DEPOSITION SUMMARY OF XXXX, M.D.

FEBRUARY 17, 2025

Venue: Zoom

Plaintiffs:

- XXXX, *as personal representative of the estate of XXXX, deceased*

Defendants:

- XXXX, M.D.
- ABCEmergency Physicians & Associates

Counsel for the Plaintiff: XXXX

Counsel for the Defendants (XXXX, M.D. and ABC Emergency Physicians & Associates): Mr. XXXX.

Court Reporter: XXXX, Notary Public

Also Present: XXXX, Personal representative

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	Direct Examination by Mr. XXXX	
4:12-5:13	After having been duly sworn in, Bernard Augustus XXXX, III said that he resided at XXX, since YYYY. He reviewed the PCR in preparation for the deposition. He is a licensed physician	Self-introduction

5:14-8:4	Dr. XXXX went to medical school at ABC University in Southern California. He then came to Spartanburg and did his residency in family practice with a lot of ER emphasis. Over the last 1 to 20 years, he had worked in multiple ERs. He was not board certified in emergency medicine. He was board-certified in family practice. He graduated in YYYY. Currently, he is working in RemoteMD. He lastly worked in ER in April YYYY. The incident occurred in December YYYY, while he was working at Rutherfordton in North Carolina.	His educational background and work history
8:5-16:16	Dr. XXXX is the owner of RemoteMD. They were on call mostly for offshore stuff. According to the maritime law, the guys onboard the rigs are supposed to have the same care. They are on call with a medic onboard. The medic is specially trained in classes that are provided by Dr. XXXX and his company. The Transocean medics attend these classes and are trained to provide on-site care. The doctors of RemoteMD backs them up. Dr. XXXX would get around 15 calls a week. The calls come to him directly from the medic. If he did not pick it up in four rings, then there is somebody else who picks it up after him. There is one doctor on primary call and one back up. Earlier it was one doctor on primary call, another on secondary call and Dr. XXXX on tertiary call. It is a 24-hour-a-day, seven day-a-week service. The calls are recorded in RingCentral. Dr. XXXX would have access to the call recordings. The calls are only audio calls.	About RemoteMD
16:17-23:17	In December YYYY, Dr. XXXX did receive a call from Cody Almand on Deepwater Atlas. At that time, Dr. XXXX was in his house. He was called regarding a gentle man who was coming back to stay at the urging of his superior officer. He complained of abdominal pain, nausea and vomiting. He clearly identified that his left lower quadrant of his abdomen was hurting. All those communication was verbal and Dr. XXXX did not see the guy. He was examined on phone. Dr. XXXX was told what the findings were. Some treatment was recommended. The call was in the evening. It did not appear acute enough to call in a helicopter. His vitals were stable. He was not tachycardic. He was given some medicine to try to help him and he went back to his room. Exhibit-1 was a follow-up visit after the patient had passed away and not the original visit. Exhibit-2 is the original visit with the patient and with Cody in December YYYY. The brief history part was created by the medic and the section below TMS was created by Dr. XXXX. When the medic calls, he gives the history over the phone and the portion of the note is send through Teams. Then Dr. XXXX responds and he sends it back to everybody who he is supposed to as a list.	XXXX call from Cody in December YYYY
23:18-28:24	According to the note, patient stated that he had a sudden onset of nausea with vomiting the previous night around 20:00. He denied previous illness and felt normal throughout the day prior to that. He denied any blood in his emesis. He stated that nausea, vomiting continued	His first telephonic call with XXX

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	throughout the night and was not helped by OTCs. Dr. XXXX said that the only OTC that would have been available would be Tylenol. According to the note, patient reported abdominal cramping that day after multiple episodes of nausea and vomiting. He continued to deny any other symptoms. He had trouble getting comfortable or sitting still due to cramping pain. He rated his pain as 10 out of 10. He was febrile. He denied that his abdomen was distended. The clinical impression was abdominal pain, nausea and vomiting. Dr. XXXX took him off tower. He was given Zofran, eight milligrams ODT, and he was given some to take back to the room with him. Because of the cramping, he was also given 20 milligrams of Bentyl. He was advised to follow-up in the morning, if his abdominal pain got worse. He was to let Cody know. He was tested for flu and COVID. He was also to get a UA due to the high possibility of it being a kidney stone. He could have only fluids. Since he had left lower quadrant abdominal pain, he could not get still. The COVID tests were negative. Dr. XXXX could not recall getting a second call. He said that every call was documented.	
28:25-39:8	Dr. XXXX talked to Mr. Almand, the following day on December 3rd, after the patient died. Bates stamped TO_233 through 234 titled Patient Contact Report at the top is a Transocean document. This is the document that the medic produces in response to any call. He did not see the document on Document 2, YYYY. He added that prior to Mr. XXXX's death, he did not see the document. According to the document, the time of the incident is 12/1/YYYY and timed 20:45. With respect to 14:50 visit on 12/02/YYYY, vitals were taken and provided to Dr. XXXX when Mr. Almand called him that day. According to the document, patient had guarding. The symptom of guarding was not relayed to Dr. XXXX. His belly was not blown up which was not identified in Dr. XXXX's record. Tenderness to palpation in his left lower quadrant was relayed to Dr. XXXX on December 2, YYYY. The bowel sounds could not be auscultated, according to the note. This was not relayed to Dr. XXXX. Urine analysis was never done. It is not uncommon, especially in a kidney stone, not to get a urine specimen. Based on the patient contact report, Dr. XXXX said that his recommendations or decisions would not change. He said that the patient was not tachycardic; his blood pressure never dropped and never had a fever.	About the patient contact report
39:9-42:8	His symptoms were not indicative of a surgical abdomen. He never had a distended or rigid abdomen. He said a perforated viscus is usually a pretty easy diagnosis because the patient is in such distress. People with kidney stone would have so much hurting pain. His pain was 10 out of 10. He said that kidney stone is the worst pain one can have. He said that a person with perforated viscus had a tender abdomen. But the patient did not have a tender abdomen. Dr. XXXX said that he was not in a situation where they could make that call at that point in time. He	About the need for onshore evaluation

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	said that in an ER setting, he would order a CAT scan. At that time, he did not deem it necessary for him to get such an evaluation onshore.	
42:9-47:16	Dr. XXXX was notified via phone call about the fact that Mr. XXXX was found deceased on December 3, YYYY. The cause of the patient's death was a perforated duodenum. He said that the perforation can be identified either through regular X-ray or CAT scan. Dr. XXXX said that his symptoms did not fit a classical perforated viscus. He said that kidney stone was on the differential. When there is blood in the urine, it is determinant of kidney stone.	About the cause of the death of the patient
47:17-52:23	The document titled Medical Standard Global Operations was marked as Exhibit-5. Dr. XXXX had not seen that document before. Section 11 was pertaining to medical emergencies in which number ten was related to acute abdomen. Dr. XXXX did not know if the patient presented with rebound tenderness. He said that the finding of tenderness in the PCR report was different and not indicative of recent rebound tenderness. He said that anybody who is having severe pain is going to have tenderness and would not want to be touched. He did not agree that the patient had an acute abdomen.	About the document titled Medical Standard Global Operations
52:24-58:5	It is Dr. XXXX who has to take the call with respect to whether or not someone needed to be evacuated from the offshore facility. There were multiple times where he had contacted Dr. XXXX with a recommendation for disembarkment. After the patient's death, he did talk to Dr. XXXX about the same on the day of death. He also talked to Cody.	About the call with Dr. XXXX
58:6-61:12	All the doctors including Dr. XXXX, Bill, Michael XXXX and William are involved in taking classes and they get continuing education credit. It was done through RemoteMD and is called OccuMedics. The training consists of lectures and videos of what a medic should do in certain situations and what is expected of them. He said that the treatment for a person identified of perforation with the help of CT is surgery.	About the training to the rig personnel
Cross-Examination by Mr. Mouton		
61:13-70:11	According to Cody's report, Mr. XXXX was to return to the medic after the XXXX 2nd visit in the clinic, if his symptoms worsened. The occurrence of perforated viscus is an unusual occurrence. He agreed that no one symptom would give an absolute diagnosis. One had to put a lot of pieces together to come up with a differential diagnosis. It was not an obvious conclusion that he had a perforated viscus in the duodenum based on the presentation given. He agreed that kidney stone can cause dehydration but said that it could not be the reason for not getting the urine sample. He agreed that abdomen if one of the areas that is difficult to evaluate. He said that when somebody has a pain of ten over ten, their pulse rate is not normal. He said that fever is not expected necessarily, in case of a perforation. While there were symptoms to suggest a surgical abdomen, there were some symptoms that	About the occurrence of perforated viscus

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	suggested that it was not the case. Mr. XXXX had a history of ulcers which is important because perforation can occur through an ulcer. He said that he had never seen a person without distended abdomen having perforation. The description of pain coming and going, increases the possibility of kidney stone. Many times, people with perforated viscus are hurting and they are quiet because it hurts to move. But the kidney stone does not hurt to move. One moves because it hurts.	
	Redirect Examination by Mr. XXXX	
70:12-75:2	Dr. XXXX said that he would described his abdomen as surgical but would describe it as he having belly pain. Even a CT scan is not 100 percent. Surgical abdomen is not a diagnosis. If CT had identified, then immediate surgery is necessary. He said that there is no guarantee, that even with the best treatment available that a person with a duodenal perforation will survive. The mortality rate is 30 to 50 percent. Perforation was in the differential list but was not high on the list when Mr. Almand relayed the patient's symptoms. Patient did not present with an acute abdomen.	About perforation on the differential
	Deposition concluded at 4:42 p.m.	

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