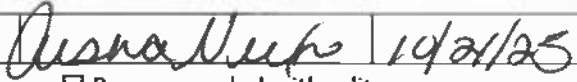



Signature Routing Slip

OD Tracking Number: _____

TO:	J. Sam Hurley		
FROM:	Suzanne Fenzel (202-724-8915)		
DATE:	October 21, 2025		
SUBJECT:	Notice of Summary Suspension - Dr. Leila Kump		
CONTACT PERSON TO PICK UP:	Suzanne Fenzel	PHONE:	202-724-8915
DESCRIPTION:	ITEM: Notice of Summary Suspension		
	ADMINISTRATION: OD-OGC	TRACKING NUMBER: <small>provided by Admin. Assistant</small>	
OD RECEIVING:	RECEIVED BY:		
	DATE:	DEADLINE: ASAP	
SIGNATURES NEEDED IN DOCUMENT			
	NAME		SIGNED
PERSON 1	J. Sam Hurley		<input type="checkbox"/>
PERSON 2			<input type="checkbox"/>
REVIEWING			
	DUE DATE	NAME	SIGNATURE
REVIEWED BY:	ASAP	Emilia Moran	emilia.moran <small>Digitally signed by emilia moran Date: 2025.10.21 12:24:34 -0400</small>
	<input checked="" type="checkbox"/> Recommended		<input type="checkbox"/> Recommended with edits
	EXPLANATION:		
REVIEWED BY:	ASAP	Aisha Nixon	 10/21/25
	<input type="checkbox"/> Recommended		<input type="checkbox"/> Recommended with edits
	EXPLANATION:		
REVIEWED BY:	<input type="checkbox"/> Recommended		<input type="checkbox"/> Recommended with edits
	EXPLANATION:		
	<input type="checkbox"/> Recommended		
REVIEWED BY:	<input type="checkbox"/> Recommended		<input type="checkbox"/> Recommended with edits
	EXPLANATION:		
	<input type="checkbox"/> Recommended		
FINAL ACTION:	<input type="checkbox"/> Not approved, must discuss		<input type="checkbox"/> Major revisions needed
	<input type="checkbox"/> Approved with minor edits		<input checked="" type="checkbox"/> Approved as is


SD Director's Approval/Signature

10/21/2025
Date

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION**



IN THE MATTER OF:

LEILA KUMP, MD

Respondent.

NOTICE OF SUMMARY ACTION TO SUSPEND LICENSE

To: Leila Kump, MD
47435 Courtney Lane
Sterling, VA 20165

In accordance with the provisions of the District of Columbia Administrative Procedure Act, D.C. Code § 2-509; the District of Columbia Health Occupations Revision Act of 1985, D.C. Code § 3-1205.15(a); and 17 DCMR § 4118, the District of Columbia Department of Health (DC Health) gives you notice of the summary suspension of your medical (MD) license, MD037264, under D.C. Code § 3-1205.15(a).

Your license is **summarily suspended** effective **immediately** upon receipt of this notice. If you wish to appeal this summary suspension of your license, you must file a request for a hearing within 72 hours after service of this notice. Should you request a hearing, one will be held within 72 hours of a timely request, and a decision will be rendered within 72 hours after the close of the hearing. The request for a hearing must be submitted in writing to Suzanne Fenzel, Senior Assistant General Counsel, DC Health. The request may be submitted by email to Suzanne.Fenzel3@dc.gov or by mail to 2201 Shannon Place, SE, 4th Floor, Washington, DC 20020. Ms. Fenzel can be reached at (202) 724-8915.

The District of Columbia (the District) is represented by the Office of the Attorney General for the District of Columbia. A copy of your hearing request and any pleading or other written communication addressed to DC Health must also be delivered to Betsy McMullen, Assistant Attorney General (AAG), Office of the Attorney General for the District of Columbia, Civil Enforcement Section, 400 Sixth Street, NW, Washington, DC 20001. You can reach AAG McMullen at (202) 706-1567 or by email at Betsy.McMullen@dc.gov.

You may appear personally at the hearing, and you may be represented by legal counsel. You have the right to produce witnesses and evidence, to cross-examine witnesses against you, to examine evidence produced, and to have subpoenas issued to require the production of witnesses and evidence.

All hearings are conducted in the English language. If you or any witnesses to be called are deaf, have a hearing impediment, or cannot readily understand or communicate the spoken English language, an application may be made to the Administrative Law Judge for the appointment of a qualified interpreter.

A request for a hearing will not stay the suspension of your license.

The summary suspension is based on the charge as set forth below.

Charge: **The Virginia Board of Medicine suspended your medical license, for which DC Health can summarily suspend your license under D.C. Code § 3-1205.15(a)(1)(A).**

You received your medical license in the District of Columbia on May 5, 2008. Currently, your medical license in the District expires on April 30, 2026.

On September 24, 2025, the Virginia Board of Medicine (Virginia Board) suspended your license to practice medicine because it concluded that there was a substantial danger to the public health or safety, among other violations of Virginia Code. According to the Statement of Allegations which supported the Virginia Board's decision to summarily suspend your license, within a four-week span, two of your patients died shortly after you performed cosmetic procedures on them. On March 21, 2025, you performed an elective in-office bilateral upper eyelid blepharoptosis repair, blepharoplasty and bilateral lower eyelids ectropion repair, blepharoplasty on Patient A, assisted by an unlicensed surgical assistant. Before the procedure, you recommended to Patient A that they not go forward with the procedure because you suspected Patient A had suffered a "quiet heart attack" several days before the procedure. However, despite warning signs, you continued with the procedure. At the end of the procedure, Patient A's skin was pale, they became unable to respond to verbal commands, and their breathing and pulse were weak. You directed your office staff to contact 911, and Patient A was transported to an emergency room where they passed away shortly thereafter. Virginia's Office of the Chief Medical Examiner found that Patient A's death was caused by "acute intoxication due to the combined effects of oxycodone, diazepam and lidocaine," drugs that you administered to Patient A during the procedure.

And on April 12, 2025, you performed a resurfacing of the skin on the face and neck of Patient B. You noticed that Patient B appeared, in your own description, "off," and that their prescription bottles of diazepam and oxycodone were almost empty, despite you only prescribing those drugs to Patient B two days earlier. Again, despite these observations, you went forward with the procedure. At the end of the procedure, Patient B developed

labored breathing and then began to suffer a seven-minute seizure. The office contacted 911, and Patient B was transported to a hospital, where a CT scan indicated that Patient B had suffered a diffuse anoxic brain injury secondary to hypoxemic respiratory failure and cardiac arrest. On April 15, 2025, Patient B was removed from life support and passed away. And once again, Virginia's Office of the Chief Medical Examiner found that Patient B's death was caused by "acute intoxication due to the combined effects of oxycodone, diazepam and lidocaine," drugs that you administered to Patient B during the procedure.

As a result of the treatment you provided to these patients, and the resulting investigation into their deaths, the Virginia Board found that you committed the following acts inappropriate for your profession: 1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of any branch of the healing arts; 2. Intentional or negligent conduct in the practice of any branch of the healing arts that causes or is likely to cause injury to a patient or patients; 3. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public; 4. Aiding or abetting, having professional connection with, or lending his name to any person known to him to be practicing illegally any of the healing arts; 5. Conducting his practice in a manner contrary to the standards of ethics of his branch of the healing arts; 6. Conducting his practice in such a manner as to be a danger to the health and welfare of his patients or to the public; 7. Performing any act likely to deceive, defraud, or harm the public; and 8. Violating or cooperating with others in violating any of the provisions of Chapters 1 (VA Code § 54.1-100 et seq.), 24 (VA Code § 54.1-2400 et seq.) and 29 (VA Code § 54.1-2900 et seq.) or regulations of the Virginia Board. Based on these findings, the Virginia Board concluded that your continued licensure presented a substantial danger to public health or safety and summarily suspended your license to practice medicine in Virginia. To date, your Virginia license has not been reinstated.

Due to the above allegations asserted by the Virginia Board and the subsequent suspension of your license to practice medicine in Virginia, DC Health reciprocally suspends your license to practice medicine in the District.

Please note under 1 DCMR § 2818.1, your failure to appear at the time and place set for the hearing, either in person or through counsel, or both, will not preclude DC Health's proceeding in this matter.

Oct. 21, 2025

DATE



J. SAM HURLEY, MPH, EMPS

Senior Deputy Director

District of Columbia Department of Health

Health Systems and Preparedness Administration

October 8, 2025

Kimberly Johnson, Esq.
Chief – Civil Enforcement Section
Office of the Attorney General
400 6th Street, N.W.
Washington, D.C. 20001

Re.: Leila Kump, MD
MD037264
47435 Courtney Lane
Sterling, VA 20165

Dear Ms. Johnson:

The District of Columbia Department of Health (DC Health) requests that your Office prepare a Notice of Summary Suspension to summarily suspend Dr. Leila Kump's medical license, License No. MD037264. Dr. Kump (Respondent) originally received her medical license on May 5, 2008. Her license was revoked on April 29, 2015 as a reciprocal action to a Maryland Board of Physicians for practicing in Maryland during a period when her license was suspended. **See Attachment A, Final Decision and Order of the Board.** Her license was reinstated on March 26, 2021 after the mandatory five-year revocation period. Currently her license expires on April 30, 2026. **See Attachment B – DC License Information.**

DC Health received notification that on September 24, 2025, the Virginia Board of Medicine (Virginia Board) summarily suspended Respondent's license to practice medicine in Virginia. **See Attachment C – Order of Summary Suspension.** According to the *Statement of Allegations*, attached to and incorporated into the *Order of Summary Suspension*, Respondent caused the death of two patients, a 73-year old woman (Patient A) and a 48-year old woman (Patient B), while performing cosmetic procedures on them. For both patients, there were indications that the procedure should not go forward. For Patient A, Respondent had "strongly encouraged" her to wait with her procedure due to a suspicion that Patient A had "suffered a quiet heart attack . . . when she complained of malaise and neck pain" several days prior to the procedure. Nonetheless, Respondent went forward with the procedure as scheduled. *Id.* at 5. For Patient B, Respondent in a written statement wrote that on the day of the procedure the patient "appeared slightly off . . . upon inspecting her bottles of oxycodone and diazepam – prescribed just two days prior – I noticed they were nearly empty." *Id.* at 12. Again, Respondent went forward with the procedure.

Patient A presented on March 21, 2025 for an "elective in-office bilateral upper eyelid blepharoptosis repair, blepharoplasty and bilateral lower eyelids ectropion repair, blepharoplasty." *Id.* at 4. During the procedure, Respondent gave the patient both oxycodone and diazepam and also injected lidocaine into the patient's eyelids during the procedure. Respondent was assisted by unlicensed surgical assistant. The procedure was recorded as starting at 2:02 pm. At 3:20 pm the Respondent noted in her Adverse Outcome Report that "the patient was notified that the surgery was about to end . . . [s]he acknowledged that she was all right." At 3:46 pm when

the procedure ended, the patient did not respond “to verbal commands. Her breathing was shallow, her pulse was weak, but palpable in the carotid arteries.” *Id.* Resuscitation was attempted and 911 was called “for a patient that was not responsive.” *Id.* at 7. Patient A never regained consciousness and was pronounced deceased at the Emergency Room at 4:33 p.m. The Office of the Chief Medical Examiner found that her death was caused by “acute intoxication due to the combined effects of oxycodone, diazepam and lidocaine.” *Id.* at 8.

On April 12, 2025, three weeks after the death of Patient A, Patient B appeared for a scheduled “resurfacing of the skin on her face and neck.” *Id.* at 11. As stated earlier, Respondent said Patient B appeared “off” and the prescription bottles of her diazepam and oxycodone were “nearly empty”. Nonetheless Respondent gave Patient B “additional doses of oxycodone with acetaminophen and/or diazepam” and then went forward with the procedure. *Id.* at 12. Additional lidocaine was applied to the patient’s face and neck. *Id.* at 13. Near the end of the procedure, the patient “suddenly became short of breath and developed labored breathing. [Respondent] asked her if she was feeling OK but the patient did not respond. She developed what appeared to be a grand mal seizure . . .” which “lasted over seven minutes.” EMS was called, and Respondent reportedly began resuscitation. *Id.* EMS reported the patient was “pulseless, apneic, blue in face and extremities.” At the hospital, a “CT scan revealed Patient B had suffered a diffuse anoxic brain injury secondary to hypoxic respiratory failure and cardiac arrest.” On April 15, 2025 Patient B was removed from life support and declared deceased. The Office of the Chief Medical Examiner “determined that Patient B’s death was caused by ‘acute intoxication due to the combined effects of oxycodone, diazepam and lidocaine.’” *Id.* at 14.

The Virginia Board found that Respondent violated, among other laws, VA Code § 54.1-2915(A)(1) (3), (4), (11), (12), (13), (16) and (18) in that she committed the following acts of unprofessional conduct:

1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of any branch of the healing arts;
2. Intentional or negligent conduct in the practice of any branch of the healing arts that causes or is likely to cause injury to a patient or patients;
3. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public;
4. Aiding or abetting, having professional connection with, or lending his name to any person known to him to be practicing illegally any of the healing arts;
5. Conducting his practice in a manner contrary to the standards of ethics of his branch of the healing arts;
6. Conducting his practice in such a manner as to be a danger to the health and welfare of his patients or to the public;
7. Performing any act likely to deceive, defraud, or harm the public; and
8. Violating or cooperating with others in violating any of the provisions of Chapters 1 (§ 54.1-100 et seq.), 24 (§ 54.1-2400 et seq.) and this chapter or regulations of the Board.

As a result, the Virginia Board concluded that a substantial danger to public health or safety warranted the summary suspension of Respondent's license.

Pursuant to D.C. Official Code §3-1205.15(a)(1)(A), Dr. Kump's license to practice medicine in the District may be summarily suspended, without a hearing, solely upon the finding of a suspension in another jurisdiction and that she has not had her license reinstated.

Please contact me or Suzanne Fenzel, Counsel to the Board of Medicine at Suzanne.Fenzel3@dc.gov or (202) 724-8915, should you need any other information.

Sincerely,

10/9/2025
DATE



J. SAM HURLEY, MRH, EMPS
Senior Deputy Director
District of Columbia Department of Health
Health Systems and Preparedness Administration

Attachments

BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: LEILA KUMP, M.D.
License Number: 0101-243155
Case Number: 247084

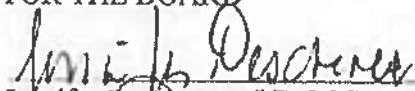
ORDER OF SUMMARY SUSPENSION

Pursuant to Virginia Code § 54.1-2408.1(A), a quorum of the Board of Medicine ("Board") met by telephone conference call on September 24, 2025, after a good faith effort to convene a regular meeting of the Board had failed. The purpose of the meeting was to receive and act upon information indicating that Leila Kump, M.D., violated certain laws and/or regulations relating to the practice of medicine in the Commonwealth of Virginia, as more fully set forth in the "Notice of Formal Administrative Hearing and Statement of Allegations," which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under Virginia Code § 54.1-2408.1(A), the Board concludes that a substantial danger to public health or safety warrants this action and ORDERS that the license of Leila Kump, M.D., to practice medicine in the Commonwealth of Virginia is SUSPENDED. It is further ORDERED that a hearing be convened within a reasonable time of the date of entry of this Order to receive and act upon evidence in this matter.

Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.

FOR THE BOARD


Jennifer DeChenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

ENTERED AND MAILED ON:

9/24/2025

STATEMENT OF ALLEGATIONS

The Board alleges that:

1. Dr. Kump violated Virginia Code § 54.1-2915(A)(3), (4), (12), (13), (16) and (18), and 18 VAC 85-20-320(A)(1) of the Regulations Governing the Practice of Medicine (“Board’s Regulations”), and 18 VAC 85-21-40(C) of the Regulations Governing Prescribing of Opioids and Buprenorphine (“Prescribing Regulations”) in that the combination of an opioid with a benzodiazepine, in conjunction with a local anesthetic, as prescribed and administered by Dr. Kump as part of a cosmetic procedure, is contrary to the standard of care and placed Patient A at risk for respiratory depression, as well as difficulty with ventilation and oxygenation, thus increasing the likelihood of a catastrophic event such as death.

Specifically:

a. On March 21, 2025, Patient A, a 73-year-old female, who appears to have been “opiate naïve,” presented to Dr. Kump’s office for an elective in-office bilateral upper eyelid blepharoptosis repair, blepharoplasty and bilateral lower eyelids ectropion repair, blepharoplasty. Prior to this procedure, Dr. Kump prescribed various medications to Patient A, including 12 dosage units of 10 mg/325 mg oxycodone with acetaminophen (C-II) and 10 dosage units of 5 mg diazepam (C-IV);¹ which were intended to be used in combination as a sedative during the procedure.² The prescribed medications were filled at a Maryland pharmacy on March 4, 2025, however, Dr. Kump’s records do not contain any information as to when they were prescribed in violation of 18 VAC 85-20-26(C) of the Board’s

¹ A review of Dr. Kump’s provider PMP demonstrates that her usual and customary practice is to prescribe oxycodone with acetaminophen and diazepam. Between May 2023 through May 2025, Dr. Kump prescribed oxycodone-acetaminophen 10-325mg and diazepam 5mg in combination 30 times to 29 patients. Notably, in a written statement dated July 22, 2025, Dr. Kump stated she has “performed 2,000 procedures under the *same* sedation, over 15 years.” (emphasis supplied).

² See Dr. Kump’s Blepharoplasty Consent Form which states in part “Blepharoplasty is sometimes done with just local anesthesia (medicine injected around your eye to numb the area). You may also be sedated (relaxed or put to sleep) by medicine from pills taken before surgery.”

Regulations. Patient A was instructed to bring these medications to Dr. Kump's office on the day of the procedure.

b. According to Dr. Kump, several days prior to the procedure, Patient A complained of "malaise and neck pain." In an email dated April 22, 2025, sent to Patient A's son ("Individual 1"), Dr. Kump disclosed that, prior to Patient A's procedure, she suspected that Patient A had "suffered a quiet heart attack . . . when she complained of malaise and neck pain. Diabetics and women suffer from quiet heart attacks . . . very commonly." Dr. Kump went on to claim that she "strongly encouraged" Patient A "to wait with her procedure . . . [u]nfortunately, she decided to go ahead with it." Despite claiming to be aware that Patient A may be at particular risk for complications, rather than delay the procedure, Dr. Kump proceeded to perform the procedure in her office rather than a more appropriate surgical facility or setting in violation of 18 VAC 85-20-340(B)(3) of the Board's Regulations.

c. On March 21, 2025, Patient A and her daughter ("Individual 2") arrived at Dr. Kump's office at approximately 1:00 p.m. Individual 2 witnessed Dr. Kump take an unknown number of pills from the oxycodone and diazepam prescription bottles that her mother had brought with her and administered them to Patient A. Approximately 45 minutes later, Dr. Kump returned to the waiting room and asked Patient A if she was "woozy." Individual 2 reported the procedure was supposed to take two (2) hours so she left Dr. Kump's office at approximately 1:45 p.m. and planned to return at 4:00 p.m. According to Dr. Kump's records, the procedure began at 2:02 p.m. and was performed with the assistance of one (1) unlicensed surgery assistant ("Individual 3") in violation of 18 VAC 85-20-330(A) and (B)(2) of the Board's Regulations.³

³ When interviewed by a Department of Health Professions Investigator ("DHP Investigator"), Individual 3 described himself as both a "Certified Ophthalmic Technician" ("COT") as well as a "surgery assistant." A COT is not a licensed medical profession in the Commonwealth of Virginia and Individual 3 is not licensed as a surgical assistant pursuant to Virginia Code § 54.1-2956.13.

d. According to a “SURGERY REPORT,” authored by Dr. Kump, in addition to the pre-procedure medications referenced above, Patient A “was given an injection of 4 ml of plain 2% lidocaine into both upper eyelids for pain control . . . [l]ower eyelid skin was injected with 8ml plain 2% lidocaine bilaterally.” In other words, according to Dr. Kump, she administered approximately 320 milligrams or more of lidocaine to Patient A. Dr. Kump’s records do not, however, document the justification for the use of an opioid analgesic in addition to lidocaine in violation of 18 VAC 85-20-26(C) of the Board’s Regulations.

e. Following the procedure, Dr. Kump authored an “Adverse Outcome Report” in which she claims that prior to the procedure Patient A “appeared slightly anxious” and that she was given, among other things, a “total of 10 mg of diazepam, 10 mg of oxycodone, 325 mg of acetaminophen . . .”

f. According to the Adverse Outcome Report, during the procedure “[Patient A] was periodically asked how she was feeling. She was communicating that she was doing fine . . . [a]t around 3:20 p.m. the patient was notified that the surgery was about to end . . . [s]he acknowledged that she was all right.” The report goes on to state that the procedure ended at 3:46 p.m. and the sterile drapes were removed. Then, “[Patient A] was asked to open her eyes. It appeared that she was not responding to verbal commands. Her breathing was shallow, her pulse was weak, but palpable in the carotid arteries.” When interviewed by a DHP Investigator, Individual 3 stated that he checked Patient A’s pulse and “her carotid artery pulse was very shallow, not deep and not as strong as expected. [Patient A’s] breathing was very shallow.”

g. In the Adverse Outcome Report, Dr. Kump stated that “1g of epinephrine was injected into the right forearm. 911 was called by the front desk. Two-person resuscitation started after the injection of epinephrine. Mouth-to-mouth resuscitation with chest compressions was conducted by Dr.

Kump and her surgical assistant. The resuscitation continued for 12 minutes until the arrival of the paramedic team.”

2. Dr. Kump violated Virginia Code § 54.1-2915(A)(1), (3), (4) and (13) in that she failed to properly handle the emergency and complications resulting from Patient A’s March 21, 2025 blepharoplasty procedure. Specifically:

a. An “Incident Summary Report” created by an officer with the Fairfax County Police Department indicates that while on scene, Dr. Kump reported that Patient A “was given several medications prior to the procedure. A sterile cover was also placed on [Patient A’s] face and skin to cover her except the eyes.” In other words, only Patient A’s eyes were visible to Dr. Kump and Individual 3 throughout the duration of the procedure. Although absent from her Adverse Outcome Report, Dr. Kump further reported to the Officer that “during the last twenty minutes of the procedure where she was suturing up [Patient A]. [Patient A] had not said anything to her or talked. Dr. Kump that (sic) she thought [Patient A] had dozed off or taken a quick nap. She explained that it was not unusual for her patients to sleep during the procedure.” Dr. Kump reported that when she lifted the sterile cover, she “noticed that [Patient A’s] skin was pale.” This detail was also absent from Dr. Kump’s Adverse Outcome Report.

b. As referenced in Allegation 1(g) above, Dr. Kump reported that she directed that Fairfax County Fire and Rescue (“EMS”) be called “for a patient that was not responsive.”

c. EMS records indicate that 911 was called at 3:41 p.m. and that they were “at the patient” at 3:51 p.m., which contradicts Dr. Kump’s statement that Patient A’s procedure ended at 3:46 p.m. Moreover, EMS records document that Dr. Kump’s medical staff informed the paramedics that Patient A received “Oxycodone/acetaminophen 10mg/325mg 3 TAB PO @ 12:45 p.m.” and “Diazepam 5mg 3 TAB” which contradicts Dr. Kump’s representation in her Adverse Outcome Report that she

administered a “total of 10 mg of diazepam” and a total of “10 mg of oxycodone, 325 mg of acetaminophen” to Patient A.

d. EMS records indicate that once on scene, paramedics observed that Patient A was fully clothed lying supine on an operating table, no pulse was felt, she was unresponsive, apneic and that her extremities were “blue cold to the touch.” EMS records state “[t]here did not appear to be any medical staff from the clinic in the pts room as we walked in.” Additionally, records indicate that at no point prior to EMS’ arrival did Dr. Kump or Individual 3 utilize an automated external defibrillator (“AED”) or administer Narcan to Patient A. Moreover, “no facility monitoring device was attached to the pt upon arrival . . .” and “no vitals of the pt were given from facility medical staff.”

e. EMS records report that paramedics immediately ventilated Patient A with a BVM (bag valve mask), placed a size 7 OPA (oropharyngeal airway) and administered 2mg of Narcan. Paramedics began monitoring Patient A’s cardiac rhythm via an EKG with the first monitored rhythm being recorded as asystole. EMS records report the time of Patient A’s cardiac arrest to be 3:30 p.m. Additionally, five (5) doses of epinephrine were given to Patient A prior to her arrival at a Virginia Hospital (“Hospital 1”). Patient A never regained consciousness and at the ER, Physician 1 pronounced her deceased at 4:33 p.m.

f. On June 24, 2025, the Office of the Chief Medical Examiner (“CME”) determined that Patient A’s death was caused by “acute intoxication due to the combined effects of oxycodone, diazepam, and lidocaine.”

g. On April 22, 2025, Individual 2 sent an email to Dr. Kump asking why her office was not equipped with an AED. Dr. Kump replied, “I have been a doctor for over 30 years. Trust me, no

doctor's office has an AED in the building except maybe some internal medicine groups. You will not find an ophthalmology or oculoplastic office that carries a defibrillator."⁴

3. Dr. Kump violated Virginia Code § 54.1-2915(A)(1), (3), (13) and (16) in that she falsely and purposefully misrepresented and/or omitted details regarding her care and treatment of Patient A, including the amount of oxycodone with acetaminophen and diazepam she administered to Patient A, and the complications related to the treatment she provided. Specifically:

a. As referenced in Allegation 2(c) above, Dr. Kump's medical staff reported that prior to the start of the procedure, Patient A was administered 30mg/975mg of oxycodone with acetaminophen and 15mg of diazepam, which is significantly higher than the dosages Dr. Kump included in her Adverse Outcome Report. In fact, the CME reported that "patients receiving a 10 mg oral dose of oxycodone averaged a peak plasma concentration of . . . 30 ng/mL . . . [t]he reported oxycodone level in the decedent's postmortem blood sample is 190 ng/mL," thus further contradicting the amount of oxycodone Dr. Kump stated she administered to Patient A (10mg).

b. Dr. Kump's "SURGERY REPORT" falsely indicates that during the procedure Dr. Kump only provided Patient A with "[l]ocal, topical" anesthesia.⁵ Dr. Kump's records for Patient A make no mention of oxycodone with acetaminophen or diazepam; this information was not documented by Dr. Kump until she was required, due to Patient A's death, to create the Adverse Outcome Report referenced in Allegation 1(e).

⁴ In fact, eight (8) days later (and after the death of Patient B, as detailed below), in a written statement to a DHP Investigator, Dr. Kump claimed that her "office is now equipped with an AED."

⁵ In an email dated April 22, 2025, Dr. Kump falsely represented to Individual 2 that "It looks like you do not understand that [Patient A] had a small procedure under local anesthesia."

c. Dr. Kump's Adverse Outcome Report failed to document the fact that Patient A had not spoken during the last 20 minutes of the procedure or the fact that when Dr. Kump lifted the sterile cover, she noticed that Patient A's skin was pale.

d. As referenced in Allegation 1(b) above, on April 22, 2025, Dr. Kump disclosed to Individual 2 that, prior to Patient A's procedure, she suspected that Patient A had "suffered a quiet heart attack" and that she had "strongly encouraged" Patient A "to wait with her procedure." However, in a written statement dated April 30, 2025, and provided to a DHP Investigator, Dr. Kump failed to disclose that her suspicions regarding Patient A's unstable health arose *prior* to the procedure. Rather, in the written statement Dr. Kump stated that since she had "not yet received [Patient A's] autopsy report" she could only "speculate" that Patient A had suffered a "silent myocardial infarction."

4. Dr. Kump violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16) and (18), and 18 VAC 85-20-320(A)(1)-(2) and (B)(4), and 18 VAC 85-20-360(B)(1)-(8) of the Regulations Governing the Practice of Medicine in that while administering anesthetic medication she failed to properly monitor and assess Patient A's physical, functional, and physiological status while under mild or moderate sedation, thus increasing the likelihood of a catastrophic event such as death.

a. As described in Allegations 1(a), (c) and (d), and 2(c), and 3(b) above, prior to the start of the procedure, Dr. Kump prescribed and administered oxycodone with acetaminophen (an opioid) along with diazepam (a benzodiazepine) to Patient A to be used as sedatives. Despite placing Patient A under, at minimum, moderate sedation and administering to her more than 300 milligrams of lidocaine, no standard monitoring (*e.g.*, blood pressure cuff, three-lead EKG, pulse oximeter or nasal cannula capable of measuring end-tidal CO₂) were utilized. According to Individual 3, neither he nor Dr. Kump "perform monitoring of blood pressure or oxygen saturation during surgery."

b. In an email dated April 22, 2025, to Individual 2, Dr. Kump stated “There is no vital monitoring required for this type of procedure.”

c. In a second written statement, dated July 22, 2025, Dr. Kump revealed to a DHP Investigator that she “had a pulse oximeter and a blood pressure cuff available on site” yet chose not to use them because “standard of practice did not require continuous electronic vital sign monitoring.”

5. Dr. Kump violated Virginia Code § 54.1-2915(A)(3), (4), (12), (13), (16) and (18), and 18 VAC 85-20-320(A)(1) of the Regulations Governing the Practice of Medicine (“Board’s Regulations”), and 18 VAC 85-21-40(C) of the Regulations Governing Prescribing of Opioids and Buprenorphine (“Prescribing Regulations”) in that the combination of an opioid with a benzodiazepine, in conjunction with a local anesthetic, as prescribed and administered by Dr. Kump as part of a cosmetic procedure, is contrary to the standard of care and placed Patient B at risk for respiratory depression, as well as difficulty with ventilation and oxygenation, thus increasing the likelihood of a catastrophic event such as death. Specifically:

a. On April 12, 2025, Patient B, a 48-year-old female, who appears to have been “opiate naïve,” presented to Dr. Kump’s office for an elective in-office CO2 resurfacing of the skin on her face and neck. Despite the death of Patient A three (3) weeks prior, Dr. Kump did not alter or make any changes to her customary and usual practice of concomitantly prescribing and administering an opioid with a benzodiazepine as a sedative, nor did she introduce procedures to properly monitor her patients physical, functional, and physiological status while under mild or moderate sedation during procedures performed in her office-based practice.

b. Similarly to Patient A, prior to the procedure, Dr. Kump prescribed various medications to Patient B⁶, including 12 dosage units of 10 mg/325mg oxycodone with acetaminophen and 10 dosage units of 5mg diazepam; both of which were intended to be used in combination as a sedative during the procedure. Patient B was instructed to bring these medications to Dr. Kump's office on the day of the procedure.

c. In her written statement, Dr. Kump stated that Patient B "appeared slightly off on the day of her procedure . . . upon inspecting her bottles of oxycodone and diazepam-prescribed just two days prior-I noticed they were nearly empty. Only 10 pills of diazepam and 12 pills of oxycodone had been prescribed, so it was concerning that such quantities had already been consumed." Even though she allegedly observed the bottles of oxycodone and diazepam were "nearly empty" Dr. Kump admittedly administered an additional 10mg of oxycodone with acetaminophen and an additional 10mg of diazepam to Patient B prior to the procedure.⁷

d. Despite being aware that Patient B may be at particular risk for complications (*i.e.*, that by Dr. Kump's own observation, Patient B likely had already consumed significant amounts of oxycodone with acetaminophen and/or diazepam), Dr. Kump administered additional doses of oxycodone with acetaminophen and/or diazepam and then performed the procedure in her office rather than rescheduling the procedure, or performing the procedure in a more appropriate surgical facility or setting, in violation of 18 VAC 85-20-340(B)(3) of the Board's Regulations. Moreover, Dr. Kump performed the procedure without the assistance of appropriately qualified personnel in violation of 18 VAC 85-20-330(A) and (B)(2) of the Board's Regulations.

⁶ Records indicate that, similarly to Patient A, Patient B was also considered "opioid native" and was not known to be a chronic opioid medication user.

⁷ According to Dr. Kump, she "limited [Patient B's] intake to one oxycodone and two diazepam pills before the procedure."

e. According to a “CO2 procedure report,” authored by Dr. Kump, in addition to the pre-procedure medications referenced above, an unspecified amount of “Lidocaine cream 10% was applied on [Patient B’s] face and neck.” Dr. Kump’s records do not document the justification for the use of an opioid analgesic in addition to lidocaine in violation of 18 VAC 85-20-26(C) of the Board’s Regulations.

f. Following the procedure, Dr. Kump authored an “Adverse Outcome Report” in which she states that near the end of the procedure “[Patient B] suddenly became short of breath and developed labored breathing. I asked her if she was feeling OK, but the patient did not respond. She developed what appeared to be a grand mal seizure . . .” which “lasted over seven minutes.” Dr. Kump directed that EMS be called. Dr. Kump could not detect breathing or heartbeat sounds and, at that point, reportedly injected Patient B with “1mg of epinephrine in her right forearm and initiated a one-person resuscitation.

6. Dr. Kump violated Virginia Code § 54.1-2915(A)(1), (3), (4) and (13) in that she failed to properly handle the emergency and complications resulting from the medications and treatment she provided to Patient B. Specifically:

a. An “Incident Summary Report” created by an officer with the Fairfax County Police Department indicates that while on scene, Dr. Kump reported that prior to the procedure, she “applied a numbing cream to [Patient B’s] face and administered two 5mg oxycodone doses along with two 5mg doses of Diazepam.” This report conflicts with the dosage of oxycodone (10mg) prescribed by Dr. Kump. Dr. Kump further reports that prior to the completion of the procedure she noticed that Patient B “began having difficulty breathing then passed out and turned blue.”

b. EMS records indicate that 911 was called at 1:04 p.m. and that they were “at the patient” at 1:15 p.m. EMS records state “arrived and found patient on a procedure table doctor doing

ineffective CPR . . . [i]mpression arrest due to pain and sedation meds for procedure . . . unknown if [Patient B] was constantly monitored by staff or BP cuff or pulse ox. Unknown how long she was (sic) seen or was breathing.” Similarly to Patient A, records indicate that at no point prior to EMS’ arrival did Dr. Kump intubate Patient B, utilize an AED or administer Narcan to Patient B.

c. Similarly to Patient A, EMS records indicate that once on scene, paramedics observed that Patient B was “Pulseless, apneic, blue in face and extremities.” Paramedics immediately ventilated Patient B with a BVM, placed a size 7 OPA (oropharyngeal airway) and administered 4mg of Narcan. Paramedics began monitoring Patient B’s cardiac rhythm via an EKG with the first monitored rhythm being recorded as ventricular fibrillation (“v-fib”). Further, Patient B’s “[r]hythm changed to asystole after 1st shock, then to PEA (“pulseless electrical activity”), ROSC (“return of spontaneous circulation”) at 1337 . . . [p]ost ROSC no spontaneous respirations or attempt to fight tube . . .” EMS records report the time of Patient B’s cardiac arrest to be 1:00 p.m.

d. Records from Hospital 1 indicate “[Patient B] presents in cardiac arrest s/p ROSC. Differentials include: hypoxia mediated cardiac arrest secondary to over sedation . . . ct head shows anoxic brain injury, which is consistent with exam.” Records indicate that a CT scan revealed Patient B had suffered a diffuse anoxic brain injury secondary to hypoxemic respiratory failure and cardiac arrest. On April 15, 2025, brain death testing was confirmed, and Patient B was removed from life support and declared deceased.

e. Similarly to Patient A, on July 15, 2025, the CME determined that Patient B’s death was caused by “acute intoxication due to the combined effects of oxycodone, diazepam, and lidocaine.”

f. As referenced in Allegation 5(c) above, Dr. Kump documented her concern that Patient B had likely consumed significant amounts of the oxycodone with acetaminophen and/or diazepam she prescribed prior to Patient B’s arrival at Dr. Kump’s office. In its Post Mortem Examination Report,

the CME stated that “patients receiving a 10 mg oral dose of oxycodone averaged a peak plasma concentration of . . . 30 ng/mL . . . [t]he reported oxycodone level in the decedent’s postmortem blood sample is 100 ng/mL,” thus confirming that the amount of oxycodone with acetaminophen Dr. Kump stated she administered to Patient B (5mg x2) was either not accurate or that Patient B had taken, mistakenly or intentionally, additional doses of the oxycodone with acetaminophen and/or diazepam prescribed to her by Dr. Kump.

g. In her written statement, Dr. Kump admitted her emergency preparedness had been inadequate and stated “we have significantly enhanced our emergency preparedness. Our office is now equipped with an AED and naloxone for potential opioid overdoses.” However, Dr. Kump made no mention of changes to her usual and customary prescribing practices nor any changes to her practices for patient monitoring.

7. Dr. Kump violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16) and (18), and 18 VAC 85-20-320(A)(1), (2) and (B)(4), and 18 VAC 85-20-360(B)(1)-(8) of the Regulations Governing the Practice of Medicine in that while administering anesthetic medication she failed to properly monitor and assess Patient B’s physical, functional, and physiological status while under mild or moderate sedation, thus increasing the likelihood of a catastrophic event such as death.

a. As described in Allegations 5(c)-(d) above, while being aware that Patient B appeared “slightly sedated” and being aware that Patient B likely had already consumed significant amounts of oxycodone with acetaminophen and/or diazepam prior to the procedure, Dr. Kump administered additional oxycodone with acetaminophen and additional diazepam to Patient B. Despite placing Patient B under, at minimum, moderate sedation, no standard monitoring (*e.g.*, blood pressure cuff, three-lead EKG, pulse oximeter or nasal cannula capable of measuring end-tidal CO₂) were utilized.

8. Dr. Kump violated Virginia Code § 54.1-2915(A)(1), (3), (4), (12), (13), (16) and (18), and 18 VAC 85-20-26(C) of the Regulations Governing the Practice of Medicine in that she failed to maintain timely, accurate and/or complete records for Patients A and B, as detailed below:⁸

a. Dr. Kump failed to document the date, type, dosage, and quantity of medications she prescribed to Patient A in violation of 18 VAC 85-21-50 of the Prescribing Regulations.

b. Dr. Kump failed to document preoperative anesthesia plans, failed to document that anesthesia plans were discussed with Patient A or B preoperatively, and failed to document the date, type, dosage, and quantity of medications she administered to Patients A and B in violation of 18 VAC 85-20-320(A)(3) and (B)(2)-(3).

c. Dr. Kump failed to document the need or rationale for the dosages of medications she prescribed and administered to Patients A and B and failed to document the justification for the use of an opioid analgesic in addition to lidocaine.

d. Dr. Kump failed to document in Patient A's and Patient B's medical records the extenuating circumstances for prescribing oxycodone with acetaminophen (an opioid) along with diazepam (a benzodiazepine) and failed to document a tapering plan to achieve the lowest possible effective doses in violation of 18 VAC 85-21-40(C) of the Prescribing Regulations.

9. Dr. Kump violated Virginia Code § 54.1-2915(A)(18), and 18 VAC 85-20-390 of the Regulations Governing the Practice of Medicine in that she failed to report Patient A and Patient B's deaths to the Board within 30 days.

10. Dr. Kump violated Virginia Code § 54.1-2915(A)(4) in that she is unable to practice medicine with safety to patients and the public due to professional incompetence. Specifically:

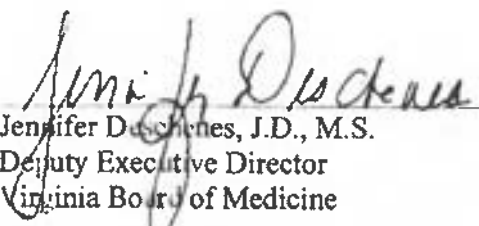
⁸ On April 30, 2025, Dr. Kump represented to a DHP Investigator that she had provided the "entire record" for Patient B.

a. Dr. Kump has a lengthy history of license discipline, to include submitting forged evaluations purportedly signed by her residency program directors, she continued to practice medicine while suspended and took steps to conceal her unlicensed practice, and lying to Board investigators. Since 2008, spanning three (3) different jurisdictions, Dr. Kump's license has been suspended four (4) times, she has been placed on probation twice, reprimanded and required to take additional continuing medical education in ethics.

b. After her inappropriate administration of sedating medications resulted in the death of Patient A on March 21, 2025 as detailed above, Dr. Kump failed to appropriately examine and revise her outpatient surgical practice – including methods of sedation, intraoperative monitoring, and resuscitations medication and equipment – leading to the death of Patient B under similar circumstances approximately three weeks later. Further, Dr. Kump does not appear to have a clear retrospective medical understanding of the factors that contributed to the deaths of Patients A and B, including her own medical decision-making.

11. Dr. Kump violated Virginia Code § 54.1-2915(A)(11), (12), (13), (16), and (18), and 18 VAC 85-20-29(A)(1) in that she aided or abetted Individual 3 in the unlicensed practice of surgical assisting, as Individual 3 is not licensed with the Virginia Board pursuant to Virginia Code § 54.1-2956.13, nor is he certified pursuant to Virginia Code § 54.1-2956.12. Specifically, in an interview with the DHP Investigator in the matter involving Patient A, Individual 3 described himself as a “Certified Ophthalmic Technician” and a “surgery assistant,” and he was present and assisting Dr. Kump with the procedures performed on Patient A, as described above. However, Individual 3 does not hold any health care licenses in the Commonwealth of Virginia.

See Confidential Attachment for the names of the patients and individuals referenced above.



Jennifer Deschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

9/24/2025

Date

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
BOARD OF MEDICINE**

IN RE: :

LEILA KUMP, M.D. :

License No.: MD037264 :

Licensee :

FINAL DECISION AND ORDER OF THE BOARD

This matter comes before the District of Columbia Board of Medicine (Board) following Dr. Leila Kump's submission of an affidavit, pursuant to D.C. Official Code § 3-1205.17, voluntarily surrendering her license to practice medicine in the District of Columbia.

By a consent order dated January 16, 2015, the Maryland Board of Physicians (the Maryland Board) revoked Dr. Kump's license to practice medicine in Maryland for a minimum period of one year. The Maryland Board took this action based on Dr. Kump's continued practice of medicine while her license to do so was in a suspended status. The Maryland Board investigated the matter and discovered that, on or about March 24, 2014, Dr. Kump "employed an optician, a billing clerk, two receptionists (front desk personnel), two optometrists, a part-time ophthalmologist, and an ophthalmic assistant." The Maryland Board subpoenaed patient records from Dr. Kump's practice, and after Dr. Kump's continued refusal to produce records subject to the compulsory process, the Maryland Board obtained seven patient records, which demonstrated that Dr. Kump provided ophthalmic care to at least these patients while her license was suspended. The dates of service ranged from December 31, 2013 through March 7, 2014.

The Maryland Board suspended Dr. Kump's license on September 20, 2013. The Maryland suspension was based on Dr. Kump's falsifying documents to fraudulently obtain her Maryland license. Dr. Kump contested the charge, and following a hearing, a Maryland administrative law judge sustained the charges relating to the fraudulent application for her Maryland license. The Maryland Board adopted the administrative law judge's findings and conclusions, and suspended Dr. Kump's license for a minimum period of one year. Despite this suspension, Dr. Kump resumed practice in December, 2013, according to the subpoenaed patient records.

As a result of the Maryland suspension, the District of Columbia Department of Health summarily suspended Dr. Kump's license to practice medicine in the District of Columbia. Although provided with an opportunity to challenge the summary suspension, Dr. Kump did not challenge the summary suspension. To date, Dr. Kump's license to practice medicine in the District remains summarily suspended. On March 25, 2015, the Board considered reciprocal action, in view of the Maryland revocation. The Board determined to take reciprocal action, or, in the alternative, to accept a voluntary surrender of Dr. Kump's license. Dr. Kump voluntarily surrendered her license to practice medicine in the District of Columbia. Dr. Kump executed an affidavit of surrender, dated March 26, 2015, pursuant to D.C. Official Code § 3-1205.17. Her affidavit of surrender is attached to this Order.

The Board accepts the surrender of the license and the Board has determined to revoke Dr. Kump's license to practice medicine, pursuant to D.C. Official Code § 3-1205.17(b).

ORDER

ACCORDINGLY, UPON CONSIDERATION of the foregoing, it is by the District of Columbia Board of Medicine,

ORDERED, that the VOLUNTARY SURRENDER of Leila Kump, M.D.'s, License No. MD037264, BE and is hereby ACCEPTED, pursuant to D.C. Official Code § 3-1205.17; and it is further

ORDERED, that the Board hereby recommends to the District of Columbia Department of Health to vacate the summary suspension of Leila Kump, M.D.'s, License No. MD037264, and it is further

ORDERED, that Leila Kump, M.D.'s, License No. MD037264, BE and is hereby REVOKED, pursuant to D.C. Official Code § 3-1205.17(b); and it is further

ORDERED, that the foregoing is a FINAL ORDER of the District of Columbia Board of Medicine.

DISTRICT OF COLUMBIA BOARD OF MEDICINE

April 29, 2015
Date

Janis M. Orlowski
By: Janis M. Orlowski, M.D., M.A.C.P.
Chairperson
vice chair
Mare E. Rankin, MD

Copies to:

Michael Stern, Esquire
Acting Chief, Civil Enforcement Section
441 4th Street, NW, Suite 630 South
Washington, DC 20001

And

Leila Kump, M.D.
11901 Jubal Early Ct.
Potomac, MD 20854
Licensee



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Search Again

License Number	First Name	Last Name	Profession
MD037264	Lella	Kump	MEDICINE
Type	Status	From State/Prov:	Issue Date:
MEDICINE AND SURGERY	Active	MD	2008-05-05
Expiration Date:	Temp. Issue Date:	Temp. Expire Date:	
2026-04-30			

Discipline Information from 1996 to Present - Please click item(s) below to view public orders

Kump MD037264 4-29-2015

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Kump MD037264 2-25-2015

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[https://dohenterprise.my.salesforce.com/stc/p/t00000000Cmng/a/eq00000HFoCQ/ODf233trgHVyFOHgtVvqyKVUBIzsj4Zmi_3y0A5s1G4\)](https://dohenterprise.my.salesforce.com/stc/p/t00000000Cmng/a/eq00000HFoCQ/ODf233trgHVyFOHgtVvqyKVUBIzsj4Zmi_3y0A5s1G4)**Practitioner Profile - Unless otherwise indicated, this information has been self-reported and has not been verified by the Board of Medicine.****DISCLAIMER**

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