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

In the Matter of the First Amended Accusation
Against:

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:
“(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
violation of, or conspiring to violate any provision of this chapter.
“(b) Gross negligence.
“(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
omissions. An initial negligent act or omission followed by a separate and distinct departure from
the applicable standard of care shall constitute repeated negligent acts.
“(1) An initial negligent diagnosis followed by an act or omission medically appropriate for
that negligent diagnosis of the patient shall constitute a single negligent act.
“(2) When the standard of care requires a change in the diagnosis, act, or omission that
constitutes the negligent act described in paragraph (1), including, but not limited to, a
revaluation of the diagnosis or a change in treatment, and the licensee’s conduct departs from the
applicable standard of care, each departure constitutes a separate and distinct breach of the
standard of care.
“(d) Incompetence.
“(e) The commission of any act involving dishonesty or corruption which is substantially
related to the qualifications, functions, or duties of a physician and surgeon.
“(f) Any action or conduct which would have warranted the denial of a certificate.
“(g) The practice of medicine from this state into another state or country without meeting
the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
apply to this subdivision. This subdivision shall become operative upon the implementation of the
proposed registration program described in Section 2052.5.
“(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
participate in an interview by the board. This subdivision shall only apply to a certificate holder
who is the subject of an investigation by the board.”

6. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
adequate and accurate records relating to the provision of services to their patients constitutes
unprofessional conduct.”
FIRST CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

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

Patient One

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

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

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

(ROBERT WILLIAM SEARS, M.D.) FIRST AMENDED ACCUSATION NO. 800-2016-024774
exemption letter was no longer valid. In order for a new valid exemption letter to be issued for
Patient One, both custodial parents would need to appear and consent, and the patient’s past
medical records were required.

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

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

Patient Two

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

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

15. An entry in the medical record maintained by Respondent for Patient Two, and dated
January 25, 2017, stated that a phone conversation was had with the patient’s mom regarding the
medical exemption letter. The mom advised that the patient’s father retracted his consent.
regarding the medical exemption letter. Respondent reminded the mother that consent is required from both custodial parents. Respondent advised that the previously issued vaccine exemption letter was no longer valid. In order for a new valid exemption letter to be issued for Patient Two, both custodial parents would need to appear and provide consent, and the patient’s past medical records were required.

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

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

**Patient Three**

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

19. Respondent issued a medical exemption letter for Patient Three, for all vaccines through July 1, 2030.
20. Included in the records are brief records from Patient Three’s mom, confirming her diagnosis of seizure disorder and from the patient’s father, confirming his ADHD diagnosis.

21. Also included in the records are Patient Three’s medical records from Valencia Pediatrics.

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

Patient Four

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

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

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

26. Giving a childhood-long medical vaccine exemption letter for all vaccines was not indicated. The family and past medical history are appropriate for an exemption for the pertussis
portion of the tetanus vaccine, but is not a contraindication or precaution to every routine
childhood vaccination. Respondent’s issuance of a rest of childhood medical vaccine exemption
letter for all vaccines is a simple departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

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

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

Patient Five

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

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

DISCIPLINARY CONSIDERATIONS

31. To determine the degree of discipline, if any, to be imposed on Respondent Robert
William Sears, M.D., Complainant alleges that on or about July 27, 2018, in a prior disciplinary
action entitled *In the Matter of the Accusation Against Robert William Sears, M.D.*, before the

(ROBERT WILLIAM SEARS, M.D.) FIRST AMENDED ACCUSATION NO. 800-2016-024774
Medical Board of California, in Case Number 800-2015-012268, Respondent's license was disciplined. Respondent's license is currently subject to a 35-month probation, and he is required to complete education course(s), a professionalism program and have a practice monitor. Discipline was imposed in the prior case for Respondent's failure to obtain necessary information regarding a patient, prior to issuing a childhood vaccination exemption letter. That decision is now final and is incorporated by reference as if fully set forth herein.

**PRAYER**

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

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

**DATED:** September 10, 2019

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

*Complainant*

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