



COLLEGE OF
PHYSIOTHERAPISTS
OF ALBERTA

Consent Guide

for Alberta Physiotherapists

October 2018

Physiotherapists are required by the Standards of Practice for Physiotherapists in Alberta and by Canadian law to obtain informed consent prior to conducting an assessment or providing treatment. The purpose of this Guide is to clarify the expectations for Alberta physiotherapists and to discuss frequently asked questions related to consent. Physiotherapists are advised to review the Consent Standard of Practice in conjunction with this document.





The College of Physiotherapists of Alberta developed this guide to provide a framework to support members in obtaining consent and to help ensure the College of Physiotherapists of Alberta's practice standards are met and that Albertans receive competent, ethical, quality physiotherapy care.

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Introduction

To give consent is to provide approval for something to happen or agreement to do something.¹ In the world of health care, consent is a cornerstone of all therapeutic interactions. The requirement to obtain informed consent for an **intervention** (assessment and/or treatment) is established in Canadian law² and reflected in the Standards of Practice for Physiotherapists in Alberta;³ however, questions often arise regarding aspects of consent, including the requirements for consent to be considered valid, documentation requirements, the frequency with which consent should be sought, and how to navigate challenging situations related to consent and consent processes.

The purpose of this guide is to clarify the expectations for Alberta physiotherapists and to discuss frequently asked questions related to consent.

Patients cannot provide valid consent if they do not fully understand what they are consenting to and the implications of that consent. Therefore, clear communication is required, the purpose of which is to provide information to enable patients to make informed decisions about accepting or refusing the proposed intervention. It is important that patients understand the nature and purpose of the intervention proposed. The consent process must include an explanation of the physiotherapy diagnosis and recommended treatment including benefits, risks, and other options for treatment. Patients must be given the opportunity to ask questions and gain further clarification if required.²

Both patients and providers must understand that patients have the right to change their mind and withdraw consent at any time.³

Effective consent conversations are enabled by communicating with patients in plain, easy to understand language. Technical terms or the use of jargon is not recommended and is contrary to the purpose of gaining informed consent.

Physiotherapists must understand that consent is an ongoing process, not a one-time event.

Equally, for consent to be valid, it must be informed.²

Guidelines for Consent

Consent must be:^{2,4}

- Given voluntarily
- Given by a patient who has capacity
- Specific to both the intervention and the person administering the intervention
- Given by a patient who is informed

Components of Informed Consent

To provide informed consent, the patient must:^{2,4}

- Be informed of the nature/purpose of the intervention
- Be informed of the benefits of the intervention
- Be informed of both the **material and special risks** of the intervention⁵
- Understand the consequences of these risks
- Be informed of **other material information** which may impact the patient's decision
- Be given reasonable and understandable answers to any questions asked about the intervention, its risks, benefits or alternatives

When determining whether informed consent was established, the law asks what the average, reasonable person in the patient's position, would expect to know prior to providing consent (both material and special risks).²

The Nine Underlying Principles of Consent

1. Autonomous

The ethical principle of autonomy or self-determination underpins the obligation to obtain informed consent. Physiotherapists are ethically and legally bound to communicate with patients so they can make informed choices regarding their own care.

2. Voluntary

Consent is invalid if obtained by coercion, undue influence, or intentional misrepresentation. Consent should be given in an environment free of fear or compulsion from others, including family members and health-care providers.

3. Informed

Consent is invalid if it is based on incomplete or inaccurate information. Consent must be based on a careful discussion of all relevant information and considerations regarding the intervention. Different strategies should be used to ensure patient understanding including: verbal explanations, handouts, visual aids, consent forms, asking a patient whether they understand the information presented, and having them explain it back to check for understanding.

4. Capacity

Consent is only valid when the person providing consent has the capacity to do so. The patient must have the ability to appreciate the nature and consequences of the consent decision.

5. Treatment Specific

As already described, the patient provides consent to a specific treatment, after being informed of the risks and benefits of the treatment proposed. A patient can consent to receive treatment and still decline certain aspects or components of the proposed treatment.

6. Provider Specific

Informed consent is personal and normally authorizes a specific person to carry out a specific intervention. Patients have the right to intervention by a health professional with whom they have a relationship and the right to consent to or decline a physiotherapist's assignment of intervention responsibilities to another individual. The physiotherapist providing the intervention is responsible to obtain the consent.

7. Format

Informed consent can be written or verbal. While the law does not generally require a "written consent", a consent form signed by the patient provides evidence that consent has been obtained.²

If an intervention is invasive, carries an appreciable risk, or is likely to be painful, it is prudent for the physiotherapist to obtain written consent.²

Verbal consent must be documented in the treatment record by the physiotherapist.³

8. Documented

Whether the physiotherapist accepts verbal consent or has the patient sign a consent form, the physiotherapist is advised to document the consent process including the information provided to the patient, and when/how consent was obtained. A signed consent form provides evidence that consent was obtained but does not necessarily indicate that the consent was informed and cannot replace a detailed informed consent discussion.²

9. Right to Refuse

Patients have the right to refuse intervention, regardless of the consequences or how beneficial or necessary a treatment may be. Patients also have the right to change their mind and withdraw previous consent at any time during care.³

Just as consent must be informed, it is important that a patient's refusal of consent/treatment be informed. "When patients decide against recommended treatment..., discussions about their decision must be conducted with some sensitivity. While recognizing an individual's right to refuse..., [physiotherapists] must at the same time explain the consequences of the refusal without creating a perception of coercion in seeking consent. Refusal of the recommended treatment does not necessarily constitute refusal for all treatments. Reasonable alternatives should be explained and offered to the patient."²

Physiotherapists are advised to document a patient's refusal, the information provided to the patient regarding risks or consequences of refusal, and the patient's rationale for refusing, if one is provided.

Capacity

Nuances of Capacity and Competence

Health-care providers often use the terms capacity and competence interchangeably. Both refer to the ability “to understand information relevant to a treatment decision, and to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.” **Competence** is determined by the courts. A person either is or is not competent. **Capacity** comes in “degrees” with one’s capacity to make decisions being impacted by the nature of the decision and risks related to the decision.⁶ For example, a young child has the capacity to make some decisions, but not others. As the child ages, the types of decisions they can make independently changes. A person’s capacity factors into the assessment of their competence, but they are not the same thing.⁶

Physiotherapists do not make legal determinations of a patient’s competence; therefore, within physiotherapy practice, the correct term to use is capacity.

When questioning someone’s capacity, the key question is “the capacity to do what?” A patient may lack capacity to consent to some components of an assessment or treatment but not others due to the nature and risks of the intervention in question.¹⁰ A physiotherapist should, therefore, consider the nature of the intervention for which the consent is being sought when determining whether the patient has the capacity to provide consent.

It is important to remember, as some authors have noted, concerns about capacity often disappear if the patient is making decisions consistent with the physiotherapist’s recommendations. However, “if you worry about a patient’s capacity to refuse some treatment, you should also worry about his capacity to accept it.”⁷

Capacity and Adult Patients

Adults over the age of 18 are presumed to have capacity until proven otherwise.⁸ Before an adult is determined legally incompetent, they must undergo a capacity assessment.⁹

If an adult is found to lack capacity a range of options is available to assist with decision making on their behalf, including Supported Decision-Making, Specific Decision-Making and Guardianship/Trusteeship. The patient may also have a Personal Directive that provides a decision maker or “agent” with the legal authority to make decisions on the patient’s behalf.⁴

If a patient lacks the capacity to give informed consent, consent must be obtained from a family member/designate with legal authority to provide it.⁶

If a physiotherapist has concerns about a patient’s capacity to provide informed consent for an intervention, the physiotherapist should enquire if a Supported Decision-Making Authorization, Guardianship, or Personal Directive is in place. If no legal arrangement is in place, the physiotherapist’s duty of care extends to raising his/her concerns with others within the patient’s circle of care, and advocating for a formal capacity assessment as appropriate to obtain appropriate supports for the patient.

As already stated, the key question about capacity is “capacity to do what?” When treating adults with diminished capacity, the physiotherapist should consider if the patient has sufficient capacity to consent to some aspects of the intervention and act accordingly.

Capacity and Minors

Individuals under the age of 18 are generally considered to lack capacity, unless there is a reason to believe otherwise. If a patient is under 18, consent must generally be obtained from the parent/guardian, and **assent** obtained from the minor.

However, a **mature minor** may give consent on their own behalf if they understand the nature and purpose of the proposed intervention and consequences of receiving/refusing it.¹¹

It is the physiotherapist’s responsibility to assess and make the determination of whether a patient under 18 is a mature minor and, therefore, able to provide consent. Some factors that may be considered in making the assessment of whether a minor is able to appreciate the nature and purpose of the intervention and the consequence of giving or refusing consent include:

- The age of the minor. Although there is no set age for a mature minor in Alberta, sixteen years of age is generally considered the threshold for recognition of maturity by the Courts. No Alberta court has recognized an individual under the age of fourteen as a mature minor¹²
- The maturity of the minor
- The nature and extent of the minor’s dependence on the parent(s). This relates to the ability of the minor to make an independent decision without coercion and influence of the parent or guardian
- The nature/complexity of the treatment

Age is not the sole, determining factor. Physiotherapists should be careful to engage in a holistic assessment of the minor patient to determine if he/she is a mature minor.

FAQ

Q: I had my patient sign a consent form when they completed their intake paperwork, so I'm covered, right?

A: Wrong! A consent signed before the patient has received information about the assessment, their physiotherapy diagnosis, the proposed treatment, and the risks/benefits and consequences of receiving or not receiving treatment is clearly not informed consent.² It is not worth the paper it is written on.

Q: Do I need to get written consent?

A: Documentation of verbal consent is considered valid and acceptable. Written consent provides concrete evidence that the patient signed a consent form but does not necessarily indicate that the consent was informed.² The best-case scenario is to obtain written consent, after having the informed consent discussion with the patient, and having documented the nature and content of that discussion.

When the risks of an intervention are more significant or more common, it is recommended that members follow the latter approach and obtain written consent following the informed consent discussion.²

Q: What about implied consent?

A: Historically, it was thought that if a patient made an appointment and attended a treatment session, their consent was implied by their actions.² However, the simple act of attending a physiotherapy appointment does not ensure that the physiotherapist has provided the patient with the necessary information to make decisions about the patient's care and that informed consent has been obtained. Attendance at a physiotherapy appointment cannot be considered "informed consent" in and of itself.

Relying on implied consent can lead to challenging situations in which the extent of consent implied becomes a matter of disagreement after the fact. It is, therefore, preferable to obtain express consent.²

However, a patient or their agent, may provide consent for a "plan of care" expected to continue over a series of treatment visits. In this case, the patient's attendance and participation with the agreed plan of care may be considered implied consent. Provided there is no significant change in the nature, expected benefits or risks of treatment, a physiotherapist may presume that consent to treatment continues. The physiotherapist is expected to provide updates and reporting to the patient (or his/her agent) throughout the course of treatment to support this ongoing consent.⁴

However, a new informed consent must be obtained whenever there is a significant change in the patient's capacity, condition, the treatment plan, expected outcomes or risks.⁴

Bear in mind that a patient may at any time withdraw consent, whether it be for the plan of care entirely or for a specific intervention. Providers are advised to informally reaffirm consent to treatment at the start of each visit.

Q: What does it mean to "informally reaffirm" consent at the start of each treatment visit?

A: Every time a patient comes for treatment, the physiotherapist should review the treatment plan for that visit and confirm that he/she has the patient's agreement to proceed. That does not mean that the physiotherapist should have a detailed consent discussion or obtain signed consent each time the patient visits the clinic. However, confirming the patient's ongoing agreement with the plan, and creating a space for the patient to decline or to ask questions about the treatment helps to avoid misunderstandings and disagreements.

Q: How do I decide if a minor has sufficient capacity to understand the nature and purpose of the proposed treatment and consequences of receiving/refusing treatment?

A: There is no clear test to determine if a minor is in fact "mature." However, the law has recognized a series of factors to be considered when making this decision. The physiotherapist should consider the patient's age, maturity and the nature and extent of the patient's dependence on his/her parents/guardians (which relates to the ability of the minor to make an independent decision without the coercion and influence of the parent or guardian). The physiotherapist should also consider the seriousness of the condition, the complexity of the treatment, and the risks related to the treatment proposed.

This is not an exhaustive list. Overall, a physiotherapist should engage in a holistic analysis of the capacity of the minor before them.

Physiotherapists should document and be able to explain how they determined that the minor was "mature" and able to make their own health-care decisions. They should also reflect on whether a group of their peers would view the decision as reasonable.

If the physiotherapist has any doubts, he/she should consider having a second health-care provider offer an opinion.¹³ Physiotherapists should also follow any employer-directed processes related to forming this determination.

Physiotherapists must also be aware that if a patient is deemed a mature minor his/her guardian has "no authority to override or veto the mature minor's decisions."¹²

Q: I have a patient who is a minor and does not qualify as a mature minor. They are from a different city and are in town attending a month-long sports camp. They have come to my clinic accompanied by their coach. Their guardian is not in town. What do I do?

A: In an emergency, health-care providers can act in the patient's best interest to provide care necessary to prevent prolonged suffering or address imminent threats to life, limb or health.² It is also possible for a guardian to appoint a person to act on behalf of the guardian in an emergency situation.¹⁴ However, physiotherapy would not typically be considered emergency care.

The best-case scenario would be to contact the patient's legal guardian by phone and obtain verbal consent. In doing so, the physiotherapist should have the person at the other end of the line verbally confirm the relationship to the patient and their authority to provide consent on the patient's behalf.

Q: I have a patient who is a minor and does not qualify as a mature minor. The patient's parents are divorced and both are remarried. Who can make health-care decisions for the patient?

A: Legal guardians are required to act in the best interest of the child at all times. A legal guardian of a child must provide consent for the child.

Key points to be aware of:

- According to the *Family Law Act*, both birth parents have equal responsibilities and powers as guardians.
- Step-parents are not guardians of the child, unless they have legally adopted the child.
- A live-in partner of the child's legal guardian is not a guardian of the child, unless they have legally adopted the child or have a court order granting guardianship.

It is reasonable to assume that a parent of a minor child is the lawful guardian of the child and can consent to intervention. However, if the physiotherapist does not know that the adult accompanying the child is the parent or legal guardian, the physiotherapist should confirm that is the case and document this in the patient file.

Further, if a physiotherapist becomes aware of circumstances that would suggest that an adult accompanying the child does not, or may not have guardianship of the child, the physiotherapist is required to ask further questions before providing non-emergency care.^{12,14}

You may want to ask the adult the following:

- Are you this child's legal guardian?
- Are you aware of anything that prevents you from having the authority to provide consent for this child?
- Are there any other guardians who need to be consulted regarding decisions for this child?⁴

Q: In the case where the birth parents of a child requiring physiotherapy are divorced, do I need to have consent from both legal guardians?

A: If one parent has sole custody of the child (i.e., the custodial parent), they become the sole guardian of the child and are, therefore, the only parent responsible for providing consent for intervention. "If a custodial parent consents to treatment for a child which appears to be in the best interests of the child, the non-custodial parent cannot stop the treatment by advising that they do not consent to the treatment." While the non-custodial parent retains the right to make inquiries and to be given information about the health, education and welfare of the child, this does not mean that the custodial parent's decisions are subject to the consultation and approval of the non-custodial parent.

If the parents share custody, they also share guardianship, therefore, both have the right to consent to treatment. One parent does not have the "authority to prevent or override the other parent's consent for treatment that is in the best interests of the child."^{12,14}

Cases of shared custody can create challenging situations for the treating physiotherapist if the guardians do not agree about treatment decisions. In such a situation, the physiotherapist will need to work with the guardians to build consensus about a plan of care and if consensus cannot be found, will need to consider the need to discontinue treatment.

The College of Physiotherapists of Alberta's Practice Advisor can provide support to work through this type of scenario.

Not sure who has the right to give consent on behalf of the child?

Ask about and document the terms of the custody order as described by the parent who brought the child for treatment. You may also request a copy of the court order declaring parental rights upon divorce, if desired.^{12,14}

Q: I am seeing an elderly patient who appears to have limited mental capacity. How do I get consent?

A: If you have concerns about an adult patient’s capacity to provide informed consent, the question becomes “who has the authority to make decisions on the patient’s behalf?” If the patient has a legal guardian, an agent identified in an enacted Personal Directive, or a Supported Decision-Making arrangement in place, the appropriate individual should be approached for consent.⁴

If no such arrangement is in place, the physiotherapist may proceed with treatment that is in the patient’s best interests with the patient’s family’s approval and the patient’s assent.²

This also has the potential to create a challenging situation, particularly if different family members cannot agree about the treatment plan. In cases where the proposed treatment is risky or there is disagreement among family members, The College of Physiotherapists of Alberta recommends that members take a cautious approach to any treatment provided, consider the need to discontinue treatment until questions of capacity and guardianship are addressed, or seek legal advice before proceeding if treatment cannot safely be discontinued.²

The College of Physiotherapists of Alberta’s Practice Advisor is available to help members who are facing this type of situation.

It would also be appropriate to discuss the issue with other health professionals within the circle of care, and to advocate for a formal capacity assessment or the appointment of an agent for the patient as appropriate.

Q: I am seeing a patient who has limited English proficiency. Do I need a trained interpreter?

A: Interpreters, including sign language interpreters, should be used if any doubt exists about a patient’s capacity to understand the implications and nuances of the English language and provide informed consent.

It is a best practice to use professional interpreters when obtaining consent from individuals with limited English proficiency. Using a family member, friend, or other health-care provider creates risk that the information will not be conveyed accurately and that consent will not be valid.

When employing an interpreter, the health professional should clearly indicate that an interpreter was used to obtain consent. It is also a best practice to have the interpreter sign a declaration stating “I, (interpreter name), interpreted the information faithfully and accurately.” It is not the interpreter’s role to determine or even indicate whether the patient understands the information provided. Their role is to faithfully and accurately interpret the communication exchanged.¹⁵

Depending on the population served by the practice, it may also be reasonable to have forms and patient education materials translated into different languages, though the success of that strategy relies on the patient’s ability to read their first language.

Q: My patient told me they use medical marijuana. Can I accept consent from them?

A: Marijuana is one of several substances that may impact a patient’s capacity to provide consent. The issue is not what substance is in use, but rather whether the substance impairs the patient’s capacity to provide consent. Physiotherapists should employ the same policies and processes as when faced with a patient who is impaired from any other substance.¹⁶

Some treatments come with more risk than others. If a physiotherapist has concerns that the patient does not appreciate the nature and consequences of the consent decision, regardless of the reason, the physiotherapists should neither seek nor accept consent for that treatment. This will impact the treatment plan and the approach the physiotherapist will take.

Again, the physiotherapist should ask himself/herself, “capacity to consent to what?” Depending on the specific situation, it is possible that the patient may have sufficient capacity to consent to lower-risk treatment options. Physiotherapist will need to use their own judgment when making this determination.

Q: My patient is making a decision that is dangerous and puts their own safety at risk. What can I do?

A: If the patient has capacity, they have the right to make their own decisions and to have those decisions respected by their health-care providers.³ Physiotherapists should explain their recommendations and concerns to the patient,² seek to understand the patient’s values and rationale for their decision and seek a solution that mitigates the situation.

However, if the patient ultimately decides to follow a different course of action from that which their health-care providers recommend, the physiotherapist must abide by the patient’s decision.³ The physiotherapist’s duty of care to the patient requires that the physiotherapist take steps to help the patient be as safe as possible within their chosen course of action.

Glossary of Terms

Assent: an expression of approval or agreement.¹⁷ In cases where a patient cannot provide consent for intervention, their assent to receive an intervention should be sought, in addition to consent from the patient's legal guardian.

Consent: permission for something to happen or agreement to do something.¹

Capacity: the degree to which an individual can understand information relevant to an assessment or treatment decision, and to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.⁶

Competence: the condition of being able to understand information relevant to an intervention decision, and to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. Competence is a dichotomous, legal construct. The level of capacity that a person has factors into the determination of legal competence.⁶

Physiotherapists don't make a legal determination of competence, therefore the correct term to use in practice is capacity.

Intervention: within this document this term is used to encompass the discrete components of assessments and treatments provided by physiotherapists.

Material Risks: those risks that are known to be associated with the treatment or can commonly occur.⁵

Other Material Information: information relevant to the patient's decision to accept or decline treatment. This includes but is not limited to: possible alternative treatments, the consequences of undertaking no treatment, economic considerations and the impact the intervention will have on the patient's lifestyle.

Special risks: those risks that may be highly unlikely but have severe consequences or may have special relevance to that particular patient.⁵

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