

55374-7

55374-7

78355-1

NO. 55374-7-1

COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION I

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STATE OF WASHINGTON,

Respondent,

v.

GORDON BERGSTROM,

Appellant.

2005 JUL 25 PM 4:35

FILED  
JUL 25 2005  
CLERK OF COURT



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APPEAL FROM THE SUPERIOR COURT FOR KING COUNTY

THE HONORABLE JOHN P. ERLICK

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**BRIEF OF RESPONDENT**

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**A. ISSUE PRESENTED**

Defendants who are already represented by counsel cannot make *pro se* motions or personally conduct their own defense unless they unequivocally elect to proceed *pro se*. In this case, the defendant was represented by counsel throughout trial and numerous sentencing hearings and never moved to proceed *pro se*. Defendant's counsel agreed with the State's calculation of the defendant's standard range. Nonetheless, at sentencing, the defendant attempted to lodge a last-minute *pro se* objection with the Court concerning his offender score. Did the Court properly deny the defendant's *pro se* motion and proceed with sentencing based on information provided by defendant's counsel? If not and in the event the matter is remanded for a new sentencing, may the State present additional evidence supporting the previously agreed calculation of the defendant's offender score?

**B. STATEMENT OF THE CASE**

The defendant, Gordon Bergstrom, was convicted of Unlawful Possession of a Firearm in the First Degree following a

jury trial before the Honorable Judge John Erlick. CP 52, 1RP 7.<sup>1</sup>  
Before and during trial, Bergstrom was represented by Mr. Norm Partington. 1RP 3.

For sentencing, Bergstrom was represented by Ms. Cathleen Gormley. 5RP 3. Prior to his sentencing hearing, Bergstrom filed a Defense Presentence Report wherein he agreed that his standard sentencing range was "87 to 116 months."<sup>2</sup> Defense Presentence Report 1. At his initial sentencing hearing on November 5, 2004, the State agreed with Bergstrom's calculation of his standard range and informed the court of Bergstrom's offender score (11). 5RP 3. Bergstrom's counsel sought an exceptional sentence below the standard range due to Bergstrom's alleged medical difficulties. 5RP 4-5. The Court denied the motion for an exceptional sentence below the standard range. 5RP 12.

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<sup>1</sup> For purposes of this response, the verbatim reports of proceedings are referenced as follows:

4/12/04 – 1RP  
4/13/04 – 2RP  
4/14/04 – 3RP  
4/15/04 – 4RP  
11/5/04 – 5RP  
11/17/04 – 6RP

<sup>2</sup> The parties have agreed to supplement the Clerk's Papers to add the Defense Presentence Report and have filed a joint Motion to Supplement with the trial court. To date however, the trial court has not yet completed that designation or numbered the additional document. Accordingly, the document is attached hereto as Exhibit A and is referenced as the Defense Presentence Report.

Bergstrom's counsel then suggested that the court sentence Bergstrom for the minimum term, but that the term could be served in Electronic Home Detection ("EHD"). 5RP 7. Because the State opposed this motion and the parties had not provided any authority or briefing to the Court, the Court continued the sentencing hearing to November 17, 2004. 5RP 11.

At the November 17, 2004 sentencing hearing, Bergstrom was again represented by Ms. Gormley. 6RP 3. Counsel for Bergstrom and the State jointly advised the Court that no statutes or case law supported Bergstrom's request to serve his sentence on EHD. 6RP 3-4. Counsel for Bergstrom then advised the Court that Bergstrom wanted to raise a scoring issue *pro se*. 6RP 4. Bergstrom's counsel did not join in this motion; in fact she disclosed to the Court that she had researched the issue somewhat and decided not to "take a position contrary" to Bergstrom. 6RP 4.

Bergstrom then *pro se* advised the Court of his belief that several of his prior convictions should be treated as "same criminal conduct," thus decreasing his offender score and his standard sentencing range. 6RP 5-6. Again, Bergstrom's counsel failed to join in her client's argument or take any position, lest she take one contrary to that of her client. 6RP 7.

The State argued that if Bergstrom wanted to make a *pro se* motion, he needed to elect to proceed *pro se* and dismiss counsel. 6RP 8. The State also objected to Bergstrom's *pro se* motion as untimely due to apparent agreement among the parties, up to that point, about Bergstrom's offender score. 6RP 7.

The Court opted not to conduct an evidentiary hearing into the issues raised by Bergstrom and proceeded with sentencing. 6RP 10. The Court sentenced Bergstrom to 87 months incarceration, the low end of the standard range for an offender with an offender score of 9 or more and the low end of the standard range reflected in the Defense Presentence Report. 6RP 12; Defense Presentence Report 1.

C. **ARGUMENT**

1. **THE TRIAL COURT PROPERLY DISREGARDED BERGSTROM'S *PRO SE* OBJECTION TO HIS OFFENDER SCORE CALCULATION BECAUSE HE WAS REPRESENTED BY COUNSEL AT SENTENCING.**

A defendant represented by counsel has no right to "hybrid" representation – where the defendant and his attorney essentially serve as co-counsel. State v. Bebb, 108 Wn.2d 515, 524, 740 P.2d 829 (1987). Criminal defendants may elect to proceed *pro se*

following a knowing, intelligent and voluntary waiver of their right to counsel, or they may be represented by counsel. Bebb, 108 Wn.2d at 525, State v. Blanchey, 75 Wn.2d 926, 938, 454 P.2d 841 (1969).

If a criminal defendant is represented by counsel, that defendant does not have a constitutional right to file a *pro se* motion. Blanchey, 75 Wn.2d at 938. When a represented defendant attempts to make *pro se* motions while represented, the court violates no rights of the defendant in ignoring the *pro se* requests. Id.

If an appellant fails to timely and effectively object during sentencing to an allegedly erroneous offender score, that issue is waived for purposes of appeal. State v. Nitsch, 100 Wn. App. 512, 523, 997 P.2d 1000 (2000).

This case is much like the one decided in Nitsch. Like Bergstrom, the defendant in Nitsch filed a presentence report in which he affirmatively agreed with the standard range calculations of the State. Nitsch, 100 Wn. App. at 522. Although the defendant in Nitsch did not raise an improper, last-minute *pro se* objection like Bergstrom did, the defendant in Nitsch similarly failed to effectively and timely raise an objection to his offender score. Id. at 521-22. In

this case, Bergstrom's attorney was the only person with authority to object to the offender score on behalf of Bergstrom or contradict the range reflected in the Defense Presentence Report, and she twice declined to do so because she was not willing to "take a position contrary to my client's." 11/17/04 RP, 4, 7. Accordingly Bergstrom, like the defendant in Nitsch, waived future objections to his offender score on appeal.

Bergstrom's *pro se* motion objecting to his offender score was made while he was represented by counsel and was, therefore, not properly before the trial court. Accordingly, Bergstrom did not effectively raise an objection to his offender score was at trial and has waived the right to raise that issue on appeal.

**2. BECAUSE OF THE UNIQUE CIRCUMSTANCES CREATED BY BERGSTROM'S UNTIMELY *PRO SE* OFFENDER SCORE OBJECTION, THE STATE SHOULD BE ALLOWED TO PRESENT EVIDENCE RELATED TO BERGSTROM'S PRIOR OFFENSES IF THE MATTER IS REMANDED FOR SENTENCING.**

At a sentencing hearing where a defendant disputes material facts related to his criminal history, the State bears the burden of proving that criminal history. State v. Cabrera, 73 Wn. App 165,

168, 868 P.2d 179 (1994). It is up to the sentencing court to conduct an evidentiary hearing on the disputed issues. RCW 9.94A.370. If a defendant effectively raises issues concerning criminal history and the State does not provide evidence establishing criminal history, the contested information may not be considered by the sentencing court. State v. Ford, 137 Wn.2d 472, 481, 973 P.2d 452 (1999).

If the State fails to meet its burden to prove criminal history at the initial sentencing hearing, the State may not be allowed to supplement the record at a resentencing. State v. Lopez, 147 Wn.2d 515, 519, 55 P.3d 609 (2002). However, the State is not precluded from introducing new supporting evidence at a remanded sentencing hearing when a defendant, “fails to specifically put the sentencing court on notice” as to apparent defects in calculating criminal history. Ford, 137 Wn.2d at 485. Preventing the State from introducing additional criminal history evidence following remand in such cases would undermine the purposes of the Sentencing Review Act to, “impose fair sentences” and could create a windfall for defendants who fail to raise defects at sentencing in the hopes that, “the appellate court will reverse

without providing the State further opportunity to make its case. Id at 485-86.

In this case, Bergstrom attempts just such a strategy. At his first sentencing hearing on November 5, 2004, Bergstrom's counsel tried to convince the Court, without any binding legal authority, that he should not have to serve his sentence in jail because of his health problems. 5RP 5. When that motion failed, Bergstrom's counsel claimed that Bergstrom should be allowed to serve his sentence on electronic home detention ("EHD"). 5RP 7. The Court continued the sentencing so the parties could look into that issue and, following such research, Bergstrom's counsel was again forced to admit that there was no statutory basis for making such a request. 6RP 4. When Bergstrom's EHD motion was accordingly denied, he attempted to raise his *pro se* sentencing motion for the first time. 6RP 6.

If this Court were to find that Bergstrom effectively raised an objection to his criminal history calculation and remand the matter for a resentencing where the State would be precluded from introducing evidence supporting its calculation of Bergstrom's offender score, Bergstrom would reap the unjustified benefit addressed in Ford. Such a holding would create an incentive for

defendants to blurt out, whether represented or not, any potential objection at sentencing in the hopes that they created a record that might benefit them on appeal. Accordingly, if the Court opts to remand for resentencing in this matter, the State should be permitted to introduce additional evidence related to Bergstrom's potential claims concerning whether his prior offenses were the same criminal conduct.

**D. CONCLUSION**

Prior to sentencing, Bergstrom's counsel agreed, through her Defense Presentence Report, that her client was subject to a standard range of 87-116 months given his criminal history. Bergstrom's counsel represented him and argued on his behalf within that report and at two sentencing hearings. It was only after counsel's arguments failed that Bergstrom attempted his improper *pro se* arguments that were not supported or joined by his attorney.

Bergstrom cannot be both represented by counsel and *pro se*. Had he an objection to his offender score, it was properly raised by his counsel, who twice specifically declined to do so. Since he did not effectively object to his offender score at trial, he cannot now object and his appeal should be denied.

If the Court nonetheless determines that Bergstrom effectively raised an objection to his offender score and remands for resentencing, equitable considerations and controlling precedent, including Ford, require that the State be permitted to introduce additional evidence at such resentencing refuting Bergstrom's claims.

DATED this 25 day of July, 2005.

RESPECTFULLY submitted,

NORM MALENG  
King County Prosecuting Attorney

By:  # 29940  
SCOTT F. LEIST, WSBA 29940  
Deputy Prosecuting Attorney  
Attorneys for the Respondent  
WSBA Office #91002

**EXHIBIT A**

**DEFENSE PRESENTENCE REPORT  
(TO BE DESIGNATED AS SUPPLEMENTAL CLERK'S  
PAPERS)**

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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF KING

STATE OF WASHINGTON, )  
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 Plaintiff, )  
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 v. )  
 )  
 GORDON BERGSTROM, )  
 )  
 Defendant. )

CAUSE NO. 03-1-05779-3 SEA  
  
DEFENSE PRESENTENCE  
REPORT

SENTENCING DATE: Nov. 5, 2004 at 1:00 p.m.  
SENTENCING COURT: The Honorable John Erlich  
CHARGE: VUFA 1  
STANDARD RANGE: 87 to 116 months

I. DEFENSE RECOMMENDATION

The defense recommends an exceptional sentence downward of 36 months with  
EHM, strict monitoring, and mandatory drug treatment.

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II. BASIS FOR DEFENSE RECOMMENDATION

Mr. Bergstrom's extraordinary medical history constitutes the basis for the defense motion for an exceptional sentence downward.

III. PROCEDURAL HISTORY

Mr. Bergstrom was convicted in March after a jury trial. His sentencing hearing has been continued multiple times due to Mr. Bergstrom's ongoing and serious medical issues.

IV. LAW AND ARGUMENT

A trial court may depart downward from the presumptive sentence where substantial and compelling circumstances are shown to exist. State v. Hadley, 54 Wn.App. 377, 773 P.2d at 879, affirmed 115 Wn.2d 275, 796 P.2d 1266 (1989). The appellate court uses an abuse of discretion standard to determine whether an exceptional sentence downward is too lenient. State v. Clemens, 78 Wn.App. 458, 462, 889 P.2d 324 (1995).

Under the SRA, mitigating factors for exceptional sentences downward must distinguish the crime itself and not merely the defendant. State v. Fowler, 145 Wn.2d 400, 411, 38 P.3d 335 (2002). In contrast the federal courts, not known for their lenient sentencing practices, allow a defendant's extraordinary personal characteristics to inform the sentencing decision. See United States v. Core, 125 F.3d 74 (2<sup>nd</sup> Cir. 1997). For example the Federal Sentencing Guides expressly allow a defendant's extraordinary physical impairment to support a downward departure from the sentencing guidelines. U.S.S.G. Sec. 5H1.4. Here, the defense urges the court to follow the lead of the federal bench and consider an exceptional sentence downward based on Mr. Bergstrom's complex and fragile medical condition.

**1. Federal and ancient precedents support an exceptional sentence downward.**

Federal case law is replete with examples of downward sentencing departures based on medical infirmity. See United States v. Rioux, 97 F.3d 648, 662-63 (2<sup>nd</sup> Cir. 1996)

(medical condition caused by kidney transplant grounds for downward departure); United States v. Baron, 914 F.Supp. 660, 662-665 (D.Mass. 1995) (significant downward departure for elderly and infirm defendant); and United States v. Roth, 1995 WL 35676, at 1 (S.D.N.Y. Jan. 30, 1995) (defendant with neuro-muscular disease had "profound physical impairment" warranting downward departure). These cases, in turn, follow an ancient tradition of "modifying a sentence to take account of a defendant's frailty." United States v. Gigante, (E.D.N.Y. 1998) *citing The Code of Maimonides*, Book XIV, Treatise One: Sanhedrin, chap. 17, para.1, Mishna Torah, The Book of Judges (Abraham M. Herschman, trans., Yale Univ. Press 1949) ("How many stripes are inflicted...as it is said: to be beaten...according to the measure of his wickedness...(Deut. 25:6)...But the number is reduced in the case of a frail man...").

Mr. Bergstrom is just such a frail man. His attached medical summary provides ample evidence of this: "His medical history is very complex due to the variety of injuries he has sustained as well as his rather marked history of malignancy." In addition, Mr. Bergstrom suffered a closed head injury resulting in memory loss. He suffers from esophageal reflux disease. He has a severe shoulder injury. He is in near constant pain.

2        **Because a substantial and compelling mitigating factor supports an exceptional sentence downward, the court may consider the purposes of the SRA in fashioning the length and term of Mr. Bergstrom's sentence.**

Under RCW 9.94A.122, a sentencing court that imposes a sentence outside of the standard range must consider the goals of the SRA. *See also Nelson*, 108 Wn.2d 491 (1987). Those goals are:

- (1) Ensure that the punishment for a criminal offense is proportionate to the seriousness of the offense and the offender's criminal history;
- (2) Promote respect for the law by providing punishment which is just;
- (3) Be commensurate with punishment imposed on others committing similar offenses;

- (4) Protect the public;
- (5) Offer the offender an opportunity to improve him- or herself;
- (6) Make frugal use of the state's and local government's resources; and
- (7) Reduce the risk of reoffending by the offender in the community.

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7 The defense sentencing recommendation comports with these goals. Thirty-six  
8 months of alternative confinement is a significant period that reflects the gravity of the  
9 conduct. Further, the drug treatment requirement fulfills the dual goals of allowing Mr.  
10 Bergstrom the chance to improve himself and reduce the likelihood that he would reoffend  
11 upon release. Finally, the sentence makes frugal use of State's resources by reducing the  
12 inevitable transports to from prison to local hospitals to treat his various injuries and  
13 illnesses.

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16 CONCLUSION

17 The downward departure proposed by the defense furthers the goals of the SRA by  
18 providing an opportunity for both punishment and reflection, and the chance for hope and  
19 rehabilitation. Retribution is the only goal of the SRA to be served by imposing a standard  
20 range sentence in this case. It is the SRA's least laudable goal, and the one least likely to  
21 benefit either society or Mr. Bergstrom. The modest downward departure proposed by the  
22 defense is the appropriate and humane sentence in this case.

23 Respectfully submitted this 3<sup>rd</sup> day of November, 2004

24  
25 

26 Cathy Gormley, WSBA #26169

MINOR & JAMES MEDICAL  
206-386-9500

BERGSTROM, GORDON

03/12/04

MARTIN L. GREENE, M.D.

**S:** Mr. Bergstrom is here for evaluation of severe esophageal symptoms.

**Hx:** This man has a rather incredible history of multiple cancers, which date back to 1986. He is currently 43 years old and under the care of Dr. Sam Cullison. He has also seen Dr. Michael Milder.

His tumors include a seminoma, lymphoma, a melanoma from his right forearm, and subsequently a liposarcoma of the left calf. So this man has had four different types of tumors. He has had multiple surgeries for these.

He tells me that he had radiation therapy as well as chemotherapy for these tumors. He says that "trashed his esophagus". He now has severe reflux of "bile" at night and wakes up coughing and choking. He also has substernal pain. He has been started on Protonix.

**MEDS:** Current medications include;  
Flexeril 20 mg daily  
Tylenol #4 as needed for pain  
Protonix, one daily, 40 mg  
ibuprofen 600 mg a day

**PMH:** Patient has had abdominal surgeries in the past, including lymph node resection and a small bowel resection for metastatic tumor.

He now tells me he is free of tumor.

An endoscopy may have been done at Group Health Hospital in 1996, but we have no records of that.

The patient has two years of college. He lives with his mother. He is a metal worker but has not worked at his profession for the last 1½ years.

**O:** Physical exam showed a man who is somewhat slender at 176 pounds, probably 6' tall. BP 110/72. Head, ears, eyes, nose and throat did not show any adenopathy that I could feel. Chest was clear. Cardiac exam unremarkable. No adenopathy in the axillae or inguinal areas. Scars were seen in the midline of his abdomen and both right and left lower quadrants. I could not feel any enlarged liver or spleen.

No other information is available at the date of this dictation.

**A:**

1. Symptomatic gastroesophageal reflux, severe.
2. History of multiple cancers, dating back to 1986 (see above for details).
3. Chronic pain syndromes.

**P:**

1. Get current lab studies.
2. Schedule for upper endoscopy.
3. Continue Protonix for now.
4. Discussion with patient after the procedures are done about diagnosis and treatment.
5. Keep Dr. Michael Milder and Dr. Cullison informed.

MARTIN L. GREENE, M.D.

r/t03/16/04/pb:m

cc: Michael S. Milder, M.D.   
Samuel W. Cullison, M.D. 

VIRGINIA MASON MEDICAL CENTER  
MED/Heather R Kroll

April 4, 2002

IDENTIFYING DATA AND CHIEF COMPLAINT:

The patient is a 41-year-old gentleman with multiple pain complaints, primarily in the left ankle and right wrist. He returns to the clinic today for completion of his evaluation which was started on March 5th, 2002. At that time, time constraints did not allow completion of the physical exam and final recommendations.

INTERIM HISTORY:

The patient has had no change in his symptoms since I initially met with him.

PHYSICAL EXAMINATION:

GENERAL: Shows the patient is pleasant, cooperative and in no apparent distress.

Neurological exam shows that he is alert and oriented times three, although there is evidence of some long term memory deficits particularly around episodes surrounding his brain injury.

Cranial nerves 2-12 are intact to specific exam. Motor exam shows 5 out of 5 strength in the upper extremity although he has pain with resistant right wrist extension. The right biceps have 5 out of 5 strength, but is smaller than the left. Lower extremity shows 5 out of 5 strength in hip flexion, knee flexion and extension, dorsiflexion and right toe movements. On the left extensor has 5 out of 5 strength, but there is weakness in his left perineal and he is really unable to move his toes 2-4 very well either to flexion or extension due to previous surgery.

Deep tendon reflexes are 1+ and symmetrical at the biceps, 1+ at the right triceps and absent at the left triceps and he had pain secondary to recent biopsy in the region. 1+ at the pronator bilaterally. Deep tendon reflexes at the knees are 2+, both the quadriceps and hamstrings. Right ankle jerk is 1+, left ankle jerk is absent. Toes are downgoing. Sensory examination shows intact pin prick sensation in the upper extremities. In the lower extremities he has decreased pin prick sensation on the left lateral foot as well as decreased light touch sensation on the left lateral foot. There is no allodynia or hyperpathia present anywhere. The patient has a normal gait pattern although he moves his left ankle somewhat stiffly. He can walk on his heels and toes, although he appears to have some weakness in the left toes.

Musculoskeletal exam shows a full range of motion of the cervical spine. Upper extremity range is full at the shoulder and elbow. The right wrist motion is full although activity causes crepitus

VIRGINIA MASON MEDICAL CENTER

April 4, 2002

MED/Heather R Kroll

CONTINUED . .

over the dorsal forearm where he has a plate. In the lower extremities, straight leg raising is 80 degrees bilaterally, hip flexion is full, internal and external rotation are both 30 degrees right and left. Knee flexion and extension are full. Ankle motion is full on the right. Dorsiflexion on the left is limited to 5 degrees. The patient has right sided knee pain with medial lateral stress on the joint. None of his lower extremity joints have any swelling, erythema or instability. None of his upper extremities joints have any swelling, erythema or instability. He has multiple scars over the left foot around the ankle and on top of the foot, also has some scars over the right forearm. These are all well healed.

IMPRESSION:

This is a 41-year-old gentleman with multiple musculoskeletal complaints, status post a history of multiple injuries. His pain appears to be primarily mechanical. I see no evidence of any significant nerve injury or any neuropathic pain. In addition to this, he does have a complex medical history of malignancy as well.

RECOMMENDATIONS:

1. In terms of management of his pain, it appears that this patient has been on opiates for a prolonged period of time. I think that continuing on the opiates is a reasonable choice for him. I would recommend that he continue on the Tylenol #4 for a total of five pills a day. He takes one in the morning, one late morning, one midday and two in the early evening. I would recommend having a contract with the patient indicating that he would receive his medications from one physician only and from one pharmacy only. Should he have a need for further pain medications due to other procedures, such as surgical procedures, this is fine as long as the physician prescribing those communicates with the primary care physician providing his medications. Maintaining the patient on good flow of the medication is fine as well as he maintains his functional capacities and does not escalate his dose.

2. The patient has been on ibuprofen in the past which sounds like it has not helped him terribly and has also caused him GI upsets. I would therefore recommend a trial of Vioxx at 25 mg a day for at least a two week period and as long as he does not have side effects. If after two weeks it does not seem to be helping his pain, I would then switch him to Celebrex 200 mg b.i.d. Once, again I would give that a two week trial before discontinuing it due to lack of effectiveness. If either of those are effective, then he can continue on that long term. If he does continue on one of

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BERGSTROM, GORDON D

MRD:Outpt

VIRGINIA MASON MEDICAL CENTER  
MED/Heather R Kroll

April 4, 2002

CONTINUED . .

those medications long term he will need to have his renal function monitored periodically.

3. Continue on Flexeril 10 mg b.i.d. is also recommended.

4. I would also recommend giving him either Protonix or Prilosec for management of his gastroesophageal reflux disease discomfort.

5. The patient has had a trial in the past on Ultram. I would recommend against further use of this medication given his history of brain injury. I unfortunately don't have full records of that injury, but he may be at increased baseline seizure risk. There is a risk of lowering the seizure threshold with Ultram and the potential of pain relieving benefits I believe are not high enough to warrant putting the patient on this medication.

6. The patient is planning to return to his primary care physician for implementation of these recommendations.

A total of 45 minutes was spent with the patient today. The majority of the time in counseling regarding management of his pain medications.

Heather R. Kroll, M.D.

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CC:  
EDWIN TEGENSELVDT MD  
616 6TH STREET  
BREMERTON, WA 98337

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VIRGINIA MASON MEDICAL CENTER  
MED/Heather R Kroll

March 5, 2002

IDENTIFYING DATA AND CHIEF COMPLAINT:

Mr. Bergstrom is a 41-year-old gentleman with multiple pain complaints, the primary one of which is left ankle pain, who is referred here by his primary care physician, Dr. Tegenfeldt for assessment per the patient's request. The patient has a very complicated medical history involving multiple malignancies and multiple injuries. Records were available for some of the history of his left ankle pain. Very little of his other records are available to me today.

HISTORY OF PRESENT ILLNESS:

History was obtained from the patient, his significant other and a portion of his medical record. The patient currently complains of primary pain in the left ankle region and left calf region along with persistent right knee pain, right wrist pain, left hand pain, bilateral shoulder pain and some left axillary lymphadenopathy which is also painful. He describes his goal as to establish a reasonable daily pain management regimen and to not get "strung out on narcotics."

With regard to the left ankle injury, the patient had an on-the-job injury in 1991 in which his left ankle he reports as having been "shattered." Apparently truck tire rims fell on the backs of his legs and twisted the left ankle on January 7, 1991. The patient had ankle instability as a result of this injury and underwent multiple surgeries. The first of these was by Dr. Floyd in November 1992 with a finding of bone fragments and possible talar dome fracture along with unstable ligaments. He had an ankle stabilization done and a medial arthrotomy to remove the bone fragments and explore the talar dome. In 1993, the bone screw and tendon washer were removed. He had a third surgery later in 1993 to repair part of the ligament, drill in the cartilage and do a gastrocnemius recession. He then underwent surgery in June 1994 to repair a herniated lateral gastrocnemius muscle belly. This repair was not successful. It was undetermined that the patient had a liposarcoma in the gastrocnemius region, and this was resected in 1996. Finally in November 1996, the patient underwent transfer of the flexor hallucis longus to the Achilles tendon and a tenodesis of the peroneus longus to the peroneus brevis. Most was done by Dr. Sig Hansen at Harborview Medical Center. The patient underwent physical therapy for his ankle in January 1997. Since that time he has continued to have persistent pain. He apparently has had some nerve entrapment symptoms over the intermediate dorsal cutaneous nerve and sural nerve. He has been treated with both physical therapy and injections. The patient was felt to be medically

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VIRGINIA MASON MEDICAL CENTER

March 5, 2002

MED/Heather R Kroll

CONTINUED . .

stable in 1997 and received a 24% permanent impairment rating and recommendation to pursue light duty work.

Despite this persistent pain in his ankle and foot, the patient reports having been able to go back to work in metal work and construction and working full time. He apparently most recently discontinued to work in June last year related in part to shoulder surgery and new diagnosis of lymphadenopathy but unrelated to his ankle problem.

Current complaints in the ankle include pain that is constant in the left ankle and the calf like a bruise with also sharp pain in the ankle joint and toes. He gets a cramping-type pain in his anterior shins which is better when he is on codeine. Ankle symptoms are worse with walking in cold weather and better on his current medications, with a hot bath and was rubbing the calf. He denies any significant numbness, tingling or weakness although he has some numbness in the left toes.

The patient has a multitude of other musculoskeletal complaints, the history of which is much less clear. One of these is complaints of right wrist pain. He had a previous fracture there with a metal plate in that. He describes a constant ache and a sharp piercing pain in the right wrist which is worse when he picks up objects and better when he decreases use of his hand and also his medications. Additionally he had an injury in June 2000 where his left fingers were smashed at work and resulted in an infection. He never opened a work injury claim for this although he did lose some work time then. He reports that his employer paid him during this time but then ultimately fired him on the count of his poor work performance during the time that he was off. He is, therefore, not on L&I at this time and currently is on DSHS. He has been having some right shoulder pain and instability related to a right shoulder dislocation that occurred at a motor vehicle accident in 4/01. He additionally has been having some left arm pain related to the presence of lymphadenopathy and recent biopsies in that arm.

**PAST MEDICAL HISTORY:**

The patient's past medical history is significant for a large number of accidents and injuries. He was involved in a motor vehicle accident in 1979 which was a pedestrian versus motor vehicle accident. He was then involved in a head on motor vehicle accident in 1980 as well. He was hospitalized both of these times at Harborview Medical Center. After one of these injuries, he sustained a closed head injury with loss of consciousness times

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several days and stayed on the rehabilitation unit. The patient is really unable to recall which of these injuries precipitated his closed head injury. I do not have any of his Harborview records from these injuries. However, he reports that on the count of the pedestrian versus motor vehicle accident he sustained a sternal fracture, a right knee injury for which he had a previous history of three reconstructive surgeries before 1974, a right forearm fracture for which he now has a metal plate which causes him persistent pain and bilateral lower extremity fractures including the right and left tibia and fibula as well as the right femur. In the 1980 accident he believes that he fractured his left hand as well as his left clavicle and believes that he refractured his left and right lower legs. Despite these multiple injuries he does describe returning to work in metal work and construction full time.

The patient's past medical history is also very significant for multiple tumors. He was diagnosed in 1986 with a seminoma which was removed. He was then diagnosed in either 1986 or 1987 with lymphoma. It is not clear to me whether this was Hodgkin's lymphoma or non-Hodgkin's lymphoma or both. This was treated with chemotherapy including bleomycin, VP-16, and cisplatin. His lymph nodes were resected and he also had a small bowel resection in 1987 due to metastases present there. He was also treated with radiation. He had a melanoma removed from the right forearm in 1996 treated simply with a local resection. The records I have indicate that he also had one removed from the left forearm. The patient did not mention this during the interview. He does note that the dermatologist would like to remove a mole on his face as well as one in his left buttock. He was diagnosed with a liposarcoma described above in the left calf in 1996 and that was treated by surgical resection.

Other past medical problems include a history of depression and the question of bipolar affective disorder as well as gastroesophageal reflux disease.

PAST SURGICAL HISTORY:

In addition to all of these things described above included three knee surgeries to the right knee in 1974, right wrist surgery in 1980, left hand surgery in 1980, reattachment of the left fifth digit distal phalanx in 1998, repair reattachment of the fourth digit on the right distal phalanx in 1984, removal of lymph nodes in the left neck and left groin in 1998 which turned out to be benign and more recent removal of lymph nodes in the left axilla

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and left elbow region in 2001. These also were not malignant. The patient also notes a history of leg and arm fractures as a child.

MEDICATION ALLERGIES:

None.

CURRENT MEDICATIONS:

1. Tylenol #4 five per day consistently running out before the end of the month and recently with withdrawal symptoms related to that.
2. Ibuprofen 800 mg three times a day.
3. Ultram 100 mg three times a day. He has been using this for one month.
4. Flexeril 10 mg b.i.d. which helps with left lower extremity cramps.
5. Prilosec 20 mg q.day.

Previous medications have included:

Indocin, Toradol, glucosamine sulfate, MSM, chondroitin sulfate, calcium, potassium, Naprosyn, oxycodone and Tylox. Additionally he has been on Paxil, Remeron, Serzone, amitriptyline and trazodone as well as Neurontin. The patient did not note any particular benefit from most of these medications and did not like his response to oxycodone and to Tylox.

REVIEW OF SYSTEMS:

The patient smokes one pack of cigarettes per day. He does not drink alcohol. He drinks one cup of coffee a day. He has worked primarily as a metal worker and in construction. Last worked in June 2001. He did note recent problems with fever, fatigue and weight fluctuation. This along with his lymphadenopathy is being worked up by another physician, Dr. Herman. He complains of change in his vision and notes some hearing problems and nasal congestion. He complains of indigestion, nausea and some withdrawal symptoms such as diarrhea. He notes some problems with numbness, weakness and headaches. He complains of anxiety, irritability, change in appetite, poor sleep and feelings of depression. When questioned more closely, the depression feelings are not daily and he says they are related to his current inability to work. He does relate a history of cycling of mood with periods of time when he slept little, was very energetic and sounds fairly hypomanic if not frankly manic. History of night sweats recently. History of previous transfusion in 1980. The patient denies any cardiac or pulmonary symptoms.

Certificate of Service by Mail

Today I deposited in the mail of the United States of America, postage prepaid, a properly stamped and addressed envelope directed to Jason Saunders, the attorney for the appellant, at Washington Appellate Project, 701 Melbourne Tower, 1511 Third Avenue, Seattle, WA 98101, containing a copy of the Brief of Respondent, in STATE V. GORDON BERGSTROM, Cause No. 55374-7-I, in the Court of Appeals, Division I, for the State of Washington.

I certify under penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

W Brame  
Name  
Done in Seattle, Washington

7/25/05  
Date

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