

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **LYNDEN L. BLUTH, M.D.**

4 Holder of License No. 10921  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case No. MD-10-0673A

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 December 8, 2010. Lynden L. Bluth, M.D., ("Respondent") appeared with legal counsel  
9 before the Board for a Formal Interview pursuant to the authority vested in the Board by  
10 A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and  
11 Order after due consideration of the facts and law applicable to this matter.  
12

13 **FINDINGS OF FACT**

14  
15 1. The Board is the duly constituted authority for the regulation and control of  
16 the practice of allopathic medicine in the State of Arizona.

17 2. Respondent is the holder of license number 10921 for the practice of  
18 allopathic medicine in the State of Arizona.

19 3. The Board initiated case number MD-10-0673A after receiving a complaint  
20 regarding Respondent's care and treatment of an 87 year-old female patient ("JW")  
21 alleging inappropriate performance of cataract surgery and inadequate follow up care and  
22 treatment of JW.

23 4. On December 1, 2009, Respondent performed cataract surgery on JW's  
24 right eye. The surgery was uneventful. However, postoperatively JW did not have visual  
25 improvement, and subsequent exams revealed macular degeneration with subretinal  
neovascular membrane and leakage as the primary cause. Treatment with Avastin was

1 ongoing in an attempt to dry up the leakage. JW alleged that Respondent did not achieve  
2 the expected result and failed to disclose the most significant pathology to her prior to  
3 surgery.

4 5. Respondent's response to the Board indicated that JW's retina could not be  
5 visualized. However, Respondent's medical record did not indicate that the retina could  
6 not be visualized, but instead described each retina as normal.

7 6. The Outside Medical Consultant (OMC) who reviewed the case found no  
8 deviation from the standard of care as far as the surgical procedure itself was concerned.  
9 However, he did believe that Respondent should have evaluated the preoperative workup  
10 and history, which indicated that other pathology was present, more completely prior to  
11 cataract surgery.

12 7. During deliberations in the Formal Interview, the Board observed that an  
13 optometrist who had examined the patient prior to the cataract surgery was able to detect  
14 some macular degeneration, which Respondent failed to note.

15 8. The standard of care when other pathology is present requires a physician to  
16 perform complete evaluation of the pathology prior to performing cataract surgery on the  
17 patient.

18 9. Respondent deviated from the standard of care by failing to perform more  
19 complete evaluation of other pathology that was present prior to performing cataract  
20 surgery.

21 10. The standard of care prior to performing surgery requires a physician to  
22 obtain full and complete informed consent from the patient and to provide accurate  
23 communication to the patient of any additional conditions that may complicate the surgical  
24 result.





1 201 East Washington Street  
2 Phoenix, Arizona 85004  
3 Attorneys for Respondent

4   
5 Arizona Medical Board Staff

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25