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| **IN THE MATTER OF** | * | **BEFORE THE MARYLAND** |
| **LEILA KUMP, M.D.** | * | **STATE BOARD OF** |
| **RESPONDENT** | * | **PHYSICIANS** |
| **License Number: D0067770** | * | **Case Number: 2226-0185** |

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## CONSENT ORDER

## PROCEDURAL BACKGROUND

The Maryland Board of Physicians (the "Maryland Board") received information that Leila Kump, M.D., (the "Respondent") License Number D0067770, was disciplined by the Virginia Board of Medicine (the "Virginia Board"). In an Order dated March 19, 2026, the Virginia Board disciplined the Respondent by revoking the Respondent's license to practice medicine in the state of Virginia.

Based on the above referenced Virginia sanction, the Maryland Board has grounds to charge the Respondent with violating the following provisions of the Maryland Medical Practice Act (the "Act"), under H. O. § 14-404(a):

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> > (21) **Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veteran's Administration for an act that would be grounds for disciplinary action under this** section,

Disciplinary Panel B ("Panel B") has determined that the acts for which the Respondent was disciplined in Virginia would be grounds for disciplinary action under

H.O. § 14-404(a). The grounds for disciplinary action under H.O. § 14-404(a) are as follows:

> (3) Is guilty of:
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> (4) Is:
>
> (i) Professionally incompetent;
>
> (18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine;
>
> (43) Except for the licensure process described under Subtitle 3A of this title, violates any provision of this title, any rule or regulation adopted by the Board, or any State or federal law pertaining to the practice of medicine[.]

With respect to Health Occ. § 14-404(a)(43), the pertinent Virginia Statutes are the following:

**Code of Virginia**

....

§ 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.

> (A) 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:
>
> (l) 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;
>
> (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;
>
> (4) Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public;

(10) Knowingly and willfully committing an act that is a felony under the laws of the Commonwealth or the United States, or any act that is a misdemeanor under such laws and involves moral turpitude;

(11) 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;

(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;

(16) Performing any act likely to deceive, defraud, or harm the public;

(18) 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;

....

§ 54.1-111. Unlawful acts; prosecution; proceedings in equity; civil penalty.

(A) It is unlawful for any person, partnership, corporation, or other entity to engage in any of the following acts:

(l) Practicing a profession or occupation without holding a valid license as required by statute or regulation.

(8) Violating any statute or regulation governing the practice of any profession or occupation regulated pursuant to this title.

....

§ 54.1-2902. Unlawful to practice without license.

It is unlawful for any person to practice medicine, osteopathic medicine, chiropractic, or podiatry or as a physician assistant in the Commonwealth without a valid unrevoked license issued by the Board.

....

§ 54.1-2903. What constitutes practice; advertising in connection with medical practice.

(A) Any person shall be regarded as practicing the healing arts who actually engages in such practice as defined in this chapter, or who opens an office for such purpose, or who advertises or announces to the public in any manner a readiness to practice or who uses in connection with his name the words or letters "Doctor,"

"Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," "N.P.," or any other title, word, letter or designation intending to designate or imply that he is a practitioner of the healing arts or that he is able to heal, cure or relieve those suffering from any injury, deformity or disease.

Signing a birth or death certificate, or signing any statement certifying that the person so signing has rendered professional service to the sick or injured, or signing or issuing a prescription for drugs or other remedial agents, shall be prima facie evidence that the person signing or issuing such writing is practicing the healing arts within the meaning of this chapter except where persons other than physicians are required to sign birth certificates.

**Virginia Administrative Code**

....

18VAC85-20-29. Practitioner responsibility.

(A) No practitioner shall:

(l) Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised[.]

Based on the action taken by the Virginia Board, the Respondent agrees to enter into this Consent Order with Panel B, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order and Consent.

## FINDINGS OF FACT

Panel B makes the following findings of fact:

1. At all times relevant hereto, the Respondent was a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on or about June 6, 2008.

2. On or about March 21, 2025, at around 1:00 p.m., a 73-year-old female ("Patient A") arrived at the Respondent's office with her daughter "for an elective in-office bilateral upper eyelid blepharoptosis repair, blepharoplasty and bilateral

lower eyelids ectropion repair, blepharoplasty." As instructed, Patient A brought several medications prescribed by the Respondent, "including 12 dosage units of 10 mg/325 mg oxycodone with acetaminophen (C-II) and 10 dosage units of 5 mg diazepam (C-IV)" in which the Respondent dispensed "an unknown number of pills" to Patient A. The Respondent's Adverse Outcome Report documents that the Respondent administered "10 mg of diazepam, 10 mg of oxycodone, 325 mg of acetaminophen."

3. The Respondent returned to the waiting room about "45 minutes later" and asked Patient A "if she was 'woozy.'" At around 2:02 p.m., the Respondent and an unlicensed surgery assistant ("Individual 1") began the procedure, in which "4 ml of plain 2% lidocaine [was injected] into both upper eyelids" and the "[l]ower eyelid skin was injected with 8ml plain 2% lidocaine bilaterally." The Respondent did not document any medical rationale for administering an opioid analgesic in addition to lidocaine.

4. According to the Respondent's Adverse Outcome Report, the Respondent and Individual 1 communicated with Patient A during the procedure, who indicated that she "was doing fine. At around 3:20 p.m., the patient was notified that the surgery was about to end ... [who] acknowledged that she was all right." However, when "the procedure ended at 3:46 p.m." and Patient A was "asked to open her eyes," she was not responsive; "her breathing was shallow, [and] her pulse was weak, but palpable in the carotid arteries." The Respondent then injected "1g of epinephrine" into Patient A's right forearm, front desk staff contacted 911, and "mouth-to-mouth resuscitation with chest compressions" was

performed by the Respondent and Individual 1 for 12 minutes until Emergency Medical Services ("EMS") personnel arrived at 3:51 p.m.

5. EMS personnel noticed that Patient A had no palpable pulse, was "unresponsive, apneic, and that her extremities were blue cold to the touch." Furthermore, EMS records did not indicate that there were "any medical staff from the clinic in the pts room" upon arrival, "no facility monitoring device was attached to the pt and no vitals of the pt were given" by the Respondent or her staff. There was no documentation to suggest that the Respondent or Individual 1 used an automated external defibrillator ("AED") or Narcan.

6. Patient A's cardiac arrest was estimated around 3:30 p.m. She was transported to a hospital, where she was pronounced deceased at 4:33 p.m. "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.'"

7. Virginia Board investigators discovered that the Respondent "falsely and purposefully misrepresented and/or omitted details" pertaining to Patient A's treatment.

a. In an Incident Summary Report authored by Fairfax County Police, the Respondent was documented as stating that she covered Patient A's face with a sterile cover, making only her eyes visible. Additionally, the Respondent stated that Patient A had not communicated to the Respondent "during the last 20 minutes of the procedure," leading the Respondent to believe the patient had fallen asleep, which the Respondent

reported was not uncommon. However, when the Respondent removed "the sterile cover, she 'noticed that [Patient A's] skin was pale.'" The Respondent did not include this information in her Adverse Outcome Report.

b. The Respondent told EMS personnel that she "administered 30mg of oxycodone with acetaminophen and 15 mg of diazepam," rather than the 10 mg of diazepam, 10 mg of oxycodone, and 325 mg of acetaminophen that was documented in her Adverse Outcome Report. Additionally, the Respondent's Surgery Report lists the Respondent as only administering "local, topical anesthesia," and did not include the administration of oxycodone with acetaminophen or diazepam until, due to Patient A's death, required to author an Adverse Outcome Report.

8. Additionally, Virginia Board investigators found that the Respondent "failed to properly monitor and assess Patient A's physical, functional, and physiological status while under sedation." The Respondent was in possession of a pulse oximeter and a blood pressure cuff; however, neither was used during the procedure. The Respondent reported that the "standard of practice did not require continuous electronic vital sign monitoring." Individual 1 corroborated that he and the Respondent do not monitor patients' blood pressure or oxygen saturation while performing surgery.

9. On April 12, 2025, a 48-year-old female ("Patient B") arrived at the Respondent's office "for an elective in-office CO2 resurfacing of the skin on her face and neck." As instructed, Patient B brought several medications prescribed

by the Respondent, "including 12 dosage units of 10 mg/325mg oxycodone with acetaminophen and 10 dosage units of 5mg diazepam."

10. In her written statement to Virginia Board Investigators, the Respondent "stated that Patient B 'appeared slightly off'" and noticed that the "bottles of oxycodone and diazepam ... 'were nearly empty.'" Despite this, the Respondent proceeded with the procedure and "administered an additional 10 mg of oxycodone with acetaminophen, ... an additional 10 mg of diazepam" and an undetermined amount of "Lidocaine cream 10% ... on [Patient B's] face and neck." There was no documented medical rationale for the Respondent to administer an opioid analgesic as well as lidocaine.

11. The Respondent neglected to "monitor and assess Patient B's physical, functional, and physiological status" despite reporting that Patient B may have consumed a large portion of the prescribed medications.

12. Near the conclusion of the procedure, Patient B developed shortness of breath, labored breathing, and experienced "what appeared to be a grand mal seizure ... [that] lasted over seven minutes." EMS was contacted, and the Respondent "reportedly injected Patient B with '1mg of epinephrine and initiated a one-person resuscitation'" after the Respondent "could not detect breathing, or heartbeat sounds."

13. EMS personnel arrived at 1:15 p.m., as the Respondent was "doing ineffective CPR." There was no indication that the Respondent "intubate[d] Patient B, utilize[d] an AED or administer[ed] Narcan."

14. Patient B was transported to the hospital, where "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's brain death was confirmed, and she was removed from life support. On or about 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.'"

a. In an Incident Summary Report authored by a Fairfax County Police officer, the Respondent was documented as stating that she "applied a numbing cream to [Patient B's] face and administered two 5mg oxycodone doses along with two 5mg doses of Diazepam ... conflict[ing] with the dosage of oxycodone (10mg) prescribed by [the Respondent]."

b. Additionally, the Respondent stated that Patient B "began having difficulty breathing then passed out and turned blue" before the procedure had been completed.

15. The Respondent's inability to understand "the deficiencies in her treatment of Patients A and B," coupled with the Respondent's disciplinary history, including submitting forged documentation, practicing with a suspended license, concealing her unlicensed practice, lying to Virginia Board investigators and facilitating Individual 1 in the unlicensed practice, the Virginia Board determined that the Respondent "is unable to practice medicine with safety to patients and the public due to professional incompetence."

16. By Order dated March 19, 2026, the Virginia Board disciplined the Respondent by revoking her license to practice medicine in the state of Virginia. A copy of the Virginia Board Order is attached hereto.

## CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that the Respondent is subject to discipline under Health Occ. § 14-404(a)(21) for the disciplinary action taken by the Virginia Board against the Respondent for an act or acts that would be grounds for disciplinary action under Health Occ. §14-404(a)(3)(ii), (4i), (18) and (43) in violation of Virginia Code § 54.1-2915(A)(1), (3), (4), (10), (11), (13), (16), and (18), § 54.1-111(A)(1) and (8), § 54.1-2902, § 54.1-2903(A), and 18VAC85-20-29 (A)(1).

## ORDER

It is, thus, by Panel B, hereby:

**ORDERED** that the Respondent's license to practice medicine in the State of Maryland be and is hereby **REVOKED**; and it is further

**ORDERED** that this Consent Order is a public document. *See* Health Occ. §§1-607, 14-411.1(b)(2) and Gen. Prov. §4-333(b)(6).

07/22/2026
Date

***Signature on File***

Christine A. Farrelly
Executive Director
Maryland Board of Physicians

## CONSENT

I, _____, acknowledge that I have consulted with legal counsel before signing this document.

[OR]

I, Leila Kump, acknowledge that I am aware of my right to consult with and be represented by counsel in considering this Consent Order. I have chosen to proceed without counsel and I acknowledge that the decision to proceed without counsel is freely and voluntarily made.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

***Signature on File***

7-17-2026
Date

Leila Kump, M.D.
Respondent

**NOTARY**

STATE OF Virginia

CITY/COUNTY OF Grant Fairfax

I HEREBY CERTIFY that on this 17th day of July, 2026, before me, a Notary Public of the State and City/County aforesaid, personally Leila Kump, M.D., and made oath in due form of law that the foregoing Consent Order was his/her voluntary act and deed.

AS WITNESS my hand and notarial seal.

Diamond McFadden

Notary Public

My Commission expires: 04/30/2030

DIAMOND MCFADDEN
NOTARY PUBLIC
REG. #00403231
MY COMMISSION EXPIRES
04/30/2030
COMMONWEALTH OF VIRGINIA

**Virginia Order, dated March 9, 2026**

**BEFORE THE VIRGINIA BOARD OF MEDICINE**

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

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**ORDER**

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## JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11), a panel of the Virginia Board of Medicine ("Board") held a formal administrative hearing on February 19, 2026, in Henrico County, Virginia, to inquire into evidence that Leila Kump, M.D., violated certain laws and/or regulations governing the practice of medicine in the Commonwealth of Virginia.

Leila Kump, M.D., appeared at this proceeding and was not represented by legal counsel.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

## FINDINGS OF FACT

1. Leila Kump, M.D., was issued License Number 0101-243155 to practice medicine on February 29, 2008, which was summarily suspended on September 24, 2025.

2. As part of a cosmetic procedure, Dr. Kump prescribed and administered an opioid with a benzodiazepine, in conjunction with a local anesthetic, which 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, Patient A was instructed to bring these medications to Dr. Kump's office on the day of the procedure.

b. 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").[3]

c. 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

[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."

[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.

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.

d. 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 . . . ."

e. 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."

f. 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."

3. Dr. Kump 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. 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. EMS records and other evidence show that Dr. Kump 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, Patient A's son ("Individual 1") 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]

4. Dr. Kump 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:

[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."

a. Dr. Kump reported to EMS that prior to the start of the procedure, Patient A was administered 30mg of oxycodone with acetaminophen and 15mg of diazepam, which is significantly higher than the dosages Dr. Kump included in her Adverse Outcome Report.

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 above.

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.

5. While administering anesthetic medication, Dr. Kump failed to properly monitor and assess Patient A's physical, functional, and physiological status while under sedation, thus increasing the likelihood of a catastrophic event such as death.

a. As described in Findings of Fact 2(a) and (c), 3(c), and 4(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 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."

[5] In an email dated April 22, 2025, Dr. Kump falsely represented to Individual 1 that "It looks like you do not understand that [Patient A] had a small procedure under local anesthesia."

b. In an email dated April 22, 2025, to Individual 1, 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."

6. As part of a cosmetic procedure, Dr. Kump prescribed and administered an opioid with a benzodiazepine, in conjunction with a local anesthetic, which 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 patient's 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 B[6], 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.

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

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. Moreover, Dr. Kump performed the procedure without the assistance of appropriately qualified personnel.

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.

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

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

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.

7. Dr. Kump 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 wqs (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. 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.

8. While administering anesthetic medication, Dr. Kump failed to properly monitor and assess Patient B's physical, functional, and physiological status while under sedation, thus increasing the likelihood of a catastrophic event such as death. As described in Finding of Fact 6(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 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.

9. Dr. Kump is unable to practice medicine with safety to patients and the public due to professional incompetence. Specifically:

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. Dr. Kump does not have a clear retrospective medical understanding of the deficiencies in her treatment of Patients A and B, including her own medical decision-making.

10. Dr. Kump 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.

11. On at least one occasion since September 24, 2025, the date Dr. Kump's license was summarily suspended by the Board, Dr. Kump willfully practiced medicine in the Commonwealth without holding a valid license.

12. The evidence showed that following the summary suspension of her license on September 24, 2025, Dr. Kump saw and treated and/or oversaw and supervised the treatment of several patients, in blatant disregard of the Board's order.

13. Dr. Kump introduced the expert opinions of Thomas Young, M.D. Dr. Young testified that he is not licensed in Virginia and not familiar with Virginia's laws, regulations, and standard of care regarding the safe prescribing of opioids. He has never prescribed diazepam or oxycodone and could not offer an opinion on whether the co-prescribing regimen that Dr. Kump followed for Patients A and B was within the standard of care.

14. Dr. Kump introduced the expert opinions of Michael Armstrong, M.D. Dr. Armstrong testified that Dr. Kump's practice of preemptively prescribing opioids and benzodiazepines in combination created avoidable risks, and that Dr. Kump failed to meet the requirements of 18 VAC 85-21-40 related to her prescribing practices. He provided an expert report and testified that Dr. Kump's actions violated the requirements of 18 VAC 85-20-320 through 18 VAC 85-20-340 for office-based sedation. He testified that he would never prescribe 30 mg oxycodone as a single dose for a patient, and that monitoring should be used with moderate sedation.

15. Dr. Kump's pattern of engaging in deceitful conduct directly related to the practice of medicine, her repeated practice of medicine with a suspended license, and failure to demonstrate an understanding of the dangerousness of her practices raise serious concerns about her competency and fitness to practice medicine.

## CONCLUSIONS OF LAW

1. Findings of Fact No. 2 and 6 constitute violations of Virginia Code § 54.1-2915(A)(3), (4), (13), (16) and (18).

2. Findings of Fact No. 3(a)-(e), and 7(a)-(d) and (f) constitute violations of Virginia Code § 54.1-2915(A)(1), (3), (4) and (13).

3. Finding of Fact No. 4 constitutes a violation of Virginia Code § 54.1-2915(A)(1), (3), (13) and (16).

4. Findings of Fact No. 5 and 8 constitute violations of Virginia Code § 54.1-2915(A)(3), (4), (13), (16) and (18).

5. Finding of Fact No. 9 constitutes a violation of Virginia Code § 54.1-2915(A)(4).

6. Finding of Fact No. 10 constitutes a violation of Virginia Code § 54.1-2915(A)(11), (13), (16), and (18), and 18 VAC 85-20-29(A)(1).

7. Finding of Fact No. 11 constitutes a violation of Virginia Code §§ 54.1-2915(A)(1), (3), (10), (13), (16), and (18), and 54.1-111(A)(1) and (8), and 54.1-2902, and 54.1-2903(A).

## ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS as follows:

1. The license of Leila Kump, M.D., to practice medicine is REVOKED.

2. Pursuant to Virginia Code § 54.1-2920, Dr. Kump shall forthwith give notice by certified mail to all current patients that her license has been revoked. Further, Dr. Kump shall cooperate with other practitioners to ensure continuation of treatment in conformity with the wishes of the patient. Dr. Kump shall also notify any hospitals or other facilities where she is currently granted privileges, and any

health insurance companies, health insurance administrators or health maintenance organizations currently reimbursing her for any of the healing arts.

3. Any violation of this Order or any statute or regulation governing the practice of medicine shall constitute grounds for further disciplinary action.

Pursuant to Virginia Code §§ 2.2-4023 and 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 and copying upon request.

FOR THE BOARD

***Signature on File***

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

ENTERED AND MAILED ON: 3/19/2026

**NOTICE OF RIGHT TO APPEAL**

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with William Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.