NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

April 9, 2021

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Guenzburger, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Anthony Scher, Esq.
Attorney at Law
800 Westchester Avenue, Suite N-641
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Isaac Steven Herschkopf, MD
201 East 37th Street, Suite L 1
New York, New York 10016-3159

RE: In the Matter of Isaac Steven Herschkopf, MD

Dear Parties:

Enclosed please find the Determination and Order (No. 21-075) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

STATE OF NEW YORK: DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER

OF

ISAAC STEVEN HERSCHKOPF, M.D.

DETERMINATION

AND

ORDER

BPMC-21-075

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("Department"). A Notice of Hearing ("NOH") and Statement of Charges, dated July 11, 2019, were served on Isaac Steven Herschkopf, M.D. ("Respondent"). A copy of the NOH and Amended SOC is attached to this Determination and Order as Appendix 1.[1] Hearings were held pursuant to N.Y. Public Health Law ("PHL") §230 and New York State Admin. Proc. Act §§301-307 and 401. The hearings were held in person at The Offices of the New York State Department of Health, at 90 Church Street, New York, New York, and via WebEx.[2] Michael Colon, Esq. - *Chair*, Linda Brady, M.D., and Airlie Cameron, M.D.[3] duly designated members of the State Board for Professional Medical Conduct ("Board"), served as the Hearing Committee ("Committee") in this matter. Kimberly A. O'Brien, Administrative Law Judge ("ALJ"), served as the Administrative Officer. The Department appeared by Daniel Guenzburger, Associate Counsel. The Respondent appeared by Anthony Scher, Esq. The Respondent denies all the factual allegations and specifications of charges [Ex. A]. Evidence

[1] The NOH & SOC, dated July 11, 2019; and amended Statement of Charges, dated September 20, 2019, were admitted into the record without objection at the Prehearing Conference (PHC) held on September 23, 2019 [Ex. 1, Ex. 1A; PHC Tr. 5, 9].

[2] Scheduled in person hearings, March 18, 2020 & March 25, 2020, were cancelled due to COVID-19. Initially, Respondent opposed moving forward via WebEx, preferring to wait until in person hearings resumed. The ALJ advised the parties that for the foreseeable future there would be no in person hearings and the parties agreed to proceed with the hearing via WebEx.

[3] The original hearing committee included Dr. Frank Iaquinta. Pursuant to PHL § 230, he was replaced on the hearing committee by Dr. Airlie Cameron, when due to illness Dr. Iaquinta became incapable of serving on the

was received, including witnesses who were sworn or affirmed, and a transcript of this proceeding was made. After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing Statement of Charges	July 17, 2019, amended September 20, 2019
Pre-Hearing Conference:	September 23, 2019
Hearing Dates:	September 24, 2019 November 7, 2019 November 20, 2019 December 3, 2019 December 17, 2019 January 7, 2020 January 21, 2020 January 27, 2020 February 26, 2020 March 11, 2020 July 22, 2020 * July 29, 2020* September 16, 2020* September 29, 2020* October 14, 2020*. **Via WebEx*
Submission of Briefs	January 4, 2021[4]
Deliberations Dates:	January 27, 2021 & February 3, 2021

Committee [ALJ Ex. 3; Tr. 766]

[4] The Department's January 4, 2021 submission included a separate five-page memorandum on the definition of "undue influence" (memorandum). The Respondent was given the opportunity to submit his own memorandum and did so.

STATEMENT OF THE CASE

The Department charged the Respondent with sixteen specifications of professional misconduct relating to the care and treatment he provided to three patients.[5] Pursuant to N.Y. Educ. Law §6530, Respondent was charged with fraudulent practice §6530(2), negligence on more than one occasion §6530(3), gross negligence §6530(4), incompetence on more than one occasion §6530(5), gross incompetence §6530(6), exercising undue influence §6530(17), moral unfitness §6530(20), and failure to maintain patient a record §6530(32). The Respondent denied each of the factual allegations and specifications of charges of professional misconduct [Ex. A].

As required by PHL §230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that based on the preponderance of the evidence the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (*See* Prince, Richardson on Evidence § 3-206 [Farrell 11th ed]).

FINDINGS OF FACT

The following Findings of Fact (FOF) were made after a review of the entire record in this matter. Citations in brackets, which refer to transcript page numbers (Tr.) and exhibits (Ex.) that were accepted into evidence, and represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and

[5] The Amended Statement of Charges reads "First and Second Specification of Charges, Negligence on More Than One Occasion" and goes on to cite factual allegations relating to all three patients, A, B & C. There is no reference to a "Third Specification." The next three specifications " Fourth Through Sixth" involve "Gross Negligence" citing factual allegations relating to all three patients, A, B & C.

rejected in favor of the cited evidence. All Hearing Committee findings are unanimous unless otherwise stated.

1. Respondent was authorized to practice medicine in New York State on or about February 3, 1978, by the issuance of license number 133525, by the New York State Education Department. Respondent graduated from New York University Medical School (NYU) in 1975. Respondent does not hold board certification in Psychiatry or any other medical specialty. [Ex. 2, Ex. A-1; Tr. 921-926, 938].

2. The charges against Respondent pertain to the outpatient psychotherapy treatment he provided to three patients, Patient A, Patient B and Patient C (three patients), through his private practice located in midtown Manhattan, New York (office). [Ex. 1 A].

3. The American Medical Association (AMA) issued Principles of Medical Ethics Annotations "*especially applicable to psychiatry*," and they "*represent the standards of conduct which define the essentials of honorable behavior for the physician.*"

SECTION 1

1. *The patient may place his/her trust in his/her psychiatrist knowing the psychiatrist's ethics and professional responsibilities preclude him/her gratifying his/her own needs by exploiting the patient. This becomes particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.*

SECTION 2

A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

1. *The requirement that the physician conduct himself with propriety in his/her profession and in all actions of his/her life is especially important in the case of the psychiatrist because the patient tends to model his/her behavior after that of his/her therapist by identification. Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control. Sexual activity with a patient is unethical.*

2. *The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to treatment goals.* [Ex. 32 at p.1&2 -"1981 EDITION Revised"].

Patient A

4. On or about June 26, 1981, Patient A began psychotherapy with Respondent. Patient A was referred to Respondent by his Rabbi. Patient A had multiple sessions per week and paid Respondent approximately $100,000 a year until he terminated therapy with Respondent in October 2010. Respondent failed to maintain a record that accurately reflects his evaluation and treatment for Patient A. [Tr. 28-43, 49-50, 293-295, 342-346, 670-672, 714-715, 719-721; Ex 3, Ex. 4, Ex. 38, Ex. 40, Ex. B].

5. In or about May of 1982, Respondent accompanied Patient A to a business meeting. [Tr. 683-684; 1149-51; Ex B at p.110-111].

6. In or about June 1983, at Respondent's direction, Patient A disinherited his sister and her children in writing. On or about November of 1984, Patient A agreed to a rabbinical arbitration regarding his and his sister's family inheritance including diamonds, gold, artwork, bonds, business interests, real estate, and the contents of a Swiss bank account. Respondent helped Patient A prepare for and attended the arbitration, and he was aware of the outcome. [Tr. 270-272, 296-297, 341-344, 678-683; Ex. 44, Ex. C, Ex. D, Ex. E].

7. In or about February 1984, at Respondent's direction, Patient A created a private charitable foundation (Foundation) that was named after a summer camp Respondent had worked at; Respondent, Respondent's Wife, and Patient A were the only board members of the Foundation; Patient A was the largest contributor to the Foundation; Respondent kept the Foundation checkbook and directed most of the donations; Respondent directed large

donations to organizations he was affiliated with including NYU and a private school his children attended and where he was a board member/trustee; and three Foundation checks, in the amount of $2,000.00 each ($6,000.00 total) were issued to Respondent "Isaac Stevens." [Tr. 52-60, 260-263, 325-326, 342-343, 684-688; Ex. 6-10, Ex. G; *See* FOF 12].

8. In or about 1985, at Respondent's direction, Patient A executed a will in which his entire multi-million-dollar estate was left to the Foundation. Respondent recommended the attorney who drafted the will, and Respondent was named executor and Respondent's wife was named successor co-executor of the will. [Ex. B; Tr. 288-292, 683-686].

9. In or about March 1985, Patient A made Respondent a joint owner of a Swiss bank account valued at approximately $900,000.00. [Tr. 255-259, 335, 689-692; Ex. 16, Ex. 17, Ex. 18].

10. In or about June 1984 through August of 2010, Respondent used Patient A's Southampton New York Estate (Patient A's Estate or Estate) for family vacations and family celebrations, and he "hosted" three summer parties each year (summer parties) without compensating Patient A. Respondent represented that the Estate was his and he took over the main house and decorated the walls with his personal memorabilia and photos of himself and his family. Respondent maintained a master guest list with hundreds of names and addresses of his friends, acquaintances, and patients. Respondent gave detailed instructions to Patient A about how he should prepare for each of the summer parties including the wording of the invitations from Respondent, food, décor, activities, and transportation. Respondent invited Patient B, Patient C, and other patients of his to the summer parties held at Patient A's Estate. Patient A, Patient B, and Patient C knew that they were all Respondent's patients, and they were also each aware that other party guests were

Respondent's patients. During this same period, at Respondent's direction and without compensation, Patient A performed hundreds of hours of secretarial services for Respondent including typing book manuscripts. [Tr. 346-347, 376-377, 702-711,731-733, 2048-2054, 2080-2087; Ex. 20, Ex. 21, Ex. 22, Ex. 23, Ex. 24, Ex. 25, Ex. 26, Ex. 27, Ex. 28, Ex. 34, Ex. 35, Ex. 35A, Ex. 36, Ex. 40, Ex. 45, Ex. B, Ex. II, Ex. QQ].

11. In or about August 1991, at Respondent's direction, Patient A executed a will in which he left his Estate to Respondent's wife and appointed Respondent as his power of attorney. [Tr. 72, 288-292, 326-347, 353-355, 694 -711; Ex. 11, Ex. 12, Ex. 13, Ex. H, Ex. M, Ex. CC].

12. In or about 1986, Respondent created a pseudonym "Isaac Stevens." Respondent with intent to deceive used the pseudonym to conceal that he was Patient A's psychiatrist, and to represent that he was a business representative/officer in Patient A's company. [Tr. 344-352, 357-359, 705-711; Ex. 19, Ex. 25, Ex. 34, Ex. 35, Ex. 46, Ex. 47, Ex. N, Ex. O, Ex. P].

Patient B

13. From in or about 1985 through 2003 Respondent treated Patient B. Respondent failed to maintain a record that accurately reflects his evaluation and treatment of Patient B. [Ex. 29; Tr. 713-729].

14. Respondent had extensive social involvement with Patient B including that at Respondent's invitation Patient B attended numerous summer parties at Patient A's Southampton Estate. A photograph taken at one of the summer parties depicts Respondent, Patient B, Patient C, and another patient all dressed in swimsuits and in close physical contact. [Tr. 731-736; Ex. 27, Ex. 28, Ex. 29].

15. Respondent had extensive business involvement with Patient B, and in or about 1987 Respondent allowed Patient B and her husband to deposit large sums of money into the Foundation account. [Ex. 29; Tr. 717-729, 737-740].

16. In or about August of 1997, Patient B told Respondent that she had named Respondent's children as the sole beneficiaries in her will, and Respondent did not object. [Ex. 29; Tr. 733-737].

Patient C

17. Respondent treated Patient C from in or about 1989 through February 1, 2004. Patient C's then boyfriend referred her to Respondent, and for approximately two years both Patient C and her boyfriend were each in treatment with Respondent, and Respondent did not object. Respondent failed to maintain a record that accurately reflects his evaluation and treatment of Patient C. [Ex. 30; Tr. 386-388, 429, 719-721, 742-743].

18. Respondent inappropriately involved himself in Patient C's wedding including hosting an ersatz bachelor party for the groom and directing Patient C not to invite or to disinvite her close friend to her wedding. In advance of her wedding, Patient C requested that Respondent make a special toast at her wedding reception and Respondent without any discussion agreed. [Ex. 30; Tr. 389-394, 437-440, 743-746].

19. Patient C testified that in or about March of 1997, toward the conclusion of a session held at Respondent's office, she asked Respondent if she could name him as in her will, and she recalled that Respondent smiled and said "You wouldn't be the first person asking me do that. I would be fine with it," and he was named an executor. [Tr. 397, 465-466, 746-747; Ex. 31].

20. Throughout the treatment period Respondent had extensive social involvement with Patient C including inviting her as his guest to summer parties at Patient A's Estate; life cycle celebrations including his 40th birthday party and his children's Bat Mitzvas; and charitable events/galas. Many of Respondent's sessions with Patient C were "running sessions." Respondent provided Patient C with a "discount" for these running sessions because she was an experienced runner and was helping him train for a marathon. Respondent did not make progress notes for these sessions. [Ex. 30, Ex. 36, Ex. I 1-18; Tr. 388-389, 435-449, 742-743, 747-757, 1861-1868].

21. Photographs taken at the summer parties depict Respondent and Patient C both dressed in swimsuits and in close physical contact. [Ex. 28, Ex. 36; Tr. 405-406; 729-733, 750-751].

22. In a letter dated February 1, 2004, Respondent without notice or discussion unilaterally terminated the psychiatrist/patient relationship with Patient C. [Ex. 30; Tr. 408-415-428, 486-490, 752-760].

DISCUSSION

The charges in this matter are based on the medical care and treatment the Respondent provided to three patients, Patient A, Patient B, and Patient C, in his private psychotherapy practice. The Department presented three witnesses: Patient A, Patient C, and an expert witness, Stephen Price, M.D. Respondent testified on his own behalf, and he presented expert witness Robert Cancro, M.D., and character witnesses Richard Joel, Esq. and Ira Kassen, MD. [6]

[6] While the Hearing Committee considered the character testimony and character letters offered into evidence, it was given limited weight as it was not central to the charges involving Respondent's care and treatment of the three patients.

Testimony of Patient A & Patient C

The Hearing Committee found both Patient A and Patient C to be very credible, and that they were both quite courageous to appear and testify before the Respondent and the Hearing Committee. Their testimony is credited in the Findings of Fact.

Testimony of the Experts

The Hearing Committee found that the two expert witnesses, Dr. Price and Dr. Cancro, were qualified by training and experience to provide opinions about whether Respondent met minimum acceptable standards of care expected of a psychiatrist working in a similar setting and with a similar patient population, during the period the care and treatment was provided [Ex. 32, Ex. 33, Ex. Y]. However, the Hearing Committee found Dr. Cancro' s testimony was limited by the fact that Respondent provided him with only Respondent's medical record for Patient A, and his specific testimony about Patient A reflected a lack of familiarity with the medical record. The Department provided Dr. Price with the patient records for all three patients and the transcripts of Patient A and Patient C's hearing testimony; Patient B did not testify. Dr. Price's opinion was based on the care and treatment Respondent provided to all three patients. Accordingly, the Hearing Committee gave Dr. Price's opinion significant weight in reaching their determination.

Dr. Price testified that in 1973 the AMA clearly articulated specific ethical standards for psychiatrists, and the standard of care was established long before this time as it is the training of the psychiatrist "about how to conduct psychotherapy" there is no alternative model [Tr. 645-646, 757-759, 797-798]. In 1981 when Respondent first began treating Patient A these ethical standards were reiterated by the AMA and continue to be the standard of care [Tr. 791-792]. Dr. Price identified Respondent's repeated deviations from acceptable standards of care in his

treatment of all three patients, and he also identified a pervasive pattern of professional misconduct. Respondent exploited "the unique position of power afforded him by the therapeutic situation" and he had inappropriate financial, social, and business involvement with these three patients where he benefitted financially, socially, and professionally.[7]

Testimony of Respondent

The Hearing Committee found that Respondent's myriad of often self-contradictory defenses belied his misconduct. Respondent contended that up until in or about 1991 there were no established ethical standards especially applicable to psychiatrists, but for prohibiting a psychiatrist from having a sexual relationship with a patient [Tr. 1866]. Respondent claimed that until the 1990's there were no prohibitions against a psychiatrist having social and business relationships with patients and his practice was guided by the "concept of beneficence, doing what the patient wants, what's in the patient's best interest..." [Tr. 1862]. In a 2006 lecture to medical students Respondent professed "*No one can lecture on medical ethics because when it comes to ethics, no one really knows*" [Ex. 41, Tr. 921–934].

Respondent conceded that each of these three patients named him and or his family members as executors and or beneficiaries in their will, and that Patient A made him joint owner of his Swiss bank account. He alleged that a colleague, Dr. Stern, advised him that it would only be a problem if he accepted money and or gifts from the patients, which he did not. Respondent professed that he did not object to the designations because among other things it is what each patient wanted, and in the case of Patient A and Patient B they had no one else. Respondent claimed that in 1991 Patient A insisted on bequeathing his Southampton Estate to his wife, and at that point Respondent and Patient A had long been friends and business associates; and Patient

[7] Dr. Price's testimony, transcript pages 633 – 904, is specifically referenced and credited in the Findings of Fact.

B's bequest to Respondent's children was mainly made to show her new husband that her son from another marriage was no longer in her life and to show her gratitude to him, and that at the time of the bequest her estate was worth very little. In the case of Patient C, Respondent said that he agreed to be named an executor because he was older than Patient C and that it was also very unlikely the patient and other named executors would predecease him.

Patient A and Patient B had their own multi-million-dollar businesses when they came to Respondent for psychotherapy, and from the outset of therapy they discussed in intimate detail their business, family, romantic and sexual relationships. Respondent professed that his psychiatrist/patient relationship with Patient A and Patient B terminated, and that he began serving each of them as a business consultant [Tr. 1117-1121]. Yet Respondent's own CV, requested by the Committee in-the-midst of his testimony, is devoid of any evidence that Respondent has any business education, training, or expertise [Ex. A-1]. Further, the progress notes reflect that both these patients were going through significant life changes and emotional turmoil at the time(s) Respondent alleged the psychiatrist/patient was coming to an end. Finally, Respondent offered no plausible explanation for why if the psychiatrist/patient relationship had ended that he did not write a termination note in the medical record and or write a termination letter.

Respondent testified at length about his progress notes and billing notes that he recorded in each of the three patient medical records.[8] He purported that where Patient A and Patient B's medical records show only billing dates that denotes the psychiatrist/patient relationship had terminated. However, Respondent conceded that he wrote progress notes in Patient A's medical

[8] While the Department charged Respondent with failing to maintain a record that accurately reflects the evaluation and treatment for Patient B, the Committee noted that Respondent failed to maintain a medical record that accurately reflects the evaluation and treatment for all three patients.

record when they were transitioning into a business relationship, explaining that most of the progress notes he took during this approximately two to three-year period were about Patient A's business. Regarding Patient B, Respondent testified that he stopped taking progress notes before the psychiatrist patient relationship had ended because a court had ordered him to turn over his progress notes, and that these notes were used against Patient B in a divorce/custody battle. He offered no explanation for why he could not keep any notes at all. Respondent also offered no explanation for why he kept his billing notes for his alleged "business consulting services" in his medical record for Patient A and Patient B. While Respondent conceded that Patient C was never a business client, he offered no plausible explanation for why at some point after each session he did not record a progress note in Patient C's medical record.

CONCLUSIONS

The Hearing Committee after due and careful consideration of the entire record determined that the Department has proven by a preponderance of the evidence that Respondent is guilty of professional misconduct having violated minimal acceptable standards of care in the psychotherapeutic relationship. The Hearing Committee sustained all the Department's factual allegations and sixteen charges of professional misconduct including negligence on more than one occasion, gross negligence, incompetence on more than one occasion, gross incompetence, exercising undue influence, fraudulent practice, moral unfitness, and failure to maintain records.[9]

First & Second Specifications

The Department alleged its first and second specifications of misconduct that Respondent practiced the profession of medicine with negligence on more than one occasion[10] as it relates to

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[9] *See above* Findings of Fact.

[10] The Department cites only two specifications of misconduct, and cites factual allegations involving all three patients. For Patient B the Department references the entire treatment period "B – *In or about 1985,...through 2003*" and specifically cites "B1 *Respondent violated acceptable ethical standards of*

Patient A, Patient B & Patient C [Ex. 1A]. Negligence is defined as "the failure to exercise the care that would be exercised by another physician" and a "deviation from acceptable medical standards in the treatment of a patient" [ALJ Ex. 2– *Definitions of Professional Misconduct Memorandum*]. The Committee found that Respondent repeatedly deviated from acceptable standards of care in the treatment of each of these three patients. Accordingly, the Committee sustained the first and second specification of misconduct.

Fourth Through Sixth Specifications

The Department alleged in its fourth, fifth and sixth specifications of misconduct that the Respondent practiced the profession of medicine with gross negligence, as it relates to Patient A, B[11] & C. Gross negligence is defined as "negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences to the patient" [ALJ Ex. 2]. The Committee found that Respondent's serious and pervasive deviations from acceptable standards of care in his treatment of each of these three patients constitutes gross negligence. Accordingly, the Committee sustained the fourth, fifth and sixth specification of misconduct.

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psychiatry by engaging in inappropriate business, financial and social arrangements with Patient B (a)*Extensive social involvement*"& B1(b)- *Inappropriate physical touching of a psychiatric patient* and/or B (2)-*failure to maintain a record that accurately reflects the evaluation and treatment of Patient B* " and omitted "B1(c) & B 1(d)." Despite these "omissions," which are likely typographical errors, the Committee concluded that the factual allegations as cited for Patient B constitute negligence on more than one occasion.

[11] The Department cites three specifications of misconduct as it relates to each of these three patients, and specific factual allegations involving each of the three patients. For Patient B the Department references the entire treatment period "B – *In or about 1985,...through 2003*" and specifically cites "B1 *Respondent violated acceptable ethical standards of psychiatry by engaging in inappropriate business, financial and social arrangements with Patient B* (a)*Extensive social involvement*"& B1(b)- *Inappropriate physical touching of a psychiatric patient* and/or B (2)-*failure to maintain a record that accurately reflects the evaluation and treatment of Patient B* " and omitted "B1(c) & B 1(d)." Despite these "omissions", regarding Patient B, which are likely typographical errors, the Committee concludes the factual allegations as cited for Patient B constitute gross negligence.

Seventh Through Ninth Specifications

The Department alleged in its seventh, eighth, and ninth specifications of misconduct that Respondent practiced the profession of medicine with incompetence on more than one occasion as it relates to Patient A, Patient B[12] & Patient C [Ex. 1A]. Incompetence is defined as "a lack of skill or knowledge necessary to practice medicine" [ALJ Ex. 2]. The Committee found that Respondent's treatment of each of these three patients shows that he lacks the requisite skill and knowledge to practice psychiatry. Accordingly, the Committee sustained the seventh, eighth and ninth specification of misconduct.

Tenth Through Twelfth Specifications

The Department alleged in its tenth, eleventh and twelfth specifications of misconduct that the Respondent practiced the profession of medicine with gross incompetence, as it relates to Patient A, Patient B[13] & Patient C [Ex. 1A]. Gross incompetence is defined as "a lack of requisite skill, knowledge, and training to practice, and that the incompetence can be characterized as significant or serious and has potentially grave consequences" [ALJ Ex. 2]. The

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[12] The Department cites three specifications of misconduct as it relates to each of the three patients, and factual allegations involving all three patients. For Patient B the Department references the entire treatment period "B – *In or about 1985,...through 2003*" and specifically cites "B1 *Respondent violated acceptable ethical standards of psychiatry by engaging in inappropriate business, financial and social arrangements with Patient B* (a) *Extensive social involvement*"& B1(b)- *Inappropriate physical touching of a psychiatric patient* and/or B (2)-*failure to maintain a record that accurately reflects the evaluation and treatment of Patient B* " and omitted "B1(c) & B 1(d)." Despite these omissions, which are likely typographical errors, the Committee concludes the factual allegations as cited for Patient B constitute incompetence on more than one occasion.

[13] The Department cites three specifications of misconduct as it relates to each of the three patients, and factual allegations involving all three patients. For Patient B the Department references the entire treatment period "B – *In or about 1985,...through 2003*" and specifically cites "B1 *Respondent violated acceptable ethical standards of psychiatry by engaging in inappropriate business, financial and social arrangements with Patient B* (a)*Extensive social involvement*"& B1(b)- *Inappropriate physical touching of a psychiatric patient* and/or B (2)-*failure to maintain a record that accurately reflects the evaluation and treatment of Patient B* " and omitted "B1(c) & B 1(d). Despite these omissions, which are likely typographical errors, the Committee concludes the factual allegations as cited for Patient B constitute gross incompetence.

Committee found that Respondent's serious and pervasive incompetence in the care and treatment of these three patients is significant and had potentially grave consequences. Accordingly, the Committee sustained the tenth through twelfth specifications of misconduct.

Thirteenth & Fourteenth Specifications

The Department alleged in its thirteenth and fourteenth specifications of misconduct that the Respondent practiced the profession of medicine with undue influence, as it relates to Patient A and Patient B.[14] Undue influence, is defined as "exercising undue influence on the patient in such manner as to exploit the patient for the financial gain of the licensee or of a third party" [Ex. 1 A]. The Committee found that Respondent deviated from acceptable standards of care by exercising undue influence on both Patient A and Patient B to exploit them for his own financial gain and or of a third party. Accordingly, the Committee sustained the thirteenth and fourteenth specification of misconduct.

Fifteenth Specification of Misconduct

The Department alleged in its fifteenth specification of misconduct that Respondent engaged in conduct in the practice of medicine that evidences fraudulent practice as it relates to Patient A [Ex. 1A]. Fraudulent practice is defined as 'an intentional misrepresentation or concealment of a known fact in the practice of medicine, which is made with the intent to deceive" [ALJ Ex. 2]. The Hearing Committee found that Respondent with intent to deceive created and used a pseudonym in public contexts to conceal his identity as Patient A's psychiatrist. Accordingly, the Committee sustained the fifteenth specification of misconduct.

[14] The Department and Respondent submitted post-hearing memorandums addressing the definition of undue influence. The Hearing Committee considered these memorandums when making its determination

Sixteenth Specification of Misconduct

The Department alleged in its seventeenth specification of misconduct that Respondent engaged in conduct in the practice of medicine that evidences moral unfitness as it relates to Patient A, Patient B and Patient C [Ex. 1A]. Moral unfitness in the practice of medicine includes exercising undue influence by exploiting the psychiatrist patient relationship for financial gain, and or fraudulent practice [*See* Ex. 32]. The Committee found that Respondent is guilty of serious acts of professional misconduct including undue influence and fraudulent practice. Accordingly, the Committee sustained the sixteenth specification of misconduct.

Seventeenth Specification of Misconduct

The Department alleged in its seventeenth specification of misconduct that Respondent failed to "maintain a record that accurately reflects the evaluation and treatment" for Patient B. Respondent repeatedly failed to make progress notes for each of the sessions he had with Patient B, and this constitutes misconduct. Accordingly, the Committee sustained the seventeenth specification of misconduct.

PENALTY

Respondent denied all the charges and throughout the proceeding he showed little insight or remorse, often portraying himself as a victim of his beneficence. The Department requested that Respondent's medical license be revoked and that in addition a ten-thousand-dollar penalty be imposed on Respondent. The Hearing Committee found that under the circumstances imposing a money penalty on Respondent would serve little or no purpose. After full consideration of the penalties available, the Committee has determined that to protect the people of the State of New York the Respondent's license to practice medicine shall be revoked.

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regarding undue influence.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. All the factual allegations, and the first, second and fourth through seventeenth specifications of professional misconduct set forth in the Statement of Charges are SUSTAINED;

2. The Respondent's medical license is REVOKED; and

3. This Determination and Order shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

DATED: Ossining, New York
April 5, 2021

[redacted]

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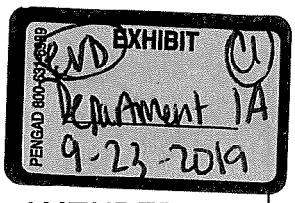
APPENDIX I



NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

ISAAC STEVEN HERSCHKOPF, M.D.

AMENDED

STATEMENT

OF

CHARGES

Isaac Steven Herschkopf, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 3, 1978, by the issuance of license number 133525 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. In or about and between June 26, 1981 and October 2010, the Respondent, a psychiatrist, treated Patient A with intensive psychotherapy for depression and anxiety.

1. Respondent exercised undue influence on Patient A in such a manner as to exploit the patient for his own personal financial gain, including but not limited to:

a. In or about February 1984, at Respondent's direction, Patient A created a private charitable foundation ("Foundation"). Respondent, Respondent's wife and Patient A were board members of the Foundation. Patient A was by far the largest contributor to the Foundation while Respondent directed almost all disbursements, including writing several checks that Respondent made out to himself personally.

b. In or about February 1984, at Respondent's direction, Patient A executed a will in which he left his entire estate to the Foundation. Patient A appointed

Respondent as executor and Respondent's wife as successor co-executor of the will.

c. In or about March 1985, at Respondent's direction, Patient A added Respondent as joint owner to Patient A's Swiss bank account. The bank account was then worth $920,000. As a joint owner, Respondent had legal authority to dispose of all funds in the joint bank account without seeking prior approval of Patient A.

d. On or about August 13, 1991, at Respondent's direction, Patient A executed a will in which he left his Southampton estate to Respondent's wife.

e. On or about August 13, 1991, at Respondent's direction, Patient A appointed Respondent as his power of attorney.

f. On or about and between June 1984 and August 2010, Respondent and his family used Patient A's Southampton estate for family vacations as well some Jewish holidays. Respondent would also host numerous parties, family celebrations and other social gatherings at Patient A's home. Respondent did not compensate Patient A for his extensive personal use of Patient A's home.

i. Further, at Respondent's direction and without compensation, Patient A spent hundreds of hours complying with Respondent's detailed instructions to set up his home for Respondent's many parties and social gatherings.

g. In or about and between 1984 and August 2010, at Respondent's direction, Patient A performed hundreds of hours of secretarial services without compensation, including but not limited to typing Respondent's book manuscripts, personal correspondence, professional correspondence, including confidential documents related to Respondent's psychiatric practice.

2. On multiple occasions, Respondent violated acceptable ethical standards of psychiatry by entering into inappropriate business, financial and social arrangements with Patient A.

3. Respondent concealed, with intent to deceive, that he was Patient A's psychiatrist by using a pseudonym, Mr. Isaac Stevens, in a variety of public contexts. For example, Respondent used the pseudonym to conceal his identity

when he represented that he was a business consultant and/or officer of Patient A's company.

B. In or about 1985, the Respondent commenced an intensive psychotherapeutic relationship with Patient B, a 28-year-old female at the onset of treatment. Patient B's active therapeutic relationship with Respondent extended through 2003.

1. Respondent violated acceptable ethical standards of psychiatry by engaging in inappropriate business, financial and social arrangements with Patient B, including but not limited to:
   a. Extensive social involvement.
   b. Inappropriate physical touching of a psychiatric patient.
   c. Permitting Patient B to deposit significant sums of money with the Foundation. As previously alleged in factual allegation A(1)(a), the Respondent was a board member of the Foundation and had the authority to make disbursements.
   d. Failing to attempt to persuade Patient B to revise her will upon being informed that the Patient had designated Respondent's children as the sole beneficiaries in her will.
2. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient B.

C. In or about 1989 the Respondent commenced a psychotherapeutic relationship with Patient C, a twenty-seven-year-old female at the onset of treatment. Respondent unilaterally terminated the relationship on February 1, 2004.

1. Respondent violated acceptable ethical standards of psychiatry by inappropriate social involvement, including but not limited to:
   a. Inviting Patient C to multiple parties hosted by Respondent at the estate of Patient A;
   b. Inviting Patient C to attend Respondent's family's " lifecycle events" such as Bat Mitzvas.
   c. Inviting Patient C to attend charitable events as Respondent's personal guest.

d. Inappropriate involvement in Patient C's wedding.

2. In Patient C's will dated August 14, 1997, Patient C designated Respondent as both contingent successor executor and contingent successor trustee. Upon being informed by Patient C of such designations, Respondent violated acceptable ethical standards of psychiatry by failing to attempt to persuade Patient C to revise her will
3. Respondent violated acceptable ethical standards of psychiatry by inappropriate physical touching.
4. In a letter dated February 1, 2004, written in response to correspondence from Patient C, Respondent deviated from accepted psychiatric standards by accusing Patient C of being deceitful, rejecting as insincere Patient C's apology for events that arose out of their social relationship, and accusing Patient C of multiple past "indiscretions". Respondent unilaterally terminated the psychotherapeutic relationship without discussing with Patient C any of the issues raised in his letter.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. Paragraphs A, A1, A1(a), A1(b), A1(c), A1(d) A1(e), A1(f), A1(g), and/or A2. .

2. Paragraphs B, Bi , B1(a) B1(b) and/or B2.

3. Paragraphs C, C1, C1(a). C1(b), C1(c), C1(d), C(2), C(3), C(4).

FOURTH THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

4. Paragraphs A, A1, A1(a), A1(b), A1(c), A1(d) A1(e), A1(f), A1(g), A2 and/or A3.

5. Paragraphs B, Bi , B1(a) B1(b) and/or B2.

6. Paragraphs C, C1, C1(a), C1(b), C1(c), C1(d), C(2), C(3), C(4).

SEVENTH THROUGH NINTH SPECIFICATIONS

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

7. Paragraphs A, A1, A1(a), A1(b), A1(c), A1(d) A1(e), A1(f), A1(g), and/or A2.

8. Paragraphs B, B1, B1(a) B1(b) and/or B2.

9. Paragraphs C, C1, C1(a). C1(b), C1(c), C1(d), C(2), C(3), C(4).

TENTH THROUGH TWELVETH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

10. Paragraphs A, A1, A1(a), A1(b), A1(c), A1(d) A1(e), A1(f), A1(g), and/or A2.
11. Paragraphs B, Bi , B1(a) B1(b) and/or B2.
12. Paragraphs C, C1, C1(a). C1(b), C1(c), C1(d), C(2), C(3) and/or C(4).

THIRTEENTH AND FOURTEENTH SPECIFICATIONS

EXERCISING UNDUE INFLUENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(17) by exercising undue influence on the patient in such manner as to exploit the patient for the financial gain of the licensee or of a third party, as alleged in the facts of:

13. Paragraphs A, A1, A1(a), A1(b), A1(c), A1(d) A1(e), A1(f), A1(g), A2 and/or A3. .

14. Paragraphs B, B1, B1(a), B1(b) and/or B2

FIFTEENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

15. Paragraphs A and A3.

SIXTEENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

16. Paragraphs A, A1, A1(a), A1(b), A1(c), A1(d) A1(e), A1(f), A1(g), A2, B, B1, B1(a), B1(b), B1(c), B1(d), C, C1, C1(a). C1(b), C1(c), C1(d), C(2), C(3) and/or C(4).

SEVENTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

17. Paragraphs B and B2.

DATE: September 20, 2019
New York, New York

[redacted]

HENRY WEINTRAUB
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Bureau of Professional Medical Conduct