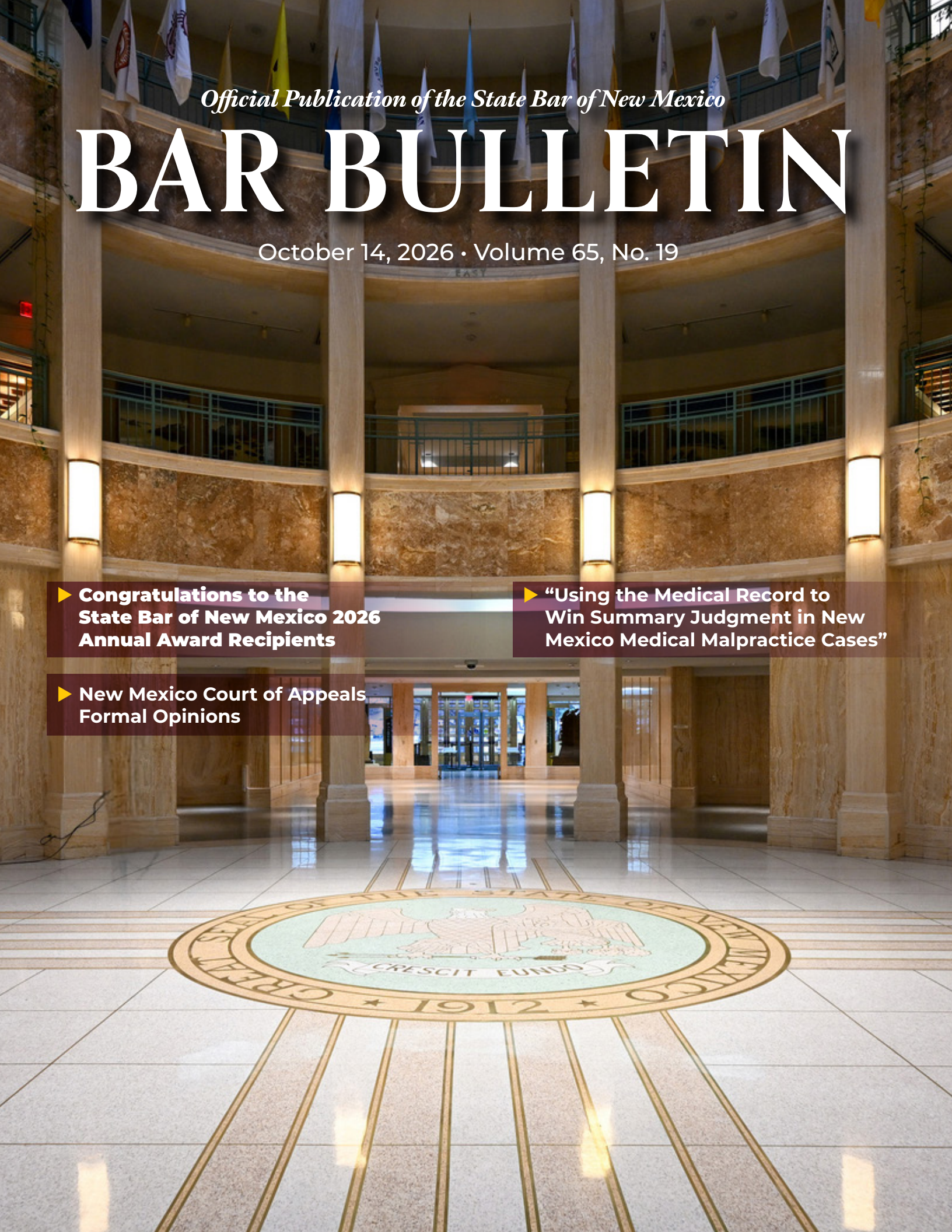


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- **Congratulations to the State Bar of New Mexico 2026 Annual Award Recipients**
- **"Using the Medical Record to Win Summary Judgment in New Mexico Medical Malpractice Cases"**
- **New Mexico Court of Appeals Formal Opinions**

Using the Medical Record to Win Summary Judgment in New Mexico Medical Malpractice Cases

By Fetsum Debessai Habtemariam

Introduction

Medical malpractice defense in New Mexico presents distinct challenges at the summary judgment stage. Although often viewed as difficult to obtain in professional negligence cases, summary judgment remains an important tool when supported by a well-developed evidentiary record. Early, strategic use of contemporaneous documentation can narrow issues, eliminate unsupported claims, and in some cases resolve litigation before trial.

Plaintiffs often advance narratives based on selective or retrospective interpretations of medical records, emphasizing hindsight critique rather than the clinical realities faced by providers at the time of treatment. Defense counsel who recognize common misreads and present the record comprehensively can narrow issues, secure favorable pretrial rulings, and improve litigation efficiency. When grounded in undisputed, record-based facts, summary judgment serves as an important safeguard against claims unsupported by competent medical evidence.

In evaluating summary judgment motions in medical malpractice cases, courts assess whether the plaintiff has produced admissible evidence creating a genuine dispute of material fact. Where the medical record reflects consistent assessment, appropriate clinical judgment, and adherence to accepted standards of care, summary judgment may efficiently resolve claims grounded in speculation rather than proof.

The Medical Record as Objective Evidence

The medical record is the most objective evidence in medical malpractice litigation, reflecting real-time clinical judgment, patient presentation, diagnostic reasoning, and ongoing assessment. Unlike post-event recollections, contemporaneous documentation shows what providers knew, observed, and reasonably did at the time care was rendered, and courts routinely rely on such records to assess whether negligence claims are supported by the evidence.

New Mexico appellate courts have repeatedly emphasized the importance of objective evidence and proper burden-shifting when evaluating dispositive motions in medical negligence cases. In *Blauwkamp v. University of New Mexico Hospital*, the Court of Appeals carefully analyzed the parties' respective prima facie burdens on summary judgment, explaining that a defendant may rely on the existing record to demonstrate an absence of evidence supporting an essential element of the plaintiff's claim, at which point the burden shifts to the plaintiff to come forward with admissible expert evidence establishing a genuine dispute of material fact.[1] The Court further made clear that summary judgment is inappropriate where competent expert testimony, grounded in the medical record, creates conflicting reasonable inferences regarding standard of care or causation.

By contrast, in *Lopez v. Reddy*, the Court of Appeals affirmed summary judgment after the district court excluded the plaintiff's sole medical expert under Rule 11-702 NMRA on the ground that the expert lacked the requisite qualifications to testify regarding the applicable surgical standard of care.[2] With the exclusion of that testimony, the plaintiffs were unable to establish a departure from the standard of care or related causation necessary to proceed, leaving no genuine dispute of material fact. As a result, the medical record remained unrebutted by admissible expert testimony.

In *Schmidt v. St. Joseph's Hospital*, the Court of Appeals affirmed summary judgment where the defendants supported their motion with affidavits, medical records, and expert testimony establishing adherence to recognized standards of medical practice and the absence of proximate causation.[3] Once the defendants made this prima facie showing, the burden shifted to the plaintiff to come forward with competent evidence, typically admissible expert testimony, demonstrating a genuine issue of material fact. Because the plaintiff failed to rebut the defendants' record-based showing, summary judgment was

proper. The decision illustrates that the medical record and supporting expert evidence are often central, rather than incidental, to dispositive motion practice in medical malpractice cases.

Taken together, these decisions show that the medical record is often the evidentiary foundation for summary judgment in medical malpractice cases. Where defendants establish compliance with the standard of care and the absence of causation through contemporaneous documentation and admissible expert testimony, summary judgment is appropriate unless the plaintiff produces competent evidence creating a genuine dispute of material fact.

Common Plaintiff Misinterpretations of the Medical Record

Certain recurring disputes regarding medical-record interpretation appear frequently in medical malpractice litigation. One common issue is timeline distortion, in which hours or days of documentation are compressed or reordered to suggest delayed or inadequate care. This approach often ignores contemporaneous notes demonstrating timely evaluation, monitoring, reassessment, and intervention. When viewed in proper chronological context, the same records often reflect consistent and appropriate clinical decision-making.

Another frequent approach is selective citation. Plaintiffs may highlight isolated or ambiguous entries while ignoring documentation reflecting patient stability, improvement, or appropriate clinical judgment. This selective reading can create the illusion of inconsistency or inattention where the record, viewed as a whole, demonstrates continuity of care. Courts evaluating summary judgment motions are often receptive to arguments that place such entries in context and explain their clinical significance.

Plaintiffs may also conflate orders with execution, assuming an order was improperly carried out when the record demonstrates appropriate follow-through or reflects that responsibility lay with a different provider, department, or service line. In complex hospital settings, this distinction is often critical and misunderstood, particularly where care involves multiple specialties or handoffs.

Finally, isolated phrases or chart entries are sometimes assigned disproportionate weight when divorced from the broader clinical context. Medical records are cumulative by nature, and individual entries must be interpreted in light of surrounding documentation. Identifying these recurring patterns allows defense counsel to anticipate arguments, address them directly, and present an accurate and comprehensive record to the court.

Reframing the Record for Summary Judgment

Effective use of the medical record begins with constructing a detailed chronological narrative integrating physician notes, nursing documentation, laboratory results, imaging, medication administration records, and orders. Rather than presenting records as a collection of disconnected exhibits, defense counsel should synthesize the documentation into a coherent timeline that reflects clinical reasoning and decision-making over time.

Defense expert opinions should be anchored in contemporaneous documentation rather than assumptions or reconstructed narratives. Experts who explicitly cite to chart entries, timestamps, and objective findings are more persuasive and more difficult to challenge. Conversely, opinions untethered from the record are vulnerable to exclusion or discounting at the summary judgment stage.

Potentially unfavorable entries should not be ignored but contextualized with relevant clinical information, including patient acuity, comorbid conditions, evolving symptoms, and institutional protocols. Presenting a coherent narrative reflecting the totality of care directly counters selective readings advanced by plaintiffs and reinforces adherence to the applicable standard of care. Where the record demonstrates continuity of care and reasoned clinical judgment, alleged deviations often prove speculative rather than evidentiary.

Summary Judgment Practice in New Mexico

Under Rule 1-056 NMRA, summary judgment is appropriate when there is no genuine dispute as to any material fact and the moving party is entitled to judgment as a matter of law. In medical malpractice cases, defense counsel should methodically link undisputed record-based facts to each element of the claim: duty, breach, and causation.

The medical record can establish compliance with the standard of care, negate causation, and expose speculative or assumption-based opinions offered by plaintiff experts. Where plaintiff experts rely on assumptions contradicted by contemporaneous documentation, those inconsistencies should be highlighted and tied directly to the absence of a genuine dispute of material fact.

Exhibits should be organized chronologically, clearly labeled, and curated to facilitate judicial review. Courts confronted with voluminous medical records benefit from clear presentation and targeted citation. A well-organized record reduces the likelihood of mischaracterization and assists the court in evaluating whether the plaintiff's claims are supported by admissible evidence.

Practical Considerations for Defense Counsel

Strategic planning early in the case enhances the effectiveness of summary judgment practice. Defense counsel should identify key clinical decision points, review timestamps carefully, and flag documentation demonstrating monitoring, reassessment, and escalation of care. Inconsistencies between the plaintiff's narrative and the medical record should be identified early and tracked throughout discovery.

Before expert retention, providing a clean chronological summary of the medical record helps focus opinions on documented facts rather than assumptions. Prior to filing a dispositive motion, counsel should confirm that all material facts are supported by the record, that exhibits are concise and easy to follow, and that the narrative accurately reflects the totality of care provided. This disciplined approach strengthens the persuasive value of the motion and minimizes the risk of oversight.

Conclusion

The medical record is a critical asset in New Mexico medical malpractice defense. Strategic review, careful framing, and comprehensive presentation can transform extensive documentation into a decisive tool for summary judgment. By anticipating common misreads, emphasizing adherence to recognized standards of care, and grounding arguments in contemporaneous evidence, defense counsel can narrow triable issues, enhance credibility with the court, and improve litigation outcomes. Thoughtful engagement with the medical record is not only a practical necessity but a cornerstone of effective medical malpractice defense advocacy.

About the Author



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Endnotes

1. *Blauwkamp v. Univ. of N.M. Hosp.*, 1992-NMCA-048, ¶¶ 9–19, 114 N.M. 228, 836 P.2d 1249.

2. *Lopez v. Reddy*, 2005-NMCA-054, ¶¶ 1, 9–10, 25–26, 137 N.M. 554, 113 P.3d 377.

3. *Schmidt v. St. Joseph's Hosp.*, 1987-NMCA-046, ¶¶ 6–7, 10–11, 18–20, 105 N.M. 681, 736 P.2d 135.