Cashman, Frank Emil – Psychiatrist

Waldock and State Farm 2014-11-10, Arbitration, Preliminary Issue, appeal rendered, FSCO 4315
https://www5.fsco.gov.on.ca/AD/4315

Dr. Waisman testified that he had many criticisms of Dr. Cashman's report, both in terms of the methodology used as well as the percentage WPI rating that Dr. Cashman applied. He pointed out that:

- Dr. Cashman did not interview Mrs. Waldock as a part of his assessment, contrary to s. 14.2 of the AMA *Guides*.
- Dr. Cashman did not appear to consider the four occupational therapy reports of Tenley Kelly, O.T.
- Dr. Cashman disregarded all of Mr. Waldock's numerous concerns and complaints, by concluding that these were symptoms all related to pain and, as such, he could not assess the score for pain.
- Dr. Cashman failed to assign a category of impairment to Mr. Waldock with respect to each injury.
- Dr. Cashman failed to apply the AMA *Guides* by failing to consider the four domains of functioning as outlined in the *Guides*.
- Dr. Cashman provided a percentage WPI rating of impairment, without providing any explanation of how he arrived at that figure.
- Dr. Cashman found that Mr. Waldock was depressed, but he failed to offer a diagnosis of that condition or explain why he believed that a diagnosis of pain disorder would not be appropriate in the circumstances.
- Dr. Cashman saw Mr. Waldock's condition as worsening, yet he failed to take that into account in his final report.
- Dr. Cashman failed to make a diagnosis of Mr. Waldock's condition. Instead he attempted to dismiss the psychiatric diagnoses of other assessors as "labeling" Mr. Waldock. Dr. Waisman opined that he could not understand these comments because Dr. Cashman's role in the Assessment process was specifically to determine what diagnoses would apply to Mr. Waldock's impairments, and thereafter apply an impairment rating to those impairments.
- Dr. Cashman's report did not support his own conclusion. For example, Dr. Cashman performed the Beck Depression inventory which revealed to him that Mr. Waldock scored in the "severe" range for depression. Using the AMA *Guides*, a severe depression rating would be between 31 to 40%. Instead, Dr. Cashman applied a 10% WPI, without explanation of how he arrived at that figure. In addition, a 10% WPI would correspond to a "mild" level of depression, which is completely contrary to Dr. Cashman's own test results and findings.
- It is unknown whether Dr. Cashman was using Table 3 of Chapter 4 of the AMA *Guides* or Chapter 14 of the *Guides* to come to his WPI rating. Dr. Waisman could not tell which approach Dr. Cashman used or if he used the AMA *Guides* at all, as Dr. Cashman did not indicate whether he was using either of these chapters.

- Dr. Cashman's assessment would correlate to a "mild" impairment. However, Dr. Waisman absolutely disagreed that Mr. Waldock's impairments should be classified as mild, based on all of the medical evidence, his own assessment, and Dr. Cashman's own report, testing and description of symptoms.

Dr. Cashman did not appear as a witness in this matter. Consequently, I find his reports are untested and present less credible evidence than that of Dr. Waisman and his colleagues.

I find that the testimony of Mr. and Mrs. Waldock is consistent with and supports Dr. Waisman's findings and conclusion that Mr. Waldock had at least a moderate impairment under all four domains of functioning, and a WPI of 35% for mental and behavioural impairments.
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I find that Arbitrator Feldman's analysis regarding the shortcomings of Dr. Shapiro is very similar to this matter before me. As Dr. Waisman pointed out, Dr. Cashman's assessment was deficient in several areas. As earlier stated, I find that these deficiencies fail to support the position of State Farm in refusing to accept the assessment that Mr. Waldock is catastrophically impaired. During cross-examination of Dr. Waisman, counsel for State Farm, perhaps inadvertently, emphasized that Dr. Cashman's assessments did not follow the requirements of the *Schedule* and the AMA *Guides*. Thus, I find I must give a little weight to Dr. Cashman's assessments (as expressed in his written report), for there is no evidence offered by the insurer to contradict Dr. Waisman's evidence.

Waldock and State Farm 2015-11-16, Arbitration, Expenses, appeal pending, FSCO 4689
https://www5.fsco.gov.on.ca/AD/4689

Prior to my decision, State Farm had been withholding benefit payments to Mr. Waldock for Attendant Care, certain Medical/Rehabilitation claims, and Housekeeping and Home Maintenance claims since it had determined, based on Dr. Cashman's report, that Mr. Waldock had not suffered a catastrophic impairment and thus was not eligible for Attendant Care, certain Medical/Rehabilitation claims, and Housekeeping and Home Maintenance claims.
[]
In my decision on the preliminary issue, issued on November 10, 2014, I referred to the oral evidence of Dr. Waisman wherein he was critical of the report prepared and submitted by Dr. Cashman to State Farm. State Farm relied upon Dr. Cashman's report to deny that Mr. Waldock had suffered a catastrophic impairment. State Farm did not bring Dr. Cashman as a witness to that Hearing and thus, I found that his report was untested and less credible evidence than that of Dr. Waisman and his colleagues at Multidisciplinary Designated Assessment Centre ("MDAC"), including Dr. Ameis.
[]
Upon considering that State Farm refused to accept Mr. Waldock's application for determination of a catastrophic impairment by relying on Dr. Cashman's report, which failed to follow the accepted guidelines to determine whether a person is catastrophically impaired; and, considering that State Farm had ample evidence that Mr. Waldock was very seriously injured and partially incapacitated as a result of the accident, I find that State Farm must be considered responsible for unreasonably withholding or delaying payments to Mr. Waldock, pursuant to the *Act*.

MacLeod v. Lambton (County), 2014 HRTO 1330 (CanLII), <http://canlii.ca/t/g9006

[143] The respondent called Dr. Cashman as an expert witness. The applicant agreed that Dr. Cashman is an expert in psychiatry. Dr. Cashman did not examine the applicant. The respondent provided him background information, the applicant's recent medical records, and the will-say statements that the applicant had disclosed during the process before this Tribunal, and asked him to address what he would want to observe in terms of the applicant's behaviour and level of symptoms in order to give the medical opinion that he was fit to discharge his duties as EMS Manager. Dr. Cashman prepared a report addressing this issue. He identified this report at the hearing, and it was admitted into evidence. He also testified about this issue at the hearing.

[149] In cross-examination, Dr. Cashman admitted that he had not received or read the applicant's job description when he opined in his April 10, 2013 report that the applicant might advertently present a risk to others if severely depressed or hypomanic. He also admitted that that the "others" whom he was referring to were frontline paramedics. When asked whether he was aware of the line of command in the EMS department, he stated that he had recently seen a job description and assumed that the EMS Manager interacted directly with frontline paramedics.

[230] I find that both Dr. Owen's and Dr. Cashman's opinions have reliable components, which are helpful in deciding when the applicant will be ready to resume his duties as EMS Manager. At the end of the day, they both believe that the applicant can return to the EMS Manager position after he is in remission; where they differ is that Dr. Owen believes that the applicant can resume his duties immediately on a graduated basis, while Dr. Cashman believes that the applicant should first be returned to a low-stress job, and if the remission continues for one year, he should then resume his EMS Manager duties. However, Dr. Cashman did not address, and I do not see, why the applicant could not resume low stress EMS Manager duties, rather than a different job, after he is in remission.

[233] My main concerns with Dr. Cashman's opinion is that he is not the applicant's treating psychiatrist, and did not appear to be fully informed about the EMS Manager's job duties, which led, in both instances, to some unfounded assumptions. For example, when he expressed his concern about the applicant advertently presenting a risk to others if he became hypomanic, he seemed to be unaware of Dr. Owen's prognosis that the applicant was unlikely to exhibit hypomanic symptoms in the future because of the progress of his bipolar disorder, which has only been depressive in recent years. Dr. Cashman also appeared to assume that in the EMS Manager role the applicant would be responsible for frontline supervision work at emergency scenes, including supervising approximately 100 paramedics. The evidence before me indicates that the applicant's duties in the EMS Manager role would be predominantly high-level management, his direct reports would be Operations Supervisors rather than frontline paramedics, and although he may occasionally be on scene during emergencies, his role would be to manage the overall situation, and not direct the frontline treatment of members of the public by paramedics.

Decision No. 1594/10, 2010 ONWSIAT 2987 (CanLII), <http://canlii.ca/t/fltll

[25] The NEL assessment was conducted in two stages. The worker first underwent an assessment by Dr. Cashman, a psychiatrist with St. Michael's hospital, which resulted in a lengthy report dated July 12, 2006. Dr. Cashman concluded that the worker suffered only a "minimal Class 1 impairment". He stated that it was "tragic that [the worker] did not return to work in 1995". He added, "[The worker] is now an invalid and has it would seem made himself one". He doubted that the worker suffered from a psychiatric syndrome related to PTSD.

[26] Based on this report, the Board granted the worker a 10% NEL award for his permanent psychiatric impairment.

[27] In a letter to the Board dated September 28, 2006, the worker complained about the manner in which Dr. Cashman had conducted his examination, setting out his concerns about some of the questions that Dr. Cashamn had asked him and the brevity of the overall interview (40 minutes). The worker requested a new NEL assessment. He added that it appeared that over 100 pages of medical reports in the Board's file may not have been sent to Dr. Cashman.

[28] The NEL Clinical Manager responded to this letter the next day, stating that she agreed to review Dr. Cashman's assessment after receiving updated medical reports from Dr. Mech. She notified the worker that once these reports were received, the NEL Clinical Specialist would determine whether a second NEL assessment was in order.

[29] Dr. Mech's response to this request is contained in a further lengthy report dated December 14, 2006. In this report, Dr. Mech states that he had "very carefully perused" Dr. Cashman's report, which he states was based on a single interview and possibly in the absence of "100 pages of data pertaining to [the worker's] condition". Dr. Mech continues:

My assessment represents over ten years experience in treating [the worker] since I saw him initially on June 17, 1996 and as a psychiatrist speaking fluent Polish had an understanding of the nuances and actual meaning of complaints which [the worker] has convened to me over the years.

I was particularly concerned by Dr. Cashman's statements that patient (sic) does not suffer from Post Traumatic Stress Disorder whereas my clinical notes from the very first interview indicates undeniably that this was the diagnosis at that time supported by the fact that he met (sic) majority of the criteria of Post Traumatic Stress Disorder.

I see his current total disability as a continuation of psychophysiological problems and [PTSD] which prevents him from attending to any kind of productive effort beyond basic activities of daily living.

[Dr. Mech then reviews the contents of his early findings and reports.]

There is no doubt that his functioning since that time was severely impaired. The fall resulted in tinnitus, an ever-present disturbing noise in his head, which he equated with dizziness, a sense that he was unstable on his legs and could fall at any time. Perhaps to a degree his tinnitus continued to symbolize the sudden threatening event, which rendered him unconscious. He as well felt that this was possibly a harbinger of more severe brain injury, which has not been

discovered. There has then been a continuation of symptoms of post-traumatic stress as well as depression arising out of fear that he could never be better.
Given above, I find his attempts to return to work and struggle against his symptoms indicative of a true desire to get better and somehow overcome his symptoms, however his inability to function at work only reinforced his sense of insecurity, inadequacy and incapacity.

I find Dr. Cashman's opinion, which seems to imply that [the worker] is simply somehow unwilling to get better grossly unfair since over the years in treating him I saw repeatedly a man who was agonizing over his inability to perform and blocked by his ongoing symptomatology.

As well over time I observed in [the worker] progressive erosion of will arising out of his ongoing problems. Although I have treated him diligently and tried to support him with medication addressing specific symptomatology, it was clear that his ongoing anxiety too not only psychological but physical toll where he was obviously totally unable to cope even in terms of activities of daily living and relied extensively on his family particularly his wife…

At the present time [the worker] functions on a markedly passive-dependent dysfunctional level. Poverty of thinking, sense of perpetual confusion, ongoing inner battle where he feels he should somehow be able to perform better and self-blame are ever present.
…

I feel that [the worker] went through a phase of "attempted recovery" when he tried to return to work only to have to quit because of the reinforcement of his post-traumatic symptomatology.

[30] Following a review of this report, the NEL Clinical Specialist determined that a further NEL assessment was not required. Rather, Dr. Mech's report was relied upon in the Board's January 4, 2007 decision to increase the worker's NEL award for permanent psychiatric impairment from 10% to 30%.