

ARTICLE 5

Medical Malpractice Act

41-5-1. Short title.

Chapter 41, Article 5 NMSA 1978 may be cited as the "Medical Malpractice Act".

History: 1953 Comp., § 58-33-1, enacted by Laws 1976, ch. 2, § 1; 1992, ch. 33, § 1.

ANNOTATIONS

The 1992 amendment, effective April 1, 1992, substituted "Chapter 41, Article 5 NMSA" for "This act".

Applicability. — Laws 1992, ch. 33, § 17 made the provisions of the act applicable only to occurrences arising on and after April 1, 1994.

Temporary provisions. — Laws 1992, ch. 33, § 15, effective March 6, 1992, provided that for the purposes of the Medical Malpractice Act, a health care provider who qualified for medical malpractice liability insurance pursuant to the provisions of the Medical Malpractice Act in effect prior to April 1, 1992 shall remain subject to the terms and provisions of the act that existed on the date of qualification and further provided that upon the date of renewal for a health care provider's policy of medical malpractice liability insurance or the date of continuation of coverage for health care providers who maintain a cash deposit with the superintendent of insurance, the provisions of the Medical Malpractice Act in effect on the dates of renewal or continuation shall apply.

Purpose of act. — This act's limitation of health care provider liability reflects a concern by the legislature for the health of New Mexico citizens as affected by the availability of physicians and malpractice coverage. *Lester ex rel. Mavrogenis v. Hall*, 1998-NMSC-047, 126 N.M. 404, 970 P.2d 590.

Scope. — The Medical Malpractice Act [Chapter 41, Article 5 NMSA 1978] covers all causes of action arising in New Mexico that are based on acts of malpractice. *Wilschinsky v. Medina*, 1989-NMSC-047, 108 N.M. 511, 775 P.2d 713.

Claim held within scope of act. — Third party's malpractice claim, resulting from injuries caused by a patient's impaired ability to drive after a doctor administered powerful drugs to the patient in the doctor's office, fell within the purpose of the Medical Malpractice Act [Chapter 41, Article 5 NMSA 1978]. *Wilschinsky v. Medina*, 1989-NMSC-047, 108 N.M. 511, 775 P.2d 713.

Proof of medical malpractice. — To prove medical malpractice, a plaintiff must show that the defendant owed the plaintiff a duty recognized by law, the defendant breached the duty by departing from the proper standard of medical practice recognized in the community, and the acts or omissions complained of proximately caused the plaintiff's injuries. *Brown v. Kellogg*,

[2015-NMCA-006](#), cert. denied, 2014-NMCERT-010.

Duty considerations. — Courts must articulate specific policy reasons when deciding whether a defendant does or does not have a duty or that an existing duty should be limited; foreseeability is not a factor for courts to consider when determining the existence of a duty because it is a fact-intensive inquiry relevant only to breach of duty and legal cause considerations. *Brown v. Kellogg*, [2015-NMCA-006](#), cert. denied, 2014-NMCERT-010.

Sources of duty for medical professionals. — A duty can be found where a medical professional exerts control over a patient with known dangerous propensities who causes injury, where a medical professional is aware of specific threats to the life of an individual and fails to disclose those threats, and where a medical professional administers powerful drugs that results in impairment to a patient who then causes injury to others. *Brown v. Kellogg*, [2015-NMCA-006](#), cert. denied, 2014-NMCERT-010.

Where duty on medical professionals not found. — Where police detective, after being examined by healthcare professionals for depression and suicidal thoughts and after being discharged with a follow-up plan for therapy, proceeded to use his service weapon to shoot his wife and kill himself, the court of appeals declined to impose a duty to order a fitness for duty evaluation on independent healthcare professionals who treat individuals with access to firearms as part of their workplace environment, because it did not fall within one of the three recognized sources of duty for medical professionals to third parties. *Brown v. Kellogg*, [2015-NMCA-006](#), cert. denied, 2014-NMCERT-010.

Representation required in malpractice action. — A non-attorney parent was required to be represented by counsel in order to bring a medical malpractice claim on behalf of his minor son. *Chisholm v. Rueckhaus*, [1997-NMCA-112](#), [124 N.M. 255](#), [948 P.2d 707](#), cert. denied, [124 N.M. 268](#), [949 P.2d 282](#).

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For comment, "Survey of New Mexico Law: Torts," see 15 N.M.L. Rev. 363 (1985).

For survey of medical malpractice law in New Mexico, see 18 N.M.L. Rev. 469 (1988).

For article, "Statutory Adoption of Several Liability in New Mexico: A Commentary and Quasi-Legislative History," see 18 N.M.L. Rev. 483 (1988).

For note, "Foreseeability vs. Public Policy Considerations in Determining the Duty of Physicians to Non-Patients - *Lester v. Hall*," see 30 N.M.L. Rev. 351 (2000).

For article, "An Economic Model Costing 'Early Offers' Medical Malpractice Reform: Trading Noneconomic Damages for Prompt Payment of Economic Damages", see 35 N.M.L. Rev. 259 (2005).

For note and comment, "Statutes of Limitations Applied to Minors: The New Mexico Court of Appeals Balance of Competing State Interests to Favor Children," see 35 N.M. L. Rev. 535 (2005).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers §§ 200 to 301.

Malpractice in connection with electroshock treatment, 94 A.L.R.3d 317.

Measure and elements of damages in action against physician for breach of contract to achieve particular result or cure, 99 A.L.R.3d 303.

Immunity of public officer from liability for injuries caused by negligently released individual, 5 A.L.R.4th 773.

Propriety of hospital's conditioning physician's staff privileges on physician carrying professional liability or malpractice insurance, 7 A.L.R.4th 1238.

Medical malpractice, administering or prescribing birth control pills or devices, 9 A.L.R.4th 372.

Propriety, in medical malpractice case, of admitting testimony regarding physician's usual custom or habit in order to establish nonliability, 10 A.L.R.4th 1243.

Duty of medical practitioner to warn patient of subsequently discovered danger from treatment previously given, 12 A.L.R.4th 41.

Hospital's liability for negligence in failing to review or supervise treatment given by doctor, or to require consultation, 12 A.L.R.4th 57.

Physician's liability for causing patient to become addicted to drugs, 16 A.L.R.4th 999.

Liability of doctor, psychiatrist, or psychologist for failure to take steps to prevent patient's suicide, 17 A.L.R.4th 1128.

Liability for wrongful autopsy, 18 A.L.R.4th 858.

Medical malpractice: instrument breaking in course of surgery or treatment, 20 A.L.R.4th 1179.

Malpractice liability based on prior treatment of mental disorder alleged to relate to patient's conviction of crime, 28 A.L.R.4th 712.

Medical malpractice: Liability for failure of physician to inform patient of alternative modes of diagnosis or treatment, 38 A.L.R.4th 900.

Recovery by patient on whom surgery or other treatment was performed by one other than physician who patient believed would perform it, 39 A.L.R.4th 1034.

Medical malpractice: liability based on misrepresentation of the nature and hazards of treatment, 42 A.L.R.4th 543.

Physician's liability to third person for prescribing drug to known drug addict, 42 A.L.R.4th 586.

Liability of physician, for injury to or death of third party, due to failure to disclose driving-related impediment, 43 A.L.R.4th 153.

Physician's or other healer's conduct in connection with defense of or resistance to malpractice action as ground for revocation of license or other disciplinary action, 44 A.L.R.4th 248.

Liability of hospital or clinic for sexual relationships with patients by staff physicians, psychologists, and other healers, 45 A.L.R.4th 289.

Homicide: physician's withdrawal of life supports from comatose patient, 47 A.L.R.4th 18.

Physician's tort liability for unauthorized disclosure of confidential information about patient, 48 A.L.R.4th 668.

Medical malpractice: *res ipsa loquitur* in negligent anesthesia cases, 49 A.L.R.4th 63.

Liability of hospital or sanitarium for negligence of physician or surgeon, 51 A.L.R.4th 235.

Medical malpractice: "loss of chance" causality, 54 A.L.R.4th 10.

Recoverability of compensatory damages for mental anguish or emotional distress for breach of service contract, 54 A.L.R.4th 901.

Tortious maintenance or removal of life supports, 58 A.L.R.4th 222.

Criminal liability under statutes penalizing abuse or neglect of the institutionalized infirm, 60 A.L.R.4th 1153.

Medical malpractice: hospital's liability for injury allegedly caused by failure to have properly qualified staff, 62 A.L.R.4th 692.

Medical practitioner's liability for treatment given child without parent's consent, 67 A.L.R.4th 511.

Applicability of *res ipsa loquitur* in case of multiple medical defendants - modern status, 67 A.L.R.4th 544.

Medical malpractice in performance of legal abortion, 69 A.L.R.4th 875.

Medical malpractice: presumption or inference from failure of hospital or doctor to produce relevant medical records, 69 A.L.R.4th 906.

Propriety and prejudicial effect of trial counsel's reference or suggestion in medical malpractice case that defendant is insured, 71 A.L.R.4th 1025.

Tort liability of medical society or professional association for failure to discipline or investigate negligent or otherwise incompetent medical practitioner, 72 A.L.R.4th 1148.

Liability of osteopath for medical malpractice, 73 A.L.R.4th 24.

"Dual capacity doctrine" as basis for employee's recovery for medical malpractice from company medical personnel, 73 A.L.R.4th 115.

Recoverability of compensatory damages for mental anguish or emotional distress for tortiously causing another's birth, 74 A.L.R.4th 798.

Liability for medical malpractice in connection with performance of circumcision, 75 A.L.R.4th 710.

Liability of hospital, physician, or other medical personnel for death or injury to mother or child caused by improper procedures during caesarean delivery, 76 A.L.R.4th 1112.

Liability for dental malpractice in provision or fitting of dentures, 77 A.L.R.4th 222.

Liability of chiropractors and other drugless practitioners for medical malpractice, 77 A.L.R.4th 273.

Liability of orthodontist for malpractice, 81 A.L.R.4th 632.

Medical malpractice: drug manufacturer's package insert recommendations as evidence of standard of care, 82 A.L.R.4th 166.

Malpractice involving hysterectomies and oophorectomies, 86 A.L.R.4th 18.

Gynecological malpractice not involving hysterectomies or oophorectomies, 86 A.L.R.4th 125.

What nonpatient claims against doctors, hospitals, or similar health care providers are not subject to statutes specifically governing actions and damages for medical malpractice, 88 A.L.R.4th 358.

Recoverability of cost of raising normal, healthy child born as result of physician's negligence or breach of contract or warranty, 89 A.L.R.4th 632.

Malpractice: Physician's duty, under informed consent doctrine, to obtain patient's consent to treatment in pregnancy or childbirth cases, 89 A.L.R.4th 799.

What patient claims against doctor, hospital, or similar health care provider are not subject to statutes specifically governing actions and damages for medical malpractice, 89 A.L.R.4th 887.

Application of "firemen's rule" to bar recovery by emergency medical personnel injured in responding to, or at scene of, emergency, 89 A.L.R.4th 1079.

Liability for incorrectly diagnosing existence or nature of pregnancy, 2 A.L.R.5th 769.

Liability of hospital, physician, or other medical personnel for death or injury to child caused by improper postdelivery diagnosis, care, and representations, 2 A.L.R.5th 811.

Liability of physician, nurse, or hospital for failure to contact physician or to keep physician sufficiently informed concerning status of mother during pregnancy, labor, and childbirth, 3 A.L.R.5th 123.

Liability of hospital, physician, or other medical personnel for death or injury to mother or child caused by inadequate attendance or monitoring of patient during and after pregnancy, labor, and delivery, 3 A.L.R.5th 146.

Liability of doctor or other health practitioner to third party contracting contagious disease from doctor's patient, 3 A.L.R.5th 370.

Liability of hospital, physician, or other medical personnel for death or injury to mother or child caused by improper choice between, or timing of, vaginal or cesarean delivery, 4 A.L.R.5th 148.

Liability of hospital, physician, or other medical personnel for death or injury to mother or child caused by improper procedures during vaginal delivery, 4 A.L.R.5th 210.

Liability of hospital, physician, or other medical personnel for death or injury to mother or child caused by improper treatment during labor, 6 A.L.R.5th 490.

Liability of hospital, physician, or other medical personnel for death or injury to mother caused by improper postdelivery diagnosis, care, and representations, 6 A.L.R.5th 534.

Liability of hospital, physician, or other medical personnel for death or injury to mother or child caused by improper diagnosis and treatment of mother relating to and during pregnancy, 7 A.L.R.5th 1.

Joint and several liability of physicians whose independent negligence in treatment of patient causes indivisible injury, 9 A.L.R.5th 746.

Malpractice in treatment of skin disease, disorder, blemish, or scar, 19 A.L.R.5th 563.

Arbitration of medical malpractice claims, 24 A.L.R.5th 1.

Medical malpractice in connection with breast augmentation, reduction or reconstruction, 28 A.L.R.5th 497.

Medical malpractice: negligent catheterization, 31 A.L.R.5th 1.

Medical malpractice physician's admission of negligence as establishing standard of care and breach of that standard, 42 A.L.R.5th 1.

Medical malpractice in connection with diagnosis, care, or treatment of diabetes, 43 A.L.R.5th 87.

Liability of pharmacist who accurately fills prescription for harm resulting to user, 44 A.L.R.5th 393.

Malpractice: Physician's liability for injury or death resulting from side effects of drugs intentionally administered to or prescribed for patient, 47 A.L.R.5th 433.

Malpractice in diagnosis and treatment of male urinary tract and related organs, 48 A.L.R.5th 575.

Liability of health maintenance organizations (HMOs) for negligence of member physicians, 51 A.L.R.5th 271.

Malpractice in diagnosis or treatment of meningitis, 51 A.L.R.5th 301.

Recovery for emotional distress based on fear of contracting HIV or AIDS, 59 A.L.R.5th 535.

Coverage of professional-liability or -indemnity policy for sexual contact with patients by physicians, surgeons, and other healers, 60 A.L.R.5th 239.

Medical-malpractice countersuits, 61 A.L.R.5th 307.

Liability of hospital or medical practitioner under doctrine of strict liability in tort, or breach of warranty, for harm caused by drug, medical instrument, or similar device used in treating

patient, 65 A.L.R.5th 357.

Discovery, in medical malpractice action, of names and medical records of other patients to whom defendant has given treatment similar to that allegedly injuring plaintiff, 66 A.L.R.5th 591.

Physical injury requirement for emotional distress claim based on false positive conclusion on medical test diagnosing disease, 69 A.L.R.5th 411.

Right to recover money lent for gambling purposes, 74 A.L.R.5th 369.

Contributory negligence or comparative negligence based on failure of patient to follow instructions as defense in action against physician or surgeon for medical malpractice, 84 A.L.R.5th 619.

Malpractice by medical or health professions, contributory negligence, comparative negligence, or assumption of risk, other than failing to reveal medical history or follow instructions, as defense in action against physician or surgeon for medical malpractice, 108 A.L.R.5th 385, §§ 3[d], 5[a, c], 6, 7[b], 15.

When does medical practitioner's treatment of patient constitute "willful and malicious injury," so as to make practitioner's debt arising from such treatment nondischargeable under § 523(a)(6) of Bankruptcy Act (11 USCS § 523(a)(6)), 77 A.L.R. Fed. 918.

41-5-2. Purpose of act. (Repealed effective January 1, 2022.)

The purpose of the Medical Malpractice Act is to promote the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers in New Mexico.

History: 1953 Comp., § 58-33-2, enacted by Laws 1976, ch. 2, § 2.

ANNOTATIONS

Delayed repeals. — [Laws 2021, ch. 16, § 17](#) repealed [41-5-2 NMSA 1978](#), effective January 1, 2022.

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Medical Malpractice Act held constitutional. *Otero v. Zouhar*, [1984-NMCA-054](#), [102 N.M. 493](#), [697 P.2d 493](#), *rev'd in part on other grounds*, [1985-NMSC-021](#), [102 N.M. 482](#), [697 P.2d 482](#).

Malpractice claims under this article do not include claims of criminal sexual assault not committed in the course of rendering professional health care services. *N.M. Physicians Mut. Liab. Co. v. LaMure*, [1993-NMSC-048](#), [116 N.M. 92](#), [860 P.2d 734](#).

Limits of recovery. — This section is not arbitrary and capricious and is rationally related to legislative goal of ensuring a source of recovery for victims of medical malpractice and curbing

runaway medical costs, relying in part on *Trujillo v. City of Albuquerque*, 1998-NMSC-031, 125 N.M. 721, 965 P.2d 305. *Fed. Exp. Corp. v. United States*, 228 F. Supp 2d 1267 (D.N.M. 2002).

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For survey of medical malpractice law in New Mexico, see 18 N.M.L. Rev. 469 (1988).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers §§ 372 to 377.

Coverage and exclusions of liability or indemnity policy on physicians, surgeons, and other healers, 33 A.L.R.4th 14, 14 A.L.R.5th 695.

Coverage of professional-liability or -indemnity policy for sexual contact with patients by physicians, surgeons, and other healers, 60 A.L.R.5th 239.

41-5-3. Definitions.

As used in the Medical Malpractice Act:

A. "health care provider" means a person, corporation, organization, facility or institution licensed or certified by this state to provide health care or professional services as a doctor of medicine, hospital, outpatient health care facility, doctor of osteopathy, chiropractor, podiatrist, nurse anesthetist or physician's assistant;

B. "insurer" means an insurance company engaged in writing health care provider malpractice liability insurance in this state;

C. "malpractice claim" includes any cause of action arising in this state against a health care provider for medical treatment, lack of medical treatment or other claimed departure from accepted standards of health care which proximately results in injury to the patient, whether the patient's claim or cause of action sounds in tort or contract, and includes but is not limited to actions based on battery or wrongful death; "malpractice claim" does not include a cause of action arising out of the driving, flying or nonmedical acts involved in the operation, use or maintenance of a vehicular or aircraft ambulance;

D. "medical care and related benefits" means all reasonable medical, surgical, physical rehabilitation and custodial services and includes drugs, prosthetic devices and other similar materials reasonably necessary in the provision of such services;

E. "patient" means a natural person who received or should have received health care from a licensed health care provider, under a contract, express or implied; and

F. "superintendent" means the superintendent of insurance of this state.

History: 1953 Comp., § 58-33-3, enacted by Laws 1976, ch. 2, § 3; 1977, ch. 284, § 1.

ANNOTATIONS

Emergency clauses. — Laws 1977, ch. 284, § 5 contained an emergency clause and was approved April 7, 1977.

Communication between medical personnel. — Communication between medical personnel is not a matter that requires expert knowledge to understand the standard of care involved and a party may be able to establish that a departure from the standard of ordinary care occurs when a clerical error affects the timeliness or accuracy of a diagnosis. *Zamora v. St. Vincent Hospital*, [2014-NMSC-035](#).

Where plaintiff was admitted to defendant's emergency room with abdominal pain; a contract radiologist performed an abdominal scan on plaintiff; the radiology report concluded that defendant had a diverticular abscess and that cancer was a possibility; the emergency physician and surgeon never received the radiologist's report; plaintiff was diagnosed with colon cancer fourteen months later; plaintiff sued defendant alleging that as a consequence of defendant's failure through an administrative inadequacy to forward the radiology report to the surgeon, plaintiff was treated for a diverticular abscess, allowing the cancer to grow; and defendant claimed that plaintiff failed to present expert testimony regarding the standard of care of communication between medical personnel, expert testimony was not required to establish the standard of care because the communication of the diagnosis by one doctor to another is subject to an ordinary negligence standard of care, which does not require expert testimony. *Zamora v. St. Vincent Hospital*, [2014-NMSC-035](#).

Malpractice claim. — The controlling inquiry in determining whether a claim constitutes a "malpractice claim" under the Medical Malpractice Act [Chapter [41](#), Article [5](#) NMSA 1978] is whether the gravamen of the claim is predicated upon the allegation of professional negligence. *Christus St. Vincent Reg'l Med. Ctr. v. Duarte-Afara*, [2011-NMCA-112](#).

Claim for equitable indemnification was a malpractice claim. — Where a patient sued a medical center and a doctor who practiced at the medical center for malpractice and the medical center sued the doctor for equitable indemnification based upon the claim that the doctor negligently caused and was partially liable for the patient's injuries, the equitable indemnification claim was a malpractice claim as that term is used in the Medical Malpractice Act [Chapter [41](#), Article [5](#) NMSA 1978]. *Christus St. Vincent Reg'l Med. Ctr. v. Duarte-Afara*, [2011-NMCA-112](#).

Defendants other than physicians. — This section's broad definition of health care provider is evidence that the legislature intended to impose liability beyond the context of the physician-patient relationship. When an individual is obliged as a condition of future or continued employment to submit to a medical examination, that examination creates a duty between the examining health care provider and the examinee. *Baer v. Regents of Univ. of Cal.*, [1994-NMCA-124](#), [118 N.M. 685](#), [884 P.2d 841](#).

Negligent misrepresentation and intentional infliction of emotional distress not "malpractice claim(s)". — Claims for negligent misrepresentation and intentional infliction of emotional distress do not first have to be presented to the medical review commission because they do not come within the definition of a malpractice claim. *Trujillo v. Puro*, [1984-NMCA-050](#), [101 N.M. 408](#), [683 P.2d 963](#), cert. denied, [101 N.M. 362](#), [683 P.2d 44](#).

Malpractice required. — The New Mexico Medical Malpractice Act covers injuries arising out

of negligence and does not cover claims not based on acts of malpractice. *Cordray v. Cnty. of Lincoln*, 320 F.Supp.2d 1171 (D.N.M. 2004).

Functional test to distinguish medical or professional negligence from ordinary negligence. — If an act involves the use of special knowledge or skill to make a judgment call as to the appropriate thing to do or not to do, then the act is of a professional nature and claims based on the act must be brought and pursued as a medical or professional negligence action and requires expert testimony to assess the resultant act or failure to act. If not, the act is not of a professional nature and expert testimony is not required. *Richter v. Presbyterian Healthcare Servs.*, [2014-NMCA-056](#), cert. denied, 2014-NMCERT-005.

Timeliness of delivery of laboratory reports. — Expert testimony is required where a plaintiff's claims address the timeliness or urgency of the delivery system of laboratory reports, including any timeliness claims that involve the efficiency and design of the delivery system, except when the required timing is set by a known standard such as an internal policy, contract or governmental regulation. *Richter v. Presbyterian Healthcare Servs.*, [2014-NMCA-056](#), cert. denied, 2014-NMCERT-005.

Maintenance of hospital charts. — Hospitals have a clearly established duty to maintain their patient's medical charts in good order, including the duty to post completed lab tests as received. Assessing a hospital's compliance with its charting duties does not require expert testimony. *Richter v. Presbyterian Healthcare Servs.*, [2014-NMCA-056](#), cert. denied, 2014-NMCERT-005.

Ordinary negligence in delivering laboratory reports. — Where decedent died when decedent developed a heart arrhythmia during surgery in 2005; the heart arrhythmia was caused by an undiagnosed condition called pheochromocytoma; in 2001, the decedent's physicians ordered lab tests that were diagnostic of pheochromocytoma; the lab results were never read or acted upon by the physicians; plaintiff sued the hospital and the laboratory for negligent delivery of the lab results in 2001; plaintiff did not raise any matters involving urgency; and plaintiff showed that the laboratory had a routine procedure for delivering lab report to physicians, plaintiff's claims against the hospital and the laboratory could be pursued as ordinary negligence claims and did not require expert testimony. *Richter v. Presbyterian Healthcare Servs.*, [2014-NMCA-056](#), cert. denied, 2014-NMCERT-005.

Opinion of treating physician as to negligence of another treating physician. — Where decedent died when decedent developed a heart arrhythmia during surgery in 2005; the heart arrhythmia was caused by an undiagnosed condition called pheochromocytoma; prior to surgery, decedent's consulting surgeon ordered lab tests that would have disclosed the pheochromocytoma; the consulting surgeon scheduled surgery to be conducted by the operating surgeon; the operating surgeon conducted the surgery before the lab results had been received and despite decedent's high potassium levels that posed a chance of death during surgery; and plaintiff sought to elicit opinions from the consulting surgeon as to which acts of the operating surgeon were negligent; the district court did not abuse its discretion in excluding the consulting surgeon's opinions as to the operating surgeon's negligence. *Richter v. Presbyterian Healthcare Servs.*, [2014-NMCA-056](#), cert. denied, 2014-NMCERT-005.

Failure to present expert testimony on the standard of medical care. — Where decedent died when decedent developed a heart arrhythmia during surgery in 2005; the heart arrhythmia was caused by an undiagnosed condition called pheochromocytoma; prior to surgery, lab tests had been ordered that would have disclosed the pheochromocytoma; the

surgeon conducted the surgery before the lab results had been received and despite decedent's high potassium levels that posed a chance of death during surgery; to establish the standard of care for the surgeon's conduct, plaintiff offered the testimony of an interventional radiology expert who testified that there was no standard practice that an interventional radiologist would use to address the complication that occurred in decedent's surgery; and plaintiff called a general surgeon to establish the standard of care applicable to decedent's surgery, but failed to lay a foundation for the general surgeon's opinion, plaintiff failed to present expert testimony on the standard of care and the district court did not err in directing a verdict in favor of the surgeon. *Richter v. Presbyterian Healthcare Servs.*, [2014-NMCA-056](#), cert. denied, 2014-NMCERT-005.

Comparative negligence of non-parties. — Where decedent died when decedent developed a heart arrhythmia during surgery in 2005; the heart arrhythmia was caused by an undiagnosed condition called pheochromocytoma; in 2001, the decedent's physicians ordered lab tests that were diagnostic of pheochromocytoma; the lab results were never read or acted upon by the physicians; in 2005, prior to surgery, lab tests had been ordered that would have disclosed the pheochromocytoma; the surgeon conducted the surgery before the lab results had been received; and the district court permitted the jury to compare the alleged negligence of the decedent's 2001 physicians, who were non-parties in the case, with the negligence of the decedent's 2005 surgeons, comparative negligence principles required the district court to consider the comparative negligence of the non-party 2001 physicians. *Richter v. Presbyterian Healthcare Servs.*, [2014-NMCA-056](#), cert. denied, 2014-NMCERT-005.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For note, "Tort Law – New Mexico Limits Recovery of Negligent Infliction of Emotional Distress to Sudden, Traumatic Accidents — *Fernandez v. Walgreen Hastings Co.*," see 30 N.M. L. Rev. 363 (2000).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 77 Am. Jur. 2d Venue § 16.

Right of tortfeasor initially causing injury to recover indemnity or contribution from medical attendant causing new injury or aggravating injury in course of treatment, 8 A.L.R.3d 639.

Liability of operating surgeon for negligence of nurse assisting him, 12 A.L.R.3d 1017.

Liability for injuries or death as a result of physical therapy, 53 A.L.R.3d 1250.

Chiropractor's liability for failure to refer patient to medical practitioner, 58 A.L.R.3d 590.

Liability of anesthetist for injuries from spinal anesthetics, 90 A.L.R.3d 775.

What constitutes physician-patient relationship for malpractice purposes, 17 A.L.R.4th 132.

Liability for injury or death allegedly caused by activities of hospital "rescue team", 64 A.L.R.4th 1200.

Recovery in death action for failure to diagnose incurable disease which caused death, 64 A.L.R.4th 1232.

Medical malpractice: who are "health care providers," or the like, whose actions fall within statutes specifically governing actions and damages for medical malpractice, 12 A.L.R.5th 1.

Venue of wrongful death action, 58 A.L.R.5th 535.

Coverage of professional-liability or -indemnity policy for sexual contact with patients by physicians, surgeons, and other healers, 60 A.L.R.5th 239.

70 C.J.S. Physicians and Surgeons § 62.

41-5-3. Definitions. (Effective January 1, 2022.)

As used in the Medical Malpractice Act:

A. *"advisory board" means the patient's compensation fund advisory board;*

B. *"fund" means the patient's compensation fund;*

C. *"health care provider" means a person, corporation, organization, facility or institution licensed or certified by this state to provide health care or professional services as a doctor of medicine, hospital, outpatient health care facility, doctor of osteopathy, chiropractor, podiatrist, nurse anesthetist, physician's assistant, certified nurse practitioner, clinical nurse specialist or certified nurse-midwife or a business entity that is organized, incorporated or formed pursuant to the laws of New Mexico that provides health care services primarily through natural persons identified in this subsection;*

D. *"hospital" means a facility licensed as a hospital in this state that offers in-patient services, nursing or overnight care on a twenty-four-hour basis for diagnosing, treating and providing medical, psychological or surgical care for three or more separate persons who have a physical or mental illness, disease, injury or a rehabilitative condition or are pregnant and may offer emergency services. "Hospital" includes a hospital's parent corporation, subsidiary corporations or affiliates if incorporated or registered in New Mexico; employees and locum tenens providing services at the hospital; and agency nurses providing services at the hospital;*

E. *"independent provider" means a doctor of medicine, doctor of osteopathy, chiropractor, podiatrist, nurse anesthetist, physician's assistant, certified nurse practitioner, clinical nurse specialist or certified nurse-midwife who is not an employee or not an agent of a hospital or outpatient health care facility. "Independent provider" includes a business entity that is not a hospital or outpatient health care facility that employs or consists of members who are licensed or certified as doctors of medicine, doctors of osteopathy, chiropractors, podiatrists, nurse anesthetists, physician's assistants, certified nurse practitioners, clinical nurse specialists or certified nurse-midwives and the business entity's employees;*

F. *"insurer" means an insurance company engaged in writing health care provider malpractice liability insurance in this state;*

G. *"malpractice claim" includes any cause of action arising in this state against a health care provider for medical treatment, lack of medical treatment or other claimed departure from accepted standards of health care that proximately results in injury to the patient, whether the patient's claim or cause of action sounds in tort or contract, and includes but is not limited to actions based on battery or wrongful death; "malpractice claim" does not include a cause of*

action arising out of the driving, flying or nonmedical acts involved in the operation, use or maintenance of a vehicular or aircraft ambulance;

H. "medical care and related benefits" means all reasonable medical, surgical, physical rehabilitation and custodial services and includes drugs, prosthetic devices and other similar materials reasonably necessary in the provision of such services;

I. "occurrence" means all injuries to a patient caused by health care providers' successive acts or omissions that combined concurrently to create a malpractice claim;

J. "outpatient health care facility" means an entity that is licensed pursuant to the Public Health Act as an outpatient facility, including ambulatory surgical centers, free-standing emergency rooms, urgent care clinics, acute care centers and intermediate care facilities and includes a facility's employees, locum tenens providers and agency nurses providing services at the facility. "Outpatient health care facility" does not include independent providers;

K. "patient" means a natural person who received or should have received health care from a health care provider under a contract, express or implied; and

L. "superintendent" means the superintendent of insurance.

History: 1953 Comp., § 58-33-3, enacted by Laws 1976, ch. 2, § 3; 1977, ch. 284, § 1; **2021, ch. 16, § 1.**

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, defined "advisory board", "fund", "hospital", "independent provider", "occurrence", and "outpatient health care facility", and revised certain definitions, as used in the Medical Malpractice Act; added new Subsections A and B, and redesignated former Subsection A as Subsection C; in Subsection C, after "physician's assistant", added "certified nurse practitioner, clinical nurse specialist or certified nurse-midwife or a business entity that is organized, incorporated or formed pursuant to the laws of New Mexico that provides health care services primarily through natural persons identified in this subsection"; added new Subsections D and E, and redesignated former Subsections B through D as Subsections F through H, respectively; added new Subsections I and J and redesignated former Subsections E and F as Subsections K and L, respectively; in Subsection K, deleted "licensed" preceding "health care provider"; and in Subsection L, after "insurance", deleted "of this state".

41-5-4. Ad damnum clause.

A patient or his representative having a malpractice claim for bodily injury or death may file a complaint in any court of law having requisite jurisdiction and demand right of trial by jury. No dollar amount or figure shall be included in the demand in any complaint asserting a malpractice claim and filed after the effective date of this section, but the request shall be for such damages as are reasonable. This section shall not prevent a patient or his representative from alleging a requisite jurisdictional amount in a malpractice claim filed in a court requiring such an allegation.

History: 1953 Comp., § 58-33-4, enacted by Laws 1976, ch. 2, § 4; 1977, ch. 284, § 2.

ANNOTATIONS

Emergency clauses. — Laws 1977, ch. 284, § 5 contained an emergency clause and was approved April 7, 1977.

Cross references. — For jurisdictional amount in magistrate court, see [35-3-3 NMSA 1978](#).

For commencement of action in district court, see Rule [1-003 NMRA](#).

For commencement of action by complaint in magistrate court, see Rule [2-201 NMRA](#).

This section refers to jurisdiction, not venue, and [38-3-1 NMSA 1978](#) governs venue in an action brought under the Medical Malpractice Act [Chapter [41](#), Article [5 NMSA 1978](#)]. *Bullock v. Lehman*, [1983-NMCA-024](#), [99 N.M. 515](#), [660 P.2d 605](#).

"Representative". — The "representative" who may bring suit for a death under this section means the same thing as the personal representative under the wrongful death statute. *Mackey v. Burke*, [1984-NMCA-028](#), [102 N.M. 294](#), [694 P.2d 1359](#), cert. quashed, [102 N.M. 293](#), [694 P.2d 1358](#) (1985), *overruled on other grounds by Chavez v. Regents of Univ. of N.M.*, [1985-NMSC-114](#), [103 N.M. 606](#), [711 P.2d 883](#).

Qualification of personal representative. — Where an original pleading alleged a valid cause of action, relation back of the appointment of the plaintiff as personal representative to the initial filing of the action did not compromise this section nor the statute of limitations. *Chavez v. Regents of Univ. of N.M.*, [1985-NMSC-114](#), [103 N.M. 606](#), [711 P.2d 883](#).

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see [7 N.M.L. Rev. 5](#) (1976-77).

41-5-5. Qualifications.

A. To be qualified under the provisions of the Medical Malpractice Act, a health care provider shall:

(1) establish its financial responsibility by filing proof with the superintendent that the health care provider is insured by a policy of malpractice liability insurance issued by an authorized insurer in the amount of at least two hundred thousand dollars (\$200,000) per occurrence or for an individual health care provider, excluding hospitals and outpatient health care facilities, by having continuously on deposit the sum of six hundred thousand dollars (\$600,000) in cash with the superintendent or such other like deposit as the superintendent may allow by rule or regulation; provided that in the absence of an additional deposit or policy as required by this subsection, the deposit or policy shall provide coverage for not more than three separate occurrences; and

(2) pay the surcharge assessed on health care providers by the superintendent pursuant to Section [41-5-25 NMSA 1978](#).

B. For hospitals or outpatient health care facilities electing to be covered under the Medical Malpractice Act, the superintendent shall determine, based on a risk assessment of each hospital or outpatient health care facility, each hospital's or outpatient health care facility's base coverage or deposit and additional charges for the patient's compensation fund. The superintendent shall arrange for an actuarial study, as provided in Section 41-5-25 NMSA 1978.

C. A health care provider not qualifying under this section shall not have the benefit of any of the provisions of the Medical Malpractice Act in the event of a malpractice claim against it.

History: 1978 Comp., § 41-5-5, enacted by Laws 1992, ch. 33, § 2.

ANNOTATIONS

Repeals and reenactments. — Laws 1991, ch. 264, § 2 repealed former 41-5-5 NMSA 1978, as amended by Laws 1991, ch. 264, § 1, and enacted a new 41-5-5 NMSA 1978, effective July 1, 1992.

Laws 1992, ch. 33, § 2 repealed former 41-5-5 NMSA 1978, as amended by Laws 1991, ch. 264, § 1, and as enacted by Laws 1991, ch. 264, § 2, and enacted a new section, effective April 1, 1992.

Applicability. — Laws 1992, ch. 33, § 17, effective March 6, 1992, makes the provisions of the act applicable only to occurrences arising on and after April 1, 1994.

Temporary provisions. — Laws 1991, ch. 264, § 12, effective July 1, 1991, provided that a health care provider who qualified under the provisions of the Medical Malpractice Act prior to July 1, 1991, shall remain subject to those terms and provisions of the act which existed on that date of qualification and that, upon the date of renewal of the health care provider's policy of malpractice liability insurance or continuation of coverage for those health care providers who have a cash deposit with the superintendent of insurance, those provisions of the act effective on those dates shall apply and the provisions of Subsection B of 41-5-6.1 NMSA 1978 shall apply for the purposes of base premium calculations.

Statute of limitations. — The Medical Malpractice Act's statute of limitations, 41-5-13 NMSA 1978, does not apply to health care providers that have not qualified under Subsection A of this section. *Roberts v. Southwest Cmty. Health Servs.*, 1992-NMSC-042, 114 N.M. 248, 837 P.2d 442.

Grant of summary judgment in favor of the hospital was reversed even though summary judgment was granted in favor of the doctor; the hospital could not take advantage of the statute of limitation in 41-5-13 NMSA 1978, as it was not a qualified healthcare provider under Subsection C of this section. *Juarez v. Nelson*, 2003-NMCA-011, 133 N.M. 168, 61 P.3d 877, overruled on other grounds by *Tomlinson v. George*, 2005-NMSC-020, 138 N.M. 34, 116 P.3d 105.

Accrual of cause of action where provider has not qualified. — In medical malpractice actions where the health care provider is not qualified under the Medical Malpractice Act [Chapter 41, Article 5 NMSA 1978], the cause of action accrues when the plaintiff knows or with reasonable diligence should have known of the injury and its cause. *Roberts v. Southwest Cmty. Health Servs.*, 1992-NMSC-042, 114 N.M. 248, 837 P.2d 442.

Superintendent to maintain list of qualified providers. — This section creates in the superintendent of insurance some requirement to maintain a list of those whose qualified status affects suits against them. *Otero v. Zouhar*, 1985-NMSC-021, 102 N.M. 482, 697 P.2d 482, overruled on other grounds by *Grantland v. Lea Reg'l Hosp.*, 1990-NMSC-076, 110 N.M. 378, 796 P.2d 599.

Federal hospital. — Although a federal hospital did not file proof of its financial responsibility as required by Paragraph A(1) and never paid into the patient's compensation fund as required by Paragraph A(2), it is a "qualified health care provider" under this section, as the financial responsibility of the United States is assured and its failure to contribute to a compensation fund is immaterial because (unlike qualified providers) it must pay its liabilities without resort to the compensation fund. *Haceesa v. United States*, 309 F.3d 722 (10th Cir. 2002).

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For comment on access to the courts and the Medical Malpractice Act: *Jiron v. Mahlab*, see 14 N.M.L. Rev. 503 (1984).

41-5-5. Qualifications. (Effective January 1, 2022.)

A. To be qualified under the provisions of the Medical Malpractice Act, a health care provider shall:

(1) *establish its financial responsibility by filing proof with the superintendent that the health care provider is insured by a policy of malpractice liability insurance issued by an authorized insurer in the amount of at least two hundred fifty thousand dollars (\$250,000) per occurrence or by having continuously on deposit the sum of seven hundred fifty thousand dollars (\$750,000) in cash with the superintendent or such other like deposit as the superintendent may allow by rule; provided that hospitals and outpatient health care facilities that establish financial responsibility through a policy of malpractice liability insurance may use any form of malpractice insurance; and provided further that for independent providers, in the absence of an additional deposit or policy as required by this subsection, the deposit or policy shall provide coverage for not more than three separate occurrences; and*

(2) *pay the surcharge assessed on health care providers by the superintendent pursuant to Section 41-5-25 NMSA 1978.*

B. For hospitals or outpatient health care facilities electing to be covered under the Medical Malpractice Act, the superintendent shall determine, based on a risk assessment of each hospital or outpatient health care facility, each hospital's or outpatient health care facility's base coverage or deposit and additional charges for the fund. The superintendent shall arrange for an actuarial study before determining base coverage or deposit and surcharges.

C. A health care provider not qualifying under this section shall not have the benefit of any of the provisions of the Medical Malpractice Act in the event of a malpractice claim against it; provided that beginning July 1, 2021, hospitals and outpatient health care facilities shall not

participate in the medical review process, and beginning January 1, 2027, hospitals and outpatient health care facilities shall have the benefits of the other provisions of the Medical Malpractice Act except participation in the fund.

History: 1978 Comp., § 41-5-5, enacted by Laws 1992, ch. 33, § 2; 2021, ch. 16, § 2.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, raised the required malpractice insurance from two hundred thousand dollars to two hundred fifty thousand dollars, raised the required amount of cash deposited with the superintendent of insurance from six hundred thousand dollars to seven hundred fifty thousand dollars; provided additional duties for the superintendent of insurance; provided that hospitals and outpatient health care facilities shall not participate in the medical review process, and that hospitals and outpatient health care facilities shall not participate in the patient's compensation fund beginning in the year 2027; in Subsection A, Paragraph A(1), after "at least", changed "two hundred thousand dollars (\$200,000)" to "two hundred fifty thousand dollars (\$250,000)", after "per occurrence or", deleted "for an individual health care provider, excluding hospitals and outpatient health care facilities", after "deposit the sum of", changed "six hundred thousand dollars (\$600,000)" to "seven hundred fifty thousand dollars (\$750,000)", and after "provided that", added "hospitals and outpatient health care facilities that establish financial responsibility through a policy of malpractice liability insurance may use any form of malpractice insurance; and provided further that for independent providers"; in Subsection B, after "additional charges for the", deleted "patient's compensation", and after "actuarial study", deleted "as provided in Section 41-5-25 NMSA 1978" and added "before determining base coverage or deposit and surcharges"; and in Subsection C, after "malpractice claim against it", added the remainder of the subsection.

41-5-6. Limitation of recovery.

A. Except for punitive damages and medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall not exceed six hundred thousand dollars (\$600,000) per occurrence. In jury cases, the jury shall not be given any instructions dealing with this limitation.

B. The value of accrued medical care and related benefits shall not be subject to the six hundred thousand dollar (\$600,000) limitation.

C. Monetary damages shall not be awarded for future medical expenses in malpractice claims.

D. A health care provider's personal liability is limited to two hundred thousand dollars (\$200,000) for monetary damages and medical care and related benefits as provided in Section 41-5-7 NMSA 1978. Any amount due from a judgment or settlement in excess of two hundred thousand dollars (\$200,000) shall be paid from the patient's compensation fund, as provided in Section 41-5-25 NMSA 1978.

E. For the purposes of Subsections A and B of this section, the six hundred thousand dollar (\$600,000) aggregate amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall apply only to malpractice occurring on or after April 1, 1995.

History: 1978 Comp., § 41-5-6, enacted by Laws 1992, ch. 33, § 4.

ANNOTATIONS

Repeals and reenactments. — Laws 1992, ch. 33, § 4 repealed former [41-5-6 NMSA 1978](#), as enacted by Laws 1992, ch. 33, § 3, and enacted a new section, effective April 1, 1995.

Laws 1991, ch. 264, § 4 repealed former [41-5-6 NMSA 1978](#), as amended by Laws 1991, ch. 264, § 3, and enacted a new [41-5-6 NMSA 1978](#), effective July 1, 1992.

Laws 1992, ch. 33, § 3 repealed former [41-5-6 NMSA 1978](#), as amended by Laws 1991, ch. 264, § 3, and as enacted by Laws 1991, ch. 264, § 4, and enacted a former section, effective April 1, 1992.

Applicability. — Laws 1992, ch. 33, § 17, effective March 6, 1992, made the provisions of the act applicable only to occurrences arising on and after April 1, 1994.

The constitutional right to trial by jury applies in cases brought under the Medical Malpractice Act. — Because causes of action brought under the Medical Malpractice Act (MMA), NMSA 1978, §§ [41-5-1](#) to -29, can be more generally described as causes of action in common-law medical negligence, and claims of common-law medical negligence were triable to a jury at the time the New Mexico Constitution was adopted and took effect, the constitutional right to trial by jury attaches to causes of action brought under the MMA. *Siebert v. Okun*, [2021-NMSC-016](#), *overruling in part* *Salopek v. Friedman*, [2013-NMCA-087](#), [308 P.3d 139](#).

The Medical Malpractice Act's nonmedical, nonpunitive damages cap does not invade the province of the jury. — The MMA nonmedical, nonpunitive damages cap gives legal consequence to the jury's finding on damages and does not violate a plaintiff's right to a jury trial under NM Const., Art. II, Sec. 12, because the right to trial by jury is satisfied when evidence is presented to a jury, which then deliberates and returns a verdict based on its factual findings. The legal consequence of that verdict is a matter of law, which the legislature has the authority to shape. *Siebert v. Okun*, [2021-NMSC-016](#), *overruling in part* *Salopek v. Friedman*, [2013-NMCA-087](#), [308 P.3d 139](#).

Where plaintiff successfully sued defendants for medical malpractice under the Medical Malpractice Act (MMA), NMSA 1978, §§ [41-5-1](#) to -29, and where, following the return of the jury's verdict, defendants moved to reduce the jury award of \$2,600,000 to conform with the \$600,000 cap on all nonmedical and nonpunitive damages in MMA actions, and where the district court denied defendants' motion, concluding that the MMA nonmedical, nonpunitive damages cap infringed the state constitutional right to a trial by jury, the district court erred in denying defendants' motion, because the MMA nonmedical, nonpunitive damages cap merely gives legal consequence to the jury's finding on damages and does not violate a plaintiff's right to a jury trial under NM Const., Art. II, Sec. 12. *Siebert v. Okun*, [2021-NMSC-016](#), *overruling in part* *Salopek v. Friedman*, [2013-NMCA-087](#), [308 P.3d 139](#).

Cap on medical malpractice damages is constitutional. — The cap on medical malpractice damages does not violate the right to trial by jury under [Article II, Section 12 of the New Mexico Constitution](#), the separation of powers clause in [Article III, Section 1 of the New Mexico Constitution](#), the equal protection clause of the United States Constitution, or the due process clause of the United States Constitution. *Salopek v. Friedman*, [2013-NMCA-087](#).

Limits of recovery. — This section is not arbitrary and capricious and is rationally related to legislative goal of ensuring a source of recovery for victims of medical malpractice and curbing runaway medical costs, relying in part on *Trujillo v. City of Albuquerque*, [1998-NMSC-031](#), [125 N.M. 721](#), [965 P.2d 305](#); *Fed. Express Corp. v. United States*, 228 F. Supp 2d 1267 (D.N.M. 2002).

Federal hospital. — Although not a "qualified health care provider" under [41-5-5 NMSA 1978](#), the liability of a federal hospital, operating in New Mexico, is subject to the \$600,000 cap in Subsection A, but not the \$200,000 cap in Subsection D, which assumes that the amount of damages in excess of \$ 200,000 would be paid by the compensation fund into which the federal government did not contribute. *Haceesa v. United States*, 309 F.3d 722 (10th Cir. 2002).

Applicability. — Where it was held that tribal law controlled in a malpractice action against the United States, the New Mexico medical malpractice cap did not apply. *Cheromiah v. United States*, 55 F. Supp. 2d 1295 (D.N.M. 1999).

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22 Am. Jur. 2d Damages §§ 288, 289; 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers §§ 367 to 371.

Contributory negligence or assumption of risk as defense in action against physician or surgeon for malpractice, 50 A.L.R.2d 1043.

Liability of chiropracist, 80 A.L.R.2d 1278.

Validity and construction of state statutory provisions relating to limitations on amount of recovery in medical malpractice claim and submission of such claim to pretrial panel, 80 A.L.R.3d 583, 26 A.L.R.5th 245.

Recovery, measure and element of damages, in action against dentist for breach of contract to achieve particular result or cure, 11 A.L.R.4th 748.

Validity of statute establishing contingent fee scale for attorneys representing parties in medical malpractice actions, 12 A.L.R.4th 23.

Validity of state statute providing for periodic payment of future damages in medical malpractice action, 41 A.L.R.4th 275.

Future disease or condition, or anxiety relating thereto, as element of recovery, 50 A.L.R.4th 13.

Recovery in death action for failure to diagnose incurable disease which caused death, 64 A.L.R.4th 1232.

Medical malpractice: measure and elements of damages in actions based on loss of chance, 81 A.L.R.4th 485.

What nonpatient claims against doctors, hospitals, or similar health care providers are not subject to statutes specifically governing actions and damages for medical malpractice, 88 A.L.R.4th 358.

Liability of hospital, physician, or other medical personnel for death or injury to mother or child caused by improper diagnosis and treatment of mother relating to and during pregnancy, 7 A.L.R.5th 1.

Validity, construction, and application of state statutory provisions limiting amount of recovery in medical malpractice claims, 26 A.L.R.5th 245.

Liability of hospital or medical practitioner under doctrine of strict liability in tort, or breach of warranty, for harm caused by drug, medical instrument, or similar device used in treating patient, 65 A.L.R.5th 357.

70 C.J.S. Physicians and Surgeons §§ 124, 127.

41-5-6. Limitation of recovery. (Effective January 1, 2022.)

A. Except for punitive damages and past and future medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall not exceed six hundred thousand dollars (\$600,000) per occurrence for malpractice claims brought against health care providers if the injury or death occurred prior to January 1, 2022. In jury cases, the jury shall not be given any instructions dealing with this limitation.

B. Except for punitive damages and past and future medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall not exceed seven hundred fifty thousand dollars (\$750,000) per occurrence for malpractice claims against independent providers. The aggregate dollar amount includes payment to any person for any number of loss of consortium claims or other claims per occurrence that arise solely because of the injuries or death of the patient. In jury cases, the jury shall not be given any instructions dealing with this limitation. Beginning January 1, 2023, the per occurrence limit on recovery shall be adjusted annually by the consumer price index for all urban consumers.

C. Except for punitive damages and past and future medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from an injury or death to a patient as a result of malpractice shall not exceed four million dollars (\$4,000,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2022. The aggregate dollar amount includes payment to any person for any number of loss of consortium claims or other claims per occurrence that arise solely because of the injuries or death of the patient. In jury cases, the jury shall not be given any instructions dealing with this limitation.

D. Except for punitive damages and past and future medical care and related benefits, the

aggregate dollar amount recoverable by all persons for or arising from an injury or death to a patient as a result of malpractice shall not exceed four million five hundred thousand dollars (\$4,500,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2023. The aggregate dollar amount includes payment to any person for any number of loss of consortium claims or other claims per occurrence that arise solely because of the injuries or death of the patient. In jury cases, the jury shall not be given any instructions dealing with this limitation.

E. Except for punitive damages and past and future medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from an injury or death to a patient as a result of malpractice shall not exceed five million dollars (\$5,000,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2024. The aggregate dollar amount includes payment to any person for any number of loss of consortium claims or other claims per occurrence that arise solely because of the injuries or death of the patient. In jury cases, the jury shall not be given any instructions dealing with this limitation.

F. Except for punitive damages and past and future medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from an injury or death to a patient as a result of malpractice shall not exceed five million five hundred thousand dollars (\$5,500,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2025. The aggregate dollar amount includes payment to any person for any number of loss of consortium claims or other claims per occurrence that arise solely because of the injuries or death of the patient. In jury cases, the jury shall not be given any instructions dealing with this limitation.

G. Except for punitive damages and past and future medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from an injury or death to a patient as a result of malpractice shall not exceed six million dollars (\$6,000,000) per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in 2026; provided that beginning January 1, 2027, the per occurrence limit shall be adjusted annually by the consumer price index for all urban consumers. The aggregate dollar amount includes payment to any person for any number of loss of consortium claims or other claims per occurrence that arise solely because of the injuries or death of the patient. In jury cases, the jury shall not be given any instructions dealing with this limitation.

H. The value of accrued medical care and related benefits shall not be subject to any limitation.

I. A health care provider's personal liability is limited to two hundred fifty thousand dollars (\$250,000) for monetary damages and medical care and related benefits as provided in Section 41-5-7 NMSA 1978. Any amount due from a judgment or settlement in excess of two hundred fifty thousand dollars (\$250,000) shall be paid from the fund except as provided in Subsection K of this section.

J. The term "occurrence" shall not be construed in such a way as to limit recovery to only one maximum statutory payment if separate acts or omissions cause additional or enhanced injury or harm as a result of the separate acts or omissions. A patient who suffers two or more distinct injuries as a result of two or more different acts or omissions that occur at different times by one or more health care providers is entitled to up to the maximum statutory recovery for

each injury.

K. Until January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility in excess of seven hundred fifty thousand dollars (\$750,000), excluding past and future medical expenses, shall be paid by the hospital or outpatient health care facility and not by the fund. Beginning January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility shall not be paid from the fund.

History: 1978 Comp., § 41-5-6, enacted by Laws 1992, ch. 33, § 4; 2021, ch. 16, § 3.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, raised the aggregate amount that can be recovered by a patient to seven hundred fifty thousand dollars per occurrence, provided that the aggregate dollar amount recoverable to a patient as a result of malpractice shall not exceed four million dollars per occurrence for claims brought against a hospital or outpatient health care facility if the injury or death occurred in calendar year 2022, four million five hundred thousand dollars if the injury or death occurred in 2023, five million dollars if the injury or death occurred in 2024, five million five hundred thousand dollars if the injury or death occurred in 2025, and six million dollars if the injury or death occurred in 2026, and that beginning in 2027, the per occurrence limit shall be adjusted annually by the consumer price index for all urban consumers, provided that the value of accrued medical care and related benefits are not subject to any limitation, removed a provision that provided that monetary damages may not be awarded for future medical expenses in malpractice claims, raised a health care provider's personal liability limit from two hundred thousand dollars to two hundred fifty thousand dollars, provided that these limits do not apply to punitive damages or to past and future medical care and related benefits, provided that until January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility in excess of seven hundred fifty thousand dollars are to be paid by the hospital or outpatient health care facility and not the patient's compensation fund, and that beginning January 1, 2027, amounts due from a judgment or settlement against a hospital or outpatient health care facility shall not be paid from the patient's compensation fund; in Subsection A, after "punitive damages and", added "past and future", and after "per occurrence", added "for malpractice claims brought against health care providers if the injury or death occurred prior to January 1, 2022"; added new Subsections B through G and redesignated former Subsection B as Subsection H; in Subsection H, after "subject to", deleted "the six hundred thousand dollar (\$600,000)" and added "any"; deleted former Subsection C, which provided "Monetary damages shall not be awarded for future medical expenses in malpractice claims.", and redesignated former Subsection D as Subsection I; in Subsection I, after "limited to", changed "two hundred thousand dollars (\$200,000)" to "two hundred fifty thousand dollars (\$250,000)", after "in excess of", changed "two hundred thousand dollars (\$200,000)" to "two hundred fifty thousand dollars (\$250,000)", after "shall be paid from the", deleted "patient's compensation", and after "fund", deleted "as provided in Section 41-5-25 NMSA 1978" and added "except as provided in Subsection K of this section"; deleted former Subsection E; and added Subsections J and K.

41-5-6.1. Repealed.

ANNOTATIONS

Repeals. — Laws 1992, ch. 33, § 18 repealed [41-5-6.1](#) NMSA 1978, as enacted by Laws 1991, ch. 264, § 5, relating to amount recoverable, effective March 6, 1992. For provisions of former section, see the 1991 NMSA 1978 on *NMOneSource.com*. For present comparable provisions, see [41-5-6](#) NMSA 1978.

41-5-7. Future medical expenses.

A. In all malpractice claims where liability is established, the jury shall be given a special interrogatory asking if the patient is in need of future medical care and related benefits. No inquiry shall be made concerning the value of future medical care and related benefits, and evidence relating to the value of future medical care shall not be admissible. In actions upon malpractice claims tried to the court, where liability is found, the court's findings shall include a recitation that the patient is or is not in need of future medical care and related benefits.

B. Except as provided in Section [41-5-10](#) NMSA 1978, once a judgment is entered in favor of a patient who is found to be in need of future medical care and related benefits or a settlement is reached between a patient and health care provider in which the provision of medical care and related benefits is agreed upon, and continuing as long as medical or surgical attention is reasonably necessary, the patient shall be furnished with all medical care and related benefits directly or indirectly made necessary by the health care provider's malpractice, subject to a semi-private room limitation in the event of hospitalization, unless the patient refuses to allow them to be so furnished.

C. Awards of future medical care and related benefits shall not be subject to the six hundred thousand dollar (\$600,000) limitation imposed in Section [41-5-6](#) NMSA 1978.

D. Payment for medical care and related benefits shall be made as expenses are incurred.

E. The health care provider shall be liable for all medical care and related benefit payments until the total payments made by or on behalf of it for monetary damages and medical care and related benefits combined equals two hundred thousand dollars (\$200,000), after which the payments shall be made by the patient's compensation fund.

F. This section shall not be construed to prevent a patient and a health care provider from entering into a settlement agreement whereby medical care and related benefits shall be provided for a limited period of time only or to a limited degree.

G. The court in a supplemental proceeding shall estimate the value of the future medical care and related benefits reasonably due the patient on the basis of evidence presented to it. That figure shall not be included in any award or judgment but shall be included in the record as a separate court finding.

H. A judgment of punitive damages against a health care provider shall be the personal liability of the health care provider. Punitive damages shall not be paid from the patient's compensation fund or from the proceeds of the health care provider's insurance contract unless

the contract expressly provides coverage. Nothing in Section 41-5-6 NMSA 1978 precludes the award of punitive damages to a patient. Nothing in this subsection authorizes the imposition of liability for punitive damages on a derivative basis where that imposition would not be otherwise authorized by law.

History: 1978 Comp., § 41-5-7, enacted by Laws 1992, ch. 33, § 5; 1992, ch. 33, § 6.

ANNOTATIONS

Repeals and reenactments. — Laws 1991, ch. 264, § 7 repealed former 41-5-7 NMSA 1978, as amended by Laws 1991, ch. 264, § 6, and enacted a new 41-5-7 NMSA 1978, effective July 1, 1992.

Laws 1992, ch. 33, § 5 repealed former 41-5-7 NMSA 1978, as amended by Laws 1991, ch. 264, § 6, and as enacted by Laws 1991, ch. 264, § 7, and enacted a new section, effective April 1, 1992.

The 1992 amendment, effective April 1, 1995, in Subsection C, substituted "six hundred thousand dollars (\$600,000)" for "five hundred thousand dollar (\$500,000)".

Applicability. — Laws 1992, ch. 33, § 17, effective March 6, 1992, made the provisions of the act applicable only to occurrences arising on and after April 1, 1994.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Validity of state statute providing for periodic payment of future damages in medical malpractice action, 41 A.L.R.4th 275.

Future disease or condition, or anxiety relating thereto, as element of recovery, 50 A.L.R.4th 13.

41-5-7. Medical expenses and punitive damages. (Effective January 1, 2022.)

A. Awards of past and future medical care and related benefits shall not be subject to the limitations of recovery imposed in Section 41-5-6 NMSA 1978.

B. The health care provider shall be liable for all medical care and related benefit payments until the total payments made by or on behalf of it for monetary damages and medical care and related benefits combined equals the health care provider's personal liability limit as provided in Subsection I of Section 41-5-6 NMSA 1978, after which the payments shall be made by the fund.

C. Beginning January 1, 2027, any amounts due from a judgment or settlement against a hospital or outpatient health care facility shall not be paid from the fund if the injury or death occurred after December 31, 2026.

D. This section shall not be construed to prevent a patient and a health care provider from

entering into a settlement agreement whereby medical care and related benefits shall be provided for a limited period of time only or to a limited degree.

E. A judgment of punitive damages against a health care provider shall be the personal liability of the health care provider. Punitive damages shall not be paid from the fund or from the proceeds of the health care provider's insurance contract unless the contract expressly provides coverage. Nothing in Section 41-5-6 NMSA 1978 precludes the award of punitive damages to a patient. Nothing in this subsection authorizes the imposition of liability for punitive damages where that imposition would not be otherwise authorized by law.

History: 1978 Comp., § 41-5-7, enacted by Laws 1992, ch. 33, § 5; 1992, ch. 33, § 6; 2021, ch. 16, § 4.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, provided that awards of past and future medical care and related benefits as a result of an act of malpractice are not subject to the limitations of recovery imposed in Section 41-5-6 NMSA 1978, and provided that beginning January 1, 2027, any amounts due from a judgment or settlement against a hospital or outpatient health care facility shall not be paid from the patient's compensation fund if the injury or death occurred after December 31, 2026; in the section heading, deleted "Future" and added "and punitive damages"; deleted former Subsections A and B, and redesignated former Subsection C as Subsection A; in Subsection A, after "Awards of", added "past and", and after "subject to the", deleted "six hundred thousand dollar (\$600,000) limitation" and added "limitations of recovery"; deleted former Subsection D and redesignated former Subsection E as Subsection B; in Subsection B, after "combined equals", deleted "two hundred thousand dollars (\$200,000)" and added "the health care provider's personal liability limit as provided in Subsection I of Section 41-5-6 NMSA 1978", and deleted "patient's compensation" preceding "fund"; added new a Subsection C and redesignated former Subsection F as Subsection D; deleted former Subsection G, which related to court findings on the estimated value of future medical care, and redesignated former Subsection H as Subsection E; and in Subsection E, deleted "patient's compensation" preceding "fund", and after "punitive damages", deleted "on a derivative basis".

41-5-8. Medical benefits prior to judgment.

A health care provider named as a defendant in a malpractice claim, or named as a respondent in a proceeding before the medical review commission created in the Medical Malpractice Act, shall have the option of paying for the patient's medical care and related benefits at any time prior to the entry of a judgment. Except as provided in Section 11 [41-5-11 NMSA 1978] of the Medical Malpractice Act, evidence of a health care provider's payment for such benefits shall not be admissible in the trial of the malpractice claim brought against it.

History: 1953 Comp., § 58-33-8, enacted by Laws 1976, ch. 2, § 8.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

41-5-9. District court; continuing jurisdiction.

A. The district court from which final judgment issues shall have continuing jurisdiction in cases where medical care and related benefits are awarded pursuant to Section 7 [41-5-7 NMSA 1978].

B. In all cases where the patient's continued need of such benefits, or the degree to which such benefits are needed is challenged at a point in time after a judgment is entered, the court, sitting without a jury, shall determine whether such need continues to exist and the extent of such need.

C. Whenever a patient petitions the district court for an increase in medical care and related benefits, the petition shall be set down for hearing at the earliest possible time and takes precedence over all matters except older matters of the same character and motions for preliminary injunctions filed pursuant to Rules 65, 66, NMR Civ. P. [Rules 1-065, 1-066 NMRA].

D. The health care provider shall have the burden of proving that the patient's need for benefits has subsided or abated, or that medical care and related benefits are not reasonably necessary, which it shall establish by clear and convincing evidence. The patient shall have the burden of proving that his need for medical care and related benefits has increased, which he shall establish by a preponderance of the evidence.

History: 1953 Comp., § 58-33-9, enacted by Laws 1976, ch. 2, § 9.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

41-5-9. District court; continuing jurisdiction. (Effective January 1, 2022.)

The district court from which final judgment issued shall have continuing jurisdiction in cases where future medical care and related benefits were awarded pursuant to Section 41-5-7 NMSA 1978 for malpractice claims arising from occurrences prior to July 1, 2021.

History: 1953 Comp., § 58-33-9, enacted by Laws 1976, ch. 2, § 9; 2021, ch. 16, § 5.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, clarified the provisions related to the district court's continuing jurisdiction over cases where future medical care and related benefits were awarded; deleted subsection designation "A", after "Section", deleted "7" and added "41-5-7 NMSA 1978 for malpractice claims arising from occurrences prior to July 1, 2021"; and deleted former Subsections B through D.

41-5-10. Patient; future examinations and hearings. (Repealed effective January 1, 2022.)

A. Any health care provider shall be entitled to have a physical examination of the patient by a physician of the health care provider's choice from time to time for the purpose of determining the patient's continued need of medical care and related benefits, subject to the following requirements:

- (1) notice in writing shall be delivered to or served upon the patient specifying the time and place where it is intended to conduct the examination. Such notice must be given at least ten days prior to the time stated in the notice. Delivery by certified mail is permitted;
- (2) such examination shall be by a physician qualified to practice medicine under the law of this state or of the state or county wherein the patient resides;
- (3) the place at which such examination is to be conducted shall not involve an unreasonable amount of travel for the patient considering all the circumstances. It shall not be necessary for a patient who resides outside this state to come into this state for such an examination unless so ordered by the court;
- (4) within thirty days after the examination, the patient shall be compensated by the party requesting the examination for all necessary and reasonable expenses incidental to submitting to the examination including the reasonable cost of travel, meals, lodging, loss of pay or other like direct expense;
- (5) examinations may not be required more frequently than at six-month intervals; except that upon application to the court having jurisdiction of the claim and after reasonable cause shown therefor, examination within a shorter interval may be ordered. In considering such application, the court should exercise care to prevent harassment to the patient;
- (6) the patient shall be entitled to have a physician or an attorney of his own choice or both present at such examination. The patient shall pay such physician or attorney himself; and
- (7) the patient shall be promptly furnished with a copy of the report of the physical examination made by the physician making the examination on behalf of the health care provider.

B. If a patient fails or refuses to submit to examination in accordance with the notice and if the requirements of Subsection A of this section have been satisfied, the court may forfeit all medical care and related benefits which would accrue or become due to him except for such failure or refusal to submit to examination during the period that he willfully persists in such failure or refusal.

C. If any patient shall persist in any injurious practice which imperils, retards or impairs his recovery or increases his injury or refuses to submit to such medical or surgical treatment as is reasonably essential to promote his recovery, the court may in its discretion reduce or suspend his medical care and related benefits until the injurious practice is discontinued.

D. Any physician selected by the health care provider and paid by the health care provider who shall make or be present at an examination of the patient conducted in pursuance of this section may be required to testify as to the conduct thereof and the findings made. Communications made by the patient upon such examination to such physician or physicians shall not be considered privileged.

E. The health care provider or the custodian of the patient's compensation fund shall pay all reasonable legal fees, cost of medical examinations and the cost of the fees of medical expert witnesses in any proceeding in which the patient succeeds in raising his medical care and related benefits or in any unsuccessful proceeding brought by the health care provider or the patient's compensation fund custodian to reduce medical care and related benefits.

History: 1953 Comp., § 58-33-10, enacted by Laws 1976, ch. 2, § 10.

ANNOTATIONS

Delayed repeals. — [Laws 2021, ch. 16, § 17](#) repealed [41-5-10](#) NMSA 1978, effective January 1, 2022.

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Validity of state statute providing for periodic payment of future damages in medical malpractice action, 41 A.L.R.4th 275.

41-5-11. Set-off of advance payments.

A. Evidence of an advance payment is not admissible until there is a final judgment in favor of the patient, in which event the court shall reduce the judgment to the patient to the extent of the advance payment. In jury cases where there is a factual dispute concerning an alleged advance payment, all questions of fact relating to such an advance payment shall be resolved by the jury after it has reached its verdict. The advance payment shall inure to the exclusive benefit of the health care provider or a party making the payment in its behalf. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equitably apportion the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it.

B. If a health care provider should elect to pay for medical care and related benefits at any time prior to the entry of a judgment, as provided in Section 8 [[41-5-8](#) NMSA 1978] of the

Medical Malpractice Act, and subsequently is found not to be liable, its legal and equitable right of recovery for all such payments shall not be foreclosed or prejudiced in any way.

History: 1953 Comp., § 58-33-11, enacted by Laws 1976, ch. 2, § 11.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

41-5-12. Claims for compensation not assignable.

A patient's claim for compensation under the Medical Malpractice Act is not assignable.

History: 1953 Comp., § 58-33-12, enacted by Laws 1976, ch. 2, § 12.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Legislative intent. — The legislature intended the Medical Malpractice Act's (MMA), 41-5-1 to -29 NMSA 1978, requirements and restrictions to apply to all "malpractice claims" covered by the MMA and, accordingly, this section bars assignment of all malpractice claims for compensation covered by the MMA. *Leger v. Gerety*, [2019-NMCA-033](#), cert. granted.

Indemnification claim barred from assignment. — In a wrongful death and medical malpractice action, where plaintiffs sued a hospital based on allegations of malpractice by a physician not employed by the hospital for which plaintiffs claimed the hospital was vicariously liable, and where the hospital filed a third-party complaint for equitable indemnification against the physician and his employer, which third-party complaint was later assigned to one of the plaintiffs as part of a settlement, the district court erred in denying the physician's motion to dismiss, because the hospital's assignment of its indemnification claim, which was predicated upon the allegation of professional negligence, was barred by the Medical Malpractice Act (MMA), 41-5-1 to -29 NMSA 1978, which prohibits the assignment of a patient's claim for compensation under the MMA. *Leger v. Gerety*, [2019-NMCA-033](#), cert. granted.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers §§ 170 to 174.

41-5-13. Limitations.

No claim for malpractice arising out of an act of malpractice which occurred subsequent to the effective date of the Medical Malpractice Act may be brought against a health care provider unless filed within three years after the date that the act of malpractice occurred except that a

minor under the full age of six years shall have until his ninth birthday in which to file. This subsection [section] applies to all persons regardless of minority or other legal disability.

History: 1953 Comp., § 58-33-13, enacted by Laws 1976, ch. 2, § 13.

ANNOTATIONS

Bracketed material. — The bracketed material was inserted by the compiler and it is not part of the law.

Compiler's notes. — The "effective date of the Medical Malpractice Act," referred to in the first sentence, is February 27, 1976.

Cross references. — For tolling of limitations period while matter under consideration of panel, see [41-5-22 NMSA 1978](#).

Amended application adding a new party does not relate back to the original filing date. — The filing of an application with the medical review commission as to one provider does not toll the limitations period as to another provider who was not named in the original application and for whom the statutory period in which to file a cause of action has passed. *Meza v. Topalovski*, [2012-NMCA-002](#), [268 P.3d 1284](#).

Where plaintiff wrongly named a health care provider in an application before the medical review commission; plaintiff amended the application to name the correct health care provider; and the amended application to add the correct health care provider was filed more than three years after the date of the alleged malpractice by the correct health care provider, the original application did not toll the statute of limitations for the untimely application filed against the originally unnamed health care provider. *Meza v. Topalovski*, [2012-NMCA-002](#), [268 P.3d 1284](#).

Section [41-5-13 NMSA 1978](#) is an occurrence-based statute of repose rather than a discovery-based statute of limitations. *Meza v. Topalovski*, [2012-NMCA-002](#), [268 P.3d 1284](#).

Section [41-5-13 NMSA 1978](#) is a statute of repose and terminates the right to any action after the specified three-year limitation period has elapsed. *Christus St. Vincent Reg'l Med. Ctr. v. Duarte-Afara*, [2011-NMCA-112](#), [267 P.3d 70](#).

Occurrence rule governs claims under the Medical Malpractice Act. — Where a patient sued a medical center and a doctor who practiced at the medical center for medical malpractice; the malpractice occurred on December 9 and 10, 2004; the three-year limitation period expired on December 10, 2007; the patient filed the complaint on December 4, 2007 and served the medical center on December 11, 2007, one day after the expiration of the three-year limitation period; and the medical center filed a third party complaint against the doctor for equitable indemnification on December 22, 2008, the medical center's claim for equitable indemnification was barred. *Christus St. Vincent Reg'l Med. Ctr. v. Duarte-Afara*, [2011-NMCA-112](#), [267 P.3d 70](#).

Dismissal without prejudice and reinstatement of complaint. — In a medical malpractice action, where defendant performed eye surgery on plaintiff on April 28, 2003; plaintiff filed a complaint for personal injuries and medical malpractice on April 27, 2006; at the time plaintiff filed the complaint, defendant's insurance carrier had improperly cancelled defendant's insurance; after defendant's insurance company reinstated defendant's insurance, plaintiff and

defendant stipulated to an order of dismissal of plaintiff's complaint; on March 20, 2008, the district court interpreted the order of dismissal as a dismissal of plaintiff's complaint, without prejudice, solely for the purpose of permitting plaintiff to obtain a review of the case by the medical malpractice commission; and reinstated plaintiff's complaint, the district court's interpretation of the order of dismissal was not an abuse of discretion and plaintiff's complaint was not barred by the three-year limitation period provided in 41-5-13 NMSA 1978, and the three-year limitation period provided in 37-1-8 NMSA 1978 stopped running at the time plaintiff filed the complaint on April 27, 2006. *Pacheco v. Cohen*, 2009-NMCA-070, 146 N.M. 643, 213 P.3d 793, cert. denied, 2009-NMCERT-006, 146 N.M. 733, 215 P.3d 42.

Constitutionality. — This section violates neither the equal protection nor the due process constitutional guarantees. *Cummings v. X-Ray Assocs.*, 1996-NMSC-035, 121 N.M. 821, 918 P.2d 1321.

Due process claim. — The constitutionality of the statute of repose, which serves to cut off a malpractice claimant's right to seek recovery, will not be evaluated under the strict-scrutiny test; the claimant's due process claim requires only a rational-basis analysis. *Cummings v. X-Ray Assocs.*, 1996-NMSC-035, 121 N.M. 821, 918 P.2d 1321.

Section violates due process. — This section violates due process because it allows medical malpractice claimants an unreasonably short period of time within which to bring an accrued cause of action. *Garcia ex rel. Garcia v. La Farge*, 1995-NMSC-019, 119 N.M. 532, 893 P.2d 428.

The provision in this section that requires a minor who experienced malpractice before the age of six to bring a claim under the Medical Malpractice Act [Chapter 41, Article 5 NMSA 1978] by his or her ninth birthday violates due process. *Jaramillo v. Heaton*, 2004-NMCA-123, 136 N.M. 498, 100 P.3d 204, cert. denied, 2004-NMCERT-010, 136 N.M. 541, 100 P.3d 807.

Due process exception to three-year period of repose. — Due process requires that a plaintiff have a reasonable amount of time in which to commence suit after any late-accruing medical malpractice claim has accrued, and therefore plaintiffs with late-accruing medical malpractice claims, *i.e.*, claims accruing in the last twelve months of the three-year repose period, shall have twelve months from the time of accrual to commence suit. *Cahn v. Berryman*, 2018-NMSC-002, *aff'g* 2015-NMCA-078, 355 P.3d 58 and *overruling in part Garcia ex rel. Garcia v. LaFarge*, 1995-NMSC-019, 119 N.M. 532, 893 P.2d 428.

Where plaintiff discovered that she had a medical malpractice claim against defendant ten and one-half months before the three-year statute of repose expired, the due process exception to 41-5-13 NMSA 1978 provided plaintiff an additional twelve months in which to commence suit, but where twenty-one months elapsed between the accrual date of plaintiff's medical malpractice claim and the date she filed suit, plaintiff's claim was barred by 41-5-13 NMSA 1978. *Cahn v. Berryman*, 2018-NMSC-002, *aff'g* 2015-NMCA-078, 355 P.3d 58 and *overruling in part Garcia ex rel. Garcia v. LaFarge*, 1995-NMSC-019, 119 N.M. 532, 893 P.2d 428.

Due process analysis. — The legislature may impose a statutory time deadline for commencing a cause of action as long as a reasonable time is provided for commencing suit. If a plaintiff is left with an unconstitutionally short period of time to file suit within the period of statute of repose, due process is violated. To fall under the due process exception to the statute of repose, the case must be unusual and involve exceptional circumstances resulting in an unusually short period of time within which to file suit. *Cahn v. Berryman*, 2015-

NMCA-078, cert. granted, 2015-NMCERT-007.

Section does not violate due process as applied. — Where plaintiff discovered she had a malpractice claim against defendant ten and one-half months before the statute of repose expired, and during the entire ten and one-half months period of time, the means for discovering defendant's identity were available and within plaintiff's control, plaintiff's due process rights were not violated because the ten and one-half month period was a constitutionally reasonable amount of time for plaintiff to bring her medical malpractice suit against defendant; plaintiff's claims against defendant were barred by this section when plaintiff filed suit against defendant eleven months after the three-year statute of repose expired. *Cahn v. Berryman*, **2015-NMCA-078**, cert. granted, 2015-NMCERT-007.

Section does not violate equal protection. — Where a patient sued a medical center and a doctor who practiced at the medical center for medical malpractice; the three-year limitation period expired on December 10, 2007; the patient filed the complaint on December 4, 2007 and served the medical center on December 11, 2007, one day after the expiration of the three-year limitation period; and the medical center's third party complaint against the doctor for equitable indemnification, which was filed on December 22, 2008, was barred, the preclusive effect of **41-5-13** NMSA 1978 did not violate the medical center's due process rights. *Christus St. Vincent Reg'l Med. Ctr. v. Duarte-Afara*, **2011-NMCA-112**, **267 P.3d 70**.

This section, as a statute of repose, does not implicate equal protection considerations because it operates uniformly upon all medical malpractice plaintiffs. *Garcia ex rel. Garcia v. La Farge*, **1995-NMSC-019**, **119 N.M. 532**, **893 P.2d 428**.

Rational basis for classification. — The classification of health care providers created by this section is supported by a rational basis. *Cummings v. X-Ray Assocs.*, **1996-NMSC-035**, **121 N.M. 821**, **918 P.2d 1321**.

Assuring adequate malpractice insurance. — By offering to qualified health care providers certain benefits that are not available to those who are not qualified, the legislature furthers its stated goal of assuring adequate malpractice insurance coverage in the New Mexico medical profession; this section was reasonably drafted to further a legitimate government interest. *Cummings v. X-Ray Assocs.*, **1996-NMSC-035**, **121 N.M. 821**, **918 P.2d 1321**.

Section does not violate prohibition against special legislation. — This section does not violate the prohibition against special legislation because it was within the competence of the legislature to determine that the high costs of malpractice insurance distinguish the class of health care providers from the class of tortfeasors generally. *Garcia ex rel. Garcia v. La Farge*, **1995-NMSC-019**, **119 N.M. 532**, **893 P.2d 428**.

Malpractice action does not implicate fundamental rights. — A malpractice claim is an attempt by a patient to obtain something he or she does not yet possess: monetary compensation for an injury caused by the negligence of a health care practitioner. As such, a medical malpractice claim generally does not, for the patient, implicate any fundamental rights such as First Amendment rights, freedom of association, voting, interstate travel, privacy, and fairness in the deprivation of life, liberty or property. *Cummings v. X-Ray Assocs.*, **1996-NMSC-035**, **121 N.M. 821**, **918 P.2d 1321**.

Section not applicable to non-qualified health care providers. — The Medical Malpractice Act's statute of limitations does not apply to health care providers that have not qualified under Subsection A of **41-5-5** NMSA 1978. *Roberts v. Southwest Cmty. Health Servs.*, **1992-**

NMSC-042, 114 N.M. 248, 837 P.2d 442.

Section applicable to wrongful death action based on malpractice. — The specific inclusion of a wrongful death claim within the definition of a malpractice claim makes the limitation period of this section applicable to a claim of malpractice resulting in wrongful death. *Armijo v. Tandysh*, 1981-NMCA-098, 98 N.M. 181, 646 P.2d 1245, cert. quashed, 98 N.M. 336, 648 P.2d 794 (1982), and cert. denied, 459 U.S. 1016, 103 S. Ct. 377, 74 L. Ed. 2d 510 (1982), *overruled on other grounds by Roberts v. Southwest Cmty. Health Servs.*, 1992-NMSC-042, 114 N.M. 248, 837 P.2d 442; *Mackey v. Burke*, 1984-NMCA-028, 102 N.M. 294, 694 P.2d 1359, cert. quashed, 102 N.M. 293, 694 P.2d 1358 (1985), *overruled on other grounds by Chavez v. Regents of Univ. of N.M.*, 1985-NMSC-114, 103 N.M. 606, 711 P.2d 883.

Section inapplicable to minor beneficiaries under Wrongful Death Act. — The tolling provisions applicable to minors under the age of nine years contained in this section apply only to minors who suffer an alleged act of malpractice and not to minors who are beneficiaries under the Wrongful Death Act [41-2-1 NMSA 1978]. *Moncor Trust Co. ex rel. Flynn v. Feil*, 1987-NMCA-015, 105 N.M. 444, 733 P.2d 1327, cert. denied, 105 N.M. 421, 733 P.2d 869.

Construction with Tort Claims Act. — District court correctly applied the law when it estopped the doctor from asserting the statute of limitations defense under 41-4-15 NMSA 1978 because by choosing to place the doctor at a private institution, and not identify him as a public employee working in a public capacity, the state engaged in conduct that conveyed the indisputable impression to persons wishing to assert a claim that the doctor was an employee of the private institution and therefore the limitation for private entities applied. *Hagen v. Faherty*, 2003-NMCA-060, 133 N.M. 605, 66 P.3d 974, cert. denied, 133 N.M. 593, 66 P.3d 962.

Occurrence rule governs claims under the Medical Malpractice Act. — The accrual date in which a patient must file a claim for medical malpractice is the date of the act or occurrence of the medical malpractice even if the patient is oblivious of any harm. *Christus St. Vincent Reg'l Med. Ctr. v. Duarte-Afara*, 2011-NMCA-112, 267 P.3d 70, cert. granted, 2011-NMCERT-010.

When cause of action accrues. — The accrual date in which a patient must file a claim for medical malpractice is the date of the act or occurrence of the medical malpractice even if the patient is oblivious of any harm. *Christus St. Vincent Reg'l Med. Ctr. v. Duarte-Afara*, 2011-NMCA-112, 267 P.3d 70.

In medical malpractice actions where the health care provider is not qualified under the Medical Malpractice Act [Chapter 41, Article 5 NMSA 1978], the cause of action accrues when the plaintiff knows or with reasonable diligence should have known of the injury and its cause. *Roberts v. Southwest Cmty. Health Servs.*, 1992-NMSC-042, 114 N.M. 248, 837 P.2d 442.

The triggering event of this section is determined by the occurrence rule. This event is unrelated to the accrual date of the cause of action, and does not entail whether the injury has even been discovered. In this sense, if, four years after the occurrence of medical malpractice, a patient learns they have been injured, their claim is forever barred because this section functions as a statute of repose. *Cummings v. X-Ray Assocs.*, 1996-NMSC-035, 121 N.M. 821, 918 P.2d 1321.

When cause of action for negligently prescribed medication accrues. — In a wrongful prescription case, the term "act of malpractice" refers to the discrete act taken by a health care provider of prescribing medication to a patient, not to any subsequent act of the patient and the three-year statute of limitations in 41-5-13 NMSA 1978 begins to run on the date medication is prescribed. *Chavez v. Delgado*, 2014-NMCA-014, cert. denied, 2013-NMCERT-012.

Where, on November 11, 2008, the patient requested a prescription for Simvastatin and the physician wrote the prescription; the next day, the physician called the prescription to the patient's pharmacy; the patient filled the prescription on December 3, 2008; on December 8, 2008, the patient was hospitalized with drug-induced rhabdomyolysis, purportedly caused by the interaction of Simvastatin and another medication the patient was taking; the patient died on February 21, 2010; and plaintiffs filed suit on December 1, 2011, the three-year statute of limitations began to run on November 11, 2008, the day the physician prescribed Simvastatin to the patient, and plaintiffs' claims against the physician were barred. *Chavez v. Delgado*, 2014-NMCA-014, cert. denied, 2013-NMCERT-012.

Fraudulent concealment. — There is no fraudulent concealment exception to the occurrence rule in this section; thus the statute of limitations did not toll for a plaintiff who filed an action more than three years after the act of malpractice, where she learned of the negligent act within the three-year period and in adequate time to file a malpractice action within three years, exercising ordinary diligence. *Tomlinson v. George*, 2003-NMCA-004, 133 N.M. 69, 61 P.3d 195, *aff'd*, 2005-NMSC-020, 138 N.M. 34, 116 P.3d 105.

To toll statute of limitations under doctrine of fraudulent concealment, a patient has the burden of showing: (1) that the physician knew of the alleged wrongful act and concealed it from the patient or had material information pertinent to its discovery which the physician failed to disclose, and (2) that the patient did not know, or could not have known through the exercise of reasonable diligence, of the patient's cause of action within the statutory period. *Kern ex rel. v. St. Joseph Hosp.*, 1985-NMSC-031, 102 N.M. 452, 697 P.2d 135.

Fraudulent concealment requires a plaintiff to demonstrate that the defendant physician knew of the alleged negligent act and concealed the negligent act from the patient or had material information pertinent to discovery of the negligent act which the defendant failed to disclose. *Tomlinson v. George*, 2005-NMSC-020, 138 N.M. 34, 116 P.3d 105.

Fraudulent concealment requires that the plaintiff demonstrate that he or she did not know, and could not have discovered through the exercise of reasonable diligence, his or her cause of action during the statutory period. *Tomlinson v. George*, 2005-NMSC-020, 138 N.M. 34, 116 P.3d 105.

Questions for fact finder in fraudulent concealment. — The question of a physician's knowledge of the error or concealment of pertinent facts that might have reasonably led to the discovery of the error and the related question of the patient's due diligence in discovering the cause of action are ordinarily for determination by the finder of fact. *Kern ex rel. v. St. Joseph Hosp.*, 1985-NMSC-031, 102 N.M. 452, 697 P.2d 135.

Statute tolled by nondisclosure of pertinent, not reasonably discoverable, facts. — The statute of limitations may be tolled where a physician has knowledge of facts relating to medical malpractice and fails to disclose such facts to the patient under circumstances where the patient may not be reasonably expected to learn of the improper acts. *Keithley v. St.*

Joseph's Hosp., [1984-NMCA-104](#), 102 N.M. 565, 698 P.2d 435.

Proof required with allegation that statute tolled by fraud. — A plaintiff who alleges that the statute has been tolled by fraud, either active or passive, must establish that she did not have the means to discover the fraud. *Keithley v. St. Joseph's Hosp.*, [1984-NMCA-104](#), 102 N.M. 565, 698 P.2d 435.

Fraudulent concealment inapplicable. — If a plaintiff discovers the injury within the time limit, fraudulent concealment does not apply because the defendant's actions have not prevented the plaintiff from filing the claim within the time period and the equitable remedy is not necessary. *Tomlinson v. George*, [2005-NMSC-020](#), [138 N.M. 34](#), [116 P.3d 105](#).

Statute of repose is not tolled by fraudulent concealment when the plaintiff knew of his or her cause of action within the statutory period. *Tomlinson v. George*, [2005-NMSC-020](#), [138 N.M. 34](#), [116 P.3d 105](#).

Metastasis of cancer not relevant trigger. — The plain language of this section establishes the date of the act of malpractice as the only relevant factor, without any reference to any subsequent harm; in New Mexico, the patient's awareness of metastasis of cancer is not the trigger for purposes of the statute of limitations. *Cummings v. X-Ray Assocs.*, [1996-NMSC-035](#), [121 N.M. 821](#), [918 P.2d 1321](#).

Claim barred. — An action by an employee against the physician employed by the employer to perform the medical examination was time barred since the examination occurred more than three years preceding the filing of the cause of action; however, an action against the employer was not barred since the employee was subsequently examined by a physician's assistant at the direction of the employer within the time period. *Baer v. Regents of Univ. of Cal.*, [1994-NMCA-124](#), [118 N.M. 685](#), [884 P.2d 841](#).

Business entities qualify as health care providers. — Professional corporations and other types of professional medical organizations under which a medical professional operates are eligible to qualify as "health care providers" under the Medical Malpractice Act [Chapter [41](#), Article [5](#) NMSA 1978] and are entitled to the benefits of the act when they are sued for medical malpractice as long as they employ or consist of members who are licensed or certified by the state to provide the medical services listed in Subsection A of [41-5-3](#) NMSA 1978. *Baker v. Hedstrom*, [2013-NMSC-043](#), *aff'g on other grounds*, [2012-NMCA-073](#).

Business entities, such as professional corporations and limited liability companies, that are involved in the medical treatment of patients and that are neither hospitals nor outpatient health care facilities, qualify as health care providers. *Baker v. Hedstrom*, [2012-NMCA-073](#), [284 P.3d 400](#), cert. granted, 2012-NMCERT-007.

Evidence insufficient to toll statute of limitations. *Ealy v. Sheppeck*, [1983-NMCA-049](#), [100 N.M. 250](#), [669 P.2d 259](#), *overruled in part by* *Juarez v. Nelson*, [2003-NMCA-011](#), [133 N.M. 168](#), [61 P.3d 877](#).

The statute of limitations was not tolled by fraudulent concealment on the part of the doctor as two different people told the individual that the doctor did not do all that he could have for the individual's husband. *Juarez v. Nelson*, [2003-NMCA-011](#), [133 N.M. 168](#), [61 P.3d 877](#), *overruled on other grounds by* *Tomlinson v. George*, [2005-NMSC-020](#), [138 N.M. 34](#), [116 P.3d 105](#).

Dismissal without prejudice. — Where the court had entered a stipulated order staying the proceedings until 30 days after the medical review commission rendered a decision on plaintiff's claim, and defendant filed a motion to lift the stay after plaintiff did not file an application with the commission, because the statute of limitations had run, the dismissal without prejudice effectively dismissed the case on a permanent basis. *Belser v. O'Cleireachain*, 2005-NMCA-073, 137 N.M. 623, 114 P.3d 303, cert. denied, 2005-NMCERT-006, 137 N.M. 766, 115 P.3d 229.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For comment on access to the courts and the Medical Malpractice Act: *Jiron v. Mahlab*, see 14 N.M.L. Rev. 503 (1984).

For survey of medical malpractice law in New Mexico, see 18 N.M.L. Rev. 469 (1988).

For note and comment, "Statutes of Limitations Applied to Minors and the New Mexico Court of Appeals' Balance of Competing State Interests to Favor Children," see 35 N.M. L. Rev. 535 (2005).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Statute of limitations applicable to malpractice action against physician, surgeon, dentist, or similar practitioner, 80 A.L.R.2d 320, 70 A.L.R.4th 535.

When statute of limitations commences to run against malpractice action based on leaving foreign substance in patient's body, 70 A.L.R.3d 7.

Amendment purporting to change the nature of the action or theory of recovery made after statute of limitations has run, as relating back to filing of original complaint, 70 A.L.R.3d 82.

Statute of limitations relating to medical malpractice actions as applicable to actions against unlicensed practitioner, 70 A.L.R.3d 114.

When statute of limitations begins to run against malpractice action in connection with sterilization or birth control procedures, 93 A.L.R.3d 218.

When statute of limitations begins to run in dental malpractice suits, 3 A.L.R.4th 318.

What statute of limitations governs physician's action for wrongful denial of hospital privileges, 3 A.L.R.4th 1214.

Statute of limitations applicable to third person's action against psychiatrist, psychologist, or other mental health practitioner, based on failure to warn persons against whom patient expressed threats, 41 A.L.R.4th 1078.

Applicability of "foreign object" exception in medical malpractice statutes of limitations, 50 A.L.R.4th 250.

Medical malpractice statutes of limitation minority provisions, 62 A.L.R.4th 758.

Medical malpractice: statute of limitations in wrongful death action based on medical malpractice, 70 A.L.R.4th 535.

Medical malpractice: when limitations period begins to run on claim for optometrist's malpractice, 70 A.L.R.4th 600.

Medical malpractice: who are "health care providers," or the like, whose actions fall within statutes specifically governing actions and damages for medical malpractice, 12 A.L.R.5th 1.

Medical malpractice statutes of limitation minority provisions, 71 A.L.R.5th 307.

70 C.J.S. Physicians and Surgeons §§ 107, 108.

41-5-13. Limitations. (Effective January 1, 2022.)

No claim for malpractice may be brought against a health care provider unless filed within three years after the date that the act of malpractice occurred, except that the times limited for the bringing of actions by minors and incapacitated persons shall be extended so that they shall have one year from and after the age of majority or termination of incapacity within which to commence the actions.

History: 1953 Comp., § 58-33-13, enacted by Laws 1976, ch. 2, § 13; 2021, ch. 16, § 6.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, extended the statute of limitations for minors and incapacitated persons bringing medical malpractice actions; after "No claim for malpractice", deleted "arising out of an act of malpractice which occurred subsequent to the effective date of the Medical Malpractice Act", and after "except that", deleted "a minor under the full age of six years shall have until his ninth birthday in which to file. This subsection applies to all persons regardless of minority or other legal disability" and added the remainder of the section.

41-5-14. Medical review commission; independent providers.

A. The "New Mexico medical review commission" is created. The function of the New Mexico medical review commission is to provide panels to review all malpractice claims against independent providers who are natural persons covered by the Medical Malpractice Act.

B. Those eligible to sit on a panel shall consist of health care providers licensed pursuant to New Mexico law and residing in New Mexico and members of the state bar.

C. The only cases that a panel will consider are cases involving an alleged act of malpractice occurring in New Mexico by an independent provider qualified under the Medical Malpractice Act. Beginning July 1, 2021, cases involving an alleged act of malpractice by a hospital or outpatient health care facility shall not be considered and such claims shall not be filed with the New Mexico medical review commission.

D. An attorney shall submit a case for the consideration of a panel, prior to filing a complaint

in any district court or other court sitting in New Mexico, by addressing an application, in writing, signed by the patient or the patient's attorney, to the director of the New Mexico medical review commission.

E. The director of the New Mexico medical review commission shall be an attorney appointed by and serving at the pleasure of the chief justice of the New Mexico supreme court.

F. The chief justice shall set the director's salary and report the salary to the superintendent in the superintendent's capacity as custodian of the fund.

History: 1953 Comp., § 58-33-14, enacted by Laws 1976, ch. 2, § 14; **2021, ch. 16, § 7.**

ANNOTATIONS

The 2021 amendment, effective July 1, 2021, revised the scope of the medical review commission, and provided that beginning July 1, 2021, cases involving an alleged act of malpractice by a hospital or outpatient health care facility shall not be considered by, or filed with, the medical review commission; in the section heading, after "Medical review commission", added "independent providers"; in Subsection A, after "claims against", deleted "health care" and added "independent", and after "providers", added who are natural persons"; in Subsection C, added "The only", after "New Mexico by", changed "health care providers" to "an independent provider", and after "the Medical Malpractice Act.", added the remainder of the subsection; and in Subsection E, after "the New Mexico medical review commission", changed "will" to "shall".

Claim submitted as of date of mailing. — The date of mailing an application for a claim to the review commission constitutes submission of the claim for purposes of Subsection D of this section. *Otero v. Zouhar*, **1985-NMSC-021**, **102 N.M. 482**, **697 P.2d 482**, *overruled on other grounds by* *Grantland v. Lea Reg'l Hosp.*, **1990-NMSC-076**, **110 N.M. 378**, **796 P.2d 599**.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For comment on access to the courts and the Medical Malpractice Act: *Jiron v. Mahlab*, see 14 N.M.L. Rev. 503 (1984).

For survey of medical malpractice law in New Mexico, see 18 N.M.L. Rev. 469 (1988).

41-5-15. Commission decision required; application.

A. No malpractice action may be filed in any court against a qualifying health care provider before application is made to the medical review commission and its decision is rendered.

B. This application shall contain the following:

(1) a brief statement of the facts of the case, naming the persons involved, the dates and the circumstances, so far as they are known, of the alleged act or acts of malpractice; and

(2) a statement authorizing the panel to obtain access to all medical and hospital records and information pertaining to the matter giving rise to the application, and, for the purposes of its consideration of the matter only, waiving any claim of privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

History: 1953 Comp., § 58-33-15, enacted by Laws 1976, ch. 2, § 15.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Section does not deprive all plaintiffs of constitutional right of access to courts. *Jiron v. Mahlab*, 1983-NMSC-022, 99 N.M. 425, 659 P.2d 311.

Unconstitutional to cause undue delay. — Where the requirement of first going before the medical review commission causes undue delay prejudicing a plaintiff by the loss of witnesses or parties, the plaintiff is unconstitutionally deprived of his right of access to the courts. *Jiron v. Mahlab*, 1983-NMSC-022, 99 N.M. 425, 659 P.2d 311.

Decision by medical review commission was not jurisdictional prerequisite to the filing of a complaint in court against a qualified health care provider for medical malpractice. *Rupp v. Hurley*, 2002-NMCA-023, 131 N.M. 646, 41 P.3d 914, cert. denied, 131 N.M. 737, 42 P.3d 842.

Subsection A procedural and not binding. — The statutory provision that claimants against health care providers first submit their claims to the commission before filing suit is a purely procedural requirement and cannot, therefore, be deemed binding; the procedural provisions of the Medical Malpractice Act, to the extent of denying plaintiff access to the courts, shall not control where the defendant has not been prejudiced. *Otero v. Zouhar*, 1985-NMSC-021, 102 N.M. 482, 697 P.2d 482, overruled on other grounds by *Grantland v. Lea Reg'l Hosp.*, 1990-NMSC-076, 110 N.M. 378, 796 P.2d 599.

Not necessary to bring each allegation before commission. — Under this section, it is not necessary that each of plaintiff's counts, nor each of plaintiff's allegations, be presented to the medical review commission, as the district court has subject matter jurisdiction over medical malpractice and battery claims not submitted to the commission where application satisfied requirements of this section. *Trujillo v. Puro*, 1984-NMCA-050, 101 N.M. 408, 683 P.2d 963, cert. denied, 101 N.M. 362, 683 P.2d 44.

Claims not necessary to bring before commission. — Claims for negligent misrepresentation and intentional infliction of emotional distress do not first have to be presented to the medical review commission because they do not come within the definition of a malpractice claim. *Trujillo v. Puro*, 1984-NMCA-050, 101 N.M. 408, 683 P.2d 963, cert. denied, 101 N.M. 362, 683 P.2d 44.

Excused failure to file claim with commission. — Misinformation supplied by the office of the state superintendent of insurance, regarding who were qualified health care providers, excused plaintiff's failure to file claim with the commission before filing a complaint in district court. *Otero v. Zouhar*, 1985-NMSC-021, 102 N.M. 482, 697 P.2d 482, overruled on other

grounds by Grantland v. Lea Reg'l Hosp., 1990-NMSC-076, 110 N.M. 378, 796 P.2d 599.

Statute of limitation tolled regardless of outcome. — This section, which tolls the statute of limitations period upon submission of a case to the commission, should be enforced according to its terms whether the commission's determination is that the health care provider is not qualified and the claim is consequently rejected, or that the health care provider is qualified and the claim is resolved on its merits. *Grantland v. Lea Reg'l Hosp.*, 1990-NMSC-076, 110 N.M. 378, 796 P.2d 599.

Application was sufficient to toll statute of limitations. — Where plaintiff filed an application to the New Mexico medical review commission (MRC) alleging that as a result of medical negligence plaintiff's pregnancy was aborted, the district court erred in dismissing the complaint against defendant on the basis that plaintiff's application was not specific enough in making allegations against defendant to trigger the Medical Malpractice Act's, NMSA 1978, §§ 41-5-1 to -29, tolling provision on plaintiff's claims against defendant. Plaintiff's application to the MRC clearly named defendant, and the application recited a brief statement of the facts describing the dates and the circumstances, as far as they were known, of the acts and omissions of named employees and physicians working in defendant's hospitals. *Romero v. Lovelace Health Sys., Inc.*, 2020-NMSC-001, rev'g A-1-CA-35177, mem. Op. (N.M. Ct. App. Oct. 26, 2017) (non-precedential).

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For comment on access to the courts and the Medical Malpractice Act: *Jiron v. Mahlab*, see 14 N.M.L. Rev. 503 (1984).

41-5-15. Commission decision required; application. (Effective January 1, 2022.)

A. No malpractice action may be filed in any court against a qualifying independent provider or the independent provider's employer, master or principal based on a theory of respondeat superior or any other derivative theory of recovery before application is made to the New Mexico medical review commission and its decision is rendered; provided, however, that an independent provider and the patient may stipulate to forego the panel process.

B. This application shall contain the following:

- (1) the name of the health care provider against which the claims are asserted;*
- (2) a short and plain statement of the grounds as to why the New Mexico medical review commission has jurisdiction over the claims being asserted;*
- (3) the specific date or date range when the malpractice allegedly occurred;*
- (4) so far as known, a brief statement of the facts supporting the patient's malpractice claim; and*
- (5) a statement authorizing the panel to obtain access to all medical and hospital*

records and information pertaining to the matter giving rise to the application and, for the purposes of its consideration of the matter only, waiving any claim of privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

History: 1953 Comp., § 58-33-15, enacted by Laws 1976, ch. 2, § 15; 2021, ch. 16, § 8.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, provided that no malpractice action may be filed based on a theory of respondeat superior or any other derivative theory of recovery before application is made to the New Mexico medical review commission and its decision is rendered, provided that an independent provider and the patient may stipulate to forego the panel process, and revised the required contents of an application to the New Mexico medical review commission; in Subsection A, after "qualifying", deleted "health care" and added "independent", after "provider", added "or the independent provider's employer, master or principal based on a theory of respondeat superior or any other derivative theory of recovery", and after "rendered", added the remainder of the subsection; and in Subsection B, deleted former Paragraph B(1) and added new Paragraphs B(1) through B(4), and redesignated former Paragraph B(2) as Paragraph B(5).

41-5-16. Application procedure.

A. Upon receipt of an application for review, the commission's director or his delegate shall cause to be served a true copy of the application on the health care providers involved. Service shall be effected pursuant to New Mexico law. If the health care provider involved chooses to retain legal counsel, his attorney shall informally enter his appearance with the director.

B. The health care provider shall answer the application for review and in addition shall submit a statement authorizing the panel to obtain access to all medical and hospital records and information pertaining to the matter giving rise to the application, and, for the purposes of its consideration of the matter only, waiving any claim of privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

C. In instances where applications are received employing the theory of respondeat superior or some other derivative theory of recovery, the director shall forward such applications to the state professional societies, associations or licensing boards of both the individual health care provider whose alleged malpractice caused the application to be filed, and the health care provider named a respondent as employer, master or principal.

History: 1953 Comp., § 58-33-16, enacted by Laws 1976, ch. 2, § 16.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Limitation on authority of director. — The director does not have any discretion to redact an applicant's legal claims or factual averments in a medical malpractice action from an application to the commission. *Kucel v. N.M. Med. Review Comm'n*, 2000-NMCA-026, 128 N.M. 691, 997 P.2d 823, cert. denied, 128 N.M. 688, 997 P.2d 820.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 70 C.J.S. Physicians and Surgeons §§ 110 to 113.

41-5-16. Application procedure. (Effective January 1, 2022.)

A. Upon receipt of an application for review, the New Mexico medical review commission's director or the director's designee shall cause to be served a true copy of the application on the independent providers against which claims are asserted. Service shall be effected pursuant to New Mexico law. If the independent provider involved chooses to retain legal counsel, the independent provider's attorney shall informally enter an appearance with the director.

B. The independent provider shall answer the application for review and in addition shall submit a statement authorizing the panel to obtain access to all medical and hospital records and information pertaining to the matter giving rise to the application and, for the purposes of its consideration of the matter only, waiving any claim of privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

C. In instances where applications are received employing the theory of respondeat superior or some other derivative theory of recovery, the director shall forward such applications to the state professional societies, associations or licensing boards of both the individual independent provider whose alleged malpractice caused the application to be filed and the independent provider named a respondent as employer, master or principal.

History: 1953 Comp., § 58-33-16, enacted by Laws 1976, ch. 2, § 16; 2021, ch. 16, § 9.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, made changes to conform to the new definition of "independent provider" as used in the Medical Malpractice Act; in Subsection A, added "New Mexico medical review" preceding "commission's", and changed "health care" to "independent" preceding "provider" throughout the section.

41-5-17. Panel selection.

A. Applications for review shall be promptly transmitted by the director to the directors of the health care provider's state professional society or association and the state bar association,

who shall each select three panelists within thirty days from the date of transmittal of the application.

B. If no state professional society or association exists, or if the health care provider does not belong to such a society or association, the director shall transmit the application to the health care provider's state licensing board, which shall in turn select three persons from the health care provider's profession and, where applicable, to [two] persons specializing in the same field or discipline as the health care provider.

C. In cases where there are multiple defendants, the case against each health care provider may be reviewed by a separate panel, or a single combined panel may review the claim against all parties defendant, at the discretion of the director.

D. Three panel members from the health care provider's profession and three panel members from the state bar association shall sit in review in each case.

E. In those cases where the theory of respondeat superior or some other derivative theory of recovery is employed, two of the panel members shall be chosen from the individual health care provider's profession and one panel member shall be chosen from the profession of the health care provider named a respondent employer, master or principal.

F. The director of the commission or his delegate, who shall be an attorney, shall sit on each panel and serve as chairman.

G. Any member shall disqualify himself from consideration of any case in which, by virtue of his circumstances, he feels his presence on the panel would be inappropriate, considering the purpose of the panel. The director may excuse a proposed panelist from serving.

H. Whenever a party shall make and file an affidavit that a panel member selected pursuant to this section cannot, according to the belief of the party making the affidavit, sit in review of the application with impartiality, that panel member shall proceed no further. Another panel member shall be selected by the health care provider's professional association, state licensing board or the state bar association, as the case may be. A party may not disqualify more than three proposed panel members in this manner in any single malpractice claim.

History: 1953 Comp., § 58-33-17, enacted by Laws 1976, ch. 2, § 17.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Bracketed material. — The bracketed material was inserted by the compiler and is not part of the law.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers §§ 374 to 376.

41-5-17. Panel selection. (Effective January 1, 2022.)

A. Applications for review shall be promptly transmitted by the director of the New Mexico medical review commission to the directors of the independent provider's state professional society or association and the state bar association, who shall each select three panelists within thirty days from the date of transmittal of the application.

B. If no state professional society or association exists or if the independent provider does not belong to a society or association, the director shall transmit the application to the independent provider's state licensing board, which shall in turn select three persons from the independent provider's profession and, where applicable, two persons specializing in the same field or discipline as the independent provider.

C. In cases where there are multiple defendants, a single combined panel shall review the claims against all party defendants. At the discretion of the panel chair, a hearing involving multiple defendants may include fewer than three panelists from the independent provider's profession and fewer than three lawyer panel members per defendant.

D. Except for cases involving multiple defendants, three panel members from the independent provider's profession and three panel members from the state bar association shall sit in review in each case.

E. The director of the medical review commission or the director's delegate, who shall be an attorney, shall sit on each panel and serve as chair.

F. A member shall disqualify the member's self from consideration of a case in which, by virtue of circumstances, the member feels the member's presence on the panel would be inappropriate, considering the purpose of the panel. The director may excuse a proposed panelist from serving.

G. Whenever a party makes and files an affidavit that a panel member selected pursuant to this section cannot, according to the belief of the party making the affidavit, sit in review of the application with impartiality, that panel member shall proceed no further. Another panel member shall be selected by the independent provider's professional association, state licensing board or the state bar association, as the case may be. A party may not disqualify more than three proposed panel members in this manner in any single malpractice claim.

History: 1953 Comp., § 58-33-17, enacted by Laws 1976, ch. 2, § 17; 2021, ch. 16, § 10.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, made changes to conform to the new definition of "independent provider" as used in the Medical Malpractice Act, mandated that a single combined panel review the claims against all party defendants in cases where there are multiple defendants, provided the panel chair the discretion to revise the composition of the New Mexico medical review commission panel when a hearing involves multiple defendants, and removed a provision relating to the composition of a panel in certain cases where the theory of respondeat superior or any other derivative theory of recovery is employed; preceding each occurrence of "provider", changed "health care" to "independent" throughout

the section; in Subsection A, after "director", added "of the New Mexico medical review commission"; in Subsection C, after "multiple defendants", deleted "the case against each health care provider may be reviewed by a separate panel, or", after "combined panel", changed "may" to "shall", after "against all", deleted "parties defendant, at the discretion of the director" and added the remainder of the subsection; in Subsection D, added "Except for cases involving multiple defendants"; deleted former Subsection E and redesignated former Subsections F through H as Subsections E through G, respectively; and in Subsection E, added "medical review" preceding "commission".

41-5-18. Time and place of hearing.

A date, time and place for hearing shall be fixed by the director and prompt notice thereof shall be given to the parties involved, their attorneys and the members of the panel. In no instance shall the date set be more than sixty days after the transmittal by the director of the application for review, unless good cause exists for extending the period. Hearings may be held anywhere in the state of New Mexico, and the director shall give due regard to the convenience of the parties in determining the place of hearing.

History: 1953 Comp., § 58-33-18, enacted by Laws 1976, ch. 2, § 18.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

41-5-18. Time and place of hearing. (Effective January 1, 2022.)

A date, time and place for hearing shall be fixed by the director of the New Mexico medical review commission and prompt notice of the hearing shall be given to the parties involved, their attorneys and the members of the panel. In no instance shall the date set be more than sixty days after the transmittal by the director of the application for review, unless good cause exists for extending the period. Hearings may be held anywhere in the state, and the director shall give due regard to the convenience of the parties in determining the place of hearing. Upon the request of one party, within ten days of the answer filed by the respondent, the hearing shall be conducted via video conference, including attorneys, witnesses and panel members appearing remotely.

History: 1953 Comp., § 58-33-18, enacted by Laws 1976, ch. 2, § 18; 2021, ch. 16, § 11.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, provided that hearings may be conducted

via video conference upon the request of a party; and after "determining the place of hearing", added "Upon the request of one party, within ten days of the answer filed by the respondent, the hearing shall be conducted via video conference, including attorneys, witnesses and panel members appearing remotely."

41-5-19. Hearing procedures.

A. At the time set for hearing, the attorney submitting the case for review shall be present and shall make a brief introduction of his case, including a resume of the facts constituting alleged professional malpractice which he is prepared to prove. The health care provider against whom the claim is brought and its attorney may be present and may make an introductory statement of its case.

B. Both parties may call witnesses to testify before the panel, which witnesses shall be sworn. Medical texts, journals, studies and other documentary evidence relied upon by either party may be offered and admitted if relevant. Written statements of fact of treating health care providers may be reviewed. The monetary damages in any case shall not be a subject of inquiry or discussion.

C. The hearing will be informal and no official transcript shall be made. Nothing contained in this paragraph shall preclude the taking of the testimony by the parties at their own expense.

D. At the conclusion of the hearing, the panel may take the case under advisement or it may request that additional facts, records, witnesses or other information be obtained and presented to it at a supplemental hearing, which shall be set for a date and time certain, not longer than thirty days from the date of the original hearing unless the attorney bringing the matter for review shall in writing consent to a longer period.

E. Any supplemental hearing shall be held in the same manner as the original hearing, and the parties concerned and their attorneys may be present.

History: 1953 Comp., § 58-33-19, enacted by Laws 1976, ch. 2, § 19.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Hearings conducted in atmosphere free of judicial intimidations. — Hearings are to be conducted in an atmosphere free of the intimidations that may accompany a court setting, and the give-and-take of the panel's deliberations, after it has heard the presentation of the parties, is to be as open and uninhibited as are a jury's deliberations at the end of a court trial. *Salazare v. St. Vincent Hosp.*, 1980-NMCA-095, 96 N.M. 409, 631 P.2d 315, *aff'd in part and rev'd on other grounds*, 1980-NMSC-124, 95 N.M. 147, 619 P.2d 823.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

41-5-19. Hearing procedures. (Effective January 1, 2022.)

A. At the time set for hearing, the attorney submitting the case for review shall be present and shall make a brief introduction of the case, including a resume of the facts constituting alleged professional malpractice. The independent provider against whom the claim is brought and the independent provider's attorney may be present and may make an introductory statement of the independent provider's case.

B. Both parties may call witnesses to testify before the panel, which witnesses shall be sworn. Medical texts, journals, studies and other documentary evidence relied upon by either party may be offered and admitted if relevant. Written statements of fact of treating independent providers may be reviewed. The monetary damages in any case shall not be a subject of inquiry or discussion.

C. The hearing shall be informal, and no official transcript shall be made. Nothing contained in this subsection shall preclude the recording or transcribing of the testimony by the parties at their own expense.

D. At the conclusion of the hearing, the panel shall deliberate and reach a decision.

History: 1953 Comp., § 58-33-19, enacted by Laws 1976, ch. 2, § 19; 2021, ch. 16, § 12.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, removed a provision that a panel, at the conclusion of a hearing, may take the case under advisement or may request additional evidence, and required that a panel, at the conclusion of a hearing, deliberate and reach a decision; preceding each occurrence of "provider", changed "health care" to "independent"; in Subsection D, after "the panel", deleted the remainder of the subsection and added "shall deliberate and reach a decision"; and deleted Subsection E.

41-5-20. Panel deliberations and decision.

A. The deliberations of the panel shall be and remain confidential. Upon consideration of all the relevant material, the panel shall decide only two questions:

(1) whether there is substantial evidence that the acts complained of occurred and that they constitute malpractice; and

(2) whether there is a reasonable medical probability that the patient was injured thereby.

B. All votes of the panel on the two questions for decision shall be by secret ballot. The decision shall be by a majority vote of those voting members of the panel who have sat on the entire case. The decision shall be communicated in writing to the parties and attorneys concerned and a copy thereof shall be retained in the permanent files of the commission.

C. The decision shall in every case be signed for the panel by the chairman, who shall vote only in the event the other members of the panel are evenly divided, and shall contain only the conclusions reached by a majority of its members and the number of members, if any, dissenting therefrom; provided, however, that if the vote is not unanimous, the majority may briefly explain the reasoning and basis for their conclusion, and the dissenters may likewise explain the reasons for disagreement.

D. The report of the medical review panel shall not be admissible as evidence in any action subsequently brought in a court of law. A copy of the report shall be sent to the health care provider's professional licensing board.

E. Panelists and witnesses shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by the Medical Malpractice Act.

F. The panel's decisions shall be without administrative or judicial authority and shall not be binding on any party. The panel shall make no effort to settle or compromise any claim nor express any opinion on the monetary value of any claim.

History: 1953 Comp., § 58-33-20, enacted by Laws 1976, ch. 2, § 20.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Panel's deliberations to be open and uninhibited. — Hearings are to be conducted in an atmosphere free of the intimidations that may accompany a court setting, and the give-and-take of the panel's deliberations, after it has heard the presentation of the parties, is to be as open and uninhibited as are a jury's deliberations at the end of a court trial. *Salazar v. St. Vincent Hosp.*, 1980-NMCA-095, 96 N.M. 409, 631 P.2d 315, *aff'd in part and rev'd on other grounds*, 1980-NMSC-124, 95 N.M. 147, 619 P.2d 823.

Extent of privilege from discovery. — The privilege exempting panelists of the medical review commission from discovery applies to the panel's deliberations and any report made by the panel, but not to testimony heard by the panel. *St. Vincent Hosp. v. Salazar*, 1980-NMSC-124, 95 N.M. 147, 619 P.2d 823.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For comment on access to the courts and the Medical Malpractice Act: *Jiron v. Mahlab*, see 14 N.M.L. Rev. 503 (1984).

41-5-21. Director; rules of procedure.

The director is authorized to adopt and publish rules of procedure necessary to implement and carry out the duties of the medical review commission. No rule shall be adopted, however,

which requires a party to make a monetary payment as a condition to bringing a malpractice claim before the medical review panel.

History: 1953 Comp., § 58-33-21, enacted by Laws 1976, ch. 2, § 21.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers §§ 374, 375.

41-5-22. Tolling of statute of limitation.

The running of the applicable limitation period in a malpractice claim shall be tolled upon submission of the case for the consideration of the panel and shall not commence to run again until thirty days after the panel's final decision is entered in the permanent files of the commission and a copy is served upon the claimant and his attorney by certified mail.

History: 1953 Comp., § 58-33-22, enacted by Laws 1976, ch. 2, § 22.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

Amended application adding a new party does not relate back to the original filing date. — The filing of an application with the medical review commission as to one provider does not toll the limitations period as to another provider who was not named in the original application and for whom the statutory period in which to file a cause of action has passed. *Meza v. Topalovski*, [2012-NMCA-002](#), [268 P.3d 1284](#).

Where plaintiff wrongly named a health care provider in an application before the medical review commission; plaintiff amended the application to name the correct health care provider; and the amended application to add the correct health care provider was filed more than three years after the date of the alleged malpractice by the correct health care provider, the original application did not toll the statute of limitations for the untimely application filed against the originally unnamed health care provider. *Meza v. Topalovski*, [2012-NMCA-002](#), [268 P.3d 1284](#).

Application was sufficient to toll statute of limitations. — Where plaintiff filed an application to the New Mexico medical review commission (MRC) alleging that as a result of medical negligence plaintiff's pregnancy was aborted, the district court erred in dismissing the complaint against defendant on the basis that plaintiff's application was not specific enough in making allegations against defendant to trigger the Medical Malpractice Act's, NMSA 1978, §§ [41-5-1](#) to -29, tolling provision on plaintiff's claims against defendant. Plaintiff's application to the MRC clearly named defendant, and the application recited a brief statement of the facts

describing the dates and the circumstances, as far as they were known, of the acts and omissions of named employees and physicians working in defendant's hospitals. *Romero v. Lovelace Health Sys., Inc.*, [2020-NMSC-001](#), *rev'g* A-1-CA-35177, mem. Op. (N.M. Ct. App. Oct. 26, 2017) (non-precedential).

Mailing decision to claimant's attorney suffices. — Mailing of the final decision of the medical review commission to a claimant in care of claimant's attorney is sufficient service for the purpose of determining recommencement of the limitation period relating to medical malpractice actions. *Saiz v. Barham*, [1983-NMCA-132](#), [100 N.M. 596](#), [673 P.2d 1329](#), cert. denied, 100 N.M. 689, 675 P.2d 421.

Claim submitted as of date of mailing. — A claim is considered to have been submitted to the medical review commission as of the date that the application for the claim is mailed to the commission. *Otero v. Zouhar*, [1985-NMSC-021](#), [102 N.M. 482](#), [697 P.2d 482](#), *overruled on other grounds by* *Grantland v. Lea Reg'l Hosp.*, [1990-NMSC-076](#), [110 N.M. 378](#), [796 P.2d 599](#).

Negligence prior to effective date of act. — This section does not apply to toll the running of the general limitation period for a personal injury claim [[37-1-8 NMSA 1978](#)], where the act of malpractice has occurred prior to the effective date of the Medical Malpractice Act, February 27, 1976 [Chapter [41](#), Article [5 NMSA 1978](#)]. *Loesch v. Henderson*, [1985-NMCA-104](#), [103 N.M. 554](#), [710 P.2d 748](#).

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

For comment on access to the courts and the Medical Malpractice Act: *Jiron v. Mahlab*, see 14 N.M.L. Rev. 503 (1984).

For survey of medical malpractice law in New Mexico, see 18 N.M.L. Rev. 469 (1988).

Am. Jur. 2d, A.L.R. and C.J.S. references. — When statute of limitations begins to run in dental malpractice suits, 3 A.L.R.4th 318.

41-5-23. Provision of expert witness.

In any malpractice claim where the panel has determined that the acts complained of were or reasonably might constitute malpractice and that the patient was or may have been injured by the act, the panel, its members, the director and the professional association concerned will cooperate fully with the patient in retaining a physician qualified in the field of medicine involved, who will consult with, assist in trial preparation and testify on behalf of the patient, upon his payment of a reasonable fee to the same effect as if the physician had been engaged originally by the patient.

History: 1953 Comp., § 58-33-23, enacted by Laws 1976, ch. 2, § 23.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was

approved February 27, 1976.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 31A Am. Jur. 2d Expert and Opinion Evidence §§ 19, 20, 40.

Necessity of expert evidence to support an action for malpractice against a physician or surgeon, 81 A.L.R.2d 597.

Competency of general practitioner to testify as expert witness in action against specialist for medical malpractice, 31 A.L.R.3d 1163.

Competence of physician or surgeon from one locality to testify, in malpractice case, as to standard of care required of defendant practicing in another locality, 37 A.L.R.3d 420.

Necessity and sufficiency of expert evidence to establish existence and extent of physician's duty to inform patient of risks of proposed treatment, 52 A.L.R.3d 1084.

41-5-24. Maintenance of records.

The director shall maintain records of all proceedings before the medical review commission which shall include the nature of the acts or omissions complained of, a brief summary of the evidence presented, the decision of the panel and any majority or dissenting opinions filed. Such records shall not be made public and shall not be subject to subpoena but shall be used solely for the purpose of compiling statistical data and facilitating on-going studies of medical malpractice in New Mexico.

History: 1953 Comp., § 58-33-24, enacted by Laws 1976, ch. 2, § 24.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

41-5-25. Patient's compensation fund; third-party administrator; actuarial studies; surcharges; claims; proration; proofs of authenticity.

A. The "patient's compensation fund" is created as a nonreverting fund in the state treasury. The fund consists of money from surcharges, income from investment of the fund and any other money deposited to the credit of the fund. The fund shall be held in trust, deposited in a segregated account in the state treasury and invested by the state investment office and shall not become a part of or revert to the general fund or any other fund of the state. Money from the fund shall be expended only for the purposes of and to the extent provided in the Medical Malpractice Act. All approved expenses of collecting, protecting and administering the fund,

including purchasing insurance for the fund, shall be paid from the fund.

B. The superintendent shall contract for the administration and operation of the fund with a qualified, licensed third-party administrator, selected in consultation with the advisory board, no later than January 1, 2022. The third-party administrator shall provide an annual audit of the fund to the superintendent.

C. The superintendent, as custodian of the fund, and the third-party administrator shall be notified by the health care provider or the health care provider's insurer within thirty days of service on the health care provider of a complaint asserting a malpractice claim brought in a court in this state against the health care provider.

D. The superintendent shall levy an annual surcharge on all New Mexico health care providers qualifying under Section 41-5-5 NMSA 1978. The surcharge shall be determined by the superintendent with the advice of the advisory board and based on the annual independent actuarial study of the fund. The surcharges for health care providers, including hospitals and outpatient health care facilities whose qualifications for the fund end on January 1, 2027, shall be based on sound actuarial principles, using data obtained from New Mexico claims and loss experience. A hospital or outpatient health care facility seeking participation in the fund during the remaining qualifying years shall provide, at a minimum, the hospital's or outpatient health care facility's direct and indirect cost information as reported to the federal centers for medicare and medicaid services for all self-insured malpractice claims, including claims and paid loss detail, and the claims and paid loss detail from any professional liability insurance carriers for each hospital or outpatient health care facility and each employed health care provider for the past eight years to the third-party actuary. The same information shall be available to the advisory board for review, including financial information and data, and excluding individually identifying case information, which information shall not be subject to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. The superintendent, the third-party actuary or the advisory board shall not use or disclose the information for any purpose other than to fulfill the duties pursuant to this subsection.

E. The surcharge shall be collected on the same basis as premiums by each insurer from the health care provider. The surcharge shall be due and payable within thirty days after the premiums for malpractice liability insurance have been received by the insurer from the health care provider in New Mexico. If the surcharge is collected but not paid timely, the superintendent may suspend the certificate of authority of the insurer until the annual premium surcharge is paid.

F. Surcharges shall be set by October 31 of each year for the next calendar year. Beginning in 2021, the surcharges shall be set with the intention of bringing the fund to solvency with no projected deficit by December 31, 2026. All qualified and participating hospitals and outpatient health care facilities shall cure any fund deficit attributable to hospitals and outpatient health care facilities by December 31, 2026.

G. If the fund would be exhausted by payment of all claims allowed during a particular calendar year, then the amounts paid to each patient and other parties obtaining judgments shall be prorated, with each such party receiving an amount equal to the percentage the party's own payment schedule bears to the total of payment schedules outstanding and payable by the fund. Any amounts due and unpaid as a result of such proration shall be paid in the following calendar years.

H. Upon receipt of one of the proofs of authenticity listed in this subsection, reflecting a judgment for damages rendered pursuant to the Medical Malpractice Act, the superintendent shall issue or have issued warrants in accordance with the payment schedule constructed by the court and made a part of its final judgment. The only claim against the fund shall be a voucher or other appropriate request by the superintendent after the superintendent receives:

(1) until January 1, 2022, a certified copy of a final judgment in excess of two hundred thousand dollars (\$200,000) against a health care provider;

(2) until January 1, 2022, a certified copy of a court-approved settlement or certification of settlement made prior to initiating suit, signed by both parties, in excess of two hundred thousand dollars (\$200,000) against a health care provider; or

(3) until January 1, 2022, a certified copy of a final judgment less than two hundred thousand dollars (\$200,000) and an affidavit of a health care provider or its insurer attesting that payments made pursuant to Subsection B of Section 41-5-7 NMSA 1978, combined with the monetary recovery, exceed two hundred thousand dollars (\$200,000).

I. On or after January 1, 2022, the amounts specified in Paragraphs (1) through (3) of Subsection H of this section shall be two hundred fifty thousand dollars (\$250,000).

History: 1978 Comp., § 41-5-25, enacted by Laws 1992, ch. 33, § 9; 1997, ch. 109, § 1; 2021, ch. 16, § 13.

ANNOTATIONS

Repeals and reenactments. — Laws 1990, ch. 111, § 2 repealed former 41-5-25 NMSA 1978, as amended by Laws 1990, ch. 111, § 1, relating to patient's compensation fund, and enacted a new 41-5-25 NMSA 1978, effective July 1, 1991.

Laws 1990, ch. 111, § 3 repealed Laws 1989, ch. 324, § 43 which enacted 41-5-25 NMSA 1978 to become effective on July 1, 1990.

Laws 1991, ch. 264, § 9 repealed former 41-5-25 NMSA 1978, as amended by Laws 1991, ch. 264, § 8, and enacted a new 41-5-25 NMSA 1978, effective July 1, 1992.

Laws 1991, ch. 264, § 10 repealed former 41-5-25 NMSA 1978, as enacted by Laws 1991, ch. 264, § 9, and enacted a new 41-5-25 NMSA 1978, effective July 1, 1993.

Laws 1992, ch. 33, § 7 repealed former 41-5-25 NMSA 1978, as amended by Laws 1991, ch. 264, § 8, and as enacted by Laws 1991, ch. 264, § 10, and enacted a new section, effective April 1, 1992.

Laws 1992, ch. 33, § 8 repealed former 41-5-25 NMSA 1978, as enacted by Laws 1992, ch. 33, § 7, and enacted a new section, effective April 1, 1993.

Laws 1992, ch. 33, § 9 repealed former 41-5-25 NMSA 1978, as enacted by Laws 1992, ch. 33, § 8, and enacted a new section, effective April 1, 1994.

The 2021 amendment, effective July 1, 2021, provided the means of funding the patient's compensation fund, required the superintendent of insurance to contract for the administration

and operation of the fund with a qualified, licensed third-party administrator, required the third-party administrator to provide an annual audit of the fund to the superintendent of insurance, revised the procedures for determining the annual surcharge on qualifying New Mexico health care providers, provided that annual surcharges shall be set by October 31 of each year for the next calendar year, and provided that, after January 1, 2022, the superintendent of insurance must approve any settlement of a claim for more than two hundred fifty thousand dollars, up from two hundred thousand dollars prior to January 1, 2022; in the section heading, after "Patient's compensation fund", added "third-party administrator; actuarial studies; surcharges; claims; proration; proofs of authenticity"; in Subsection A, after "patient's compensation fund", deleted "to be collected and received by the superintendent for exclusive use for the purpose stated in the Medical Malpractice Act" and added "is created as a nonreverting fund in the state treasury. The fund consists of money from surcharges, income from investment of the fund and any other money deposited to the credit of the fund", after "invested", deleted "and reinvested by the superintendent with the prior approval of the state board of finance" and added "by the state investment office", and after "Medical Malpractice Act", deleted "The superintendent shall have the authority to use fund money to purchase insurance for the fund and its obligations" and added the remainder of the subsection; added a new Subsection B and redesignated former Subsection B as Subsection D; in Subsection C, after "fund", added "and the third-party administrator"; in Subsection D, after "The surcharge shall be determined by the superintendent", deleted "based upon sound actuarial principles, using data obtained from New Mexico experience if available" and added the remainder of the subsection; deleted former Subsection E; added a new Subsection F and redesignated former Subsections F and G as Subsections G and H, respectively; in Subsection H, Paragraphs H(1) through H(3), added "until January 1, 2022, and deleted former Subsection H, which related to the superintendent contracting for an independent actuarial study of the patient's compensation fund; and added Subsection I.

The 1997 amendment, effective June 20, 1997, added the third sentence in Subsection A.

Applicability. — Laws 1992, ch. 33, § 17, effective March 6, 1992, made the provisions of the act applicable only to occurrences arising on and after April 1, 1994.

Law reviews. — For article, "Medical Malpractice Legislation in New Mexico," see 7 N.M.L. Rev. 5 (1976-77).

41-5-25.1. Patient's compensation fund advisory board; created; membership; powers and duties.

A. The "patient's compensation fund advisory board" is created to advise the superintendent and the third-party administrator. The office of superintendent of insurance shall provide staff services to the advisory board. The advisory board shall be established by July 2, 2021.

B. The nine-member advisory board shall consist of:

- (1) two representatives from the New Mexico trial lawyers association;
- (2) two representatives of a statewide association representing hospitals;

- (3) two representatives of a statewide association representing physicians;
- (4) two patient or patient advocate representatives; and
- (5) one representative of a statewide association representing certified nurse practitioners.

C. Members of the advisory board shall be chosen annually by their organizations, as applicable, and the patient or patient advocate representatives shall be chosen by the chief justice of the supreme court from nominations made by the New Mexico trial lawyers association. Members of the advisory board are entitled to receive per diem and mileage pursuant to the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978], but shall receive no other compensation, perquisite or allowance.

D. The advisory board shall elect a chair and a vice chair. A majority of the members constitutes a quorum for the transaction of business. All decisions of the advisory board shall be by majority vote of the members present.

E. The advisory board shall convene at least twice a year or at the request of the superintendent to:

- (1) review the process and data for the setting of the surcharges for all qualified health care providers pursuant to the Medical Malpractice Act;
- (2) advise the superintendent concerning surcharge data accumulation and results;
- (3) advise the superintendent on the surcharges to be set by the superintendent; and
- (4) prepare an annual report to the legislature on the operations and financial condition of the fund no later than the first day of each year's legislative session.

History: 1978 Comp., § 41-5-25.1, enacted by [Laws 2021, ch. 16, § 14](#).

ANNOTATIONS

Effective dates. — [Laws 2021, ch. 16, § 18](#) made [Laws 2021, ch. 16, § 14](#) effective July 1, 2021.

41-5-26. Malpractice coverage.

A. The filing of proof of financial responsibility with the superintendent, as provided in Section [41-5-5](#) NMSA 1978, shall constitute a conclusive and unqualified acceptance of the provisions of the Medical Malpractice Act.

B. Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of the Medical Malpractice Act is void.

C. Every policy issued under the Medical Malpractice Act is deemed to include the following

provisions:

(1) the insurer assumes all obligations to pay an award imposed against its insured under the provisions of the Medical Malpractice Act; and

(2) any termination of a policy by an insurer shall not be effective unless written notice of such termination has been mailed by certified mail to both the insured and the superintendent at least ninety days prior to the date the cancellation is to become effective, except that an insurer may terminate a policy if a billed premium payment is thirty days past due upon ten days' prior written notice mailed by certified mail to the insured of the failure of the insured to pay premiums, and an insured may terminate his policy by written request to the insurer but the effective date of termination shall be not sooner than ten days after the receipt by the insurer of the written request to terminate. In all cases when a policy is terminated for failure of the insured to pay premiums or at the request of the insured, the insurer shall notify the superintendent in writing immediately of the effective date of termination of the policy. The insurer shall remain liable for all causes of action accruing prior to the effective date of the termination, unless otherwise barred by the provisions of the Medical Malpractice Act.

History: 1953 Comp., § 58-33-26, enacted by Laws 1976, ch. 2, § 26; 1977, ch. 284, § 4.

ANNOTATIONS

Emergency clauses. — Laws 1977, ch. 284, § 5 contained an emergency clause and was approved April 7, 1977.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers § 62.

Wrongful cancellation of medical malpractice insurance, 99 A.L.R.3d 469.

Propriety of hospital's conditioning physician's staff privileges on his carrying professional liability or malpractice insurance, 7 A.L.R.4th 1238.

Coverage and exclusions of liability or indemnity policy on physicians, surgeons, and other healers, 33 A.L.R.4th 14, 14 A.L.R.5th 695.

Health provider's agreement as to patient's copayment liability after award by professional service insurer as unfair trade practice under state law, 49 A.L.R.4th 1240.

Liability insurance: what is "claim" under deductibility-per-claim clause, 60 A.L.R.4th 983.

41-5-26.1. Birthing workforce retention fund created.

A. The "birthing workforce retention fund" is created in the state treasury. The purpose of the fund is to provide malpractice insurance premium assistance for certified nurse-midwives or physicians whose insurance premium costs jeopardize their ability to continue their obstetrics practices in New Mexico. The fund shall consist of appropriations, gifts, grants and donations to the fund. The fund shall be administered by the department of health, and money in the fund is appropriated to the department of health for the purpose of making awards pursuant to the

provisions of this section.

B. The department of health shall develop procedures and rules for the application for and award of money from the birthing workforce retention fund, including criteria upon which to evaluate the need of the applicant and the merits of the application. The rules shall require that the applicant be a certified nurse-midwife licensed in New Mexico or a physician licensed in New Mexico and that the applicant demonstrate need by showing that medicaid patients or indigent patients constitute at least one-half of the obstetric practice of the applicant. The certified nurse-midwife or physician shall have a malpractice liability insurance policy in force. Subject to availability of funds, an award shall not be less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000). An award shall be disbursed based on the percentage of medicaid patients or indigent patients seen in the practice and on the certified nurse-midwife's or the physician's intent to continue obstetrics practice in New Mexico during the period covered by the award. An award shall not be granted to provide premium assistance for tail coverage purchased upon practice termination. Priority for the awarding of money from the birthing workforce retention fund shall be in the following order:

- (1) to certified nurse-midwives; and
- (2) to family practice physicians and obstetricians.

C. The department of health shall annually report to the legislative finance committee on the status of the birthing workforce retention fund.

D. Disbursements from the birthing workforce retention fund shall be made by warrant of the department of finance and administration pursuant to vouchers signed by the secretary of health or the secretary's authorized representative. Any unexpended or unencumbered balance remaining in the fund at the end of a fiscal year shall not revert but shall remain to the credit of the fund.

E. As used in this section, "tail coverage" means insurance coverage providing an extended reporting period for any claims related to conduct that occurred during the period covered by a claims-based medical malpractice policy after it has expired or been canceled.

History: [Laws 2008, ch. 73, § 1](#); [2015, ch. 59, § 1](#).

ANNOTATIONS

The 2015 amendment, effective June 19, 2015, amended requirements for disbursement of money awards from the birthing workforce retention fund; in Subsection B, after "obstetric practice of the applicant", deleted "and that malpractice insurance premiums have increased every year for two years", after "(\$10,000)", deleted "and" and added "An award", and after "patients seen in the practice", added "and on the certified nurse-midwife's or the physician's intent to continue obstetrics practice in New Mexico during the period covered by the award. An award shall not be granted to provide premium assistance for tail coverage purchased upon practice termination."; and added Subsection E.

41-5-27. Report by district court clerks.

Within thirty days of entry of judgment, the clerk of the district court from which judgment issues shall forward the name of every health care provider against whom a judgment is rendered under the Medical Malpractice Act to the appropriate board of professional registration and examination for review of the fitness of the health care provider to practice his profession. In cases where judgments are entered against hospitals or other institutional health care providers, on the basis of respondeat superior or some other derivative theory of recovery, the clerk of the district court shall forward the name of the individual health care provider whose negligence caused the injury to that health care provider's board of professional registration and examination for such review. Review of the health care provider's fitness to practice shall be conducted in accordance with law.

History: 1953 Comp., § 58-33-27, enacted by Laws 1976, ch. 2, § 27.

ANNOTATIONS

Emergency clauses. — Laws 1976, ch. 2, § 32 contained an emergency clause and was approved February 27, 1976.

41-5-28. Payment of medical review commission expenses.

Unless otherwise provided by law, expenses incurred in carrying out the powers, duties and functions of the New Mexico medical review commission, including the salary of the director, shall be paid by the patient's compensation fund. The superintendent, in his capacity as custodian of the fund, shall disburse fund money to the director upon receipt of vouchers itemizing expenses incurred by the New Mexico medical review commission. The director shall supply the chief justice of the New Mexico supreme court with duplicates of all vouchers submitted to the superintendent. Expenses paid by the fund shall not exceed three hundred fifty thousand dollars (\$350,000) in any single calendar year; provided, however, that expenses incurred in defending the commission shall not be subject to that maximum amount.

History: 1953 Comp., § 58-33-28, enacted by Laws 1976, ch. 2, § 29; 1991, ch. 264, § 11; 1997, ch. 108, § 1.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, substituted "three hundred fifty thousand dollars (\$350,000)" for "two hundred fifty thousand dollars (\$250,000)" in the last sentence.

The 1991 amendment, effective July 1, 1991, substituted "two hundred fifty thousand dollars (\$250,000)" for "one hundred fifty thousand dollars (\$150,000)" in the final sentence; added the proviso at the end of the final sentence; and made minor stylistic changes throughout the section.

41-5-28. Payment of medical review commission expenses. (Effective January 1, 2022.)

Unless otherwise provided by law, expenses incurred in carrying out the powers, duties and functions of the New Mexico medical review commission, including the salary of the director of the commission, shall be paid by the fund. The superintendent, in the superintendent's capacity as custodian of the fund, shall disburse fund money to the director upon receipt of vouchers itemizing expenses incurred by the commission. The director shall supply the chief justice of the New Mexico supreme court with duplicates of all vouchers submitted to the superintendent. Expenses of the commission paid by the fund shall not exceed five hundred thousand dollars (\$500,000) in any single calendar year; provided, however, that expenses incurred in defending the commission shall not be subject to that maximum amount.

History: 1953 Comp., § 58-33-28, enacted by Laws 1976, ch. 2, § 29; 1991, ch. 264, § 11; 1997, ch. 108, § 1; 2021, ch. 16, § 15.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, increased the annual limit on commission expenses to five hundred thousand dollars from three hundred fifty thousand dollars; after "shall not exceed", changed "three hundred fifty thousand dollars (\$350,000)" to "five hundred thousand dollars (\$500,000)".

41-5-29. Reports.

On January 31 of each year, the superintendent shall, upon request, provide a written report to all interested persons of the following information:

- A. the beginning and ending calendar year balances in the patient's compensation fund;
- B. the total amount of contributions to the patient's compensation fund; and
- C. any other information regarding the patient's compensation fund that the superintendent considers to be important.

History: 1978 Comp., § 41-5-29, enacted by Laws 1992, ch. 33, § 10.

ANNOTATIONS

Applicability. — Laws 1992, ch. 33, § 17, effective March 6, 1992, made the provisions of the act applicable only to occurrences arising on and after April 1, 1994.

Severability . — Laws 1992, ch. 33, § 16, effective March 6, 1992, provided that if any part or application of the act is held invalid, the remainder or its application to other situations or persons shall not be affected.

41-5-29. Fund reports. (Effective January 1, 2022.)

On January 31 of each year, the superintendent shall, upon request, provide a written report to all interested persons of the following information:

A. the beginning and ending calendar year balances in the fund;

B. an itemized accounting of the total amount of contributions to the fund;

C. all information regarding closed claims files, including an itemized accounting of all payments paid out; and

D. any other information regarding the fund that the superintendent or the legislature considers to be important.

History: 1978 Comp., § 41-5-29, enacted by Laws 1992, ch. 33, § 10; 2021, ch. 16, § 16.

ANNOTATIONS

The 2021 amendment, effective January 1, 2022, required the superintendent, upon request, to provide an itemized accounting of the total contributions to the patient's compensation fund and to provide all information regarding closed claims files; in the section heading, added "Fund" preceding "reports; in Subsection B, added "an itemized accounting of"; added a new Subsection C and redesignated former Subsection C as Subsection D; and in Subsection D, after "superintendent", added "or the legislature".