HB0100S01 compared with HB0100

~~{Omitted text}~~ shows text that was in HB0100 but was omitted in HB0100S01
inserted text shows text that was not in HB0100 but was inserted into HB0100S01

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Electroconvulsive Therapy {~~Prohibition~~ } Administration Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Jake Sawyer

Senate Sponsor:

LONG TITLE

General Description:

This bill {~~prohibits providing~~ } addresses the administration of electroconvulsive therapy {~~to minors~~} .

Highlighted Provisions:

This bill:

- prohibits providing electroconvulsive therapy to minorsunless the minor has catatonia;
- **establishes informed consent requirements for the administration of electroconvulsive therapy;**
- **provides that if a physician fails to comply with informed consent requirements for electroconvulsive therapy:**
  - **it is unprofessional conduct; and**
  - **the physician is presumed to have lacked informed consent for purposes of the Utah Health Care Malpractice Act;**
- defines terms; and
- makes technical and conforming changes.

HB0100

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26B-5-401 , as renumbered and amended by Laws of Utah 2023, Chapter 308

26B-5-402 , as renumbered and amended by Laws of Utah 2023, Chapter 308

26B-5-403 , as last amended by Laws of Utah 2024, Chapters 240, 245

26B-5-404 , as renumbered and amended by Laws of Utah 2023, Chapter 308

78B-3-406 , as last amended by Laws of Utah 2024, Chapter 278

ENACTS:

58-1-514 , Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26B-5-401** is amended to read:

26B-5-401. Definitions.

In addition to the definitions in Section 26B-5-301, as used in this part:

(1) "Catatonia" means the same as that term is defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(2) "Child" means a person under 18 years old.

[~~(2)~~] (3) "Commit" and "commitment" mean the transfer of physical custody in accordance with the requirements of this part.

(4)

(a) "Electroconvulsive therapy" means the use of a device, including a pulse generator and stimulation electrodes, to treat mental disorders and psychiatric disturbances by inducing in the patient a major motor seizure by applying a brief intense electrical current to the patient's head.

(b) "Electroconvulsive therapy" includes treatment known as electroshock therapy or shock treatment.

[~~(3)~~] (5) "Legal custody" means:

(a) the right to determine where and with whom the child shall live;

(b) the right to participate in all treatment decisions and to consent or withhold consent for treatment in which a constitutionally protected liberty or privacy interest may be affected, including antipsychotic medication{[, }[~~electroshock~~] electroconvulsive{ therapy,~~]~~} and psychosurgery; and

(c) the right to authorize surgery or other extraordinary medical care.

[~~(4)~~] (6) "Physical custody" means:

(a) placement of a child in any residential or inpatient setting;

(b) the right to physical custody of a child;

(c) the right and duty to protect the child; and

(d) the duty to provide, or insure that the child is provided with, adequate food, clothing, shelter, and ordinary medical care.

[~~(5)~~] (7) "Residential" means any out-of-home placement made by a local mental health authority, but does not include out-of-home respite care.

[~~(6)~~] (8) "Respite care" means temporary, periodic relief provided to parents or guardians from the daily care of children with serious emotional disorders for the limited time periods designated by the division.

Section 2. Section **26B-5-402** is amended to read:

26B-5-402. Treatment and commitment of minors in the public mental health system.

A child is entitled to due process proceedings, in accordance with the requirements of this part, whenever the child:

(1) may receive or receives services through the public mental health system and is placed, by a local mental health authority, in a physical setting where [~~his~~] the child's liberty interests are restricted, including residential and inpatient placements; or

(2) receives treatment in which a constitutionally protected privacy or liberty interest may be affected, including the administration of antipsychotic medication{[, }[~~electroshock~~] electroconvulsive{ therapy,~~]~~} and psychosurgery.

Section 3. Section **26B-5-403** is amended to read:

26B-5-403. Residential and inpatient settings -- Commitment proceeding -- Child in physical custody of local mental health authority.

(1) A child may receive services from a local mental health authority in an inpatient or residential setting only after a commitment proceeding, for the purpose of transferring physical custody, has been conducted in accordance with the requirements of this section.

(2)

(a) [~~That~~] The commitment proceeding described in Subsection (1) shall be initiated by a petition for commitment, and shall be a careful, diagnostic inquiry, conducted by a neutral and detached fact finder, [~~pursuant to~~] in accordance with the procedures and requirements of this section.

(b) If the findings described in Subsection (4) exist, the proceeding shall result in the transfer of physical custody to the appropriate local mental health authority, and the child may be placed in an inpatient or residential setting.

(3) The neutral and detached fact finder who conducts the inquiry:

(a) shall be a designated examiner; and

(b) may not profit, financially or otherwise, from the commitment or physical placement of the child in that setting.

(4) Upon determination by a neutral and detached fact finder that the following circumstances clearly exist, the neutral and detached fact finder may order that the child be committed to the physical custody of a local mental health authority:

(a) the child has a mental illness;

(b) the child demonstrates a reasonable fear of the risk of substantial danger to self or others;

(c) the child will benefit from care and treatment by the local mental health authority; and

(d) there is no appropriate less-restrictive alternative.

(5)

(a) The commitment proceeding before the neutral and detached fact finder shall be conducted in as informal manner as possible and in a physical setting that is not likely to have a harmful effect on the child.

(b) The child, the child's parent or legal guardian, the petitioner, and a representative of the appropriate local mental health authority:

(i) shall receive informal notice of the date and time of the proceeding; and

(ii) may appear and address the petition for commitment.

(c) The neutral and detached fact finder may, in the neutral and detached fact finder's discretion, receive the testimony of any other person.

(d) The neutral and detached fact finder may allow a child to waive the child's right to be present at the commitment proceeding, for good cause shown. If that right is waived, the purpose of the waiver shall be made a matter of record at the proceeding.

(e) At the time of the commitment proceeding, the appropriate local mental health authority, [~~its~~] the local mental health authority's designee, or the psychiatrist who has been in charge of the child's care prior to the commitment proceeding, shall provide the neutral and detached fact finder with the following information, as it relates to the period of current admission:

(i) the petition for commitment;

(ii) the admission notes;

(iii) the child's diagnosis;

(iv) physicians' orders;

(v) progress notes;

(vi) nursing notes; and

(vii) medication records.

(f) The information described in Subsection (5)(e) shall also be provided to the child's parent or legal guardian upon written request.

(g)

(i)

(A) The neutral and detached fact finder's decision of commitment shall state the duration of the commitment.

(B) Any commitment to the physical custody of a local mental health authority may not exceed 180 days.

(C) Prior to expiration of the commitment, and if further commitment is sought, a hearing shall be conducted in the same manner as the initial commitment proceeding, in accordance with the requirements of this section.

(ii) At the conclusion of the hearing and subsequently in writing, when a decision for commitment is made, the neutral and detached fact finder shall inform the child and the child's parent or legal guardian of that decision and of the reasons for ordering commitment.

(iii) The neutral and detached fact finder shall state in writing the basis of the decision, with specific reference to each of the criteria described in Subsection (4), as a matter of record.

(6)

(a) A child may be temporarily committed for a maximum of 72 hours, excluding Saturdays, Sundays, and legal holidays, to the physical custody of a local mental health authority in accordance with the

procedures described in Section 26B-5-331 and upon satisfaction of the risk factors described in Subsection (4).

(b) A child who is temporarily committed shall be released at the expiration of the 72 hours unless the procedures and findings required by this section for the commitment of a child are satisfied.

(7)

(a) A local mental health authority shall have physical custody of each child committed to [~~it~~] the local mental health authority under this section.

(b) The parent or legal guardian of a child committed to the physical custody of a local mental health authority under this section, retains legal custody of the child, unless legal custody has been otherwise modified by a court of competent jurisdiction.

(c) [~~In cases when~~] If the Division of Child and Family Services or the Division of Juvenile Justice and Youth Services has legal custody of a child committed to the physical custody of a local mental health authority under this section, that division shall retain legal custody for purposes of this part.

(8)

(a) The cost of caring for and maintaining a child in the physical custody of a local mental health authority shall be assessed to and paid by the child's parents, according to their ability to pay.

(b) For purposes of this section, the Division of Child and Family Services or the Division of Juvenile Justice and Youth Services shall be financially responsible, in addition to the child's parents, if the child is in the legal custody of either of those divisions at the time the child is committed to the physical custody of a local mental health authority under this section, unless Medicaid regulation or contract provisions specify otherwise.

(c) The Office of Recovery Services shall assist [~~those~~] the divisions described in Subsection (8)(b) in collecting the costs assessed pursuant to this section.

(9)

(a) Whenever application is made for commitment of a minor to a local mental health authority under any provision of this section by a person other than the child's parent or guardian, the local mental health authority or [~~its~~] the local mental health authority's designee shall notify the child's parent or guardian.

(b) The parents shall be provided sufficient time to prepare and appear at any scheduled proceeding.

(10)

(a)

(i) Each child committed pursuant to this section is entitled to an appeal within 30 days after any order for commitment.

(ii) The appeal described in Subsection (10)(a)(i) may be brought on the child's own petition or on petition of the child's parent or legal guardian, to the juvenile court in the district where the child resides or is currently physically located. [~~With regard to a child in the custody of the Division of Child and Family Services or the Division of Juvenile Justice and Youth Services, the attorney general's office shall handle the appeal, otherwise the appropriate county attorney's office is responsible for appeals brought pursuant to this Subsection (10)(a).~~]

(iii) Except as provided in Subsection (10)(a)(iv), the appropriate county attorney's office is responsible for appeals brought under this Subsection (10)(a).

(iv) The attorney general's office shall handle appeals regarding a child in the custody of the Division of Child and Family Services or the Division of Juvenile Justice and Youth Services.

(b)

(i) Upon receipt of the petition for appeal, the court shall appoint a designated examiner previously unrelated to the case, to conduct an examination of the child in accordance with the criteria described in Subsection (4), and file a written report with the court.

(ii) The court shall then conduct an appeal hearing to determine whether the findings described in Subsection (4) exist by clear and convincing evidence.

(c) Prior to the time of the appeal hearing, the appropriate local mental health authority, [~~its~~] the local mental health authority's designee, or the mental health professional who has been in charge of the child's care prior to commitment, shall provide the court and the designated examiner for the appeal hearing with the following information, as it relates to the period of current admission:

(i) the original petition for commitment;

(ii) admission notes;

(iii) diagnosis;

(iv) physicians' orders;

(v) progress notes;

(vi) nursing notes; and

(vii) medication records.

(d) Both the neutral and detached fact finder and the designated examiner appointed for the appeal hearing shall be provided with an opportunity to review the most current information described in Subsection (10)(c) prior to the appeal hearing.

(e)

(i) The court shall notify the child, the child's parent or legal guardian, the person who submitted the original petition for commitment, and a representative of the appropriate local mental health authority [~~shall be notified by the court~~]of the date and time of the appeal hearing.

(ii) [~~Those persons~~] The persons described in Subsection (10)(e)(i) shall be afforded an opportunity to appear at the hearing.

(iii) In reaching its decision, the court shall review the record and findings of the neutral and detached fact finder, the report of the designated examiner appointed pursuant to Subsection (10)(b), and may, in [~~its~~] the court's discretion, allow or require the testimony of the neutral and detached fact finder, the designated examiner, the child, the child's parent or legal guardian, the person who brought the initial petition for commitment, or any other person whose testimony the court deems relevant.

(iv) The court may allow the child to waive the right to appear at the appeal hearing, for good cause shown.

(v) [~~If that waiver is granted~~] If the court grants the waiver described in Subsection (10)(e)(iv), the purpose shall be made a part of the court's record.

(11) Each local mental health authority has an affirmative duty to conduct periodic evaluations of the mental health and treatment progress of every child committed to [~~its~~] the local mental health authority's physical custody under this section, and to release any child who has sufficiently improved so that the criteria justifying commitment no longer exist.

(12)

(a)

(i) A local mental health authority or [~~its~~] the local mental health authority's designee, in conjunction with the child's current treating mental health professional may release an improved child to a less restrictive environment, as they determine appropriate.

(ii) Whenever the local mental health authority or [~~its~~] the local mental health authority's designee, and the child's current treating mental health professional, determine that the conditions

justifying commitment no longer exist, the child shall be discharged and released to the child's parent or legal guardian.

(iii) With regard to a child who is in the physical custody of the State Hospital, the treating psychiatrist or clinical director of the State Hospital shall be the child's current treating mental health professional.

(b) A local mental health authority or [~~its~~] the local mental health authority's designee, in conjunction with the child's current treating mental health professional, is authorized to issue a written order for the immediate placement of a child not previously released from an order of commitment into a more restrictive environment, if the local authority or [~~its~~] the local authority's designee and the child's current treating mental health professional has reason to believe that the less restrictive environment in which the child has been placed is exacerbating the child's mental illness, or increasing the risk of harm to self or others.

(c)

(i) The written order described in Subsection (12)(b) shall include the reasons for placement in a more restrictive environment and shall authorize any peace officer to take the child into physical custody and transport the child to a facility designated by the appropriate local mental health authority in conjunction with the child's current treating mental health professional.

(ii) Prior to admission to the more restrictive environment, copies of the order shall be personally delivered to the child, the child's parent or legal guardian, the administrator of the more restrictive environment, or the administrator's designee, and the child's former treatment provider or facility.

(d)

(i) If the child has been in a less restrictive environment for more than 30 days and is aggrieved by the change to a more restrictive environment, the child or the child's representative may request a review within 30 days of the change, by a neutral and detached fact finder as described in Subsection (3).

(ii) The neutral and detached fact finder shall determine whether:

[~~(i)~~] (A) the less restrictive environment in which the child has been placed is exacerbating the child's mental illness or increasing the risk of harm to self or others; or

[~~(ii)~~] (B) the less restrictive environment in which the child has been placed is not exacerbating the child's mental illness or increasing the risk of harm to self or others, in which case the neutral and detached fact finder shall designate that the child remain in the less restrictive environment.

(e) Nothing in this section prevents a local mental health authority or [~~its~~] the local mental health authority's designee, in conjunction with the child's current mental health professional, from discharging a child from commitment or from placing a child in an environment that is less restrictive than that designated by the neutral and detached fact finder.

(13)

(a) Each local mental health authority or [~~its~~] the local mental health authority's designee, in conjunction with the child's current treating mental health professional shall discharge any child who, in the opinion of [~~that local authority~~] {~~-~~} the local mental health authority, or [~~its~~] the local mental health authority's designee, and the child's current treating mental health professional, no longer meets the criteria specified in Subsection (4), except as provided [~~by~~] in Section 26B-5-405.

(b) The local mental health authority and the child's current treating mental health professional shall assure that any further supportive services required to meet the child's needs upon release will be provided.

(14)

(a) Even though a child has been committed to the physical custody of a local mental health authority under this section, the child is still entitled to additional due process proceedings, in accordance with Section 26B-5-404, before any treatment that may affect a constitutionally protected liberty or privacy interest is administered.

(b) [~~Those treatments include, but are not limited to,~~] The treatments described in Subsection (14)(a) include antipsychotic medication{[~~,~~ }[~~electroshock~~] electroconvulsive{ therapy,[~~}~~]} and psychosurgery.

Section 4. Section **26B-5-404** is amended to read:

26B-5-404. Invasive treatment -- Due process proceedings.

(1) [~~For purposes of~~] As used in this section, "invasive treatment" means treatment in which a constitutionally protected liberty or privacy interest may be affected, including antipsychotic medication{[~~,~~ }[~~electroshock~~] electroconvulsive{ therapy,[~~}~~]} and psychosurgery.

(2) The requirements of this section apply to all children receiving services or treatment from a local mental health authority, [~~its~~] the local mental health authority's designee, or [~~its~~] the local mental health authority's provider regardless of whether a local mental health authority has physical custody of the child or the child is receiving outpatient treatment from the local mental health authority, [~~its~~] the local mental health authority's designee, or the local mental health authority's provider.

(3) A child to whom this section applies may only receive electroconvulsive therapy if the child is diagnosed with catatonia.

[~~(3)~~] (4)

(a) The division shall [~~promulgate~~] make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, establishing due process procedures for [~~children~~] a child prior to any invasive treatment as follows:

(i) with regard to antipsychotic medications, if either the parent or child disagrees with that treatment, a due process proceeding shall be held in compliance with the procedures established under this Subsection [~~(3)~~] (4);

(ii) with regard to psychosurgery{~~[~~ and ~~]~~}[~~electroshock~~] electroconvulsive{ therapy~~]~~} , a due process proceeding shall be conducted pursuant to the procedures established under this Subsection [~~(3)~~] (4), regardless of whether the parent or child agree or disagree with the treatment; and

(iii) other possible invasive treatments may be conducted unless either the parent or child disagrees with the treatment, in which case a due process proceeding shall be conducted pursuant to the procedures established under this Subsection [~~(3)~~] (4).

(b) In [~~promulgating~~] making the rules [~~required by~~] described in Subsection [~~(3)(a)~~] (4)(a), the division shall:

(i) consider the advisability of utilizing an administrative law judge, court proceedings, a neutral and detached fact finder, and other methods of providing due process for the purposes of this section[~~.~~] ; and

(ii) [~~The division shall also~~]establish the criteria and basis for determining when invasive treatment should be administered.

Section 5. Section **5** is enacted to read:

58-1-514. {~~Prohibition on providing~~ } Informed consent requirements for electroconvulsive therapy {~~to a minor~~} -- Special provisions for electroconvulsive therapy for youth.

(1) As used in this section:

(a) "Adult" means an individual who is 18 years old or older.

(b) "Advance health care directive" means the same as that term is defined in Section 75A-9-101.

(c) "Agent" means the same as that term is defined in Section 75A-9-101.

(d) "Capacity" means the same as that term is defined in Section 75A-9-102.

(e) "Catatonia" means the same as that term is defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(f) "Coercion" means influencing or attempting to influence an individual using force, threats, or intimidation.

(g) "Default surrogate" means the same as that term is defined in Section 75A-9-101.

(a){(h)}

(i) "Electroconvulsive therapy" means the use of a device, including a pulse generator and stimulation electrodes, to treat mental disorders and psychiatric disturbances by inducing in the patient a major motor seizure by applying a brief intense electrical current to the patient's head.

(ii) "Electroconvulsive therapy" includes treatment known as electroshock therapy or shock treatment.

(i) "Emancipated minor" means a minor who is emancipated under Section 80-7-105.

(j) "Informed consent" means consent that is:

(i) voluntary;

(ii) free from coercion or undue influence; and

(iii) a written expression by the individual giving consent that states that:

(A) the individual fully understands the information presented in required disclosures; and

(B) the individual agrees to the administration of electroconvulsive therapy.

(k) "Memory assessment" means a screening test for mild cognitive impairment that assesses a patient's cognitive abilities, including memory, attention, language, and visuospatial skills.

(b){(l)} "Minor" means an individual who is younger than {~~25~~} 18 years old.

(m) "Physician" means an individual licensed under Chapter 67, Utah Medical Practice Act, or Chapter 68, Utah Osteopathic Medical Practice Act.

(n) "Power of attorney for health care" means the same as that term is defined in Section 75A-9-101.

(o) "Psychiatrist" means in individual who:

(i) is a physician; and

(ii) is board eligible for a psychiatry specialization recognized by the American Board of Medical Specialists or the American Osteopathic Association's Bureau of Osteopathic Specialists.

(p) "Required disclosures" means the information a physician is required to provide under Subsection (3).

(q) "Undue influence" means when a person uses a relationship or position of authority, trust, or confidence to influence an individual to make a decision by:

(i) exploiting the trust, dependence, or fear of an individual;

(ii) knowingly assisting or causing another to exploit the trust, dependence, or fear of the individual; or

(iii) gaining control deceptively over the decision making of the individual.

(2) Only a physician may administer electroconvulsive therapy.

(3) Before administering electroconvulsive therapy to an individual, the physician shall provide to the individual giving informed consent the following information in a format that explicitly states in writing:

(a) the nature and seriousness of the mental condition that requires treatment with electroconvulsive therapy;

(b) the nature of the procedures that will be followed in administering electroconvulsive therapy, including anesthesia, and the purposes of the procedures;

(c) an identification of any procedures described in Subsection (3)(b) that are experimental;

(d) the nature, degree, duration, and probability of significant risks, side effects, or adverse effects that may result from the administration of electroconvulsive therapy, including:

(i) memory changes of events prior to, during, and immediately following the administration of electroconvulsive therapy;

(ii) fractures and dislocations of bones;

(iii) the probability of significant temporary post-treatment confusion requiring special care;

(iv) the possibility of:

(A) permanent memory dysfunction, including the possible degree and duration of memory loss;

(B) permanent, irrevocable memory loss;

(C) seizures; and

(D) death;

(e) that there is a division of opinion as to the efficacy of electroconvulsive therapy;

(f) the benefits of electroconvulsive therapy that may reasonably be expected;

(g) the probable degree and duration of improvement or remission of the patient's condition that may be advantageous for the patient;

(h) an offer to answer any questions including questions concerning the electroconvulsive therapy treatment and the procedures described in Subsections (3)(a) through (c);

(i) a notice that the individual giving informed consent may withdraw consent at any time;

(j) a statement that the consent is for an individual electroconvulsive therapy treatment and that additional treatments require renewed consent;

(k) an explanation of the side effects of anesthesia; and

(l) a supplemental statement about the individual patient that includes:

(i) indications for electroconvulsive therapy for the patient;

(ii) the patient's medical evaluation results;

(iii) contraindications to electroconvulsive therapy;

(iv) the results of the patient's psychiatric and other medical consultations that are relevant to the administration of electroconvulsive therapy;

(v) known current medical conditions that may increase the possibility of injury or death as a result of electroconvulsive therapy; and

(vi) a statement that electroconvulsive therapy is medically necessary by two physicians, including:

(A) at least one psychiatrist; and

(B) at least one physician who has personally examined the patient.

(2){(4)} A {~~health care provider, as defined in Section 78B-3-403 and who is licensed under this title,~~ } physician may not {~~provide~~ } administer electroconvulsive therapy to a minor{~~.~~} , unless:

(a) the minor has been diagnosed with catatonia;

(b)

(i) the minor's parent, guardian, or person described in Subsection 78B-3-406(6), gives informed consent for each administration of electroconvulsive therapy; or

(ii) if the minor is an emancipated minor:

(A) the emancipated minor's agent, default surrogate, or person described in Subsection 78B-3-406(6), gives consent for each electroconvulsive therapy treatment; or

(B) the emancipated minor's consent is expressed in an advance health care directive;

(c) the physician documents the following in the minor's record:

(i) the clinical justification for the use of electroconvulsive therapy to treat the individual's condition;

(ii) required disclosures;

(iii) other, less intrusive therapies that:

(A) were considered to treat the minor's condition; and

(B) have been administered to the minor to treat the minor's condition, and the results of the treatment;

(d) the minor and the individual giving informed consent receive:

(i) a copy of the written expression of informed consent;

(ii) an oral explanation of required disclosures in simple, nontechnical terms in the primary language of:

(A) the minor and the individual giving informed consent for the minor; or

(B)

(I) the emancipated minor; or

(II) the individual giving informed consent for the emancipated minor;

(e) the physician administers a memory assessment to the minor, if appropriate given the minor's condition, before and after each administration of electroconvulsive therapy; and

(f) electroconvulsive therapy is ordered by a psychiatrist, or in consultation with a psychiatrist if the physician is not a psychiatrist.

(5) A physician may not administer electroconvulsive therapy to an adult unless:

(a)

(i) the adult has capacity and gives informed consent for each administration of electroconvulsive therapy; or

(ii) if the adult lacks capacity as determined under Title 75A, Chapter 9, Uniform Health Care Decisions Act:

(A) the adult's agent or default surrogate gives informed consent for each administration of electroconvulsive therapy;

(B) the adult's informed consent is expressed in an advance health care directive; or

(C) a person described in Subsection 78B-3-406(6), gives informed consent for each administration of electroconvulsive therapy;

(b) the physician documents the following in the adult's record:

(i) the clinical justification for the use of electroconvulsive therapy to treat the adult's condition;

(ii) required disclosures;

(iii) other, less intrusive therapies that:

(A) were considered to treat the adult's condition; and

(B) have been administered to the individual to treat the adult's condition, and the results of the treatment;

(c) the individual giving informed consent for the administration of electroconvulsive therapy to the adult receives:

(i) a copy of the written expression of informed consent; and

(ii) an oral explanation of required disclosures in simple, nontechnical terms in the primary language of the individual giving informed consent;

(d) the physician administers a memory assessment to the adult before and after each administration of electroconvulsive therapy; and

(e) electroconvulsive therapy is ordered by a psychiatrist, or in consultation with a psychiatrist if the physician is not a psychiatrist.

(6) Informed consent given as described in this section may be withdrawn at any time.

(7)

(a) Except as provided in Subsection (7)(b), the requirements of this section apply in addition to any requirements described in Title 75A, Chapter 9, Uniform Health Care Decisions Act, and any other applicable provision of law.

(b) If any provision of this section conflicts with any other provisions of law, the more specific or more restrictive law shall control.

(3){(8)} A violation of this section is unprofessional conduct.

(4){(9)} A rule adopted under this title that defines "unprofessional conduct" shall be consistent with this section.

Section 6. Section **78B-3-406** is amended to read:

78B-3-406. Failure to obtain informed consent -- Proof required of patient -- Defenses -- Consent to health care.

(1)

(a) When a person submits to health care rendered by a health care provider, it is presumed that actions taken by the health care provider are either expressly or impliedly authorized to be done.

(b) For a patient to recover damages from a health care provider in an action based upon the provider's failure to obtain informed consent, the patient must prove the following:

(i) that a provider-patient relationship existed between the patient and health care provider;

(ii) the health care provider rendered health care to the patient;

(iii) the patient suffered personal injuries arising out of the health care rendered;

(iv) the health care rendered carried with it a substantial and significant risk of causing the patient serious harm;

(v) the patient was not informed of the substantial and significant risk;

(vi) a reasonable, prudent person in the patient's position would not have consented to the health care rendered after having been fully informed as to all facts relevant to the decision to give consent; and

(vii) the unauthorized part of the health care rendered was the proximate cause of personal injuries suffered by the patient.

(2) In determining what a reasonable, prudent person in the patient's position would do under the circumstances, the finder of fact shall use the viewpoint of the patient before health care was provided and before the occurrence of any personal injuries alleged to have arisen from said health care.

(3) It shall be a defense to any malpractice action against a health care provider based upon alleged failure to obtain informed consent if:

(a) the risk of the serious harm which the patient actually suffered was relatively minor;

(b) the risk of serious harm to the patient from the health care provider was commonly known to the public;

(c) the patient stated, prior to receiving the health care complained of, that he would accept the health care involved regardless of the risk; or that he did not want to be informed of the matters to which he would be entitled to be informed;

(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 risks were disclosed, if the health care provider reasonably believed that additional disclosures could be expected to have a substantial and adverse effect on the patient's condition; or

(e) the patient or the patient's representative executed a written consent which sets forth the nature and purpose of the intended health care and which contains a declaration that the patient accepts the risk of substantial and serious harm, if any, in hopes of obtaining desired beneficial results of health care and which acknowledges that health care providers involved have explained the patient's condition and the proposed health care in a satisfactory manner and that all questions asked about the health care and its attendant risks have been answered in a manner satisfactory to the patient or the patient's representative.

(4) The written consent shall be a defense to an action against a health care provider based upon failure to obtain informed consent unless the patient proves that the person giving the consent lacked capacity to consent or shows by clear and convincing evidence that the execution of the

written consent was induced by the defendant's affirmative acts of fraudulent misrepresentation or fraudulent omission to state material facts.

(5) This act may not be construed to prevent any person 18 years old or over from refusing to consent to health care for the patient's own person upon personal or religious grounds.

(6) Except as provided in Section 76-7-304.5, the following persons are authorized and empowered to consent to any health care not prohibited by law:

(a) any parent, whether an adult or a minor, for the parent's minor child;

(b) any married person, for a spouse;

(c) any person temporarily standing in loco parentis, whether formally serving or not, for the minor under that person's care and any guardian for the guardian's ward;

(d) any person 18 years old or older for that person's parent who is unable by reason of age, physical or mental condition, to provide such consent;

(e) any patient 18 years old or older;

(f) any female regardless of age or marital status, when given in connection with her pregnancy or childbirth;

(g) in the absence of a parent, any adult for the adult's minor brother or sister;

(h) in the absence of a parent, any grandparent for the grandparent's minor grandchild;

(i) an emancipated minor as provided in Section 80-7-105;

(j) a minor who has contracted a lawful marriage;

(k) an unaccompanied homeless minor, as that term is defined in the McKinney-Vento Homeless Assistance Act of 1987, Pub. L. 100-77, as amended, who is 15 years old or older; and

(l) a minor receiving tobacco and nicotine cessation services under Section 26B-7-522.

(7) A person who in good faith consents or authorizes health care treatment or procedures for another as provided by this act may not be subject to civil liability.

(8) Notwithstanding any other provision of this section[~~,~~] :

(a) if a health care provider fails to comply with the requirement in Section 58-1-509, the health care provider is presumed to have lacked informed consent with respect to the patient examination, as defined in Section 58-1-509[~~.~~] ; and

(b) if a physician fails to comply with the requirements in Section 58-1-514, the physician is presumed to have lacked informed consent with respect to the administration of electroconvulsive therapy, as defined in Section 58-1-514.

Section 7. **Effective date.**

Effective Date.

This bill takes effect on May 6, 2026.

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