GOVERNMENT OF THE DISTRICT OF COLUMBIA
BOARD OF MEDICINE

IN RE :
:
LOKESH VUYYURU, M.D. :
MD048629 :
Applicant :

FINAL DECISION AND ORDER OF THE BOARD

This matter comes before the District of Columbia Board of Medicine (the "Board") pursuant to the Health Occupations Revision Act (HORA), D.C. Official Code § 3-1201.01 (2009). The Board has broad jurisdiction to regulate the practice of medicine and to impose a variety of disciplinary sanctions upon a finding of a violation of HORA. D.C. Official Code, § 3-1201.03; *Mannan v. District of Columbia of Medicine*, 558 A.2d 329,333 (D.C. 1989). The Council of the District of Columbia, in amending the HORA, "intended to strengthen enforcement of it licensing laws." *Davidson v. District of Columbia Board of Medicine*, 562 A.2d 109, 113 (D.C. 1989). And the HORA "was designed to 'address modern advances and community needs *with the paramount consideration of protecting public interest*.'" *Joseph v. District of Columbia Board of Medicine*, 587 A.2d 1085,1088 (D.C. 1991) (*quoting* Report of the D.C. Council on Consumer and Regulatory Affairs on Bill 6-317, at 7 (November 26, 1985)) (emphasis added by court).

Background

Dr. Lokesh Vuyyuru (Respondent) filed an application to practice medicine in the District of Columbia in June, 2020. Upon review the District of Columbia Board of Medicine (the Board) decided to deny the application. On December 14, 2021, the Board issued to Applicant a Notice of Intent to Deny Licensure (the NOI), concerning his District of Columbia

medical license application. The NOI charged D.C. Official Code § 3-1204.14(a)(3) as the basis for the denial, in that Respondent's license was disciplined by a licensing, disciplinary or peer review body for conduct that would be grounds for disciplinary action in the District of Columbia. Specifically, his license was revoked on May 19, 2006 by the Virginia Board of Medicine after finding that Respondent had, among other things, breached the standard of care leading to the deaths of two patients and the performance of unnecessary operations on three patients. Subsequent to the Virginia action, Respondent's licenses were revoked in Illinois, New Jersey and New York. The Virginia Board of Medicine also denied Respondent's application for reinstatement in 2010.

Respondent was served with the NOI via personal service on August 23, 2022, after attempts of service through certified mail were unsuccessful. Respondent timely requested a hearing and the Board elected to hold it before a quorum of the Board. D.C. Official Code § 3-1205.19 authorizes the Board to conduct hearings and issue final decisions. The hearing in this matter took place on April 26[1], May 31[2] and June 28[3], 2023. The Government of the District of Columbia (Government) was represented by Assistant Attorney General for the District of Columbia, Chris Southcott. Respondent was represented by attorneys John Clifford and Richard Condit. Both the Government and Respondent provided testimony and admitted exhibits into evidence.

Several motions were submitted as preliminary matters. Respondent filed a *Motion to Produce Requested Witnesses and/or Issue Subpoenas* on April 24, 2023, and a *Motion for*

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[1] A quorum consisting of Dr. Anderson (Chair), Dr. Raczynski, Dr. Bandealy, Dr. Gaymon-Doomes, and Dr. Strudwick were present.

[2] A quorum consisting of Dr. Anderson (Chair), Dr. Raczynski, Dr. Bandealy, Dr. Dawson and Mr. Rich were present.

[3] A quorum consisting of Dr. Anderson (Chair), Dr. Dawson, Dr. Raczynski, Dr. Smith, Dr. Strudwick and Mr. Rich were present. One board member left the hearing early.

Summary Decision on April 25, 2023. Government made an oral *Motion in Limine* at the beginning of the hearing on April 26, 2023. Respondent and Government made arguments on Respondent's *Motion for Summary Judgment* but the Board held the decision on that motion in abeyance (discussed in the Findings of Fact and Conclusions of Law, below). Respondent's *Motion to Produce Requested Witnesses* was denied in part and granted in part. His request to subpoena the Board members regarding their decision to issue the NOI was denied as inappropriate, as this hearing was occurring before the Board, and violative of the Board's deliberative decision-making authority. Subpoenas for three witnesses: Frank Myers, former Executive Director of the Board, Angela Braxton, a former Health Licensing Specialist, and LaJuan Jeffries, a current employee, were denied as the first two were no longer employed by D.C. Health, Ms. Jeffries was on sick leave, and their testimony related to a business process for which other employees were available. The request for Charles Annor, a current Health Licensing Specialist, and Edward Rich, from the Office of General Counsel who handles Freedom of Information (FOIA) requests, to be available to testify were granted.

Government's *Motion in Limine* was a request to limit evidence to only that which was relevant to the basis in the NOI, specifically whether or not the Respondent's license had been revoked in another jurisdiction on grounds for which disciplinary action could result in the District. Respondent argued that he should be able to provide "documents and other things to demonstrate that the actions taken by Virginia are at best questionable." (Tr. P. 52). The Board ruled that no evidence would be admitted attacking the decision by the Virginia Board, as "by the statutory terms, the fact alone of discipline by another licensing authority allows "reciprocal" discipline in the District if the conduct would be grounds for discipline here." (*Falkenstein v. District of Columbia Bd. of Med.*, 727 A.2d. 302, 302 (D.C. 1999)). However the Board ruled

Respondent could introduce evidence in regard to his practice and education after the date the Virginia Order revoking his license was entered, to determine if he was sufficiently rehabilitated.

Respondent and Government made arguments on Respondent's *Motion for Summary Decision* but the Board held the decision on that motion in abeyance. and Government provided a written response. Subsequently, prior to the second day of hearing on May 28, 2023, Government submitted a written response to Respondent's *Motion for Summary Decision* and also submitted the *District of Columbia's Motion to Reopen and Correct the Record* to correct prior testimony about the original issuance of the license, to which Respondent responded. At the beginning of the May 28 hearing, the Board denied the *Motion for Summary Decision*. It found that in accordance with testimony, staff did not have the authority to issue licenses when there was a history of discipline, and specifically not for Respondent's application. (Apr. 26 Tr. p. 142 and p. 175). By statute and regulation, it is the Board who determines if an application is sufficient. While the Board may have delegated authority to approve licenses in certain circumstances to staff, an application such as the one from Respondent does not fall within that authority due to his negative history. Assuming for the sake of argument that a license was issued in error, the Board found that that agency had the authority to rescind it, particularly since as in this case the first time Respondent was made aware that he was issued a license was when he was told it was rescinded. Thus the *Motion for Summary Decision* was denied and Government's *Motion to Reopen* was denied as moot, and the hearing on the NOI, this issue within the Board's purview, would go forward.

During the hearing, four exhibits from the Government were admitted: the *Notice of Intent to Deny* (G. Ex. 1); the *Order Before the Virginia Board of Medicine in Re: Lokesh Babu Vuyyuru, M.D.*, (Virginia Revocation Order) dated May 19, 2006, (G. Ex. 3), the *Order Before*

the Virginia Board of Medicine in Re: Lokesh Babu Vuyyuru, M.D. (Virginia Order Denying License Reinstatement), dated Nov. 16, 2010 (G. Ex. 4), and Respondent's Application (G. Ex. 5). Two witnesses, Charles Annor and Aisha Nixon, testified for the Government.

Five exhibits from Respondent were admitted: the Curriculum Vitae (CV) of Dr. Vijaypal Arya (R. Ex. 4); the CV of Dr. Stuart Horwitz (R. Ex. 5); the CV of Dr. Richard Ashby (R. Ex. 6); an excerpt from the CPEP evaluation (pp. 37 – 65 of R. Ex. 7); Respondent's Application with additional materials (Parts 1-5, R. Ex. 19) and Patient Records 1 – 6 (R. Ex. 22). Respondent and three witnesses testified on behalf of Respondent: Dr. Arya, Dr. Horwitz, and Dr. Ashby.

Findings of Fact

1. Applicant graduated from the Guntur Medical College, Guntur, India, in 1983. He completed a residency program at Wyckoff Heights Hospital, Brooklyn, New York from 1987 – 1990, and did a one-year fellowship in gastroenterology at Southern Illinois University, Springfield, Illinois. He moved to Virginia in 1991 for an additional three years of fellowship training. (May 31 Tr . pp. 127 – 130). He received his license to practice medicine in Virginia on July 1, 1991. (G. Ex. 3 at 2).

2. Respondent practiced gastroenterology in Virginia from 1994 until August 10, 2005, when his license was suspended by the Virginia Board of Medicine ("Virginia Board"). (May 31 Tr. p. 133).

3. Respondent's license was summarily suspended by the Virginia Board of Medicine (Virginia Board) on August 10, 2005. (G. Ex. 3 at 1). The Virginia Board subsequently held a hearing and found, among other things, that:

A. Respondent performed medical procedures on Patient A without establishing the clinical necessity for the procedures. "The complications Patient A experienced were a result of Dr. Vuyyuru's decision for prolonged and unnecessary intubation. The death of Patient A was the result of Dr. Vuyyuru's failure to act within the standard of care." (G. Ex. 3 at 2-3). This was a violation of VA Code §§ 54.1-2915(3) and (13)[4]. (*Id.* at 8).

B. Respondent performed an endoscopic retrograde cholangiopancreatography ("ERCP") on Patient B, an approximately twenty-seven minute procedure for which he ordered the administration of Versed and Demerol "without ensuring that the patient was adequately monitored. At the time of administration of each dose of Versed and the dose of Demerol, the record does not support the need for additional sedation and pain relief. Patient B went into respiratory distress and became unresponsive, but was resuscitated shortly thereafter. Patient B suffered hypoxia, developed anoxic encephalopathy, and was discharged in a vegetative state." (*Id.* at 3). This was a violation of VA Code §§ 54.1-2915(3) and (13). (*Id.* at 8).

C. Respondent performed an ERCP on Patient D, a one hundred four (104) year old woman. "Dr. Vuyyuru performed this risky diagnostic procedure, ignoring relative

[4] VA Code § 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.
The Board may refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; impose a monetary penalty or terms as it may designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct:
(3) 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; and
(13) Conducting his practice in such a manner as to be a danger to the health and welfare of his patients or to the public.

contraindications such as renal failure, atrial fibrillation, right heart failure, and advanced malignancy. He further did not consider the patient's age. The patient suffered cardiopulmonary arrest immediately following the procedure and died approximately one week later. Dr. Vuyyuru's treatment of Patient D was contrary to sound medical judgment and a violation of the applicable standard of care." (*Id.* at 4). This was a violation of VA Code §§ 54.1-2915(13). (*Id.* at 8).

D. Respondent's "evaluation of Patients E, I and K demonstrate a pattern of faulty clinical judgment in his section of patients for diagnostic and therapeutic ERCPs." (Id at 4). This was a violation of VA Code §§ 54.1-2915(3) and (13). (Id. at 9).

E. Respondent's "records of controlled substances failed to satisfy statutory requirements." He failed to maintain a proper record receipt of the Schedule 11-V controlled substances in his practice, and the controlled substance medication log conflicted with the medication quantities recorded in the patient records for eight (8) patients. (*Id.* at 6). This was a violation of VA Code §§ 54.1-2915(13), (16) and (17)[5]. (*Id.* at 9).

F. Respondent failed to immediately provide records when this practice was investigated, and failed to provide them when a *subpoena duces tecum* was served. He did provide the records about a week later. (*Id.* at 6-7). This was a violation of VA Code §§ 54.1-2915(17) and (18). (*Id*. at 9).

4. As a result of its findings, the Virginia Board revoked Respondent's license to practice medicine in the state of Virginia on May 19, 2006. (*Id.*).

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[5] VA Code §§ 54.1-2915.A
(16) Performing any act likely to deceive, defraud, or harm the public; and
(17) Violating any provision of statute or regulation, state or federal, relating to the manufacture, distribution, dispensing, or administration of drugs.

5. As a result of the revocation by the Virginia Board, the state of Illinois revoked Respondent's license to practice medicine in Illinois on March 12, 2009. (G. Ex. 4 at 2).

6. As a result of the revocation by the Virginia Board, the state of New York revoked Respondent's license to practice medicine in the state of New York on or about May 19, 2009. (*Id.*).

7. As a result of the revocation by the Virginia Board, the revocation in Illinois, and an action by New York summarily suspending his license in 2006, the state of New Jersey revoked Respondent's license to practice medicine in the state of New Jersey on or about June 10, 2009. (*Id.*).

5. Respondent submitted an application to reinstate his license in Virginia. A hearing was held on the application, and the Virginia Board, finding that Respondent was "incompetent to practice medicine and surgery with safety to the patients and the public" (*Id.* at 2), denied his application. (*Id.*).

6. Respondent has not practiced in the United States since on or about August, 2005, when his license in Virginia was summarily suspended (*Id.*; *see also* May Tr. p. 150).

7. Respondent practiced medicine in India from December 2014 until February 2018. (May 31 Tr. p. 151; G. Ex. 5 at 412-413). He has done some telemedicine in India since then. As of May 31, 2023, the last time he was physically in India practicing medicine was in September 2019 where he apparently acted in a consulting role. (May 31 Tr. p. 151). Between May 31, 2023 and the hearing on June 28, 2023, Respondent returned to India and saw seven patients (R. Ex. 22 and June 28 Tr. pp. 71 to 82).

8. Respondent submitted an application to the District of Columbia Department of Health (DC Health) for a license to practice medicine on or about June 2, 2020 (G. Ex. 5 at 32,

dated but unsigned application). The application was approved by a Health Licensing Specialist (HLS) in August of 2020 although, based on the application being incomplete and given Respondent's history of discipline, the HLS had no authority to approve the license. (May 31 Tr. pp. 112 – 114 testimony of Mr. Annor; p. 175, testimony of Ms. Nixon: "Q: Does a Health Licensing Specialist have the authority to approve an application of an individual whose license has been revoked in another jurisdiction? A: No.").

9. DC Health only became aware of the license being approved in error when Respondent inquired about the status of his application. DC Health rescinded the approval of the license and worked with Respondent to obtain the items that were missing from his application. (V. Exh. 19 at 6, Reference form for unspecified period dated Jan. 20, 2021; p. 25, Malpractice Claims Explanation dated Jan. 21, 2021; pp. 160 - 207, email correspondence).

10. The Board of Medicine subsequently issued a Notice of Intent to Deny the application on December 14, 2021, on the grounds that Respondent was disciplined by a licensing authority for conduct that would be grounds for disciplinary action in the District of Columbia. (G. Exh. 1).

11. Respondent underwent a Center for Personalized Education for Professionals (CPEP) Assessment in the summer of 2020 "as part of the process to reinstate his license in Virginia, which was revoked in 2005." (G. Ex. 5, p. 56). The CPEP Assessment Report (CPEP Report), said Respondent "demonstrated several strengths as well as areas of education need." The CPEP Report recommended that Respondent participate in a "structured, individualized Education Intervention to address the identified needs." *Id.* The evaluation consisted of two clinical interviews with board-certified gastroenterologists; three simulated patient encounters, and documentation of the interviews with the simulated patients; and an exam. Respondent

passed the SAGES Fundamentals of Endoscopic surgery examination but declined CPEP's recommendation to take the electrocardiogram interpretation exam. *Id*. at 58 – 59.

While the CPEP Report stated Respondent's medical knowledge was "generally adequate," he showed some significant weakness related to one of his stated areas of expertise, ECRP:

> However, he did demonstrate some limited areas of incomplete or outdated knowledge in several of the topics discussed. For example, in discussing an ERCP in a young woman with recurrent abdominal pain, abnormal liver function studies, and suspected dysfunction of the sphincter of Oddi, he was not aware that sphincter manometry is not currently recommended, and showed some difficulty in describing the current indications for a liver biopsy. In a patient with acquired immunodeficiency syndrome (AIDS) and diarrhea, he was not able to describe the association between folate and B12 deficiency and tropical sprue, nor was he aware of the current recommendation for use of budesonide in the primary management of collagenous colitis. In describing the new biologic treatments for ulcerative colitis, he was able to describe the use of infliximab, but was incorrect on the dosing interval. Similarly, he appeared to be unaware of the current use of the thiopurine methyltransferase (TPMT) enzyme level to assist in the dosing of azathioprine for the treatment of autoimmune hepatitis.
> *Id.* p. 60.

This is in marked contrast to Respondent's testimony about his skills. Regarding his previous practice in Virginia performing ERCP, Respondent stated: "And everybody cannot do it. As I told you, out of 50 gastroenterologists, probably 5 of us doing [it]. I am one of the biggest referenced physician[s] to perform these procedures other than Medical College of Virigina." (May 31 Tr. p. 136). According to his testimony, ERCP is one of the techniques he continued to perform in India: "that's what I did in India. Not only basic upper endoscopy, colonoscopies, PEGS, not only these basic procedures but also advanced ERCPs and pancreas work I do." (May 31 Tr. p. 153).

The CPEP Report also raised concerns about Respondent's clinical judgment and reasoning, finding them "marginally adequate." CPEP assessed his overall approach as "logical and organized" but despite this:

> However, both consultants identified some concerns. Although Dr. Vuyyuru approach to hypothetical patients was organized, he at times appeared to miss key elements of history in the cases presented, especially in determining prior alcohol or tobacco use, or a family history of gastrointestinal disease. In a few cases discussed, his differential diagnosis was somewhat incomplete, such as failing to consider tropical sprue or small bowel neoplasms in a young male with human immunodeficiency virus (HIV) infection, frequent traveling, and persistent diarrhea. Similarly, his investigative work-up showed deficits in some cases, such as not considering biopsies for eosinophilic esophagitis in a male with heartburn and dysphagia, failing to obtain biopsies for H. pylori during an esophagogastroduodenoscopy (EGD) for gastric complaints, or in failing to recommend an upper endoscopy in a patient with multiple risk factors for Barrett esophagitis. He did not mention stool studies to rule out underlying infection in a hypothetical patient with newly diagnosed ulcerative colitis. His treatment planning occasionally lacked key elements, such as not considering tapering or discontinuation of opioids in a hypothetical patient with constipation-predominant irritable bowel syndrome who was on chronic opioid therapy, omitting a recommendation for a cholecystectomy in a woman with resolving gallstone pancreatitis, or a follow-up endoscopy in a patient who had undergone prior ligation of esophageal varices. He also showed some relative inflexibility in his management plan for problems such as autoimmune hepatitis or Crohn disease, in which he appeared to have difficulty in adjusting the treatment regimen to the comorbidities and nuances of the individual patient.

Id. at 62 – 63.

The "deficits" in his investigative work-up, and "difficulty in adjusting the treatment regimen to the comorbidities and nuances of the individual patient" are reminiscent of the failures in standards of care identified by the Virigina Board. (G. Ex. 3, *infra*.).

CPEP evaluated Respondent's record keeping of the simulated patient encounters, as "adequate with room for improvement." (G. Ex. 5 at 63). Similarly, evaluation of his physician-patient communication was "mixed." "Technically the interviews were adequate but the was a lingering impression that he simply wanted to get through the interviews as soon as possible." (*Id*. at 64). The Board finds the CPEP Report indicated Respondent was not competent to practice safely in the District absent additional education and supervision.

12. CPEP produced an Educational Intervention Plan (Education Plan) for Respondent in April 2021, designed to address the needed improvements identified in the CPEP report. (R. Ex. 7; G. Ex. 7 at 22)[6]. The Learning Goals for the CPEP Plan included:

1. "To improve evidence-based medical knowledge . . ";

2. "To *consistently* demonstrate appropriate clinical judgment . . ." (emphasis in the original);

3. To . . . . "learn principles of documentation that are based on recommendations and requirements of nationally recognized organizations such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS) and recommendations of national specialty societies and will *consistently* demonstrate appropriate patient care documentation . . . " (emphasis in the original);

4. Practice-based learning; and

5. "To consistently demonstrate appropriate communication skills . . ." (emphasis in original).
Id. at 27 – 28.

CPEP identified two "modules" to achieve the identified Learning Goals. Module A activities were for Respondent to complete on his own and included, among other things, documenting all activities, continuing medical education, and "self-study on an Education Log provided by CPEP." *Id.* at 28. Module B, Patient Care Enhancement, required a Preceptor, to be approved by CPEP, who would provide Respondent with coaching and feedback in accordance with CPEP requirements. *Id.* at 32. Per the Education Plan, the Preceptor and the practice monitor, if any, should not be the same person:

> The preceptor's role is not the same as a practice monitor, who is expected to focus on patient safety, evaluate the physician's practice, and report to an authoritative entity. The preceptor should be able to focus only on the Education Plan. CPEP strongly recommends that the preceptor and the practice monitor not be the same individual.
> *Id.* at 47.

[6] For the sake of clarity, future references to the Education Plan will only be to the G. Ex. 7 and page number, to avoid confusion with the page numbers of R. Ex. 7 which was not admitted in its entirety.

13. Despite having the CEPP Education Plan since 2021, Respondent provided no evidence of compliance or commitment to it. No signed version of the Education Plan was admitted. Respondent provided no updated continuing medical education (CME) documentation or indication that he had started the "Module A" items. Respondent also has no clear plan for a preceptor or practice monitor. According to Respondent, Dr. Horowitz agreed to be his preceptor. Previously a Dr. Brown had been willing to act as a Preceptor for Respondent, but had unfortunately died. Therefore according to Respondent, Dr. Horowitz, Dr. Brown's former partner, was going to act as preceptor "to monitor [a] couple of areas of my practice. . . at the Endoscopy Center, [owned] by Dr. Horowitz." (June 28 Tr. at 34-35). "Inpatients (sic) is in the hospital, like ERCP and which I plan [to] take the help [of] Dr. Horowitz and he's going to supervise all this practice and the procedures." (*Id.*) However Dr. Horowitz testified that the practice he shared with Dr. Brown was closed December 31, 2022, after the death of Dr. Brown. (May 31 Tr. at 27). Dr. Horowitz is currently "practicing part-time in long-term care about 20 hours a week . . And … considering doing [*locum tenens*][7] in gastroenterology in the near future." (May 31 Tr. at 41). While Dr. Horowitz testified he was willing to do whatever was needed as a preceptor and "believed" he had reviewed the Education Plan (May 31 Tr. at 33), his view of the preceptor role did not show a clear understanding of CPEP's plan, whether he would be a CPEP preceptor or a practice monitor, and certainly did not in any way support Respondent's later testimony that he would be working with Dr. Horowitz at the (now closed) Endoscopy Center. Dr. Horowitz also said he's "had no discussions about that with the CPEP company as to the details of how this would go other than this information that I've seen that was provided to Dr. Kenneth Brown [who] was going to do the same thing." (May 28 Tr. at 45).

[7] *Locum tenens* means working on a contract basis, usually to fill in for the absence of another physician.

While the Education Plan is thorough and comprehensive, without a strong plan for execution it fails to begin to remedy the significant concerns regarding Respondent's competence, considering the events in Virigina that led to his revocation, the lack of practice in the intervening years in the United States, and the issues raised in the CPEP Report.

14. The Board appreciates the testimony from Dr. Arya and Dr. Ashby, but finds their testimony irrelevant to the issue at hand, as their testimony was limited to their knowledge of Respondent's practice prior to his revocation.

Conclusions of Law

1. The Board finds by a preponderance of the evidence that Respondent's license to practice medicine in the state of Virginia was revoked on May 19, 2006, and the bases for that revocation constitute grounds for a similar result in the District of Columbia pursuant to D.C. Code § 3-1205.14(c). Specifically, his license was revoked for violating laws and regulations related to the handling of controlled substances (D.C Code § 3-1205.14(25)); practicing below the acceptable standard of care and causing significant harm and even death to patients (D.C. Code §§ (26) and (28)); and failing to cooperate in a board investigation (D.C. Code § 3-1205.14(42)).

2. The Board finds that applicant's license to practice a health occupation was revoked or suspended in another state, and the basis of the license revocation or suspension would have caused a similar result in the District. D.C. Code § 1205.03(c).

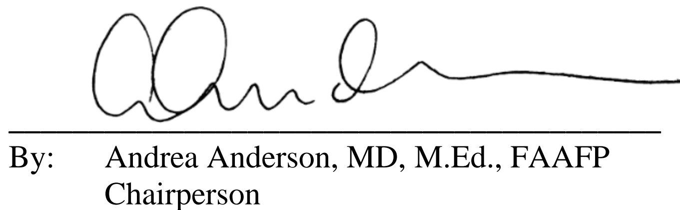
3. Respondent has not shown that his practice has remediated in the time since it was revoked in 2006. Although not required, the Board allowed testimony regarding Respondent's rehabilitation from the acts which led to the revocation in 2006 in Virigina, and proof of his performance since then. The Respondent is within his right to disagree with the findings of the Virginia Board but the revocation of Respondent's license in Virigina remains valid. The CPEP

Report in 2020 illustrated how the errors in practice and judgment found by the Virginia Board in 2006 continue today. The minimal examples of his practice in India do not counter these issues. The Board agrees with the Virginia Board when it found in 2010, in denying Respondent's application for reinstatement, that Respondent "neither recognized nor remediated the issues regarding his lack of clinical judgment that resulted in the revocation of his license." (G. Ex.4 at 3).

ORDER

UPON CONSIDERATION of the evidence and testimony presented at the hearings in the matter on April 26, May 31 and June 28, 2023, and the entire record herein, it is this 15th day of March, 2024, **ORDERED** that the medical license application of Lokesh Vuyyuru, M.D., shall be and is hereby **DENIED**.

DISTRICT OF COLUMBIA BOARD OF MEDICINE



03.15.2024
Date

By: Andrea Anderson, MD, M.Ed., FAAFP
Chairperson

Judicial Review of Final Actions by a Board

Pursuant to D.C. Official Code § 3-1205.20:
Any person aggrieved by a final decision of a board or the Mayor may appeal the decision to the District of Columbia Court of Appeals pursuant to D.C. Official Code § 2-510.

NOTE: Any appeal noted to the Court of Appeals must be filed within 30 days of the final decision of the Board. See D.C. Court of Appeals Rule 15(a).

D.C. Official Code, §2-510 provides:

(a) Any person suffering a legal wrong, or adversely affected or aggrieved, by an order or decision of the Mayor or an agency in a contested case, is entitled to a judicial review thereof in accordance with this subchapter upon filing in the District of Columbia Court of Appeals a written petition for review. If the jurisdiction of the Mayor or an agency is challenged at any time in any proceeding and the Mayor or the agency, as the case may be, takes jurisdiction, the person challenging jurisdiction shall be entitled to an immediate judicial review of that action, unless the Court shall otherwise hold. The reviewing Court may by rule prescribe the forms and contents of the petition and, subject to this subchapter, regulate generally all matters relating to proceedings on such appeals. A petition for review shall be filed in such Court within such time as such Court may by rule prescribe and a copy of such petition shall forthwith be served by mail by the clerk of the Court upon the Mayor or upon the agency, as the case may be. Within such time as may be fixed by rule of the Court, the Mayor or such agency shall certify and file in the Court the exclusive record for decision and any supplementary proceedings, and the clerk of the Court shall immediately notify the petitioner of the filing thereof. Upon the filing of a petition for review, the Court shall have jurisdiction of the proceeding, and shall have power to affirm, modify, or set aside the order or decision complained of, in whole or in part, and, if need be, to remand the case for further proceedings, as justice may require. Filing of a petition for review shall not in itself stay enforcement of the order or decision of the Mayor or the agency, as the case may be. The Mayor or the agency may grant, or the reviewing Court may order, a stay upon appropriate terms. The Court shall hear and determine all appeals upon the exclusive record for decision before the Mayor or the agency. The review of all administrative orders and decisions by the Court shall be limited to such issues of law or fact as are subject to review on appeal under applicable statutory law, other than this subchapter. In all other cases the review by the Court of administrative orders and decisions shall be in accordance with the rules of law which define the scope and limitations of review of administrative proceedings. Such rules shall include, but not be limited to, the power of the Court:

(1) So far as necessary to decision and where presented, to decide all relevant questions of law, to interpret constitutional and statutory provisions, and to determine the meaning or applicability of the terms of any action;

(2) To compel agency action unlawfully withheld or unreasonably delayed; and

(3) To hold unlawful and set aside any action or findings and conclusions found to be:

(A) Arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) Contrary to constitutional right, power, privilege, or immunity;

(C) In excess of statutory jurisdiction, authority, or limitations or short of statutory jurisdiction, authority, or limitations or short of statutory rights;

(D) Without observance of procedure required by law, including any applicable procedure provided by this subchapter; or

(E) Unsupported by substantial evidence in the record of the proceedings before the Court.

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