IN THE 2nd CIRCUIT COURT OF DAVIDSON COUNTY, TENNESSEE
AT NASHVILLE



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| GILBERT OLERUD and Wife, ANNETTE RAE OLERUD, Individually and as Next of Kin of RACHEL CAMILLE OLERUD, Plaintiffs, v. DR. WALTER M. MORGAN, III and THE VANDERBILT UNIVERSITY, Defendants. | Civil Action No. 07C2101<br>Judge McClendon<br>Jury Demand<br>Motion Set: 01-16-13 at 2 pm |

**PLAINTIFFS' RESPONSE TO DEFENDANTS' THIRD RENEWED MOTION FOR SUMMARY JUDGMENT**

## I. PLAINTIFFS' INTRODUCTORY COMMENTS

A. Concisely stated, Plaintiffs respond to the "Defendants' Third Renewed Motion for Summary Judgment" by stating that the Defendants have resubmitted a causation issue which was previously considered by the Court in both prior summary judgment motions. The Court has concluded that there are genuine issues of material fact regarding causation. That previous determination is strengthened (rather than diminished) by the recent evidentiary deposition of Dr. David Becton on September 20, 2012. Dr. Becton (whose expert opinions have previously been sought and relied upon by Defendant Vanderbilt University) strongly supports Plaintiffs' positions on both the breach of the standard of care and causation. The Plaintiffs have never taken the position that Dr. Morgan's decision to not perform a biopsy in the initial December 22, 2005 meeting constitutes a deviation in the acceptable standard of professional practice. Pediatric surgeon Dr. Martin Bell acknowledges that concession in the initial draft of his affidavit. On the contrary, consistent with the applicable statutes and regulations regarding the maintenance and preservation of

medical records (to guarantee proper follow up) each of the testifying doctors in the case (pediatric surgeon Dr. Martin Bell and pediatric oncologist Dr. David Becton) consistently agree that the medical records violation **caused** (more probably than not) the fatal failure to effect a proper follow-up of the child in the Spring of 2006, which "probably" would have resulted (at that time) in a biopsy, excision of the "full margins of the tumor," and chemotherapy. Those steps, according to Dr. Becton, "probably" ("very likely") would have saved the child's life.

B. Ironically, the difficult spoliation issue in the case (resulting from the Defendants' **either** failure to generate a proper record on December 22, 2005, or subsequent loss or destruction of the record) remains as the strongest point of attack on behalf of the Defendants. Having violated the applicable statutes regarding the preservation of the important record, the Defendant, for the third time asks the Court to grant summary judgment dismissal. Although the absence of a clinical record for the date of the initial encounter, describing the size, texture and location of the lump is asserted by Plaintiffs' experts **as a factual basis** for the errors, which ultimately killed Rachel Olerud, Defendants ask that, as a point of law, those opinions be disregarded. The Court has declined to grant a default judgment to the Plaintiffs on the spoliation issue, but the issue remains as a viable evidentiary issue in the case. Plaintiffs presume they will be entitled to the appropriate jury instruction that: (a) the Defendant/hospital has the burden of proof to explain the missing record; and (b) as an issue of fact for the jury's determination, there is a resulting presumption (where not adequately explained) that the missing record would be adverse to the Defendants' position. The third application for summary judgment (as with the previous two motions) presumptuously skirts past that issue, and continues to selectively excerpt from the Plaintiffs' expert witnesses' testimony those acknowledgments where they state, **based on the clinical record (i.e., excluding the family's**

**testimony) it is "difficult" to establish the causation requirements.** Conversely, **if** the **family's testimony** regarding size, texture and location of the lump (as of December 2005 and January 2006 are accurate -- an issue of fact for the jury), a complete excision of the margins of the tumor "probably" would have saved the child's life. Dr. Bell, as a pediatric surgeon, states that there is a definite connection between the failure to maintain the treatment record and the proper, needed follow up. Dr. Becton, as a pediatric oncologist, strongly supports the conclusion that there was a greater than 50% likelihood of survival if there had been a proper follow up in the Spring of 2006, with complete excision of the margins of the cancerous tumor.

C. In the present (third) application, the Defendants invite the Court to selectively excerpt the truthful and candid acknowledgments by Drs. Bell, Horadam and Becton regarding the difficult challenges presented by the absence of documentation in the clinical record of the December 22, 2005 encounter. A complete, contextual reading of those depositions (particularly Dr. Becton) explains why that is inappropriate. Plaintiffs therefore reiterate, for a third time, that the spoliation issue arising from the unexplained violation of the statutes remains directly connected to the Defendants' most recent effort to avoid liability in a claim where both liability and causation are strongly supported by the evidence.

## II. DOCUMENTS RELIED UPON IN RESPONDING TO THE DEFENDANTS' THIRD RENEWED MOTION FOR SUMMARY JUDGMENT

A. Plaintiffs rely on the content of the two previous Responses to Plaintiffs' Motion for Summary Judgment, and incorporate those arguments herein without unnecessary duplication.

B. The below Memorandum of Law.

C. The evidentiary deposition of Dr. David Becton.

D. Plaintiffs' Third Response to Defendants' Statement of Undisputed Material Facts.

## III. DISCUSSION OF APPLICABLE LEGAL PRINCIPLES AND EVIDENTIARY CITATIONS

A. Plaintiffs will not rehash the voluminous content of its two previous responses. Instead, Plaintiffs will attempt to narrowly focus on a response to Defendants' reasserted causation "facts."

B. Although Dr. Morgan evaluated the child on his initial visit of December 22, 2005, and presumably recorded his observations, instructions to the parent, and his professional thoughts regarding follow-up, there is no clinical record which contains that information. The parties are left to rely upon the subjective, post-litigation recollections of Dr. Morgan and his staff. On page 2 of the Defendants' memorandum (final paragraph), the following acknowledgment is stated by the Defendants:

> **"Following the appointment cancellation, Dr. Morgan reviewed Rachel Olerud's medical records and determined it was acceptable for the appointment to have been cancelled based upon the information provided by Mrs. Olerud(see Access Audit, attached to Smith Affidavit; Morgan Affidavit, ¶ 4, Oct. 13, 2009)."**

C. Exactly what "records" are being referenced is uncertain. Presumably, Dr. Morgan is referencing the limited information which he had received from the child's pediatrician, Dr. Ricafort, who had arranged for an immediate, emergency appointment on December 22, 2005. The records before the Court confirm that, until the child presented months later for treatment of the (by then metastasized) advancing cancer, there were no Vanderbilt records. Unexplained in the record, and contrary to clearly stated laws which define the record maintenance as a "component of the acceptable standard of professional practice," Vanderbilt and Dr. Morgan casually state to the Court

that they simply do not know what happened to the important records, which are (defined by statute as) significant in the evaluation of all medical causation issues (according to Plaintiffs' experts). When Dr. Morgan's discovery deposition was taken eight (8) months after the commencement of the litigation (at a time when he was presumably fully prepared), he offered no reasonable response to Plaintiffs' counsel's inquiry regarding what search efforts had been expended, and why more had not been accomplished in that regard. He mentioned no file "note" regarding a conversation with the mother. No such memo or note was contained in the records supplied.

D. Having acknowledged earlier in his testimony the importance of complete and accurate records in such an encounter, his deposition testimony (and all subsequent affidavits) are silent in describing **why he would have appeared to answer questions under oath eight (8) months after the filing of the litigation**, with the apparent casual certainty **that the record did not exist**, and that he did not need to know of its contents in expressing his opinions regarding the need for the child's follow-up, **and** the post-suit evaluation of the causation issues. That curious and still unexplained circumstance is an issue of fact, standing alone, which the jury should be permitted to evaluate. Dr. Morgan acknowledges (at least as of the date of his deposition on April 4, 2008) that he is not certain what records he may have received from Dr. Ricafort prior to the child's visit (Deposition of Dr. Walter M. Morgan, III, p. 22 at line 14 and line 20).

After acknowledging the importance of the general practice (Deposition of Dr. Walter M. Morgan, III, p. 28 at line 8), Dr. Morgan (again, eight months after the suit was served upon him) provides the following responses regarding the record:

> "Q. Do you have any idea whether there was a treatment note prepared, whether it was lost, or what might have happened with regard to the treatment note for that day?

A. I really don't know what happened to the note. Normally, I dictate notes following the visit, either immediately following the visit or at the completion of the day seeing patients in clinic. And why there is not a note from this, I don't know. I don't know whether it was dictated and lost in transcription, whether -- whether the dictation was overlooked, I don't know." (Deposition of Dr. Walter M. Morgan, III, p. 28 at lines 10-21).

E. Subsequently, after acknowledging awareness that the child returned to the hospital months later with an aggressive, advanced cancer, Dr. Morgan is asked what efforts he and his staff may have expended to try to locate the important clinical record:

"Q. Since this issue has arisen, has anyone gone back to look at the computer hard drive to confirm that it was in fact downloaded, that it made it that far?

A. Not as far as I know." (Deposition of Dr. Walter M. Morgan, III, p. 30 at lines 3-6).

"Q. Has anyone gone back -- since the arising of this issue, has anyone gone back to the company responsible, whoever and wherever they are located, to see if they have a backup system for their computers and to see if it can be pulled from the computer backup program on the server?

A. Not that I'm aware." (Deposition of Dr. Walter M. Morgan, III, p. 31 at lines 8-14).

F. Now, in its third summary judgment motion application, the Defendants repeatedly emphasizes the Plaintiffs' "causation" problems in the case, extending apparently from the acknowledged difficulties in grading and staging the cancer as of December 22, 2005.

G. As previously briefed and discussed in the prior motions, there are other relevant and important issues of fact which deal with the very nature of the cancer: Defendants' Memorandum of Law (p. 3) describes the cancer as a "malignant tumor with rhabdoid features." Dr. Becton, as a highly qualified and experienced pediatric oncologist (who has previously offered his opinions on

behalf of Vanderbilt University) states that the child was suffering from a less aggressive form of cancer, a soft tissue sarcoma with rhabdoid features) (Deposition of Dr. David L. Becton, p. 30 at line 23).

H. The Vanderbilt physicians who ultimately treated the child's advanced, metastasized cancer were so uncertain about the type of cancer that they sent the pathology documentation to a Texas oncology center for clarification of the type and nature of the cancer. Dr. Horadam, the Texas oncologist whose expert testimony remains relevant on the issues pertaining to the type and grading of the cancer, strongly asserts that the analysis of the survival probability is complicated by documented uncertainties regarding the **type** of cancer, which was never actually confirmed. Further, that analysis is complicated by the absence of a properly prepared clinical note from the first visit. The Defendants (and their experts) selectively choose to simply skirt past that important medical issue which bears directly upon the ultimate legal issues in the case. The defense takes the position that the underlying medical fact issues should be resolved in a conclusory manner in favor of the Defendants.

I. As an example, referencing the first full paragraph at the top of page 10 of the Defendants' Memorandum of Law, the Defendants (again impacting the spoliation issue) state in a conclusory manner that Dr. Bell based his opinion that Dr. Morgan breached the standard of care on the erroneous assumption that these events did not take place because ". . . we have no evidence that they did." (Discovery Deposition of Dr. Martin Bell, p. 60 at line 21). In that citation (as with others contained in both the present and previous motions for summary judgment), the Defendants inappropriately excerpt Dr. Bell's comments regarding what can be medically concluded **from the clinical record**, in contrast to what may be factually concluded in the case based upon the family

member's testimony. Omitted from the comments in that paragraph, and the subsequent discussion, is any plausible explanation why Dr. Morgan and his staff provide subjective recollections **after** the deposition of Dr. Bell. Where were those subjective recollections when he provided his deposition testimony eight (8) months after the suit was served upon him? Where is the explanation regarding where, and how, he recorded **in any medical chart** the conclusions described by Mr. King in paragraphs 1 and 2 on page 10 of the Defendants' memorandum. If Dr. Morgan took the steps which he describes (first paragraph at the top of page 11) in reviewing the child's record, contemporaneous with his staff's January discussion with Ms. Olerud, why would he not have discovered the missing record at that time? Why was the glaring records error not corrected at that time? What could he have referred to (i.e., regarding the size, texture, location, instructions to the parents) if he did not review a medical note from the December 22, 2005 encounter? In the face of clearly worded statutes and regulations which describe the importance of generating and maintaining the record, ". . . as a component of the acceptable standard of practice," why are the foregoing points not legitimate issues of fact which the jury should consider in evaluating the difficult causation issues of the case? The same argument applies to the previously noted observations regarding the similar lack of candor in addressing the importance of the missing records in Dr. Morgan's deposition eight months after the lawsuit was filed. Should the jury not be permitted to determine, as an issue of fact, that either Dr. Morgan or his staff destroyed whatever record existed when it became clear that the child was doomed due to the improper handling of her medical case? While failing to address the disputed medical issues which stem from the missing records, the Defendants have again excerpted, out of context, acknowledgments by each of the Plaintiffs' experts regarding the "problematic" nature of: (a) identifying the type of the cancer; (b) the size, texture and location to assist in determining the stage

of the cancer; and (c) whether, from a **clinical documentation** context, the lump observed on December 22, 2005 was in exactly the same location, and was in fact the same lump, which aggressively grew several months later and eventually took the child's life.

J. One final important note: In referencing page 11 (paragraph II), the Defendants again incorrectly, and in a conclusory manner, offer the following statement, out-of-context, in referencing Dr. Becton's opinions:

> **"Dr. Becton, Plaintiffs' only causation expert, did not testify that Dr. Morgan's failure to create a medical record or failure to evaluate the cancelled follow-up appointment were the proximate cause of any injury to Rachel Olerud." (Memo at p. 11) (Emphasis added.)**

Plaintiffs respectfully respond that that is just not correct. Dr. Bell's causation testimony, standing alone, might be insufficient. But, it is admissible in complementing and clarifying Dr. Becton's more complex oncology opinions. Pediatric surgeon Dr. Martin Bell limits his causation findings **only** to the extent that he is called upon to provide complex oncology-related opinions. He has no hesitation in stating that the absence of the record was a causative factor in the failure to identify and treat the cancer, whatever its true nature might be. That is an example of the out-of-context references which have been offered for the Court's consideration, all of which stem directly or indirectly from the spoliation issue and the Defendants' own misconduct.

K. The actual, correct context of Dr. Bell's causation opinions (in which he admits that he is not an expert on the oncology, progression issues) is as follows:

> "However, there was no follow-up visit, and no records of those instructions, which is problematic. The failure by the physician and his office to insure a careful follow-up is below the prevailing standard of care and may have substantially contributed to the progression of the disease. It is intuitive and reasonable to conclude that a delay in diagnosis and treatment of a cancerous condition is typically adverse to a positive outcome. Certainly, in any situation involving the diagnosis and

> treatment of any serious medical condition (including a cancer such as a soft tissue sarcoma) a positive outcome is minimized and impeded by a delay in diagnosis. Although it is impossible to say with certainty that the biopsy of the swollen lymph nodes on December 22, 2005 would have necessarily altered the eventual outcome, it is not unreasonable to state, from a standard of 'more probable than not,' that Rachel Olerud's chances of survival (and positive response to available treatment methods) would have been enhanced if the cancer had been identified as early as possible, rather than July of 2006, affording her a much earlier opportunity to obtain surgical excision and to begin chemotherapy." (Affidavit of Dr. Martin J. Bell, p. 6 at ¶ 6(b)).

L. Elsewhere, while strongly supporting the criticism of the standard of care and the **basic** causation observations regarding obvious harm, Dr. Bell candidly and truthfully states that, particularly in light of the missing records, the more complex cancer progression issues should be deferred to a pediatric oncologist (Affidavit of Dr. Martin J. Bell, p. 2 at ¶ 4(a)).

> "I do not need to refer to a pediatric oncologist in expressing the opinion, within reasonable medical certainty, that it is probable that the chances of survival, and the progression of any cancer, were negatively impacted by the delay in diagnosis from December 22, 2005 until July 26, 2006 . . ." (Affidavit of Dr. Martin J. Bell, p. 3 at ¶ 4(c)).

The Defendants are plainly wrong about Dr. Bell's testimony: He **does** provide **both** standard of care **and** causation testimony which complements the oncologist's proof. He declines to discuss the subtle, complex intricacies of the cancer pathology. Drs. Becton and Horadam supply that evidence. Even the treating Vanderbilt pediatric oncologists had trouble identifying the cancer. Dr. Bell competently testifies as follows:

> "Q. On the issue of causation in that letter, you said that issue requires an authoritative statement from another expert.
>
> A. Yeah, I don't change my mind about that. An oncologist is going to have some different perspective from a surgeon, but surgeons make decisions about therapy often related to mass lesions as we're talking about that are based on their assessment of: If I don't do this now, if I just let this sit, there's a high risk that, you know, that this patient is going to have a bad outcome. And so there is both intuitive belief as well as a lot of experience and

literature that says delayed diagnosis is bad for prognosis, and that doesn't require an oncologist's training." (Deposition of Dr. Martin Bell, p. 27 at line 17 through p. 28 at line 6.)

"Q. Right. But what I'm trying to get at is what is your professional background and experience that would allow you to give those kinds of opinions? I understand your positions from a treatment perspective, but now I'm talking about really more of a prognosis perspective. That's not something that you have extensive background in like a pediatric oncologist would have, correct?

A. Well, I can say -- I don't mean to duel with you -- but I can say that if I see a patient with stage 4 disease, that I can make a pretty good estimate of prognosis. And if I see a patient with stage 1 disease, I can make similarly a pretty good prognostic statement." (Deposition of Dr. Martin Bell, p. 30 at line 13 through p. 31 at line 2.)

M. Dr. Bell, as a pediatric surgeon, expresses the opinion that the failure by Dr. Morgan's staff to comply with Tennessee law (and the applicable standard of care) regarding the generation of the medical record on December 22, 2005 more probably than not **caused** the failure by Dr. Morgan and his staff to properly follow up in January or February of 2006. The Defendant invites the Court to rule on that issue of fact, as a matter of law. **Both** Dr. Bell and Dr. Becton express the opinion that the child was "harmed" by that failure to properly follow up, although Dr. Bell concedes that the more complex oncology issues should be evaluated by a pediatric oncologist. Dr. Becton, a pediatric oncologist whose opinions have been sought by Vanderbilt in the past, emphatically states that an early intervention, and complete excision of the margins around the nodule in January or February of 2006, would have "certainly" enhanced the child's probability of survival above the 50% probability standard. The foregoing facts preclude the granting of summary judgment on an issue that should be submitted to a jury for its determination.

N. The Defendants' conclusion regarding the evidentiary absence of a connection between the missing record and the failure to follow-up, just disregards and ignores the Plaintiffs' experts:

"Q. Right. But you're not critical -- because you're not critical of Dr. Morgan's evaluation and treatment plan based on that initial visit, what is it about the lack of a medical record for that visit that you believe affected this child's care?

A. Because it impinges on the follow up, which didn't occur. You need to have both and they're both missing. So: I saw this child today, she has a 1.5-centimeter, slightly inflamed, tender mass in the suboccipital scalp and there's a contiguous enlarged lymph node I believe. And then a differential diagnosis and instructions and follow-up visit.

None of that is there. There's no dispute that some of it was done; that he did examine the child, but he didn't record anything for future reference for himself or for any other physician that might have seen this child two months subsequently, and three months subsequently had they moved to Georgia. And that's not appropriate.

And then there's no -- there's no statement in the record that Mrs. Olerud, she doesn't debate it, but there's no statement in the record that Mrs. Olerud called the office and the appointment was not kept, and there's nothing that the physician recorded or his proxies that says: Patient called, lesions better, not coming' and never, therefore, gave him the opportunity to say: no, that's not the way we do it, call her back, tell her I need to see the kid." (**Deposition of Dr. Martin Bell**, p. 56 at line 22 through p. 58 at line 2.)

"Q. Concisely summarized and as narrowly as you can describe this -- and, again, on a standard of likelihood or more probable than not -- specifically what is your opinion regarding the causal connection between the failure of Dr. Morgan's office to insure a proper follow-up evaluation and the eventual death of Rachel Olerud?

A. Had there been a proper follow-up, at the time that that was scheduled, the total course of this detected lesion was a couple of months. That raises significant suspicion that the lesion is potentially more than just a benign cyst, potentially a malignant lesion of some sort. One cannot make a histologic diagnosis on physical examination.

Had months elapsed at the time of the -- two or more months elapsed at the time of the second visit, the opportunity then existed to implicate the possibility that this is something that needs histologic diagnosis, and a biopsy at that point or shortly thereafter.

It is both factual and intuitive that for the vast majority of malignancies, early diagnosis gives a better prognosis. It doesn't guarantee survival, but it certainly enhances it. And so not having that opportunity and, therefore, not carrying out that biopsy allows the tumor to remain inside with either local expansion or metastatic changes, which ultimately in this child proved lethal." (**Deposition of Dr. Martin Bell**, p. 35 at line 16 through p. 36 at line 23.)

"Q. And so are you -- based upon what I've read to you, the fact that a follow-up appointment was scheduled for this patient, the mother called back, reported that one lump had gone away and the other one had shrunk in size and both had become non-tender, are you suggesting that you believe Dr. Morgan fell below the standard of care in that circumstance?

A. I want to phrase this as carefully as I can. When he first saw the tumor or the mass, it had been there for a month. At the time of that telephone call, it was not approximately two months that the mass persisted. It had changed some. It seems to me that rather than leaving this to a conversation between someone who is unidentified and a lay person that the instructions were not adequate; that for my own practice, and what I believe is the standard, if the mass had not completely regressed, I have always told -- and I think that this is the standard -- I have always told the parents to come back; that I want to feel the mass itself.

There are no measurements in the chart at the initial visit and there's no subsequent visit, so there are no measurements of reliability. All we have is conversations. And clearly, the lay view of a situation is not an expert view.

So in terms of the standard of care, I believe that Dr. Morgan did fall below the standard of care in that there are no measurements at the outset; in that there was no conversation with him, but rather with some presumably lay person, but certainly a second party injected into this; and a judgment left to a parent as opposed to an expert pediatric surgeon to make his own best judgment based on two visits since the lesion had persisted, even though it had changed." (**Deposition of Dr. Martin Bell**, p. 42 at line 14 through p. 43 at line 25.)

O. Dr. Becton's testimony is direct and consistent:

"Q. With regard to the absence of a chart note, a medical record from Dr. Morgan's first encounter with Rachel Olerud, what is your opinion regarding the standard of care, the acceptable standard of professional practice?

A. I think its -- its essential to have a record of what the lump looked like on that initial presentation. So I think that, for whatever reason that there's not a note, it still falls below the standard of care." (**Evidentiary Deposition of Dr. David L. Becton**, p. 29 at lines 1-13).

P. Thereafter, in elaborating upon the general causation observations offered by pediatric surgeon Dr. Bell, Dr. Becton, with the benefit of great experience in dealing with childhood soft tissue sarcomas states the following:

"Well, there's no question that if she had had a follow-up visit and the lump had been resected earlier, that would have affected the longevity. I can say that greater than a 50% probability, that if she had had a follow-up visit and a resection of the residual mass, that there was a very good likelihood, at that time, that her results would have been much better." (**Deposition of Dr. David L. Becton**, p. 30 at line 23 through p. 31 at line 7).

Q. Dr. Becton's observations regarding the expert affidavit of Vanderbilt's supporting witness (Dr. Thomas William McLean) confirm that, in an indirect manner, even Dr. McLean acknowledges the importance of evaluating a potentially malignant tumor by recording the size, firmness, and general texture of the lump at its first stage of evaluation (Deposition of Dr. David L. Becton, pp. 44-45).

"I think there's a -- I think there's a good chance, more likely than not, that her survival was greater than 50%." (**Deposition of Dr. David L. Becton**, p. 47 at lines 1-4).

## IV. SUMMARY

The Defendants contend there is no connection between the missing medical records and the ensuing, fatal failure to follow up in Rachel Olerud's cancer diagnosis. In attempting to entirely

eliminate the expert causation opinions of pediatric surgeon Dr. Martin Bell, the Defendants overlook (for a third time) an important point: There may be discrete, separate aspects to evidence of "medical causation": (a) that medically diagnosed "harm" has resulted from medical negligence; and (b) the more subtle and complex "causation" issues regarding how quickly, and under what circumstances, an undiagnosed rare cancer may progress beyond the 50% survival demarcation line. Both Drs. Becton and Bell have provided competent expert opinions pertaining to the causal relationship between the missing record, the failure to follow up, and the child's ultimate demise.

Respectfully submitted,

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**CERTIFICATE OF SERVICE**

I hereby certify that a true and exact copy of the foregoing has been forwarded, via U.S. mail, postage prepaid and facsimile transmission, to the following: Mr. David King, Bass, Berry, Sims, PLLC, AmSouth Center, 150 Third Avenue South, Suite 2800, Nashville, TN 37201, on this the 9th day of January, 2013.

**Wm. Kennerly Burger**

cc: Mr. and Mrs. Gilbert Olerud

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