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BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation  
Against:

Case No. 800-2016-024774

FIRST AMENDED ACCUSATION

Robert William Sears, M.D.  
26933 Camino De Estrella  
Capistrano Beach, CA 92624

Physician's and Surgeon's Certificate  
No. A 60936,

Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 25, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A 60936 to Robert William Sears, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

**JURISDICTION**

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

“(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

“(1) Have his or her license revoked upon order of the board.

“(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

“(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

“(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

“(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

“(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.”

5. Section 2234 of the Code, states:

“The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

1       “(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the  
2 violation of, or conspiring to violate any provision of this chapter.

3       “(b) Gross negligence.

4       “(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or  
5 omissions. An initial negligent act or omission followed by a separate and distinct departure from  
6 the applicable standard of care shall constitute repeated negligent acts.

7       “(1) An initial negligent diagnosis followed by an act or omission medically appropriate for  
8 that negligent diagnosis of the patient shall constitute a single negligent act.

9       “(2) When the standard of care requires a change in the diagnosis, act, or omission that  
10 constitutes the negligent act described in paragraph (1), including, but not limited to, a  
11 reevaluation of the diagnosis or a change in treatment, and the licensee’s conduct departs from the  
12 applicable standard of care, each departure constitutes a separate and distinct breach of the  
13 standard of care.

14       “(d) Incompetence.

15       “(e) The commission of any act involving dishonesty or corruption which is substantially  
16 related to the qualifications, functions, or duties of a physician and surgeon.

17       “(f) Any action or conduct which would have warranted the denial of a certificate.

18       “(g) The practice of medicine from this state into another state or country without meeting  
19 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not  
20 apply to this subdivision. This subdivision shall become operative upon the implementation of the  
21 proposed registration program described in Section 2052.5.

22       “(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and  
23 participate in an interview by the board. This subdivision shall only apply to a certificate holder  
24 who is the subject of an investigation by the board.”

25       6.     Section 2266 of the Code states: “The failure of a physician and surgeon to maintain  
26 adequate and accurate records relating to the provision of services to their patients constitutes  
27 unprofessional conduct.”

28     ///

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 7. Respondent Robert William Sears, M.D. is subject to disciplinary action under  
4 section 2234 (c), in that he was negligent in his treatment of four minor patients. In the case of  
5 each patient, he issued a vaccination exemption letter without an appropriate medical basis,  
6 leaving these patients and their future contacts at risk for preventable and communicable diseases.  
7 The circumstances are as follows:

8 **Patient One**

9 8. Patient One, a then seven-year-old child, was seen by Respondent on one occasion,  
10 on May 4, 2016. Patient One was accompanied by his mother. He was seen for a chief complaint  
11 of vaccine exemption. His past medical history documented psoriasis and no prior vaccines. No  
12 other past medical history was documented. His family history included autoimmune disorders,  
13 lupus, psoriasis (in Dad), inflammatory bowel disease, irritable bowel syndrome (in Dad), severe  
14 gluten sensitivity in Mom and Aunt, suspected CD in aunt, neurodevelopmental disorders,  
15 ADD/ADHD (in Dad), psychiatric disorders, schizophrenia (Dad), bipolar, and depression. No  
16 social history was documented. His examination documented, "psoriatic plaques on scalp, back  
17 of neck and ears." The rest of the exam is documented as normal. The assessment was that the  
18 patient qualified for medical exemption from vaccines for family history of autoimmune disorders  
19 (Dad and others), inflammatory bowel disease (Dad), neurodevelopmental disorders (Dad),  
20 psychiatric disorders (Dad), and child's own autoimmune disorder. He was diagnosed with viral  
21 infection, unspecified, and feeding difficulties.

22 9. On the same date, a medical exemption letter was generated for Patient One,  
23 exempting him from all vaccines for the rest of his childhood, through July 1, 2025.

24 10. An entry in the medical record maintained by Respondent for Patient One, and dated  
25 January 25, 2017, stated that a phone conversation was had with the patient's mom regarding the  
26 medical exemption letter. The mom advised Respondent that the patient's father retracted his  
27 consent regarding the medical exemption letter. Respondent reminded the mother that consent is  
28 required from both custodial parents. Respondent advised that the previously issued vaccine

1 exemption letter was no longer valid. In order for a new valid exemption letter to be issued for  
2 Patient One, both custodial parents would need to appear and consent, and the patient's past  
3 medical records were required.

4 11. Patient One's medical records contain an amended copy of the medical exemption  
5 letter dated May 4, 2017, stating the original exemption letter is no longer valid and should be  
6 disregarded due to a change in family circumstances and consent.

7 12. Giving a childhood-long medical vaccine exemption letter to Patient One, based on a  
8 diagnosis of psoriasis, without immunosuppressive medication, is a simple departure from the  
9 standard of care. The diagnosis and the patient's family history are not a known contraindication  
10 or precaution to routine childhood vaccination.

11 Patient Two

12 13. Patient Two, who is the sister of Patient One, was seen by Respondent on one  
13 occasion, on May 4, 2016. Patient Two was also accompanied to her visit by her mother. She  
14 was seen for a chief complaint of "vaccine exemption appt." Her past medical history is only  
15 documented as significant for bee sting allergy. Her family history is identical to that of Patient  
16 One. It included autoimmune disorders, lupus, psoriasis (Dad), inflammatory bowel disease,  
17 irritable bowel syndrome (Dad), severe gluten sensitivity in Mom and Aunt, suspected CD in  
18 aunt, neurodevelopmental disorders, ADD/ADHD (Dad), psychiatric disorders, schizophrenia  
19 (Dad), bipolar, and depression. No social history was documented. Her examination was normal.  
20 Weight and height were documented, but no vital signs were documented. She was diagnosed  
21 with viral infection, unspecified, and feeding difficulties. The assessment discussed that Patient  
22 Two qualified for a medical exemption from vaccines based on review of her past medical  
23 history, family history, and current state of health.

24 14. On the same date, a medical exemption letter was generated for Patient Two,  
25 exempting her from all vaccines for the rest of her childhood.

26 15. An entry in the medical record maintained by Respondent for Patient Two, and dated  
27 January 25, 2017, stated that a phone conversation was had with the patient's mom regarding the  
28 medical exemption letter. The mom advised that the patient's father retracted his consent

1 regarding the medical exemption letter. Respondent reminded the mother that consent is required  
2 from both custodial parents. Respondent advised that the previously issued vaccine exemption  
3 letter was no longer valid. In order for a new valid exemption letter to be issued for Patient Two,  
4 both custodial parents would need to appear and provide consent, and the patient's past medical  
5 records were required.

6 16. Patient Two's medical records contain an amended copy of the medical exemption  
7 letter dated May 4, 2017, stating the original exemption letter is no longer valid and should be  
8 disregarded due to a change in family circumstances and consent.

9 17. Giving a childhood-long medical vaccine exemption letter to Patient Two, based on  
10 the identified family history alone, is a simple departure from the standard of care.

11 Patient Three

12 18. Patient Three was seen by Respondent on one occasion, on August 29, 2016. The  
13 minor patient was almost five-years-old, at the time of the visit. She was seen for a chief  
14 complaint of vaccine medical exemption. Her medical records show no symptoms, no vaccines,  
15 and no past medical history. Her family history is extensive and includes a second cousin having  
16 had a severe vaccine reaction with developmental regression and eventual diagnosis of autism  
17 spectrum disorder. The patient's family history also included mention of autoimmune disorders,  
18 neurological disorders, including seizure disorder (Mom), and 10 relatives with  
19 neurodevelopmental disorders including autism, ADHD/ADD and dyslexia (Dad), and OCD  
20 (mom). An intake questionnaire completed by a parent confirms this history. Her physical  
21 examination was normal. Weight and height were documented, but no vital signs were  
22 documented. The assessment discussed that Patient Three qualified for a medical exemption  
23 from vaccines based on a family history of vaccine reaction in a family member, autoimmune  
24 disorders, inflammatory bowel disease, neurological problems, neurodevelopmental disorders,  
25 and psychiatric disorders.

26 19. Respondent issued a medical exemption letter for Patient Three, for all vaccines  
27 through July 1, 2030.

1           20. Included in the records are brief records from Patient Three's mom, confirming her  
2 diagnosis of seizure disorder and from the patient's father, confirming his ADHD diagnosis.

3           21. Also included in the records are Patient Three's medical records from Valencia  
4 Pediatrics.

5           22. Giving a childhood-long medical vaccine exemption letter to Patient Three, who did  
6 not have a documented existing contraindication to routine childhood vaccination, is a simple  
7 departure from the standard of care.

8           Patient Four

9           23. Patient Four was seen by Respondent on one occasion, on August 8, 2016, for a chief  
10 complaint of obtaining a vaccine medical exemption. The patient was twelve-years-old. Her  
11 medical records show no current symptoms. However, her past medical history showed that she  
12 had all vaccines aside from the pertussis series. She received a DTaP as a first round at two  
13 months of age. She had an encephalitis-like reaction with inconsolable high-pitched screaming  
14 for more than three hours and off and on crying for another one to two days. Past medical  
15 records showed that Patient Four received the DT for the other dosages. Further pertussis  
16 dosages were contraindicated in this patient. Patient Four's family history included several  
17 autoimmune disorders, neurological disorders including epilepsy, neurodevelopmental disorders,  
18 ADD/ADHD, and psychiatric disorders. In addition, one cousin had an encephalitis type  
19 reaction. Patient Four's physical examination was normal. The patient's weight and height were  
20 documented, but no vital signs were recorded. The assessment discussed that Patient Four  
21 qualified for a medical exemption from vaccination due to family history of vaccine reactions in a  
22 family member, autoimmune disorders, neurological and neurodevelopmental disorders,  
23 psychiatric disorders and the patient's own past severe reaction to vaccines.

24           24. Respondent issued a medical exemption letter for Patient Four, for all vaccines for the  
25 rest of childhood.

26           25. Respondent requested and obtained Patient Four's prior medical records.

27           26. Giving a childhood-long medical vaccine exemption letter for all vaccines was not  
28 indicated. The family and past medical history are appropriate for an exemption for the pertussis

1 portion of the tetanus vaccine, but is not a contraindication or precaution to every routine  
2 childhood vaccination. Respondent's issuance of a rest of childhood medical vaccine exemption  
3 letter for all vaccines is a simple departure from the standard of care.

#### 4 **SECOND CAUSE FOR DISCIPLINE**

##### 5 **(Failure to Maintain Adequate Records)**

6 27. Respondent is subject to disciplinary action under Code section 2266 in that he failed  
7 to maintain adequate medical records in the case of Patients One, Two, and Five.

8 28. Paragraphs 8 - 17 are incorporated here as though fully set forth.

##### 9 **Patient Five**

10 29. On October 11, 2017, Patient Five, who was 10-years-old, presented to Respondent  
11 with a chief complaint of numbness of bilateral knees for every day of the past month. The  
12 physical examination reflects normal bilateral lower extremities, normal DTRs, FROM, non-  
13 tender and back/spine WNL. The assessment is "normal exam." The etiology is unclear and the  
14 plan is to observe. The documented exam is brief and only focused on the legs and spine.  
15 Laboratory results were reviewed and Vitamin D (5000 IU daily) and iron supplements (25 mg  
16 daily) were recommended. No follow-up is documented regarding the medication, nor was  
17 follow-up blood work recommended regarding the length of treatment with vitamin D and iron  
18 supplements.

19 30. Respondent failed to maintain adequate and accurate records in the case of four  
20 patients. In the case of Patient's One and Two, Respondent failed to obtain and document an  
21 appropriate and accurate past medical history, physical exam and family/social history. In the  
22 case of Patient Five, Respondent failed to document a thorough history and exam, or follow-up  
23 instructions related to the vitamins and supplements he recommended that the patient take.

#### 24 **DISCIPLINARY CONSIDERATIONS**

25 31. To determine the degree of discipline, if any, to be imposed on Respondent Robert  
26 William Sears, M.D., Complainant alleges that on or about July 27, 2018, in a prior disciplinary  
27 action entitled *In the Matter of the Accusation Against Robert William Sears, M.D.*, before the  
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1 Medical Board of California, in Case Number 800-2015-012268, Respondent's license was  
2 disciplined. Respondent's license is currently subject to a 35-month probation, and he is required  
3 to complete education course(s), a professionalism program and have a practice monitor.  
4 Discipline was imposed in the prior case for Respondent's failure to obtain necessary information  
5 regarding a patient, prior to issuing a childhood vaccination exemption letter. That decision is  
6 now final and is incorporated by reference as if fully set forth herein.

7 **PRAYER**

8 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
9 and that following the hearing, the Medical Board of California issue a decision:

- 10 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 60936,  
11 issued to Robert William Sears, M.D.;
- 12 2. Revoking, suspending or denying approval of Robert William Sears, M.D.'s authority  
13 to supervise physician assistants and advanced practice nurses;
- 14 3. Ordering Robert William Sears, M.D., if placed on probation, to pay the Board the  
15 costs of probation monitoring; and
- 16 4. Taking such other and further action as deemed necessary and proper.

17  
18 DATED: September 10, 2019

  
KIMBERLY KIRCHMEYER  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
Complainant

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