessary, by health appraisal procedures by monitoring as to their adaptation to the correctional environment."

In this assumed environment, I'm going to ask you several questions concerning the deputies.

First, did Deputy Young meet even a minimal standard of care when she, according to her testimony, saw Brian Cort enter the van

on his own two feet under his own volition, and, again, by her own testimony, saw him being carried out by two deputies into a holding cell next to the loading area of the stockade?

MR. JOLLY: Objection, predicate. Objection, it is an incomplete -- it presupposes an incomplete and inaccurate hypothetical.

Number 3, the standard has not been asserted from which you wish him to make the -- from which you are asking him to make the evaluation, and, therefore, there is an improper predicate. Go ahead.

BY MR. LUCAS:

Q. Before you go on, let me ask one other question.

I take it, if I remember correctly, you said that you read the deposition of Deputy Young?

A. Yes.

Q. And you have also read the records from Prison Health Services, Inc., pertaining to the medical care of this particular individual?

A. Yes.

Q. And you have also read the depositions

of other deputies who surrounded Brian Cort during the time he was going through this ordeal?

A. Yes.

Q. Now, I have also given you the standards that have been set down in policy by the Sheriff, have I not?

A. Yes.

Q. Then in order to clarify the question, I would like you to answer that question as to does it meet the standards that are set down by the policy; two, does it meet the standards of any common sense humane approach to one human being to another; and, finally, does it meet any minimal type of medical standard that even a layman would have to adopt?

MR. JOLLY: Same objections that I made before, plus, relevancy. Please continue.

THE WITNESS: Well, first, the policy which is entitled, Disabled Inmate Care, 7.12, requires that she communicate this presumed injury or the change in his status from being ambulatory to not being ambulatory to appropriate personnel.

That appropriate personnel in this particular case would be Nurse Hinson 'that claims she was only told about a shoulder injury and was never told he could not walk.

Secondly, she should have, just using common sense, realized that this was a presumed injury that, indeed, he walked into the van and now he is not only no longer walking but is lying on the floor of the van and not responding.

She should have made the presumption that that was an acute medical problem, that it was, indeed, a traumatic injury, and should have appropriately tried to obtain medical care.

What happened is that instead of his getting immediate medical care and having paramedics or other trained personnel remove him from the van, a group of deputies literally carried him out of the van by hands and feet, and that was an inappropriate way for them to proceed.

They, as well, should have realized that Mr. Cort was injured and that this

was not an appropriate way of removing a patient from a circumstance such as this.

I mean, these people are trained in accidents. They know about the approach to auto accidents. They know about stabilizing people. They know about calling the paramedics in. They are people who are trained to deal with accidents, presumably both inside the prison as well as outside the prison.

And, clearly, this did not conform with any training that law enforcement agencies give to their people regarding traumatic situations.

BY MR. LUCAS:

Q. Doctor, did the two deputies who carried Brian Cort to the automobile on the second trip he was making to the county jail, transporting him to the city jail, finding and locating a wheelchair because he could not walk, reporting that none of his extremities were working including his arms, and then refusing or in least not communicating with any medical personnel when they arrived, violate those same standards that we just discussed with

Deputy Young and other deputies?

MR. JOLLY: I'll assert the same objections that I made before as to the prior hypothetical seeking the prior opinions in terms of predicate, the factual background for the opinions, for the asking of the opinions, as well as the relevancy.

THE WITNESS: Yes, for the same reason that these individuals are trained in public safety.

And while they may not be paramedics, they are certainly trained in knowing the circumstance under which they should call paramedics to provide care.

They are not even ambulance drivers, but confronted with an individual such as this they certainly should know that this patient needs not only acute medical attention but they certainly aren't qualified to physically move the patient from one place to another because of the possibility of causing them additional damage.

BY MR. LUCAS:

Q. Doctor, remembering also that you have

read the deposition testimony of these deputies and medical records and Prison Health Service records, did the Sheriff's deputies in ward cell 2-C, that is, the psychological ward at the main jail, Broward County Jail, act reasonably with any standard of behavior as we have previously discussed when they refused Brian Cort food and water on request, when they refused his request for movement to the infirmary for over 12 hours, when they required him to cross the floor to get water if he needed it, and by ignoring his reports that his legs would not move and he was not able to move his lower extremities and his arms were becoming numb?

MR. JOLLY: Objection. It is not -- relevancy, predicate, qualifications, and the opinion is based upon an incomplete and inaccurate hypothetical.

And the basis for the opinion, the standard which is to be applied, has not been established.

With that, have at it.

BY MR. LUCAS:

Q. We have already discussed most of

those, but I just want you to at any time, Doctor, if you find that these questions are contrary to the information or facts that you have read from the records that you have read, by all means correct me and make any changes that are necessary.

A. The facts, as you have just outlined them, I think are not contrary to any understanding that I have from reading any of

matter.

It is -- it is certainly not acceptable for human beings in general to ignore the cries and pleas of other human beings for food and water.

In this particular circumstance, though, we are not talking about just people without training. We are talking about public safety officers who know about these kinds of things. I mean, they have been taught the circumstances under which they need to call in medical personnel.

These are the people who are the first responders to accident sites of all sorts,

and those sorts of accidents can range from auto accidents to fires to earthquakes to floods.

And, you know, these are the people that we depend upon to respond. And even though they are in the detention facility, that's their full-time job.

Now, these are people who are basically public safety officers. They have more than the usual citizens' obligation to respond when a citizen is in trouble. That's what they have chosen to do in life, and they have, you know, totally ignored that in terms of their treatment of Mr. Cort during those periods of time when he was begging for food, water, and medical care in terms of being taken to the infirmary.

Not only did they not meet the standards that are set up for them, but I find that their behavior was particularly egregious.

MR. JOLLY: Objection, not responsive. Move to strike.

BY MR. LUCAS:

Q. Just to cover one thing, why would you say that the behavior is egregious, and what do

you mean by that?

MR. JOLLY: Objection, relevancy. Objection, that's an opinion which is far beyond the scope of his capability. Please continue.

MR. LUCAS: I disagree with that. We will deal with that later.

MR. JOLLY: I know, Paul.

MR. LUCAS: I realize that.

THE WITNESS: Well, what I mean by that is that I think it is particularly cruel. I think it certainly is not only behavior that I don't expect from public safety people, I don't expect this from the average citizen walking out on the street.

I mean if you saw this kind of individual sitting down in the lobby of the hotel, I would not expect any person to walk by them and simply ignore their cries for help.

But when you are talking about people who are trained as public safety officers to respond to public needs, this becomes a particularly cruel act.

BY MR. LUCAS:

Q. That will be on all that particular

item, Doctor.

THE VIDEOGRAPHER: Off the record in 10:04.

(Whereupon a short break was had.

THE VIDEOGRAPHER: Back on the record at 10:05. Please proceed.

BY MR. LUCAS:

Q. Doctor, I have two additional questions that relate to different parts of your testimony.

First, we have discussed the harm that delayed medical care caused Brian in terms of his original injury and his development of quadriplegia.

However, if at any time during those first few hours of injury, the first hour, the second hour, the third hour, or the sixth hour, or the seventh hour he had been given proper care and been brought to proper medical attention, could that have made an improvement in his condition within a reasonable degree of medical probability?

MR. JOLLY: Objection, predicate.

Objection, qualifications. Objection, it .is asking for an opinion or calling for **an** opinion based upon an incomplete and inaccurate **hypothetical.** Please.

THE **WITNESS: Yes.**

BY MR. LUCAS:

Q. The second question is I wonder if you can just briefly describe or show to the jury by a drawing or any way that you wish exactly what type of injury occurred in that C5 level when the original fracture occurred as you can either see from the x-rays or just by explanation?

Let me explain what I mean by this. You have already stated that there **was** fragmentation, that there were several pieces of bone. You have indicated that the direction, most likely, was from a blow **from behind.**

But could you explain that so that the jury can really explain what happened to that vertebra'when it was first broken?

MR. JOLLY: Same objection, qualifications and predicate, but please continue.

THE WITNESS: We are not going to be

able to look at the x-ray on the video. So as best I can do, maybe we can make a sort of crude drawing and I am not an artist.

Let me draw something out here and we will see if we can kind of represent what is on the x-ray.

What we are talking about on the x-ray is -- on x-rays that are numbered C-002 through C-005, and I am drawing as best I can, realizing that I'm a terrible artist, what this x-ray looks like.

That's what a vertebral body in this case looks like, that is, that's what this particular fractured C-5 vertebrae looks like on x-ray.

This part down here is called the vertebral body and the rest of this is called the neural arch, and the vertebral body ordinarily should be perfectly round and not have this v-shape in it.

The v-shape on the x-ray represents a fracture. There is another fracture on the x-ray which basically goes in this direction down here.

So that's a fracture of the vertebral body, and, actually, there are other pieces in there as well that is consistent with several different kinds of mechanisms

The neural arch is this part here And where these two pieces do not meet here, these two pieces should be lined up And I have drawn it where you can see me drawing this wavy line where there is a fracture on both sides of the neural arch.

The fact that this bone is fractured and this bone is fractured here makes this an unstable fracture That means that movement of the head or neck is going to cause these things to move around in a way in which they injure the spinal cord.

Now, let's see, maybe you can give me that yellow marker and I will sort of show you where the spinal cord is

The spinal cord -- Miss, can you see the yellow on there? Okay

The body of this -- this is the front of the body and this is the back of your neck This is the front of your neck This big

bone is called the vertebral body, and the neural arch is behind it toward the back of your neck.

And in between those two things is a cavity, and that cavity is the spinal canal and inside the spinal canal runs the yellow spinal cord.

And what happens is that when you bre'ak these bones, these bones then impinge or touch directly bruising the spinal cord.

What also happened in this case on -- let me have one of your black pens there and we will draw in where there was additional bleeding which occurred.

There is bleeding in this area of the spinal cord or the spinal canal which not -- which in addition to the damage caused to the spinal cord by these bones caused additional damage to the spinal cord, the yellow, by compressing, by putting pressure on it.

So that's what you can see from the CT scan that was done on the 13th in the first hospital, Florida Medical Center, where he was taken by his mother.

BY MR. LUCAS:

Q. Thank you very much.

Doctor, we will mark this drawing as Plaintiff's D, and we will conclude this portion for the examination at this tine.

MR. LUCAS: Let's go off while they are marked.

THE VIDEOGRAPHER: Off the record in 10:12.

(Whereupon a short break was had.)

(Said document was marked for identification as Plaintiff's Exhibit Number D.)

THE VIDEOGRAPHER: Back on the record in 10:14. Pleasé proceed.

C R O S S - E X A M I N A T I O N

BY MR. JOLLY:

Q. Dr. Baker, I'm Bruce Jolly. We have met before, obviously.

In this case before I ask you any further questions, would you refer to the x-rays that you have reviewed, would you refer to the CT scan and identify them so that we can be

reasonably confident later that the ones to which you -- the ones upon which you have relied to this point will be the ones that the jury will eventually see.

They are not being marked. They are not going to be attached, but I want you to have some -- there to be some reference point?

A. Yes, sir.

Of the films of the neck, that is, the lateral C-spine x-rays, there are two such films, and the only one that's readable is the one that has hand markings on it that say number 27, cross table lateral. So that differentiates those two films.

The CT of the scan -- the CT scan of the neck that I'm talking about in the top right hand corner has a series of numbers right underneath Brian Cort's name.

The first number is 23429 which appears to identify the patient, because it is present on all of the slices, but then each slice is identified by a separate number right next to it.

This particular film, the first

two images are marked in this corner 00 -- they are marked C-002, C-003, and C-004, and there is one more image that has -- on a different film has C-005.

Q. How many x-rays have you reviewed?

A. There are only two x-rays here and there is one CT scan consisting of six films.

Q. Six?

A. Yes.

Q. Have you reviewed each of the CT scans?

A. You mean of these films?

Q. The six separate films.

A. Yes.

Q. Are you aware of whether there are any other x-rays which are in existence which you haven't reviewed?

A. I believe there is an MRI that was taken in some point in time including a myelogram, CT myelogram, that was taken in North Broward, which is where his neurosurgery was performed after transfer from the Florida Medical Center, and it is my understanding that those x-rays and MRIs are lost.

Q. The CT scans that y'ou have reviewed, the films one through six, am I right on that? Do they show different things?

A. Oh, sure. They show different vertebral bodies. I mean, some of them are normal and some of them aren't.

Q. So the CT scans which show abnormalities are contained in CT scans two, three, and four?

A. Two, three, four, and five.

There may be some other abnormalities on some of the other scans. I was just looking primarily for the major injuries.

Q. And when the CT scans are numbered two, three, four, and five, it represents a scan of the vertebrae in that level --

A. No.

Q. -- two, three, four?

A. No.

There is another film that references where the slices were taken, and there is a single picture which will show all of the slices that were taken, and each of those slices is marked by a white line and a number

that identifies it.

Q. Are there any CT scans of which you are aware that are in existence which you have not referred?

A. Well, there was a CT myelogram done in North Broward.

Q. Other than that?

A. No.

Q. Now, with respect to your qualifications, are you familiar with the organization known as the National Spine Society?

A. Actually, I don't remember one way or the other. There, are a whole bunch of neurosurgical societies, some of which I know and some of which I don't, but I am not a member of any of them, actually.

Q. Are you familiar with that particular organization?

A. I actually don't recall whether I heard of them or not.

Q. Whether *you* are familiar or not, you are not a member?

A. That's true.

Q. Are you familiar with the American Association of Neurosurgeon?

A. Yes.

Q. Are you a member?

A. No.

Q. What is that?

A. That is a society that -- whose membership is limited to neurosurgeons.

Q. Are you familiar with the organization known as the Congress of Neurosurgeons?

A. I think I've heard of them, yes.

Q. Are you a member?

A. Yes.

Q. What is it?

A. Again, it is a society of neurosurgeons.

Q. Are you familiar with the organization known as American Academy of Orthopedic Surgeons?

MR. LUCAS: Before you answer, let me move to strike this line of questioning for relevancy and materiality.

THE WITNESS: Yes.

BY MR. LUCAS:

Q. Are you a member?

A. No.

Q. What is it?

A. A group of orthopedic surgeons.

MR. LUCAS: Same objection as before.

BY MR. JOLLY:

Q. And with respect to the American Association of Neurosurgeon, do you know how one becomes a member?

MR. LUCAS: Same objection and motion.

BY MR. JOLLY:

Q. The requirements?

A. No, other than you clearly have to be a neurosurgeon and you probably have to be board certified as well.

Q. The same question with regard to the Congress of Neurosurgeon.

A. No.

Q. How does one become a member?

MR. LUCAS: Let me just raise a standing objection, if I may.

MR. JOLLY: Sure.

BY MR. JOLLY:

Q. The same question with regard to the American Academy of Orthopedic Surgeons, how does one become a member?

A. Well, you have to be trained as an orthopedic surgeon. I don't know whether you have to be board certified or not and then you apply and pay your dues.

Q. You are not trained as a neurosurgeon?

A. No.

Q. You are not trained as an orthopedic surgeon?

A. No.

Q. Have you heard of the organization American Academy of Physical Medicine and Rehabilitation?

A. Yes.

Q. What is it?

A. Physical medicine and rehabilitation is a specialty of medicine that deals specifically with the rehabilitation of individuals who mostly have limitations of their physical abilities as a result of trauma.

Q. Are you a member?

A. No.

Q. Do you know how one becomes a member?

A. Well, that particular group *you* have to have -- been trained, that is, complete a residency in physical medicine and rehabilitation.

I do not know whether you have to be board certified to be a member.

Q. Can you generalize the special courses or the special training that a neurosurgeon would receive separate and apart from the training that you have received in your specialty as an emergency room physician?

A. Well, sure.

Emergency physicians take basically four years of postgraduate training after medical school. That involves the initial diagnosis and treatment involving everything from fractures to heart attacks.

Neurosurgery is a specialty that deals solely with the diagnosis and definitive care of neurological diseases that are amenable to surgical therapy and those involve the brain and the spinal cord. That's a seven-year

residency program after medical school.

Q. And would you agree that the courses in least in that seven year additional -- required in that additional seven years are for the most part directed to treatment, diagnosis, surgery, for the spine and for the spinal column?

MR. LUCAS: Objection, form.

THE WITNESS: And the brain.

BY MR. JOLLY:

Q. And the brain.

A. Yes, absolutely.

I mean, that's specifically what a neurosurgical residency is all about. It is how to do surgery on the brain and spinal cord and I include the vertebral column as part of that.

Q. Before reviewing the materials which relate to this litigation, have you ever treated an injury comparable to what you have testified and observed?

A. Well, I have treated spinal cord injuries, but you have to understand that my practice stops at the ER door.

Q. I understand that.

A. So that when the patient goes to the operating room or to the ICU, my care stops completely. I mean, I have nothing to do with that.

I have treated patients who are paraplegic and quadriplegic acutely as a result of trauma. I don't remember specifically ever treating a patient with this exact sort of CT scan or x-ray.

Q. Have you ever participated in surgery on a spinal injury comparable to Mr. Cort's?

A. Not since medical school.

Q. How many spinal surgeries have you participated in since medical school?

A. None. I basically don't go to the operating room.

Emergency physicians stay in the emergency department to take care of the next patient while the neurosurgeons and others take their patients upstairs.

Q. If I'm understanding your direct correctly, the questions that were asked by Mr. Lucas, you are an emergency room physician?

A. Yes.

Q. You -- patients come to you at the emergency room?

A. Yes.

Q. To the extent possible, you obtain a history from them?

A. Yes.

Q. Of what occurred in this particular instance?

A. Yes.

Q. As well as perhaps their general physical situation before the injury?

A. That's true.

Q. You want to know as much about them as possible when you are doing the diagnosis which you are doing?

A. Yes.

Q. You obviously look in their physical situation?

A. Yes.

Q. What is going on?

A. Correct.

Q. How do they look?

A. Yes.

Q. What things can I see, for example, to the naked eye, first of all?

A. Yes.

Q. And you balance what you see, what you observe with the clinical findings as rendered from diagnostic testing, correct?

A. Yes.

You mean such as x-rays and laboratory tests?

Q. Sure.

A. Sure.

Q. And then based upon that, your job as an ER physician is to stabilize?

A. That's correct.

My job is to stabilize the patient, to find the life threat, keep the patient alive, and then determine which specialists will be needed to definitively treat the patient.

Q. With regard to claims of paralysis or quadriparesis which seem to stem from an injury to the spinal column, you are going to contact and refer out to a neurosurgeon?

A. Oh, sure.

Q. Before this litigation, have you ever been retained as an expert for the purpose of rendering an opinion as to the cause of a spinal injury, the cause?

A. Yes, sir.

I mean, I have reviewed cases of spinal injury. But whether anybody has specifically asked me about the cause, I can't remember actually.

Q. Do you have a recollection of ever previously being retained and actually rendering an opinion that a spinal injury was related to a trauma as distinct from an axial load?

A. I don't think you quite mean that because an axial load, of course, can be from trauma. I mean, most of these axial loads --

Q. My fault. I meant trauma to the back of the neck, trauma to the front of the neck as opposed to an axial load.

Have you ever before rendered an opinion distinguishing those as the basis for injury?

A. No.

Q. In this case, you know, you have been

hired and your fees accrue in what rate?

A. I charge $450 an hour to review materials.

Q. And to this point the amount of time expended in the review is what?

A. I don't know exactly, but probably an the order of 20 hours.

Q. Have you ever previously been retained to testify as to the standard of care imposed on providing health care to detainees in a detention setting?

A. I have reviewed a couple of cases involving health care of people in correctional facilities, yes.

Q. Have you ever rendered an opinion in court, been permitted to testify as to the standard of care required in a detention setting as it relates to medical care?

A. Well, I think I have given depositions in those matters. I mean, I can't name them. I can't cite them for you, time and place. I don't think I have ever testified live in court.

Q. Have you done any research sufficient to be able to determine what the standard of

care is as it relates to medical care to be rendered in detention facilities in Florida?

MR. LUCAS: Let me object to the point that this case does not involve the standard of medical care by the medical practitioners at Prison Health Services, Inc., or their employees to the extent that no care in all was provided by the Sheriff's deputies, and that does become an issue in the case.

MR. JOLLY: Well, you know, I'm going to ask that be stricken from the record and we will deal with that later.

MR. LUCAS: You are constantly trying to interject an issue that does not belong here.

MR. JOLLY: Let me --

MR. LUCAS: And settled in another case.

MR. JOLLY: Okay.

BY MR. JOLLY:

Q. Let me ask *you* this, have you done any research to determine the standard of care owed in a detention facility as it relates to medical care? And I don't care whether it is provided by detention staff or medical staff.

I want to know if you know what they are supposed to do as it is **imposed** on them by law?

A. Only as defined by their policies and procedures. I have not read the laws regarding these matters.

Q. Do you know the relationship between the health care provider, the actual physicians group, the medical provider, and detention staff as it relates to who does **what**, whose obligations are whose as it relates to medical care?

MR. LUCAS: In this case?

THE WITNESS: I think so, sure.

BY MR. JOLLY:

Q. **Where** did you **see** where it is spelled. out who does what?

A. I don't think that there are any specifics regarding that. I mean --

Q. That's why I **am asking** what *you* have seen.

A. Nothing in particular.

Q. Have ***you*** reviewed the contract as between the health care provider and the

defendant in this case, the Sheriff, as it relates to who does what as it relates to providing medical care?

MR. LUCAS: Objection to relevancy and materiality.

THE WITNESS: No.

MR. LUCAS: Move to strike.

BY MR. JOLLY:

Q. Have you reviewed the specific training provided to any of the detention staff to which you have kind of referred as you have testified?

A. No, I have not seen their training manuals.

Q. Do you know what specific training was provided to them?

And, Doctor, I ask you that question because you kept talking about training and professionals, talking about training the police.

I'm asking you do you know what training was provided to this group of detention staff?

A. No, not specifically.

Q. Do you know what specific instructions that they were given as it relates to how they are to handle inmates that are injured, complaining of injury -- that are either injured or complaining of injury?

A. No. I have not seen the specifics of their instructions.

Q. Do you know the parameters of what they can do by virtue of their training, by virtue of their instructions as it relates to an inmate who claims injury or who is injured?

A. I had not seen the documents outlining those parameters.

Q. You indicated that you have reviewed Nurse Hinson's deposition?

A. Yes.

Q. Do you recall that Nurse Hinson noted that Mr. Cort was extremely flaccid?

A. Yes.

Q. Is it your recollection that when she first saw him on his return to the North Broward -- to the stockade, that he was, in fact, lying down?

A. Yes.

Q. That he was lying on his back?

A. Yes.

Q. That she tested to determine whether he was responsive to verbal or tactile stimuli?

A. Yes.

Q. That, in fact, in response to that his eyelids fluttered?

A. Yes.

Q. That his pupils were pinpoint bilaterally?

A. Yes.

Q. That his blood pressure was 130 over 70 with a pulse of 80?

A. Actually, I don't recall the exact vital signs.

What page are you reading from?

Q. 16, lines four through 16.

A. Correct.

Q. Do you recall that'she -- and that was about 7:30 PM, correct?

A. Yes.

Q. Can you tell me as we sit here now how much time passed from the time of the incident in the van until Nurse Hinson first saw

Mr. Cort?

A. Not precisely.

We think that the incident occurred about 5:00 or 5:30, and she is recording this exam in 7:30 but that doesn't necessarily mean that the exam occurred in 7:30. It could be well that the documentation occurred in 7:30, which is, I suspect, what actually happened.

Q. So you cannot tell me -- and that was what my question was -- how much time had actually passed between the time of the incident in the van and her observation of him?

A. That's true.

Q. First observation?

A. Yes, that's true.

Q. Do you recall that it was after she first saw him noted in 7:30 that she saw him again in 7:35?

A. Yes.

Q. Roughly five minutes later?

A. Right.

Q. And at that time he was aroused to tactile stimuli? 19, 16 through 21.

A. Yes.

Q. That he opened his eyes and then he was muttering incoherently?

A. Yes.

Q. That he was lifting his arms to protect his face?

A. Yes.

Q. That his respirations were unlabored?

A. Yes.

Q. And by this time she had already called, I think, a nurse Dudley, had she not?

A. Yes.

Q. And after this second view, by this time she called Dr. Diz Pi?

A. Yes.

Q. Now, you understand that Dr. Diz Pi is the psychiatric provider?

A. Yes.

MR. LUCAS: Let me object to this point in that that portion of her testimony is hearsay which is refutable by Dr. Diz Pi.

MR. JOLLY: I'm going to ask that that be stricken.

BY MR. JOLLY:

Q. Did you read that Nurse Hinson has testified that she called Dr. Diz Pi?

A. Yes.

Q. Do you recognize from the materials before you that Dr. Diz Pi was the psychiatric doctor that was on call?

A. Yes.

Q. You clearly understand, you do not, that Nurse Hinson -- and whether you agree with her or you don't -- she makes it very clear and you understand her to make it very clear that she believed rightly or wrongly that Cort was suffering from a psychiatric condition?

A. That's true.

Q. There was no sign of physical injury that you are able to tell anyone observed?

A. That's true.

Q. And as you reviewed all of these materials, there really was no indication of physical injury anyway?

A. That's true.

Q. I think you have indicated previously on deposition if somehow this had resulted in

Brian Cort's death the medical examiner would have had a tough time indicating that there was any cause.

MR. LUCAS: Objection.

BY MR. JOLLY:

Q. Is that a fair statement?

MR. LUCAS: It is a distortion of prior testimony.

BY MR. JOLLY:

Q. If I'm wrong, Doctor --

A. You know, what I said is the medical examiner on first view would have a tough time. In other words, what I meant was by externally examining the body apparently there weren't any injuries.

Q. Did you note that Nurse Hinson saw Cort again in 9:55 PM?

A. Yes.

Q. That he was lying quietly?

A. Yes.

Q. Did you note that she was unable to determine whether Cort was conscious or unconscious? 28, line 24.

A. Yes, I know.

She said he was not responding. But when asked whether he was conscious or unconscious, she didn't know.

Q. She used an ammonia inhalant.

A. Right.

Q. What is that?

A. An ammonia inhalant is an ampule of ammonia that we -- smelling salts that we break, put in front of the patient's nose.

When they breathe the ammonia vapor in, it is a very noxious and irritating substance. And most people who are feigning illness will very violently either push your hand away or sit up or do something to avoid having to further inhale the ammonia vapor.

Q. What do you recall she noted as to his response?

A. Minimal.

Q. Was there any response?

A. Well, let's see, what she said was, "A moan. He may have turned his head. He may have moved his fingers a little bit." That's her answer.

Q. What notation, if any, do you recall

her making that she ever observed him walk? Let me help you, there is none.

A. Right.

Q. Do you have any recollection that she ever said she saw him walk?

A. No.

I actually, specifically, recall that when asked if she saw him walk she said no and she had never been told that he couldn't walk.

Q. Do you recall that she observed that he was carried out by his feet and shoulders and did not offer resistance?

A. Yes.

Q. Now, let's go back.

When she first sees him in 7:30, the symptoms that she describes or the respcnses to the actions that she took, you know, what does that tell you?

A. Not much actually.

I mean, fluttering of the eyelids, we sometimes see in hysterical patients.

Q. Which means -- when you mean

hysterical, you mean what?

A. I mean somebody who is not physically ill but is feigning their illness.

It is one of the reasons why you then proceed to use ammonia on a patient, and it takes -- well, actually, I can't say that I have ever seen anybody not react to ammonia who was a feigning their illness.

I mean, it is a very irritating substance and people are just not going to breathe it for more than a few breaths before reacting violently to remove it.

Q. Have you, in your experience, ever noted a psychiatric patient who exhibits the signs reported, the conditions reported by Nurse Hinson?

A. Excuse me, can you repeat that again?

(Record read as requested.)

MR. JOLLY: Sure, Madam Reporter.

(Record read as requested.)

THE WITNESS: Yes, with the exception of a minimal response to ammonia.

BY MR. JOLLY:

Q. Up to that point had you observed short of that response or lack of response, have you, in your **experience**, observed psychiatric patients who are exhibiting the symptoms that she describes?

A. Yes.

Q. Are you satisfied within a reasonable degree of medical probability that the injury that you have been discussing was not the result of trauma, a blow to the front, the anterior portion to the throat area?

A. Yes.

Q. Why?

A. Well, because there was no **evidence** of any damage to the neck or specifically to the trachea.

I mean, in order to get to the vertebrae which was fractured, you need to transmit force all the way from the front of the neck to the vertebral body which is basically about halfway back.

And in between those two structures you have several vital structures,

the most important of which is the trachea. You almost -- I mean, I just simply cannot imagine doing the amount of damage that he had to the vertebrae, sustaining that amount of damage, without doing truly significant damage to the front of the neck, crushing the windpipe causing hemorrhage, that sort of thing.

Q. I think it is on the CT scan, isn't it, that you can actually tell that there is no damage to the thoracic area?

A. You mean to the trachea.

Q. What did I say?

A. Thoracic area.

Q. Don't ever listen to me. I meant the trachea.

A. Yes, I think you are right.

Q. I mean, my recollection is literally you can look at the CT scan, see the area, and it looks whole --

A. That's true.

Q. -- the trachea?

A. Yes.

Q. And if it was a blow to the front, you would expect that there be evidence of injury?

A. I would expect --

Q. To cause this injury?

A. Not only that, I would expect the patient to be having respiratory injury.

Q. And there was no indication of that?

A. That's true.

Q. There is no evidence of -- if I have understood you correctly, looking at the back of this man, Mr. Cort, there was no evidence of external injury apparent to the back of the neck?

MR. LUCAS: I am going to object to this. It is a slight distortion of the testimony that was given.

BY MR. JOLLY:

Q. I would never distort what you have said.

A. I think the answer --

Q. Tell me where I am wrong, if I'm wrong.

A. It is not clear that anybody actually examined the back of the neck. That's the problem.

Q. Well, let me ask you, you are an

ER physician. Brian Cort came in to you when you are on duty, *you* are going to look at the back of the neck?

A. You can't. He is in a collar that immobilizes the neck.

The only thing that you can do with that collar is examine the small area where the front of the collar is cut out so that I can get to the trachea or the windpipe in case I have to do a surgical procedure.

Q. Right.

A. But other than that, you don't take off the collar. You leave the collar on. You don't examine the back of the neck. You don't turn it. You don't move it, and you just leave well enough alone.

Q. Nurse Hinson, do you recall any indication that she observed him to determine injury, physical injury?

A. Yes, she did.

She, in fact, in particular says we sat him up to look in his back but she thought this was a shoulder injury, and nowhere does she specifically say I looked in his neck.

What she noted injury to the back of the neck?

A. None.

Q. Dr. Metamoros --

A. Yes.

Q. -- you read his deposition?

A. Yes.

Q. You have read his statement?

A. Yes.

Q. You are aware that he also examined Mr. Cort while he was incarcerated.

A. Yes.

Q. Do you recall that he, too, examined the back of the neck?

A. I don't recall specifically about the neck. I do recall his saying that he did examine the patient and found no injuries.

Q. All right. Which was my follow-up question, what indication, if any, is there from him that he observed injury, external injury, to the neck?

A. None.

Q. How hard a -- if I understood you correctly, you are not saying it was a huge blow

that -- a catastrophic blow *that* would have been necessary to do this kind of damage if it came from the back? And if I'm wrong, tell me I'm wrong.

MR. LUCAS: Before you go on, can you repeat that question again, please?

MR. JOLLY: Include the stutters.

(Record read as requested.)

BY MR. JOLLY:

Q. Doctor, the neck is what I meant to say.

MR. LUCAS: I do have to object. I don't think that was the testimony given by the doctor.

BY MR. JOLLY:

Q. Which is why I want you to tell me where I'm wrong.

A. I think this would take a significant large blow to the neck. You might even be able to find a neurosurgeon or orthopedic surgeon to tell you how many pounds.

Q. You can't.

A. I can't. I don't know.

Q. But regardless of the degree or force necessary, you are not suggesting that it was going to leave an area of a wound which is observable to a lay person or to the observer, naked observation -- observation of the naked eye?

A. Considering the three mechanisms possible and that specific question, if this had come from an anterior injury, I would have expected virtually anyone, adult, to be able to recognize the injury, because I think it really would have been devastating.

In terms of an axial load from his head butting into this chain linked fence, I would have expected there to be some pretty obvious injuries, lacerations, scalp hematomas, that sort of thing.

Concerning the posterior injury, it is possible since he was an African-American that he could have had some bleeding under the skin caused by a blunt object that would have been missed by someone not really trained to look for that kind of injury.

Q. He comes to you in the ER, you are no

going to look at the back of his neck in all?

A. Absolutely not, not going to take off that C-collar. I don't care what is going on, we are not going to take off that C-collar because the **only** thing that I need to save this man's life is manage his airway and I can do that with the C-collar on.

Q. So you wouldn't expect any ER physician to look at the back of the neck by removal of the collar under the circumstances?

A. No.

As a matter of fact, that would be neglect if a physician did that in the ER.

Q. One of the things I picked up when we were talking before, I think you said that, frankly, the mechanics of the injury are not important to you as an ER physician.

A. That's true.

Q. The CT scans to which you have referred do not demonstrate or in least exhibit injury to the back of the neck?

A. Soft-tissue injury, that's true.

Q. You are relying on the end result, the damage to the vertebrae, in making the

conclusion that you have made the force came from behind?

A. That's true, in the failure to observe the soft-tissue damage in the other two areas, the top of the head or the front of the neck.

Q. What is a hematoma?

A. Bleeding of the soft tissue.

Q. There was a hematoma observed, was there not, by Dr. -- I want to say it is Dr. -- the ER physician, Dr. Isaacson?

MR. LUCAS: No.

BY MR. JOLLY:

Q. Dr. Gelbard.

A. There is an epidural hematoma, but that's inside the spinal cord.

Q. Which is my question.

What is an epidural hematoma?

A. That means that inside this spinal canal defined by the body and the neural arch that there is a collection of blood between the bone and the yellow which is the spinal cord, but that's all inside the bony cage, so to speak, of the vertebral body.

Q. In any of the reports that you have

reviewed, did you note any other hematoma, bruising, to the back of the neck?

A. No.

Q. Under the circumstances, wouldn't you expect there to be a hematoma present causing -- in the area of the blow which resulted in the injury to the vertebrae?

A. Well --

Q. Somebody should have picked it up.

MR. LUCAS: Well --

BY MR. JOLLY:

Q. Okay. Would you have expected it to be there?

MR. LUCAS: Before you answer --

MR. JOLLY: That's the question.

MR. LUCAS: In this question, let's say, I object to the commentary made after the question. Reask the question.

THE WITNESS: Remember that --

BY MR. JOLLY:

Q. That's a yes or no, Doctor. I haven't done that to you yet, but I am going to do it to you this time.

MR. JOLLY: Madam Reporter, the last

question.

(Record read as requested.)

MR. LUCAS: No, that's not the question. That's what we -- I move to strike. That was the comment.

MR. JOLLY: Let me rephrase it. We'll just -- I will start from scratch because I think some of Paul's objections are appropriate.

BY MR. JOLLY:

Q. Would you not as an ER physician, as a treating physician, expect to observe a hematoma, bruising, in the area of the blow which caused the injury to the trachea -- to the vertebrae that we have been talking about?

A. Yes, that's true.

Q. No one observed it.

A. That's true.

Q. What special training, if any, have you received in the biomechanics of spinal cord injuries?

A. Only that which most emergency physicians get.

Q. There is specialized training provided

over and above that provided ER physicians, is there not, on the biomechanics of spinal cord injuries?

A. Well, sure. Neurosurgeons and orthopedic surgeons who deal with these injuries have special training.

Q. When we are talking about biomechanics, what are we talking about?

A. We are talking about the physics of the forces involved.

Q. The cause?

A. Yes.

Q. What specialized training do you have in the biomechanics of cervical injuries?

A. Well, you know, there is a lot written about this. In fact, the textbook that I coedited even has in the section of spinal cord injury -- I think it is called spinal fractures, but we talk about the mechanism of injury.

Q. I'm talking about the training that you have had in the field of bio -- in the study of biomechanics of cervical injuries, specialized training over and above anything that you have received as an ER physician.

A. None.

Q. And, again, you would expect a neurosurgeon to have had such additional specialized training in the biomechanics, the causal factors, involved in cervical injuries?

A. Sure.

MR. LUCAS: Objection to form.

THE WITNESS: As a part of their general training in neurosurgery.

BY MR. JOLLY:

Q. Have you ever taught a course in the study of the biomechanics of spinal cord injuries?

A. No.

Q. Cervical injuries? Same question.

A. No.

Q. Have you ever taught a specialized course in the area generally of spinal cord injuries?

A. Well, no.

As you know, I have given a lecture that basically is structured by the American College of Surgeons regarding spinal cord injuries.

It is designed specifically to be given to emergency physicians but certainly have not taught neurosurgeons or orthopedic surgeons about the specifics of those things.

MR. JOLLY: Can we go off the record for one second?

MR. LUCAS: Sure.

THE VIDEOGRAPHER: Off the record at 10:56.

(Whereupon a short break was had.)

THE VIDEOGRAPHER: Back on the record at 11:05. Please proceed.

BY MR. JOLLY:

Q. Dr. Baker, if I have understood you correctly, the biomechanics of injury are not generally important to you as an ER physician?

A. That's true.

Q. As you have reviewed the materials provided to you from which you have formulated your opinions, did you note whether the mother was present at the emergency room?

A. I think that she was. I don't recall specifically, but I think she was.

As I recall, she and the aunt drove Mr. Cort to the ER after he was discharged.

Q. And that she spoke to the emergency room physician, Dr. Isaacson?

A. I don't recall the details of that.

Q. Do you recall that she was in attendance, was present, with Mr. Cort at the North Broward Detention Center?

MR. LUCAS: Objection --

MR. JOLLY: I meant the North Broward Hospital. That was a -- sorry.

THE WITNESS: I actually don't recall.

BY MR. JOLLY:

Q. Do you know whether she had conversation with Dr. Gelbard?

A. Dr. Gelbard was the neurosurgeon?

Q. Right.

A. I don't remember.

Q. Doctor, the same question with regard to Dr. Schultz.

A. I don't remember the specifics, but, you know, I do know that she was physically present in Florida and he was hospitalized for

some time. So I suspect there were conversations.

Q. In your recall and in your review of the medical records, did you note that the history provided was in least, in part, given by the mother as it -- go ahead.

MR. LUCAS: I was going to say in which hospital or in which location?

MR. JOLLY: Both.

MR. LUCAS: Okay. I would have to object to that as a misinterpretation of the medical records if you are referring to both hospitals.

THE WITNESS: Actually, I don't recall.

BY MR. JOLLY:

Q. What indication, if any, do you recall seeing that the mother ever indicated to medical staff, Florida Medical Center or North Broward, the information to which you earlier alluded that he had been beaten by detention staff, Mr. Cort?

A. Actually, I don't recall any.

Q. She didn't say that, did she?

MR. LUCAS: Objection.

MR. JOLLY: I'll correct it.

MR. LUCAS: All right.

BY MR. JOLLY:

Q. What notation, if any, do you recall seeing that the mother ever indicated to any medical person, physician, nurse, in either Florida Medical Center or the North Broward Hospital that her son had been beaten by detention staff?

A. I don't.

Q. And you didn't -- as you have reviewed the medical records, You seen no indication of a -- of multiple blows to his body, to Mr. Cort's body?

A. That's true.

Q. There is really no indication with the exception of the one blow to which you have alluded that he sustained a series of blows?

A. That's true.

Q. Or that he was struck with any object on any other part of his body?

A. That's true.

Q. That he was kicked?

A. That's true.

Q. That he was punched?

A. Correct.

Q. There is really nothing to indicate that he was the -- subjected to a beating involving more than one person?

A. That's true.

Q. You have talked earlier -- you have testified earlier that, I think, you gave four implements or objects which could be the cause here of this blow to which you have alluded which caused the injury to the vertebrae, right?

A. Well, there is others. I mean, anything that is blunt can do it.

Q. Well, I was struck by the limited ones that you mentioned, a baton.

A. True'.

Q. Which happened to be uniquely the kind of thing that could be police related or law enforcement?

A. Well, sure. I mean you are going to be looking at the kinds of things --

Q. A blackjack --

A. -- that are available in a jail.

Q. Well, you don't know that batons are available in the Broward County Jail?

A. That's true.

Q. You don't know that blackjacks are available in the Broward County Jail?

A. That's true.

Q. Do you know what training the detention staff at the Broward County Jail receive as it relates to martial arts?

A. No.

Q. And I think there might have been one or two more and I couldn't write fast enough.

What else did you say?

A. Well, I mentioned -- I think I mentioned a baseball bat.

Q. I don't recall that the Broward County Jail routinely issues baseball bats but --

A. No, but there was specific reason for mentioning baseball bats because there was some question about --

Q. Good point.

A. -- whether a baseball bat had been involved in the original altercation that led to

his arrest.

Q. So that could be an implement that could cause that kind of damage?

A. Sure.

Q. Would you agree with me that a -- have you ever seen photographs of the inside of the van?

A. I have seen a Xeroxed copy. They are hard for me to look in because they are tiny little, you know, pictures.

Q. Are you able to describe for me the van's cargo area configuration?

A. Well, I know that it is -- got a divider between the front and back consisting cf this chain linked material and Plexiglas.

I know that it is divided in half sort of in the long -- in the length of the van sort of, and I think the left half was for women and right half was for men, and I recall there is a sort of bench down either side with a little aisle in between.

Q. The bench is made of what as you recall?

A. I don't know.

Q. You would agree with me, would you not, that it -- the injury that you have testified about is consistent with a striking of the back of the neck on the bench?

MR. LUCAS: Objection.

THE WITNESS: That could be, right.

MR. LUCAS: Before you go on, I have to object to the characterization. Go ahead.

BY MR. JOLLY:

Q. I mean that's the kind of blunt -- the corner would be the kind of blunt instrument to which you have alluded --

A. Yes.

Q. -- assuming that occurred?

A. Yes, that could be.

Q. You do not and you are not prepared to testify, I don't think, within a reasonable degree of medical probability that this man, Cort, was struck by a person with an object?

A. No, that's not my testimony in all.

Q. You don't have that opinion because you don't know?

A. That's true.

Q. All you know is some blunt impact of

some kind was caused, in your opinion, to the back of the neck?

A. That's true.

Q. It may have been self-inflicted as far as you know?

A. That's also true.

MR. LUCAS: Objection, without foundation or predicate inasmuch as the man was handcuffed.

BY MR. JOLLY:

Q. I don't mean that he struck himself, but that he, by his actions, put his body in such a position that he caused himself to fall against to strike the bench?

A. Sure.

Both yesterday and today we have not talked about --

Q. Well, I am backwards.

A. -- who may have caused the injury. We were just talking about the possible mechanism of injury.

Q. What is a burst fracture?

A. A burst fracture refers to a vertical compression fracture, that is, from an axial

Load. What we mean by that is a load down, straight down, causing compression along the long axis of the vertebral column in which the pressure would be transmitted.

It either could be from the top of the head or it could be from the bottom of the feet. If one jumps out, you could have a a compression fracture.

You get a burst fracture of the lower spine rather than the neck. You get it in the back, the lower back. But a burst fracture --

Q. But it is a burst fracture?

A. It's a burst fracture.

What it means is that the compression is such that when you press down on the bone, the sides of it burst outward.

Q. Would you expect a -- would it be consistent that a burst fracture would come from an axial load as opposed to trauma, a blow to the front or the back?

A. Yes.

Q. Was this injury a burst fracture?

A. Well, that's not entirely clear.

Dr. Gelbard did not exactly say it was a burst fracture. In fact, he never used those words. He said it was maybe, sort of, and the actual vertical nature of the one part of the fracture is consistent with a burst fracture.

So, you know, that's not entirely clear exactly what the multiple compounds may have been in this fracture.

Q. Do you interpret what you have seen irrespective of what others may have said that this was a burst fracture?

A. Well, what happened to the vertebral body is consistent with a compression fracture.

What isn't consistent is the fracture of the neural arch which would be unusual. Not impossible, just unusual.

Q. Well, that brought back the obvious question for my purposes.

Can you exclude within a reasonable degree of medical probability that this fracture is the result of an axial load?

MR. LUCAS: I am going to object because that has already been asked and answered

in reverse.

He has already given his opinion within a reasonable degree of medical probability in opposition to that.

MR. JOLLY: I don't know about that.

BY MR. JOLLY:

Q. But can you exclude it within a reasonable degree of medical probability?

A. I don't think you can absolutely exclude it. What I have said is --

Q. I don't think you have to.

A. Well, what I have said is what I think is most probably or most likely the cause of this.

Q. But within a reasonable degree of medical probability, can you sit here in front of this jury and tell them that this injury is not the result of an axial load?

MR. LUCAS: Objection. The question has been asked and answered and the standard is reasonable degree of medical probability as to causation.

BY MR. JOLLY:

Q. Please continue.

A. I think you can say that this is -- injury is not solely the result of an axial load.

Q. Where does that take us?

A. Well, where that takes us is that if you are going to propose that there was an axial force applied here to cause the burst fracture, there must have been some other force that was then applied to fracture the neural arch.

That could be a hyperflexion. In fact, I think, in fact, there was an interpretation --

MR. JOLLY: We are going to break right now just to switch tapes and then we will pick up right where you were.

We are off.

THE VIDEOGRAPHER: Off the record with the end of tape one of the deposition of Dr. Frank Baker in 11:17.

(Whereupon a short break was had.)

THE VIDEOGRAPHER: Back on the record with the beginning of tape two of the deposition of Dr. Frank Baker at 11:19. Please proceed.

THE WITNESS: As I recall, there was an interpretation of a CT myelogram, I believe, in North Broward where the radiologist opined that he thought this was consistent with a hyperflexion injury.

BY MR. JOLLY:

Q. You know, something we have never talked about, what if there were if -- I want you to assume inside the van that he struck the top of his head, falling struck the back of his head.

Would that be -- the back of his neck, would that be consistent with the injuries that you have seen --

MR. LUCAS: Before you do.

BY MR. JOLLY:

Q. Within a reasonable degree of medical probability?

MR. LUCAS: Objection. I think you'd first have to indicate exactly how it is he struck the top of his head, how he fell, and where he fell, and what he struck before that question can be answered with any reasonable degree of probability.

BY MR. JOLLY:

Q. Okay. But you can still answer that as phrased.

A. It is possible that these injuries could have been caused by multiple mechanisms, yes.

Q. You cannot exclude within a reasonable degree of medical probability, can you, that there was an axial load involved in this?

MR. LUCAS: Asked and answered.

THE WITNESS: I think what I said was I think I can exclude that as the sole cause.

BY MR. JOLLY:

Q. Okay. What is an axial load compression injury?

A. I think we have already talked about that. I mean, basically that's the burst fracture that you have made mention of before where you get vertical loading on the spinal -- on the vertebral column.

Q. Give a classic example.

A. Head butting. A classic example is the football injury. It's a head butting of one football player by another.

Q. You see, if I have understood you correctly, some compression in this injury'to the vertebrae --

A. Yes.

Q. -- you do not, correct?

MR. LUCAS: I'm going to object to this. This was asked and answered in a previous deposition which the doctor testified that he did not see compression to the fracture, but compression within the spinal column as a result of the injury. Now you are trying to distort that.

MR. JOLLY: Oops.

THE WITNESS: I think what I previously said yesterday was that I couldn't exclude that there was some compression compound to this fracture.

BY MR. JOLLY:

Q. Some axial load component?

A. Yes.

Q. What are the biomechanics -- what are the dynamics that you have concluded occurred with respect to this injury?

A. Well, what I have said is based on

what I see on the x-ray and the lack of physical evidence of trauma to the top of the head and the front of the neck reaching the conclusion that the injury must have been from behind from the neck.

Q. You have worked backwards?

A. No. I have just taken the two into conjunction.

Q. Can you tell me the dynamics of the accident?

You have told me what isn't there, and, therefore, why you don't think it is one thing, but what is the causal dynamics of the accident then?

A. The causal dynamics would have to be a blow to the posterior neck through the spinous process.

Q. And when that occurred, what happens internal? When you look at the guts of the spine, when you look at the guts of the vertebrae, there is the blow to the back.

What does it do? How does it affect the final condition?

A. It splits the vertebrae vertically and

breaks the neural arch.

Q. Why?

A. Because you have a -- fundamentally you have a circle. And when you are going to -- in any circular bone when you break a circle, you break it in more than one place.

And you break the circle not by coming down on it this way but by coming in from the side, which explains the multiple fractures around the neural arch.

Q. Did you note that the vertebrae was retropulsed backwards?

A. That's true.

Q. And when I use the term backwards, that's probably a mistake, I think I mean going like to the behind of me.

A. Yes. That's fine.

Q. Posterior?

A. Yes.

Q. You did note that?

A. Sure.

Q. But if I recall you -- what you said yesterday, you do not believe that is consistent with an axial loading force?

A. That would have to be associated with both vertical compression and some sort of flexion injury.

Q. And by flexion, please demonstrate that.

A. Flexion (indicating).

Q. Extension?

A. (indicating).

Q. Backwards?

A. Extension, backwards.

Q. So you think the retropulsion is the product or the result of a flexion of the neck?

A. Yes, but -- no.

Q. I mean if I am wrong, tell me. You know this stuff better than I do.

A. I think what you are doing is that you are trying to explain how the mechanism of injury resulted in what we actually see on the x-ray in terms of the positioning, and I don't think that they are necessarily related because of all the movement that subsequently occurred.

I mean, let's presume that this injury, regardless of how it occurred, occurred around the time of this van business. Let's

assume that it occurred in the van.

It is an unstable injury and there are another 18 hours that lapses during which time he is picked up by his hands and feet, picked up by his feet and his shoulders, he is laid on his back, he is sat up by the nurse, he is rolled on his side.

All of these things are going to make all of those bones which are now free-floating fragments move around.

So where they moved and how they got there is more a function or in least partly a function of all the movement of his head and neck that occurred between the injury and the x-ray some 30 some hours later.

So, you know, you cannot look in that x-ray and say as a result of the exact positioning of these fragments where the blow occurred. I just don't see that that's possible.

Q. The epidermal hematoma which Dr. Gelbard noticed, you do not perceive as being related to the trauma to the blow.

That's not the bruise from the

blow?

A. Oh, it could have been, sure.

Q. Do you know one way or the other?

A. No.

Q. You cannot quantify, can you, within a reasonable degree of medical probability the amount of benefit that Mr. Cort would have received had intervention been earlier, the kind of intervention that you provide at the ER?

A. I think as -- I think the best you can say is this --

Q. First say yes or no.

MR. LUCAS: If it can only be answered by yes or no.

BY MR. JOLLY:

Q. Can that be answered yes or no with an explanation?

A. There is no -- this is no precise numerical figure that somebody can give you in terms of what he predictably was going to end up with.

Q. You could not predict with medical certainty the outcome of his neurologic functioning and intervention in an emergency

room comparable to the services you provide and provided earlier?

MR. LUCAS: Don't answer that yet. Please repeat the question slowly.

(Record read as requested.)

MR. LUCAS: Okay. I've gone far enough.

I am going to object, first of all, to the attempt to insert a standard of medical certainty which doesn't exist in the State of Florida.

MR. JOLLY: I said reasonable.

MR. LUCAS: And reasonable certainty is not the same as probability.

MR. JOLLY: Reasonable medical probability is what I meant to say, Paul.

MR. LUCAS: Okay.

MR. JOLLY: And I'll make that correction.

MR. LUCAS: And the second thing --

MR. JOLLY: I did say that.

MR. LUCAS: I'm not sure that you have -- I have to object also because I think

you are asking for an absolute predictability based on some numerical equation which the doctor has already testified that he cannot give medically.

So to that extent, the question has been asked and answered.

BY MR. JOLLY:

Q. First, can you quantify it?

A. Not with any precision, no.

Q. You wanted to make a general statement. What would that general statement be?

A. Well, you know, the general statement is that there are two things going on here.

One is the initial injury. Early treatment of Methylprednisolone, 20 percent of those people do much better than they would have without it. That's as good as you can get.

The second is that he had an epidural hematoma. I can't tell you precisely in what point in time it started, but an epidural hematoma has a six hour golden period.

If you get it within six hours, you can expect to see some improvement. If you

haven't done it, if you haven't corrected or evacuated the hematoma after six hours, you have lost everything that you might have gained.

Q. You were first contacted by Mr. Lucas when regarding this case?

A. Maybe a year and a half ago.

Q. When did you first formulate the opinions that you have today with regard to, one, the mechanics of the injury, and two, the -- well, let's leave it in that, the mechanics of the injury.

A. Well, I suppose, I first formulated an opinion regarding the mechanics of the injury after reading the medical records that I had been sent.

Q. When you first formulated your opinion, you did not have the benefit of the CT scan?

A. That's true.

Q. When you first formulated your opinion, you did not have the benefit of the x-rays?

A. That's true.

Q. Ordinarily in the formulation process,

do you not wish to have those records available?

A. Oh, absolutely.

MR. LUCAS: Let me raise an objection, as Counsel is aware these x-rays and CT's were gone for several years and missing, and your question implies that we have deliberately withheld them.

MR. JOLLY: I don't mean to imply, and Mr. Lucas seems to think I'm implying. I represent to you I'm not implying. There is a place I'm going, but that wasn't it.

BY MR. JOLLY:

Q. Now, would you -- my question was ordinarily you want that stuff.

Whether it was lost by accident or not, you want it when you are going through it to make a decision as to what opinions you have, right?

A. Sure.

Q. The more information you have the better?

A. Absolutely.

Q. And the reports, themselves, that you reviewed are really narratives of what the

doctors have said that they did of what they said they saw?

A. Yes, that's true.

Q. So looking at the x-rays and the CT scans helps you to determine what really happened -- no, what the condition is?

A. That is true.

Q. Ordinarily wouldn't you want to see those before you firm up your opinion as it relates to the condition of this man?

A. Well, in terms of his condition, his condition is obvious from the medical records.

I mean, what you are talking about is really firming up opinions about what happened. And as I have said all along, those x-rays are only partially helpful because you have to put it in the context of what else is apparent, and what is painfully not apparent is external injury.

Q. By the way, you know, you have been very critical of the detention staff.

What was it that the detention staff -- what physical indications were there to detention staff sufficient to overcome -- I'm

sorry, let me rephrase all of that.

As you were going through the records that you reviewed, the depositions that you reviewed, did you note that medical staff were involved from the point in time -- I apologize. I am going to rephrase all of that.

Did you note that detention staff testified that they were relying on information provided to them, the diagnosis provided to then! by health care providers?

MR. LUCAS: Objection, unless you specify as to when these statements are made and at what time they are relying on.

MR. JOLLY: I'll rephrase it.

BY MR. JOLLY:

Q. At any time did you note that detention staff acted contrary to instructions of medical staff throughout his stay at the detention center at any time after the van incident?

MR. LUCAS: I have to object, again, because I believe the record is clear that there are no instructions from medical staff until the middle of the day of the 12th of March of 1993.

MR. JOLLY: You know, I don't have to agree with that. I don't think that's an accurate statement.

MR. LUCAS: I understand that, but I think you are implying something --

BY MR. JOLLY:

Q. Well, let me ask you, do you recall the detention staff, those involved in transporting Mr. Cort from the stockade to the jail, were advised that they could use a transportation vehicle other than the van?

A. Yes.

Q. Who told them to do that?

A. A Nurse Hinson.

Q. I'll go back to another question.

Do you have any recollection that the detention staff ever acted independent of, from their testimony, independent of information provided to them by health care staff, either Dr. Metamoros or any of the nurses?

MR. LUCAS: Same objection as before. Move to strike.

THE WITNESS: Independent of?

MR. LUCAS: I know what bothers me

about this --

THE WITNESS: Are we talking about --

MR. LUCAS: The question assumes a fact not -- or an implication not in evidence, and, that is, that there were instructions or information given by medical staff to deputies which there was not. So I object to that question.

BY MR. JOLLY:

Q. Do you recall that nurses periodically throughout his detention observed him, Cort? And I'm not talking any specific time.

I'm just talking about from the time of the van incident was medical staff involved in some level?

MR. LUCAS: Well, I am not sure which of the two questions you are asking, but I am --

MR. JOLLY: Paul, what you did on direct was really, I thought, unfair. So you are making these speeches and I accept that --

MR. LUCAS: If you want to give a hypothetical and ask him to answer a question, I won't object to that.

MR. JOLLY: I'm asking from what his

review -- I'm not asking a hypothetical. I don't want an opinion. What I want is what he recalls of his review of the records from which he has based his opinions as to the involvement of detention staff.

THE WITNESS: Yes, there was.

BY MR. JOLLY:

Q. Medical staff was involved?

A. Yes.

Q. Do you recall that the deputies have testified that they were acting on information provided to them by medical staff as tc how this man was to be cared for?

MR. LUCAS: Objection, unless as specified as to time and within the three-day period at which he was located in the jail.

THE WITNESS: It is my recollection that a certain group of deputies were told by Nurse Hinson on how they were permitted to transport the patient back to the main jail, and that the purpose of that transfer was to go to a section known as 2-C.

BY MR. JOLLY:

Q. Two Charlie.

A. Which was a psychiatric, I think, holding area and that purpose of this was for psychiatric clearance.

Q. Where in the materials that you have reviewed do you recall any detention staff person being told that Inmate Cort was suffering from a physical and not a mental problem?

A. There never was.

Q. Do you have a recollection of all information provided by medical staff to detention staff was that the problem was psychiatric and not physical?

A. I think that is the level of input that they got from Nurse Hinson.

Q. Your CV, that which has been attached as Plaintiff's A' for ID, consists of 22 pages, correct?

A. I haven't counted them.

Q. I did.

A. Okay.

Q. By the way, I didn't count them, but it goes through page 22. If you mislabeled them, there might be more.

But, anyway, pages 6 through 22

of the CV relate to your publications, I think.

A. I'll take your word for it.

Q. How many of those listed publications deal specifically and are oriented to cervical injuries or spinal injuries?

A. Only one, that would be the textbook in emergency medicine published by the Mosby Company.

Q. Are you -- do you have an opinion as to whether the injury was complete at the time of whenever it occurred as opposed to being incomplete?

A. Well, I think it was -- I think it was clearly incomplete because there was evidence of progression after the injury.

Q. And by that you mean what?

A. That the patient's neurologic status further deteriorated.

Q. Are there any materials that you sought in order to evaluate this matter that were not provided to you but you said I need to see this and you didn't get it?

A. Well, originally, I said the x-rays, let's see what the x-rays look like. They're

gone. Nobody has them.

Q. To this late date, as we are sitting here for purposes of your trial testimony, is there anything that you asked for that you didn't get?

A. No.

Q. Is there anything out there that you think might -- is there anything else out there that you would like to review that you might think would play some role in the opinions that you have or have rendered?

A. No, actually because the things that might have given us some hint were the operative reports from the 13th and 18th, and I have read those and neither one of them reflects any soft-tissue damage.

Q. Which tells you what?

A. Well, you know, that would be sort of the smoking gun of, you know, where did the blow come from and neither is there any evidence in any of the physical exams of any soft-tissue damage to the top of the head.

So you are sort of scratching your head as to, well, what is the mechanism of

injury here.

You know, all the pieces aren't there that you would like to be able to say, well, this is how it clearly happened.

MR. JOLLY: I have no further questions.

REDIRECT EXAMINATION

BY MR. LUCAS:

Q. Just a couple, Doctor, a couple of general questions.

You were asked whether cr not you had seen a case similar to this in your background.

Are most of your cases involving neck and cervical injuries similar, or are they all different in terms of actual injury and severity of injury?

A. Well, in terms of what we see and what I deal with, which is the fact that someone comes in with an acute neurological injury, they are relatively straightforward in terms of what I do. They are almost all the same.

What we do is we immobilize the neck, if it has not already been immobilized.

If it has, you leave it alone and don't take it off.

We then do a **series of diagnostic** tests which range from starting out with a history and physical exam through doing x-rays and CT scans.

And emergency treatment in the emergency department, per se, which after **immobilization really** only consists of the use of Methylprednisolone.

After that, everything is up to the neurosurgeons. We do nothing. And from that point of view, they are all the **same** with the exception that some of these patients have a life threat, an immediate life threat, and that's usually going to be airway, unless they have some associated injuries associated with the automobile accident or whatever the cause was.

Q. Would that also apply then to Brian Cort if he had **been** brought into the emergency room maybe with or without a collar but otherwise requiring emergency aid?

A. Sure.

Q. What you are discussing is essentially you are looking in them as people who are in life threatening or nonlife threatening situations.

Then you look at them and diagnose a determination of their cervical break, and then you stabilize and send them out to someone else?

A. Sure. Actually, it is called the A, B, C's; airway, does he have an airway; breathing, is he breathing; C, circulation, in other words, is his heart beating, does he have a blood pressure, is he bleeding externally; and, D, assertive definitive diagnosis and definitive treatment.

Definitive diagnosis in this case would have been A, B, C were okay, definitive diagnosis is he has a C-spine fracture, call the neurosurgeon.

Q. Now, Doctor, have you seen similar to, I think, you called them -- when you talked about football coming together. What is it?

A. Head butting injuries?

Q. Head butting.

A. Yes.

Q. Have you seen several of those when they have come in?

A. Sure.

Q. So you are used to the type of compression fractures and burst fractures that arise from that type of injury?

A. Oh, sure.

Q. You also have seen victims of either beatings or assaults that have come in with a broken neck?

A. Oh, sure.

I mean, we have seen everything from assaults and beatings to people jumping out of windows to going through the windshields of cars.

Actually, the most common cause are flexion/extension injuries associated with car accidents.

Q. Doctor, I want to ask you about something.

When you review cases for legal-medical matters, those things that you go to trial, do you customarily rely on deposition

testimony as well as medical records and x-rays and CT's in order to formulate your opinion?

A. Well, yes, to the extent that, you know, my job as an expert is to try to reach a conclusion believing everything that everybody says.

And when there is a disagreement, obviously that's for the jury to determine what is truth and what isn't truth, and then I can only answer questions given various hypotheticals.

But ordinarily my job is to try to believe everybody and come up with an explanation that allows everybody to be believable.

Q. Essentially do you use the depositions and testimony, including the hearsay testimony included therein, in evaluating cases and providing opinions?

A. Sure.

I mean I have no reason to believe that any document or any testimony is false. I mean my job is to assume that it is all true.

Q. I take it that if something is missing from a file that's given to you, whether it'be x-rays, CAT scans, some medical records, whatever it is, you come to your conclusion as to what is reasonable and most probable from a medical viewpoint based on the evidence that is given to you in any point?

A. Sure.

You have to deal with what you have available, and one of the jobs as an expert is to be able to change his opinion given ne'w evidence.

Q. Aside from the comments, observations made by Nurse Hinson when she first saw this man after he was injured, did you see any indication. of any communication between the Sheriff's deputy or any medical personnel belonging to Prison Health Services, Inc., until 11:45 on the day of March 12, 1993?

A. No.

Q. Would there -- were there indications, nevertheless, that should have been available or seen by a deputy or anyone else that this man was injured and hurting?

MR. JOLLY: Objection, that's speculative. Go ahead.

THE WITNESS: I think there were indications that they saw what he was and wasn't doing; that he wasn't moving his legs; that he could barely hold a cup of water; that when he tried to drink the cup of water, a deputy had to help move his elbow to get the cup of water to his mouth.

So, you know, there were clearly indications that something was going on here that wasn't normal.

MR. JOLLY: Objection. Let me just object and ask that that be stricken, but go ahead.

BY MR. LUCAS:

Q. Was his report of history to a deput of significance? Was it symptomatic of a problem?

A. Oh, sure, that history being that he couldn't move his legs. He said I can't move my legs.

THE VIDEOGRAPHER: Off the record at 11:48.

(Whereupon a short break was had.)

THE VIDEOGRAPHER: Back on the record. at 11:49. Please proceed.

BY MR. LUCAS:

Q. Doctor, assuming for the moment the possibility that there was a hematoma below the skin in back of the neck where a blow might have occurred, would that have dissipated or evaporated or gone away within a matter of a week or two?

A. Well, that certainly would begin to resolve. How much it would have resolved and how much would have been detectable is really a function of how large it was and exactly where the blow was vis-a-vis the incision that was made by the surgeon.

Q. Is it possible that a black and blue mark or hematoma, whatever, the bruising would not be visible on an Afro-American with a particular dark pigmentation?

MR. JOLLY: Objection, predicate. Objection, it is an incomplete and inaccurate hypothetical.

MR. LUCAS: Assuming --

MR. JOLLY: No.

BY MR. LUCAS:

Q. Assuming that that was the truth in this case?

A. Yes.

Q. Is it possible that a blow could have been delivered on the back of the neck causing the injury that it did without leaving any bruising on the surface of the skin?

MR. JOLLY: Objection, relevancy. Go ahead, and it is an improper hypothetical.

THE WITNESS: Yes.

BY MR. LUCAS:

Q. Have you in your experience in the ER and seeing the number of people that come down with single or multiple injuries, have you seen individuals who have been beaten who may be internally injured to a great degree but do not show great external injuries or indications of a beating?

A. Yes, that's true.

Q. Doctor, am I correct in saying this is primarily a problem of a failure to diagnose and

stabilize initially insofar as Brian Cort is concerned?

MR. JOLLY: Objection, form. It is leading. Objection, it is incompletely inaccurate. He's asking for an opinion based upon an incomplete and inaccurate hypothetical, relevancy and predicate and qualifications.

MR. LUCAS: Okay. We will rephrase it.

BY MR. LUCAS:

Q. Doctor, assuming the original facts that I gave you in this case during our original interrogation and examination and assuming that you have read all the medical records and you have read the depositions, which you have said, is there a problem with diagnosis and stabilization in this case insofar as Brian Cort is concerned?

MR. JOLLY: Objection, vague. Go ahead.

THE WITNESS: Yes.

BY MR. LUCAS:

Q. Is that the primary problem?

A. Yes.

MR. **LUCAS:** That's all I have..

MR. JOLLY: Just one question.

REC**ROSS-EXAMINATION**

BY MR. JOLLY:

Q. Mr. Lucas asked you about injury from a beating not always being observable externally, right?

A. I think he talked about not necessarily from a beating. I think he talked about internal injuries not having -- not being observable.

Q. There were no internal injuries anywhere on the body with the exception of the specific area of C-3 through C-5 indicating **a** beating?

A. That's true.

MR. JOLLY: No further questions.

REDIRECT EXAMINATION

BY MR. LUCAS:

Q. Actually my question was going back to his question.

In your work at the hospital as an ER physician, do you see individuals coming in to that hospital who may have **internal**

injuries from a beating but who did not *exhibit* external signs *of* a beating?

A. *Yes.*

MR. LUCAS: Okay. Thank you.

MR. JOLLY: No further questions.

Dr. Baker, nice to meet you.

THE VIDEOGRAPHER: Of€ the record with the conclusion of the deposition of Dr. Frank Baker at 11:53.

AND FURTHER DEPONENT SAITH NOT...

STATE OF ILLINOIS)
) SS.
COUNTY OF C Θ o K)

I, ELIZABETH R. **MALA-SKWAREK,** Certified Shorthand Reporter and Notary Public in and for the County of Cook, State of Illinois, do hereby certify that on the 16th of August, **A.D.,** 1997, the evidence deposition of the witness, FRANK J. BAKER, 11, M.D., called by the Plaintiffs, was taken before me, reported stenographically and was thereafter reduced to typewriting through computer-aided transcription.

The said evidence deposition was taken at the offices of Marriott Suites Hotel, 6155 River Road, Rosemont, Illinois, and there were present Counsel as previously set forth.

The said witness, **FRANK** J. BAKER, II, M.D., was first duly sworn to **tell** the truth, the whole truth, and nothing but the truth, and was then examined upon oral interrogatories.

I further certify that the foregoing is a true, accurate and complete

record of the questions asked of and answers made by the said witness, at the time and place hereinabove referred to.

The undersigned is not interested in the within case, nor of kin or counsel to any of the parties.

Witness my official signature and seal as Notary Public, in and for Cook County, Illinois on this 19th day of August, A.D., 1997.

Elizabeth R Mala Skwarek, CSR

License No. 084-003931

FRANK J. BAKER II, M.D.
39 TIMBER COURT
OAKBROOK, ILLINOIS 60523
630-941-9096
Facsimile 630-941-9044

Diplomate
American College of Emergency Medicine
Diplomate
American Board of Internal Medicine
Diplomate
American Board of Forensic Examiners
Diplomate
American Board of Forensic Medicine

Fellow
American College of Emergency Physicians
Life Fellow
American College of Forensic Examiners

CURRICUEUM VITAE

TELEPHONE NUMBER: HOME: 630-941-9099
DATE OF BIRTH: 30 OCTOBER 1945
MARITAL STATUS: MARRIED

EDUCATION

1963 - 1967	Bachelor of Arts (Chemistry) Elmhurst College Elmhurst, Illinois
1967 - 1971	Doctor of Medicine Loyola Stritch School of Medicine Maywood, Illinois
1982 - 1984	Masters Business Administration Health Administration and Policy Executive Program (XP52) University of Chicago, M.B.A. Chicago, Illinois
1971 - 1972	Internship, Straight Medicine University of Chicago Hospitals Chicago, Illinois
1972 - 1974	Resident, Internal Medicine University of Chicago Hospitals Chicago, Illinois

DEFENDANT SHERIFF'S
DEP. EX. NO. A
FOR ID. AS OF 8/15/94 mm

EMPLOYMENT

1974 - 1978	**Assistant Professor** Division of **Emergency Medicine** and **Department** of **Medicine** **University** of **Chicago** Pritzker **School of Medicine**
1978 - 1984	**Associate Professor** **Department of Emergency** Medicine and **Department of Medicine** **University** of **Chicago** **Pritzker School** of **Medicine**
1984 - Dec. 1987	**Professor** **Department of Emergency Medicine** and **Department** of **Medicine** **University** of **Chicago** **Pritzker School of Medicine**
April 1977 - June 1978	**Acting Director** **Division** of **Emergency Medicine** **University of Chicago Hospitals**
July 1978 - July 1987	**Chairman** **Department of Emergency** Medicine **University of Chicago Hospitals**
1976 - 1987	**Founder and Project Medical Director** Chicago **South Mobile** Intensive Care Program
November 1982 - July 1987	**Founder and Director** **University of Chicago Aeromedical Network**
May 1988 - Present	**Attending Physician, Emergency Department,** MacNeal Memorial Hospital, Berwyn, Illinois

CORPORATE BOARD DIRECTORSHIPS

Universal Health Foundation	January 1996

LICENSES AND BOARD CERTIFICATIONS

State of Indiana License	1985
DEA Registration	1972
State of Illinois License	1972
Diplomate, National Board of Medical Examiners	1972
Diplomate, American Board of Internal Medicine	1973
Diplomate, American Board of Emergency Medicine (initial certification)	1980
Diplomate, American Board of Emergency Medicine (Recertification)	1992
Fellow, American College of Emergency Physicians	1982
Diplomate, American Board of Forensic Examiners	1996
Diplomate, American Board of Forensic Medicine	1996
Life Fellow, American College of Forensic Examiners	1996
National Affiliate Faculty, American Heart Association	1978
Advanced Cardiac Life Support, American Heart Association	1977
Basic Life Support, American Heart Association	1977
Instructor, Advanced Trauma Life Support, American College of Surgeons	1981

HONORS AND AWARDS

Beta Beta Beta, Blue Key
Illinois Chapter of the American College of Emergency Physicians,
"Bill B. Smiley, M.D., Meritorious Service Award"
1988 Aerospatiale Helicopter Corporation, Aeromedical Achievement Award

COMMUNITY ACTIVITIES

Finance Committee Chairman
St. John Lutheran Church
LaGrange, Illinois **1990-1993**

Member, **Coordinating Council**
St. John Lutheran **Church**
LaGrange, Illinois **1990-1993**

Member, Senior & Men's Choirs
St. John Lutheran **Church**
LaGrange, Illinois **1988-present**

MACNEAL HOSPITAL ACTIVITIES

Member, Department of Family **Practice, Quality Assurance Committee** **1990-present**

PROFESSIONAL ASSOCIATIONS

Associate, American College of Physicians	1973-1975
Member, American College of **Emergency** Physicians	1975-present
Member, Illinois Chapter, American College of **Emergency Physicians**	1975-present
Member, **American College of Physicians**	1975-present
Member, Undersea Medical Society	1975-1984
Fellow, Institute of Medicine of *Chicago*	1977-1982
Member, Society of Teachers of Emergency Medicine	1977-1987
Member, Chicago Foundation for Medical Care	1978-1981
Member, International Civil Defense, Geneva	1978-1985
Member, **University Association for Emergency** Medicine	1978-1987
Member, **International Society** of **Disaster Medicine**	1979-1981

Member, Club of Mainz Emergency Association (world-wide membership limited to 100)	1981-1987
Member, World Assoc. of Emergency & Disaster Medicine (formerly Club of Mainz, as above)	1987-present
Executive Committee Member, World Association of Emergency & Disaster Medicine	1987-1992
Member, American Society of Hospital Based Emergency Aeromedical Services (ASHBEAMS)	1983-1988
Member, Helicopter Association International	1983-1989
Member, ASTM	1987-1988
Member, American Medical Association	1988-present
Member, Chicago Medical Society	1988-present
Member, Advisory Board, Saudi Arabian Anaesthetic Association	1990-present
Member, American Board of Forensic Examiners	1994-present
Member, American College of Physician Executives	1995-present

UNIVERSITY OF CHICAGO
PRITZKER SCHOOL OF MEDICINE & HOSPITALS AND CLINICS ACTIVITIES

Alternate, Clinical Faculty Advisory Committee	1974-1975
Member, Internship Rotating Committee	1974-1987
Faculty Secretary, Division of Emergency Medicine	1974-1975
Delegate, Clinical Faculty Advisory Committee	1976-1977
Member, Task Force on Graduate Medical Education	1976-1977
Member, Cardiopulmonary Resuscitation Committee	1977-1987
Chairman, Cardiopulmonary Resuscitation Committee	1978-1987
Preceptor, Physical Diagnosis Class	1978-1979
Interviewer, Committee on Admissions	1978-1987
Member, Executive Committee of the Medical Staff	1978-1987
Member, Nursing Director Search Committee	1980
Member, Ambulatory Care Task Force	1980-1981
Alternate Councilor, Council of the University Senate	1980-1981
Chairman, Hospital Disaster Plan Committee	1980-1987
Member, Hospital Admission and Consultation Policy Committee	1981
Member, Ad Hoc Committee on IBX	1982
Councilor, Council of the University Senate	1984-1985
Member, Strategic Planning Committee	1986-1987
Member, Management Utilization Review Committee	1986-1987

UNIVERSITY OF CHICAGO
GRADUATE SCHOOL OF BUSINESS ACTIVITIES

Chairman, 52nd Group of the Executive Program	1982-1983
Preceptor, Graduate School of Business, Health Administration Program	1983-1987
Judge, Touche Ross & University of Chicago, Graduate School of Business Consulting Challenge	January 1988 January 1989
Candidate Interviewer	1996-Present

PROFESSIONAL ACTIVITIES (outside the University of Chicago)

Special Advisor, Department of Emergency Medical Services, Illinois Department of Public Health	1977-1988
Consultant, Trauma Severity Index Project Center for Health Systems Research and Analysis University of Wisconsin, Madison, Wisconsin	1978
Assistant Editor, Abstract Section: *Annals of Emergency Medicine*	1978-1982
Consultant, *The Physician's Underwater and Hyperbaric Handbook* Published by the Undersea Medical Society Bethesda, Maryland	1978
Review Editor, *Journal of the American Medical Association*	1978-present
Official Representative for the American College of Emergency Physicians to the 3rd International Congress on Disaster Medicine Monte Carlo, Monaco	April 1979
Associate Editor, *Emergency Department News*, New York	1979-1982
Member, Long Range Subcommittee for Mobile Intensive Care and Paramedic Education, Chicago	1980

Co-Chairman, Board of Physicians for Mobile Intensive Care and Paramedic Education, Chicago	1981
Consultant, *"CPR - To Save a Life,"* film for Encyclopedia Britannica Corporation, Chicago, Illinois	1981
Editorial Board, Journal *of Emergency Medicine*	1982-1983
Preceptor, Health Systems Management Program, Rush University, Chicago	1983
Adjunct Faculty, Chicago City-Wide Paramedic Program	1983-1984
Member, EMS Committee, Helicopter Association International	1984-1987
Reviewer, Residency Review Committee American College of Emergency Medicine	May 1984
Member, Research Committee, American Society of Hospital Based Emergency Aeromedical Services	1984-1987
Reviewer, "CHEST," The Official Journal of the American College of Chest Physicians	1986-present
Member, Editorial Board, *"Ambulatory Medicine Alert"*	1987-1988
Coordinating Consultant Physician, *Universal Health Conference '91,* A Joint Venture between the USSR State Committee for Science and Technology, The Ministry of Public Health of the Moscow City Council, and the Ministry of Public Wealth of the Russian Federation	April 1991- October 1991
United States Co-Chairman Scientific Committee, Second *Universal Health Conference, Exhibition and "Micro-Hospital"* (TM) Sponsored by the Ministry of Public Health, Republic of Uzbekistan, C.I.S., Ministry of Science, Higher Education and Technology Policy, Russia, C.I.S., and the Khokimiyat (Mayor) of the City of Samarkand, Uzbekistan, C.I.S.	October 1991- Sept. 1993
Medical Director, *"Micro-Hospital"* (TM) *Second Universal Health Conference*, Samarkand, Uzbekistan, C.I.S.	October 1991- Sept. 1993
United States Co-Track Leader Scientific Committee, *Third Universal Health Conference, "Micro-Hospital"* (TM) *Workshop & Exhibition 1995* Sponsored by the Ministry of Public Health, Republic of Kazakhstan, C.I.S., Ministry of Science, Higher Education and Technology Policy, Russia, C.I.S.	Sept. 1993- April 1995

United States Co-Medical Director, *"Micro-Hospital"* (TM) *Third Universal Health Conference, "Micro-Hospital"* (TM) *& Exhibition 1995*, Almaty, *Kazakhstan*, C.I.S. — Sept. 1993-April 1995

United States Co-Track Leader Scientific *Committee, Fourth Universal Health Conference, "Micro-Hospital"* (TM) *Workshop & Exhibition 1996* Sponsored by the Ministry of Sciency & Technology Policy, Russia, C.I.S., Universal Health Association, Chicago, Illinois, U.S.A. — May 1995-Sept 1996

United States Co-Medical Director, *"Micro-Hospital"* (TM) *Fourth Universal Health Conference, "Micro-Hospital"* (TM) *& Exhibition 1996*, Moscow, Russia, C.I.S. — May 1995-Sept. 1996

Chairman, Scientific Committee, *Fifth Universal Health Conference, "Micro-Hospital"* (TM) *Workshop & Exhibition 1997* Sponsored by the All-Russian Center on Disaster Medicine; Ministry of Health of Russia, Ministry *of* the Russian Federation for Civil Defense, Emergencies and Elimination of Consequences of Natural Disasters (EMERCON); Ministry of Science and Technology, Russia, C.I.S.; The World Association of Disaster and Emergency Medicine (WADEM), Safar Center for Resuscitation Research, Pittsburg, Pennsylvania, U.S.A.; and *the* Universal Health Association, Chicago, Illinois, U.S.A. — May 1996-Sept. 1997

Medical Director, *"Micro-Hospital"* (TM) *Fifth Universal Health Conference, "Micro-Hospital"* (TM) *& Exhibition 1997*, Moscow, Russia, C.I.S. — May 1996-Sept. 1997

AMERICAN BOARD OF EMERGENCY MEDICINE (ABEM)

Examiner, Test Committee — 1981-1983

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP)

Faculty/Councilor ACEP/EDNA, Innovations in Emergency Medicine	1975
Councilor (Illinois), National Council Meeting	1975-1978
Member, Continuing Education Committee	1976-1979
Member, Council Tellers, Credentials and Elections	1978-1979
Member, National Scientific Meetings Committee	1978-1979
Member, Scientific Assembly Program Committee	1978-1979
Coordinator, Advances in Emergency Medicine Series	1978-1979
Chairman, Scientific Assembly Abstracts, Atlanta	1979
Member, Symposium Committee	1980

Fellow, American College of Emergency Physicians	1982-present
Liaison Representative, American Heart Association Subcommittee on Emergency Cardiac Care	1982-1987
Participant, ACEP's Pilot Course on Disaster Management & Planning for Emergency Physicians, Emmitsburg, Maryland	1983
Member, Disaster Committee	1984-1985

ILLINOIS CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Member, Scientific Assembly Committee	1975-1977
Member, Board of Directors	1975-1979
Member, Executive Committee	1975-1979
Co-Coordinator, Scientific Assembly Committee	1975-1979
Faculty, Illinois/Missouri Chapters ACEP/EDNA	1975-1976
Chairman, Education Committee and Scientific Assembly Committee	1976-1977
Chairman, Emergency Medical Services Committee	1976-1977
President-Elect	1976-1977
President	1977-1978
Chairman, Ad Hoc Committee on Liaisons with Professional Organizations	1977-1978
Chairman, Structure and Reorganization Committee	1977-1978
Chairman, Executive Committee	1977-1978
Member, Nominating Committee	1978-1979
Member, ACLS Committee	1978-1979
Chairman, Ad Hoc Committee on Awards	1978-1979
Immediate Past-President	1978-1979

UNIVERSITY ASSOCIATION FOR EMERGENCY MEDICINE

Member, Site Selection Committee	1978-1987
Official Liaison between the University Association for Emergency Medicine and the Emergency Department Nurses Association	1978-1980

SOCIETY OF TEACHERS OF EMERGENCY MEDICINE

Member, Board of Directors	1978-1981
Coordinator, STEMI Advanced Cardiac Life Support Instructor Course for Faculty in Emergency Medicine	1979
President-Elect	1979-1980
Editor, *STEM LETTER*	1979-1980
President	1980-1981

Representative, Council of Academic Societies/Association of American Medical Colleges, Washington, D.C.	1978-1980
Member, Consultation Committee	1981-1987

AMERICAN HOSPITAL ASSOCIATION

Faculty, Institute for Disaster Preparedness	1975
Faculty, National Joint Conference on Improving Hospital Emergency Medical Services, Chicago	1977
Faculty, National Joint Conference on Improving Hospital Emergency Medical Services, New Orleans	1978

CHICAGO HEART ASSOCIATION

Member, Emergency Care Committee	1977-1990
Chairman, Advanced Cardiac Life Support Committee	1977-1980
Co-Chairman, Emergency Care Committee	1978-1980
Chairman, Emergency Care Committee	1980-1983
Member, Board of Governors	1982-1987
Member, Advanced Cardiac Life Support TAG Committee	1977-1987
Member, Public Policy & Government Relations Committee	1986

AMERICAN HEART ASSOCIATION

Member, National Faculty, Training Network for ACLS and BLS	1982-1987
Liaison Representative, American Heart Association Subcommittee on Emergency Cardiac Care	1982-1989
Member, Subcommittee on Standards for Cardiopulmonary and Emergency Cardiac Care	1983-1987
Review and Revision of the Standards and Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Dallas, Texas	July 1985

EMERGENCY MEDICAL SERVICES COMMISSION OF METROPOLITAN CHICAGO

Mid-South Area Wide Health Organization Representative to Committee on Communications and Transportation	1974-1987
Member, Executive Committee	1975-1987
Member, Mobile Intensive Care Committee	1975-1987

Member, Drug and Paramedic Education Subcommittee, MICU Committee	1975-1976
Vice-Chairman, Disaster Committee	1975-1976
Chairman, Area Wide Hospital Emergency Services	1975-1977
Co-Chairman and Keynote Speaker, Disaster Workshop	1976
Moderator and Panelist, Workshop on Alcohol Abuse	1974
Chairman, Disaster Preparedness Committee	1977-1980
Member, Hospitals Committee of the Emergency Medical Commission	1982-1987
Voting Member, Areawide Emergency Hospital Services Committee	1983-1987

DISASTER DRILLS

Senior Physician, Medical Command, Mid-South Disaster Drill	1974
Senior Physician Observer, Lincoln Park-Lakeview Disaster Drill	1974
Senior Physician Observer, Northside Commission Disaster Drill	1975
Coordinator, Mid-South Disaster Drill	1976
Co-Coordinator, Mid-South Disaster Drill	1977
Moderator, Disaster Critique	1985

COURSES TAUGHT

1. CPR Preceptor, Basic Emergency Medical Technician Course, Archdiocese of Chicago School, Chicago, June 1977.
2. Orientation program for entering medical students, Pritzker School of Medicine, University of Chicago, September 1977.
3. CPR Elective, Pharmacology of Depressive Illness, Continuing Education Symposium University of Chicago, Center for Continuing Education, Chicago, October 1977
4. CPR Instructor's Course, Cook County Sheriff's Department, Maywood, Illinois, March 1978
5. Chicago Federal Executive Board, CPR Program, Chicago, May 1978
6. Chicago Federal Executive Board, CPR Program Chicago, June 1978
7. *"Introduction to Cardiopulmonary Resuscitation"* University of Chicago Pritzker School of Medicine, Orientation Program for entering medical students, September 1979
8. Twentieth International Conference on Legal Medicine, American College of Legal Medicine, Houston, Texas, May 1980
9. Physician Base Station Course, CHRIST HOSPITAL, *Oak* Lawn, Illinois, October 1981
10. *"Abdominal Trauma"* and *"Extremity Trauma,"* Advanced Trauma Life Support Course (ATLS), Chicago Committee on Trauma, American College of Surgeons, Evanston, Illinois May 1982
11. Physician Base Station Course, Department of Emergency Medicine, University of Chicago, July 1982

12. American College of Emergency Physicians Disaster Course, Los Angeles, California, February 1984
13. *"Abdominal Trauma"* and *"PASG Application/Removal,"* ATLS Course, Chicago Committee on Trauma of the American College of Surgeons, Evanston, Illinois May 1984
14. American College of Emergency Physicians Disaster Course, Chicago, Illinois July 1984
15. "Abdominal Trauma" ATLS Course, Chicago Committee on Trauma of the American College of Surgeons, Evanston, Illinois November 1984

ADVANCED CARDIAC LIFE SUPPORT COURSES

1. *"Adjuncts to Airway Management,"* Lutheran General Hospital, Park Ridge, Illinois Aug. 1977
2. *"Arrhythmia Identification,"* South Chicago Community Hospital, Chicago, Ill., Dec. 1977
3. *"Essential Drugs in Cardiac Care,"* University of Chicago Hospitals, February 1978
4. *"Stabilization and Transportation,"* University of Chicago Hospitals, February 1978
5. *"Useful Drugs in Advanced Cardiac Life Support,"* University of Chicago Hospitals Feb. 1978
6. *"Useful Drags in Advanced Cardiac Life Support,"* Michigan Heart Association, Grand Rapids, Michigan, March 1978
7. *"Adjunctsto Circulation,"* Airway Station, Lake Forest Hospital, Lake, Forest, Ill., Mar. 1978
8. *"Defibrillation,"* Airway Station, South Chicago Hospital, Chicago, Illinois, June 1978
9. *"Intravenous Techniques,"* American Medical Association Meeting, St. Louis, MO., June 1978
10. *"Useful Drugs in Advanced Cardiac Life Support,"* University of Chicago Hospitals, July 1978
11. *"Introduction to Advanced Cardiac Life Support,"* Therapy for Dysrhythmia Station, Illinois Masonic Medical Center, Chicago, Illinois, July 1978
12. "Acid *Base Balance,"* Therapy for Dysrhythmia Station, Northwest Community Hospital, Arlington Heights, Illinois, January 1979
13. *"Defibrillation,"* Therapy for Dysrhythmia Station, Ingalls memorial Hospital, Harvey, Illinois, March 1979
14. Affiliate Faculty, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois, March 1980
15. *"Advancesin Basic Life Support,"* Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois, March 1980
16. *"Defibrillation,"* Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois, March 1980
17. *"Acid Base Balance,"* University of Chicago, Department of Emergency Medicine, July 1980
18. *"IV's,"* Michael Reese Medical Center course for physicians, September, 1980

19. *"Monitoring and Dysrhythmia,"* University of Chicago, Department of Emergency Medicine, Center for Continuing Education, November 1980
20. *"Defibrillation Cardioversion,"* University of Chicago, Department of Emergency Medicine Center for Continuing Education, November 1980
21. ACLS Affiliate Faculty Update, Chicago and Illinois Heart Affiliates, Northwestern University Hospital, Chicago, Illinois, January 1982
22. ACLS Affiliate Faculty, Senior Medical Students, Pritzker School of Medicine, April 1982
23. ACLS Affiliate Faculty, Senior Medical Students, Pritzker School of Medicine, May 1982
24. ACLS Affiliate Faculty, Department of Medicine Faculty, University of Chicago, June 1982
25. *"Acid Base Balance"* and *"PatientManagement,"* University of Chicago, June 1982
26. ACLS Instructor Affiliate Faculty, Department of Emergency Medicine, April 1983
27. ACLS Affiliate Faculty, Senior Medical Students, Pritzker School of Medicine, April 1983
28. *"AcidBase Balance"* and *"IV Techniques,"* University of Chicago Hospitals, June 1983
29. Faculty Sponsor, St. Catherine's Hospital, East Chicago, Indiana, June 1986.

PANEL DISCUSSIONS

1. *"MobileIntensive Care and Radiotelemetry,"* Symposium for Emergency Nurses, Chicago, Illinois 1977
2. *"Stump the Experts,"* Illinois Combined Scientific Assembly, American College of Emergency Physicians, Emergency Department Nurses Association, April 1977
3. *"In the Pit* or *in the Pulpit-Emergency Department v. Traditional Services as Training Sites,"* Society of Teachers of Emergency Medicine, Scientific Assembly, Atlanta, Georgia, October 1979
4. *"Slave Shop or Training* Ground," Second Annual Society of Teachers of Emergency Medicine Silver Tongue Orators Debate, American College of Emergency Physicians/Society of Teachers of Emergency Medicine Scientific Paper Presentation, Las Vegas, Nevada, September 1980
5. *"The Impact of Emergency Medical Specialists on Surgical Cure in the Emergency Room,"* Committee of Issues of the Association for Academic Surgery, The University of Alabama, November, 1980
6. *"Organizational and Physiological Problems in Airplane and Airport Disasters,"* Chairman, International Symposium on *Airplane* and *Airport* Disasters, Mainz, Germany, March *1981*
7. *"Management of Complex Cases in Emergency Medicine,"* Illinois Combined Scientific Assembly, Chicago, Illinois, April 1982
8. *"Scientific Paper Discussion,"* 1982 Scientific Assembly, San Francisco, California, September 1982
9. *"Do Trauma Centers Make a Difference?"* American College of Surgeons, 68th Annual Clinical Congress, Chicago, Illinois, October 1982
10. *"Ethics and Morals in Emergency Medical Services,"* Tenth Annual Combined Scientific Assembly, Itasca, Illinois, May 1984

11. *"TraumaScore Concept and Patient Treatment,"* Northern Illinois Medical Center Trauma Center, McHenry, Illinois, May 1984
12. *"Aeromedical Transport Teams,"* Emergency Medical Services Symposium, St. Mary of Nazareth Hospital, Chicago, Illinois, September 1985
13. *"Cardiology Update,"* Porter Memorial Hospital, Valparaiso, Indiana, November 1985
14. *"Changing Times, Changing Opinions: How Should Trauma Centers be Designated and How Should the Trauma Center System be Integrated with the Existing EMS System?"* Illinois Chapter, American College of Emergency Physicians Winter Symposium, *Lake* Geneva, Wisconsin, February 1986
15. *"Can You Top This One?"* Illinois Emergency Nurses Association Thirteenth Annual Scientific Assembly, Oakbrook, Illinois, April 1986

PUBLICATIONS

TEXTBOOK

EMERGENCY MEDICINE: Concepts and Clinical Practice, P. Rosen, F. Baker, G. Braen, R. Dailey, R. Levy, The C.V. Mosby *Co.*, St. Louis, MO., First Edition, March, 1983

EMERGENCY MEDICINE: Concepts and Clinical Practice, P. Rosen, F. Baker, R. Barkin, G. Braen, R. Dailey, R. Levy, The C.V. Mosby Co., St. Louis, MO., Second Edition, Oct. 1987

JOURNAL ARTICLES

1. Kohn, *M.*, Baker F.: *Hyperbaric Therapyfor CO Intoxication (letter).* JACEP 4(2):161, Mar/April, 1975
2. Fauman, B., Baker, F., Coppleson, L., Rosen, P., et al.: *Psychosis Induced by Phencyclidine.* JACEP 4(3):223, May/June, 1975
3. Baker, F., Rosen, P., et al.: *Diabetic Emergencies: Hypoglycemia and Ketoacidosis.* JACEP 5(2):119, February, 1976
4. Sternbach, G., Baker, F.: *The Emergency Joint: Arthrocentesis and Synovial Fluid Analysis.* JACEP 5(10):787, October, 1976
5. Gerschke, G., Baker, F., Rosen, P.: *Pulsus Paradoxus as a Parameter in the Treatment of the Asthmatic.* JACEP 6(5): 191, May 1977
6. Baker, F., Sternbach, G., Rosen, *P.*: *Case Reports in Emergency Medicine, 1974-1976.* Technomic Publishing Company, Westport, Connecticut, 1977. Participant in Case Report Discussions.
7. Rothstein, R., Baker, F: *Tetanus: Prevention and Treatment.* JAMA 240(7):675,1978
8. Baker, F., Franaszek, J.: *Coordination and Cooperation of Public and Private Agencies in the Design and Operation of a Major Metropolitan Disaster Plan.* Proceedings of the First International Conference in Israel on Mass Casualty Management, Safad, Israel, September, 1978

9. Baker, F: ***Regional Disaster Planning.*** **In the Organization and** Administration of **Emergency Medical Care (Sternbach,** G. **Editor), Technomic Publishing Company, Westport, Connecticut, 1978**
10. Baker, F.: ***Radio Telemetry and Mobile Intensive Care.*** In the **Organization and** Administration of **Emergency** Medical **Care. (Sternbach, G. Editor),** Technomic Publishing **Company,** Westport, **Connecticut, 1978**
11. Lumpkin, J., **Baker, F., Franaszek,** J.: ***Alcoholic Ketoacidosis in a Pregnant Woman.*** **JAGEP 8(1):21, January 1979.**
12. Baker, **F:** ***Management of Mass Casualty Disasters.*** **Topics** in **Emergency** Medicine 1(1), **March 1979**
13. Baker, F: ***Management of Crash Site: City of Chicago Disaster Plan.*** **Pulse 6:** Summer **1979**
14. Baker, **F:** ***Hospital physician's Role in Disaster Planning and in the Management of the Disaster Site: The City of Chicago Disaster Plan.*** **Disaster Medicine: Types and** Events of **Disasters, Organization in** Various **Disaster Situations. (Frey, R,** Safar, **P.: Editors),** Springer-Verlag, Berlin, **Germany, 1980**
15. **Graber, T.,** ***Yee,*** **A., Baker,** F: ***Magnesium: Physiology, Clinical Disorders and Therapy.*** **Annals of Emergency** Medicine 10(1):49, January, **1981**
16. **Baker, F., Straws, R., Walter,** J.: ***Cardiac*** **Arrest, Chapter 4,** EMERGENCY MEDICINE: Concepts **and Clinical** Practice **(Rosen, P., et al.,** editors) St. Louis, MO., **The C.V. Mosby Co., March 1983, First Edition**
17. Janson, ***C.,*** Birnbaum, ***G.,*** Baker, F: ***Hypophosphatemia.*** Annals of Emergency **Medicine** 12:107, **February, 1983**
18. *Baker,* F. **Straws,** R., **Walter,** J: ***CardiacArrest,*** **Chapter 4, EMERGENCY** MEDICINE: **Concepts and** Clinical **Practice** (Rosen, **P. et** al., **Editors) St. Louis,** MO., The C.V. Mosby Co., **March, 1983, Second Edition**
19. **Springer, G.F.,** *Baker,* F: ***Cranial Burr Hole Decompression in the Emergency Department.*** **The American** Journal **of Emergency Medicine, November, 1988. W.B. Saunders,** Vol. **6,** Number **6**
20. **Baker, F:** ***Narcotic Poisoning; Conn's Current Therapy,*** **W.B.** Saunders **Company, 1990**

LECTURES AND SCIENTIFIC PRESENTATIONS

1. ***"Obesity,"*** Hyde **Park** Community Health **Organization,** ***Chicago,*** Illinois, September **1973**
2. ***"Diabetic Emergencies,"*** Illinois **Regional** ***American*** **College of Emergency Physicians Meeting, Chicago, Illinois, April 1974**
3. ***"Diabetic Emergencies,"*** **National American College of Emergency Physicians Scientific Assembly, Washington, D.C., November,** 1974
4. ***"Malignant Hypertension/Hypertensive Emergencies,"*** **Illinois Missouri Regional American College** of Emergency Physicians **Scientific Assembly,** St. Louis, **MO., April, 1975**

5. *'Diabetic Emergencies,"* Illinois/Missouri Regional American College of Emergency Physicians Scientific Assembly, St. Louis, Mo., April, 1975
6. ***"Carbon Monoxide Poisoning,"*** Illinois/Missouri Regional American College of Emergency Physicians Scientific Assembly, St. Louis, Mo., April 1975
7. ***"Regional Disaster Planning, Components of Urban Disaster Planning,"*** Institute of Disaster Preparedness Workshop, American Hospital Association, Chicago, Illinois, May, 1975
8. ***"CarbonMonoxide Poisoning,"*** Paramedic Continuing Education Program, North Suburban Association of Health Resources, September, 1975
9. ***"Malignant Hypertension/Hypertensive Emergencies,"*** National American College of Emergency Physicians Scientific Assembly, Las Vegas, Nevada, October, 1975
10. ***"CarbonMonoxide Poisoning,"*** Frontiers of Medicine, Chicago, Illinois, November, 1975
11. ***"Metabolic Causes of Shock,"*** Emergency Department Nurses Association Symposium on Shock, Chicago, Illinois, January, 1976
12. ***"Care of Hypertensive Emergencies,"*** Chicago Medical Society, Midwest Clinical Conference, March, 1976
13. ***"DiabeticEmergencies,"*** Chicago Medical Society, Midwest Clinical Conference, Chicago, Illinois, March, 1976
14. ***"General Guidelines for Disaster Mobilization,"*** Illinois Chapter of the American College of Emergency Physicians Scientific Assembly, Chicago, Illinois, April, 1976
15. ***"Electrocardiography for the Emergency Physician,"*** Illinois Chapter of the American College of Emergency Physicians Scientific Assembly, Chicago, Illinois, April, 1976
16. ***"CarbonMonoxide Poisoning,"*** Illinois State Medical Society's Annual Meeting, Chicago, Illinois, April, 1976
17. ***"Pneumonia,"*** Emergency Medicine: Theory and Procedure, University of Chicago Division of Emergency Medicine, Continuing Education Symposium, July, 1976
18. ***"Malignant Hypertension/Hypertensive Emergencies,"*** Emergency Medicine, Theory and Procedure, University of Chicago Hospitals and Clinics, Division of Emergency Medicine, Continuing Education Symposium, July 1976
19. ***"RegionalDisaster Planning,"*** Keynote presentation, Disaster Preparedness Workshop, *Chicago* Hospital Council, Chicago, Illinois, July, 1976
20. ***"Metabolic Causes of Shock,"*** Pre-Hospital and Emergency Medical Technician Symposium, Northwestern Memorial Hospitals/American Association of Trauma Specialists, Chicago, Illinois, August, 1976
21. ***"Shock,"*** Pre-Hospital and Emergency Medical Technician Symposium, Northwestern Memorial Hospital, August, 1976
22. ***"Carbon Monoxide Poisoning,"*** Christ Hospital, Trauma Day, *Oak* Lawn, Illinois, October, 1976
23. ***"Pulsus Paradoxus in Asthma,"*** American College of Emergency Physicians Scientific Assembly, New Orleans, Louisiana, October, 1976
24. ***"Mobile Intensive Care Radiotelemetry,"*** Christ Hospital Public Relations Society, Oak Lawn, Illinois, November, 1976
25. ***"Diabetic Emergencies,"*** Holy Cross Hospital, Chicago, Illinois, January, 1977

26. *"Use and Interpretation of Arterial Blood Gases,"* **Symposium** for Emergency Nurses, **Chicago,** Illinois, **February, 1977**
27. *"Treatment of Multi-System Injuries in the Community Hospital Emergency Department,"* The **Swedish** Covenant **Hospital, Chicago,** Illinois, **February, 1977**
28. *"Post-Operative Complication in Diabetes,"* **Riverside Hospital,** Kankakee, Illinois, March, 1977
29. *"Salicylate Poisoning,"* Illinois Combined Scientific Assembly, Illinois Chapter, American College of Emergency Physicians, Chicago, Illinois, **April, 1977**
30. *"MobileIntensive Care and Radiotelemetry,"* **The** Organization **and** Administration of Emergency Medical *Care,* Chicago, Illinois, **May, 1977**
31. *"RegionalDisaster Planning,"* **The** Organization **and Administration** of Emergency Medical Care, **Chicago,** Illinois, May, **1977**
32. *"CarbonMonoxide Poisoning,"* The Organization **and Administration** of Emergency **Medical** Care, **Chicago,** Illinois, **May, 1977**
33. *"Metabolic Causes of Confusion and Coma,"* Emergency Medicine: Theory and Procedure, University *of* Chicago, Division of Emergency Medicine, **Continuing** Education Symposium, **June, 1977**
34. *"MobileIntensive Care and Radiotelemetry,"* Emergency Medicine Theory and Procedure, **University** of Chicago, Division of Emergency Medicine, Continuing Education **Symposium,** June, **1977**
35. *"MalignantHypertension/Hypertensive Emergencies,"* Emergency Medicine: Theory and **Procedure,** University *of* **Chicago,** Division of Emergency Medicine, Continuing Education Symposium, June **1977**
36. *"CarbonMonoxide Poisoning,"* Emergency Medicine: Theory and Procedure, University of Chicago Hospitals and **Clinics, August,** 1977
37. *"The Chicago Disaster Pian,"* **Grand** Rounds, Division of Emergency Medicine, University **of** Chicago, August, 1977
38. *"Hospital Physicians Role in Disaster Planning and Management of the Disaster Site - The City of Chicago Disaster Plan,"* International Conference on Disaster Medicine, Mainz, **Germany,** September, **1977**
39. *"TheEmergency Medical Care System,"* National Joint Conference on Improving Hospital Emergency Services, American **Hospital** Association, Chicago, Illinois, November, **1977**
40. *"Chest Pain,"* Grand Rounds, Division of Emergency Medicine, University of Chicago, **January, 1978**
41. *"Use and Interpretation of Arterial Blood Gases,"* Symposium for Emergency Nurse, Chicago, Illinois, **January, 1978**
42. *"EmergencyCare for Heart Attacks - CPR,"* taped demonstration WBBM-TV Channel 2, **Chicago,** Illinois, February, **1978**
43. *"Use* **of** *Nitronox Analgesia in the Emergency Department,"* **Grand** Rounds, Division of Emergency Medicine, **University** of **Chicago, March,** *1978*
44. *"Organization and Implementation of Hospital Disaster Care Plan,"* Disaster Symposium, Emergency **Department Nurses** Association, Champaign **Chapter,** Champaign, Illinois, **March,** 1978

64. *"Adult Pulmonary Infection,"* Comprehensive Review in Emergency Medicine, Chicago Illinois, December, 1979
65. *"Respiratory Physiology,"* Comprehensive Review in Emergency Medicine. Chicago. Illinois, December 1979
66. *"A Panoply of Emergenc* Care," Second Combined Continuing Education, American College of Emergency Physicians/Emergency Department Nurses Association, Chicago, Illinois, May, 1990
67. *"Directions in Emergency* Care," Keynote Opening Address, Illinois Chapter of the American College of Emergency Physicians Combined Scientific Assembly, Chicago, Illinois, May, 198(
68. *"Diabetic Ketoacidosis,"* Emergency Medicine Departmental Meeting, Medical Services Incorporated, Chicago, Illinois, May, 1980
69. "Tricyclic *Ingestions,"* Wisconsin Chapter American College of Emergency Physicians Fall Symposium, Wisconsin Chapter, ACEP, Milwaukee, Wisconsin, October, 1980
70. *"Adult Pulmonary Infection,"* Comprehensive Review in Emergency Medicine, Chicago, Illinois, November, 1980
71. *"Respiratory Physiology,"* Comprehensive Review in Emergency Medicine, Chicago, Illinois, November, 1980
72. *"Acid* Base Balance," Comprehensive Review in Emergency Medicine, Chicago, Illinois, November, *1980*
73. *"Carbon Monoxide Poisoning,"* Christ Hospital, Oak Lawn, Illinois, February, 198
74. *"Decision Making in the Emergency Department,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, February, 1981
75. *"Lessons from a Jumbo Jet Crash in a Major Metropolitan Area: American Airlines* Flight *191,"* International Symposium on Airplane and Airport Disasters, Mainz, Germany, March, 1981
76. *"Airplane and Airport Disasters,"* Video-tape demonstration, International Symposium on Airplane and *Airport* Disasters, Mainz, Germany, March, 1981
77. *"New Developments in Artificial Blood Substitutes,"* 7th Annual Combined Scientific Assembly, Illinois Chapter, American College of Emergency Physicians, April, 1981
78. *"Respiratory Physiology,"* Comprehensive Review in Emergency Medicine, Chicago, Illinois, May, 1981
79. *"Pulmonary Infections* in *Adults,"* Comprehensive Review in Emergency Medicine, Chicago, Illinois, May, 1981
80. *"Artificial Blood Substitutes,"* Annual Clinic Day, Northern Illinois Medical Associates, May, 1981
81. *"Acid Base Balance,"* Comprehensive Review in Emergency Medicine, Chicago, Illinois, May, 1981
82. *"Artificial Blood Substitutes,"* McHenry Hospital *Annual* Clinic Day, McHenry, Illinois, May 1981
83. *"General Trauma Management,"* Specialty Review in Emergency Medicine, Cook County Graduate School of Medicine, Chicago, Illinois, July, 1981
84. *"Physician Base Station Course,"* Christ Hospital, Oak Lawn, Illinois, October, 1981

85. *"New Development in the Emergency Treatment of Asthma,"* Scientific Assembly, American College of Emergency Physicians, New Orleans, Louisiana, September, 1981
86. *"Lessons from a Jumbo Jet Crash in a Major Metropolitan Area: American Airlines Flight 191,"* Rush-Presbyterkin St. Luke's' Hospital, Disaster Committee, Chicago, Illinois December, 1981
87. *"Respiratory Physiology,"* Comprehensive Review in Emergency Medicine, American College of Emergency Physicians, Chicago, Illinois, March, 1982
88. *"Pulmonary Infections in Adults,"* Comprehensive Review in Emergency Medicine, American College of Emergency Physicians, Chicago, Illinois, March, 1982
89. *"Acid Base,"* Comprehensive Review in Emergency Medicine, American College of Emergency Physicians, Chicago, Illinois, March, 1982
90. *"Regional Disaster Planning,"* Freshman Course in Emergency Medicine, Pritzker School of Medicine, Chicago, Illinois, April, 1982
91. *"Artificial Blood Substitutes,"* Cardiology Grand Rounds, Department of Medicine, University of Chicago, April, 1982
92. *"Evaluating the Multi-Trauma Patient,"* American College of Osteopathic Emergency Physicians, Chicago, Illinois, May, 1982
93. "Chest *Auscultation,"* Nursing Telemetry Course, Department of Emergency Medicine, June, 1982
94. "Endocrine *and Metabolic Emergencies,"* Cook County Graduate School of Medicine Chicago, Illinois, June, 1982
95. *"Respiratory Physiology,"* Comprehensive Review in Emergency Medicine, Chicago, Illinois, June 1982
96. *"Pulmonary Infections in Adults,"* Comprehensive Review in Emergency Medicine, American College of Emergency Physicians, Chicago, Illinois, June, 1982
97. *"Acid Base,"* Comprehensive Review in Emergency Medicine, Chicago, Illinois, June, 1982
98. *"Decision Making in the Emergency Department,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, July, 1982
99. *"Approach to Trauma,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, July, 1982
100. *"General Trauma Management,"* Cook County Graduate School of Medicine, Chicago, Illinois, August, 1982
101. *"Decision Making: The Key Question,"* Symposium on Decision Making in the Field, Department of Emergency Medicine, University of Chicago, August, 1982
102. *"Diabetic Emergencies,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, October, 1982
103. *"Diabetic Emergencies,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, January, 1983
104. *"Hospital Based Emergency Aeromedical Services,"* Cardiology Grand Rounds, Department of Medicine, University of Chicago, March, 1983
105. *"Hyperbaric Oxygen,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, April, 1983

106. *"Nitrous in the Emergency Department,"* Illinois Combined Scientific Assembly, Chicago, Illinois, April, 1983
107. *"Adult and Pediatric Shuck,"* Paramedic Recertification Review, Illinois Masonic Medical Center, April, 1983
108. *"Cooperation Between the Public and Private Sectors in EMS Design and Implementation : The Chicago Consortial Approach,"* First International Urban Emergency Medical Services System Symposium/Workshop, New York City, New York, June, 1983
109. *"Hospital Based Emergency Aeromedical Services,"* Perinatal Group, University of Chicago Hospitals and Clinics, June, 1983
110. *"Decision Making in the Emergency Department,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, July, 198:
111. *"Emergency Medical Helicopter Transport,"* Department of Emergency Medicine University of Chicago, March, 1984
112. *"Disasters,"* Grand Rounds, Department of Emergency Medicine, University of Chicago, March, 1984
113. *"Aeromedical Transport Issues in Disaster Preparedness,"* Disaster Committee, Rush-Presbyterian-St. Luke's Medical Center, *Chicago,* Illinois, April, 1984
114. *"Introduction to Emergency Medicine,"* Department of Emergency Medicine, University of Chicago, July, 1985
115. *"Trauma and the Elderly,"* City of Chicago, Department of Health, Chicago, Illinois, October, 1984
116. *"Uses and Abuses of the Air Ambulance,"* EMS Exposition, Porter Memorial Hospital, Valparaiso, Indiana, November, 1984
117. *"Helicopters in EMS,"* Eleventh Annual Scientific Assembly, Chicago, Illinois, May, 1985
118. *"Assessment Tools for Trauma Scoring,"* Twelfth Annual Scientific Assembly, *Chicago,* Illinois, April, 1985
119. *"Pre-Hospital Care: Aeromedical Systems,"* Scientific Assembly, Las Vegas, Nevada, October, 1985
120. *"Use of Helicopters for Disaster Scene Response,"* American Trauma Society-Wisconsin Division Annual Meeting, Milwaukee, Wisconsin, November, 1985
121. *"Organization of Disaster Medical Response: Lessons from Practice,"* Disaster Management and Planning for Physicians, Wright State University School of Medicine, Dayton, Ohio, May, 1986
122. *"The Impact of Hospital-Based Aeromedical Service, The Changing Role of the Emergency Department: New Challenges for the '80's,"* New England Hospital Assembly, Framingham, Mass., September, 1983.
123. *"Management of Thoracic Injury,"* Emergency Care Seminar, December, 1983
124. *"Multiple Trauma,"* Department of Education, Beloit Memorial Hospital, Beloit, Wisconsin, July, 1986
125. *"Introduction to Emergency Medicine."* Department of Emergency Medicine. University of Chicago, July, 1986

126. *"EMS: Aeromedical Systems,"* Scientific Assembly, American College of Emergency Physicians, Atlanta, Georgia, September, 1986
127. ***"Innovative Diabetic Management,"*** Illinois Emergency Nurses Association, 13th Annual Scientific Assembly, Oakbrook, Illinois, April, 1987
128. ***"The Use of an Aeromedical Service for the Transport of Patients on Intra-Aortic Balloon Pumps in the Regionalization of Medical Care,"*** Fifth World Congress on Emergency and Disaster Medicine, Rio de Janeiro, Brazil, May, 1987
129. ***"Crash of a Helicopter on a Hospital Roof: Prevention and Damage Control,"*** Fifth World Congress on Emergency and Disaster Medicine, Rio de Janeiro, Brazil, May, 1987
130. ***"The Effects of Aeromedical Transport on the Survival of Burn Patients,"*** Fifth World Congress on Emergency and Disaster Medicine, Rio de Janeiro, Brazil, May, 1987
131. ***"Aeromedical Crashes in the United States: An Epidemic of Recklessness or the Cost of Doing Business?"*** Fifth World Congress on Emergency and Disaster Medicine, Rio de Janeiro, Brazil, May, 1987
132. ***"Crash of a Helicopter on a Hospital Roof: Lessons for Hospital Evacuation,"*** Fifth World Congress on Emergency and Disaster Medicine, Rio de Janeiro, Brazil, May 1987
133. ***"Field Treatment and Evacuation Modalities,"*** Disaster and Mass Casualty Symposium of the Canadian Trauma Society, Montreal, Canada, February, 1988
134. ***"Multi-Hospital Disaster Preparedness,"*** Disaster and Mass Casualty Symposium of the Canadian Trauma Society, Montreal, Canada, February, *1988*
135. *"Medical Care on Commercial Aircraft: Is It or Is It Not Available?"* Sixth World Congress on Emergency and Disaster Medicine, Hong Kong, September, 1989
136. ***"Emergency Medicine in the U.S.A.: An Overview,"*** Universal Health Conference, Moscow, Russia, October, 1991
137. ***"Technological Advances in Hospital Emergency Care- The United States Experience,"*** Universal Health Conference, Moscow, Russia, October, 1991-
138. ***"Emergency Medicine in the U.S.A.: An Overview,"*** Second Universal Health Conference, Exhibition and "Micro-Hospital"(TM), Samarkand, Uzbekistan, C.I.S., September, 1993
139. ***"Technological Advances in Hospital Emergency Care: The United States Experience,"*** Second Universal Health Conference, Exhibition and "Micro-Hospital"(TM), Samarkand, Uzbekistan, C.X.S., September, 1993

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BROWARD COUNTY SHERIFF'S OFFICE

DATE	MANUAL	DISTRIBUTION	SECTION
04-20-92	STANDARD OPERATING DETENTION	ALL DETENTION EMPLOYEES	MEDICAL

SUBJECT:

DISABLED INMATE CARE

RESCIND ☐ NEW

AMEND ☐

POLICY:

It will be the policy of the Department of Detention to provide proper care protection to inmates who are mentally, physically or developmentally disabl

PROCEDURE:

A. Inmates who present mental, developmental and/or physical disabiliti should be identified through intake screening and/or health appraisa procedures.

B. Detention personnel and medical personnel will communicate with each ocher when an inmate is suspected or diagnosed as having a mental, physical or developmental disability and determine a course of actio treatment and/or handling of the inmate.

C. Inmates who are determined to be disabled should be *referred* for follow-up to an appropriate community service agency or facility whe necessary.

D. Community referral agencies include, but are not limited to:

1. Broward County Mental Health Department
2. Veterans' Administration, Miami, Florida

E. In actions regarding disabled inmates, the medical staff and the fac administration will confer and agree on the following:

1. Housing assignments
2. Program assignments
3. Disciplinary measures
4. Transfers

F. Disabled inmates, particularly chose who exhibit mental or developm disabilities, should be closely monitored as co their adaptation to ~~correctional environment~~ correctional environment.

BROWARD COUNTY SHERIFF'S OFFICE

DATE	MANUAL	DISTRIBUTION	SECTION	NI
04-20-92	STANDARD OPERATING DETENTION	ALL DETENTION EMPLOYEES	MEDICAL	7

SUBJECT:

INMATE HEALTH CARE

RESCIND ☐ NEW
AMEND ☐

POLICY:

It will be the policy of the Department of Detention to treat inmates in a hu manner and to provide for necessary health care while they are incarcerated i the Broward County Jail Facilities. Overall procedures will be established f inmate health care and to prohibit certain acts related to inmate health care

PROCEDURE:

A. The Health Care Provider will provide or furnish medical or dental prosthesis to an inmate when the health of the inmate would otherwise adversely affected as determined by the staff physician or dentist.

B. The use of inmates for medical, pharmaceutical or cosmetic experiment strictly prohibited.

C. This policy does not preclude the use of new medical treatments and/o procedures which are not readily available, but which may be helpful t the inmate. However, such treatment or procedure must have the expre written consent of the inmate.