

## NewsLetter

January 2006

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#### **DAC's Eliminated**

*What does this all mean?  
Are we better off?*



### 6. MEDICAL

#### **Mild Traumatic Brain Injury**

*Understanding mild  
brain injury (MBI)*



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## No more DAC's ... PAF's, PPN's ...

*What does this all mean?  
Are we better off?*

### **D**AC's to be Eliminated as of March 1, 2006.

Designated Assessment Centres or "DAC's" were implemented as part of the 1994 changes to the Ontario Insurance Act (Bill 164). The design behind DAC's was to provide independent, unbiased assessments to resolve disagreements between accident victims and their insurance companies as to entitlement to benefits. Insurance companies are responsible for paying for the cost of the assessments and for making the arrangements to set up the assessments.

The Liberal government introduced changes to Regulation 403/96 which eliminates Designated Assessment Centres (DAC's) which takes effect on March 1, 2006. The new regulation will eliminate DAC's and replace them with Insurer Examinations (IE's) conducted by health care practitioners selected specifically by the insurer.

This regulation was drafted with the hope of improving auto insurance by ensuring that insurance money is effectively being spent on medical care or other services for accident victims rather than on DAC assessments. The DAC process has been criticized as redundant, favouring insurers and subjecting accident victims to probing assessments that either create or result in roadblocks to benefits. Critics also claimed that the DAC process was too costly, too slow and duplicated the insurer's examination.

In essence, the new system will substitute IE's for the DAC's. Without DAC's, the amended Regulation allows parties with disputes over benefits to proceed directly to the dispute resolution system at FSCO or to the Courts following mediation. Insurers who wish to challenge this will have to request a separate medical exam from a health care provider of their

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## Points to Consider

choice prior to making a determination of benefit entitlement.

The insurance industry has supported the elimination of DAC's in the hopes that the process of obtaining accident benefits would become less complicated while at the same time result in increased savings for insurance companies. However, the net result of the proposed Regulation will likely see a shift from expenses of a DAC system to expenses of an IE system with no anticipated savings.

Overall, lawyers will adjust to the new system. On the contrary, the adjustment of a file will be an extreme wake up call to adjusters as they can no longer deny a benefit and then simply send an insured to a DAC to confirm their denial and be done with the case.

Consequently, DAC reports can no longer be used to correct adjusters' mistakes and reinstate benefits which were originally denied. Adjusters must now be better trained in order to rely on their own knowledge in making decisions on behalf of insurance companies.

### 1

#### Section 24 Examinations and 42 Assessments without DAC's

An insurer may request an IE pursuant to s.42 of the SABS to assess the reasonableness of any type of benefit that the insured person claims, including housekeeping and handyman benefits. The new system will essentially reflect the approach taken in tort claims: the insurer and insured will each obtain their own assessments to advance their respective positions. Presumably, the object is to make it easier to resolve disputes where there are opposing positions taken in s.24 and s.42 assessments in the absence of a "neutral" third assessor.

An IE report does not necessarily have to support an adjuster's denial of a benefit. Yet an insured must undergo an IE before a decision can be made. Interestingly, an IE could recommend a benefit however an adjuster can still maintain a denial.

Amendments to this section will allow providers who are not regulated health professionals to conduct assessments, though the application for approval of that assessment must be submitted by a regulated health professional. Prior approval from the insurer is still required before conducting an examination under s.24.

There are no longer different criteria regarding assessments to prepare a treatment plan depending on whether

the insured had received treatment under a pre-approved framework. In all cases, prior insurer approval would not be required for up to three examinations to prepare a treatment plan if the cost of each examination is under \$200.00. Additionally, insurers must respond to applications for examinations within two days.

### 2

#### "Rebuttal Assessment"

A "rebuttal assessment" is what an insured is entitled to in response to an IE report. Under s.42.1(8), the total amount payable for an assessment or examination for the preparation of a report and any related expenses permitted under s.24 is:

1. If the assessment or examination is limited to an examination of the material provided under subsection 42(10), the maximum amount payable is \$450.00.

2. If the assessment or examination is not limited to nor required by this section to be limited to an examination of the material provided under subsection 42(10), the maximum amount payable is,

i. \$900.00 if the assessment / examination is conducted by one or more members of a health profession and at least one of them is a physician who is legally authorized to practice in a medical specialty other than family medicine, or

ii. \$775.00 if the assessment / examination is conducted by one or more members of a health profession who are not physicians.

All amounts payable under this section are to be paid by the insurer within 30 days after receipt of an invoice for the amounts.

Also under s.42.1(8), amendments have been made to allow for an insured to apply for mediation even before the insurer sends the insured to an IE which significantly speeds up the dispute resolution process. The rebuttal assessment is intended to be a paper review of the file, and not a full assessment as required under s.24 or s.42. Also, there is no monetary limit on the amount that can be spent by an insured on a rebuttal assessment with respect to catastrophic determination.

The addition of section 24.1 is entirely new. For the injured person to get their own treating practitioner's fees paid for consulting with the insurer examination (IE) doctor, they must be the person who prepared the document (disability certificate, treatment plan, attendant care needs or catastrophic designation) and the fees they charge cannot exceed the ordinary fee for a 30 minute consultation.

## 3 Procedure for Claiming Benefits – Section 32(6)

Failure to give notice within seven days of an intention to claim benefits can result in a maximum delay of 45 days of benefits under sections 35 (IRB), 38 (Med/Rehab), 39 (Attendant Care) or 41 (Death Benefits). Failure to comply, without reasonable explanation, means the insurer can delay paying benefits for up to 45 days after receiving the application or 10 business days after the insured person has complied with a request for information or examination under oath, whichever is later.

## 4

### New: Pre-Claim Examinations – Section 32.1

This is a new category of examination which allows insurers to have injured parties examined before a claim for benefits has been made, after obtaining the written and signed consent of the insured. These examinations can take place at the insurer's expense, with the consent of the injured person, while in hospital or within three days after discharge to determine whether a person is entitled to a benefit. These assessments can be multi-disciplinary. Even if it is found that the person requires a benefit, there is no obligation to pay until application is made and a disability certificate filed. Although the report cannot be used to deny a claim for rehabilitation, attendant care, as well as housekeeping and handyman benefits, it does nevertheless give the insurer the opportunity to collect information that could limit access to benefits.

With this new provision, it appears insurers have an expanded right to examinations. There is no control on what insurers can pay for IE's. While it is in the interest of insurers to control their expenses, it is predicted that there will be many more of them under the proposed regulations. This provision, while it requires the consent of the injured person, gives the insurer another advantage as it is silent on legal representation of the injured person. There is no obligation on the insurer to either make the request through a legal representative, if the person has one, or, if no lawyer, advise the injured person of their right to have legal advice.

## 5

### IRB, NEB or Caregiver and Housekeeping or Home Maintenance Expenses

When applying for these benefits, the insured will have to submit a disability certificate. Within 10 days, the insurer must either pay the benefit or notify that a s.42 examination is required. An insurer cannot deny entitlement until it receives a s.42 report, although the insurer would be able to determine that

an insured is not entitled to a specified benefit before conducting a s.42 exam if the insured fails to provide a disability certificate requested by the insurer, fails to attend a s.42 examination, or fails to obtain treatment, participate in rehabilitation or make efforts to return to employment. Within five days of receiving the s.42 report, the insurer will have to communicate its decision regarding entitlement and provide the report to the insured and his or her health practitioner.

Thus if an insured wants to claim a benefit they must submit a completed disability certificate with the application. Once the insurer gets these two documents it can pay the benefit or ask for additional information or compel the insured to submit to an examination under oath. The insurer can also choose to insist on a section 42 (IE) examination. Even if the insurer opts to request more information or conduct an examination under oath, they can still, after doing so, either pay the benefit or insist on a section 42 examination.

The insurer can deny the IRB or housekeeping benefit if the injured person did not submit a disability certificate; or, if the insurer has received an IE under section 42; or, if the injured person failed to give the person doing the IE the information required under section 42(10). If the information required under s.42(10) is not provided as required, the insurer can refuse to pay the benefits between the time of the failure to provide the information and the ultimate compliance with the duty to provide it.

## 6

### Determination of Continuing Entitlement to Specified

If at any point the insurer wishes to determine whether the insured continues to be entitled to a benefit, the insurer would inform the insured that they require a new disability certificate and that they require the person to undergo a s.42 examination. An insurer would normally not be able to terminate a benefit until it receives a s.42 report. However, a benefit could be terminated without a s.42 examination if the insured fails to provide a disability certificate, fails to attend a s.42 examination or fails to obtain treatment, participate in rehabilitation or make efforts to return

to employment. There is no obligation to pay the benefit after the IE like there was with the DAC if the DAC was in favour of the insured's position.

# 7

## Medical and Rehabilitation Benefits

An insurer will still have to respond to a treatment plan within 14 days and the response would indicate what goods and/or services the insurer has agreed to cover. If the insurer does not agree to pay for all of the goods and/or services set out in the insured's treatment plan, it will have to notify the insured that it requires a s.42 examination. The insurer also has to notify the insured that it requires a s.42 examination if it believes the insured has an impairment that falls under a pre-approved framework (PAF). As is currently the case, insurers who fail to respond to treatment plans within 14 days would be required to pay for goods and/or services incurred up to the time they did finally respond. Within five days of receiving the s.42 report, the insurer will have to communicate its decision regarding entitlement and provide a copy of the report to the insured and the insured's health practitioner.

An insurer normally would not be able to deny entitlement until it receives a report from the s.42 examiner, however the insurer would be able to determine that there was no entitlement to a specified benefit before conducting a s.42 examination if the insured fails to attend a s.42 examination.

# 8

## Attendant Care Benefit

An application for attendant care must be in the form of an assessment of attendant care needs. The Form 1 (Assessment of Attendant Care Needs) changes to a form approved by the Superintendent of FSCO, and no longer under the SABS. To apply for an attendant care benefit, an insured would be required to submit to an assessment of attendant care needs. Within 10 days, the insurer has to pay the benefit or notify the insured that it requires a s.42 examination if it did not agree with the expenses. No expenses are required to

**The insurer's right to medical examinations of the injured party is dramatically expanded.**

be submitted to qualify for this benefit, however, an insurer can refuse to pay if the insured does not attend a s.42 examination. Within five days of receiving the s.42 examination report, the insurer would have to communicate its decision regarding entitlement and provide the report to the insured and his or her health practitioner. The insurer does not have to pay for expenses incurred before the Form 1 is submitted.

The insurer can demand repeated attendant care assessments. When asked, the insured person must submit the attendant care assessment within 10 days after receiving notice that the insurer requires one. At the same time, the insurer can insist on a s.42 IE. Where the person is receiving attendant care benefits after the second anniversary of the accident (catastrophic cases), the insurer can only get s.42 IE's if they are at least a year apart [s.39(10)(b)].

Five days after getting the s.42 report, the insurer must tell the injured person and the practitioner who prepared the assessment of attendant care needs what they have determined regarding entitlement to the benefit. This section again requires compliance with s.42(10) relating to the injured person's obligation to provide the IE assessor with medical information. This, like many other new provisions, dramatically expands the insurer's right to medical examinations of the injured party.

## Determination of Catastrophic Impairment

The insured will still be required to submit an application for determination of catastrophic impairment to his or

her insurer. Within 30 days of receiving this application, the insurer has to either notify the insured that it has accepted the application or that it requires an examination under s.42. An insurer will be able to refuse to pay any benefits that are payable only if the insured failed to attend a s.42 examination. Within five days of receiving the s.42 examination report, the insurer will have to communicate its decision regarding entitlement and provide a copy of the report to the insured and the insured's health practitioner.

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## Examinations Required by Insurers

S.42 examinations are used by insurers to respond to applications for benefits or to determine whether an insured continues to be entitled to a benefit. Examinations are to be conducted by regulated health professionals or experts in vocational rehabilitation. Treatment and assessments under a PAF would not be subject to a s.42 examination. When an insurer requests an examination, it must notify the insured of the reasons, whether it would only involve a paper review, who will be conducting the examination, and the date, time and place of the examination. Notices can be verbal but would also have to be confirmed in writing. Paper reviews would only be conducted to evaluate requisitions of s.24 exams or to determine whether a proposed treatment plan involves an impairment that falls under a PAF. Examinations must be scheduled with at least five days' notice but not more than ten days after the insured receives the notice from the insurer. For catastrophic determinations, the examination must be scheduled with at least five days' notice but not more than 20 days after the insured receives notice of the fact that the insurer requires an examination. While the examination must be within 30 kms (or, 50 kms in some cases) of the insured person's residence, that does not mean the insurer cannot have the doctor travel. This implies that the insurer's right to choose the assessor has no practical limit.

# 9

## Transition Period

As of March 1, 2006, DAC's will be no longer. However, in the event that a benefit denial has already been issued by an insurer before the implementation date, the insured will still have to submit to a DAC. Moreover, if the insurer initiates a DAC assessment for a catastrophic impairment determination or to assess attendant care needs before the implementation date, the insurer would still be required to use a DAC. As well, if the insurer does not respond to an application for benefits within the time frames in the SABS before the implementation date, the insurer would still have to use a DAC.

It is also important to note that insurers may not request an IE after a DAC assessment is conducted to use it to overturn the DAC report.

## Preferred Provider Networks (PPN's)

The idea behind PPN's is that insurance companies would treat WAD I, II, and III soft tissue injuries outside of the Pre-Approved Framework guidelines in an effort to replace an insured's benefits under the Statutory Accident Benefits Schedule with an altered, more cost effective set of benefits. Insured persons must voluntarily sign a waiver to be involved with the PPN. The PPN engages a roster of medical professionals who sign a quality control agreement with the insurer in an effort to offset the liability of insurers.

The PPN consists of two phases: the Acute Phase and the Sub-Acute Phase. The Acute Phase is the first phase and occurs within the first three weeks after a soft tissue injury is sustained. The

Acute Phase consists of nine treatment sessions over the course of three weeks. People who claim income replacement benefits are allowed a maximum of four more sessions over another two weeks to support their return to work.

The Sub-Acute Phase occurs from three to six weeks following soft tissue injury and consists of treatment if the insured person is deemed not fit to function or work at the beginning of the fourth week of treatment. The Sub-Acute Phase consists of eight sessions over another three week time span. For people who claim IRB's, a maximum of four more sessions over a further two weeks is allowed to support a return to work. On the other hand, if treatment is not deemed to be required at all, a patient can be given a home exercise program with a maximum of three one-on-one sessions.

Under the PPN scheme, an insurer can send a patient to a multi-disciplinary evaluation (MDE) at another treatment centre which consists of a medical exam, functional exam and a psychological screen if necessary. If the outcome of the MDE recommends interdisciplinary rehabilitation to facilitate recovery, treatment will be offered for another two to four weeks.

Under the PAF, a WAD III injury, which is far more serious and complicated is not treatable, whereas under the PPN, treatment for a WAD III injury has been restricted to a maximum number of treatment sessions and then referred for an insurer's examination. Under the PPN protocol, it is expected that housekeeping and attendant care are not necessary, except for those with WAD III injuries. If a claimant is having difficulty with housekeeping and home care duties, the health practitioner could undertake an activities of daily living assessment and in-home visit by a physiotherapist or an occupational therapist. If the assessment reveals that the claimant needs attendant care, then the health practitioner has to help the claimant fill out a Form 1. If housekeeping is required for more than six weeks, the claimant will most likely have to undergo a multidisciplinary evaluation (MDE). The health practitioner must determine if the claimant is unable to work and facilitate the completion of a disability certificate, an OCF 2 and a jobsite assessment.

PPN's will ultimately limit the treatment that can be provided to an injured person and removes the treatment decisions from the insured's treating health care practitioners to those favoured by the insurer.

## Addressing Insurer Breaches under The Unfair and Deceptive Practices Act

In an effort to balance the insurer's new right under the expanded s.42, there is a broadening of the behaviour that constitutes an "unfair or deceptive act or practice" on the part of the insurer as per the new Unfair or Deceptive Acts or Practices Regulation.

If an insurer does any of the following, it will be deemed to be an "unfair or deceptive act or practice":

1. Failing to pay within the timelines prescribed in the SABS;
2. Failing to give notice as required;
3. Denying entitlement to a benefit without first obtaining a report under s.42. (This puts into question whether even an adjuster's log notes could fall into the area of bad faith);
4. Misrepresenting or unfairly presenting the conclusions of the s.42 examination;
5. Requesting s.42 examinations when the insurer ought to know it is not reasonably required;
6. Arranging a s.42 assessment with a person who is not qualified to conduct one; and
7. Failing to obtain written consent of the insured for a pre-claim examination.

These unfair and deceptive acts have to be reported to the Superintendent of Insurance, who may investigate and order the insurer to cease doing any act, or remedy the situation or even cease engaging in the business of insurance. What is more, the aforementioned acts will be used by insureds to claim punitive damages against insurance companies.

**Unfair and deceptive acts have to be reported**

## Conclusion

Despite the expected goals of the new regulations with the elimination of DAC's, there will likely be little cost saving to insurance companies and a system that is no less complicated than before.

It is also anticipated that there will be far more conflict between IE's and treating health care providers than there was between DAC's and treating health care providers. IE's will most likely be conducted by insurance industry "preferred providers", meaning that one can expect the interests of the insurer to be prominent in these assessments.

One of the biggest advantages to insurers is the fact that there are no limits in terms of what can be spent on IE's or how broad the scope of the IE will be. Assessments can be conducted from multiple specialties if so desired. On the other hand, the injured person cannot afford to do so on the same scale as the insurer. There is a significant administrative cost to these regulatory changes which merely adds to the burden on the system.

While DAC's are to be eliminated, they are being replaced by many more IE's. Instead, effective changes to the system should involve fewer assessments and dramatic simplification of the regulations. Alternatively, what we have now are more assessments and more complexity.

Are we really better off? [G&A](#)

M E D I C A L  
C O N S U L T A N T



## STAT:

In 2006, there will be an estimated 16,000 to 20,000 individuals who will sustain a brain injury in Ontario.

## Mild Traumatic Brain Injury

### Introduction and Statistics

The survival rate following an injury to the brain is improving due to advancements in emergency care and the development of technology that makes vehicles safer to operate.

Based on demographics from the Ontario Brain Injury Association (OBIA), there will be an estimated 16,000 to 20,000 individuals who will sustain a brain injury next year in Ontario as a result of traumatic brain injury.

Some 3,000 Ontarians a year suffer brain damage, leaving them with severe physical, cognitive and/or behavioural problems that permanently affect their lives.

Most traumatic brain injury are as a result of a motor vehicle accident and are attributable to driver error.

It is not surprising then, that motor vehicle insurance claims involving traumatic brain injury are on the rise. As such, the need to develop an understanding of mild, moderate and severe brain injury and the need to be able to access expertise in this area is obvious.

### Definitions

This article will confine itself to a discussion of mild traumatic brain injury. However, in order to fully understand what is meant by mild brain injury, mild, moderate and severe brain injury needs clarification. Perhaps the first indicator of brain injury will be on transport to the hospital or in the emergency unit by way of a **Glasgow Coma Scale (GCS)** measure. The GCS is the most widely used scoring system to quantify the level of consciousness. The GCS is scored between 3 and 15: 3 being the worst; 15 being the best. It is composed of three parameters — best eye response, best verbal response, best motor response.

For the purpose of the Statutory Accident Benefit Schedule (SABS) under the Insurance Act, a Coma score of:

- **13 or higher** correlates with a mild brain injury;
- **10 to 12** is a moderate injury;

## Great Debate

For well over a century the validity and voracity of symptoms following mild brain injury have been at the center of a great debate among doctors.

- and, **9 or less** is considered severe or “catastrophic”.

More specifically, a person with mild traumatic brain injury is a person who has had a traumatically induced physiological disruption of brain function as manifested by at least one of the following:

1. any period of loss of consciousness;
2. any loss of memory for events immediately before or after the accident;
3. any alteration in mental state at the time of the accident (e.g., feeling dazed, disoriented, or confused);
4. focal neurological deficit(s) that may or may not be transient but where the severity of the injury does not exceed the following:
  - a. loss of consciousness of approximately 30 minutes or less;
  - b. after 30 minutes, an initial Glasgow Coma Scale (GCS) of 13-15; and
  - c. posttraumatic amnesia (PTA) not greater than 24 hours.

However, there are times when a person with a minor brain injury (MBI) never receives a GCS measure because they were not transported to the hospital and not seen in emergency. The symptoms of an MBI seem to surface when the individual is exposed to situations that demand certain resources. Other ways of determining that someone has experienced a mild brain injury is by observing the clients’ behaviour or by hearing a particular constellation of complaints (i.e., memory loss, lack of ability to maintain attention, personality change, fatigue, and dizziness) or by neuropsychological testing.

### Anatomical Substrate

There is an anatomical substrate for the propensity of the symptoms or complaints that occur when a deceleration – acceleration incident occurs. There are bony protuberances within the skull in the areas of the frontal and temporal lobe that will act to shear neural tissues. This symptomatology is consistent with the area of the brain that would be affected.

This kind of physical evidence was not always available to the scientist or to the doctors that were trying to make a connection between a physical change to the brain and the symptoms of MBI. Moreover, there were long periods of time when the certain social and ideological pressures came to bear that eclipsed the scientific investigation into the causal relation-

ship between brain structures and the symptoms of MBI. What will follow is the historical explanation for the delay in understanding the link between the syndrome and the cause.

### Great Debate

For well over a century the validity and voracity of symptoms following mild brain injury have been at the center of a great debate among doctors. The collection of symptoms has come to be called post concussion syndrome, chronic brain syndrome, mild brain injury (MBI) as well as post-traumatic syndrome, to name a few.

Thinking and behavioural disorders such as — disturbances of memory, mood, attention, concentration, depression, fatigue, and increased mental effort required for tasks constitute the major sources of disability following MBI. The difficulty of distinguishing between the primary neurological damage, and secondary psychosocial problems is often difficult and can stir controversy, especially where normal neurological findings are noted.

Although controversy surrounding MBI is not new, it gained added momentum in the 1860’s. A growing school of thought emerged that gave credence to the disorder. Prominent scientists offered theories concerning causality, but without hard evidence of structural damage to the brain, such theories were quickly discredited. However, the flood of patients bringing such complaints continued to grow in proportion to the increases in mechanized transport.

During the 1860’s there was an ever mounting amount of railway travel with a high incidence of collisions and sudden stops. Increasingly, doctors embraced the opinion that the post-traumatic disorders resulting from these injuries occurred from mechanical damage to the brain and spinal cord.

The scientific atmosphere at the time was increasingly influenced by prominent psychiatrists such as Freud and Charcot, and terms such as “hysteria” and “functional” were gaining popularity. Social and political changes along with legislation providing for Worker’s Compensation had profound influence. Malingering was considered a common cause of otherwise unexplainable railway injuries among both passengers and workers. Over the next century the sentiment in both the scientific community and general public was clearly biased against any organic explanation for MBI.

In the 1960's the advent of diagnostics imaging devices such as CT Scans, MRI's, and PET Scans gave new credence to theories of organic injury of the brain. However, in the best cases such scans have shown only slight, diffuse abnormalities in a small number of cases. It is thought that the newer quantitative EEG's or brain mapping with increased sensitivity from computer analysis may provide greater insights.

### The Role of the Personal Injury Lawyer

With these greater insights and changing climates come an added responsibility to lawyers and their medical consultants to recognize and appreciate the MBI syndrome. Of particular importance is the lawyer's ability to properly interview the new client with MBI. Often, at the time of the initial client/lawyer interview, there is not abundant information available. If possible, the interview should include a spouse, a relative or a friend.

In general, these are the determinations that the lawyer must make:

- whether or not consciousness was lost.
- duration of unconsciousness.
- whether or not there was an alteration of consciousness.
- duration of altered consciousness.
- in detail, the specifics of how the injury occurred.
- the history of previous head injury or concussion by interview with the patient and family.
- previous alcohol use.
- previous substance use.
- previous vocational pursuits, positions, and durations.
- previous leisure pursuits, to include hobbies, athletics, and other recreational pursuits.
- academic history (to rule out pre-existence of attentional deficit disorder or learning disabilities).
- social/legal history.

### The Role of the Medical Consultant

If there is a Medical Consultant on staff, there are further medical considerations:

- past medical history
- family medical history
- current medication; chronicle changes in medications. Correlate symptomatology with medications and side effects. Determine use of over-the-counter medications.
- review of headache history. Characterize

headaches to differentiate for sinusitis, tension, TMJ dysfunction, medication/substance withdrawal, migraine. Headaches should be fully characterized and described.

- characterize and describe all **visual** complaints. Differentiate blurred vision from diplopia. Evaluate visual fields and ocular motor skills. Determine presence of photophobia, image suppression, image persistence.
- characterize and describe all pain complaints as well as past/current treatments for same.
- characterize all complaints of dizziness, imbalance, dyscoordination.
- evaluate balance by single-foot standing, Romberg, star-march.
- evaluate history of balance in low-light conditions.
- evaluate cardiac status and serum glucose levels as possible contributors to dizziness.
- current sleep patterns — time to bed, time to sleep, times awake, activities during wakefulness, rise time, and restedness upon awakening.
- dietary habits.
- exercise routine.
- caffeine usage and chronicle any changes since injury.
- If available:
  - Review EEG's.
  - Review CT scans of the head.
  - Review skull x-rays.
  - Review cervical x-rays, CT's, and MRI's.

### The Good News

The good news is that the majority of people with mild brain injuries will recover spontaneously over time without any therapeutic intervention. **The estimate is reported as high as 90%.**

It is the other 10% who will experience long-term symptoms that may interfere with their occupation, family relationships and their ability to engage in social activities. Why is it that so many people go on to their pre-accident life-style without too much trouble while others are faced with continuing problems? Wouldn't it be great to have a crystal ball so that we could predict the outcome? There are ways that we can better predict those who will over-come the brain injury and those who will succumb to the problems that may follow an MBI. Please follow our next newsletter for our list of extraneous variables that could interfere with recovery following an MBI. **G&A**

## EVENTS 2006

### January 13

#### Mild to Moderate Traumatic Brain Injury: Current and Emerging Trends

*Hilton Hotel, Toronto, ON  
Presented by Sunnybrook & Women's  
College Health Sciences Centre*

### February 2, 3

#### Coming Together: A Community Brain Injury Conference

*The Waterloo Inn & Conference Centre,  
475 King Street North, Waterloo, ON*

FOR MORE INFORMATION:

*Patti Lehman, Executive Director, BIAWW*

### February 6

#### Workshop: Life After DACs

*Toronto Rehab Institute  
8:30 a.m. to 12:30 p.m.*

*For public and private TBI rehab professionals, insurers and legal representatives regarding the new auto insurance regulations that will come into place when the Designated Assessment Centre (DAC) system is abolished on March 1, 2006.*

KEYNOTE SPEAKER:

**Willie Handler**

*Financial Services Commission of Ontario (FSCO)*

### February 14 - 17

**Level One:**

#### OBIA Certificate Training Program: Home and Community-Based Rehabilitation

*Brook University, St. Catharines, ON*

GUEST SPEAKERS:

**Drs. Barry Willer, Dawn Good and  
Sherrie Bieman-Copland**

FOR MORE INFORMATION:

*Ruth Wilcock, OBIA Office*

*905.641.8877, ext.238*

WEB SITE: [www.obia.on.ca](http://www.obia.on.ca)

EVENTS  
2006

February 15


**Trauma Nursing Conference 2006**  
**Innovations in Trauma Care**  
**What's New After 30 Years**

Delta Toronto East Hotel  
2035 Kennedy Road, Scarborough

FOR MORE INFORMATION, VISIT  
[www.traumanursing.ca](http://www.traumanursing.ca)

## KEYNOTE SPEAKER:

**Terry Evanshen**

Professional Motivational Speaker; and from  
the movie, "The Man Who Lost Himself"

Surround yourself with people  
who believe in you.

It will make all the difference. Anyone with a bad  
attitude, get them off your team today!

TERRY EVANSHEN

February 17

**CPA Ontario's SKI & SNOWboard Day 2006**

Craigleith Ski Club, Collingwood, Ontario

Presented by The Dominion of Canada  
General Insurance Company

Highlights of the day include a fun ski  
and snowboard races for all levels; a mono-ski  
demonstration; complimentary beginner ski  
and snowboard lessons; a silent auction;  
draw prizes and awards.

## FOR MORE INFORMATION:

**Lynn Mineque**

Manager Special Events, CPA Ontario

☎ 1.877.422.1112

416.422.5644, ext.221

EMAIL: [lynn.mineque@cpaont.org](mailto:lynn.mineque@cpaont.org)

May 1 - 7

**2006 Visa Paralympic World Cup**

will be staged over seven days of  
action in Manchester

FOR MORE INFORMATION, VISIT  
[www.visaparalympicworldcup.com](http://www.visaparalympicworldcup.com)

May 4 - 5

**13th Annual Conference on**  
**Neurobehavioural Rehabilitation in ABI:**  
**Back to Basics: The Management of**  
**Challenging Behaviour in ABI**

Hamilton Convention Centre, Hamilton, ON

## FOR MORE INFORMATION:

Georgie Georgious,

Education Specialist and Chair:

2006 Conference Planning Committee

EMAIL: [georgg@bhsc.ca](mailto:georgg@bhsc.ca)

May 12 - 13

**Transitions Conference 3:**  
**Growing Up Ready**

Toronto, ON

## FOR MORE INFORMATION:

Stephanie Maybee

Bloorview MacMillan Children's Centre

## EMAIL:

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May 24 - 26

**Level Two: Advanced Brain Injury**  
**Rehabilitation**

Brock University, St. Catharines, ON

## GUEST SPEAKERS:

**Drs. Barry Willer, Dawn Good and**  
**Sherrie Bieman-Copland**

## FOR MORE INFORMATION:

Ruth Wilcock, OBIA Office

905.641.8877, ext.238

## WEB SITE:

[www.obia.on.ca](http://www.obia.on.ca)

June 8 - 9

**The Multicontext Approach to**  
**Cognitive Rehabilitation: Awareness,**  
**Memory and Executive Dysfunction**

Peterborough, ON

Presented by Joan Togli, Ph.D. OTR

## FOR MORE INFORMATION:

**Mindworks** 705.741.3412

## EMAIL:

[info@mindworksgroup.ca](mailto:info@mindworksgroup.ca)

## WEB SITE:

Registration forms available on our  
web site: [www.mindworksgroup.ca](http://www.mindworksgroup.ca)

EVENTS  
2007

June 16 - 19, 2007

**Festival of International Conferences**  
**on Disability, Aging and Technology**

presents 4 concurrent conferences  
held in Toronto, ON:

1. Growing Older with a Disability
2. 2nd International Conference on Technology and Aging
3. Advances in Neurorehabilitation
4. Caregivers: Essential Partners in Care

## FOR MORE INFORMATION:

Sheila Casemore,

Provincial Assistant, Government Relations,  
Ontario March of Dimes

☎ 416.425.3463

## TOLLFREE:

☎ 1.800.263.3463, ext.388

## WEB SITE:

[www.ficdat.ca](http://www.ficdat.ca)

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