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MEDICAL MALPRACTICE LEGISLATION
IN NEW MEXICO

RUTH L. KOVNAT*

Delivery of the benefits of health care at a cost acceptable to most persons in the United States is a particularly vexing social problem. Even though more than 8% of the Gross National Product is spent for health care\(^1\) and physicians' and hospital charges have escalated at a much greater rate than other items in the Consumer Price Index,\(^2\) there are significant quantitative and qualitative weaknesses in

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2. CONSUMER PRICE INDEX, U.S. AVERAGES FOR SELECTED ITEMS, 1970-75, AVERAGE ANNUAL INDEX (1967=100)

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<thead>
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<td>137.7</td>
<td>182.1</td>
<td>139.1</td>
<td>133.1</td>
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<td>1974</td>
<td>146.8</td>
<td>150.9</td>
<td>150.5</td>
<td>201.5</td>
<td>152.0</td>
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<tr>
<td>1975 (January to August average)</td>
<td>160.1</td>
<td>166.4</td>
<td>166.2</td>
<td>231.1</td>
<td>164.4</td>
<td>159.3</td>
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<tr>
<td>Percentage increase</td>
<td>150.5</td>
<td>201.4</td>
<td>209.5</td>
<td>662.7</td>
<td>180.1</td>
<td>120.9</td>
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the health services provided to the public. Dissatisfaction engendered by those weaknesses in respect both to quality of care and methods of bearing the costs of that care has caused consideration of a panoply of national health insurance proposals. However, unless and until one or several of these plans is adopted, health care in the United States will be provided largely by private physicians and hospitals. Payment of the direct costs of care will continue to be made by consumers of care and by a variety of third-party payers. One of

3. In 1975, for example, 5.3 million of 13.2 million preschool children were not immunized against polio, measles, rubella, diphtheria, whooping cough and tetanus and one-third of all pregnant women failed to receive pre-natal care. *Hearings: National Health Insurance, 1975 supra* at 55.


5. PROPORTION OF PERSONAL HEALTH CARE EXPENDITURES MET BY PRIVATE INSURANCE

From 1950 to 1973, private health insurance paid for an increasing proportion of total expenditures for personal health care. In that period health expenditures grew annually at an average rate of 9.4 percent while insurance benefits increased 14.3 percent. As a result, the share met by insurance grew from less than one-tenth in 1950 to over a fourth in 1973.

<table>
<thead>
<tr>
<th>Year</th>
<th>Personal health care expenditures</th>
<th>Private insurance benefits</th>
<th>Percent of expenditures</th>
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<tr>
<td></td>
<td>(in millions)</td>
<td>Amount (in millions)</td>
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<tr>
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<td>1960</td>
<td>23,680</td>
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<tr>
<td>1965</td>
<td>34,821</td>
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<td>1970</td>
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<td>1971</td>
<td>70,559</td>
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<tr>
<td>1972</td>
<td>78,052</td>
<td>19,526</td>
<td>25.0</td>
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<tr>
<td>1973</td>
<td>85,894</td>
<td>21,614</td>
<td>25.2</td>
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Average annual percentage increase

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<th>Percent</th>
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<td>1950-55</td>
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<td>1960-65</td>
<td>8.0</td>
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<td>1965-73</td>
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1 All expenditures for health services and supplies other than (1) expenses for prepayment and administration, (2) government public health activities, and (3) expenditures of private voluntary agencies for other health services.

the important mechanisms for regulation of the quality of health care will continue to be the civil action filed by a consumer of health care injured because of the negligence of the health care provider. And one of the costs of the present system of health care which will have to be better accounted for is the cost of its negligently inflicted injuries. Indeed it is the allocation of this real cost of medical care, which has precipitated the medical malpractice crisis.6

THE ELEMENTS OF A MEDICAL MALPRACTICE CRISIS

In 1976, the Legislature of New Mexico enacted the Medical Malpractice Act7 and the Professional Liability Fund Act8 in response to a widely-held perception that a medical malpractice crisis existed in the state. New Mexico was not alone in this perception. In 1975 and 1976, 45 states enacted some form of legislation to relieve the malpractice dilemma.9 The event which immediately triggered public concern in this state was the announced withdrawal, in 1975, of the Travelers Insurance Companies as the underwriter of the New Mexico Medical Society’s professional liability program.10 The Company’s withdrawal from the insurance market threatened providers of health care.

6. If viewed from this perspective, the medical malpractice crisis can be seen as only one facet of a complex social problem. Availability of health care depends on providing incentives to persons to furnish health services. Fees, among other things, ordinarily provide such incentives. Avoidance of liability in a negligence action may have some quality control impacts on the practitioner’s conduct; on the other hand, if the practitioner must bear the cost of his patient’s injury, there is a powerful disincentive to furnishing the service at all. If there are insufficient providers of health care, the quality of care declines. Until recently, costs of injuries were thought to be tolerable by both providers of health care and their liability insurance carriers. This was so because the tort system which allocated the costs of negligently inflicted injury left so much of the burden on the injured party himself. See text accompanying notes 22 to 58 infra. Consequently, the total cost of medical care has been imperfectly calculated to the extent that there has been no accounting for the costs of injuries which have not been shifted from the one injured to another. So long as this was the case, malpractice insurance premiums were paid by the practitioner with relatively minor complaint because the cost of the premium could be spread to patients through increased fees for services. The contributions of the insurance premium to the increased cost of medical service of course has been accounted for in the direct costs of delivery of medical care.

None of this is to suggest that the negligence action is the only available means of quality control. Peer review and professional standards are undoubtedly of greater significance. Nor is the fear of liability the most significant disincentive to furnishing medical services. High entry requirements to the medical profession combined with geographical maldistribution and the high cost of medical resources are the most important obstacles to adequate delivery of health care.

10. Correspondence between the Travelers Insurance companies and The New Mexico Medical Society on file at the office of the New Mexico Law Review.
care in New Mexico with a lack of protection against liability claims. Of at least equal importance, the withdrawal jeopardized the remedy of a patient suffering because of the negligent acts of such a health care provider even though his right to a remedy could be established employing ordinary negligence principles.

The attitude of the Travelers Insurance Companies was typical of the insurance industry. It was simply that there was no profit in writing medical liability insurance and that they would prefer to be out of the business altogether. The causes of that attitude have been analyzed elsewhere. In summary, they are:

1. *Increase in frequency of claims.* Blame for this increase has often been laid on the legal profession and its practice of undertaking representation of malpractice claims on a contingency fee basis. This is so even though a study of the increase of malpractice litigation concluded that the majority of malpractice claims are justified and that unjustified claims were effectively screened by plaintiffs' attorneys.

The insurance industry also blamed the increase in frequency of claims on increasing judicial receptivity to loosening traditional common law principles which were effective obstacles to plaintiff's ability to reduce a claim to judgment.

2. *Increase in size of verdicts.* The insurance industry's explanation for this phenomenon is that courts have permitted plaintiffs' cases to be increasingly decided by juries. They have accomplished this by classifying more medical malpractice cases as those to which the doctrine of res ipsa loquitur properly applies, thus permitting the
plaintiff to get to a jury on the issue of negligence without the need for experts.  

Insurance companies and medical practitioners are also critical of large pain and suffering awards which are based on nebulous standards.

3. Actuarial difficulties. The insurance industry suspects the credibility of the data which is available for its premium determination. In a given state, there are only a relatively few physicians who form the base rate. The vast majority of claims are filed against practitioners in certain specialties and the numbers of health care providers in these fields is too small to provide a sufficient actuarial base for accurate premium determination. Furthermore, since most medical malpractice coverage protects the practitioner against any claims owing out of negligent acts performed during the policy period, volatility in numbers and sizes of claims prejudice the integrity of the insurance plan. The premium rate is based on historical trends, but these are not valid in a rapidly changing market. Because it takes time to discover claims and settle them, the premium rate designed to cover the claim is inadequate. It is very difficult to predict what the ultimate losses from a particular period of coverage are.

From what has been said, it is apparent that many of the objections of the insurance industry to continuing in the business of writing medical malpractice insurance could be met by legislation modifying the operation of the underlying tort rules for allocating losses. In New Mexico and elsewhere, the industry and organized medicine thus turned to the task of lobbying for the desired legislation. This happened even though the judicial lowering of the common law barriers to successful prosecution of malpractice claims

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17. See text accompanying notes 39-43 infra.
19. The highest risk physicians are ordinarily those who practice in the surgical specialties. The lowest risk physicians are those who practice administrative medicine and psychiatry, so long as they do not perform electro-shock therapy. See New Mexico Medical Society Physicians and Surgeons Professional Liability Rates, on file at the office of the New Mexico Law Review.
21. The interest of the New Mexico Medical Society in getting restrictions on malpractice actions embedded in legislation lay in its plans to form its own medical liability insurance company to cover its membership. The medical society insurance company would thus have the benefit of the protective legislation. See 1975 Interim Report of the Ad Hoc Committee to Study Liability Insurance of the New Mexico Medical Society [hereinafter 1975 Interim Report], on file at the offices of the New Mexico Law Review.
which had arguably taken place in other states had not taken place in New Mexico.\textsuperscript{22}

\textbf{BEFORE 1976: MEDICAL MALPRACTICE IN NEW MEXICO}

The pre-1972 development of the common law of malpractice in New Mexico has already been described ably in this law review.\textsuperscript{23} To understand fully the setting in which the Medical Malpractice Act was adopted, an updating of the common law is in order.

\textit{Standard of Care}

In \textit{Cervantes v. Forbis},\textsuperscript{24} the supreme court was presented with a summary judgment for defendant orthopedic surgeons. Plaintiff alleged negligent treatment of a broken right femur, and on opposing the motion for summary judgment specifically relied on defendants' description of a surgical procedure during which a pin designed to connect and properly align bone fragments protruded from the patient's leg requiring a new incision for proper placement. Plaintiff offered no other evidence. Defendants offered in support of their motion for summary judgment only their own opinions that treatment given did not depart from medical standards in the community. Plaintiff argued in response that the facts stated gave rise to a permissible inference of negligence, either because they are within common knowledge of laymen or because the doctrine of res ipsa loquitur obviates the necessity of additional proof to establish a prima facie case.

In affirming the summary judgment for defendants, the court stated the general rule that to establish a physician's negligence in the treatment of his patient, the plaintiff must, unless exceptional circumstances are present, show, by expert testimony, that the defendant departed from recognized standards of medical practice in the community. Absent production of such testimony, there is no issue of fact for the jury and summary judgment for defendants is proper.

The requirement that the standard of care applicable to a physician's conduct, the breach of the standard and the causal connection between them be established by experts has been reiterated by the court\textsuperscript{25} and has been incorporated into Uniform Jury Instructions.\textsuperscript{26} Because a plaintiff may experience difficulty in obtain-

\textsuperscript{22} See text accompanying notes 24-63 infra.
\textsuperscript{23} Roehl, \textit{The Law of Medical Malpractice in New Mexico}, 3 N.M.L. Rev. 294 (1973).
\textsuperscript{24} 73 N.M. 445, 389 P.2d 210 (1964).
\textsuperscript{26} N.M.U.J.I. 8.1:
In (treating) (operating upon) (making a diagnosis of) the plaintiff, the doctor
ing expert witnesses, this requirement is a substantial barrier to successful prosecution of a malpractice claim.\(^7\)

Despite the clear enunciation of this rule, in 1976 the court of appeals reversed a motion for summary judgment for defendants in *Lucero v. Albuquerque Anesthesia Services.*\(^8\) Plaintiff alleged that defendant anesthesiologist negligently administered anesthesia in that his hand had not been anesthetized and further that his lung had been punctured. Plaintiff established that his lung was punctured and that the anesthetic did not take effect, but did not offer expert evidence to establish the applicable standard of care and the way in which defendant had breached it. In support of his motion for summary judgment, defendant offered affidavits strikingly similar to those offered by defendants in *Cervantes.* He stated, among other things, that he complied with the standards common to similar practitioners in the Albuquerque community. His statements were confirmed by the affidavit of another anesthetist. The court focused on the burden of the movant for summary judgment. It ruled that defendant had failed to make a prima facie showing that no genuine issue of material fact existed because he had failed to show the specific ways in which the ineffective anesthesia and lung puncture fell below the required standard of care.\(^9\) Although the court specifically stated that it did not depart from the general rule that plaintiff must show by experts that the result occurred because the physician failed to meet the applicable standard, the consequence of its holding would have been that defendants must prepare for a full trial. The supreme court reversed the court of appeals without opinion, and reinstated the district court’s summary judgment for defendants, presumably on the basis of *Cervantes.*\(^0\)

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27. See Markus, *Conspiracy of Silence,* 14 Clev.-Mar. L. Rev. 520 (1965). Also see Medical Economics, Aug. 28, 1961 where it was reported that out of 214 physicians only 27% of general practitioners and 31% of specialists would appear on behalf of plaintiff where a surgeon removed the wrong kidney.


29. The court of appeals relied heavily on Smith v. Klebanoff, 84 N.M. 50, 499 P.2d 368 (Ct. App. 1972), cert. denied, 84 N.M. 37, 499 P.2d 355 (1972), to reach this result. In *Smith,* defendants supported their motion for summary judgment with affidavits specifically explaining that the injury is an inherent danger of the surgical procedure because of anatomic proximity of the injured part to the part of the body on which the surgery was performed. The court ruled that this showing satisfied their burden of showing that no genuine issue of material fact existed. Plaintiff offered an affidavit of an expert which did not give a satisfactory explanation as to how the expert arrived at the opinion that defendants’ conduct breached standards of medical practice. It was held that plaintiff’s offering did not rebut defendant’s specific offering. Summary judgment for defendants was affirmed. Plaintiff was unable to avoid adverse summary disposition even though he had an expert.

30. As yet unreported.
The Locality Rule

The plaintiff's difficulty in obtaining experts to testify on his behalf is compounded if it is necessary that the experts be from the same community as that of the defendant physician. Nevertheless, that is the prevailing common law rule in New Mexico. In an early case, expert testimony of physicians who were from Albuquerque was permitted to support plaintiff's claim of negligence against a Los Alamos physician. The alleged negligence took place in the administration of morphine. The court concluded that the standard of care and skill required of physicians in administering morphine is the same in Albuquerque and Los Alamos and thus ruled that the experts were competent. Despite that precedent and even though the Uniform Jury Instruction adopted and approved by the supreme court merely requires a physician to exercise skill "giving due consideration to the locality involved," the court of appeals has recently retained the "strict locality rule" which it believed to be demanded by Cervantes. In Gandara v. Wilson, the court ruled that evidence offered by an El Paso, Texas, expert was incompetent as to alleged negligent conduct of defendant in Silver City, New Mexico.

Situations Where Experts Are Not Required to Establish Plaintiff's Malpractice Claim

The Cervantes court recognized two classes of cases in which plaintiff could present an issue of fact for the jury even though he lacked expert witnesses. If exceptional circumstances within the common knowledge of laymen are present or if the case is one where the res ipsa loquitur rule is applicable, plaintiff may get to the jury without expert evidence. We turn now to consider the scope of these exceptions in New Mexico.

A. Exceptional Circumstances

In only one case, Mascarenes v. Gonzales, has an appellate court

34. Cervantes v. Forbes, 73 N.M. 445, 448, 389 P.2d 210, 213 (1964). The Cervantes standard is: "Before a physician or surgeon can be held liable for malpractice in the treatment of his patient, he must have departed from the recognized standards of medical practice in the community, or must have neglected to do something required by those standards" (emphasis added).
agreed that lay evidence was sufficient to support a verdict for a patient. The court did so on the grounds that where the negligence is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required. The facts demonstrated by plaintiff were: when defendant chiropractor massaged her back, she felt a crack or pop and experienced great pain; a physician who examined her after this episode testified that she was in acute distress, but x-rays did not reveal any fracture; a radiologist who took another set of x-rays about a week later testified that four of the plaintiff's ribs were fractured and that the fracture had been sustained within two weeks. The only evidence on plaintiff's behalf with respect to the standard of care required by chiropractors and defendant's breach was adduced by calling him as an adverse witness. He testified as follows:

Q. Alright, would you say, Doctor, that under the practice by reasonable prudent chiropractors in the State of New Mexico, that it is not possible to fracture a rib in the manner described by plaintiff's exhibits nos. 1 through 3?  
A. That is correct.  
Q. Alright, so that if a rib is fractured, something unusual must have happened, is that correct?  
A. Very unusual.  

The court characterized a spine manipulation resulting in broken ribs as one not peculiarly within the knowledge of medical men and so appropriately resolved by a jury without resort to experts. It is frankly difficult to ascertain the extraordinary circumstances which exist here to take it out of the ordinary rule. It is tempting to conclude that the court altered the standard because the defendant was a chiropractor and not a physician or surgeon, even though the court paid lip service to the notion that rules governing the establishment of negligence were the same for chiropractors as for physicians and surgeons.

B. Res Ipsa Loquitur

In some states, notably California, an expanded version of res ipsa loquitur has been accepted, largely to counteract the difficulty a plaintiff has in obtaining expert evidence.

The notion that "an injury speaks for itself" and thus expert witnesses are not necessary to establish plaintiff's prima facie case in

38. Id. at 752, 497 P.2d at 254.  
a medical malpractice action has not been received hospitably by the New Mexico courts. In Buchanan v. Downing the supreme court affirmed a summary judgment for defendant. Defendant administered an injection to plaintiff. The injection site immediately reddened. After suffering an open wound at the site of the injection for some time, plaintiff ultimately had to undergo a skin graft. In opposition to defendant's motion for summary judgment, plaintiff offered no evidence of any expert witness supporting his allegation of negligence, but relied on the statement of one of defendant's expert witnesses. The statement was, "This is not a natural reaction to such an injection."\(^4\)

Plaintiff contended that this is a sufficient showing that the accident would not have happened had it not been for defendant's negligence.\(^4\) The court rejected plaintiff's argument and insisted that experts are necessary to establish negligence even as to a matter so familiar to lay people as the administration of an injection. The court expressly declined to follow the California line of cases because they are too sweeping and place too great a burden on a defendant doctor.\(^4\)

**Informed Consent**

When the gist of a patient's complaint is that a provider of health care undertook a therapy without disclosing fully the risks of the procedure, the alleged wrong is failure to obtain "informed consent."\(^4\) Consent obtained without adequate disclosure was considered to be ineffective and early cases held that an action of battery would lie where consent was obtained under such circumstances.\(^4\) More recently, courts have held that whether or not the

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40. 74 N.M. 423, 394 P.2d 269 (1964).
41. *Id.* at 425, 394 P.2d at 271.
42. [F] or the res ipsa loquitur doctrine to apply these elements must exist: (1) that the action be of the kind which ordinarily does not occur in the absence of someone's negligence; (2) that it must be caused by an agency or instrumentality within exclusive control and management of the defendant. Tafoya v. Las Cruces Coca-Cola Bottling Co., 59 N.M. 43, 278 P.2d 575, 578 (1955).
45. See, e.g., Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905), *overruled on other grounds*, Genzel v. Halverson, 248 Minn. 527, 80 N.W.2d 854 (1957); Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105
physician’s failure to disclose particular risks is wrongful is a question of negligence, not battery, and expert testimony is necessary to establish the duty to disclose. An intermediate position is that the failure of a health care provider to disclose risks is negligence, but that plaintiff need not furnish expert testimony to make out the prima facie case. It is this position which had been accepted in New Mexico as early as 1962 in Woods v. Brumlop. The clear holding in that case, is that absent special circumstances, failure to disclose constitutes malpractice and presents a fact issue for determination by the jury without the need for expert testimony. However, this has been substantially muddied by the recent case Demers v. Gerety.

In Demers, the court of appeals affirmed a judgment entered upon a jury verdict for plaintiff. Plaintiff was 40 years old with a sixth-grade education. His native language was French and he spoke only broken English. He consulted defendant because of a lump, diagnosed as a ventral hernia, located some distance away from the site of an ileostomy which had been performed earlier by another surgeon. During the examination plaintiff stated that if repair of the hernia involved surgery on the ileostomy, he did not want defendant to do it. Defendant agreed not to touch the ileostomy. Plaintiff signed a consent form which described the operation as “repair of ventral hernia.” A second consent form was signed by plaintiff describing the operation as “repair of ventral hernia and revision of ileostomy and repair of hydrocele.” Plaintiff did not recall signing the second form, but testified that he was awakened by a nurse after having been given sleeping medication and asked to sign something in the dark. The court held that the jury found that plaintiff was not competent when he signed the consent, that the consent was ineffective, and that the defendant lacked authority to perform the surgery. He is therefore liable for all damages proximately caused by the procedures he performed. The supreme court granted defendant’s


petition for certiorari and reversed on a procedural ground. On remand, the court of appeals reversed and remanded for a new trial, stating that in malpractice cases, the burden of proof rests on the plaintiff and that "inadequate disclosure" cases are not exceptions to this rule. It relied on two cases which had held that expert testimony is required to establish inadequate disclosure, and on one case which distinguished the situation where no disclosure had been made from one where some disclosures had been made. Whether a physician has advised his patient of risks is a question of fact concerning which lay witnesses are competent to testify and the establishment of which is not dependent on expert testimony. On the other hand, the inadequacy of actual disclosures must be established by expert testimony of medical witnesses showing that such disclosures are not in accordance with those a reasonable medical practitioner would make under the same or similar circumstances.

After Demers, it is unclear in New Mexico whether plaintiff requires expert testimony to establish either the fact of non-disclosure or the inadequacy of disclosure. The action of the court of appeals in remanding for a new trial suggests some backing off from the standard articulated in Woods even where the question is whether or not any disclosure had been made. In any event it is clear that the common law doctrine of informed consent is not an expansive one in New Mexico. It is surely not a panacea for plaintiff's difficulty in obtaining expert witnesses.

Statute of Limitations

The common law of New Mexico with respect to the statute of limitations has already been set out in this Law Review. It is sufficient to say that the rule articulated in Roybal v. White that in medical malpractice action the statute of limitations starts to run

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50. 86 N.M. 144, 520 P.2d 869 (1974).
53. See text accompanying note 48 supra.
from the date of the defendant's wrongful act and not from the date of the discovery of the injury is still the law. The "long tail" problem of the insurance industry is largely attributable to the acceptance of the view, in other jurisdictions, that the statute of limitations does not start to run until plaintiff has discovered his injury.

THE MEDICAL MALPRACTICE ACT

Despite the judicial inhospitality in New Mexico to reducing the plaintiff's burden of establishing a malpractice claim, legislation was sought to assure that the judiciary be disabled from so doing. We turn now to an evaluation of the Act and its impact on malpractice claims. The objectives of the New Mexico Medical Society were summarized: to define the standard of care in terms of the recognized standards of medical practice in the locality, to restrict actions based on lack of informed consent, to require that contracts assuring results to be obtained from health care procedures be

57. See text accompanying note 20 supra.
60. The Medical Malpractice Act of 1976 contains no such restriction, but a restriction on claims based on lack of consent was included in Section 4 of N.M. House Bill 29, 32d Legis., 2d Sess. (1976).

Section 4. CONSENT TO TREATMENT—The right to recover based on an alleged failure by a health care provider to disclose to the patient the alternatives to the professional treatment provided and the reasonably foreseeable risks and benefits involved, as a reasonable medical practitioner under similar circumstances would have disclosed the same, is limited to those instances involving either: non-emergency treatment, procedure or surgery; or a procedure which involves invasion or disruption of the integrity of the body.

For a cause of action therefor it must also be established that a reasonably prudent person in the patient's position would not have undergone the treatment if he had been fully informed.

It shall be a defense to any malpractice claim based on an alleged failure to obtain an informed consent that:

A. the risk not disclosed is too commonly known to warrant disclosure; or
B. the patient assured the health care provider he would undergo the treatment, procedure, or diagnosis regardless of the risk involved, or the patient indicated to the health care provider that he did not want to be informed of the matters to which he was entitled to be informed; or
C. consent by or on behalf of the patient was not reasonably possible; or
D. the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which such alternatives or risks were disclosed to the patient because it reasonably believed that the manner and extent of such disclosure could be expected to adversely and substantially affect the patient's condition.
in writing,61 to prohibit the ad damnum clause, to limit recovery, to establish a medical review commission,62 to establish limitation periods in individual malpractice actions, and to establish the qualifications of health care providers under the Act.63

An Analysis of the Act's Provisions

A. Standard of Care

A "malpractice" claim is defined as any cause of action 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.64 Apart from that definition of a malpractice claim, the Medical Malpractice Act is silent with respect to the appropriate standard of care in medical malpractice cases. Proposed legislation65 defined malpractice as a departure from the recognized standards of medical practice in the locality or community. If that language had been enacted, adherence to the rule that malpractice must be established by experts in the community would undoubtedly have been demanded by ordinary rules of statutory construction. As it now stands, there is nothing in the Medical Malpractice Act which should be construed to limit common law development on matters relating to the proper standard of care governing the conduct of health care providers.

61. This section was also lost in the process of enactment. N.M. House Bill 29, 32d Legis., 2d Sess. (1976).

62. Such a panel was already in existence and resort to it could be held on a voluntary basis. Note, The New Mexico Medical-Legal Malpractice Panel—An Analysis, 3 N.M.L. Rev. 311 (1973).

63. It is interesting to note that some available legislative approaches to remedy the malpractice problem were not considered fully in New Mexico. Among them are: (1) fixed attorney's fees (Apparently it was thought that this could be accomplished by Supreme Court rule. See 1975 Interim Report supra note 21); (2) elimination of the collateral source rule (See 1976 Report of the Special Advisory Panel on Medical Malpractice, State of New York at 39); (3) procedural alternatives to litigation such as arbitration. Furthermore, there seems to have been no attempt to use the "crisis" as an opportunity to move for "no-fault" legislation (See generally, J. O'Connell & R. C. Henderson, Tort Law, No-Fault and Beyond (1975). See also, J. O'Connell, Ending Insult to Injury, No-Fault Insurance for Products and Services (1975); Havighurst & Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Insurance, 1974 Ins. L. J. 69; Keeton, Compensation for Medical Accidents, 121 U. Pa. L. Rev. 590 (1973).


65. See Discussion Drafts of An Act Concerning Medical Malpractice Insurance, on file at the offices of the New Mexico Law Review.
providers and the means of establishing such standards. The courts are thus free to develop rules which may permit in some cases that standards be established by lay testimony or by experts from a different locality. Neither is modification of the ordinary rule that the doctrine of res ipsa loquitur does not apply to medical malpractice cases foreclosed by the statute.

B. The Ad Damnum Clause

"No dollar amount or figure shall be included in the demand in any complaint in a malpractice claim, but the request shall be for such damages as are reasonable." Although it is clear that elimination of a dollar amount in an ad damnum clause does not alter the amount of damages to which a plaintiff is entitled, and thus has no limiting effects on plaintiff's recovery, elimination of the clause has been of considerable importance to the medical profession. Because plaintiffs are free to allege any amount of damages they choose, frequently very high amounts are alleged even though they cannot be proved. The alleged figure may be picked up by the news media and exaggerate the adverse publicity to which a provider of health care is exposed. It is for this reason that dollar amounts stated in ad damnum clauses are a special irritant to the medical profession and the elimination of them is a feature of virtually every substantive malpractice act recently enacted.

C. Limitation of Recovery

"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 may not exceed $500,000 per occurrence." Obviously, the most direct method of holding down the costs of malpractice claims experienced by health care providers and their insurance carriers is by imposing a limit on recovery, and provisions like New Mexico's are prominent characteristics of all the legislative responses

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66. See text accompanying notes 24-29 infra. See also text accompanying note 37 infra.
67. See text accompanying notes 31-35 infra.
68. See text accompanying notes 39-43 infra.
70. Plaintiff is entitled to the damages supported by the evidence. Only in the case of a default judgment is a plaintiff limited to the amount of damages stated in the complaint. See N.M. R. Civ. P. 54(c), F.R. Civ. P. 54(c). Otherwise, amendments to ad damnum clauses shall be freely granted. See N.M.R. Civ. P. 15, F.R. Civ. P. 15.
72. See Appendix V: Selected Provisions, State Malpractice Legislation.
to the malpractice crisis.\textsuperscript{74} Because limitations on recovery also have the most dramatic impacts on the value of a plaintiff's claim, challenges to the provision ought to be expected. Possible challenges to such limitations of recovery are based on a variety of state and federal constitutional grounds.\textsuperscript{75}

As an example, in 1975 Illinois enacted legislation which limited the maximum amount recoverable "on account of injuries by reason of medical, hospital or other healing art malpractice"\textsuperscript{76} to $500,000. The provision has been successfully challenged in \textit{Wright v. Central Du Page Hospital Association}.\textsuperscript{77} In that case, plaintiff sought to recover damages from a hospital and physicians for injuries suffered while he was confined to defendant hospital as a patient of defendant physician. In his complaint he sought a declaratory judgment that the statutory limitation on recovery conflicted with a state constitutional provision which prohibited special legislation,\textsuperscript{78} and was a denial of equal protection guaranteed by the fourteenth amendment and the state constitution. The Supreme Court of Illinois affirmed a judgment of the court below and held that legislation which limits recovery only in malpractice actions to $500,000 is arbitrary and constitutes a special law in violation of section 13 of article IV of the Illinois Constitution.\textsuperscript{79}

Plaintiff's principal argument was that the clause unreasonably discriminated against the most seriously injured victims of medical malpractice by limiting their recovery but did not so limit the recoveries of persons who were only moderately injured. The evil of the classification is in imposing the burden of malpractice insurance premiums saved by virtue of the limitation on the most seriously injured victims of the health care delivery system by making them bear their own losses above $500,000. Others similarly situated except that their injuries are less severe are able to shift their losses

\textsuperscript{74} See Appendix V: Selected Provisions of State Malpractice Legislation.

\textsuperscript{75} It may be contended that limiting a common-law right without providing a substitute violates the 14th Amendment due process clause of the United States Constitution, or the guarantee-of-a-remedy provision or the due process clause of a state constitution. It may also be argued that limitations of liability create impermissible classifications between those with provable injuries above the limitation and those below or between victims of the wrongful conduct of health care providers as opposed to victims of all other wrongfully inflicted injuries, all in violation of equal protection guarantees. See \textit{Graley v. Satayatham}, 74 Ohio Op.2d 316, 343 N.E.2d 832 (Ct. C.P. 1976) where limitation of recovery provision held to conflict with Ohio Constitutional provision, Ohio Const. art. IV, \textsection{5(D) which nullifies all laws in conflict with Rules of Civil Procedure. Held: Civil Rules \textsection{8(A), 11, and 54(c) prevail over the limitation of recovery provision in Ohio Revised Code \textsection{2307.43.}

\textsuperscript{76} Ill. Stat. Ann. ch. 70, \textsection{101 (Smith-Hurd Supp. 1976).}

\textsuperscript{77} 63 Ill.2d 313, 347 N.E.2d 736 (1976).

\textsuperscript{78} Ill. Const. art. IV, \textsection{13.}

\textsuperscript{79} 63 Ill.2d at \textsection{743, 347 N.E.2d at 743.}
completely. The court was singularly unimpressed with defendants’ arguments in support of the clause which analogized the limitations of recovery in the malpractice act to limitations of recovery in wrongful death and dram shop Acts. Since at common law neither a wrongful death nor dram shop action was available, a limitation on the amount of recovery is proper. The legislature has power to limit a remedy on a right which it creates. Similarly, the court rejected as precedent the Workmen’s Compensation Act because it provides a statutory remedy in exchange for the negligence action an employee might have against his employer, whereas the Malpractice Act does not. The court was unwilling to find that the lower insurance premiums and therefore lower costs of medical care for all recipients was a sufficient quid pro quo to justify limiting the recovery of the most seriously injured of medical malpractice victims.

The Idaho limitation of recovery provision has also been challenged. The Supreme Court of Idaho, however, upheld the constitutionality of its statute as against a contention that it contravened article I, section 18 of the state constitution which provides that “courts of justice shall be open to every person, and a speedy remedy afforded for every injury of person, property or character.” It found nothing in that constitutional provision which constrained the legislature from modifying the common law. As against the attack that the limitation of recovery created a discriminatory classification, the court found inadequacies in the factual record and remanded the case for additional evidence, findings, and conclusions.

In addition to imposing an absolute limit on recovery except for punitive damages and medical care and related benefits, the New Mexico Act provides for a relatively detailed judicial procedure to implement the limitation. It prohibits an instruction to the jury on the limitation. If the jury returns a malpractice award in excess of $500,000 it requires that the jury be given a special interrogatory asking the value of accrued medical care and related benefits. Only if the special interrogatory shows that the value of the accrued medical care and related benefits equals or exceeds the amount of the jury award, may the court enter judgment thereon. Otherwise,
the court must reduce the jury award by the difference. Furthermore, future medical expenses shall not be part of the award. In all malpractice claims where liability is established, the jury shall find whether the plaintiff is in need of future medical care without inquiring into the value of the service. Indeed the statute provides that evidence is not admissible on the issue. If a plaintiff is found to need future care, it shall be furnished without regard to the $500,000 limitation, by the defendant health care provider, and the statute confers continuing jurisdiction to supervise the furnishing of future medical care in such cases.

Separation of Powers

The facially apparent problem in the legislative scheme is the conflict between the legislative and judicial departments of state government. The New Mexico Constitution divides the powers of the government into three distinct departments and prohibits any person or persons charged with the exercise of powers properly belonging to one of these departments from exercising any power belonging to either of the others unless expressly permitted in the constitution. The constitution specifically bars the legislature from passing special laws regarding the practice in courts of justice or changing the rules of evidence in any trial or inquiry. It also specifically grants to the supreme court superintending control over all inferior courts.

As early as 1936, in State v. Roy, the court held the power to promulgate rules regulating pleading, practice and procedure for the district courts ought to be taken as committed solely to the supreme court to avoid confusion in the methods of procedure and to provide uniform rules of pleading and practice. In Roy, there was no conflict

87. Id. As an example if the jury returns a verdict of $575,000, but finds that the value of the accrued medical benefits is only $45,000, the jury award must be reduced to $545,000.
88. Id.
90. Id., § 58-33-7C. The health care provider is himself liable only up to a total of $100,000. Payments in excess are to be made by the patient’s compensation fund, also established by the Act. N.M. Stat. Ann. § 58-33-25 (Inter. Supp. 1976).
92. N.M. Const. art. III, § 1. Such express constitutionally granted powers of the legislature are in e.g., N.M. Const. art. VI, § 16 (legislature may increase number of district judges in any judicial district); N.M. Const. art. VI, § 17 (legislature shall provide for compensation of judges of district court); N.M. Const. art. VI, § 13 & § 23 (jurisdiction of district and probate courts).
93. N.M. Const. art. IV, § 24.
94. N.M. Const. art. VI, § 3.
95. 40 N.M. 397, 60 P.2d 646 (1936).
between any rule promulgated by the court and any law enacted by
the legislature. But in *Southwest Underwriters v. Montoya*, the
court found a conflict between Rule of Civil Procedure 41(e) which
required dismissal of civil cases with prejudice in two years if plain-
tiff failed to take any action to bring the case to determination and a
statute which extended such time to three years. It held that the
legislative act infringed on the court's exercise of its constitutional
duties in that it purported to direct a change of judicial procedure.

In 1976, this view was reaffirmed in *Ammerman v. Hubbard Broadcast-
ing, Inc.* which held that a statute designed to protect confidential
sources of newsmen from disclosure in a judicial proceeding is
not binding on a court. It found that the statute created a testi-
monial privilege in conflict with Rule 501 of the New Mexico Rules
of Evidence, and since the legislature lacks constitutional power to
prescribe rules of evidence and procedure, the privilege created by
statute is unconstitutional.

An examination of the limitations of recovery provision in the
Medical Malpractice Act and the procedure outlined for its im-
plementation reveal a number of conflicts with Rule 54(c) which
provides that every final judgment shall grant the relief to which the
party in whose favor it is rendered is entitled. The relief to which a
party is entitled is that relief supported by the evidence. Rule
15(b)' affirms that policy of the rules in that it provides that
issues tried with consent are to be treated as if they were raised by
the pleadings and even if the evidence is objected to, the court may
still permit amendment when the presentation of the merits will be
advanced and the opposing party suffers no prejudice thereby. To
the extent that the limitation prevents a person from recovering his
full relief when he can show damages in excess of $500,000 exclusive
of future medical care, the legislature has intruded into an area with-
in the judicial power of the courts.

The statutory prohibition against instructing the jury on the
limitation flies directly in the face of Rule of Civil Procedure 51(a)
which requires the court to instruct the jury regarding the law ap-

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100. N.M. R. Civ. P. 15(b).
101. A person with high earning capacity who is seriously and permanently injured while
relatively young would not find it difficult to show impairment of earning capacity and pain
and suffering in excess of $500,000.
licable to the facts in the cause unless such instructions be waived.\footnote{102} In promulgating Rule 49,\footnote{103} the supreme court seems to have fully exercised its superintending power over the inferior courts in respect to the relationship between a jury finding on a special interrogatory and its general verdict.\footnote{104} The Malpractice Act imposes a different mandate on the district court than does Rule 49. It defines as inconsistent a general verdict which is in excess of $500,000 by more than the value of accrued medical benefits. It then requires the court to preserve the $500,000 limitation. Because the Act requires the court to engage in a procedure other than the procedure required by Rule 49, the danger of non-uniform rules of practice governing the courts envisioned by the supreme court in \textit{State v. Roy}\footnote{105} is manifest.

The provision of the Act dealing with future medical care also seems to intrude on areas fully committed to the supreme court’s superintending power over inferior courts. The statute prohibits the admission of evidence on the value of future medical care and related benefits.\footnote{106} Rule 43 provides that all evidence shall be admitted which is admissible under the statutes on the rules of evidence, and in any case, the statute or rule which favors the reception of the evidence governs.\footnote{107}

Although it seems clear that the legislature has the constitutional power to alter the jurisdiction of the district courts,\footnote{108} its attempt in the Malpractice Act to establish the burdens of proof applicable to showing either an increase or decrease in the patient’s need for future medical care\footnote{109} also seems to encroach on traditional judicial powers.\footnote{110}

\footnote{102}{\textit{See} Britton v. Boulden, 87 N.M. 474, 535 P.2d 1325 (1975). Error in instructions on question of damages is not reversible when jury resolves question of liability in favor of defendant. By implication failure to instruct on damages where jury must reach the question is reversible error.}

\footnote{103}{N.M. R. Civ. P. 49.}

\footnote{104}{\textit{Id.} When the special finding of facts is inconsistent with the general verdict, the former shall control the latter, and the court shall give judgment accordingly.}

\footnote{105}{40 N.M. 397, 608 P.2d 646 (1936).}


\footnote{107}{N.M. R. Civ. P. 43(a).}

\footnote{108}{N.M. Const. art. VI, § 13.}


\footnote{110}{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.}

\footnote{110}{\textit{See, e.g.,} N.M. R. Civ. P. 8(c) where traditional affirmative defenses are enumerated.}
**Equal Protection and Due Process**

Like the Federal Constitution, the New Mexico Constitution guarantees equal protection and due process of laws.\(^{111}\) It also prohibits special legislation.\(^{112}\) Since the sorts of classifications prohibited by equal protection considerations are also those which make legislation special,\(^{113}\) it is useful to consider these together.

The Medical Malpractice Act classifies both vertically and horizontally. It treats victims of one sort of negligence differently from all other victims of negligence. Persons injured as a result of an act of malpractice are not only limited in their recovery by the statutory provisions rather than by their proof, but even if their proof doesn’t support recovery above $500,000, they are required to submit to physical examinations from time to time to determine their continuing need for medical care\(^ {114}\) despite the fact that all other personal injury awards include future medical benefits.\(^ {115}\) Furthermore, other provisions of the Act require that a person injured by an act of malpractice apply to a Medical Review Commission as a condition precedent to filing the malpractice action in court.\(^ {116}\) No other plaintiff in a personal injury action is so required.

Within the vertical classification there is also a horizontal one. Those malpractice victims whose proof supports recoveries above $500,000 are limited in their recovery whereas those whose injuries are less than the limitation can recover damages for their entire injuries.

Identifying a legislative classification, however, is not sufficient to show either denial of equal protection or prohibited special legislation. In order to offend either constitutional provision, the legislative classification must be arbitrary and without a rational basis.\(^ {117}\)

Nor does the Federal Constitution require situations which are dif-

\(^{111}\) N.M. Const. art. II, § 18.

\(^{112}\) N.M. Const. art. IV, § 24.

\(^{113}\) See State v. Athison, T. & S.F. Ry. Co., 20 N.M. 562, 151 P. 305 (1915). Statutory or constitutional provisions against special legislation on a subject do not prevent legislature from dividing legislation into classes and applying different rules as to each. But classification must be based on substantial distinctions, and not be arbitrary, and must apply to every member of the class or every subject matter under similar conditions.


\(^{115}\) It is clear that the purpose of this provision is to reduce the jury’s speculation at the time of verdict about the future need for care. Presumably, if the provision of future care is based on its need, the cost of the benefit will be reduced or at least be more realistic.


different in fact to be treated in law as though they were the same.\textsuperscript{118} The equal protection clause does deny the power to legislate that different treatment be accorded to persons placed by a statute into different classes on the basis of criteria wholly unrelated to the objective of that statute.\textsuperscript{119} To determine whether legislation has impermissibly classified then, it is necessary to ascertain the objective of the statute.\textsuperscript{120}

The express 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.\textsuperscript{121} The assumption is that the monetary limitation along with the elimination of present awards for future medical benefits, as well as other modifications of the common law tort actions,\textsuperscript{122} will decrease losses and therefore make writing of professional liability insurance more attractive to the insurance industry.

Since the experience of professional liability insurers in New Mexico based on the application of the common law of malpractice had not resulted in losses greater than the premium rate would bear,\textsuperscript{123} it is not at all obvious that the statutory limitation of recovery will make it more likely that professional liability insurance will be available.\textsuperscript{124} Indeed the feasibility study\textsuperscript{125} for a physician-owned mutual professional liability insurance company only assumed

\begin{table}[h]
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\begin{tabular}{|c|c|c|c|c|c|}
\hline
Policy Year & Earned Exposure & \multicolumn{2}{c|}{100/300} & \multicolumn{2}{c|}{Loss Est. Ultimate Incurred} \\
\hline & & Earned Prem. & Incurred & Development & Incurred \\
\hline & & @ Current Rates & @ 1-31-75 & Factor & Losses \\
\hline 1971 & 180 & 281,875 & 137,837 & 1.429 & 196,962 \\
1972 & 363 & 564,094 & 127,771 & 1.754 & 224,110 \\
1973 & 477 & 1,679,715 & 309,839 & 2.50 & 774,598 \\
\hline Total & 1,020 & 1,525,684 & 575,442 & & 1,195,670 \\
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\end{tabular}
\end{table}

\textsuperscript{118} Tigner v. Texas, 310 U.S. 141 (1939).
\textsuperscript{119} Reed v. Reed, 404 U.S. 71 (1971).
\textsuperscript{120} McGeehan v. Bunch, 88 N.M. 308, 540 P.2d 238 (1975).
\textsuperscript{123} See Review of Proposed Rate Increase in Professional Liability Insurance for the New Mexico Medical Society, April 14, 1975, prepared by Milliman & Robertson, Inc. On file at office of New Mexico Law Review.
\textsuperscript{124} See letter from Leon Zaccaro, Travelers Insurance Co. to Dr. U. G. Hodgin, President, N.M. Medical Society, January 28, 1975, requesting a rate increase of 74% and stating that the program has been successful to date, on file at offices of New Mexico Law Review. See also Review of Proposed Rate Increase in Professional Liability Insurance for the New Mexico Medical Society, April 14, 1975, Milliman & Robertson, Inc. On file at offices of New Mexico Law Review.
\textsuperscript{125} Prepared by Milliman & Robertson, Inc., October 24, 1975, on file at offices of New Mexico Law Review.
a legislative effort which would produce a 15% reduction in loss costs in January 1977.\textsuperscript{126} The consultants refused to evaluate the impact of limiting legislation.\textsuperscript{127} Nevertheless, the prospectus of the New Mexico Physicians Mutual Liability Company indicated that if the 1976 legislature failed to pass remedial legislation, the Board of Directors voted not to activate the company even though it also stated that the effect of the legislation on professional liability insurers was unknown.\textsuperscript{128} In short, the relationship of the limitation of recovery provision, its related statutory procedure and the temporary provision scheduling yearly payments of awards over $35,000\textsuperscript{129} to the goal of attracting the insurance industry back into New Mexico is unknown. Passage of the legislation did encourage formation of the mutual company, but with a dearth of information available about the true actuarial impact of the legislation, a strong argument can be made that its classifications are arbitrary.

\textsuperscript{126} Id. at 3.
\textsuperscript{127} Id. at 5.
\textsuperscript{128} Prospectus, N.M. Physicians Mutual Liability Company, on file at offices of New Mexico Law Review.
\textsuperscript{129} [1976] Laws of N.M., ch. 2, § 30 provided:

A. Amounts reached by settlement after the court's jurisdiction has been invoked or awarded by the jury or the court sitting without a jury and in excess of thirty-five thousand dollars ($35,000), exclusive of costs, shall be reduced by the court to a schedule of yearly payments to be made to the patient and any other parties who have obtained judgments as a result of the malpractice claim. The schedule shall apply only to that portion of the judgment in excess of thirty-five thousand dollars ($35,000). The number of yearly payments to be made and the amount of each such payment shall be within the discretion of the trial court. In constructing its payment schedule, the trial court shall consider such factors as the patient's age, probable life expectancy and needs. However, in no instance shall the entire amount of the settlement or award be scheduled to be paid over a period of more than three years. The court's action in constructing such payment schedules shall be reviewable only in the event of an abuse of judicial discretion. The health care provider or a party acting in its behalf shall make payments as ordered by the court until such time that the total damages awarded bearing interest at the legal rate have been paid.

B. In instances where a malpractice claim is settled without invoking the jurisdiction of the court, the parties shall construct a payment schedule for any amount greater than thirty-five thousand dollars ($35,000). Malpractice claims to be settled for more than one hundred thousand dollars ($100,000) shall be void, to the extent they exceed one hundred thousand dollars ($100,000), absent the written approval of the superintendent.

C. After March 1, 1981, the parties shall not be required to schedule settlements or judgments as provided in this section. After March 1, 1981, the court shall not schedule judgments as provided in this section. However, all judgments scheduled prior to March 1, 1981, shall continue in full force and effect throughout the duration of the scheduled period.

This mechanism too arguably encroaches on a procedural area exclusively committed to the courts. \textit{See} text accompanying notes 92-110 \textit{supra}.
In *McGeehan v. Bunch*, the supreme court considered the constitutionality of the automobile guest statute against a challenge that it violated the equal protection clauses of the state and federal constitutions. It held it void because no matter how laudable the state’s interest in promoting generosity, it is irrational to reward generosity by denying to non-paying guests the common law remedy for negligently inflicted injury. The court was unable to discern how denial of recovery to guests encourages hospitality. Similarly, since there is no indication either that the limitation of recovery provision in the medical malpractice statute is necessary to hold down losses or produces enough actuarial certainty to induce the writing of professional liability insurance, it is irrational to deny those malpractice victims suffering losses above $500,000 their common law remedy.

The due process challenge to the limitation of recovery provision takes a somewhat different line. The argument is that the due process clause prohibits a legislature from modifying a common law remedy without providing an adequate substitute for it. The principle is derived from dictum in *New York Central Railroad Co. v. White* where the Supreme Court rejected challenges to New York’s Workmen’s Compensation law but doubted that the state could abolish all rights of action for an injury without setting up something adequate in its stead. In *Munn v. Illinois* however, the Court held that a person has no vested interest in any rule of the common law. Indeed it considered it the responsibility of the legislature to remedy defects in the common law as they develop and adapt it to changing times and circumstances. And in *Silver v. Silver* a Connecticut statute abrogating an automobile guest’s action for negligence against his host was upheld on the basis that it is for the legislature to

130. 88 N.M. 308, 540 P. 2d 238 (1975).
131. The counter-argument is of course available. In fact, the Mutual Company organized because of the limitation. Even if this was irrational, in that the Company could not predict the impact of the limitation on its losses, the existence of the limitation of recovery gives the Company enough of an appearance of security to start writing insurance. In its first communication to its members, it stated that because the new bill limits liability and delays payments of awards, its actuary is confident that its projections are sound and its goals reasonable. In this sense, the legislative classification is rationally related to its objective and therefore permissible.
132. 243 U.S. 188 (1916).
133. 94 U.S. 113 (1876).
134. There is authority for the view that an accrued claim is a vested right which cannot be modified consistent with due process requirements. The New Mexico legislature has not created this problem in the Malpractice Act. Is saving clause provides that the Act does not apply to acts of malpractice occurring prior to its effective date (Feb. 27, 1976). [1976] Laws of N.M. ch. 2, § 28.
135. 280 U.S. 117 (1929).
determine whether there had been an increase in the evils of vexatious litigation in this class of cases.\textsuperscript{136}

Most modern cases which have considered this problem have involved challenges to automobile no-fault statutes.\textsuperscript{137} With a relatively minor exception,\textsuperscript{138} these statutes have been upheld. It is notable, of course, that the general pattern of automobile no-fault statutes does provide a quid pro quo for the modification of the common law remedy.\textsuperscript{139} Victims of automobile accidents are guaranteed a limited recovery without regard to fault in exchange for the pain and suffering award. New Mexico's Malpractice Act provides no certainty of award to a person injured as a result of malpractice "accident" in exchange for the limitation. All uncertainties which pertain at common law continue to exist under the act including the possible defense of contributory negligence.\textsuperscript{140} The only arguable benefit to claimant is the general reduction of malpractice premiums and lower direct costs of medical care.\textsuperscript{141}

Despite the lack of an adequate statutory substitute for the full common law remedy, the limitation ought to be upheld against a due process challenge.\textsuperscript{142} Policy-making ought to be in the hands of the legislature. To permit a court to prohibit legislative change unless a substitute remedy is proscribed is to place too much specific policy making power in the hands of the courts. The legislature ought to be free to modify common law so long as the objectives of legislation are permissible and the means chosen to achieve these are rational. If the limitation of recovery is rational and satisfies equal protection


\textsuperscript{139} In Cyr v. Farias, 372 N.E. 2d 890 (Mass. 1975), the Massachusetts Court upheld the no-fault statute even though plaintiff was not a resident of Massachusetts and therefore not entitled to the certain benefits of personal injury protection.


\textsuperscript{141} The actual existence of this benefit is seriously in doubt. See text accompanying notes 123-131 supra.

\textsuperscript{142} See text accompanying notes 92-143 for conclusions concerning separation of powers and equal protection challenges.
standards, admittedly arguable here, then the lack of a substitute for the loss of recovery above $500,000 ought not to be deemed in itself a denial of due process.

The Medical Review Commission

The Malpractice Act creates a medical review commission to consider all cases involving any alleged act of malpractice occurring in New Mexico by health care providers qualified under the Act. Indeed no malpractice actions may be filed in any court against a qualifying health care provider before application is made to the commission and its decision is resolved. The director of the commission is to be an attorney who shall choose the hearing panels and the panels shall consist of three licensed health care providers and three members of the bar. The application of the claimant and the answer of the health care provider must contain authorization for access to all medical records for purpose of consideration of the matter and for no other purpose. Hearings must be set within 60 days of the director’s transmitting the application to the health care provider’s state professional society. Both sides may present evidence although no inquiry may be made of monetary damages. The panel is to 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. The panel’s decisions are not binding on any party nor is the decision or report admissible as evidence, but where its findings are affirmative as to the two questions, the director and the professional association concerned will cooperate with the patient in finding an expert to assist with trial preparations and to testify on behalf of the patient. The running of the statute of limitations is tolled with submission of the case to the panel and doesn’t start to run until 30

143. For rationality of limitation, see text accompanying notes 123-131 supra.
days after the panel's decision is filed and served on the claimant by certified mail.\textsuperscript{152}

The mandatory use of the review commission is an extension of a pre-existing voluntary malpractice screening panel.\textsuperscript{153} The voluntary panel operated continually from 1963 on and had heard 173 cases against 207 physicians up until the enactment of the Medical Malpractice Act. It had found for the patient in fifty-one of its cases and for defendants in one hundred-fifty-six of its cases. The others had been cancelled or withdrawn.\textsuperscript{154}

The screening panel has two principal purposes: to prevent court filing of non-meritorious malpractice claims and to furnish experts to those with meritorious claims. A by-product of the process seems to be encouragement of settlements\textsuperscript{155} even though the panel is to make no effort to settle or compromise any claim or express any opinion on the monetary value of the claim.\textsuperscript{156}

Except that the Act makes application to the commission a condition precedent to filing a civil action, there is every indication that previous practice will continue and that the panel will function as it

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
Year & Cases & Doctors & For Plntf. & For Def. & Cancel or Withdraw \\
\hline
1964 & 1 & 1 & 0 & 1 & 0 \\
1965 & 4 & 4 & 2 & 2 & 0 \\
1966 & 10 & 11 & 4 & 7 & 0 \\
1967 & 9 & 10 & 4 & 6 & 0 \\
1968 & 12 & 15 & 3 & 12 & 0 \\
1969 & 16 & 25 & 8 & 17 & 0 \\
1970 & 19 & 22 & 5 & 17 & 2 \\
1971 & 11 & 12 & 5 & 7 & 3 \\
1972 & 7 & 8 & 3 & 5 & 2 \\
1973 & 9 & 10 & 3 & 7 & 6 \\
1974 & 31 & 35 & 7 & 28 & 4 \\
1975 & 32 & 34 & 6 & 28 & 5 \\
\hline
Total & 161 & 187 & 50 & 137 & 22 \\
\hline
1976 & & & & & \\
3/27/76 & 9 & 17 & 1 & 16 & 0 \\
4/8/76 & 3 & 3 & 0 & 3 & 0 \\
\hline
\end{tabular}
\caption{Medico-Legal Reviews}
\end{table}


did before. Since an evaluation of the voluntary panel has already been made, it will not be repeated here.

What must be considered here, however, is whether there is anything in the mandatory scheme which is constitutionally offensive. The requirement that a claimant submit his claim to a panel for decision before filing a civil action can be argued to be an unreasonable limitation on access to courts in violation of due process. However, the Act requires that panel procedure be relatively speedy and evaluation of the voluntary screening panel indicates no problem of undue delay. It is conceivable that a particular claimant will be prejudiced by the loss of witnesses, etc. should undue delay be introduced by the panel requirement. This seems remote however and apart from that sort of circumstance the Act’s requirement that the panel be used seems not in conflict with due process.

Furthermore, since neither the panel’s hearing record or its conclusion is admissible in the judicial proceeding, the procedure can’t be attacked on the basis that it interferes with a meaningful jury trial. This provision ought to fall only if its requirements together with the limitation of recovery provision and its implementing procedure are held to create an arbitrary classification and thus offend equal protection guarantees.

Statute of Limitations

The Act provides that no claim for malpractice arising out of an act of malpractice occurring after February 27, 1976 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 six years shall have until his ninth birthday.

The general statute of limitations in New Mexico provides that actions must be filed within three years for an injury to the person. In malpractice cases, the statute has been interpreted to mean that a cause of action accrues at the time of the wrongful act causing the injury. The limitation provision in the Malpractice Act is simply a codification of the present common law, and ought not to offend due process so long as the period is not unreasonably short so as to be an impenetrable barrier to suit.

Despite what seems to be clear legislative intent to commence the running of the limitation period from the date of the act of malpractice, there is some risk of contrary judicial interpretation. For example, in Indiana, the Malpractice Act required that the action be filed within 2 years from the date of the act, omission or neglect complained of. The general statute provides that actions be commenced within two years after the cause of action has occurred. Despite the clarity of the legislative intent, an appellate court has construed the malpractice limitation of action provision to include the provision that the statute will not commence to run until the plaintiff in the exercise of reasonable care ought to have known of the malpractice to avoid unreasonable harshness to the plaintiff.

The limiting question, of course, is whether a statute commencing the running of the period from the date of the act of malpractice in the situation where no reasonable person could have discovered the

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165. The protection of this provision is not limited to health care providers qualified under the Act. It is unclear whether the omission of the modifier “qualified” before health care providers is an inadvertence or whether the legislature intended to extend the protection of the statutorily defined limitation to all health care providers. See N.M. Stat. Ann. § 58-33-3A (Inter. Supp. 1976).
169. See Jiminez v. Weinberger, 417 U.S. 628 (1974). See also Cessna v. Montgomery, 63 Ill.2d 71, 344 N.E.2d 447 (1976); Owen v. Wilson, 537 S.W.2d 543 (Ark. 1976). A statute of limitations commenced to run when act of negligence took place and such 2 year statute is not a denial of due process even though discovery of injury was not possible until after 2 year period has elapsed.
170. Considering the interpretation given to the general personal injury statute of limitations, the risk is admittedly slight.
injury within the applicable period is a denial of due process. Since this is a case where the statute is an impenetrable barrier to the courts a cogent argument can be made that this is a denial of due process. Proper factual development would be required before this conclusion could be reached.\footnote{174 See Landgraff v. Wagner, 26 Ariz. App. 49, 546 P.2d 26 (1976).}

The Medical Malpractice limitation of action provision does raise an equal protection problem.\footnote{175 See N.M.L. Rev. 271 at 282 (1976).} The statute treats those who have readily discoverable injuries differently from those with injuries that are not discoverable within three years. However, since there is greater evidence that later discovered claims does disrupt premium rate-making than there is for the proposition that limitations of recovery will reduce losses enough to keep premiums at a tolerable level,\footnote{176 See text accompanying note 20.} there may be a more rational connection between the limitation of action provision and the statutory purpose than for other provisions of the Act.

**CONCLUSION**

The limitation-of-recovery provisions of the New Mexico Malpractice Act, so crucial to the legislative remediation sought by organized medicine and the insurance industry, seem the most vulnerable to constitutional attack. The Act contains a severability clause, so that the remaining provisions will stand even if the limitation of recovery falls. However, apart from the mandatory prior submission of claims to a screening panel, the remaining provisions accomplish little more than a codification of the present common law of medical malpractice in the state. Since this is the only benefit, the consequent inhibition of common law creativity seems an unfortunate loss.

Solutions which are satisfactory both to the public and to health care providers and insurers do not easily suggest themselves. Surely quality of care assessments such as the Professional Standards Review Organization (PSRO) program\footnote{177 42 U.S.C. § 1320 c-1 to c-19 (Supp III 1973). See Brook, Brutoco & Williams, The Relationship Between Medical Malpractice and Quality of Care, 1975 Duke L. J. 1197.} ought to be encouraged. Peer review of competency of health care providers could be accomplished through state relicensure requirements.\footnote{178 See generally, Derbyshire, Medical Ethics and Discipline, 228 J.A.M.A. 59 (1974). See also N.M. Stat. Ann. § 67-42-1 to -11 (Inter. Supp. 1976), which provides for restriction, suspension or revocation of license to practice medicine in case the licensee is unable to practice medicine with reasonable skill or safety to patients by reason of mental illness, physical illness or habitual or excessive use or abuse of drugs.} Some scholars argue that
a limited kind of no-fault insurance will reduce the costs of the present fault system in allocating losses.\textsuperscript{179} Arbitration of medical disputes might be explored as a means of reducing the costs of allocating losses. A creative use of remittitur could also be employed to control egregiously large malpractice awards.

It seems that the solution to the malpractice crisis does not lie in the present legislative response. Continuing efforts to understand and resolve the problem in terms of the goals of reducing the overall costs of malpractice care, including its maloccurrences are still to be undertaken and remain a challenge to the medical and legal professions.

APPENDIX I

JOINT MEDICAL-LEGAL PLAN FOR SCREENING MEDICAL NEGLIGENCE CASES

I PURPOSE

The fundamental purposes of this Plan are twofold: On the one hand, to prevent where possible the filing in Court of actions against physicians and their employees for professional malpractice in situations where the facts do not permit at least a reasonable inference thereof; and, on the other hand, to make possible the fair and equitable disposition of such claims against physicians as are, or reasonably may be, well founded.

Both professional groups recognize that the mere filing of a malpractice action in court, however unjustified medically it may be, causes substantial harm to the reputation and practice of the physician concerned. Both groups recognize, at the same time, that persons having legitimate and meritorious grievances against physicians have heretofore often encountered the greatest difficulty in substantiating the claims with expert testimony in court.

The instrumentality hereby jointly created for the purposes outlined above shall be known as the Joint Screening Panel of the New Mexico Medical Society and New Mexico State Bar, hereafter referred to as the Panel.

II
COMPOSITION OF THE PANEL

The Panel shall consist of the members of the Medical-Legal Committees of the Medical Society and the State Bar composed of an equal number from each profession not to exceed a total of twenty-five. In addition, there shall be a Panel Chairman, who shall be a lawyer, and one or more alternate Panel Chairmen to be selected by the Panel.

III
CASES SUBMITTED

Cases which the Panel will consider shall include all cases involving any alleged act of professional malpractice occurring in New Mexico by a physician, his servants, agents, or employees. Any attorney may submit a case for the consideration of the Panel by addressing an application, in writing, signed by both himself and his client, to the Executive Director of the New Mexico Medical Society who shall serve as Secretary of the Panel. 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.

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 complaint, and, for the purposes of its consideration of the matter only, waiving his client’s 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.

3. An agreement that the deliberations and discussions of the Panel and of any member of the Panel in its deliberation of the case will be confidential within the Panel and privileged as to any other person, and that no Panel member will be asked to testify in any action where he has previously sat as a Panel member related to such action.

4. A request that the Panel consider the merits of the claim and render its report to him, the physician involved, or his attorney.

5. A statement as to whether court action has been filed and that the attorney has read, understood, and subscribes to the Plan for screening medical malpractice cases and has advised his client thereof and that the client agrees to the submission of the facts pursuant to the Plan.
6. A twenty-five dollar fee shall accompany each application for a hearing which shall be used solely for the expenses of administration of the Plan.

Applications for review shall be promptly transmitted by the Panel Secretary to the Chairman of the respective Medical-Legal Committees of the Medical Society and State Bar, who shall canvass the Panel members within thirty (30) days from the date of transmittal of the application. Thereafter, a determination shall be made by the Chairman as to which committee members will sit in review on the case and which, if any, additional physicians or attorneys shall be called to become advisors to the Panel for such case. Any member shall disqualify himself from consideration of any case which, by virtue of his circumstances or official position, he has or may have any personal or official connection, or as to which he feels that his presence on the Panel for any reason inappropriate, considering the purpose of the Panel. (Except for the Panel Chairman who shall preside at a hearing, there shall be no greater number of one profession than the other hearing in any one case.) A date, time and place for hearing shall then be fixed by the Panel Secretary and prompt notice thereof shall be given to the parties involved, their attorneys, and the Panel Chairman. In no instance shall the date set be more than sixty (60) days after the transmittal by the Secretary of the application for review.

IV
DEFINITIONS

By “substantial evidence” is meant evidence upon which reasonable men can agree that a fact is established, or upon which they may fairly differ concerning the establishment of the fact. It means more than merely any evidence and more than a scintilla, and contemplates such relevant legal evidence as a reasonable person might accept as sufficient to support a conclusion. (Wilson v. Employment Security Comm., 74 NM 3, 389 P.2d 855 (1964); Tapia v. Panhandle Steel Erectors Co., 78 NM 86, 428 P.2d 625 (1967).)

“Malpractice” as used herein is defined as a departure either by action, neglect or inattention from the recognized standards of medical practice in the locality or community, or a failure to do something required by those standards, which proximity results in injury to the patient. (Cervantes v. Forbis, 73 NM 445, 389 P.2d 210, 213 (1964); Scribner v. Seidenberg, 80 NM 573, 458 P.2d 825, 826 (app. 1969).) Likewise, absent an emergency situation making it unreasonable to do so, there is included within the term, the failure
to make a reasonable disclosure of all significant facts, i.e., the nature of the infirmity (so far as reasonably possible), the nature of the operation or treatment, and the more probable consequences and difficulties inherein therein. (Woods v. Brumlop, 71 NM 221, 377 P.2d 520, 524 (1962).)

By "locality" or "community" is meant the same or similar locality or community where a different or lower standard from that applicable in the locality wherein the medical panel members practice, or a place or community materially smaller in size, distant from a larger center or otherwise not having available facilities, personnel, or continuing training possibilities, so as to make unreasonable the application of a standard which would otherwise be required. No standard lower than that applicable generally shall be applied without proof being offered that such standard is unreasonably high for the locality in question; however, neither should any standard be applied that would excuse failure to keep abreast and use the best modern methods of treatment possible considering the circumstances of the case, the distance from a larger community with better facilities, the facilities and personnel immediately available, to the end that the responsibility of a physician shall not be unduly or narrowly restricted or confined. (Flock v. J.C. Palumbo Fruit Co. (Ida. 1941) 118 P.2d 707, 714; Warmock v. Kraft (Cal. App. 1939) 85 P.2d 505; 70 CJS 950, Physicians & Surgeons, Sec 43; 41 Am. Jur. 205, Physicians & Surgeons, Sec 87; 37 ALR 3d 420.)

Not included within the terms are intentional acts of a physician which are not proper in the treatment of a patient and which would be grounds for revocation of his license to practice.

V

PROCEDURE BEFORE THE PANEL

At the time set for hearing the attorney submitting the case for review shall be present and shall state his case, including a resume of the facts constituting alleged professional negligence which he is prepared to prove. The physician or physicians against whom the claim is brought, and his, or their attorney, or attorneys, may be present and may make a statement of his or their case. Both parties may call witnesses to testify before the Panel. They shall not be sworn. Medical texts, journals, studies, etc., relied upon by either party may be offered and admitted if relevant. Also, written statements of fact, without opinions, of treating physicians may be reviewed. The monetary damages in any case shall not be subject of inquiry or discussion. The hearing will be informal and no official
record shall be kept. 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 (30) days from the date of the original hearing unless the attorney bringing the matter for review shall in writing consent to a longer period. Any second hearing shall be held in the same manner as the original hearing, and the parties concerned and their attorneys may be present.

The deliberations of the Panel shall be and remain secret; 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 professional malpractice; and (2) whether there is reasonable medical probability that the claimant was injured thereby. The Panel shall make no effort to resolve disputed questions of fact except to determine whether, in its judgment, there is substantial evidence to support the facts alleged and presented by the claimant at the hearing. The Panel shall make no effort to settle or compromise any claim nor express any opinion on the monetary value of any claim.

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 and such 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 Panel. 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 shall be 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 dissenter or dissenters may likewise explain the reasons for disagreement. The names of neither the Panel members constituting the majority nor those dissenting shall be disclosed. The decision and dissenting opinion, if any, reached in any case shall be treated in every respect as confidential between the Panel and its members, on the one hand, and the persons directly concerned in the case on the other hand, and may not be used as evidence nor referred to in any way in any subsequent litigation.

In any case where the Panel has determined that the acts complained of were or reasonably might constitute professional mal-
practice and that the claimant was or may have been injured thereby, the Panel, its members and the Medical Society will cooperate fully with the claimant in retaining a physician or physicians qualified in the field of medicine involved, who will consult with and testify on behalf of the claimant, upon his payment of a reasonable fee to the same effect as if the said physician or physicians had been engaged originally by the claimant. In a case where the Panel has determined that there is no substantial evidence that the acts complained of constituted malpractice and/or reasonable medical probability that the claimant was injured thereby, the attorney bringing the matter for review shall thereafter refrain from filing any Court action unless personally satisfied that strong and overriding reasons compel such action to be taken in the interest of his client, and that it is not done to harass or gain unfair advantage, in negotiations for settlement. It is not intended that the submission of any case to the Panel shall be considered as a waiver by the attorney or his client of their ultimate right to decide for themselves whether the case shall be filed. However, an attorney who brings a case before the Panel shall weigh its conclusion in the greatest professional good faith.

The Panel is authorized to adopt and publish rules of procedure necessary to implement and carry out the foregoing.

*Original Plan Approved:*

  New Mexico Medical Society, November 16, 1963  
  State Bar of New Mexico, October 8, 1963  
  Board of Bar Commissioners, November 23, 1963

*Current Revision Approved:*

  New Mexico Medical Society, November 13, 1971  
  Board of Bar Commissioners, December 4, 1971

**APPENDIX II**

**NEW MEXICO MEDICAL SOCIETY AND STATE BAR RULES OF PROCEDURE OF THE MEDICO-LEGAL MALPRACTICE PANEL**

Pursuant to and in compliance with the Medical-Legal Plan for Screening Malpractice Cases, the following Rules of Procedure are hereby adopted:

1. In the application for review the attorney for the claimant shall state in reasonable detail the elements of the doctor's conduct which are believed to constitute professional negligence, dates and the
names and addresses of all doctors and hospitals having contact with the claimant. Should counsel intend to rely on any additional elements of professional negligence, he shall file an amended application so alleging not less than 7 days prior to the hearing date; otherwise, upon a plea of surprise, the matter may be continued so that all complaints may be heard. No more than one continuance shall be allowed.

2. The Panel may hear a claim where the statute of limitation has run when tolled or waived by agreement between the parties or where suit has been previously filed against the doctor involved.

3. By appearing before the Panel, the parties consent that no attempt will be made to use as impeaching evidence in Court any statement made by any person during a hearing before the Panel.

4. Medical records:

   (a) Immediately upon receipt of the notice of hearing the attorney for the claimant and the doctor involved or his attorney shall either forward to the Executive Director of the Medical Society copies of all medical records or reports of which they have custody or make the same available for inspection by counsel upon reasonable notice. Should there be additional medical records, the Executive Director shall obtain the same and the claimant shall execute any authorizations as may be necessary for this purpose.

   (b) Prior to the hearing, counsel for the parties and the Panel members selected to hear the case shall be furnished copies of the medical records and reports obtained by the Executive Director, where practicable. If not practicable, then and, in that event, such records shall be available for inspection by counsel and the Panel members.

   (c) In the event the doctor involved has not previously delivered his records to the Executive Director, he shall bring the same with him to the hearing.

5. It shall not be considered a violation of the Statement of Principles or the doctor-patient privilege for counsel prior to the hearing to confer with any doctor other than the doctor involved, who will testify at the hearing or who has treated or had professional contact with the claimant. He shall not consult any person selected as a member of the Panel.

6. After the notice of the hearing date has been given, counsel and the parties should make every effort to be ready to proceed on such date. Requests to postpone a hearing should be made through the Executive Director of the Medical Society. Such requests will be granted only in extreme cases.
7. Counsel for the respective parties may be present during the presentation of the opposing party's case. However, the parties themselves and their witnesses may not be so present without specific authorization of the Panel hearing the case.

8. Cross-examination shall not be permitted. Should counsel desire a question to be propounded to an opposing party or his witnesses, such question shall be submitted in writing to the chairman who shall propound the same if deemed by him to be relevant or material.

9. Presentation of testimony from independent experts or doctors having no connection with the case is not necessary in order to have the Panel find substantial evidence of professional negligence or lack thereof. However, it is permissible, if desired by either party, upon agreement, or upon request of the Panel.

10. Upon receiving a favorable decision on the issue of malpractice and damage, should the attorney for the claimant desire a medical witness to testify in any subsequent civil litigation, he shall so advise the Executive Director of the Medical Society and of the field of medicine involved. Within a reasonable time thereafter, the Executive Director shall inform the attorney the name and address of such witness.

11. No request for a rehearing by the Panel will be entertained.

Effective January 1, 1968.
Revised and approved:
New Mexico Medical Society, November 13, 1971
Board of Bar Commissioners, December 4, 1971

APPENDIX III

DISPOSITION OF HEARINGS
MEDICAL LEGAL PANEL
1966 THROUGH 1973

The statistics which follow are based upon responses from 91 of 110 medical-legal hearings conducted between March 1966 and June 1973. Each of the 91 cases included in these statistics is represented by at least one response, and in some cases, two or three responses from an overall response rate of roughly 83 percent.

Cases Where Negligence Was Found

1. Number pending .............................................. 2
2. Number settled before suit filed by amount:
   $  0-$ 1,000 ......................................................... 0
1,000- 5,000 .............................................. 1  
5,000- 10,000 ........................................... 0  
Over 10,000 ............................................. 0  

3. Number settled after suit filed, but before trial, by amount:  
$ 0-$ 1,000 .............................................. 1  
1,000- 5,000 ......................................... 3  
5,000- 10,000 ......................................... 3  
Over 10,000 ........................................... 11  

4. Number which went to Trial:  
Verdict for defendant ................................... 4  
Verdict for plaintiff, by amount:  
$ 0-$ 1,000 .............................................. 0  
1,000- 5,000 ......................................... 0  
Over 10,000 ........................................... 0  

5. Number cases dropped or withdrawn after Panel found Negligence ........................................... 1  

Cases Where No Negligence Was Found  
6. Number pending ...................................... 2  
7. Number dropped without suit or settlement ........... 40  
8. Number dropped or dismissed after suit filed .......... 1  
9. Number settled before suit, by amount:  
$ 0-$ 1,000 .............................................. 0  
1,000- 5,000 ......................................... 0  
5,000- 10,000 ......................................... 0  
Over 10,000 ........................................... 0  
10. Number settled after suit, but before trial, by amount:  
$ 0-$ 1,000 .............................................. 0  
1,000- 5,000 ......................................... 4  
5,000- 10,000 ......................................... 1  
Over 10,000 ........................................... 5  
11. Number that went to trial:  
Verdict for defendant ................................... 2  
Verdict for the plaintiff, by amount:  
$ 0-$ 1,000 .............................................. 0  
1,000- 5,000 ......................................... 0  
5,000- 10,000 ......................................... 0  
Over 10,000 ........................................... 0  
Amt. Unknown ............................................ 1  

Cases Withdrawn Prior to Hearing Before Panel  
12. Number where suit filed but pending .................. 1
13. Number where case dropped ........................................ 1
14. Number where suit brought:
   Verdict for defendant ........................................ 1
   Verdict for plaintiff, by amount:
   $ 0-$ 1,000 ........................................ 0
   1,000- 5,000 ........................................ 3
   5,000- 10,000 ....................................... 1
   Over- 10,000 ....................................... 1
15. Number cases where no followup information was available .1
   Total Cases Responding ..................................... 91

APPENDIX IV

1975 SURVEY OF ONLY THOSE PHYSICIANS RECEIVING
"NO NEGLIGENCE" DECISIONS BY THE MEDICAL-LEGAL PANEL

1. Total responses .............................................. 84
   83% (84 responses of a possible 101)
2. Cases Dropped (no further action after panel hearing) ........ 59
   70% dropped
3. Cases Pursued (in spite of “no negligence finding by
   panel”)—30% pursued ....................................... 25
   A. Pending further action .................................. 11
   B. Settled prior to trial .................................... 11
      $600,000
      2,000
      25,000
      12,000
      10,000
      3,000
      35,000
      16,000
      2 settlements with unknown amounts
      1 case dropped with no payment
   C. Tried in court ........................................... 3
      Decisions for plaintiff ................................. 0
      Decisions for doctor ................................. 3
APPENDIX V

Selected Provisions of State Malpractice Legislation

A. Statute of Limitation Provisions:

1. Florida:

   **95.11 Limitations other than for the recovery of real property**
   Actions other than for recovery of real property shall be commenced as follows:

   * * * * *

   (4) Within two years.—

   * * * * *

   (b) An action for medical malpractice shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence; however in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued. An “action for medical malpractice” is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care. The limitation of actions within this subsection shall be limited to the health-care provider and persons in privity with the provider of health care. In those actions covered by this paragraph in which it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury within the 4-year period, the period of limitations is extended forward 2 years from the time that the injury is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed 7 years from the date the incident giving rise to the injury occurred. Fla. Stat. Ann. § 95.11(4) (West Supp. 1976).

2. Illinois:

   **§ 22.1 Tort or breach of contract actions arising from patient care**
   No action for damages for injury or death against any physician or hospital duly licensed under the laws of this State, whether based upon tort, or breach of contract, or otherwise, arising out of patient care shall be brought more than 2 years after the date on which the claimant knew, or through the use of reasonable diligence should have known, or received notice in writing of the existence of the injury or death for which damages are sought in the action, whichever of such date occurs first, but in no event shall such action be brought more than 4 years after the date on which occurred the act or omission or occurrence alleged in such action to have been the cause of such injury or death.
If the person entitled to bring the action is, at the time the cause of action occurred, under the age of 18 years, or insane, or mentally ill, or imprisoned on criminal charges, the period of limitations does not begin to run until the disability is removed. Ill. Ann. Stat. ch. 83, § 22.1 (Smith-Hurd Supp. 1977).

3. Louisiana:

§ 5628. Actions for medical malpractice

A. No action for damages for injury or death against any physician, chiropractor, dentist, or hospital duly licensed under the laws of this state, whether based upon tort, or breach of contract, or otherwise, arising out of patient care shall be brought unless filed within one year from the date of the alleged act, omission or neglect, or within one year from the date of discovery of the alleged act, omission or neglect; provided, however, that even as to claims filed within one year from the date of such discovery, in all events such claims must be filed at the latest within a period of three years from the date of the alleged act, omission or neglect.

B. The provisions of this Section shall apply to all persons whether or not infirm or under disability of any kind and including minors and interdicts. La. Rev. Stat. Ann. § 5628 (West Supp. 1977).

4. Maryland:

§ 5-109. Actions against physicians.

An action for damages for an injury arising out of the rendering of or failure to render professional services by a health care provider, as defined in § 3-2A01 of this article shall be filed (1) within five years of the time the injury was committed or (2) within three years of the date when the injury was discovered, whichever is the shorter. If the claimant was under 16 years of age at the time the injury was committed, the time shall commence when he reaches the age of 16.


5. Nevada:

11.400 Medical malpractice actions.

1. Except as provided in subsection 2, an action for injury or death against a health care provider as defined in subsection 5 shall not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:
(a) Injury to or wrongful death of a person, based upon such a health care provider's alleged professional negligence; or
(b) Injury to or wrongful death of a person for rendering professional services without consent; or
(c) Injury to or wrongful death of a person for error or omission in such health care provider's practice.

2. This time limitation is tolled for any period during which such health care provider has concealed any act, error or omission upon which such action is based and which is known or through the use of reasonable diligence should have been known to such health care provider. Nev. Rev. Stat. § 11.400(1) (1975).

6. North Dakota:

28-01-18. Actions having two-year limitations.—The following actions must be commenced within two years after the cause of action has accrued:

* * * * *

3. An action for the recovery of damages resulting from malpractice, provided, however, that the limitation of an action against a physician or licensed hospital will not be extended beyond six years of the act or omission of alleged malpractice by a nondiscovery thereof unless discovery was prevented by the fraudulent conduct of the physician or licensed hospital.

This limitation shall be subject to the provisions of section 28-01-25. N.D. Cent. Code § 28-01-18 (Supp. 1975).

B. Limitation of Remedies Provisions:

1. Florida:

768.54 Limitation of liability and patient's compensation fund

* * * * *

(2) Limitation of liability.—

(a) All hospitals shall, unless exempted under paragraph (c), and all health care providers other than hospitals may, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated assessment into the fund pursuant to subsection (3) prior to practicing during any year.

(b) Each health care provider shall not be liable for an amount in excess of $100,000 per claim for claims covered under subsection (3) in this state if, at the time the incident giving rise to the cause of the claim occurred, the health care provider:

1. Had:
   a. Posted bond in the amount of $100,000 per claim;
   b. Proved financial responsibility in the amount of $100,000 per
claim to the satisfaction of the board of governors of the fund through the establishment of an appropriate escrow account;
c. Obtained medical malpractice insurance in the amount of $100,000 or more per claim from private insurers or the Joint Underwriting Association established under § 768.53; or
d. Obtained self-insurance as provided in § 768.52, providing coverage in an amount of $100,000 or more per claim, and
2. Had paid, for the year in which the incident occurred for which the claim was filed, the fee required pursuant to subsection (3).
(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to meet claims arising out of the rendering of medical care or services in this state shall not be required to participate in the fund:
1. Post bond in an amount equivalent to $10,000 per claim for each hospital bed in said hospital, not to exceed a $2,500,000 annual aggregate;
2. Prove financial responsibility in an amount equivalent to $10,000 per claim for each hospital bed in said hospital, not to exceed a $2,500,000 annual aggregate, to the satisfaction of the board of governors of the fund through the establishment of an appropriate escrow account;
3. Obtain professional liability coverage in an amount equivalent to $10,000 or more per claim for each bed in said hospital from a private insurer, from the Joint Underwriting Association established under § 768.53, or through a plan of self-insurance as provided in § 768.52; however, no hospital shall be required to obtain such coverage in an amount exceeding a $2,500,000 annual aggregate.
(d) 1. Any health care provider who does not participate in the fund, or participates and does not meet the provisions of paragraph (b), shall be subject to liability under law without regard to the provisions of this section. Fla. Stat. Ann. § 768.54(2) (West Supp. 1976).

2. Idaho:

39-4204. Physicians liability.—The limit of civil liability for damages of a licensed physician, as aforesaid, to or on the account of injury to or death of any one (1) patient arising out of any treatment or course of treatment shall be one hundred fifty thousand dollars ($150,000), and to or on account of injury to or death of two (2) or more patients arising out of any one (1) occurrence shall be an aggregate of three hundred thousand dollars ($300,000); provided, however, the provision of the above aggregate limit is not to be construed as extending or enlarging such exposure or liability to or on account of any one (1) patient.

39-4205. Hospital liability.—The limit of civil liability for
damages of a licensed acute care hospital, as aforesaid, to or on account of injury to or death of any one (1) patient arising out of any treatment or course of treatment shall be one hundred fifty thousand dollars ($150,000), and to or on account of injury to or death of any two (2) or more patients arising out of any one (1) occurrence shall be an aggregate of three hundred thousand dollars ($300,000) or the total of the number of patient hospital beds in the facility multiplied by ten thousand dollars ($10,000), whichever figure be greater; provided, however, the provision of the above aggregate limit is not to be construed as extending or enlarging such exposure or liability to or on account of any one (1) patient. Idaho Code §§ 39-4204 to -4205 (Supp. 1976).

3. Illinois:
§ 101. Maximum recovery
In all actions in which the plaintiff seeks damages on account of injuries by reason of medical, hospital or other healing art malpractice, the maximum recovery to which the plaintiff may be entitled or for which judgment may be rendered for any plaintiff is $500,000. Ill. Ann. Stat. ch. 83, § 101 (Smith-Hurd Supp. 1977).

4. Oregon:
752.040. Limitation of physician’s liability for professional negligence; requirements for and conditions of limitation of liability; payment of amounts in excess of limitation of liability.
(1) When a physician licensed under ORS chapter 677 is insured by an insurer licensed and approved by the Insurance Commissioner or under a self-insurance plan approved by the Insurance Commissioner against legal liability for damages arising out of professional negligence for the injury or death of a human being in the sum required under subsection (2) of this section, and if the physician has paid the current annual fee required under ORS 752.080, the physician shall not be liable to any person beyond the limits of such professional liability insurance.

(2) The amount of professional liability insurance required to obtain the limitation of liability granted by subsection (1) of this section is:
(a) For a physician in physician class 1 or 2, $100,000 for each occurrence and $100,000 aggregate for occurrences of any one year or $100,000 for each claim made and $100,000 aggregate for claims made in any one year;
(b) For a physician in physician class 3 or 4, $300,000 for each occurrence and $300,000 aggregate for occurrences of any one year or $300,000 for each claim made and $300,000 aggregate for claims made in any one year; or
(c) For a physician in physician class 5 or 6, $500,000 for each occurrence and $500,000 aggregate for occurrences of any one year or $500,000 for each claim made and $500,000 aggregate for claims made in any one year.

(3) Any physician who carries a claims made policy or is protected by approved self-insurance and who discontinues practice may obtain a limitation of liability for himself and his insurer by maintaining the claims made policy by paying the premiums required by the insurer or approved self-insurer for coverage after retirement and by paying the annual fee then required for the same period as the insurer or approved self-insurer requires a premium to be paid.

(4) When an individual obtains a final judgment or award in a civil action or arbitration proceeding brought against a physician for professional negligence or agrees to an approved settlement of his claim for damages against a physician for professional negligence, if that individual does not receive the full amount of his judgment, award or approved settlement from an insurer or approved self-insurer or the physician because of the limitation of liability granted by subsection (1) of this section, that individual shall receive compensation in the remaining unpaid amount of his judgment, award or approved settlement from the Medical Excess Liability Fund as provided in ORS 752.010 to 752.140.

(5) When a complying physician’s professional liability insurance coverage required under this section for occurrences for any one year is exhausted or insufficient to fully pay the claimant the full amount of his final judgment award or approved settlement due to prior final judgments, awards or approved settlements, the claimant shall be entitled to recover the difference between the remaining coverage and the full amount of his final judgment, award or approved settlement from the Medical Excess Liability Fund.

(6) Upon a showing to the court of the insufficiency of the physician’s remaining professional liability coverage, the court shall issue an order to the Insurance Commissioner directing him to pay the difference between the remaining coverage and the final judgments, awards or approved settlements subject to the limitations of this section.

(7) After payment by the insurer or approved self-insurer on behalf of its insured physician of his remaining coverage and after issuance of a court order requiring the Insurance Commissioner to pay the difference from the Medical Excess Liability Fund, the claimant shall execute and deliver to the physician a full and complete satisfaction of his judgment or a complete release of all claims against the physician and his insurer for the occurrence which was the basis of the claim. Or. Rev. Stat. § 752.040 (1975).