NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

SUBCOMMITTEE ON MIDWIVES

Co-chairs:
Senator Louis Pate
Representative Sarah Stevens

FINAL REPORT
TO THE
FULL COMMITTEE

MARCH 11, 2014

TRANSMITTAL LETTER

March 11, 2014

To Members of the Joint Legislative Oversight Committee on Health and Human Services:

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Midwives, respectfully submits the following final report.

Representative Sarah Stevens
Co-Chair

Senator Louis Pate
Co-Chair

SUBCOMMITTEE MEMBERSHIP

Senate Members	House Members
Senator Louis Pate, Chair	**Representative Sarah Stevens, Chair**
Senator Jeff Tarte	**Representative Marilyn Avila**
Senator Mike Woodard	**Representative Michael Wray**

Committee Staff:	
Edna Pearce, Senate Clerk	Lisa Brown, House Clerk
Barbara Riley, Research Division	Amy Jo Johnson, Research Division
Lisa Wilks, Legislative Drafting Division	Sarah Kamprath, Research Division
David Rice, Fiscal Research Division	Susan Jacobs, Fiscal Research Division

SUBCOMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Midwives, was created by S.L. 2013-360 (SB 402), Section 12I.2. The enacted legislation required the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to study whether certified nurse-midwives should be given more flexibility in the practice of midwifery. In conducting the study, the Subcommittee was required to consider whether a certified nurse-midwife should be allowed to practice midwifery in collaboration with, rather than under the supervision of, a physician actively engaged in the practice of obstetrics and licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes.

The Subcommittee met 3 times from January 14, 2014 until March 7, 2014. This section of the report provides a brief overview of the Subcommittee proceedings. Detailed minutes and copies of handouts from each meeting are online and on file in the Legislative Library. (http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144)

OVERVIEW OF TOPICS AND PRESENTERS

January 24, 2014

Review of House Bill 204: Update/Modernize/Midwifery Practice Act.

Lisa Wilks, Committee Counsel

Perspectives on House Bill 204

- Alex Miller, Lobbyist, Affiliate, American College of Nurse-Midwives
- Docia Hickey, M.D., Member, Board of Directors, North Carolina Medical Society
- Haywood Brown, M.D., Past-President North Carolina Obstetrical and Gynecological Society, Chair, Department of Obstetrics and Gynecology, Duke University School of Medicine, Professor of Obstetrics and Gynecology, Duke University School of Medicine
- David Kalbeck, Director, Public Information, North Carolina Board of Nursing
- Anna Baird Choi, Allen, Pinnex and Nichols, PA
- Marcus Jimison, North Carolina Medical Board
- Christina Apperson, North Carolina Medical Board

February 26, 2014

Education and Training of Nurse Midwives

Rebecca Bagley, DNP, CNM, Director, Midwifery Concentration, College of Nursing East Carolina University

Nurse Midwife Scope of Practice in North Carolina

Rebecca Bagley, DNP, CNM

February 26, 2014 (continued)

Trends in the Supply and Distribution of Obstetrical Delivery Providers in North Carolina

Erin Fraher, PhD., Director, Program on Health Workforce Research and Policy Cecil G. Sheps Center for Health Services Research

Supervision and Collaboration, Regulation of Nurse Midwives in Other States

Barbara Riley, Committee Counsel

Insurance for Nurse Midwives and Supervising MD's

Amy Jo Johnson, Committee Counsel

March 7, 2014

Physician Supervision of Certified Nurse-Midwives

Dr. John Thorp, McAllister Distinguished Professor
Division Chief, Women's Primary Healthcare
Vice Chair of Research, Department of OB-GYN
UNC Schools of Medicine and Public Health

Overview and Discussion of the Subcommittee Report

SUBCOMMITTEE FINDINGS AND RECOMMENDATIONS

The findings and recommendations below are based on information provided to the subcommittee.

FINDING 1: CERTIFIED NURSE MIDWIVES: CURRENT SUPERVISION REQUIREMENTS.

In North Carolina, Certified Nurse Midwives (CNM), under the supervision of a physician actively engaged in the practice of obstetrics, provide prenatal, intrapartum, postpartum, newborn, and Interconceptual care. A CNM is authorized to write prescriptions for drugs in accordance with the same conditions applicable to a nurse practitioner.

In North Carolina, a CNM must provide evidence of the arrangement for physician supervision. Under the rules developed by the Joint Subcommittee of the North Carolina Medical Board and the Board of Nursing, the evidence required is a written document detailing the nature and extent of the supervision and a delineation of the procedures to be adopted and followed by the CNM and the supervising physician, including clinical practice guidelines for the delivery of health care services, ongoing communication, and periodic and joint evaluation of services rendered.

FINDING 2: CERTIFIED NURSE MIDWIVES: EDUCATION AND TRAINING

CNM's are highly educated, experienced, and trained in the practice of midwifery and taught to Practice in consultation and collaboration with physicians and other health care providers.

A CNM is a registered nurse who has obtained a graduate degree and has completed a midwifery education program accredited by the Accreditation Commission for Midwifery Education. CNM's must pass a national certification exam administered by the American Midwifery Certification Board. To maintain certification, a CNM must be recertified every 5 years and complete continuing education requirements.

CNM's are taught to practice within the health care system that provides for consultation, collaboration, or referral to a physician or other health care provider as indicated by the health status of the woman or newborn.

In addition to fundamental courses covering reproductive physiology, pharmacology, physical assessment, and others, midwifery education and training includes specific courses on patient safety and quality assurance of patient safety, advanced life support for obstetrics, and certification in advanced fetal monitoring.

FINDING 3: INCREASE SUPPLY OF OBSTETRICAL HEALTH CARE PROVIDERS IN UNDERSERVED AREAS

North Carolina needs to expand the number of obstetrical health care providers in the State, especially in underserved areas.

Data from the Cecil G. Sheps Center for Health Services Research, UNC-CH, shows that 24 counties in the State have no obstetrical care provider, either physician or CNM's. There has been a slight decline in the number of physicians providing deliveries in the past 10 years. This decline is due to a significant decrease in the number of family physicians doing deliveries and providing prenatal care. 47 counties in North Carolina do not have a CNM.

East Carolina University's School of Nursing offers the only midwifery education program in the State. 78% of the graduates of that program have chosen to practice in North Carolina.

FINDING 4: CERTIFIED NURSE MIDWIVES: IMPACT OF PHYSICIAN SUPERVISION REQUIREMENT

North Carolina's requirement of physician supervision places some unnecessary restrictions on CNM practice and can result in well-qualified CNM's choosing to practice in other states.

The physician supervision requirement for CNM's has, in some cases, prevented CNM's from practicing in the State. Some CNM's have been unable to find a supervisory physician despite diligent efforts to secure an agreement. Others have had their practice abruptly closed as a result of the physician unexpectedly terminating the supervisory agreement. The abrupt closure of a CNM practice can present difficulties to patients who are forced to find alternative obstetrical care mid-way through a pregnancy.

FINDING 5: CERTIFIED NURSE MIDWIVES: OTHER STATES ALLOW INDEPENDENT PRACTICE

Twenty-four states and the District of Columbia allow CNM's to practice independently, without a collaborative or supervisory practice agreement with a physician.

Currently, States are split with 24 states and the District of Columbia allowing independent practice, and 26 states requiring a written collaborative or supervisory agreement with a physician. Of the 24 states that allow independent practice, Vermont, Maine, Colorado, and Nevada require practice under a written agreement for a period of time before the CNM may practice independently.

FINDING 6: CERTIFIED NURSE MIDWIVES: ALTERNATIVE TO WRITTEN PRACTICE AGREEMENT WITH ADDITIONAL EXPERIENCE REQUIREMENTS

With the addition of an experience requirement, CNM's in North Carolina should be allowed to practice in collaboration with physicians and other health care providers without the need for a written practice agreement.

While CNM's receive thorough and extensive education and training in nurse-midwifery education programs, there is a necessity for hands-on experience gained through actual practice. Just as medical doctors are expected to complete an internship program after medical school, CNM's and their patients would also benefit from a similar period of supervised experience. A 24-month, 2,400 hours transition to practice period under the supervision of a physician or an experienced CNM would enhance the quality of care provided by CNM's to their North Carolina patients.

FINDING 7: CERTIFIED NURSE MIDWIVES: GRACE PERIOD AFTER UNEXPECTED TERMINATION OF WRITTEN PRACTICE AGREEMENT

CNM's practicing pursuant to a written practice agreement should have a grace period after an unexpected termination of the agreement in which to obtain practice agreement with another physician or experienced CNM.

Unexpected termination of required supervisory agreements can be disruptive for both the CNM whose practice is closed and for the patients who suddenly find themselves without an obstetrical health care provider. A grace period of up to 90 days would provide a CNM with adequate time to find a new supervisory physician or CNM, or in the case the CNM decides to close the practice, time for patients to transition to a new provider.

RECOMMENDATION: SUPPORT THE ENACTMENT OF UPDATE/MODERNIZE MIDWIFERY PRACTICE ACT BY THE GENERAL ASSEMBLY.

The Subcommittee on Midwives, Joint Legislative Oversight Committee on Health and Human Services, recommends that the Joint Legislative Oversight Committee on Health and Human Services support the enactment by the General Assembly of 2013-LUz-137 which (1) would allow the independent practice of midwifery by certified nurse midwives who have at least 2,400 hours and 24-months experience in the practice of midwifery under the supervision of a physician or a certified nurse-midwife with 4 or more years of experience and (2) provide for a 90-day grace period for a CNM to obtain a written practice agreement when the CNM's existing practice agreement is terminated.

PROPOSED LEGISLATION

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

U **D**

BILL DRAFT 2013-LUz-137 [v.6] (03/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/7/2014 12:24:21 PM

Short Title:	Update/Modernize Midwifery Practice Act.	(Public)
Sponsors:	(Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO UPDATE AND MODERNIZE THE MIDWIFERY PRACTICE ACT, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES, SUBCOMMITTEE ON MIDWIVES.

Whereas, certified nurse-midwives are advanced practice registered nurses who are formally educated with current requirements for graduate level education and have achieved certification by the American Midwifery Certification Board; and

Whereas, North Carolina ranks 44th in the nation in infant mortality and 37th in maternal mortality; and

Whereas, women in North Carolina face disparities in access to prenatal health care services as half of North Carolina counties have three or fewer obstetricians, 31 counties have no obstetricians, and 46 counties have no certified nurse-midwives; and

Whereas, women in North Carolina face disparities in primary health care services as 78 counties are designated as health professional shortage areas by the Health Resources and Services Administration; and

Whereas, the American Congress of Obstetricians and Gynecologists projects a workforce shortage of obstetricians/gynecologists and recommends certified nurse-midwives as part of the solution; and

Whereas, care by certified nurse-midwives within a health care system has been shown to produce high quality outcomes at lower costs; and

Whereas, access to care by certified nurse-midwives has specifically been shown to decrease rates of neonatal and infant mortality, low birth weight, medical intervention, and caesarean section; and

Whereas, the requirement to practice under the supervision of a physician creates an undue restriction on the practice of certified nurse-midwives and inappropriate liability for the physician; and

Whereas, 24 states and the District of Columbia allow certified nurse-midwives to practice independently, without a collaborative or supervisory practice agreement with a physician; and

Whereas, the Institute of Medicine has found access to care from certified nurse-midwives has improved primary health care services for women in rural and inner city

areas and recommends removing scope-of-practice barriers, such as the requirement of physician supervision, and allowing certified nurse-midwives to practice to the full extent of their education and training; and

Whereas, the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives have jointly stated that obstetricians/gynecologists and certified nurse-midwives "are experts in their respective fields of practice and are educated, trained, and licensed, independent providers" and that obstetricians/gynecologists and certified nurse-midwives "should have access to a system of care that fosters collaboration among licensed, independent providers"; and

Whereas, the Federal Trade Commission has found that removing restrictions on the practice of advanced practice registered nurses such as certified nurse-midwives "has the potential to benefit consumers by expanding choices for patients, containing costs, and improving access"; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-18.7. Limitations on nurse-midwives.**

(a) Any certified nurse-midwife approved under the provisions of Article 10A of this Chapter to provide midwifery care may use the title "certified nurse-midwife." Any other person who uses the title in any form or holds himself or herself out to be a certified nurse-midwife or to be so approved shall be deemed to be in violation of this Article.

(b) A certified nurse-midwife is authorized to write prescriptions for drugs if all of the following conditions are met:

(1) The certified nurse-midwife has current approval from the joint subcommittee established under G.S. 90-178.4.

(2) The joint subcommittee as established under G.S. 90-178.4 has assigned an identification number to the certified nurse-midwife that appears on the written prescription.

(3) The joint subcommittee as established under G.S. 90-178.4 has provided to the certified nurse-midwife written instructions about indications and contraindications for prescribing drugs and a written policy for periodic review of the drugs prescribed.

(c) The joint subcommittee of the North Carolina Medical Board and the Board of Nursing, established under G.S. 90-178.4, shall adopt rules governing the approval of individual certified nurse-midwives to write prescriptions with any limitations the joint subcommittee deems is in the best interest of patient health and safety, consistent with the rules established for nurse practitioners under G.S. 90-18.2(b)(1)."

SECTION 2. G.S. 90-178.2 reads as rewritten:

"**§ 90-178.2. Definitions.**

~~As used in this Article:~~The following definitions apply in this Article:

(1) Certified nurse-midwife. – A nurse licensed and registered under Article 9A of this Chapter who has completed a midwifery education program accredited by the Accreditation Commission for Midwifery Education, passed a national certification examination administered by the American Midwifery Certification Board, and has received the professional designation of 'Certified Nurse-Midwife' (CNM). Certified nurse-midwives

practice in accordance with the Core Competencies for Basic Midwifery Practice, the Standards for the Practice of Midwifery, the Philosophy of the American College of Nurse-Midwives (ACNM), and the Code of Ethics promulgated by the ACNM.

(1a) Collaborating provider. – A physician licensed to practice medicine under Article 1 of this Chapter for a minimum of four years and who is or has engaged in the practice of obstetrics or a certified nurse-midwife who has been approved to practice midwifery under this Article for a minimum of four years.

(1b) Collaborative provider agreement. – A formal, written agreement between a collaborating provider and a certified nurse-midwife with less than 24 months and 2,400 hours of practice as a certified nurse-midwife to provide consultation and collaborative assistance or guidance.

(2) "Interconceptional care" includes but is not limited to:

~~a. Family planning;~~

~~b.~~a. Screening for cancer of the breast and reproductive tract;

~~c.~~b. Screening for and management of minor infections of the reproductive organs;

c. Gynecologic care, including family planning, perimenopause, and postmenopause care; and

(3) ~~"Intrapartum care" includes but~~Intrapartum care. – Care that focuses on the facilitation of the physiologic birth process and includes but is not limited ~~to:~~to the following:

a. ~~Attending women in uncomplicated labor;~~Confirmation and assessment of labor and its progress.

b. ~~Assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation;~~Identification of normal and deviations from normal and appropriate interventions, including management of complications, abnormal intrapartum events, and emergencies.

b1. Management of spontaneous vaginal birth and appropriate third-stage management, including the use of uterotonics.

c. Performing ~~amniotomy;~~amniotomy.

d. Administering local ~~anesthesia;~~anesthesia.

e. Performing episiotomy and ~~repair; and~~repair.

f. Repairing lacerations associated with childbirth.

(4) "~~Midwifery" means the~~Midwifery. – The act of providing prenatal, intrapartum, postpartum, newborn and interconceptional care. The term does not include the practice of medicine by a physician licensed to practice medicine when engaged in the practice of medicine as defined by law, the performance of medical acts by a physician assistant or nurse practitioner when performed in accordance with the rules of the North Carolina Medical Board, the practice of nursing by a registered nurse engaged in the practice of nursing as defined by ~~law, or the rendering of childbirth assistance in an emergency situation.~~law, or the performance of abortion, as defined in G.S. 90-21.6.

(5) ~~"Newborn care" includes~~Newborn care. – Care that focuses on the newborn and includes, but is not limited ~~to:~~to, the following:

a. Routine assistance to the newborn to establish respiration and maintain thermal ~~stability;~~stability.

b. Routine physical assessment including APGAR ~~scoring;~~scoring.

c. Vitamin K ~~administration; and~~administration.

d. Eye prophylaxis for opthalmia neonatorum.

e. Methods to facilitate newborn adaptation to extrauterine life, including stabilization, resuscitation, and emergency management as indicated.

(6) ~~"Postpartum care"includes~~Postpartum care. – Care that focuses on management strategies and therapeutics to facilitate a healthy puerperium and includes, but is not limited ~~to:~~to, the following:

a. Management of the normal third stage of ~~labor;~~labor.

b. Administration of ~~pitocin and methergine~~uterotonics after delivery of the infant when ~~indicated; and~~indicated.

c. Six weeks postpartum evaluation exam and initiation of family planning.

d. Management of deviations from normal and appropriate interventions, including management of complications and emergencies.

(7) ~~"Prenatal care" includes~~Prenatal care. – Care that focuses on promotion of normal pregnancy using management strategies and therapeutics as indicated and includes, but is not limited ~~to:~~to, the following:

a. ~~Historical and physical assessment;~~Obtaining history with ongoing physical assessment of mother and fetus.

b. Obtaining and assessing the results of routine laboratory ~~tests; and~~tests.

b1. Confirmation and dating of pregnancy.

c. Supervising the use of prescription and nonprescription medications, such as prenatal vitamins, folic acid, ~~iron, and nonprescription medicines.~~and iron."

SECTION 3. G.S. 90-178.3 reads as rewritten:

"**§ 90-178.3. Regulation of midwifery.**

(a) No person shall practice or offer to practice or hold oneself out to practice midwifery unless approved ~~pursuant to~~ under this Article.

(b) A ~~person~~ certified nurse-midwife approved ~~pursuant to~~ under this Article may practice midwifery in a hospital or non-hospital ~~setting and~~setting. The certified nurse-midwife shall ~~practice under the supervision of a physician licensed to practice medicine who is actively engaged in the practice of obstetrics.~~consult, collaborate with, or refer to other providers licensed under this Article, if indicated by the health status of the patient. A ~~registered nurse~~certified nurse-midwife approved ~~pursuant to~~ under this Article is authorized to write prescriptions for drugs in accordance with ~~the same conditions applicable to a nurse practitioner under G.S. 90-18.2(b).~~G.S. 90-18.7(b).

(b1) A certified nurse-midwife with less than 24 months and 2,400 hours of practice as a certified nurse-midwife shall: (i) have a collaborative provider agreement with a collaborating

provider and (ii) maintain signed and dated copies of the collaborative provider agreement as required by practice guidelines and any rules adopted by the joint subcommittee of the North Carolina Medical Board and the Board of Nursing. If a collaborative provider agreement is terminated before the certified nurse-midwife acquires the level of experience required for approval under this Article, the certified nurse-midwife shall have 90 days from the date the agreement is terminated to enter into a collaborative provider agreement with a new collaborating provider. During the 90-day period, the certified nurse-midwife may continue to practice midwifery as defined under this Article.

(c) Graduate nurse midwife applicant status may be granted by the joint subcommittee in accordance with G.S. 90-178.4."

SECTION 4. G.S. 90-178.4(a) reads as rewritten:

"(a) The joint subcommittee of the North Carolina Medical Board and the Board of Nursing created ~~pursuant to~~ under G.S. 90-18.2 shall administer the provisions of this Article and the rules adopted ~~pursuant to~~ under this Article; Provided, however, that actions of the joint subcommittee ~~pursuant to~~ under this Article shall not require approval by the North Carolina Medical Board and the Board of Nursing. For purposes of this Article, the joint subcommittee shall be enlarged by ~~four~~ seven additional members, including ~~two certified midwives~~ five nurse-midwives appointed upon the recommendation of the North Carolina Affiliate of the American College of Nurse-Midwives and two ~~obstetricians~~ physicians actively engaged in the practice of obstetrics who have had working experience with ~~midwives.~~certified nurse-midwives."

SECTION 5. G.S. 90-178.4 is amended by adding the following new subsections to read:

"(a1) Any certified nurse-midwife who attends a planned birth outside of a hospital setting shall obtain a signed informed consent agreement from the certified nurse-midwife's patient that shall include:

(1) Information about the risks associated with a planned birth outside of the hospital.

(2) A clear assumption of those risks by the patient.

(3) An agreement by the patient to consent to transfer to a health care facility when and if deemed necessary by the certified nurse-midwife.

(4) If the certified nurse-midwife is not covered under a policy of liability insurance, a clear disclosure to that effect.

(a2) Any certified nurse-midwife who attends a planned birth outside of a hospital setting shall provide to each patient a detailed, written plan for emergent and nonemergent transfer, which shall include:

(1) The name of and distance to the nearest health care facility licensed under Chapter 122C or 131E of the General Statutes that has at least one operating room.

(2) The procedures for transfer, including mode(s) of transportation and method(s) for notifying the relevant health care facility of impending transfer."

SECTION 6. G.S. 90-178.4(b) reads as rewritten:

"(b) The joint subcommittee shall adopt rules ~~pursuant to~~ under this Article to establish each of the following:

(1) A fee which shall cover application and initial approval up to a maximum of one hundred dollars ~~($100.00);~~($100.00).

(2) An annual renewal fee to be paid by January 1 of each year by persons approved ~~pursuant to~~under this Article up to a maximum of fifty dollars ~~($50.00);~~($50.00).

(3) A reinstatement fee for a lapsed approval up to a maximum of five dollars ~~($5.00);~~($5.00).

(4) The form and contents of the applications which shall include information related to the applicant's education and certification by the ~~American College of Nurse-Midwives; and~~American Midwifery Certification Board.

(5) The procedure for establishing ~~physician supervision~~collaborative provider agreements as required by this Article."

SECTION 7. G.S. 90-178.5 reads as rewritten:

"**§ 90-178.5. Qualifications for ~~approval.~~approval; independent practice.**

(a) In order to be approved by the joint subcommittee ~~pursuant to~~ under this Article, a person ~~shall:~~shall comply with each of the following:

(1) Complete an application on a form furnished by the joint ~~subcommittee;~~subcommittee.

(2) Submit evidence of certification by the ~~American College of Nurse-Midwives;~~American Midwifery Certification Board.

(3) Submit evidence of ~~arrangements for physician supervision; and~~a collaborative provider agreement as required by G.S. 90-178.3(b1).

(4) Pay the fee for application and approval.

(b) Upon submitting to the joint subcommittee evidence of completing 24 months and 2,400 hours of practice as a certified nurse-midwife pursuant to a collaborative provider agreement, a certified nurse-midwife is authorized to practice midwifery independently in accordance with this Article."

SECTION 8. G.S. 90-178.7 reads as rewritten:

"**§ 90-178.7. Enforcement.**

(a) The joint subcommittee may apply to the Superior Court of Wake County to restrain any violation of this Article.

(b) ~~Any person who violates G.S. 90-178.3(a) shall be guilty of a Class 3 misdemeanor.~~No person shall perform any act constituting the practice of midwifery, as defined in this Article, or any of the branches thereof, unless the person shall have been first approved under this Article. Any person who practices midwifery without being duly approved and registered, as provided in this Article, shall not be allowed to maintain any action to collect any fee for such services. Any person so practicing without being duly approved shall be guilty of a Class 3 misdemeanor. Any person so practicing without being duly approved under this Article and who is falsely representing himself or herself in a manner as being approved under this Article or any Article of this Chapter shall be guilty of a Class I felony."

SECTION 9. Article 10A of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-178.8. Limit vicarious liability.**

(a) No physician or physician assistant, including the physician assistant's employing or supervising physician, licensed under Article 1 of this Chapter or nurse licensed under Article

9A of this Chapter, shall be held liable for any civil damages as a result of the medical care or treatment provided by the physician, physician assistant, or nurse when:

(1) The physician, physician assistant, or nurse is providing medical care or treatment to a woman or infant in an emergency situation; and

(2) The emergency situation arises during the delivery or birth of the infant as a consequence of the care provided by a certified nurse-midwife approved under this Article who attends a planned birth outside of a hospital setting.

However, the physician, physician assistant, or nurse shall remain liable for his or her own independent acts of negligence.

(b) No health care facility licensed under Chapter 122C or 131E of the General Statutes shall be held liable for civil damages as a result of the medical care or treatment provided by the facility when:

(1) The facility is providing medical care or treatment to a woman or infant in an emergency situation; and

(2) The emergency situation arises during the delivery or birth of the infant as a consequence of the care provided by a certified nurse-midwife approved under this Article who attends a planned birth outside of a hospital setting.

However, the health care facility shall remain liable for its own independent acts of negligence.

(c) Nothing in this section shall be construed to limit liability when the civil damages to this section are the result of gross negligence or willful or wanton misconduct."

SECTION 10. This act is effective when it becomes law.