March 3, 2021

Honorable Richard D. Roth, Chair and Members,
Senate Business, Professions, and Economic Development Committee
State Capitol, Room 2053
Sacramento, CA 95814

Honorable Evan Low, Chair, and Members
Assembly Business and Professions Committee
Legislative Office Building, Room 379
Sacramento, CA 95814

Re: Joint Sunset Oversight Hearing, Medical Board of California

Dear Senator Roth, Assemblymember Low, and Members of the Committees:

The Center for Public Interest Law (CPIL) respectfully submits the following testimony relevant to the Committees' sunset review of the Medical Board of California (MBC). As public comments and remarks from members of the Senate Rules Committee recently made clear at its February 3, 2021 hearing on the confirmation of three licensee members of MBC, **public trust in the Board's ability to protect patients is extremely low**. To that end, CPIL proposes retention of the Board but makes the following major recommendations (which are explained more fully below):

1) **Establish a Public Member Majority on the Board:** Add two public members to the composition of the Board—one from each house of the Legislature—to ensure public protection remains the highest priority of the Board.

2) **Appoint an Enforcement Monitor:** As the Board itself recognizes in its Sunset Report, investigation and case processing times are simply unacceptable for public protection. The Committees need not look further than the Board's February 21, 2021 accusation of Santa Clara County's former chief pediatrician for children in foster care, Patrick Steven Clyne, **filed 20 years after allegations surfaced that he had sexually abused foster youth living in his home**, to be convinced that a thorough investigation of the Board's enforcement process is imperative.

3) **Create an Ombuds Office:** An independent Ombudsperson to facilitate the complaint process and improve dialogue with patient advocates would improve public trust and improve internal efficiencies at the Board.

4) **Increase Licensing Fees:** A robust enforcement program is impossible with starved resources. This is a must.

Center for Public Interest Law
5998 Alcalá Park, San Diego, CA 92110-2492
P: (619) 260-4806 | F: (619) 260-4753 | www.cpil.org

About the Center for Public Interest Law

CPIL is a nonprofit, nonpartisan academic and advocacy organization based at the University of San Diego School of Law. For over 40 years, CPIL has studied occupational licensing and monitored California agencies that regulate business, professions, and trades, including the Medical Board and other Department of Consumer Affairs (DCA) health care boards. CPIL has focused heavily on MBC since 1989 when it published *Physician Discipline in California: A Code Blue Emergency* ("*Code Blue*"), a 100-page report based on three years of research which revealed the minimal output, fragmented structure, and questionable priorities of the Medical Board's enforcement program. Based on that report, the Legislature passed at least five MBC enforcement program reform bills between 1990 and 2000.[1] After continuing reports of problems at MBC's enforcement program were published in 2002, the Legislature passed SB 1950 (Figueroa) in 2002, which required the DCA Director to appoint a "Medical Board Enforcement Monitor." After a competitive bidding process, the Director appointed CPIL's then Administrative Director, Julianne D'Angelo Fellmeth, to that position in October 2003. Over a two-year period, she directed an in-depth investigation and review of MBC's enforcement and diversion programs, culminating in two reports containing 65 concrete recommendations for reform.[2] At least five pieces of reform legislation (SB 231 in 2005; SB 1438 in 2006; AB 1127 in 2011; SB 304 in 2013; AB 1886 in 2014) have been enacted in response to these reports, mirroring many of the recommendations.

Increase Public Member Representation on the Board

CPIL wholeheartedly supports the suggestion that Senate President pro Tempore Toni Atkins made at the conclusion of the February 3, 2021 Rules Committee hearing that **two public members should be added to the Board** to give the public—and not physicians—the majority of the Board. This is a recommendation for which we have been advocating for decades—particularly following the U. S. Supreme Court's decision in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, 574 U.S.494 (2015). This holding included the bold general rule that where a regulatory board is controlled by active market participants in the occupation the board regulates, it lacks state sovereignty and thus is subject to federal antitrust liability unless the state can show that it is actively supervising these boards. Currently, California exercises no such supervision according to the standards set forth by the Court. In fact, CPIL sponsored legislation to provide that review for all such vulnerable state agencies in SB 1195(Hill) in 2016, but it was defeated after vigorous trade association lobbying. Thus, as it stands, boards with a majority of licensee members, like MBC, are at significant risk of exposure to an antitrust lawsuit and the treble damages that would result. Changing the Board's composition to a public member majority is not only the right thing to do for public protection, but it will decrease the Board's risk of exposure to lawsuits.

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[1] SB 2375 (Presley) (Chapter 1597, Statutes of 1990); SB 916 (Presley) (Chapter 1267, Statutes of 1993); SB 609 (Rosenthal) (Chapter 708, Statutes of 1995); AB 103 (Figueroa) (Chapter 359, Statutes of 1997); SB 16 (Figueroa) (Chapter 614, Statutes of 2000).

[2] Julianne D'Angelo Fellmeth and Thomas A. Papageorge, *Initial Report of the Medical Board Enforcement Monitor* (November 1, 2004) (hereinafter "*Initial Report*"); Julianne D'Angelo Fellmeth and Thomas A. Papageorge, *Final Report of the Medical Board Enforcement Monitor* (November 1, 2005).

For the same reasons, the current public member vacancies on the Board are troubling. At this writing, there are three public member vacancies on the Board—two to be appointed by the Governor and one by the Speaker of the Assembly. The public is woefully underrepresented on MBC, and its current supermajority of physician members increases the potential for anticompetitive decisionmaking.

Appoint an Enforcement Monitor to Assess the Existing Program and Recommend Improvements for Public Protection

As mentioned above, in 2002, after continuing reports of problems at MBC's enforcement program, the Legislature passed SB 1950 (Figueroa), which required the DCA Director to appoint a "Medical Board Enforcement Monitor," a position ultimately filled by CPIL's then Administrative Director, Julie Fellmeth. Notably, a May 2002 committee analysis of the bill described the circumstances which ultimately resulted in the appointment of the Enforcement Monitor, "[It is] apparent . . . that public confidence in the Board's enforcement program and the transparency of its public disclosure policies is thin and, if possible, getting thinner; on the verge of evolving into a 'crisis.' For physicians and patients it makes sense to have a vigorous, trusted regulatory program in place that prevents as many patients as possible from being damaged in the first place." These same concerns exist today.

Just last week, the San Jose Mercury News reported[3] that MBC filed an accusation seeking to revoke Santa Clara County's former chief pediatrician's medical license for children in foster care, Dr. Patrick Clyne. Shockingly, the report details **20 years of reports of abuse before the Board filed the accusation,** specifically, that Clyne had been accused of sexual abuse for decades by Santa Clara County social workers, parents, guardians, therapists, a juvenile probation officer, and staff at two residential group homes based on the accounts of 13 children; had been the subject of a civil lawsuit filed on behalf of a former foster youth who alleged that Clyne had sexually abused him when he was eight years old and living in Clyne's home; was removed from his position as chief pediatrician for the foster care system by Santa Clara County in 2011 after the Santa Clara County District Attorney's Office found substantial evidence that Dr. Clyne committed multiple crimes of moral turpitude, specifically sexual assaults; was barred by the California Department of Social Services in 2013 from ever becoming a foster parent again, and prohibited him from working with any children or adults in state-licensed facilities. In a testament to this incredibly broken system, a license search for Clyne on the Board's BreEZe database lists his license as "Renewed and Current," although it does show that an accusation has been filed. None of the above troubling past would be known to the parents of any of his patients. **This means he will continue to practice—where he serves low-income clients in a rural, immigrant community south of Santa Cruz—likely for years before his case is resolved.**

While it is unclear at this point (to the public anyway) why it took the Board so long to file an accusation against Dr. Clyne, what is clear is that this case alone exemplifies the dire need to quickly identify and remedy the breakdowns in the system that allowed—and continues to allow—Dr. Clyne to prey on the most vulnerable of our society.

[3] *See* Karen De Sá, *After decades of sex abuse claims, state moves to stop former Santa Clara chief pediatrician from practicing medicine*, San Jose Mercury News, February 23, 2021.

Regardless of whether the Committees determine that an Enforcement Monitor is warranted at this time, the following pressing issues with respect to the Board's enforcement program must be expeditiously addressed during this Sunset Review process:

- ***Inefficient Investigations and Lack of Collaboration with Prosecutors***: As the Board mentioned in its Sunset Report, and as some members of these Committees may recall, the Board's Vertical Enforcement program[4] was repealed at MBC's request in 2019. A central recommendation of the Enforcement Monitor's Initial Report in 2004, Vertical Enforcement (also known as "VE" or Vertical Prosecution), required MBC and the Health Quality Enforcement (HQE) unit of the Attorney General's Office to utilize VE in investigating and prosecuting MBC disciplinary matters, and—in order to fully and efficiently implement VE—transfer MBC's investigators into HQE where the prosecutors who specialize in physician discipline matters are located. The Enforcement Monitor cited a number of benefits that would likely result from the use of VE and the transfer, including (1) improved efficiency and effectiveness arising from better communication and coordination of efforts—including more efficient recognition of cases deserving interim suspension order (ISO) treatment due to the early involvement of the prosecutor, (2) reduced case cycle times—including decreased time to procure needed medical records due to the earlier involvement of the prosecutor, (3) the earlier closure of investigations where the Board will not be able to sustain its burden of proof, (4) improved commitment to cases by both investigator and prosecutor, (5) improved morale, recruitment and retention of investigators, (6) improved training for investigators and prosecutors, and (7) the potential for improved perception of the fairness of the process (in that the investigators would no longer be subject to actual or perceived pressures or undue influence by the physician-dominated Medical Board).[5]

  While the Legislature did accept the recommendation to institute VE at the Board, it did not transfer the investigators to the AG's office. Thus, the program was never implemented as intended, and the structural and geographical separation of investigators from prosecutors created a host of problems throughout the program's tenure. To complicate matters, the Legislature—effective July 1, 2014—transferred MBC's investigators not to the Attorney General's Office as suggested by the Monitor, but to the Department of Consumer Affairs, thus introducing a third party into the already fraught relationship between MBC and HQE. This transfer caused investigator attrition and investigative case cycle times to skyrocket immediately. Ultimately, these problems led to the sunset of the program and the return to the "hand-off" model of investigation, in which investigators at the Department of Consumer Affairs' Health Quality Investigations Unit (HQIU) investigate the complaints on their own, and then "hand-off" the investigations to the Attorney General's Office.[6] We are only now

[4] Gov't Code § 12529.6 (enacted in 2006).

[5] *Initial Report* at Chapter VII, pages 138–40. Note that complex white collar crime cases, including civil unfair competition matters in the offices of the district attorney throughout California, are routinely investigated by investigators supervised by deputy district attorneys. These are not simple cases that can be investigated and then "handed off" to a prosecutor previously uninvolved in the matter. Issues including the elements of the offense, what evidence is needed to prove those elements, and how such evidence can be obtained and organized for effective and admissible presentation require early attorney involvement.

[6] For a complete history of the implementation and eventual sunset of VE, *see* the following issues of the *California Regulatory Law Reporter*, available at https://digital.sandiego.edu/crlr/: Volume 23, Issue 1 (Fall 2017) at 37–40; Volume 23, Issue 2 (Spring 2018) at 46–47; Volume 24, Issue 2 (Spring 2019) at 44–45.

seeing the impact of this sunset, and the numbers are not good. The investigation times and overall case processing times are at unacceptable levels. The Board itself recognized that it did not realize the cost savings or reduction in investigation times that it anticipated after the program's sunset.

At the Board's February 2021 meeting, it held a lengthy discussion with a representative from the Attorney General's office representing HQE. The Board members expressed concern as to the increasing number of days it was taking the AG's office to file a case. The AG's office reported that a contributing factor is the sunset of VE. Alarmingly, the AG's office reported that HQE returned 77 cases to the Board for further investigation in FY 19/20—**11 times the number returned in FY 16/17** before VE was sunset. Not only that, but the Board's Sunset Report reveals that investigation cycle times increased by two months since the sunset of VE. Delayed investigations—including investigations of egregious matters—delay the filing of accusations against physicians, which filing makes the matter public so patients can protect themselves from potentially dangerous doctors. Obviously, this is a multi-pronged problem that has severe public safety impacts.

In light of the significant public protection implications of the current state of the Enforcement Program, the Board's recommendation for "improved communication" with HQIU set forth in New Issue #3 of its Sunset Report is dangerously insufficient.

CPIL again reiterates its recommendation that the **investigators should move to the Attorney General's Office as originally proposed** so that all of the team members (prosecutors and investigators) can work together as expeditiously as possible to maintain consumer protection. At a minimum, the Legislature should consider reverting to the system in which the investigators are employed by the Board, and the Attorney General assigns a Deputy in District Office (DIDO) to work in each MBC field office to provide legal assistance and guidance to investigators.[7]

- ***Inadequate Compliance with Mandated Reporting:*** The Board's Sunset Report recognizes some troubling instances. It does not believe it is receiving critically important mandated reports set forth in sections 800, *et seq* of the Business and Professions Code. For example, MBC reported it only received one report from a coroner in FY 19/20 pursuant to section 802.5, which requires coroners to report to the Board if the cause of death may be the result of a physician's gross negligence.[8] It also rightly suspects that entities are not submitting reports pursuant to section 805.01, which requires peer review bodies to report certain actions being taken against a licensee after an investigation if the conduct relates to incompetence or gross or repeated deviation from the standard of care involving death or serious bodily injury, the use of controlled substances, repeated acts of excessive prescribing, or sexual misconduct. These are the most serious forms of misconduct, and yet the Board has never received more than 18 reports in a single year according to its Annual Reports; in fact, in four out of the six years since the statute was enacted, the Board received less than ten reports pursuant to 805.01. And even with respect to the reports MBC does receive, there is no mechanism in place that

[7] *See Initial Report*, Chapter VII.

[8] *See* MBC Sunset Review Report at p. 99.

will allow the Board to proactively audit and ensure that it is actually receiving these statutorily-mandated reports.[9]

The Enforcement Monitor found the reporting of adverse peer review events pursuant to section 805 to be the single highest source of information for the Board with respect to the detection of unethical and dangerous physicians. Yet it has no mechanism in place to ensure adequate reporting, nor does it appear to be utilizing this powerful tool to its full potential.[10] Indeed, in a recent Public Records Act request to the Board, CPIL requested all documents evidencing discipline issued for failure to file reports pursuant to sections 805 *et seq*., and received only a list of four physicians and two hospitals for the entirety of the requested five year period.

In addition, the Clyne case raises questions as to whether enhanced reporting and communication needs to take place between county officials and the Board when such rampant complaints about a physician's sexual misconduct are being raised.

- ***Subversion of Business and Professions Code § 2220.7 by physicians and their lawyers***: In the past 15 years, CPIL has spearheaded an effort to ban the insertion of so-called "regulatory gag clauses" into civil settlement agreements by licensees of state regulatory boards. These clauses generally prohibit a regulated defendant in a malpractice/ negligence action who agrees to pay a monetary settlement from requiring the plaintiff to agree to: (1) not complain to the defendant's licensing board, (2) withdraw any previously-filed complaint to the licensing board, and/or (3) refuse to cooperate in any investigation initiated by the licensing board. Essentially, these clauses allow an unscrupulous licensee to conceal from that licensee's own regulator information about misconduct committed by the licensee.

  In 2006, the Medical Board included a provision in an omnibus licensing bill that prohibits doctors from including a regulatory gag clause in a civil settlement agreement; Governor Schwarzenegger signed that bill, that language is now in Business and Professions Code section 2220.7.[11] In 2012, then-Assemblymember Jerry Hill successfully carried AB 2570 (Hill), which expands section 2220.7's prohibition to all licensees of all DCA boards and bureaus (*see* Business and Professions Code section 143.5). [12]

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[9] *See, e.g., id.* at p. 100 ("Board relies on outreach" to assure it receives reports from clerks of courts pursuant to section 803, 803.5, 803.6 involving licensee felony convictions or judgments in which licensee is responsible for death or personal injuries); p. 101 (Board reports that new forms were created and placed on its website with respect to required reporting by health care facilities if any written allegation of sexual abuse or sexual misconduct is made against a licensee pursuant to section 805.8, but does not disclose whether it has *received* any such reports since the law's effective date on 1/1/2020, or how it intends to track them); p. 101 ("Adverse events appear to be reported as required" pursuant to section 2216.3, which requires accredited Outpatient Surgery Settings to report adverse events to the Board within five days of the incident, but Board does not report how it can verify this information; similarly, the Board states that licensees must report deaths that occur outside the hospital setting to the Board, but does not indicate whether or not it receives these reports).

[10] *See Initial Report* at 111–112.

[11] Our first two efforts—AB 320 (Correa) (2004) and AB 446 (Negrete McLeod) (2005)—were vetoed by Governor Schwarzenegger.

[12] This legislation continues longstanding legal precedent and policy established by the Legislature in Business and Professions Code section 6090.5 (a 35-year-old statute prohibiting lawyers who are defendants in legal malpractice

CPIL is aware that—despite sections 143.5 and 2220.7 and the considerable caselaw that preceded them—defendants in civil malpractice/ negligence actions are inserting vague confidentiality clauses in civil settlement agreements. **These clauses can be interpreted by plaintiffs as regulatory gag clauses masquerading as confidentiality agreements, causing them to hesitate to report misconduct to regulatory boards.** Even worse, the vague confidentiality clauses are often accompanied by oral assertions and threats asserting that plaintiffs cannot report the misconduct to the regulatory boards, but which cannot be proven and/or are made in the context of mediation and are thus privileged.

CPIL knows of only one case in which the Medical Board has enforced section 2220.7; in 2009, it imposed a public letter of reprimand on a physician for including a vague confidentiality clause in a civil settlement agreement (details available upon request). The clause read as follows: "To preserve the confidentiality of the terms and conditions of this settlement, including the settlement amount, **the Parties agree that neither they nor their attorney nor representative shall reveal to anyone, other than may be mutually agreed to in writing, any of the terms of this Settlement Agreement,** the allegations giving rise to this litigation, and the name, likeness, or address of the Released Defendants. The parties further agree that neither they nor their attorneys will disclose in any manner the facts relative to any released defendants' involvement in this case. The above provision is meant to include publication, fictionalization, recitation or other disclosure of any of the facts of this case relative to any released defendant." (emphasis added). MBC learned about the settlement because it was over $30,000, and it was reported to the Board under section 801.01 of the Business and Professions Code.

Additionally, another case challenging the validity and legality of an almost identical confidentiality clause is pending in the First District Court of Appeal (again, details available upon request). In that case, counsel for the physician not only included the vague confidentiality clause which they now insist bars the plaintiff from complaining to the Medical Board but is also insisted on structuring the agreed-upon $100,000 settlement amount as follows: **Defendant physician will pay $70,000.01 from her own funds, leaving her malpractice insurance company to pay $29,999.99 from her insurance policy—thus evading not only section 2220.7 but also section 801.01.** If this gambit succeeds, MBC will never learn of this $100,000 settlement—nor will this physician's patients ever become aware

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actions from including gag clauses in civil settlement agreements) and reinforced by multiple courts striking down gag clauses as void as against public policy. *See, e.g.*, *Cariveau v. Halverty*, 83 Cal. App. 4th 126 (2000) ("[T]he inclusion of a restrictive confidentiality clause in the Forbearance Agreement is not only directly connected to [defendant's] misconduct, but is an instance of misconduct in itself. …To countenance this agreement would encourage future … violators to hide their misdeeds in a secret agreement free from the light of regulatory scrutiny."); *Picton v. Anderson Union High School*, 50 Cal. App. 4th 726 (1996) (applicable to teachers); M*ary R. v. Division of Medical Quality of the Board of Medical Quality Assurance*, 149 Cal. App. 3d 308 (1983) ("[T]he stipulated order of confidentiality is contrary to public policy, contrary to the ideal that full and impartial justice shall be secured in every matter and designed to secrete the evidence in the case form the very public agency charged with the responsibility of policing the medical profession. … Such a stipulation is against public policy, similar to an agreement to conceal judicial proceedings and to obstruct justice.").

of these and other settlements given the disclosure requirements set forth in sections 803.1 and 2027. [13]

The Medical Board and the Legislature should explore this issue in order to ensure that MBC is receiving information about physician misconduct that it is entitled and mandated to receive. As the Medical Board Enforcement Program Monitor said in her Initial Report, "regulatory gag clauses cause many serious problems—both for the Medical Board that is being deprived of information about its own licensees by its own licensees and for unsuspecting patients who continue to be exposed to unscrupulous and/or incompetent physicians because MBC cannot take appropriate disciplinary action against them…."[14]

A vague confidentiality clause such as the one quoted above is no more than a regulatory gag clause masquerading as a confidentiality clause and should also be banned and/or clarified to expressly say that the clause does not preclude the plaintiff/consumer from contacting the defendant's regulatory agency.

- ***Physician Health and Wellness Program:*** CPIL welcomes the Board's suggestion in New Issue #6 that it should be more proactive in identifying potential areas of patient harm before that harm actually occurs. However, we caution these Committees, and the Board itself, that any newly-established Physician Health and Wellness Program must be carefully monitored in order to avoid the dire patient safety consequences of the Board's former diversion program.[15] We are especially concerned by the Board's use of the term "confidential" when describing this program (*see* Sunset Report at p. 216). The secret nature of the diversion program was devastating to patients, and patients and the Board must continue to be apprised of participants in any Board-sponsored program in order to adhere to the Board's statutory obligation to protect the public as its paramount priority.

An Independent Ombuds Office Would Improve Public Trust and Operational Efficiencies

MBC's Sunset Review Report identifies consumer complaints as the "heart" of the Board's enforcement program. This makes the dismal scores from customer satisfaction surveys about the complaint process—not to mention the heart-wrenching stories from patient advocates about their experience with the Board and the complaint process—an area of grave concern as to the public's trust in the Board and its ability to protect the public.

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[13] We are aware that the practice of settling civil cases just below the $30,000 level is common. Regrettably, so is the more clearly unlawful practice of reporting $29,999 and then rewarding the plaintiff beyond this amount, as has been documented to us. This practice is now joined with the vague but seemingly comprehensive confidentiality provisions which are reasonably interpreted (especially by non-attorneys or those unfamiliar with applicable law) as prohibiting patient-initiated reporting of licensee wrongdoing to the Medical Board. These two practices must be policed by the Board, with explicit prohibitions and serious sanctions where pursued. Not only must the Board police these practices; it should notify the State Bar where any attorney is involved in them.

[14] *Initial Report* at 113.

[15] *Id*. at Chapter XV; *Final Report* Chapter XV (finding significant patient safety concerns and recommending safeguards for continued operation); *See also* Elaine M. Howle, State Auditor, *Medical Board of California's Physician Diversion Program: While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public* (June 7, 2007), available at http://bsa.ca.gov/pdfs/reports/2006-116R.pdf. (report leading to ultimate abolishment of the program).

The Board reports that over the past four years, those consumers who have completed the Board's survey **consistently rank the handling of their complaints as either "poor" or "very poor."** And of the complainants who were unable to get the assistance they desired from MBC, zero were provided alternatives. Results like these erode public trust in the Board, whose paramount priority is to protect consumers.

After studying the problem, CPIL recommends an independent ombudsperson (or ombuds office) to better manage consumer complaints. Scandinavian for "representative," ombuds offices work in a variety of contexts across the globe, including government agencies, colleges and universities, corporations, hospitals and other medical facilities, and news organizations. The two primary duties are typically (1) to work with individuals and groups to explore and assist them in determining options to help resolve conflicts, problematic issues, or concerns, and (2) to bring systemic concerns to the organization for resolution. Ombuds offices have proliferated in U.S. federal agencies over the past 50 years but are still rare in California government (two examples are in the Medi-Cal Managed Care and Mental Health Office and the Department of Aging).

A 2016 report on the value of the Ombudsman in Federal Agencies[16] emphasized the neutral role as promoting public trust, characterizing ombudsmen as a powerful way to ensure government is accessible and responsive to the needs and concerns of both external and internal stakeholders. Ombudspersons "humanize government" and help people navigate with and within an agency. They also triage problems and prevent escalation, exploring less adversarial means of resolution and avoiding the formal complaint processes when appropriate. Perhaps the most valuable service an ombuds provides is helping to identify themes and systemic issues that support the improvement of an organization's mission.

Despite the Board's efforts to host patient advocate meetings and update consumer informational brochures, there remains a significant disconnect between individuals who have deeply suffered due to doctors' actions regulated by the Board. It is clear that improved communication alone will not bridge this growing divide; a systemic solution is desperately needed.

Additionally, as observers of MBC Board meetings for the past four decades, it is apparent to us that there has been an increasing and unfortunate breakdown in the relationship between the Attorney General's office and the Board in recent years. This not only impacts the day-to-day operations of the Board, but it has grave consequences for consumer protection in terms of case processing times, during which unethical or incompetent physicians continue to practice. An independent ombuds office could also play a role as a neutral party in facilitating and streamlining disputes as they arise in relationships such as these going forward.

Increase Licensing Fees

It has been 15 years since any kind of fee increase has occurred. The Board has more than justified its need for additional funds—funds which are critical to enhancing the enforcement program so that it may achieve the Board's paramount priority of public protection. CPIL also supports the Board's additional requests for enforcement enhancements, specifically as to conditions for tolling

[16] Administrative Conference of the United States, *The Ombudsman in Federal Agencies--FINAL REPORT* (2016), available at https://www.acus.gov/report/ombudsman-federal-agencies-final-report-2016.

the statute of limitations, increased inspection powers, and established timeframes for pharmacies to turn over records to the Board.

CPIL appreciates your consideration of this testimony and these recommendations.

Sincerely,

Bridget Fogarty Gramme
Administrative Director and Supervising Attorney
Center for Public Interest Law
University of San Diego School of Law

cc Kristina Lawson, President, Medical Board of California
William Prasifka, Executive Director, Medical Board of California
Kimberly Kirchmeyer, Director, Department of Consumer Affairs
Hon. Toni Atkins, Senate President pro Tempore
Hon. Anthony Rendon, Speaker of the Assembly

NEWS > CRIME AND PUBLIC SAFETY

After decades of sex abuse claims, state moves to stop former Santa Clara chief pediatrician from practicing medicine

New allegations surface against Dr. Patrick Clyne at clinic near Watsonville

By KAREN DE SÁ | Special to the Bay Area News Group
PUBLISHED: February 23, 2021 at 9:31 a.m. | UPDATED: February 23, 2021 at 3:06 p.m.

The state of California has taken its first formal action to end the medical career of Santa Clara County's former chief pediatrician for children in foster care, 20 years after allegations surfaced that he had sexually abused boys living in his home and patients as young as 6 years old.

An accusation filed Friday by the state Attorney General seeks to pull the medical license of Patrick Clyne, 59, charging him with "unprofessional acts" and "gross negligence," based on his treatment of six patients, ages 6 to 16. The filing details accounts of sexually abusive exams on children in Clyne's private practice near Watsonville between 2014 and 2019, alleging he told them to walk naked in his office and examined their genitals without gloves or apparent medical necessity.

The recent accusations are strikingly similar to reports about Clyne's exams that Santa Clara County health, law enforcement and medical authorities have received since 2001.

Dr. Patrick Clyne

"I'm furious that here we are 15, 20 years later, and there are six more victims of this guy," said Dana Scruggs, a Santa Cruz County attorney representing a former foster youth who sued Clyne last year alleging he sexually abused him as a young child. "Over a period of 20 years, with the number of kids that have come forward: What is he doing with a license to practice medicine?"

Attempts on Monday to reach Clyne at his office and through his attorney were unsuccessful. But in the past, he has denied allegations from more than a dozen children — abused and neglected kids who lived with him when he was a licensed foster parent, or whom he treated in the Santa Clara County children's shelter or public hospital — describing their reports as lies or misunderstandings. He has never been arrested.

Clyne, who in recent years has been practicing pediatrics with low-income clients in a rural, immigrant community south of Santa Cruz, can fight the medical board and the attorney general's office in the administrative courts, if he chooses. He can also continue to practice medicine until his case is resolved.

It isn't clear why the medical board took action now, and a spokesperson declined to comment Monday, citing the confidentiality of an ongoing case.

In addition to allegations of improper exams, the Feb. 19 filing accuses Clyne of failing to properly prescribe and monitor psychotropic prescriptions for patients with attention-deficit disorders. The rare scrutiny follows a Mercury News investigation that led to a 2016 state law requiring the medical board to prioritize "investigations of repeated acts of excessive prescribing, furnishing, or administering psychotropic medications to a minor."

Abuse allegations against Clyne surfaced most recently in a civil suit filed in Santa Cruz Superior Court last year on behalf of Kyle, a former foster youth identified by first name only. Kyle has long told authorities that Clyne sexually abused him, beginning when he was 8 years old and placed in the pediatrician's home between 1995 and 1998.

And according to court records, Clyne has been accused of sexual abuse for decades by Santa Clara County social workers, parents, guardians, therapists, a juvenile probation officer and staff at two residential group homes, mostly based on the accounts of 13 children placed in his care, beginning in 2001.

Prosecutors never charged him, but in 2011, the Santa Clara County District Attorney's Office — which had relied on Clyne as an expert witness in child abuse cases — notified defense attorneys that there was "substantial evidence that Dr. Clyne committed multiple crimes of moral turpitude, specifically sexual assaults."

Based on that account, Santa Clara County fired Clyne that same year, removing him from his job of 14 years.

Two years later, the California Department of Social Services barred Clyne from ever becoming a foster parent again, and prohibited him from working with any children or adults in state-licensed facilities.

Santa Clara County Executive Jeff Smith, the official who fired Clyne, called this latest development "bittersweet — very bitter, a little bit sweet."

"It's really sad that the medical board didn't take action much earlier in the process," Smith said. "It would have prevented additional victims from suffering."

Kyle, who is now 35 and lives in the East Bay, called the new filing both heartening and devastating.

"Twenty years ago, I tried to tell people about this," he said in an interview Monday.

Kyle said he is pleased that there are finally efforts to pull Clyne's medical license, but added: "It's really mind-boggling how he's still getting away with it."

Karen de Sá is a former investigative reporter for The Mercury News and The San Francisco Chronicle and is now executive editor of The Imprint, a nonprofit news outlet covering child welfare and juvenile justice. She can be reached at kdesa@imprintnews.org.