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SC Court of Appeals

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

George C. James, Jr., Circuit Court Judge

Case No.: 2010-CP-40-5705

Doris F. Atkinson and William E. Atkinson, Jr., ...Appellants,

v.

James A. Williams, Jr., M.D., and South Carolina
Oncology Associates,..Respondents.

FINAL RESPONDENTS' BRIEF

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STATEMENT OF THE ISSUE ON APPEAL

Did the trial court properly refuse to charge the jury on spoliation of evidence, where there was no evidence under the Respondent's control that was concealed or misplaced, and the lost evidence had no relevance to the Appellant's liability claims?

STATEMENT OF THE CASE

This appeal arises from a week-long medical malpractice trial that resulted in a defense verdict for Dr. James Williams and South Carolina Oncology Associates. Despite the length of the trial and the significant amount of evidence presented to the jury, this appeal involves only a single issue. Specifically, the Appellants challenge the trial judge's decision not to include a "spoliation of evidence" charge in his instructions to the jury. The judge declined to give a spoliation charge for several reasons, but primarily because there was no proof the Respondents played any role in causing the evidence to be lost or unavailable.

The Appellants commenced this action in the Richland County Court of Common Pleas in 2010. The Respondents filed and served a timely Answer, and the case proceeded to a full period of discovery. After the conclusion of discovery, the case came to trial before the Honorable George C. James, Jr. on October 8, 2012.

During the week-long trial, the judge permitted both sides to present their complete cases. As a result, the jury heard from thirteen different witnesses, including several medical experts. Through their experts, the Appellants presented three theories of liability. First, the Appellants alleged Dr. Williams committed malpractice during the first surgery he performed on Mrs. Atkinson by doing an unnecessary lysis of bowel adhesions. Second, the Appellants claimed Dr. James Williams breached the standard of

care during his treatment and diagnosis of Faye Atkinson after the first surgical procedure he performed on her. Third, the Appellants alleged Dr. Williams was negligent for performing a second surgical procedure too soon and without sufficient informed consent. Dr. Williams and his practice rebutted those allegations through expert testimony.

The evidence at trial demonstrated that during the first surgical procedure Dr. Williams was forced to remove a section of Faye Atkinson's bowel. Dr. Williams could not recall the exact size of the section he removed, and the pathology report following the surgery did not list the length of that section. The evidence showed that Dr. Williams gave the section to a surgical tech in the operating room to be transported to the pathology department, but there was no evidence of what, if anything, the tech did with the sample after receiving it. However, neither of the Appellants' experts testified that not knowing the length of the removed bowel section affected their opinions as to liability or hampered their ability to evaluate the care Dr. Williams provided.

Following the close of evidence on the fifth day of trial, Dr. Williams and his practice made directed verdict motions, which the trial judge denied. During that session outside the jury's presence, the Appellants claimed they were entitled to a "spoliation of evidence" jury charge based on the missing section of the bowel removed in the first surgery. [R. pp. 884-885.] The trial judge ultimately concluded that no sanction for spoliation of evidence was warranted under the facts of this case. [R. pp. 884-885.] Nevertheless, the judge informed the Appellants' attorney he could point to the lost bowel section in conjunction with the Appellants' theory that Dr. Williams had "generally been lax in following up with the standard of care." [R. p. 886, lines 3-4.]

The Appellants' attorney included an argument to that effect in his closing statements. [R. pp. 901-903.]

The trial judge then gave the jury instructions that did not include any mention of spoliation of evidence. [R. pp. 843-880.] Afterwards, the judge gave both sides the opportunity to object to the jury charge, but neither side made any challenges. [R. p. 880-883.] Based on the absence of any objections, the trial judge submitted the case to the jury. The jury deliberated for roughly an hour-and-a-half before returning defense verdicts in favor of Dr. Williams and his practice. [R. pp. 885-886.]

The Appellants filed motions for a new trial and JNOV on October 22, 2012. [R. pp. 17-45.] The Appellants sought JNOV based on evidence of alleged lack of informed consent prior to the second surgery performed by Dr. Williams. [R. pp. 17-45.] Primarily, though, the Appellants moved for a new trial based on the Thirteenth Juror Doctrine due to the trial judge's decision not to give the jury a spoliation of evidence charge. [R. pp. 17-45.] The trial judge denied all of the motions in an Order filed on December 11, 2012. [R. pp. 3-5.] The Appellants then filed their Notice of Appeal.

STATEMENT OF THE FACTS

In the early spring of 2007, a gynecologist examining the Appellant Faye Atkinson discovered an ovarian mass that she suspected might be cancerous. [R. pp. 399-400.] The gynecologist conducted initial tests, which indicated there was a risk of ovarian cancer. [R. pp. 401-402, 453.] For that reason, the doctor referred Atkinson to Dr. James Williams, a gynecological oncologist with South Carolina Oncological Associates in Columbia. [R. pp. 399, 480-481.]

Dr. Williams' first examination of Atkinson occurred on April 13, 2007. After examining Atkinson, Dr. Williams said surgery was necessary to take out the mass. [R. p. 400.] The surgery would also remove the ovaries because Atkinson was post-menopausal. [R. pp. 406, 485-486.] Dr. Miller explained to Atkinson that the surgery carried a risk of causing problems with her bowel. [R. pp. 498-501.] Nevertheless, Atkinson agreed to have the surgery, which was scheduled for April 25, 2007. [R. pp. 489-491.] Atkinson also signed an informed consent form for the surgery. [R. pp. 489-491.]

Atkinson had undergone previous abdominal surgery at a hospital in Hartsville, SC, roughly ten years earlier. [R. p. 398.] During that prior procedure, the surgeon had to remove a section of Atkinson's bowel. [R. p. 398.] Although the evidence at trial did not show the exact amount of bowel removed in that procedure, Atkinson believed it to be approximately 8-10 inches. [R. p. 446.] Thus, Atkinson indisputably had a shortened bowel before Dr. Williams ever saw or treated her.

The previous abdominal surgery resulted in the forming of adhesions along Atkinson's remaining bowel, which is a common side effect of such surgery. Adhesions are bands of scar tissue that bind parts of tissue or organs together. When adhesions form in the abdominal region, they can cause bowel obstructions, and they can also make future abdominal surgeries significantly more difficult to perform.

The purpose of the first surgery by Dr. Williams was to remove the ovarian mass and the ovaries so that tests could determine whether or not Atkinson had cancer. When the procedure began, however, Dr. Williams found numerous abdominal adhesions. [R. pp. 492-496.] The adhesions blocked access to the ovaries, and Dr. Williams was

required to perform extensive adhesiolysis. [R. pp. 496-498.] This is a process in which a surgeon separates the tissue that is stuck together by adhesions. [R. pp. 496-498.] Adhesiolysis is a difficult process due to the tough and sticky nature of adhesions. A sharp object such as scissors or a scalpel is often required to unstick the tissue, and that was the case in Atkinson's surgery. [R. p. 499.] As a result, the adhesiolysis led to creation of some small holes in the bowel called enterotomies. [R. p. 499.] Such holes are an unfortunate but common consequence of adhesiolysis of abdominal adhesions due to the thinness of the bowel. [R. p. 499.] Although the holes can sometimes be stitched closed, they generally require removal of the affected segment of the bowel. [R. pp. 499-501.] The surgeon then reconnects the remaining portions of bowel.

The creation of enterotomies in this surgery forced Dr. Williams to remove a section of Atkinson's bowel. [R. pp. 499-501.] The surgery was ongoing when the bowel section was removed, which meant there was no opportunity for Dr. Williams to measure that section.[1] Instead, following the standard procedure, Dr. Williams gave the removed section to a surgical tech in the operating room, who was responsible for taking it to the pathology department. [R. p. 503.] The pathology report following the surgery did not list or discuss the bowel section, however. Dr. Williams did not know what happened to the bowel section after the surgical tech (who was an employee of the hospital, not Dr. Williams' practice) took possession of it. [R. p. 503.] Neither the surgical tech nor any other hospital employees from the surgery were called as witnesses to try to answer that question.[2] Significantly, though, there was <u>no</u> evidence Dr. Williams

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[1] Dr. Williams could later recall only that he had to remove "feet" of Atkinson's bowel. However, Dr. Williams has never argued that the amount of bowel he removed was not significant.

personally or intentionally misplaced the bowel section. The undisputed evidence revealed Dr. Williams had no further contact with the bowel section after giving it to the surgical tech during the surgery.

The four-hour surgery concluded with the successful removal of the ovaries and the suspect mass, which tests revealed to be benign. [R. pp. 492, 503.] Atkinson's progression in the first few days following the surgery was fairly routine. [R. p. 506.] By the seventh day following surgery there was even some discussion of releasing her from the hospital. [R. p. 507.] Around that time, however, Atkinson began experiencing increasing episodes of nausea. There were two likely alternative explanations for the nausea: Either the bowel had not fully "woken up" following the abdominal surgery (a condition known as an "ileus"), or there was a partial small bowel obstruction ("SBO"). [R. pp. 515-520.]

Dr. Williams performed tests for a possible partial SBO, but the results were inconclusive. [R. pp. 518-519.] Thus, Dr. Williams decided to monitor Atkinson's condition over the next several days in the hopes of getting a clearer diagnosis. [R. p. 519.] During that time, Atkinson continued to have occasional nausea. She was offered a nasal gastric tube ("NGT")[3] to provide some relief from the nausea, but repeatedly declined that offer. [R. pp. 528-529.] Atkinson had experienced trouble with an NGT following her abdominal surgery in the 1990s, and she did not want to repeat those problems. [R. pp. 528-529.]

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[2] The hospital was never a party to this action.

[3] An NGT is a finger-wide tube inserted through a patient's nose that extends into the stomach and helps to drain materials that would otherwise be vomited out.

After Atkinson's condition did not improve over the next several days, Dr. Williams met with her on May 18, 2007 to discuss possible surgery to address a partial SBO. [R. pp. 531-534.] Atkinson requested a second opinion regarding the need for surgery, and she met with Dr. Harris Parker for that evaluation on May 21, 2007. [R. p. 534.] Dr. Parker believed Atkinson had a partial SBO, and he recommended attempting bowel stimulation with a laxative. [R. pp. 547, 725.] When that non-surgical option did not produce the desired result, Dr. Parker concurred with Dr. Williams' recommendation of surgery. [R. pp. 536, 728.] Dr. Williams explained the risks involved in the surgery to Atkinson, who agreed to have the procedure. [R. pp. 548-549.]

Dr. Williams performed the second surgery on May 28, 2007. [R. p. 547.] As he did in the first surgery, Dr. Williams encountered numerous adhesions that required adhesiolysis and the removal of some portions of the bowel. [R. pp. 550-551.] However, the surgery confirmed the existence of a partial SBO and resolved that condition. [R. pp. 553-554.] Dr. Williams did not see any evidence of more serious conditions such as a bowel perforation or leak while performing the surgery. [R. p. 554.]

Roughly five days after the second surgery, it appeared a leak had developed in Atkinson's bowel. [R. p. 561.] Because Dr. Williams had left for a scheduled vacation by that time, Dr. Parker assumed the care of Atkinson. Dr. Parker performed four surgeries between June 3 and June 11, 2007 to address the leaking bowel. [R. p. 732-737.] In the first of those procedures, Dr. Parker discovered two bowel perforations of unknown origin, which required the removal of additional sections of the bowel. [R. pp. 734-735.] Between the second surgery performed by Dr. Williams and the four procedures by Dr. Parker, approximately 28 inches of bowel were removed. [R. p. 618.]

The sections of bowel removed in those procedures were unhealthy and could not be left in place. [R. pp. 553-557.] Furthermore, the removal of sections of the bowel was one of several known and accepted risk of the type abdominal surgery that Atkinson underwent. [R. pp. 122, 290, 488-489.]

STANDARD OF REVIEW

"[A] trial court's decision granting or denying a new trial will not be disturbed unless the decision is wholly unsupported by the evidence or the court's conclusions of law are controlled by an error of law." *Holroyd v. Requa*, 361 S.C. 43, 52, 603 S.E.2d 417, 422 (2004). "In deciding whether to assess error when a new trial motion is denied, [the appellate court] must consider the testimony and reasonable inferences therefrom in the light most favorable to the nonmoving party." *Welch v. Epstein*, 342 S.C. 279, 302-03, 536 S.E.2d 408, 420 (2000).

ARGUMENT

The trial judge properly refused to give a spoliation charge because there was no evidence Dr. Williams lost or destroyed the bowel section, and its unavailability did not impact the Appellants' ability to present their liability claims to the jury.

On appeal, the Appellants claim only that the trial court erred in failing to grant a new trial because he did not include a "spoliation of evidence" charge in his jury instructions.[4] Although the Appellants' post-trial motions also sought relief for other reasons, the Appellants have not presented those issues or arguments in their brief. Thus, the Appellants have waived those issues. *See Video Gaming Consultants, Inc. v. South*

[4] While the Appellants also claim the trial judge erred in failing to grant their JNOV motion for the same reason, the decision not to give a jury charge, even if erroneous and prejudicial, would not be grounds for judgment as a matter of law in the Appellants' favor.

Carolina Dept. of Rev., 342 S.C. 34, 42, 535 S.E.2d 642, 646 n. 7 (2000) ("an issue not argued in the brief is deemed abandoned and precludes consideration on appeal"); Rule 208(b)(1)(B), SCACR ("Ordinarily, no point will be considered which is not set forth in the statement of the issue on appeal."). As a result, the sole issue on appeal involves the trial judge's decision not to give a spoliation of evidence charge.

"The trial judge must charge the correct law to the jury. ... 'When reviewing a jury charge for alleged error, an appellate court must consider the charge as a whole in light of the evidence and issues presented at trial.' ... A trial court's refusal to give a properly requested charge is reversible error only where the requesting party can demonstrate prejudice from the refusal." *Vogt v. Murraywood Swim & Racquet Club*, 357 S.C. 506, 512, 593 S.E.2d 617, 620-21 (Ct. App. 2004).

In the present case, the trial judge correctly ruled the Appellants were not entitled to a jury charge on spoliation of evidence. Yet, even if that decision was erroneous, it did not result in any prejudice to the Appellants because the unavailable piece of evidence did not affect their theories of liability. Therefore, no reversible error exists, and this Court should affirm the result below.

(A) The decision not to give a spoliation charge was correct.

The trial judge refused to give the jury a spoliation-based "negative inference" charge because there was no evidence Dr. Williams lost or destroyed any evidence under his control. Simply put, the judge concluded no "spoliation" had occurred. This was the correct conclusion under the evidence presented at trial, and the Court should affirm the result below.

Black's Law Dictionary defines "spoliation" as "[t]he intentional destruction of evidence." (6th ed. 1991). According to this definition, spoliation occurs when a party intentionally destroys or conceals something that would otherwise be relevant evidence at trial. Here, there is no question the section of bowel removed in the first surgery was unavailable for trial. The other elements are lacking, however, because there is no evidence Dr. Williams lost or destroyed the bowel section, let alone that he did so intentionally. As discussed below, the undisputed evidence reveals that the loss of the bowel section occurred only <u>after</u> it left Dr. Williams' control. Consequently, there was no basis for a spoliation charge.

Dr. Williams was the only witness to testify regarding the section of bowel removed in the first surgery, which means his account is undisputed.[5] Dr. Williams removed the bowel section and immediately handed it over to a surgical tech, who was an employee of the hospital. [R. p. 503.] It was the surgical tech's responsibility to take the bowel section to the pathology department. [R. p. 503.] Dr. Williams does not know what happened to the bowel section after he handed it off to the surgical tech. [R. p. 503.] Nor does he have any knowledge of why the pathology department did not mention the bowel section in its report. [R. p. 503.] Thus, the record shows only that Dr. Williams, following the standard procedure, relinquished the bowel section to the surgical tech in the operating room. What happened to the bowel section after that remains a mystery, but there is <u>no</u> evidence Dr. Williams destroyed the bowel section or caused it to become lost. This point is crucial for purposes of a spoliation analysis.

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[5] Even if there had other testimony to contradict Dr. Williams' explanation, the Court would have to view the evidence in the light most favorable to Dr. Williams, as the Respondents were the nonmoving parties.

Significantly, there was no indication at trial that Dr. Williams deviated from normal procedures when he gave the bowel section to the surgical tech. While the Appellants' medical experts testified generally that a tissue sample should not go missing, none of them faulted Dr. Williams for handing the bowel section to the surgical tech. None of them said Dr. Williams had an obligation to take the section to the pathology department personally. Indeed, there was no evidence that anyone other than the surgical tech bore the responsibility for transporting the bowel section.

In addition, there was no evidence the surgical tech was Dr. Williams' employee or agent. The surgical tech was an employee of the hospital where the surgery occurred. He was not an employee of Dr. Williams or South Carolina Oncology Associates, and the Appellants never presented any evidence that Dr. Williams had the right to control the surgical tech's work. As a result, there is no basis for any argument that Dr. Williams acted vicariously through the surgical tech. Yet, even if such an argument were possible, it would not aid the Appellants because there is also no evidence the surgical tech personally lost or destroyed the bowel section. It is <u>possible</u> the surgical tech misplaced the bowel section, but it is equally possible the section made it to the pathology department and was lost or discarded there. Although the evidence shows the surgical tech was the last person known to have had possession of the bowel section, it does not support anything more than speculation that the surgical tech was responsible for losing or discarding it. For this reason, attempting to establish an agency relationship between Dr. Williams and the surgical tech would not avail the Appellants.

All of the relevant facts point to one unavoidable conclusion: Dr. Williams did not lose or destroy the bowel section. He handed that section to a surgical tech, who was not

his employee, with the understanding that the section would go to the pathology department. Although it is unclear what did happen to the bowel section, it is clear what did not. There is nothing in the record even to suggest, let alone prove, that Dr. Williams played any role in causing that item to be unavailable as evidence. For this reason, there was no spoliation of evidence and no basis for a "negative inference" jury charge.

In arguing for a new trial, the Appellants rely almost entirely on *Stokes v. Spartanburg Reg. Med. Ctr.*, 368 S.C. 515, 629 S.E.2d 675 (Ct. App. 2006). As the trial judge recognized, however, the absence of any involvement by Dr. Williams in causing the absence of the evidence makes this case distinguishable from *Stokes*.

The plaintiff in *Stokes* was the personal representative of the estate of the decedent, who died following a surgical procedure performed at the defendant Spartanburg Regional Medical Center ("the Hospital").[6] The decedent entered the Hospital for a procedure to remove his cancerous thyroid and lymph nodes. *Id.* at 517, 629 S.E.2d at 676. The surgery was successful, but afterwards, the decedent began to experience pain and had trouble breathing. *Id.* The decedent eventually stopped breathing, and efforts to revive him were unsuccessful. *Id.* at 517-18, 629 S.E.2d at 676-77. The attending physician listed "respiratory failure" as the official cause of death, but the reason for the death was a disputed issue in the ensuing malpractice lawsuit. *Id.* The plaintiff claimed the death resulted from a lack of oxygen, which would not have occurred if the medical staff had followed the standard of care. *Id.* at 518, 629 S.E.2d at 677. The Hospital argued the decedent died from a "sudden and unexpected event, most

[6] Four other defendants, including the physicians involved in the decedent's care, were originally part of the case as well. For reasons that do not appear in this Court's opinion, however, the Hospital was the only defendant involved in the appeal.

probably a heart attack." *Id.* at 519, 629 S.E.2d at 677. Thus, the cause of death was the primary dispute at trial.

A potential spoliation issue arose during trial regarding two missing items of evidence. This Court described the controversy in the following terms:

> During trial, [the plaintiff] pointed out two pieces of medical documentation that were missing from [the decedent's] medical records. First, there was evidence that blood had been drawn from [the decedent's] artery during the code. This blood sample was drawn so that an arterial blood gas could be performed, which would indicate whether oxygen was reaching [the decedent's] bloodstream. The medical records, however, did not contain the results from this test. The second piece of missing evidence was the vital signs flow chart prepared by the floor nurse at the time of [the decedent's] death. The Hospital was unsure why the chart was missing, but speculated that it was misplaced during the code.

368 S.C. at 519, 629 S.E.2d at 677. Based on the missing evidence, the plaintiff requested – without objection – a "negative inference" jury charge. *Id.*, 629 S.E.2d at 677-78. Although the judge initially agreed to give the charge, his actual instructions did not include the requested language. *Id.* The judge refused to recharge the jury, which returned a defense verdict for the Hospital. *Id.* The plaintiff then appealed.

This Court reversed and remanded, concluding that the trial judge should have given the "negative inference" charge to the jury. The Court found there was testimony that two pieces of medical evidence under the Hospital's control were missing at trial. Given that testimony, the Court believed the following language "reflects the law of South Carolina":

> I charge you that <u>when a **party** fails to preserve material evidence</u> for trial, it is for you to determine whether the party has offered a satisfactory explanation for that failure. If you find the explanation unsatisfactory, you are

> permitted – but not required – to draw the inference that the evidence would have been unfavorable to the party's claim.

368 S.C. at 522, 629 S.E.2d at 679 (emphasis added). The Court concluded the trial judge erred in not giving that charge. *Id.*

Significantly, though, the Court did not reverse and remand for a new trial until it also found the absence of the charge was prejudicial. The Court explained its finding of prejudice as follows:

> [The plaintiff's] malpractice claim against the Hospital hinged on the jury believing [the decedent] died from lack of oxygen rather than from a sudden and unexpected heart attack. Both pieces of evidence [the plaintiff] alleges are missing would have helped determine how [the decedent] died. Thus, it was crucial to [the plaintiff's] case that the jury know it could draw a negative inference from the Hospital's failure to produce those important pieces of evidence.

368 S.C. at 522, 629 S.E.2d at 679. For that reason, the Court believed a new trial was warranted.

The present case is distinguishable from *Stokes* for at least two reasons. First, unlike the Hospital in *Stokes*, Dr. Williams did not have custody and control over the evidence when it went missing. The only defendant involved in the *Stokes* appeal was the Hospital, which obviously controlled the reports and charts its employees created. The Hospital had an obligation to maintain those materials, and there was no evidence that any other person or entity had that responsibility. For that reason, the Hospital was subject to a "negative inference" charge as a sanction for its failure to fulfill that obligation. The same responsibility or obligation did not exist with respect to Dr. Williams, who had no control over what happened to the bowel section after he handed it

to a surgical tech in the middle of surgery. Thus, the rationale underlying the *Stokes* decision does not apply in the present case.

Granted, the Court did not explicitly discuss the Hospital's culpability in *Stokes*, but that was only because there was no need to do so. The Hospital was clearly the entity in control of the missing materials, and the plaintiff was making no efforts to attribute the Hospital's failure to preserve those materials to anyone else. The requested "negative inference" charge affected only the Hospital. This meant there was no reason for the Court to focus on the role of the Hospital's fault in warranting the "negative inference" charge. Consequently, *Stokes* does not stand for the proposition that <u>any</u> missing evidence entitles a plaintiff to a "negative inference" charge against <u>any</u> defendant. As the charge language approved in *Stokes* demonstrates, such an instruction is only proper when the party against whom it will apply is responsible for the evidence being unavailable.

The other leading cases in South Carolina further reveal the importance of culpability in deciding to grant spoliation-related relief. *Welsh v. Gibbons*,[7] the first modern case to address spoliation remedies, concerned a plaintiff who possessed the allegedly defective product but refused to let the defendant test it. The Supreme Court concluded the jury should be allowed to learn of and consider that refusal in its deliberations. In *Kershaw Co. Sch. Bd. of Educ. v. U.S. Gypsum Co.*,[8] the "negative inference" charge applied to the plaintiff school district because it violated a court order by removing asbestos from one of its buildings before the defendant could test it. The

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[7] 211 S.C. 516, 46 S.E.2d 147 (1948)

[8] 302 S.C. 390, 396 S.E.2d 369 (1990)

Supreme Court determined the jury charge, rather than dismissal of the plaintiff's lawsuit, was the appropriate sanction because the violation of the order appeared to have been unintentional. Conversely, striking a pleading was an acceptable sanction in *QZO, Inc. v. Moyer*,[9] because the party in possession of a computer intentionally deleted information before producing it pursuant to a court order.

All of those cases involve different facts, but they share one common feature: The Courts applied spoliation sanctions only against parties who had custody and control of the evidence but failed (or refused) to make the evidence available to the other side. None of those cases involved sanctions imposed on parties who did not have the requisite custody and control of the evidence, and the Respondents have not found any other authorities granting relief against such non-culpable parties. Thus, the Respondents respectfully submit that the jury charge requested by the Appellants does not represent the law of South Carolina, at least with regard to parties who are not personally responsible for the missing evidence.

Here, as previously discussed, there is no evidence whatsoever that Dr. Williams lost or discarded the bowel section he removed in the first surgery. Dr. Williams gave the bowel section to a hospital employee, whose job it was to take it to the hospital's pathology department. From the moment the bowel section left Dr. Williams' hands, it came under the custody and control of the hospital, and the hospital was responsible for preserving it. Dr. Williams had no control over the hospital or its employees, and it would be fundamentally unfair to penalize Dr. Williams for the hospital's failure to save

[9] 358 S.C. 246, 594 S.E.2d 541 (Ct. App. 2004)

or make a record of the bowel section. Again, the Respondents are not aware of any authority for such a broad application of the "negative inference" charge.

The Appellants apparently attempt to maneuver around Dr. Williams' lack of responsibility for the missing bowel section by claiming he should have inquired about the section when the pathology report did not mention it. The problem with this argument is that it relies entirely on speculation. Because no one knows when the hospital lost or discarded the bowel section, there is no way to know whether follow-up inquiries by Dr. Williams would have done any good. For example, if the hospital had already discarded the bowel section by the time Dr. Williams read the pathology report, no amount of follow-up questions by Dr. Williams would have uncovered or preserved any evidence. It is theoretically possible that questions by Dr. Williams might have caused someone at the hospital to find the bowel section, but it is equally possible that such questions would have been fruitless. As a result, any conclusion by a fact finder based on this argument would necessarily consist of impermissible guesswork.[10]

By requesting a "negative inference" charge, the Appellants were asking the trial judge to punish Dr. Williams for something that was not his fault. Again, there is no evidence that Dr. Williams did anything other than follow the normal procedure by turning the bowel section over to a hospital surgical tech immediately after removing it. Dr. Williams was not responsible for transporting that section to the pathology

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[10] This conclusion might be different if, for example, there had been evidence that the pathology department received the bowel section and held it for a certain number of days before discarding it. In that situation, an argument could exist that follow-up inquiries might have led to preservation of the sample. But the record in this case contains no such evidence. No one knows what happened to the bowel section after the hospital took control of it, and no one knows when it was lost or discarded. Indeed, there was not even any evidence of how long the pathology department would have preserved the sample if it had arrived in that department.

department, nor did he have a duty (or even the ability) to preserve it. Whatever errors caused the bowel section to be lost or discarded were solely attributable to the hospital, and Dr. Williams had no control over those events. The Appellants presented no evidence to the contrary, relying instead on speculation and insinuation. Those efforts were not sufficient to create a legal basis for a "negative inference" charge, and the trial judge properly denied that request.

In addition, giving a "negative inference" instruction under these facts would create an overly broad new standard that would ignore one of the key elements of "spoliation of evidence." As discussed above, South Carolina's case law has treated spoliation-based relief as a <u>sanction</u> for a party's misconduct, usually during discovery. The parties' actions in making the evidence unavailable have ranged from an apparently inadvertent oversights (*Kershaw County Bd. of Educ.* and *Stokes*) to willful defiance of court orders (*Welsh* and *QZO*), and the facts of the cases have been varied. But in <u>all</u> of the cases, the courts struck pleadings or used the "negative inference" charge in order to punish a party's failure to make available evidence under that party's control. This punitive nature of spoliation-based relief serves as a unifying factor for the applicable cases.

Granting a "negative inference" charge in cases like the one at bar would remove that punitive aspect and create de facto strict liability for any missing evidence. Taken to its logical conclusion, the Appellants' position would allow for spoliation-based relief against a party any time evidence that <u>might</u> have been harmful to that party's case is missing <u>for any reason</u>. It would not matter whether or not the party actually played a role in concealing or destroying that evidence. The focus would shift from the party's

conduct to the simple fact that potentially harmful evidence was unavailable. Thus, a party could face a "negative inference" charge even when there was no evidence that the party did anything wrong. The Respondents respectfully assert that this is not the law of South Carolina, nor should it be.

The traditionally punitive nature of spoliation-based relief also rebuts one of the Appellants' other implicit assertions. The Appellants appear to suggest that the trial judge should have given the "negative inference" charge and then allowed the jury to decide whether or not to hold the missing bowel section against Dr. Williams. The problem with that position is that because the "negative inference" charge is essentially a sanction, it sounds inherently punitive. The charge tells the jury it can assume the missing evidence was harmful to a party, which creates at least an inference that the party must have acted improperly in preventing that evidence from being available at trial. For cases in which there is culpability on the spoliator's part, that inference is simply part of the sanction. But for cases like this one, the inference casts unfair and speculative aspersions upon the party. Thus, it is not a simple matter of giving the "negative inference" charge and letting the jurors decide for themselves. The charge is not so neutral in application. Rather, the charge creates an inference of wrongdoing, and it has no place in cases where there is no evidence the party destroyed or concealed anything.

The present case illustrates this point. The jury heard only that Dr. Williams gave the bowel section to a surgical tech after he removed it, just as he was supposed to do, and that he did not know what the hospital did with the bowel section afterwards. The jury heard no testimony that Dr. Williams had any further duties or responsibilities with regard to the bowel section. And the jury certainly never heard any evidence indicating

that Dr. Williams played any role in losing or disposing of the bowel section. In short, the evidence at trial (as opposed to the Appellants' unsupported speculation) provided no basis to blame Dr. Williams for the bowel section being unavailable. Nevertheless, a "negative inference" charge would have at least implied to the jury that Dr. Williams must have had something to do with the missing bowel section. The charge also would have allowed the jury to punish Dr. Williams for that evidence being unavailable, even though there was no proof he was responsible for its absence. The trial judge properly avoided those risks by declining the give the requested charge.

In South Carolina, spoliation is about more than evidence being unavailable. It is not at all uncommon for cases to involve documents or other pieces of evidence that are no longer available by the time of trial. Yet, those cases do not always invoke spoliation issues. This is because "spoliation of evidence" contains an element of culpability. The law intends spoliation-based remedies to be both a method to assist the party who does not have access the evidence and a sanction against the party who was responsible for its unavailability. The spoliation doctrine serves these dual purposes, and it does not apply in the absence of some fault by the non-moving party. That fault might involve anything from negligence to intentional concealment, but there must be a showing of some culpability directly attributable to the non-moving party. Without that, spoliation would become an overly broad and unfair doctrine that does not serve its intended purpose.

The trial judge's decision not to give a "negative inference" charge kept the spoliation doctrine within its proper bounds. The Appellants are effectively asking this Court to remove the fault element of the spoliation doctrine and allow its application in any case involving missing evidence. South Carolina law does not support such an

expansive new application. Therefore, this Court should decline the Appellants' invitation and affirm the result below.

(B) The trial judge's decision was not prejudicial to the Appellants.

As previously discussed, the trial judge properly determined a spoliation-based charge was not warranted because there was no evidence Dr. Williams caused the bowel section to be unavailable for trial. Even if that decision had been erroneous, however, the Appellants would not be entitled to any relief because the absence of a "negative inference" charge was not prejudicial. The Appellants were still able to present their full case to the jury, and the unknown actual length of the bowel section removed in the first surgery had no effect on their liability theories. In addition, the Appellants were able to discuss the missing bowel section and argue that its absence was an indication of Dr. Williams' overall lack of care in his treatment of Atkinson. Thus, the decision not to give the requested charge did not hamper the Appellants' ability to prosecute their case against Dr. Williams.

(1) The Appellants' theories of liability did not rely upon the missing bowel section.

Throughout the trial the Appellants focused their case on three somewhat alternative liability theories. First, the Appellants alleged the adhesiolysis of adhesions performed in the first surgery was too extensive. Second, the Appellants claimed Dr. Williams violated the standard of care in his treatment of Atkinson after the first surgery. That theory focused primarily on an allegation that Dr. Williams failed to diagnose and treat a bowel perforation, which caused Atkinson to experience excessive vomiting and related problems after the first procedure. Third, the Appellants argued Dr. Williams conducted the second operation when it was not medically required and without the

proper informed consent. Significantly, none of those theories involved or depended in any way upon the amount of bowel removed during the first surgery.

As a threshold matter, it is important to note what was not in dispute at trial. The Respondents admitted that Atkinson did not have short bowel syndrome prior to the events of April, May and June of 2007, but that she had short bowel syndrome afterwards. Dr. Williams further admitted that he removed "feet" of Atkinson's bowel during the first surgery and that additional amounts had to be removed in the subsequent procedures. In short, this was not a case in which the Appellants claimed the Respondents removed sections of her bowel while the Respondents denied it. The Respondents conceded a significant amount of Atkinson's bowel was removed. The dispute at trial was whether negligence on Dr. Williams' part resulted in the removal of more bowel than would otherwise have been necessary, and whether the surgeries caused complications unrelated to the bowel resections. As discussed below, the exact length of the section removed in the first surgery was not important, or even relevant, to those disputes.

The Appellants' first theory of liability, relating to the amount of adhesiolysis done in the first surgery, did not require any discussion or examination of the missing bowel section. One of the Appellants' medical experts opined that Dr. Williams violated the standard of care during the first surgery because the amount of adhesiolysis Dr. Williams performed was "not necessary in order to complete the surgery." [R. p. 89, lines 16-20.] Although the expert answered unrelated questions about the missing bowel section, he never stated (or event suggested) that knowing the amount of bowel removed in the first surgery was necessary for his opinion about that surgery. Specifically, the

expert did not testify that the missing section would have demonstrated anything about the amount of adhesions or the need (or lack thereof) for extensive adhesiolysis. The expert based his opinion on Dr. Williams' original decision to "run the bowel" (*i.e.* unsticking adhesions from one end of the bowel to the other) during the surgery, which the expert felt was unwarranted. [R. p. 89.] That decision, the expert believed, was negligent in and of itself because it led to the unnecessary removal of a bowel section. The exact length of that section was not a significant factor for the expert's opinion. The expert was able to form that opinion based solely on Dr. Williams' testimony that he removed "feet" of the bowel. Consequently, the missing bowel section itself was not relevant to this opinion.[11]

The dispute regarding the adhesiolysis in the first surgery was whether Dr. Williams needed to do it in the first place. The Appellants' expert said he did not, while Dr. Williams testified it was necessary in order to gain access to the ovaries. This was essentially a battle of medical opinions. The only physical evidence that could have made one opinion more likely to be true than the other would have been a "snapshot" of Atkinson's abdominal cavity at the moment when the surgery began. A section of the bowel removed at some point later during the four-hour procedure had no bearing on whether or not the amount of adhesiolysis was excessive. Indeed, the Appellants' expert

[11] The expert did state that the missing bowel section would have shown whether Dr. Williams caused one hole or several holes during the first surgery. Again, though, the expert's opinion focused on the <u>decision to perform the extensive adhesiolysis</u>, not the actual performance of the surgery. Bowel perforations are known and common results of adhesiolysis, which meant the decision to "run the bowel" made such perforations likely. Thus, it did not matter for purposes of the expert opinion whether one hole or multiple holes existed. In any event, Dr. Williams admitted at trial that multiple perforations were caused during the surgery. [R. p. 499.]

never claimed otherwise. For that reason, the absence of the bowel section (and of a spoliation charge) did not prejudice this theory of liability.

There was also no prejudice with regard to the second theory of liability – *i.e.* Dr. Williams' treatment of Atkinson following the first surgery. The Appellants' experts described several problems they saw in that post-surgery treatment by Dr. Williams. Essentially, though, the experts contended Dr. Williams failed to diagnose and properly treat a bowel perforation. [*See*, *e.g.*, R. pp. 105-106.] It is unnecessary to present or discuss the specifics of those opinions. For present purposes, it is enough to note that the amount of bowel removed in the first surgery had nothing to do with the experts' opinions regarding post-surgery care. The experts believed Dr. Williams failed to diagnose a bowel perforation that existed after the first surgery. Dr. Williams and his experts opined no perforation existed.[12] The length of the bowel section removed in the first surgery, or the number of holes in it, had no relevance to this dispute over whether a bowel perforation was present after the first surgery. Again, the Appellants' experts never even claimed otherwise.

Finally, the missing bowel section had no possible relevance to the third theory of liability, which dealt with the decision to perform the second surgery. The Appellants' experts faulted Dr. Williams for performing a second surgical procedure when a more conservative treatment appeared to be working. The Appellants also claimed Dr. Williams failed to get the necessary informed consent from Atkinson prior to the second surgery. The Respondents denied both allegations, arguing the surgery was necessary to

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[12] Dr. Williams diagnosed and treated a partial small bowel obstruction, a diagnosis confirmed by other doctors who treated Mrs. Atkinson as well as the Respondents' medical experts.

resolve the partial small bowel obstruction and Atkinson gave informed consent. There was competing evidence on those disputes, including expert medical opinions supporting both sides. None of that evidence, however, had anything to do with the missing bowel section from the first surgery. The experts never discussed that bowel section in this context, nor did they suggest the missing section could have shed any light on whether the second surgery was warranted. Thus, the missing bowel section had no conceivable nexus to this third theory of liability.

The Appellants essentially alleged that Dr. Williams made a negligent decision to "run the bowel" and perform extensive adhesiolysis during the first surgery. They claimed that decision caused bowel perforations and resections and set in motion a series of events that led to missed diagnoses, improper post-surgery care and several additional surgeries. They argued the end result was that Atkinson left the Respondents' care with a greatly shortened small bowel and short bowel syndrome. This served as the Appellants' unifying theme at trial.

Significantly, though, those allegations were not dependent upon the exact length of the bowel section removed during the original surgery. The first allegation involved a decision made before the removal of that bowel section, and the other two concerned unrelated events that occurred weeks after that removal. Simply put, the Appellants did not need the bowel section (or its exact measurement) to present their full case to the jury. The exact length of that section did not make any of their allegations more or less likely to be true. Nor did the Appellants need the jury to infer anything about the bowel section in order to prove their case. The bowel section was not relevant to the real issues

in dispute, and therefore, the judge's decision not to charge the jury regarding its unavailability did not hamper the Appellants' efforts at trial.

The unavailable evidence's lack of relevance plainly distinguishes this case from *Stokes v. Spartanburg Reg. Med. Ctr.*, 368 S.C. 515, 629 S.E.2d 675 (Ct. App. 2006). As discussed above in section (A) of this brief, the primary liability issue in *Stokes* was a dispute over the cause of a surgical patient's death. The plaintiff argued the patient died from a lack of oxygen caused by the defendant hospital's negligence; the hospital claimed he died from a sudden, unpreventable heart attack. As this Court noted, the two pieces of evidence missing from the hospital's records "would have helped determine how [the patient] died." *Id.* at 522, 629 S.E.2d at 679. "Thus, it was crucial to [the plaintiff's] case that the jury know it could draw a negative inference from the Hospital's failure to produce those important pieces of evidence." *Id.*

Here, on the other hand, the missing bowel section was not crucial to the Appellants' case. That bowel section could not have told the jury anything at all about whether Dr. Williams performed unnecessarily extensive adhesiolysis, whether he failed to diagnose and treat a bowel perforation after the first surgery, or whether he conducted a second surgery needlessly or at least too quickly. Those were the issues in dispute at trial, and the missing bowel section had no relevance to any of them. Consequently, the prejudicial impact of the decision not to give a spoliation charge in *Stokes* was absent in the present case. The Appellants could – and did – fully present their case to the jury without such a charge, and its absence did not harm their case in any way.

Furthermore, it is important to recall that Dr. Williams admitted he removed "feet" of Atkinson's bowel during the first surgery. Although Dr. Williams could not

give the jury the exact measurement, he never attempted to minimize the removal made in the first surgery. In other words, this was not a case in which the defendant surgeon denied removing something or said he removed a much smaller amount than the plaintiff claimed. The Respondents conceded all along that the series of surgeries beginning in April of 2008 led to Atkinson having a significantly reduced small bowel and small bowel syndrome. As a result, the jury did not have to infer anything about the missing bowel section. The general length of that section was never in any real dispute.

The dispositive question at trial was not whether Atkinson wound up with short bowel syndrome after her hospital stay in April through May of 2007. Rather, the question was whether her condition was the unavoidable result of a proper course of medical treatment or the consequence of negligence by Dr. Williams. The missing bowel section would not have answered that question, or even helped to answer it. The resolution of that dispute involved other evidence, all of which the jury had. Therefore, the decision not to give a spoliation charge did not result in any prejudice to the Appellants' ability to present their theories of liability in this case.[13]

(2) <u>The trial judge permitted the Appellants to make arguments about the missing bowel section being lost without implying what it would have shown.</u>

As discussed above, the missing bowel section was not relevant to the Appellants' theories of liability. What that section would or would not have shown had no impact on the Appellants' claims or the jury's ability to reach its decision. In addition, there was no evidence that Dr. Williams caused the bowel section to be lost or destroyed. Thus, it is

[13] In fact, as previously discussed, giving such a charge in this case would have been unfairly prejudicial to the Respondents, as there was no evidence Dr. Williams caused the bowel section to be lost or destroyed.

questionable whether there should have been any testimony at all regarding the fact that the bowel section was not preserved. Nevertheless, even though the trial judge denied the request for a spoliation charge, he allowed the Appellants to mention and argue that fact in their closing statements to the jury. That decision gave the Appellants a benefit that prevented any prejudice from the arising due to the absence of a spoliation charge.

After declining to give a spoliation charge, the trial judge described to the Appellants' attorney what he would be able to do during closings:

> I will permit you to argue the lost bowel, not in the context of him either having something to do with it, because there's no evidence of it, and not in the context of it must have shown something bad or it should have would probably [sic] be here. <u>You can – you can argue that it is a further indication of his – your theory ... [that he's] just generally been lax in following up with the standard of care. In other words, he didn't even exercise diligence to follow up on that missing bowel</u>.

[R. p. 885, line 20 – p. 886, line 6 (emphasis added).] The Appellants' attorney proceeded to make several references to the missing bowel section during his closing statements. [R. pp. 901-904.] Essentially, the attorney reminded the jury of the fact that the bowel section was missing and asked the jurors not to believe any arguments that Atkinson did not have short bowel syndrome or that the syndrome was caused by her previous abdominal surgery in the 1990s. [R. pp. 901-904.] Of course, the Respondents never made any such arguments, either during closing statements or at any other point in the trial.

The Appellants' closing statements brought the missing bowel section back to the jury's attention and reinforced the fact that it was unavailable. The statements reminded the jury that Dr. Williams removed "feet" of the bowel in the first surgery and that

Atkinson had short bowel syndrome after her treatments with the Respondents. In doing those things, the Appellants' closing statements reinforced their theme of the case more than any jury charge would have done. Thus, the judge's decision not to give a spoliation charge did not prevent the Appellants from stressing the missing bowel section to the jury. That it was not relevant to their theories of liability, or that the jury did not assign significance to it, is of no consequence for present purposes. All that matters now is that the judge allowed the Appellants to call extra attention to the fact that the bowel section was unavailable at trial. This leniency by the judge prevented his decision not to give a spoliation charge from having any prejudicial effect.

(3) The Respondents never argued the Appellants failed to prove their case based on the absence of the bowel section.

The absence of a spoliation charge was also non-prejudicial because the inability to produce the bowel section did not put the Appellants at any disadvantage. The Respondents never argued that Dr. Miller did not remove "feet" of Atkinson's small bowel during the first surgery. The Respondents also never disputed that Atkinson had short bowel syndrome following her series of surgeries in April through June of 2007. The real question was not whether parts of the bowel were removed or whether short bowel syndrome was the end result. The issue was whether or not Dr. Williams followed the standard of care in his treatment of Atkinson. The specific details of the bowel section removed in the first surgery were not necessary to resolve that question.

Even if those details had been necessary, the Appellants were able to reconstruct them through other evidence. The Appellants were able to present the following information based on testimony from the treating doctors and medical experts: (1) the approximate length of Atkinson's small bowel roughly one month before she first saw

Dr. Williams, based on a CT scan, (2) an admission by Dr. Williams that he removed "feet" of the small bowel in the first surgery, (3) the amounts of small bowel removed in the second surgery by Dr. Williams and the surgeries by Dr. Parker, and (4) the amount of small bowel remaining as of the time of trial.[14] Those pieces of information gave the jury sufficient evidence to figure out roughly how much small bowel Dr. Williams resected in the first procedure. Thus, to the extent it was even relevant, at least an approximate length of the bowel section was before the jury, and the specific length would have been merely cumulative.

In addition, the Respondents never even hinted – let alone argued – that the Appellants had failed to prove their case from an evidentiary standpoint because they could not produce the bowel section. Stated another way, there was no argument that the Appellants failed to prove Dr. Williams removed a section of the small bowel in the first surgery. Nor did the Respondents argue the absence of the bowel section (or facts about it) was fatal to the Appellants' case in any other way. Indeed, Dr. Williams only addressed the bowel section when the Appellants' counsel asked him about it, and the Respondents' trial attorney did not use the bowel section as the basis for any of his arguments to the jury. All of this means the Appellants were not in a position where they needed information about the bowel section but did not have it, and the Respondents pointed out that shortcoming to the jury. None of that happened in this case.

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[14] One of the Appellants' experts testified a CT scan taken in March 2007 appeared to show a "normal" amount of small bowel, which could anywhere from 14 to 18 feet for a woman of Atkinson's size. [R. p. 883.] He admitted his estimate might not account for the amount of bowel removed in the 1995 abdominal surgery, believed to be 8-10 inches. [R. pp. 446, 883.] Other testimony established that a total of roughly 28 inches of the bowel were removed in Dr. Williams' second surgery and Dr. Parker's surgeries. [R. pp. 617-618.] One of Atkinson's physicians estimated she had 20-22 inches of bowel remaining as of the time of trial. [R. p. 147.]

A comparison of this case and *Stokes v. Spartanburg Reg. Med. Ctr.* once again reinforces this point. The parties in *Stokes* disagreed sharply about what caused the patient's death, and the missing information from the hospital's records was directly relevant to that dispute. The defendant hospital almost certainly argued at trial that the plaintiff had failed to prove the patient died as a result of malpractice by the hospital's employees, as opposed to natural causes. Such an argument would have relied, at least implicitly, on the absence of evidence from the medical records corroborating the plaintiff's theory. Thus, the missing evidence played a central role at trial in *Stokes*.

The same is not true here. Although the Appellants repeatedly referenced the missing bowel section, the Respondents did not rely on its absence. More significantly, the Respondents did not claim the lack of specific information about the bowel section meant the Appellants could not prove their case. Consequently, the missing evidence in *Stokes* had an importance that simply does not exist in the present case. This is yet another reason why the trial judge properly concluded *Stokes* is distinguishable.

Again, the Respondents never attempted to make this a case about the Appellants' lack of proof. The Respondents instead asserted that Dr. Williams adhered to the applicable standards of care throughout his treatment of Atkinson. They did not deny that Atkinson wound up with short bowel syndrome, but argued the condition was an unavoidable complication arising from necessary surgical procedures. The Appellants, on the other hand, claimed different and better care could have prevented that result. This was the dispute the jury had to decide after hearing a week's worth of evidence. The absence of the bowel section (or of specific information about it) had no conceivable impact on the jury's decision, and nothing the jury could have inferred from the bowel

section would have aided the Appellants' case. For that reason, the absence of a spoliation charge based on the bowel section did not result in any prejudice to the Appellants, and this Court should affirm the result below.

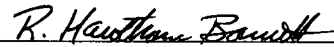
CONCLUSION

The Appellants sought to punish the Respondents with a "negative inference" jury charge even though there was no evidence Dr. Williams played any part in causing the bowel section to be lost or destroyed. The only evidence on this question showed that Dr. Williams followed the standard procedure by turning the bowel section over to a surgical tech in the operating room after he removed it. To this day, no one knows what happened to the bowel section after the hospital's employee assumed control over it, but there is no basis for attributing its disappearance to Dr. Williams. Thus, giving a spoliation-based charge in this case would have been punishing Dr. Williams even though there is no evidence he was guilty of any wrongdoing. The trial judge properly rejected that unjust result by declining to give the "negative inference" charge.

In addition, the Appellants sustained no prejudice from the judge's decision. The real disputes in this case had nothing to do with the missing bowel section, and it was not a vital – or even an important – part of the Appellants' case. While they referred to it frequently, this was just a tactic designed to make the Respondents look bad. But the truth is that the missing bowel section would not have provided any information that the Appellants' needed to establish their claims. The central dispute concerned the aftermath of the first surgical procedure, and the bowel section simply was not relevant to those events. Therefore, the decision not to give a spoliation charge did not harm the Appellants or prevent them from fully presenting their claims.

After a full trial, the jury determined the Respondents were not liable for malpractice. The jury considered all of the Appellants' evidence and arguments, but concluded Atkinson's regrettable condition did not arise from any negligence by Dr. Williams. The Appellants are understandably disappointed with that result, but they have failed to provide any basis for this Court to grant a new trial. Accordingly, this Court should affirm the defense verdicts and corresponding judgment in favor of the Respondents.

Respectfully submitted,



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RULE 211(b), SCACR CERTIFICATION

The undersigned, an attorney in this matter for the Respondents, certifies that this Final Respondents' Brief complies with Rule 211(b), SCACR.

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

George C. James, Jr., Circuit Court Judge

Case No.: 2010-CP-40-5705

Doris F. Atkinson and William E. Atkinson, Jr., ...Appellants,

v.

James A. Williams, Jr., M.D., and South Carolina
Oncology Associates,...Respondents.

PROOF OF SERVICE

The undersigned, an attorney in this matter for the Respondents, certifies that I have this **28th day of April, 2014**, served a copy of the **Final Respondents' Brief** upon counsel for the Appellants by causing it to be deposited in the United States mail with sufficient postage attached, addressed to: Daryl J. Corbin, Esq.; Corbin Law Firm; P.O. Box 447; Florence, SC 29503.

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