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FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO September 22 20 16  
BY D. Firdaus ANALYST

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

In the Matter of the Accusation Against:  
**ROBERT SEARS, M.D.**  
26933 Camino de Estrella  
Capistrano Beach, California 92624  
Physician's and Surgeon's Certificate  
No. A60936,  
  
Respondent.

Case No. 800-2015-012268  
**A C C U S A T I O N**

Complainant alleges:

**PARTIES**

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).
2. On or about September 25, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A60936 to Robert Sears, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2018, unless renewed.

**JURISDICTION**

3. This Accusation is brought under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

1           4.     Section 2227 of the Code states:

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

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

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

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

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

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

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

21          5.     Section 2234 of the Code, states:

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

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

27          “(b) Gross negligence.

28

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

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

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

11           “(d) Incompetence.

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

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

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

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

22           6. Section 2266 of the Code states:

23           “The failure of a physician and surgeon to maintain adequate and accurate records relating  
24 to the provision of services to their patients constitutes unprofessional conduct.”

25           ///

26           ///

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1 **FIRST CAUSE FOR DISCIPLINE**

2 (Gross Negligence)

3 7. Respondent Robert Sears, M.D. is subject to disciplinary action under section 2234(b)  
4 in that he was grossly negligent in his care and treatment of patient J.G., a minor, who he saw for  
5 six office visits between April 2014 and May 2015. The circumstances are as follows:

6 8. On April 3, 2014, two-year-old J.G. presented to Respondent for the first time. He  
7 was seen by Respondent for what the medical records describe as a “2 year.” The visit of this date  
8 includes a summary of the patient’s history with a brief description of J.G.’s prior vaccination  
9 reaction, as described by the patient’s mother. Her description included, “shut down stools and  
10 urine” for 24 hours with 2 month vaccines and limp “like a ragdoll” lasting 24 hours and not  
11 himself for up to a week after 3 month vaccines.

12 9. Respondent wrote a letter dated April, 13, 2014, excusing patient J.G. from all future  
13 vaccinations. The letter indicates that the patient’s kidneys and intestines shut down after prior  
14 vaccination and that at three months the patient suffered what appears to be a severe encephalitis  
15 reaction for 24 hours, starting approximately ten minutes after his vaccines, with lethargy,  
16 limpness, and poor responsiveness. The letter stated that, “Due to the severity of this second  
17 reaction, I recommend no more routine childhood vaccines for the duration of his childhood.”

18 10. The letter dated April 13, 2014, was not maintained in patient J.G.’s medical chart in  
19 Respondent’s office.

20 11. On May 14, 2014, patient J.G. had a consult visit with Respondent for constipation.  
21 A pertinent history was obtained, the abdominal exam was normal and a detailed treatment plan  
22 was devised.

23 12. On June 23, 2014, patient J.G. presented to Respondent with a chief complaint of  
24 headache with a history of patient being “hit on head with hammer” by Dad two weeks prior to  
25 the visit. A mention is made of a split lip prior to hammer incident without any additional history.  
26 A physical examination indicates, “no residual marks now.” No additional physical exam,  
27 including neurological testing, was performed and no assessment with plans was recorded.  
28

1 13. An Emergency Response Notice of Referral Disposition dated June 25, 2014 with  
2 "Allegations cannot be substantiated - case closed" outcome is maintained in the patient chart.

3 14. On January 13, 2015, patient J.G. presented to Respondent with possible flu. He had  
4 a history of not eating, fever, and cough for three weeks, with lethargy, and a diagnosis of croup  
5 recorded per the nurse. His records indicate that the patient's previous diagnoses were treated  
6 with Xopenex and steroids. His OM (otitis media) was treated with Omnicef, all "improved now"  
7 with "flu today suddenly." A diagnosis of flu was made and Tamiflu was prescribed.

8 15. On March 11, 2015, patient J.G. again presented to Respondent. The only history  
9 recorded on that date included abdominal pain with a physical exam. Diagnoses made at that time  
10 included constipation resolved and mild OM. The plan included miralax, magnesium, aloe,  
11 garlic, and testing with urine culture.

12 16. On May 7, 2015, patient J.G. saw Respondent for the last time. Patient J.G. presented  
13 with upper respiratory illness/viral. Serous otitis media was diagnosed and garlic prescribed.

14 17. The standard of care requires that a physician evaluating a patient for a possible  
15 reaction to vaccines obtain a detailed history of the vaccines previously received as well as the  
16 reaction/reactions that occurred. Based on that information the physician should provide an  
17 evidence-based recommendation for future immunizations.

18 18. Respondent was grossly negligent and departed from the standard of care in that he  
19 did not obtain the basic information necessary for decision making, prior to determining to  
20 exclude the possibility of future vaccines, leaving both patient J.G., the patient's mother, and his  
21 future contacts at risk for preventable and communicable diseases.

## 22 **SECOND CAUSE FOR DISCIPLINE**

23 (Repeated Negligent Acts)

24 19. Respondent Robert Sears, M.D. is subject to disciplinary action under section 2234  
25 (c) in that he was repeatedly negligent in his care and treatment of patient J.G. The circumstances  
26 are as follows:

27 20. Paragraphs 7 through 18 are incorporated by reference as though fully set forth.

28 21. Respondent departed from the standard of care by:

1 (a) Failing to obtain the basic information necessary to make a decision  
2 related to the withholding of future vaccines; and

3 (b) Failing to conduct neurological testing as part of the physical examination  
4 of patient J.G. on June 23, 2014, when he presented to Respondent with complaints of headache,  
5 following head trauma.

6 **THIRD CAUSE FOR DISCIPLINE**

7 (Failure to Maintain Adequate and Accurate Records)

8 22. Respondent Robert Sears, M.D. is subject to disciplinary action under section 2266 in  
9 that he failed to maintain adequate and accurate records related to the care and treatment of  
10 patient J.G.

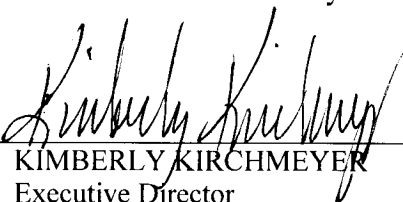
11 23. Specifically, Respondent did not maintain a copy of the letter he prepared exempting  
12 patient J.G. from future vaccinations and he failed to document an adequate physical examination  
13 of the patient on his visit of April 23, 2014, and merely wrote, "no residual marks."

14 **PRAYER**

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

- 17 1. Revoking or suspending Physician's and Surgeon's Certificate Number A60936,  
18 issued to Robert Sears, M.D.;
- 19 2. Revoking, suspending or denying approval of his authority to supervise physician  
20 assistants, pursuant to section 3527 of the Code;
- 21 3. If placed on probation, ordering him to pay the Board the costs of probation  
22 monitoring; and
- 23 4. Taking such other and further action as deemed necessary and proper.

24  
25 DATED: September 2, 2016

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